

**IN PURSUIT OF THE IDEAL MASCULINE BODY:
A PHENOMENOLOGICAL-HERMENEUTIC APPROACH**

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Abstract

A phenomenological-hermeneutic approach was used to research men's experience with attempting to achieve an 'ideal' masculine body. The current North American 'ideal' male body, media and cultural influences, a continuum of exercise and dieting behaviors, steroid use, addictions, eating disorders, and personality traits associated with bodybuilders and individuals with eating disorders were presented as factors that may provide insight into this phenomenon. Eight male research participants were interviewed in regards to their experiences with attempting to achieve an 'ideal' masculine body. A dramaturgical life story approach to interviewing was used. A follow-up interview was conducted to allow each research participant to comment on the emerging themes shared by the researcher. The nine themes that emerged from the participants' stories are: (1) I am not good enough, (2) judging genetics, (3) spiraling into obsession, (4) extreme commitment, (5) join the club, (6) no one understands me, (7) control, (8) it's all an optical illusion, and (9) overcoming the obsession. The results of this thesis combined with the literature suggest the following three conclusions. First, men who attempt to achieve an ideal masculine body may be vulnerable to external messages about their bodies. Second, pre-existing personality traits and/or mental health issues may contribute to this vulnerability. Third, some men may attempt to deal with complex mental health issues by taking their 'frustrations' and 'aggression' out in the gym, rather than by seeking counselling. The implications for helping professionals are discussed. The limitations of this approach are acknowledged and directions for future research are suggested.

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Chapter 1: Introduction

There has been a tremendous amount of research on women's attempts to achieve an ideal body. Research has shown that many women use diet and exercise to maintain and enhance their physical health and overall well-being, while some women may engage in extreme behaviours that lead to eating disorders such as anorexia nervosa (self-induced starvation) and bulimia nervosa (a cycle of bingeing and purging). Research is beginning to reveal that many men may experience similar issues (Andersen, 1999; Marzano-Parisoli, 2001; Monaghan, 2001; Phillips & Castle, 2001; Pope, Phillips, & Olivardia, 2000).

While women of various ages may engage in diet and exercise behaviours in an attempt to get 'smaller,' men of various ages may engage in similar behaviours in an attempt to get 'bigger.' Specifically, men may use heavy weight lifting (i.e., bodybuilding or powerlifting), dieting, 'natural' supplements, and possibly steroids in order to achieve greater muscle mass and lower body fat (Klein, 1993; Monaghan, 2001; Pope et al., 2000). There are a number of reasons why some men may desire to change their body through these means. Some individuals may wish to obtain the level of muscularity seen in sports, entertainment, and popular magazines (Pope et al., 2000). Other individuals may strive to excel at a specific sport or may have reached a plateau in their training (Pope et al., 2000). As well, manipulating one's perceived less-than-ideal body into the supposedly desired ideal may be viewed as a means to obtain power, success, money, and love (Marzano-Parisoli, 2001, Weigers, 1998).

As is often seen in women with eating disorders, men's exercise behaviours also may spiral out of control into obsessive-compulsive, driven, and addictive behaviours

(Davis, 1993; Davis et al., 1997b). Some men may believe that ‘more is better’, and thus may engage in exercise behaviours that become diagnosable disorders such as anorexia nervosa, bulimia nervosa, and/or muscle dysmorphia (a preoccupation with the size of one’s muscles). Men who engage in these behaviours also may become addicted to steroids in the pursuit of hyper-masculinity. Even though serious adverse effects of steroid use are well known (e.g., damage to the liver and cardiovascular, central nervous, musculoskeletal, endocrine, and reproductive systems), steroid users may believe that the perceived benefits of their use far outweigh their consequences.

This thesis attempts to answer the question “what are men’s experiences with attempting to achieve an ideal body?” Interestingly, gym owners and managers did not believe that members of their gyms would respond to this research opportunity. First, they did not want to acknowledge that members of their gyms may be using steroids, and second, they did not believe that individuals who used would admit their use to a complete stranger. However, all the men who volunteered for this study willingly shared their personal experiences with attempting to achieve an ideal body through heavy weight lifting, dieting, and supplement/steroid use. In fact, most interviews lasted in excess of three hours. The men who participated in this study reported that it was a relief to share their story and stated that they were grateful for the opportunity to reflect on their personal experiences.

The Implicated Researcher

The researcher is fully implicated in phenomenological-hermeneutic research (Osborne, 1990). In order for the reader to understand the researcher’s interpretation of the data, it is important for the reader to understand her personal orientation to the

phenomenon. The researcher had a personal experience with obsessive-compulsive weight lifting, a distorted body image, and an eating disorder. This experience allowed her to become fully immersed in the phenomenon of heavy weight lifting and steroid use, as these men reportedly experienced similar issues. As the research evolved, she realized that many of the themes emerging from the research participants' experiences with attempting to achieve an ideal body were similar to her own experiences. However, in order to differentiate between the research participant's experiences and her own experiences, the researcher relied solely on interview transcripts and confirmed the emerging themes with the research participants to increase reliability and validity. The reader also may find some threads of similarity with his or her own life experiences.

The literature review (Chapter 2) examines the current North American 'ideal' body, media influence, and cultural construction of the body. Healthy versus unhealthy exercise, diet, and steroid use are presented. Definitions of substance abuse, eating disorders, and muscle dysmorphia follow. The chapter concludes with a discussion of affective disorders and personality traits/disorders that are often associated with bodybuilders and individuals with eating disorders.

The methodology section (Chapter 3) outlines the phenomenological-hermeneutical approach and its applicability to this research question. In-depth interviews were conducted with eight research participants and the interviews were analyzed for recurring themes. Consideration is paid to ethical and legal considerations associated with this study.

The results section (Chapter 4) presents a profile of each research participant followed by the themes that emerged from the interviews. Verbatim quotes, paraphrases, and non-personal identifiers (e.g., pseudonyms) are used with respect to confidentiality.

The discussion section (Chapter 5) evaluates the results that emerged from the themes, specifically internalizing negative messages; the relationship between weight lifting, steroid use, and eating disorders; and the relationship between weight lifting, steroid use, and mental health issues. Implications for counsellors are discussed, specifically prevention, initial intervention, and treatment. Directions for future research and limitations of the study are addressed. The implicated researcher is revisited.

Chapter 2: Literature Review

There are many mental, physical, and emotional motivations behind the phenomenon of attempting to achieve an ideal masculine body. The literature review examines the current North American 'ideal' masculine body, media influence, and cultural construction of the body. An exploration of the exercise continuum, dieting, and steroid use follows. Addictive aspects of exercise and steroid use, eating disorders, and a definition of muscle dysmorphia are addressed. Finally, affective disorders and personality traits associated with bodybuilders and individuals with eating disorders may provide further insights into the phenomenon of attempting to achieve an ideal masculine body.

The Current North American 'Ideal' Masculine Body

A nude male, complete with 'ripped' biceps and shoulders, a large chest, 'perfect' six-pack abdominal muscles, muscular thighs, and chiseled facial features dominates the cover of the May 2002 Gentlemen's Quarterly (GQ) magazine. This is an example of the current North American 'ideal' masculine body that men may be expected to achieve in order to be perceived as attractive, healthy, and successful (Monaghan, 1999). This 'healthy' body allegedly is easy to achieve with the right combination of diet and exercise as portrayed in 'health' or 'fitness' magazines. In reality, it may take a tremendous amount of hard work, rigid dieting, and the right combination of steroids in order to achieve (Marzano-Parisoli, 2001; Monaghan, 1999; Pope et al., 2000). Joe Decker, the "World's Fittest Man" in 2002, stated "I work out on what I call the Nausea Scale, with 1 being mildly upset and 10 being full-blown hurlin'. I try to keep it around 8 or 9. If I don't get a little throw-up in my mouth, then I'm not working out hard enough" (Ruben,

2002, p. 196). According to images portrayed in popular media, this may be what men are expected to do in order to reach the current North American ideal masculine body.

Media Influence

A muscular, lean and ‘ripped’ masculine body often appears in magazines, television programs and commercials, entertainment, and sports (Cusamano & Thompson, 1997; Davis et al., 1997b; Epling & Pierce, 1996a; Klein, 1993; Marzano-Parisoli, 2001; Weigers, 1998). A norm of physical perfection may have become so commonplace that it desensitizes individuals, causing them to internalize images which may negatively impact their body image and self-esteem (Cusamano & Thompson, 1997). These media-related images may foster discrepancies between ‘natural’ and ‘ideal’ images of the body (Cusamano & Thompson, 1997).

Television images may flash by the viewer’s eyes in seconds while magazine images capture an image of perfection in a single moment in time, are long-lasting, and may be referred to repeatedly. Often, books and magazines are used as primary sources for fitness and nutrition information (Kleiner et al., 1990). Fitness and bodybuilding magazines such as “Muscle and Fitness” and “Flex” may contribute to the current North American ideal body by mythologizing in their pages beliefs, attitudes, behaviors, and images of physical perfection and hyper-masculinity (Klein, 1993). These magazines also contain the “lure of celebrity” (Klein, 1993, p. 91) in that many professional bodybuilders and individuals whose bodies match the current masculine ideal are immortalized in print. In turn, these individuals may become role models for the people whose bodies may be perceived as less than ideal. Klein (1993) asserts that professional bodybuilders’

weight training programs, diets, and supplement regimes are printed so the general public may learn the ‘secrets of their success’ and follow suit.

Although bodybuilding magazines may appear to be health-related and provide fitness and health information to the general public, Klein (1993) asserts that their primary function is to attract a broader audience to increase the sale of merchandise and the spread of bodybuilding ideology. Klein (1993) further asserts that the covers of these magazines, which usually include a scantily-clad female draped over a muscular male, are meant to appeal to a man’s desire to be more attractive to women, and thus feel better about himself. The key to meeting these desires appears to be building a better body (Klein, 1993).

The ‘ideal’ North American lifestyle appears to be linked to physical attractiveness and identity. There may be little room left for the average man when the general public is constantly bombarded by ideal images in the media, sports, and entertainment (Marzano-Parisoli, 2001). In fact, “never before in history have images of people who meet the latest cultural ideals of beauty, health, and physical performance been so often presented to so many people” (Marzano-Parisoli, 2001, p. 217). Athletes may attempt to carve an individual niche for themselves by surpassing the limits of physical ability, possibly with the use of artificial means (e.g., steroids). With such idealistic role models, the average person may attempt to transcend his everyday existence by striving to achieve similar status and recognition through pushing the limits of his physical body through diet, exercise, and the use of chemical substances (Marzano-Parisoli, 2001). This emphasis on obtaining an ‘ideal’ body may be a cultural phenomenon.

Cultural Construction of the Body

There may be a cultural emphasis on one's ability and determination to manipulate one's body into the desired ideal in order to obtain success, power, money, and love (Marzano-Parisoli, 2001; Weigers, 1998). "The size and shape of the body operates as a marker of personal, internal order (or disorder) and as a symbol for the emotional, moral, or spiritual state of the individual" (Marzano-Parisoli, 2001, p. 221).

The natural body may be perceived as defective and an obstacle to one's freedom and self-realization, whereas a 'perfect' body may be perceived as the means to achieve one's desires (Marzano-Parisoli, 2001). Instead of being viewed as the physical manifestation of a person, the body may become an object to be manipulated for the attainment of goals and treated as a material possession for the pleasure, admiration, and exploitation of others (Marzano-Parisoli, 2001).

People whose bodies do not resemble the current cultural ideal, or whose bodies are defective in any way, may become "devalued people because of their devalued bodies" (Hannaford, 1985, as cited in Marzano-Parisoli, 2001, p. 220). A cultural objectification of people's bodies may result in unhealthy images (Wendell, 1996).

Wendell (1996) asserts the following:

Everyone is subjected to cultural pressure to deny bodily weaknesses, to dread old age, to feel ashamed of and responsible for their distance from the ideals, and to objectify their own bodies at the expense of subjective bodily awareness. These pressures foster a desire to gain/maintain control of our bodies; conversely, the myth that we can control our bodies encourages us to strive to meet bodily ideals.

(p. 91)

Individuals who are able to manipulate their body into the current cultural ideal may be awed and respected (Marzano-Parisoli, 2001; Weigers, 1998). As the body conforms to cultural beauty standards evident in the media, entertainment, and sports, its value may actually increase (Epling & Pierce, 1996b; Marzano-Parisoli, 2001). The physical construction of the body may be viewed as the means to obtain success, money, power, and love (Marzano-Parisoli, 2001). Constructing a superior body, or the hyper-masculine physique of a bodybuilder, through exercise may be viewed as the means to obtain an ideal masculine body.

The Exercise Continuum

Exercise behaviors may be viewed on a continuum that ranges from activities that are healthy, sociable, and enjoyable to behaviors that may be addictive and/or pathological (Russell & Ryder, 2001). Type and frequency of exercise do not necessarily indicate healthy or unhealthy levels of exercise, although exercise frequency may predict underlying motivations of an addictive nature (Davis, 2000).

Healthy exercise may be viewed as a way to maintain one's health and may be accompanied by positive and sustained feelings of achievement and satisfaction (de la Torre, 1995), increased self esteem, and a positive body image (Henry, 2000). Individuals interested in attaining and maintaining physical fitness and health, improving their strength and ability for a specific sport (e.g., track and field, hockey, etc.), or lifting weights to pass the time (e.g., prison inmates) may be considered to exercise in a healthy manner.

Unhealthy exercise may be viewed as a means to transform one's body into an 'ideal' and may be considered excessive, obsessive-compulsive, driven, out of control

(Davis et al., 1997b), or addictive (Davis, 2000; de la Torre, 1995). Individuals who participate in unhealthy exercise may continue to exercise when sick or injured, or may feel anxious if they miss an exercise session due to forces outside of their control (Davis et al., 1997b). Individuals who exercise excessively may place more importance on their appearance and focus more on their body than individuals who exercise primarily for health benefits and relaxation (Davis & Fox, 1993; Yesalis & Cowart, 1998). Obsessive-compulsive exercise may be viewed as obligatory and thus provides a sense of control and moral superiority (de la Torre, 1995). A rigid exercise schedule may interfere with one's social and/or occupational functioning (Davis et al., 1997b). Many Olympic athletes, marathon runners, triathletes, power lifters, and hard-core bodybuilders may be perceived as exercising in an unhealthy or obsessive manner (Monaghan, 1999).

Excessive exercise may become highly addictive (Davis, 2000; Davis et al., 1999; Schwerin & Corcoran, 1992; Taylor, 1991). The pleasure of living in a relatively healthy body may evolve into a desire to obtain an even more healthy body, which may then cause distress over not having a 'perfect' body. Excessive physical activity mimics addictive behaviours in that it "increase[s] circulating levels of endogenous opiates—specifically the beta-endorphins—that activate dopamine in the brain's ...reward centers" (Davis et al., 1999, p. 222). Individuals who exercise excessively may become "progressively fanatic" (Davis, 2000, p. 281) in nature, experience a craving for exercise, and require longer or more frequent workouts to produce the desired reinforcement effect. As with other addictions, individuals may continue to exercise even when pleasure is no longer gained or when it becomes painful and exhausting (Davis, 2000; Davis et al.,

1999). As one excessive exerciser described, living becomes “absolutely unbearable” (Davis, 2000, p. 284) after a few days without exercise.

Weight training is a specific type of exercise that may be viewed on this continuum.

Weight Training

Moderate weight training may be viewed as a healthy means to build and maintain bone mass, muscle strength, physical endurance, coordination, improve sports performance, rehabilitate injuries, as well as enhance overall health (American Academy of Pediatrics, Committee on Sports Medicine and Fitness, 2001; Bouchard, Shephard, & Stephens, 1994; Chilibeck, Sale, & Webber, 1995; Monaghan, 2001; Schlumberger, 2002; Tomporowski, 2001). Although the initial motivation for beginning a weight-training program may be to improve one’s health or train for a specific sport, there is a potential for one’s training to spiral out of control into a dangerous obsession (Klein, 1993). Individuals who participate in weight lifting may begin at the healthy end of the exercise spectrum and move towards the unhealthy end of the spectrum (Klein, 1993).

Bodybuilding

Bodybuilding, a multi-billion dollar industry worldwide (Prokop & Neveux, 1994), is a sport that was developed out of the desire to change one’s body (Klein, 1993). The ultimate goal of bodybuilding is to transform one’s body into a symmetrical shape with a high degree of muscle mass and vascular definition (Kleiner, Bazzarre, & Litchford, 1990). This goal of transforming one’s body into physical perfection may only be achieved through partaking in a “multitude of training, diet, and health practices that may place [individuals] at notable risk for immediate and future health problems”

(Kleiner et al., 1990, p. 966). Bodybuilding may seduce people into thinking they can feel better about themselves by transforming their bodies with a fixed amount of self-discipline, effort, and time. “The dead-end job, unfulfilled relationship, or generalized angst may continue, but you can feel better about yourself by controlling the last vestige of your ever-shrinking empire, your body” (Klein, 1993, p. 40).

Klein (1993) conducted an ethnographic study of bodybuilders and found that men may attempt to meet other developmental needs through bodybuilding. For example, Klein (1993) asserts that social bonding through sport may contribute to a sense of belonging and thus enable men to establish important relationships. As well, Klein (1993) suggests that men who seek admiration of their physical accomplishments may turn to the gym to have those needs met by others who may be seeking similar admiration. In this manner, a desire for camaraderie may be met through shared interest in sport, which may lead men to believe as if they are an important member of a group or tribe.

Keen (1991) theorized that mythologies such as tribal archetypes, which may be seen in harsh initiation rites for boys (e.g., hazings and insults), now may be played out through building a muscular and strong body; “From the beginnings of recorded human history to the present day the most important...instruction boys receive about manhood is: Masculinity requires a wounding of the body” (p. 31). This wounding inflicted by tribal elders as an initiation to manhood now may be played out in the gym through the use of personal trainers and/or training partners. Klein (1993) described the purpose of the training partnership as physically bringing out the best in each other, pushing “beyond self-imposed limits, beyond pain and exhaustion” (p. 67). In his study of bodybuilders,

Klein (1993) found that training partners ‘psych each other up’ using a variety of tactics that include encouragement, harassment, ridicule, and physical assistance or abuse.

Klein (1993) suggests that bodybuilders may attempt to compensate for such feelings of weakness, hurt, and vulnerability by developing an imposing physical image. “Striving to be like their perceptions of their fathers (i.e., strong) is simultaneously a way of getting closer to a rejecting parent and coming to grips with a failed primary relationship” (Klein, 1993, p. 117). Instead of confronting sources of conflict, Klein (1993) suggests that the troubled male may instead take out his frustrations on his body; he may seek to gain control over that which he has little control by attempting to build up his physical body to compensate for his perceived weaknesses.

Men who wish to gain control over their bodies and seek to attain an ideal masculine form may find that bodybuilding and weight training demands far more than lifting heavy weights to build muscle mass and strength. Men who are attempting to change their bodies also may believe they need to change their eating habits.

Dieting

Dieting may be viewed on a continuum that ranges from healthy behaviors (e.g., eating a variety of foods that meet the body’s daily nutritional requirements) to unhealthy behaviors (e.g., rigid dieting similar to that associated with eating disorders, to be described) (Russell & Ryder, 2002). Dietary manipulations are generally made in an attempt to reduce body fat in order to reveal “in sharp detail the size, shape, vasculature, and striations of skeletal muscle tissue, giving the desired ‘cut’ or ‘ripped’ appearance sought after by bodybuilders” (Hickson et al., 1990, p. 266). Magazines, books, peers,

and trainers are the most often used sources of nutrition information (Kleiner, Bazzarre, & Litchford, 1990).

Dietary practices for bodybuilders often include regimented food consumption ('force-feeding'), food restriction, and food supplementation. Research has shown that bodybuilders may consume up to three times the recommended dietary allowance (RDA) for protein (Kleiner et al. 1990), decrease carbohydrate consumption (Hickson et al., 1990), severely restrict fat consumption (Hickson et al., 1990; Kleiner et al., 1990), and may consume 70 percent or more of the RDA for most nutrients (Kleiner et al., 1990). In addition to high protein consumption, low carbohydrate consumption, and minimal fat consumption, Kleiner et al. (1990) found that 100 percent of male bodybuilders also use nutritional supplements (e.g., protein powder, creatine, meal replacements, herbal energy supplements, etc.). Bodybuilders also tend to dedicate a large amount of time to planning their meals and snacks, and often demonstrate a high level of "dietary rigidity and control" (Kleiner et al., 1990, p. 965).

Despite their commitment to training and dieting, some men still may not achieve the results they desire, and may believe they need to take the next step in reaching their goals of attaining physical perfection—using anabolic steroids.

Anabolic Steroids

The instrumental use of steroids and steroid accessory drugs (e.g., growth hormone, ephedrine, caffeine, diuretics, etc.) is widely accepted in the bodybuilding subculture (Evans; 1997; Monaghan, 1999), even though the use of steroids tends to be viewed negatively by non-users (Schwerin & Corcoran, 1992). Steroid use is rampant in top-level bodybuilding competitions (Klein, 1993), and even non-competitive individuals

may use steroids to “achieve the look of a bodybuilder” (Klein, 1993, p. 148). Individuals generally find all the information they want about steroids from other literature at the gyms they attend as well as other steroid users (Wright et al., 2001).

Many individuals begin using steroids because they have exhausted their physical capabilities and desire a competitive edge (Evans, 1997). Motivations to use steroids may include desire to gain muscle mass, compete as a professional bodybuilder, speed up muscularity, overcome training plateaus, out of curiosity, for vanity or cosmetic reasons, to improve training (Wright, Grogan & Hunter, 1991), and/or to increase exercise tolerance (Tamaki et al., 2001). Some men may spend thousands of dollars on a cycle of steroids, yet lie about their drug use to claim attaining their physical changes ‘naturally’ (Klein, 1993; Wright et al., 2001). There are physical benefits, physical side effects, psychological changes, and potential for addiction associated with steroid use.

Physical Benefits

The major physical benefits associated with steroid use are increase muscle size and strength (Haupt & Rovere, 1984). It is controversial whether or not steroids actually improve athletic performance (Haupt & Rovere, 1984), however, in regards to achieving an ideal body, increased muscle size and definition appear to be the most important motivations for using steroids. The use of steroids alone does not account for an increase in muscle size and strength; individuals must combine steroid use with strength training in order to achieve the desired effect (Haupt & Rovere, 1984).

Steroid use contributes to increased muscle size and strength in a number of ways. First, increased testosterone in the body facilitates muscle growth by increasing protein synthesis (American Academy of Pediatrics Committee on Sports Medicine and Fitness,

1997). Second, steroids provide a motivating effect (e.g., diminished fatigue) that allows athletes to train for longer periods of time and to recover more quickly (Haupt & Rovere, 1984). Third, individuals notice changes in their bodies and are thus motivated to continue using steroids (Taylor, 1991). In addition to benefits, there are numerous physical side effects associated with steroid use.

Physical Side Effects

Most steroid users are aware of the physical risks associated with steroid use. However, they tend to be mistrustful of medical warnings about steroid use, believing that there has not been enough research (Wright et al., 1991). Steroid users also tend to minimize negative side effects relative to perceived positive effects on their physique and self-image (Wright et al., 1991).

The medical and scientific communities have found that chronic steroid use may result in liver damage, changes in the reproductive symptom, musculoskeletal damage (e.g., muscle strains/ruptures), endocrine problems, integument (e.g., acne, male pattern baldness, edema, etc.), deepening of the voice, cardiovascular problems, urinary difficulties, and disorders of the immune system (American Academy of Pediatrics Committee on Sports Medicine and Fitness, 1997). There also may be psychological changes associated with steroid use.

Psychological Changes

Psychological changes often occur in individuals who use steroids (American Academy of Pediatrics Committee on Sports Medicine and Fitness, 1997; Bahrke & Wright, 1992; Kleiner et al., 1990; Pope & Katz, 1988). These symptoms may range from mild to extreme in different individuals. Most research assessing the affective changes

athletes encounter tends to be biased towards negative outcomes accompanying steroid use (Riem & Hursey, 1995, as cited in Monaghan, 2001).

Steroid users also may report significantly higher levels of anger, vigor, paranoia, and total mood disturbance when on a steroid use cycle (Burnett & Kleiman, 1994; Cooper et al., 1996; Humbert, 1990; Pope & Katz, 1994). Other symptoms may include increased aggression and hostility (Sharp & Collins, 1998), euphoria and grandiosity (e.g., a belief that nothing in the world could hurt them), and symptoms of hypomania or mania (Pope & Katz, 1988). Some individuals may report psychotic symptoms such as auditory hallucinations of voices, paranoid delusion, or paranoid jealousy (Pope & Katz, 1988).

Physical acts of violence associated with steroid use are known as 'roid rage'. According to bodybuilders in Monaghan's (2001) study, there is a clear distinction between aggression (elevated irritable mood) and actual physical acts of violence, the latter of which is not condoned by the bodybuilding community. Bodybuilders assert that individual personality traits are heightened by drug use, which then may lead to physical acts of violence (Monaghan, 2001). It is clear that a risk associated with steroid use is increased aggression which may then lead to physical violence if provoked. However, it is not clear whether 'roid rage is associated with type or dosage of steroid (Pope & Katz, 1988), affective changes and/or psychotic symptoms associated with steroid use (Monaghan, 2001, or psychological symptoms that already existed within the individual that were exacerbated by the use of steroids (Monaghan, 2001).

Almaas (2001) proposes a different theory that may enhance an understanding of the 'roid rage phenomenon. He suggests that individuals who experience severe and

opposing feelings of grandiosity and emptiness may be prone to intense anger and irrational rage (Almaas, 2001). This rage may be provoked by real or imagined insults, such as not being seen, understood, or appreciated in the way he desires to be (Almaas, 2001). In individuals who experience increased aggression combined with impulsivity, this may be experienced as 'roid rage.

Although there are many negative psychological effects associated with steroid use, there are also many perceived positive psychological effects. Many steroid users report positive psychological changes such as increased confidence, mental focus, peer recognition, social status, vocational performance, and sexual performance (Olrich & Ewing, 1999). Additional psychological changes may include motivating effects that induce a state of euphoria and diminish fatigue (Bahrke & Wright, 1992; Evans, 1997). Haupt and Rovere (1984) found that steroid users reported thinking about sex more often when they were on a cycle of steroids than when not on a cycle of steroids. (Schwerin & Corcoran, 1992) found that steroid users also may believe that they become more physically powerful and sexually aggressive while using steroids. These perceived positive effects along with massive potential for increased muscle size and strength may motivate individuals to use steroids despite their well documented risks. Positive physical and psychological changes associated with steroid use may contributed to steroid addiction.

Steroid Addiction

Steroid addiction is similar to, yet unique from, other addictive substances (Schwerin & Corcoran, 1992). In addition to physical addiction, steroids also may contribute to a strong psychological addiction. The psychological addiction may consist

of pride associated with gaining muscle and becoming stronger, as well as heightened brain impulses that contribute to a more 'macho' attitude (Taylor, 1991). Unfortunately, these steroid-induced personality changes may result in moodiness, grandiosity, mania, and/or hostility (Taylor, 1991). "No other drug addiction has been so tied up with both a direct psychological and physiological addiction pattern and such a powerful impact on body image...steroids may be more addicting than cocaine" (Taylor, 1991, p. 74).

Withdrawing from steroids may produce symptoms similar to that of withdrawal from other addictive substances. Symptoms of hyperactivity, anxiety, irritability, and insomnia as well as physical symptoms associated with withdrawal such as hot flushes, nausea, and vomiting have been associated with steroid withdrawal (American Academy of Pediatrics Committee on Sports Medicine and Fitness, 1997) as well as major depression (Pope & Katz, 1988).

The spiral from mild to extreme exercise and dieting behaviors, as well as the use of nutritional supplements and steroids, appears to mimic the continuum of behaviors associated with eating disorders.

Eating Disorders

Seemingly innocent attempts to become 'healthy' and 'fit' may spiral into a self-destructive cycle of obsessive-compulsive exercise, extreme dieting, steroid use, and self-loathing associated with dangerous disorders such as anorexia nervosa, bulimia nervosa, muscle dysmorphia, and other disordered eating/exercise behaviours (Marzano-Parisoli, 2001; Pope et al., 2000; Russell & Ryder, 2001). There is a high frequency of childhood trauma (e.g., physical abuse or sexual abuse) in men with eating disorders (Klein, 1993; Philpott & Sheppard, 1998).

Pope et al. (1993) identified a subgroup of body builders whose weight lifting and food preparation activities consumed such huge amounts of time that they interfered with normal daily functioning. These individuals were found to have a rate of body-image disturbance similar to that in individuals with eating disorders (Pope et al., 1993).

Research has shown that individuals who participate in weight lifting as an athletic event (e.g., bodybuilders) may be more prone to eating disorders than casual exercisers (Brooks et al., 2000; Burkes-Miller, 1998; David, 1992; Taub & Blinde, 1992).

Anorexia and Bulimia.

The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR) describes the criteria for anorexia as being a refusal to maintain weight above a minimally normal standard (85 percent of desired weight), intense fear of gaining weight, disturbance of body image, and abnormal reproductive hormone functioning (American Psychiatric Association, 2000). The two subtypes of anorexia are listed as restricting type (i.e., severe dieting) and binge-eating/purging type (i.e., dieting combined with binge eating and/or vomiting or excessive exercise), which also is associated with bulimia nervosa (American Psychiatric Association, 2000). The characteristics for bulimia include binge eating, which consists of ingesting a large amount of food (up to 20,000 calories, or the amount of food a normal adult would eat in 10 days, based on a 2000 calorie per day intake) in a discrete period of time; a sense of lack of control during the binge eating episode; and inappropriate compensatory behavior to prevent weight gain, such as fasting, excessive exercise, self-induced vomiting, misuse of laxatives, diuretics, enemas, or other medications (American Psychiatric Association, 2000).

There are many similarities between bodybuilding and eating disorders, specifically anorexia nervosa. Marzano-Parisoli (2001) asserts that anorexia nervosa and bodybuilding may lie along the same pathological continuum. In fact, bodybuilding may be considered “reverse anorexia” (Andersen, 1999, p. 73). Individuals with anorexia strive to *decrease* their size no matter how thin they are while bodybuilders strive to *increase* their size no matter how big they are; “the ideal to attain is the same: a flesh that does not wiggle” (Marzano-Parisoli, 2001, p. 219). It has been found that approximately 80 percent of individuals with anorexia nervosa and 50 percent of individuals with bulimia nervosa exercise excessively during their disorder (Davis, 2000; Davis et al., 1997b). In addition to strict exercise regimes, bodybuilders and power lifters may exhibit other behaviors similar to those of individuals with anorexia and bulimia, including rigid food restriction; binge-eating; self-induced vomiting; and/or abuse of laxatives, diuretics, herbal supplements, or other harmful substances (Anderson, 1999; Claude-Pierre, 1997; Davis, 2000; Pope et al., 2000).

Bodybuilders and individuals with anorexia tend to worship the ideal body while at the same time rejecting their natural body (Marzano-Parisoli, 2001). It is asserted that bodybuilders and individuals with anorexia may:

act upon their body in order to be accepted and use their bodies as a way of controlling their lives. The real goal of bodybuilders and anorexics is the control of their bodies and its sensations, as if the control of their bodies could induce the control of their lives and the admiration of all others. (Marzano-Parisoli, 2001, p. 225)

In both bodybuilding and anorexia, bodily sensations (e.g., hunger, exhaustion, pain) are denied and manipulated, and a war is waged on the body in reaction to dangerous external ideals (Marzano-Parisoli, 2001). Dehydration, overly restrictive diets, and excessive exercise may be debilitating for both bodybuilders and individuals with anorexia (Klein, 1993). Such individuals may adhere to such rigid dietary and exercise routines that their normal daily functioning is impaired (Pope et al., 1993). They may disguise how weak and poor they feel inside while others around them cheer them on for portraying an image of health.

Body image distortion, common in bodybuilding and eating disorders, may be further defined in a definition of muscle dysmorphia.

Muscle Dysmorphia

Muscle dysmorphia, which Pope et al. (2000) propose to be a sub-category of body dysmorphic disorder, is a relatively new phenomenon that may contribute to a rise in eating disorders among males. Muscle dysmorphia includes specific behaviours such as long hours of lifting weights and/or doing aerobic exercise, excessive attention to diet, and use of substances (e.g., steroids) and/or excessive exercise despite knowledge of negative physical or psychological consequences such as osteoporosis, stress fractures, and muscle damage (Kilpatrick & Caldwell, 2001; Phillips & Kastle, 2001). The diagnostic criteria for muscle dysmorphia includes a preoccupation with the idea that one's body is not sufficiently lean and muscular, clinically significant distress or impairment in social and/or occupational functioning due to preoccupation with muscle size (e.g., canceling family engagements in order to work out), and a primary focus on

being too small or inadequately muscular (Pope et al., 2000). In reality, these men may be excessively muscular (Phillips & Kastle, 2001).

A preoccupation with muscle size may cause individuals to assess their bodies by staring at themselves in mirrors for long periods of time “posing and assessing” (Taylor, 1991, p. 74) their muscularity and body symmetry. It may appear to the casual observer that bodybuilders scan their bodies with “unabashed self-admiration” (Klein, 1993, p. 25). However, Klein (1993) suggests that bodybuilders tend to use mirrors to openly and critically examine each body part and to split their bodies into distinct parts with certain attributes that need to be sculpted. Klein (1993) also asserts that the bodybuilder would like to honestly admire his reflection in the mirror, but can't:

Inside that body is a mind that harbors a past in which there is some scrawny [or chubby] adolescent or stuttering child that forever says, “I knew you when...”

The metamorphosis is doomed to remain incomplete. The individual gets a new body, maybe a new self-image, but one so lacking in substance that only constant reassurance from a friendly mirror can allay the fear of not having changed at all (p. 40).

This mirror gazing phenomenon is found in individuals with body dysmorphic disorder. Veale & Riley (2001) found a number of motivations that may contribute to this phenomenon, including (a) an “eternal hope” (p. 1389) that they will look differently, (b) a desire to know exactly how they look stemming from an uncertainty about their body image, (c) a belief that they will feel worse if they don't look in the mirror, and (d) a desire to camouflage their appearance.

Individuals who attempt to achieve an ideal body (e.g., bodybuilders and individuals with eating disorders) often have certain features of diagnosable mental disorders and personality traits.

Mental Disorders and Personality Traits

Bodybuilders and individuals with eating disorders have been found to possess certain features of mental disorders and personality traits that distinguish them from other individuals (American Psychiatric Association, 2000; Davis et al., 1999; Grilo et al., 2003; Klein, 1993). Personality traits specifically associated with bodybuilders include obsessive-compulsive features, anti-social behavior, borderline traits, low self-esteem, and difficulty handling failures (Klein, 1993). Personality traits associated with individuals diagnosed with eating disorders include obsessive-compulsive features, anxiety, borderline traits, perfectionism, and identity disturbance (Davis, Claridges, & Cerullo, 1997; Davis et al., 1999). These individuals may possess other features such as impulse-control problems, anxiety symptoms, substance abuse, mood lability, sexual impulsivity, greater frequency of suicide attempts, and personality disturbances (American Psychiatric Association, 2000).

Mood disorders (i.e., Dysthymic Disorder and Major Depressive Disorder [American Psychiatric Association, 2000]), and specific personality disorders (i.e., Avoidant Personality Disorder [Grilo et al., 2003], Borderline Personality Disorder [American Psychiatric Association, 2000; Davis et al., 1997a; Grilo et al., 2003]; Narcissistic Personality Disorder [Davis et al., 1997a]; and Obsessive-Compulsive Personality Disorder [American Psychiatric Association, 2000; Davis, Claridges, & Cerullo, 1997; Grilo et al., 2003] have been found to be associated with individuals with

eating disorders. Not all individuals with an eating disorder may have a co-occurring personality disorder, but “the co-occurrence rates...are sufficiently high to warrant careful consideration” (Grilo et al., 2003). Definitions of these disorders may provide further understanding into why certain individuals may wish to attain an ideal body.

Mood Disorders

Dysthymic Disorder. Individuals with Dysthymic Disorder have experienced a chronically depressed mood for at least two years (American Psychiatric Association, 2000). At least two of the following symptoms are present during periods of depressed mood: increased or decreased appetite, increased or decreased sleeping, low energy, low self-esteem, poor concentration or difficulty making decisions, and feelings of hopelessness (American Psychiatric Association, 2000). Individuals also may report self-criticism, feelings of inadequacy, and subjective feelings of irritability (American Psychiatric Association, 2000).

Depression is associated with eating disorders because malnutrition may cause secondary symptoms of depression (American Psychiatric Association, 2000). Therefore, individuals who have had an eating disorder for an extended period of time may demonstrate symptoms closer to that of Dysthymic Disorder, while individuals who are in a state of severe starvation may demonstrate symptoms closer to that of a Major Depressive disorder.

Major Depressive Disorder. Individuals with eating disorders may present with depressive symptoms such as low mood, social withdrawal, insomnia, decreased interest in sex, and irritability (American Psychiatric Association, 2000). Some individuals may meet the criteria for Major Depressive Disorder (American Psychiatric Association,

2000). These symptoms are often associated with the starvation that accompanies eating disorders. A Major Depressive Episode consists of “a period of at least two weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities” (American Psychiatric Association, 2000, p. 349). At least four of the following symptoms must accompany the depressed mood: changes in appetite or weight, sleep, and physical activity; decreased energy; difficulty making decisions, thinking, or concentrating; feelings of guilt or worthlessness; or recurrent thoughts of death or suicidal ideation, plans, or attempts (American Psychiatric Association, 2000).

Theories of depression. Almaas’ (2001) and Lowen’s (1983) theories about depression may enrich an understanding of Major Depressive Disorder and Dysthymic Disorder. Almaas (2001) and Lowen (1983) suggest that depression consists of an absence of joy and excitement about oneself and a feeling of heavy emptiness because of failed attempts to be seen as special and unique by others. Lowen (1983) postulates that depression may be a result of pursuing unrealistic goals that have no direct relation to everyday life. An individual may feel helpless and hopeless about himself, his work, his relationships, and his future. Although he has tried everything in his power to achieve what he wants, he may believe that nothing has worked (Almaas, 2001). Lowen (1983) further suggests that depression may be a denial of feeling or the denial of the true self. The individual may create an appearance of happiness while experiencing conflicting internal feelings.

There is often a co-existing personality disorder with depressive disorders and eating disorders (American Psychiatric Association, 2000; Gabbard, 1994).

Personality Disorders

Avoidant. The DSM-IV-TR describes individuals with Avoidant Personality Disorder (APD) as having “a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation” (American Psychiatric Association, 2000, p. 718). The diagnostic criteria for APD include four or more of the following: (a) avoidance of occupational activities that require interpersonal contact because of fears of disapproval, criticism, or rejection; (b) unwillingness to become involved with others unless certain of being liked; (c) restraint within close relationships because of the fear of being shamed or ridiculed; (d) preoccupation with being criticized or rejected in social situations; (e) inhibited in new interpersonal situations because of feelings of inadequacy; (f) viewing the self as inferior, inept, or unappealing; (g) unusually reluctant to take risks or engage in new activities because they may be embarrassing (American Psychiatric Association, 2000).

Gabbard (1994) associates avoidant personality traits with shyness. He suggests that “what avoidant [individuals] generally fear is any situation in which they must reveal aspects of themselves that leave them vulnerable” (Gabbard, 1994, p. 604).

Borderline. The DSM-IV-TR describes individuals with Borderline Personality Disorder (BPD) as having a “pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity” (American Psychiatric Association, 2000, p. 706). The diagnostic criteria for BPD includes demonstrating five or more of the following attributes: (a) frantic efforts to avoid abandonment (whether real or imagined); (b) a pattern of “unstable and intense” relationships; (c) identity disturbance; (d) impulsivity in at least two areas that may be self-harming (e.g., spending,

substance abuse, sex, reckless driving, binge eating); (e) suicidal threats, gestures, behavior, or self-mutilating behavior; (f) affective instability that usually lasts a few hours and rarely more than a few days; (g) chronic feelings of emptiness; (h) inappropriate anger or difficulty controlling anger; (i) transient paranoid ideation (American Psychiatric Association, 2000).

Individuals with BPD often demonstrate sudden or dramatic shifts in their views of themselves, others, and the world around them (Gabbard, 1994). They also may have extreme reactions to interpersonal stresses, and may use the term ‘depression’ to describe chronic feelings of boredom, loneliness, or emptiness (Gunderson & Zanarini, as cited in Gabbard, 1994).

Narcissistic. The DSM-IV-TR describes individuals with Narcissistic Personality Disorder (NPD) as having a “pattern of grandiosity, need for admiration, and lack of empathy” (American Psychiatric Association, 2000, p. 714). The diagnostic criteria for NPD include five or more of the following: (a) a grandiose sense of self-importance; (b) preoccupation with fantasies of success, power, beauty, or ideal love; (c) believes he or she is “special” and unique; (d) requires excessive admiration; (e) sense of entitlement; (f) takes advantage of others; (g) lacks empathy; (h) is often envious of others or believes that others are envious of him or her; (i) demonstrates arrogant or haughty behaviors or attitudes (American Psychiatric Association, 2000).

Almaas’ (2001), Lowen’s (1985), and Gabbard’s (1989, 1994) theories of narcissism may provide a deeper understanding of the narcissistic personality. Almaas (2001) believes that narcissism may be understood as an issue with one’s self identity, specifically, the alienation from one’s true self. He suggests that narcissistic traits may

include a pervasive sense of emptiness, vulnerability, insecurity, psychosomatic preoccupations, depression, a general uneasiness with oneself, projecting an image of a false self, or experiencing a “mistaken identity” (Almaas, 2001, p. 7). Lowen (1985) believes that narcissism may manifest itself as concern with the superficial aspects of the self (e.g., appearance) to the exclusion of everyone and everything else. Almaas (2001) and Lowen (1985) believe that narcissistic feelings of grandiosity and exaggerated sense of specialness may contain equal and opposite feelings of emptiness, worthlessness, purposelessness, alienation, and/or deficiency.

Gabbard (1989, 1994) postulates that there are different forms of pathological narcissism. For example, he suggests that ‘hypervigilant’ narcissism involves being highly sensitive to the reactions of others, inhibited or shy, being more attentive to others than to the self, and proneness to feeling hurt, ashamed, or humiliated (Gabbard, 1989). On the other extreme, ‘oblivious’ narcissism may involve having no awareness of the impact of one’s actions on others, aggression, arrogance, self-absorption, desire to be the center of attention, and being impervious to having one’s feelings hurt by others (Gabbard, 1989). Gabbard (1989) also postulates that highly sensitive individuals may develop an arrogant, aggressive exterior to compensate for their internal shyness or feelings of shame.

Obsessive Compulsive. The DSM-IV-TR describes individuals with Obsessive-Compulsive Personality Disorder (OCPD) as having a “preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency” (American Psychiatric Association, 2000, p. 725). The diagnostic criteria for OCPD include demonstrating four or more of the following

attributes: (a) painstaking attention to details, rules, lists, order, organization, or schedules; (b) perfectionism that interferes with task completion; (c) excessive devotion to work to the exclusion of leisure and relationships; (d) excessive concern about matters of morality, ethics, or values; (e) inability to discard worthless objects even when their sentimental value is gone; (f) reluctance to delegate work to others unless they are able to meet exact standards; (g) miserly spending habits; (h) stubbornness and rigidity (American Psychiatric Association, 2000).

Perfectionism and self-imposed high standards of performance often contribute to distress in individuals with OCPD (American Psychiatric Association, 2000). Individuals with OCPD also may be extremely self-critical about mistakes (American Psychiatric Association, 2000). Gabbard (1994) asserts that intimate relationships are difficult for individuals with OCPD, because they may have a need to control others and also may suffer from a great deal of self-doubt, which may cause significant others to find them difficult to live with.

An exploration of mood disorders and personality disorders points to an idea that individuals who feel badly about themselves may seek to feel better about themselves. If vulnerable individuals interpret media images of an 'ideal' masculine body as being linked to achieving an 'ideal' life, then it makes sense for such individuals to attempt to achieve an ideal body.

Summary

As the literature reveals, there are many reasons why individuals may attempt to achieve an ideal body. However, most of the literature is based on women's experiences, and this study asks men what their experiences are with attempting to achieve an ideal

masculine body. The following chapter examines the phenomenological-hermeneutic approach to this research question and outlines the research procedures utilized in this study.

Chapter 3: Methodology

This chapter examines the research methodology process used in this study. Qualitative methodology lends itself well to research that requires an in-depth examination of an individual's experience of a phenomenon. Self-reports and qualitative methods may be used to obtain information about body image and self-esteem to provide full and detailed descriptions of the individual's experience (Schwitzer, Rodriguez, Thomas, & Salimi, 2001). An in-depth exploration of inter-connectedness between an individual's body image and sense of self in regards to attempting to change his body may provide greater texture and detail of one's lived experience than a solely quantitative approach (Neuman, 1997).

For this research, a phenomenological-hermeneutic methodology was utilized in order to elicit participants' experiences with attempting to achieve an ideal masculine body. Van Manen (1990) states that phenomenological-hermeneutic research requires: (1) a phenomenological sensitivity to lived experience; (2) a hermeneutic ability to make interpretive sense of the phenomena; and (3) a way with language in order to allow the research process to contribute to one's thoughtfulness and tact. These three requirements for phenomenological-hermeneutic research are discussed, along with the reliability and validity of this methodology. The actual research procedure followed in this study, specifically, the selection of research participants, interview procedure, data analysis, and compliance with ethical standards, are addressed. Finally, a profile of the research participants is presented.

Phenomenology

Phenomenology is the study of lived experience (Jardine, 1990; Van Manen, 1990). Phenomenology is important to this research because it establishes that the lived experience of an individual provides a foundation on which to build a human psychology. The essence of phenomenology is a “search for what it means to be human” (Van Manen, 1990, p. 12). Phenomenology leads us away from quantitative, scientific descriptions and back to life itself (Jardine, 1990). Phenomenological research may be described as soliciting descriptive accounts of actual experiences as they are lived in everyday social settings in order to more fully and deeply comprehend human behavior and experience (von Eckartsberg, 1998; Jardine, 1990; Van Manen, 1990).

Phenomenological research allows us to examine a small part of the world and then arrive at a deeper, richer understanding that allows us to reconnect with the world. Nixon (1992) asserts that phenomenology allows us to explore “stories of the research participants [that] are capable of astounding us, stopping us in our tracks, and bringing forth both confusion and new understanding” (p. 97). Captivating stories may help us to better understand that which is common, ordinary, and directly concerns us (Van Manen, 1990). Phenomenological research is based on the following:

to do research is always to question the way we experience the world, to want to know the world in which we live as human beings. And since to *know* the world is profoundly to *be* in the world in a certain way, the act of researching—questioning—theorizing is the intentional act of attaching ourselves to the world, to become more fully part of it, or better, to *become* the world. (Van Manen, 1990, p. 5, italics in original)

Phenomenological Reflection

Conscious reflection is an important aspect of phenomenology. Being conscious is the only way that humans are aware of, and relate to, the world (Van Manen, 1990). In phenomenology, three acts of consciousness are utilized. First, the phenomenon is brought into the consciousness of the individual/s being studied. Second, the phenomenon is brought into the consciousness of the researcher and individuals who read the research. Third, the act of becoming conscious about a phenomenon in others allows one to reflect upon and become conscious of the phenomenon within oneself.

A person can only consciously reflect on an experience *after* having lived through the experience (Van Manen, 1990). Thus, phenomenological reflection is *retrospective*, rather than *introspective* (Van Manen, 1990). However, simple conscious recollection of an experience does not constitute phenomenological research. One also must examine the meaning behind, or intentionality, of that experience.

Intentionality. Intentionality is crucial to phenomenological reflection. Von Eckartsberg (1998) described intentionality as the sense that “human consciousness is always and essentially oriented toward a world of emergent meaning” (p. 5). The notion of intentionality allows research to investigate the “commonalities of experience and not drift off into the pure subjectivity of personal experience” (Nixon, 1992, pp. 94-95). We must remember that the topic of this research is not the participant’s narrative itself, but the intentionality of, or meaning behind, their experience. A turn to hermeneutic analysis allows this research to be respectful of both the lived experience and the meaning behind the lived experience.

Hermeneutic Analysis

The emphasis of hermeneutic analysis is on interpreting and understanding a phenomenon. This provides a structure for uncovering themes that may arise from dialogues with research participants (Riessman, 2002; Sass, 1998; Van Hesteren, 1986; Wiklund, Lindholm, & Lindstöm, 2002). Van Manen (1990) describes hermeneutic analysis as being the desire to make sense of an experience using the process of “insightful invention, discovery, [and] disclosure” (p. 90) to reduce or simplify a phenomenon. A hermeneutic analysis of personal narratives may illuminate “individual and collective action and meanings, as well as the processes by which social life and human relationships are made and changed” (Laslett, 1999, p. 392). By investigating the meaning of personal narratives, we may come to a richer and deeper understanding of the world in which we live.

A hermeneutic refinement of phenomenology posits that we cannot sit outside the world as if we are totally transparent. That is, the researcher is unable to observe the world from a perspective of pure objectivity because the researcher is already within the world. Within the hermeneutic context, “our prejudice or pre-judgement of a topic does not have to be shunned because it is from here that we understand...our prejudice can also contain an attitude of how we are going to be transformed in the future” (Nixon, 1992). Wiklund et al. (2002) assert the following:

The trick is to interact with data and yet keep some kind of distance from it by dealing with the researcher’s pre-understandings during the interpretation process. Inherent in our pre-understanding is a struggle to approach the text with an open mind, as pre-understandings tend to direct the researcher’s ‘eye’ in a particular

direction. By dealing with pre-understandings it is possible to take account of the barriers they create, and to approach data from new and different perspectives. (p. 114)

Interpreting the meaning that exists in the dialogue between researcher and research participant depends on the audience. If the researcher is able to maintain an open mind, listen closely, engage in dialogue, and seek to understand the experiences of others, he/she may be able to uncover a deeper layer of meaning beneath the everyday language used by the participant. The depth of this understanding may be described in the following manner:

If the primary goal of interpretation is not the passive reflection of what was in the speaker's mind, but the full explication of the meanings lying implicitly in the discourse of text-analogue, then the listener's or interpreter's prejudices can be understood to play a positive rather than negative role in that "fusion of horizons" characteristic of all true understanding. (Sass, 1998, p. 253)

Despite a researcher's concentrated efforts to arrive at an accurate interpretation of meaning, "a phenomenological description is always *one* interpretation, and no single interpretation of human experience will ever exhaust the possibility of yet another complementary, or even potentially *richer* or *deeper* description" (Van Manen, 1990, p. 31, italics in original). The language used by the research participant provides a starting point for the basis of this understanding.

Language

Language "gives a voice to the living text" (Jardine, 1990, p. 221) and texture to an individual's experience. Language uses two forms in phenomenological-hermeneutic

research. First, language appears as a dialogue between the researcher and research participant (Packer, 1985). Second, language leads to an increased understanding and meaningful interpretation when the conversation is artfully interpreted and described (Packer, 1985).

The art of dialogue is essential to a phenomenological-hermeneutic approach (Jardine, 1990; Packer, 1985; Van Manen, 1990). Through dialogue, the researcher is able to refine understandings, correct misunderstandings, and arrive at a more complete interpretation of the meaning of an experience (Packer, 1985). Conversation allows us to forget ourselves as we attend to the voice of another (Packer, 1985). The gathering of lived experience material may begin with conversational interviewing (Van Manen, 1990). The dialogue that exists between researcher and research participant is different than that between friends, so a structure and purpose for the conversation must be used. Cochran's (1985, 1986) dramaturgical method uses a narrative format to elicit stories from individuals. This method encourages individuals to use a story format, with a beginning, middle, and end, to describe their experience. The researcher must listen and attend to the themes arising from these dialogues and be "careful not to expect too much [and] be prepared...for the possibility that *nothing* will come forth" (Jardine, 1990, p. 230, italics in original).

An artful description and interpretation of an experience may reveal a deeper and fuller meaning of the studied phenomenon (Nixon, 1992; Van Manen, 1990). The description of a phenomenon (phenomenology) may be objective, while the interpretation of a phenomenon (hermeneutics) may be subjective (Van Manen, 1990). Objectivity allows the researcher to remain true to the research participant's story. Subjectivity

allows the researcher to use his or her perspective and insight to “disclose the object in its greatest depth” (Van Manen, 1990, p. 20). While describing and interpreting the object of a phenomenological-hermeneutic study, the researcher must “be strong in [the] orientation of the object of study in a unique and personal way while avoiding the danger of becoming arbitrary, self-indulgent, or of getting captivated and carried away by our unreflected preconceptions” (Van Manen, 1990, p. 20). Striving for precision and exactness is important in describing and interpreting the material gathered in phenomenological research. Therefore, it is important to examine the reliability and validity of this research methodology.

Reliability and Validity

There is a need to determine the accuracy and trustworthiness of phenomenological-hermeneutic research. “This is a methodology that tries to ward off any tendency toward constructing a predetermined set of fixed procedures, techniques and concepts that would rule-govern the research project” (Van Manen, 1990, p. 29). The researcher may contribute to the reliability and validity of the research by attending to the research participants’ stories in a sensitive manner and striving for a quality interpretation (Nixon, 1992).

Reliability tends to refer to consistency, replicability, and stability in measurement. However, because phenomenology is a descriptive human science, reliability is “always context bound” (Osborne, 1990, p. 87). For example, different interviewers of different research participants may produce situations in which multiple perspectives may lead to a similar description of a shared phenomenon (Osborne, 1990). Strategies to increase the reliability of a phenomenological-hermeneutic approach many

include: (a) ensuring accuracy in recording and transcribing (Peräkylä, 1997), (b) carefully describing the procedures used and data analysis (Osborne, 1990), (c) using verbatim illustrations of data interpretations (Johnson, 1997), and (d) maintaining accurate records of transcriptions and interpretations (Koch, 1994; Priest, 2002).

Validity refers to the “trustworthiness of the interpretations of the data” (Priest, 2002). The following steps have been outlined in order to serve as a validity check for the emerging data: (a) “bracketing” (Osborne, 1990, p. 87) the researcher’s orientation to the phenomenon to provide the reader with the opportunity to understand his/her interpretation of the data, (b) seeking and utilizing participant feedback (Johnson, 1997) to check for “goodness of fit” (Osborne, 1990, p. 87), (c) using participants’ verbatim descriptors, and (d) ongoing analysis and peer evaluation of the findings (Robson, 1993).

The themes that emerge from this research, the impact this research has on the reader, and the influence it is on future research will determine its truth value. The researcher recognizes that the research must have an “air of humility and helplessness because the validity of this research cannot be guaranteed in advance” (Nixon, 1992). The honest narratives and intensity of experience provided by the research participants have become the basis for the understanding and interpretation of this phenomenon.

Research Procedure

Selection of Research Participants

Analytic criteria. The analytic criteria included men between the ages of 20 and 40 who (a) had been lifting heavy weights one or more hours per day, four or more days per week, for a minimum of six months, (b) had been told, or recognized themselves, that exercise may be interfering with their social life or work life, (c) may or may not be using

steroids and/or other supplements associated with building muscle mass, and (d) were able to fully articulate their experience. Participation in heavy weight lifting was the primary criteria, as weight lifting is viewed as a primary means used in an attempt to change one's body. Heavy weight lifting included 3 or more sets of 60 to 70 percent, or higher, of one's maximum weight lifting capacity. Participants followed a self-prescribed exercise program, a body-building or power-lifting program, a prescribed exercise program found in a popular fitness magazine or book, or a program designed by a fitness trainer. The use of steroids was secondary in this research as individuals may be able to change their bodies with or without the use of steroids. The rationale for such strict criteria was to identify individuals who utilized exercise beyond a healthy range, as previously discussed, in order to examine the phenomenon of heavy weight lifting and steroid use.

Selection method. Initially, letters of introduction (see Appendix A) were discussed with colleagues, friends, and acquaintances, and given to owners/managers of fitness facilities. Posters (see Appendix B) were displayed at four participating fitness facilities in southern Alberta (The Fitness Club, Lethbridge; The Right You, Lethbridge; Universal Fitness, Medicine Hat; and Everybody's Business, Medicine Hat). Two fitness facility managers refused to display posters or speak to gym members because they did not want their gym to be associated with steroid use. Two participants responded to the displayed posters, two participants were referred by managers of fitness facilities, one participant responded to the letter of introduction, one participant was referred by another research participant, and two participants were referred by acquaintances of the researcher. Research participants stated that they "did not know anyone else" who would

meet the criteria, although they exercised at a facility where heavy weight lifting predominated and referred to acquaintances during their interviews who they knew were involved in similar activities.

The researcher did not know seven of the eight research participants. However, the researcher personally knew one of the research participants who had been referred by the manager of one of the fitness facilities. She decided that because she had only known him in the context of working together at a fitness facility seven years prior to beginning this research, and had no contact with him in the past seven years, there was no conflict of interest and proceeded with the interview.

Individuals became collaborative partners in the research process by engaging in dialogue with the researcher, clarifying and discussing themes and issues that arose from the research, exploring themes generated from the research, and discussing their experiences with the research process with the researcher.

Interview Procedure

After an initial screening process, two interviews were conducted with each research participant. Interview locations included the University of Lethbridge, Medicine Hat YMCA, and Medicine Hat Hospital. The initial screening process consisted of questions regarding current diet and exercise programs, whether other individuals were concerned that their exercise was interfering with their social or occupational functioning, steroid and/or supplement use, and age (see Appendix C).

Initial interviews ranged from seventy five minutes to four hours in length, with an average length of 2.75 hours. An adaptation of Cochran's (1985, 1986) dramaturgical method was used to elicit the research participants' stories. The dramaturgical method

used a narrative format to elicit stories from individuals. Research participants were asked to use a story format, with a beginning, middle, and end, to describe their evolution into weight lifting and steroid use. The beginning was described as when they first became interested in weight lifting, the middle was the months or years in which they became more involved with heavy weight lifting and steroid/supplement use, and the end was considered to be the present. The researcher used empathic listening and paraphrasing (Rogers, 1961) to encourage the research participants to tell their stories. An interview guideline was used to address general topics related to the research question (see Appendix D).

Individual follow-up interviews with participants were arranged once the data was analyzed and themes had emerged. Six months elapsed between the initial interview and the follow-up interviews due to the four month term that elapsed between the initial interview with the first research participant (November, 2002) and the second research participant (February, 2003), plus the two months it took for the researcher to analyze the data and write the first draft of the themes. Follow-up interviews lasted approximately ten to fifteen minutes and were conducted by telephone. This follow-up interview allowed the participants an opportunity to discuss the results of the study and their experience with the research process. It also allowed the researcher the opportunity to thank research participants for their willingness to participate in this research. Each participant was offered a one to two page summary of the relevant findings of the study.

The initial interview was audio taped and later transcribed to provide the researcher with an accurate record in which to begin data analysis. The follow-up

interview also was transcribed. The tapes and transcripts will be destroyed five years after publication of the research.

Data Analysis

The data was analyzed using a phenomenological-hermeneutic approach whereby the researcher became immersed in the data in a search for meaning. The researcher attempted to minimize her subjective biases related to the phenomenon of heavy weight lifting and steroid use in men by documenting her reactions to the stories of the research participants, distancing herself from the text by approaching the data from different perspectives, and validating themes arising from the stories by discussing them with the research participants.

First, the interview transcriptions were read and a naïve interpretation was achieved based on the researcher's assumptions (Wiklund et al., 2002). This made it possible for the researcher to question her interpretations and examine alternative ways to approach the text. Second, the researcher explored the structure and overall thematic quality embodied within each narrative to determine underlying meanings and truths shared between narratives (Van Manen, 1990; Wiklund et al., 2002). These themes were discussed with the research participants and the researcher's supervisor to determine the accuracy of the researcher's perception of the themes. The themes and the researcher's interpretation of their meaning were presented in the final write-up using verbatim quotes, paraphrasing, and pseudonyms, with respect to confidentiality. If quotes were edited to avoid repetition or altered in order to fully express their meaning, then ellipses [...] were used.

As a supplement to each transcription, the researcher gained a sense of the whole by writing a summary of each interview immediately following each interview, as well as writing relevant memos throughout the research process. This allowed the researcher the opportunity to determine important themes and/or information gathered during interviews and examine and/or revise themes for later interviews. Because of the extended time lapse between interviews, these summaries and memos were invaluable to the researcher throughout the writing process.

Compliance with Ethical Standards

A number of ethical standards must be upheld when conducting phenomenological-hermeneutic research, particularly when the researcher interviews members of the opposite sex (Schwalbe & Wolkomir, 2002). Free and informed consent, privacy and confidentiality, right to inquire about research, balance of harm and benefit, researcher safety, and legal issues will be addressed.

Research participants signed a consent form that verified that they had given their informed consent for the following: participation in a one and a half to two hour initial interview and a 30 to 45 minute follow-up interview; audio taping of the interview; publication of the material in the researcher's Master's of Education: Counselling Psychology thesis document, academic journals and/or books, and/or presentations made at conferences and/or university classes (see Appendix E). The consent form also outlined the legal responsibilities of the researcher, the participant's right to withdraw from the research at any time (i.e., before and after interviews, after being given transcripts, after reading summaries, and after reading a final copy of the material), and confidentiality. Professional contacts were listed (i.e., researcher, thesis supervisor, and

chair of the University of Lethbridge Faculty of Education Human Subject Research Committee). Research participants were asked to leave a contact phone number and address with the researcher so that she could contact them to clarify information, set up subsequent interviews, and mail them a copy of their transcript and summary of the research findings.

Research participants were informed that all identifying material will be omitted, and only self-selected pseudonyms and ages would be used in written material. Interview transcripts were seen only by the researcher, transcriber, and thesis supervisor. Only information pertinent to the research question was included in the thesis. Research participants were given a copy of their transcript and asked to omit any identifying material that the researcher unintentionally may have missed. The researcher did not reveal the names of research participants to each other. When one research participant referred another participant to the researcher, the researcher did not reveal the contents of the interviews to each other.

Research participants were provided with phone numbers and email addresses of the researcher, the thesis supervisor (Dr. Gary Nixon), and the Faculty Human Subjects Chair (Dr. Cathy Campbell) so they could inquire about the research at any time.

The researcher, thesis supervisor, and participants had access to the original data (participants only had access to their own individual audio tape and transcript). The research data was stored in hard copy, on computer disc, and on audio tape at the researcher's home. Research participants were provided with a one to two page summary of the research findings. All hard copies of transcriptions, audio tapes, and computer discs will be destroyed five years after publication of the research.

An ethical concern with in-depth interviewing of personal issues is that there is the potential for participants to become overwhelmed when they expose personal truths they may not have examined thoroughly. The use of informed consent, the ability to stop the interview at any time and the researcher's ability to make referrals to a suitable counselling therapist mitigated this ethical concern. The researcher informed participants that personal information would be revealed to the thesis supervisor and/or medical personnel only if the participant became overwhelmed with the depth of the issues he revealed, or discussed the intent to harm himself or others. None of the participants indicated a need for the researcher to make such referrals.

A second ethical concern was that steroids are illegal substances, and the researcher recognized that conducting a study where illegal substances are mentioned may cause unforeseen difficulties. However, the researcher recognized that performance-enhancing substances were readily available, and did not intend to inquire into the names, amounts, or sources of steroids, nor publish such information that may unintentionally be revealed by research participants. Only information relevant to the research question was transcribed and published.

Researcher safety. The researcher took the following steps to guard her personal safety, as research has shown that some men who use steroids may act in a sexually aggressive manner towards females (Schwerin & Corcoran, 1992): (a) all interviews were conducted in public locations during office hours when other individuals were available if the researcher required assistance in any manner, (b) voicemail and email services were specifically set up for the purpose of this research and will be cancelled after the research is complete, (c) posters were not distributed at the gym where the researcher chooses to

exercise, (d) no personal information was disclosed to the research participants, and (e) the researcher intended to end an interview and contact her supervisor immediately if there were any difficulties with a research participant. The researcher refused one interview when a respondent insisted that the interview be done at his home rather than in a public location, otherwise, the researcher had no concerns with her personal safety during this research.

Legal issues. Research participants were encouraged not to reveal information regarding the distribution of steroids. The use or distribution of steroids was not a focus of this study, nor was it questioned or mentioned by the researcher during the course of the interviews. The researcher was informed by a Crown Prosecutor in Medicine Hat that “a citizen is under no obligation to report a crime that he/she has witnessed,” (Dorothy Smith, personal interview, October 15, 2002) and that the researcher would be under no legal obligation to report the use or distribution of steroids by research participants. The researcher was informed that should a research participant be found guilty of a crime such as distributing illegal substances, and it is revealed to police that the researcher knew about the crime previously, the researcher may be subpoenaed and her documents seized by a search warrant. The consent form clearly outlined the legal obligations of the researcher (see Appendix E).

Research Participants

Based on the interview data, the following is a general profile of the research participants including their age, location, level of education, occupation, marital status, and involvement in weight lifting and steroid use. Eight individuals who exemplified the analytic criteria became research participants. Participants ranged in age from 21 to 35

and lived in southern Alberta. All were employed in a variety of occupations (i.e., personal trainer, emergency rescue, night auditor at a hotel, security guard, financial consultant, oilfield, and medical). Five were single, one was married, and two reported being in long-term relationships (over two years).

Of the eight participants, six reported heavy weight lifting at the time of their interviews. One participant was recovering from a broken wrist, and one participant was recovering from a back injury, however both reported lifting heavy weights immediately before their injuries and intended on returning to their prior exercise level upon recovery. Two participants reported using steroids at the time of their interviews, two reported using steroids in the past two years, and four reported never using steroids but reported the use of other muscle-building supplements (two at the recommended level and two beyond the recommended level). No participant reported that exercise was interfering with his work or social life at the time of his interview, however six participants reported that exercise had interfered with their work and/or social life within in the past two years. All participants were able to articulate their experiences.

By interviewing men who meet the research criteria and reflecting on their individual experiences, the researcher was able to describe and interpret several shared themes that were related to the phenomenon of attempting to achieve an ideal body. The following chapter presents an individual profile of each research participant and the themes that arose from the interviews as interpreted by the researcher and validated by the research participants.

Chapter 4: Results

The purpose of this research was to seek a greater understanding of men's lived experience with the phenomenon of attempting to achieve an ideal masculine body. In order for the reader to gain an understanding of the participants' individual perspectives, a profile of each man is presented. An exploration of the themes generated from the interviews follows. Verbatim quotes, paraphrases, and non-personal identifiers (e.g., pseudonyms) are used. If quotes have been edited to avoid repetition or altered for clarification then ellipses [...] are used.

Meet the Participants

Bob

Bob was a 30 year old competitive body builder turned non-competitive power lifter. He began weight lifting during his teens to improve his strength and endurance for playing hockey. Bob sought training and diet advice from bodybuilders, became a personal trainer, and was fully committed to his training regime. He experimented with natural supplements before turning to anabolic steroids, which gave him incredible physical gains, greater confidence and a feeling of being in control of his life, as well as hair loss, digestive problems, and mood swings. Bob's relationships suffered because of the hours he spent training and preparing food. After meeting his goals of competing in a bodybuilding competition, Bob sank into a depression and began using marijuana. When Bob began to re-evaluate his priorities in life, he decided that he no longer was willing to spend his financial, physical, or emotional resources on steroids to continue training for bodybuilding competitions. Bob found a new training partner and ways to put the "fun"

back into training by experimenting with the “science of strength training,” rather than trying to transform his body into an unrealistic and unattainable ideal.

David

David was a 35 year old man who had retired from several years of competitive power lifting. He first became interested in weight training at the age of 20 when a girlfriend encouraged him to get into shape. David described himself as a heavy drinker who believed that power lifting helped him overcome his “negative” addiction. David sought the advice of a trainer and other power lifters in regards to training programs, diets, and supplements. He “was a day away from using steroids,” but backed out at the last minute because he was afraid that steroids might increase his potential for aggression and may contribute to his addictive tendencies. David enjoyed the sense of power that he gained from the admiration of others, as well as the sense of superiority he felt over those not involved in power lifting. He also discovered a sense of brotherhood by belonging to an elite group of power lifters. David sank into a “debilitating void” when he retired from competitive lifting. He found that it took a long time to “get himself back” after years of obsessive training and he continued to seek ways to maintain a positive outlook on life.

Jake

Jake was a 25 year old competitive bodybuilder who began lifting weights at the age of 12. He described himself as a “shy fat kid” who didn’t fit in with others. He wanted to become a huge, muscular man who deserved respect and admiration. When Jake was 16, his mom passed away and left him a letter that said she was proud of him for lifting weights, and he never stopped. He considered himself to be a “hardcore bodybuilder” and was able to identify every bodybuilding icon in his vast collection of

bodybuilding magazines. Jake considered himself to be an 'expert' in everything related to training, dieting, and steroid use. At one point, he considered living in Mexico to obtain legal steroids. Jake 'tested' his past girlfriends and his wife by having them prove their loyalty to and acceptance of him by injecting steroids for him. He began to suffer serious injuries due to over-training. Despite winning bodybuilding competitions, standing in front of crowds of over 1200 people with little clothing on, and receiving compliments on his size from complete strangers, Jake felt uncomfortable taking off his shirt at his local gym and in front of his wife. No matter how big he was, Jake still felt like the "fat kid" he remembered from his childhood.

Josh

Josh was a 23 year old man who described himself as a "freak." During his teens, he was a "golden boy" who played hockey to make his parents proud. He believed he needed to take steroids to "become the best" and, as a result, was banned from playing. He was devastated that he had let his parents down, and attempted suicide at age 18. After being hospitalized, Josh vowed never to be "weak" again. In fact, he wanted to become the biggest, strongest "freak" imaginable. He weight trained for hours each day, dieted rigorously, and intended on using steroids until he was "man size" at age 30. He believed that bodybuilding helped him to control his aggression and tendency towards violence, work out his frustrations, calm down his hyperactivity, keep out of trouble with the law, and allowed him to sleep at night. Josh said that he had a very addictive personality, and if he wasn't training he knew he would become extremely depressed and use drugs and alcohol to cope with life. Josh was scared of being weak, paranoid about his girlfriend cheating on him, and afraid of not being respected by others. He was bound

and determined to “be the best” by working harder, weight training like a “freak,” and using more steroids than anyone else.

Kyle

Kyle was a 21 year old man who became involved in weight lifting for health reasons. He was a “skinny kid” who started weight lifting at age 14, and was pleased when he started to gain weight and muscle mass. He wanted to gain more weight and strength, but didn’t intend on using steroids to meet his goals. Kyle questioned himself as to why he wasn’t satisfied with his body the way it was. He liked being fit enough to approach any situation knowing he was strong enough to perform without hesitation. He considered himself to lift weights moderately, and supplemented his diet with protein powder and other ‘natural’ supplements. He worried about getting older, and wanted to keep in shape to remain as healthy as he could for as long as he could. Maintaining physical, mental, and spiritual balance was important to Kyle.

Matt

Matt was a 27 year old non-competitive bodybuilder. He started working out at the age of 13, and had not taken more than a few weeks off except when he broke his wrist a few weeks before his interview for this research. He wrote reports on nutrition and steroids in junior high, and was always up to date on the latest research. When he was younger, he considered using steroids but was “too broke” to buy them. When he had the means to buy steroids, he decided it was “not worth the psychological addiction”. Matt recognized that at 18 years of age he was “very extreme” with his workouts, and was consumed by thoughts of dieting, getting bigger, and his appearance. At that time he realized that his life “had no balance,” and over the next few years sought to maintain

balance in his life so he could be happier. His physical appearance remained important to him, as did remaining strong and fit for his career in rescue and law enforcement. Even though he was generally happy with his physique, a driving force inside him kept telling him that “it just never will be good enough.”

Ryan

Ryan was a 23 year old non-competitive bodybuilder. He described himself as a “bad kid, a very bad kid” with an “addictive personality” who used weight lifting to “keep out of trouble.” Ryan was a risk-taker who wanted to push beyond his physical limits (e.g., he once was towed behind a truck going 80 kilometers per hour while rollerblading). Within a month of beginning to lift weights, he decided to use two cycles of steroids “for the quick fix.” When he gained the weight he wanted, he continued lifting weights seven days per week, working every body part every day, and when he wasn’t able to lift weights he ran 40 kilometers a day. He wanted to weigh 280 pounds, and was willing to do anything to get there. Ryan believed he was an independent individual who relied on no one but himself.

Scott

Scott was 30 year old physical trainer who began weight training while playing college soccer. He decreased body fat and increased muscle mass by going on two self-prescribed “gaining programs”, which involved an intense weight training program and rigid dieting. He used an excessive amount of ‘natural’ supplements before and after workouts for increased energy, muscle recovery, pain reduction, muscle gain, fat reduction, and to help him “make it through the day.” Scott knew that he was over-training and became injured easily, but still couldn’t stop. School, work, and relationships

interfered with his workouts and dieting. Scott experienced nervousness, restlessness, and agitation that spiraled into paranoia and suicidal depression. Once Scott began to live a more balanced life, he began to focus on learning how to trust himself and others again.

Themes

A number of unique and interrelated themes evolved from the interviews with research participants. These themes are presented using the evolving story format that was utilized during the interviews, and the participants' stories are allowed to speak for themselves. The researcher's interpretation is used as a supplement to enhance their meaning and draw further attention to the interrelatedness and depth of the themes.

This section begins with an exploration of the message that participants received as children that they were "not good enough." This message led them to judging their bodies and their genetic predisposition and engaging in weight lifting and dieting behaviors. Although these behaviors may have begun innocently, many appeared to spiral into obsession. Most participants committed themselves to intense training and became part of an elite group of like-minded individuals. Most participants believed they were misunderstood by family and friends, and thus isolated themselves from important relationships, which often led to symptoms of severe depression. The more their lives spiraled out of control, the more they attempted to gain control over their lives by throwing themselves into their training. After several years of training, most participants began to realize it was all an optical illusion, and sought to reorganize their priorities and seek balance in their lives. What had once been an obsession began to dissolve through time.

I am Not Good Enough

A theme that underlined the participants' motivation to attempt to achieve an ideal body was that of internalizing negative messages about their bodies. Each man had received implicit or explicit messages at a young age that his body, and therefore his whole being, was not good enough. Being skinny, fat, average looking, or average at sports was not acceptable. These messages were received from family, friends, strangers, television, children's toys, and magazines. As an outcome of internalizing these messages, participants began to compare their physical bodies to other individuals' bodies (whether real or cartoon) and found themselves lacking. In a variety of ways, these men perceived that their physical bodies were not good enough as they were and therefore required change.

The more severe the participants perceived their flaws to be, the greater the changes they believed they required. For example, Kyle perceived himself to "kind of a skinny kid," and thought "Well, let's see if [I] can add a bit of weight." On the other hand, some participants reported being ostracized, teased, and cajoled about their body size by family members, friends and strangers. These messages cut them to the core and caused them to become extremely sensitive to messages about their bodies. Jake, a competitive bodybuilder, revealed the hurt he felt when teased by others about his weight:

There [were] always people who were picking on me...girls didn't like me because I was fat and freckle-faced...they would always say all sorts of things. I remember crying, going home crying and my mom trying to calm me down and my brother laughing at me...he knew it bothered me so that was the way he

could...do something or say something and then he knew I would be mad or upset. That was really a bad time, probably from [age] eight to twelve until I said, "Okay, this is enough."

Although twelve years had passed since Jake had heard these messages, he had internalized them and continued to believe that he was the same "fat kid" whose body, and therefore his whole person, was not good enough.

Even though a participant may not have received explicit negative messages about his body as a child, he may still have compared his body to others' bodies and found his lacking. David believed that "most guys in high school kind of fill out and have some arms" and that he was "basically like a rack of ribs [with] small arms." Kyle, Bob, and Matt also believed that they were "really skinny" in comparison to others and sought to increase their size through weight lifting.

Participants involved in team sports in high school received messages that being "average" was not enough and that they should seek to become greater than average. Bob was encouraged by his hockey coach to begin weight lifting to become more fit as a goalie. Scott was encouraged by his soccer coach to train with weights to increase his leg strength. Josh internalized the message that he should "be the best":

I was 16 when I did my first lift...I just wanted to be the best. I was playing hockey and had the scouts looking at me so I just wanted to be the best. I had to be the fastest. I was the golden boy in my family so I couldn't let anyone down. That was the biggest thing. So just be the best. Take the needles. Get big. Get strong. Get fast. Be the best. That was the bottom line.

The impact of cartoons and toys on a child's perception of his body is not to be underestimated. For example, cartoons may be viewed as harmless ways for children to pass the time, however, they may contain implicit messages about the body. Matt discussed the impact that childhood cartoons and toys had on his desire to change his body:

When I was a kid watching 'The Smurfs', my favorite smurf was Hefty Smurf...because he had the muscles on him. And that was just a little kid. I wasn't old enough to understand the difference really, but that was something that just attracted me to it. And then you look at the little toys I had as a kid, obviously being a farm kid I liked the cowboy stuff, but it was the cowboy with the big muscles and the clean shaven guy who I always liked the most... I always thought that was so cool when I was a kid.

Not only did these messages impact the participants as children, but similar media messages continued to influence them as adults. Television, movies, magazines, and other publications further reinforced the participants' beliefs that their bodies were not good enough. Nearly all the participants cited Arnold Schwarzenegger (a movie star and bodybuilding icon) as a major influence on their body image:

Terminator T2 [movie] came out with Arnold all huge and pumped up and I was kind of going you know, "Arnold's a big tall guy, I'm a big tall guy... Yeah, wouldn't that be ideal?" (David)

All participants cited fitness and bodybuilding publications as major influences on the way they judged their bodies as adults. Matt, who had been influenced by the Smurfs

as a child, said that he continued to be drawn towards “the guys with the big muscles” on the covers of fitness and health magazines and books. Ryan recognized the following:

It’s nice to have the magazine body...everyone wants it but no one can really have it because any picture you see in a magazine is airbrushed. It’s so altered... You can never really have what is shown, but for some reason everyone wants it.

Participants reported a tendency to continually appraise other peoples’ bodies according to some internalized ideal of strength, size, and muscularity that they had internalized. If they perceived that someone had bigger arms, they criticized themselves for not having bigger arms. If someone at their gym was putting on size and “looking good,” they either envied him from afar or approached him for training or dieting advice. Bob described his views of another bodybuilder who he had trained for a competition:

Basically I wished that I had his genetics and I wished that would have been me looking the way that he did up on stage. While I’m totally happy for him and I know I’m a real important person to him, and I totally feel awesome about his accomplishment, I do wish it would have been me...I told him straight out...“Man, you look so good. I totally wish I could do and look the way that you do.” I told him that, not in a way that made him feel like I wasn’t happy for him but, or not in a way that I made him feel like I was totally jealous and whatever. Just that I was envious, I guess.

The participants appeared to have internalized negative messages about their bodies as children and continued to believe those messages as adults. As children, they likely did not understand the source of those messages, but as adults they did. Instead of

questioning the validity of the messages they had received as children, they reported blaming themselves for having a less than perfect body.

Judging Genetics

Participants judged their own genetic predisposition according to extremely high standards of 'good' and 'bad'. Half the participants stated they were "fighting" their genetics, while the other half stated they were "enhancing" their genetics. No matter which way it was labeled, the men tended to both blame and praise their genetic predispositions for the way their bodies looked and responded to training and dieting. They wanted their bodies to "grow faster and bigger. I am trying to cheat genetics" (Josh).

The men appeared to hold very high standards of 'good' and 'bad' genetics. They also recognized that their perceptions of 'good' genetics and 'bad' genetics were individual; "It's an opinion. You know it's like trying to define beauty. Which one of the body builders is more beautiful? In your opinion you might be judging it entirely different than I am" (David).

Participants stated that 'bad' genetics were to blame if they were unable to attain the size, strength, and definition results they desired. Participants believed that 'bad' genetics caused the body to be 'scrawny' where it should be big (e.g., arms and chest), 'flabby' where it should have well-defined muscles (e.g., abdominal area) and 'imbalanced' where it should be symmetrical (e.g., biceps and triceps, quadriceps and hamstrings). The men believed that these 'bad' genetics 'cheated' them out of the strong, muscular bodies they desired and deserved. Bob described his fight against 'bad' genetics:

You know my parents are small, small boned and my dad's probably 160 pounds and my mom is like 100 pounds and they're small people. My brothers are tall and skinny and, you know, I'm fighting my genetics all the time...I'm trying to look differently than my genetic predisposition.

The 'bad' genetics of other individuals were pitied. These men believed that individuals who were physically unattractive or had to 'fight off' obesity had 'bad' genetics that could not be changed. They were grateful that they did not have the 'worst' type of genetics which caused individuals to become obese. Jake noted that he had been "fat" as a child, and although he wanted to be "big," he did not want to be "fat." As a result of comparing their own genetics to other people's genetics, participants recognized that they were generally grateful for the genetics they had, but still were not satisfied.

Participants believed that 'bad' genetics belonged to parts of the body that remained small and required extra training to achieve size (e.g., chest, shoulders, and arms), while 'good' genetics belonged to specific parts of the body that became muscular easily (e.g. legs). Josh's view of his genetic breakdown exemplifies this distinction between 'good' genetics and 'bad' genetics:

My shoulders will grow retarded but I still have little arms. I can grow a massive chest and massive back but my legs are a little small. I can get big calves, just not big quads. Like I've never had triceps growth and they are starting to grow now but I'm over-training them.

'Good' genetics were praised if the men gained the muscular size and definition they desired. 'Good' genetics were envied and idolized in other individuals. For example, Arnold Schwarzenegger and Dorian Yates (bodybuilding icons) were reported to have

admirable genetics because they had ‘massive’ bodies. Participants longed for the ‘good genetics’ of other individuals. Matt figured he “should have that guy’s size and that guy’s definition all at once.”

There was a tendency to see only ‘good’ genetics in other individuals and ‘bad’ genetics in oneself. For example, Matt stated the following:

If I see a 22 year old kid who’s got a better physique than I’ve got, in my opinion, than I become hard on myself....We are playing genetics against genetics and that’s not a fair comparison, but you do it anyways....You analyze everybody and everything individually, so it depends who they are, and what they are doing and how you analyze them....On myself then I see what’s bad and what needs to be worked on. You know, I don’t really see as much as the positive as I do the negative. But that’s what drives you to train hard.

Once the men identified that they had ‘bad’ genetics that required work and ‘good’ genetics that required enhancement, they turned to the training programs that Arnold Schwarzenegger and Dorian Yates promised would transform their bodies into the muscular ideal that they desired--weight lifting, dieting, and steroids.

Spiraling into Obsession

Behaviors associated with changing one’s body appeared to progress along a continuum. Most participants’ attempts to ‘gain a little muscle’ often spiraled into obsessive behaviors that began to consume greater and greater amounts of time and energy. What began as supposedly ‘healthy’ behaviors (e.g, exercising to become more ‘fit’) often spiraled into more extreme behaviors (e.g., training to become ‘massive’ or a ‘freak’). All participants began with weight training, then focused on dieting and using

'natural' supplements, and half the participants made the decision to use steroids. Over time, most participants became so focused on their training, dieting, and steroid use behaviors that they began to neglect other areas of their lives.

Weight lifting promises to transform one's body 'naturally.' The basic philosophy of weight lifting is simple—lift a certain weight a certain way and the muscles involved will change in shape, size, strength, and definition. David described the basis of weight lifting as “our sport is a fairly stupid one. We're trying to overcome gravity... repeatedly.”

For each of the men, the spiral into obsession began with reading over-the-counter health and fitness magazines. “Men's Health,” “Muscle and Fitness,” and “Muscle Mag” were three magazines cited by participants. Jake described the importance of these publications in his bodybuilding career:

I've been reading “Muscle Mag” since 1989. I've got a collection that my father-in-law is ready to kill me because he's had to move so many times. I've got so many boxes full and I can tell you, to me hardcore is you can show me a cover, you can show me the color of the top of the magazine and I'll tell you who's on it. To me they're the bible.

The weight lifting programs touted by these magazines were allegedly designed by bodybuilding professionals who guaranteed results if the programs were followed exactly. Participants reported that they based their initial training programs on the information found in these magazines. Once the men found that these programs were too generic and they did not fully achieve the promised results, they often sought out more research to help them individualize their program. Instead of questioning the validity of

the research they were doing or the integrity of the training program they were following, they blamed themselves and believed that they were doing something wrong. They began to spend more time training, doing research, questioning themselves, asking others for advice, and seeking answers to the questions “What should I be doing?” and “What am I doing wrong?” Matt described his continuous search for the ‘perfect’ program:

The consuming part of it isn’t necessarily in the gym, but it is in the back of your mind a lot. That you’re not constantly more about this, or more about that. What can I be doing for this? You know, like how I can get my calves like that? Can I get my chest bigger? What should I be doing here? Should I be doing high reps low reps? You are constantly thinking of stuff like that. (Matt)

Most participants began weight training at a ‘healthy’ end of the continuum, working their muscles until fatigued and getting enough rest for them to recover. However, some participants pushed the limits of training and subscribed to the belief that ‘more is better,’ and thus moved towards the ‘unhealthy’ and obsessive end of the exercise continuum. Bob, Scott, and Jake described twice-daily workouts. Ryan described his routine of training every muscle seven days a week:

I would go for the hour and a half [and] I would do everything, I would do upper body, lower body, which you’re not supposed to do, you’re supposed to give yourself a rest in between. I did go seven days a week, didn’t give myself a break...If there was a muscle that could feel that wasn’t sore and tired I’d keep going until it was.

The participants decided that if weight lifting alone was not giving them the results they desired, they would focus on the next aspect of their training program—their

diet. Where weight training promised stronger, bigger muscles, dieting promised lower body fat and increased muscle definition. Dieting often began with restricting certain foods (e.g., fats and carbohydrates) and increasing protein consumption (e.g., chicken breasts, egg whites, and tuna). This often spiraled into a rigid obsession where determining food intake requirements and preparing meals consumed huge amounts of time and energy. According to the participants, individuals who were serious about building muscle and decreasing body fat had to eat at pre-set times during the day in order to conserve energy for training and provide fuel to their growing muscles (e.g., pre-workout meals and post-workout meals). Scott's description of force-feeding protein and nutrients into his body was echoed by most of the participants:

I figured out how many calories I wanted... and figured out what type of, the number of carbs [carbohydrates], proteins, and fats I wanted for each single meal, and the types of carbs, proteins, and fats and then I figured it out between anywhere from five to seven meals per day including pre-workout meal, post-workout meal, meal before bed, what kind of breakfast I wanted, etc....And that seemed to work.

Although diet was an important component to their body shaping program, most participants soon recognized how boring and tedious it became to prepare and consume the same low-fat, high-protein meals day after day:

I'll cook all my food on Sunday for the week or at least till Wednesday and then on Wednesday there's leftovers from supper that I can either roast or something that I can use to spice it up because it gets pretty bland. But the cooking...my God, the food intake is so much more. People think when you're on a diet for a

contest that you're going to eat less and it's the exact opposite. You're eating more... You get so sick of it because... it's so bland and you're not hungry. (Jake)

Some participants built 'cheat days' into their diet (e.g., eating foods with perceived low nutritional value and usually high fat) in order to tolerate the intense food restriction. However cheating on a diet was terrifying, especially for Jake:

Guilt. Oh man... I remember I cheated a bit and I bought a Snickers bar... and I had to hide out. I was literally hiding. I think I almost got arrested that time too... I stopped beside the street before my friend's house so I could eat this chocolate bar so no one would see me. So I was sitting there in my car and this lady keeps looking at me through the window... not five minutes later a cop came up behind me... I thought, "How stupid would this look if he came up to my window and asked me what am I doing and I would say I'm eating a chocolate bar because I don't want my friends to see me?"

Some participants, especially those involved in bodybuilding, believed that the amount of time they invested in preparing meals, eating meals, and researching nutrition information was comparable to individuals with eating disorders; "I might be developing an eating disorder because I like my six pack [abdominals] and I like to be lean. Instead of eating a full meal I'll... [drink] more drinks than eating now [and take] meal replacements... That's not right" (Josh).

As much as they tried to transform their bodies 'naturally' through weight training and dieting, participants found that 'the natural way' did not provide the results they were looking for. Where initially the men may have been interested in proper nutrition to support their training and lose some body fat, they began to believe that nutrients from

food were not enough and ‘natural’ supplements were required to enhance their diets.

Supplement use generally began with the addition of food supplements such as protein and creatine, and spiraled into greater consumption of other ‘natural’ supplements such as stimulants, muscle builders, and the ‘ACE stack’ (which consisted of aspirin, caffeine, and ephedrine). Scott describes how his good intentions spiraled into obsession:

I started thinking more about the four food groups and starting off with a balanced diet...potentially adding this and that...supplements...meal replacements, protein...creatine...glutamine, any type of amino acid that would come in a pill, more ephedrine, caffeine, herbal energy pills, anything that I thought might help that I could add to my diet, get results a little quicker...I had my multivitamin, I had my ephedrine, caffeine, and aspirin, [and]I can’t even remember, there were a couple of other things as well.

Bob also tried everything he could to obtain results ‘naturally’: “I remember taking every supplement that I could think of in health food stores like weight gainers, every natural thing that was supposed to increase testosterone levels and everything that you could think of.” Most participants admittedly became addicted to the use of supplements.

When training, dieting, and ‘natural’ supplement options were exhausted, and nothing seemed to be working anymore, steroids seemed to be the only logical choice to obtain results. Even though they knew the risks associated with steroid use, the pull of steroids was tremendously strong, as seen by David’s statement:

It was the good angel saying, “Be smart. Don’t do that.” And then there was our egos and our lack of self-esteem going, “Come on. Get big. Get strong.” I mean

you are tempted [to use steroids] every time you walk in... somewhere and see a big guy on drugs.... You have cravings.

Participants reported going through an extensive decision making process before deciding to use, or not to use, steroids. The men who chose not use steroids did so because they believed that risks far outweighed the benefits, for financial reasons (e.g., “poverty” versus “ethics”), and because they had a fear of increasing their aggressive tendencies or experiencing personality changes. The men who chose to use steroids made their decision based on one of two viewpoints--either to use steroids “for the quick gain” or to believe that all other options had been exhausted and there was no other choice. For example, Josh chose to use steroids at the age of 16 because he believed it would increase his chances of going professional in hockey:

I was the golden boy and everyone looked at me like “you’re doing so good in hockey and the junior scouts are looking at you” and, maybe, pros, and it was almost tangible. So it was so close so I thought that this little prick, this little needle, it’s so close that this won’t hurt me. This will just help me. I didn’t look at the long runs of getting busted.

Bob believed that he had exhausted all his options with weight training, dieting, and ‘natural’ supplement use, and therefore had no choice but to take the next step and use steroids; “I just wanted to not be in there busting my ass for nothing.”

Participants believed that steroid use was not “the easy way out,” as was so often believed by non-steroid users (Schwerin & Corcoran, 1992). Bob summarized these beliefs in the following statement:

Everybody's attitude towards anabolic steroids who haven't used them is basically that they are the easy way out, that they are a lazy person's way of getting results. But they're really not. In order to get results using anabolics you have to eat more because your body can absorb more nutrients, your metabolism goes up, you have to train harder because your body can recover faster....

Otherwise you're not going to get results, you're just going to waste your money.

Participants initially used minimum doses of supposedly 'mild' steroids, and gradually spiraled into higher doses of stronger, potentially more dangerous steroids. When some individuals reflected on their "crazy days" of steroid use, they realized that they had gone too far. Bob told his story of surviving dangerous levels of steroid use with pride because he had not died:

It was totally getting carried away...I was taking veterinary steroids, horse steroids....I was taking, the dosages that you read on the bottle that they give to race horses, I was taking more than that and that was only one of the things that I was taking. It was just crazy. (Bob)

Participants who used steroids separated side effects into two categories-- 'physical' side effects' and 'psychological' side effects. Physical side effects experienced by each user varied, but the most undesirable side effects noted by participants included hair loss, bloating, testicular shrinkage, acne, and jaundice. Participants reported that they were willing to tolerate these physical side effects because they had already inflicted physical pain on their bodies through intense training and rigid dieting. Bob believed that "more negative side effects equals more positive side effects."

The four participants who used steroids noted psychological side effects such as moodiness, increased irritability, and aggression. Two participants reported experiencing ‘roid rage, and stated that they needed to stay away from bars while on a cycle of steroids because of their tendency to get into fights with other men, which resulted in assault charges. For example, Ryan stated that the “tiniest, tiniest things” bothered him while he was using steroids, like the sound of his alarm clock—he reported going through several alarm clocks because he would “throw a little temper tantrum” and throw them across the room. On the other hand, Josh reported that he had never been affected by ‘roid rage because he was a shy, mild mannered person and therefore believed it is a “figment of your imagination.”

Participants who used steroids also noted a high tendency towards depression when they had completed a cycle of steroids. Although they loved how steroids increased their muscle strength and size and were willing to tolerate physical side effects, they admittedly struggled with the psychological side effects. After their psychological struggles with steroid use, two participants believed that their steroid using days were over, while the others were willing to tolerate physical side effects in order to “get bigger.”

Even though there were times when the participants were proud of their physical accomplishments and satisfied with their bodies, they believed that they were never big enough. There was always more to achieve. Jake believed that “more is better when it comes to bodybuilding...if you take things a little beyond what the norm is, those are the people who are growing and those are the people who are showing the results.” Josh believed there was no end in sight to the possibilities for gaining size:

I just want to be a freak. If your legs are double the size of mine, you're a freak. If your neck is popping out with veins and you can't even get rid of the veins in your shoulders, you're a freak. There is no other definition that you could be put under. And I want to be one of those freaks.

Participants reported being disappointed when their results disappeared after they quit training, dieting, or using steroids. Bob remembered "kind of feeling like I was a little bit betrayed and misinformed because I guess I thought that my results would stay." In order for the participants to continue experiencing results, there was no option but to remain committed to training, dieting, and steroid use.

Extreme Commitment

Commitment to training appeared to be a symbol of what each man believed himself to be-- strong, dedicated, full of pride and committed to his goals. According to the participants, if a man does not stand by his word, he is lazy, non-committal, and therefore a lesser human being. Commitment to training became a symbol of their commitment to life; it was the "raw essence of who we are" (David). Intense focus and acceptance of pain appeared to be the key requirements for extreme commitment.

Intense focus was a cornerstone of commitment to training. Mental preparation, or 'psyching' oneself up for the lift, was crucial to one's physical development:

Be all about business. Get down to business. That's my motto....Put your music on, focus into yourself, start thinking about yourself, don't even think about how many reps you're on right now.... Just go until muscle failure and then snap out of it. Ok, now we're getting down to business because I can barely move my arm... Focus. You gotta focus. (Josh)

Preparing for the lift demanded individual ritual and focus. Participants described breathing as a means to focus before the actual lift (e.g., taking three deep breaths). Focus often required greater intensity as the men became more involved in training and lifted heavier and heavier weights. For example, David described his focus when psyching himself up to do a heavy lift during a power-lifting competition:

You kind of get into a mental head space and basically I looked up, and wherever I look up at is what I lock onto. And this one woman happened to be sitting right in front of me and I hooked onto her...I can just imagine the amount of energy I was blasting at her and I mean I was so laser-like focused on her and it was funny because the look on her face was just like a deer in the headlights.

Physically aggressive and chemical means were also used to intensify one's focus before a lift. Bob once split his head open on a bar to find the inner aggression and focus to do a squat. Scott relied on ephedrine (a 'natural' stimulant) and caffeine to fuel his workouts. David sniffed ammonia to open his nasal passages before heavy lifts at competitions.

The acceptance of physical pain was a second key component of commitment to training. Muscle growth demanded discomfort, and participants stated that it was crucial to train until muscle fatigue (e.g., exercising until the muscle was too sore and tired to lift the weight). Slight muscle soreness was expected after a workout, but participants often described going to the other extreme. Josh remembered "straining so hard I hurt another muscle that I wasn't even using. How the hell did I hurt that muscle when I'm not even working that muscle?"

David admitted that “if we just keep picking up heavy things we’ll get stronger... but the other thing is that you’ll destroy every joint in your body and you’ll end up just being a crippled heap at the end of the day.” Participants often described crippling pain in their quest for muscle growth, as seen in Jake’s description:

I’ve just noticed that it seems like every other month now I’ve either got a muscle pulled or my rotator cuff is, I just snapped a tendon last week in my rotator [cuff]. Things are a lot stiffer. I’ve had to cut down on the amount of weight I use because my knees are worn out and I find that like it sounds like there’s gravel in them...it was to the point where I could cry because of the aching. And I’m only 25 years old. I feel like I’m 50.

Participants described injuries incurred from weight training as symbols of strength and commitment to one’s sport. Injuries were not viewed as the body’s signals for rest or healing, but rather as signs that the program was working and gains were being made.

Individual commitment to training was important, but equally important was experiencing a sense of belongingness.

Join the Club

Participants belonged to fitness centers or bodybuilding gyms where they could train with like-minded individuals. They reported experiencing a sense of camaraderie and belongingness at these gyms, but this was tentative and viewed with caution, as intense competition was equally as prevalent. Participants reported that they did not feel a sense of camaraderie with all gym goers, only those with whom they shared the same

intensity of training. Jake described his experience of meeting a like-minded steroid user while on holidays:

The second I saw him...I said, "Oh, juicer" and...he told me...that when he saw me he said, "Oh, juicer." He hit his girlfriend, like he poked her in the side and said, "Look" and that's exactly what I had done to [my wife]. I had seen him, we kind of made an eye contact like 'Hey', a kind of 'hello', a fellow gym guy. We just knew. So we hung out with them and that was really good.

Participants reported that training with like-minded individuals was invigorating because such individuals tended to be encouraging, willing to 'spot' (provide support to lift a heavy weight) others if they required assistance, and often were willing to share training and dieting tips when asked. There was always someone 'bigger' around to compare oneself to and therefore provide extra incentive to train harder. Some participants trained with a partner or personal trainer which helped them maintain focus on their goals, especially when training for a competition. Jake and his cousin were both involved in training, which contributed to some 'friendly competition':

I was always the one pushing the envelope, taking more [steroids]. I did two shots [of steroids] at once...it was just like a game between [my cousin and I] and I wanted to be the first one to...say that, "Yeah, I took two shots at the same time." And it took me about 20 minutes to line up because every time I would go to stick this one in this hand would move because I'm looking over here and I finally did it. I got them in at the same time and that was like, "Yeah". That was great.

Training partnerships were initially viewed as friendships because the men were committed to a common interest. However, these 'training friendships' were tentative

because once the men had met their goals, or something went wrong with the relationship (e.g., training advice went awry), they often ended abruptly. Bob described a training partnership that ended bitterly:

I got in a bit of an altercation with the guy that was training me...he basically was pissed at me because I [didn't have time to] help him [one] day and wouldn't talk to me...He didn't give me my drug routine...I don't know if he was trying to get back at me or what the deal was. (Bob)

Participants believed that they were different from other individuals who trained at the gym. Their general belief was that other men “who go to the gym...have something to prove. They have chips on their shoulders...most of them are arrogant” (Josh).

Participants did not believe that they themselves were arrogant, although some individuals recognized that they wanted to “be the best” or “had a bit of an ego.” They rated themselves differently than other men who worked out, even though they recognized that their goals were similar.

Participants who were beginning to ease up on their commitment to training recognized that there was a type of ‘gang mentality’ associated with belonging to a gym. David described this as a sense of belonging:

There's something about being included in a group and I think people tend to forget that sometimes or don't even realize they are doing it... It's just like an unwritten rule, you're here, it's just a time that we're together and we think alike and we're of like-minded goals....There's this huge bond and...it was like...a boys club. Everybody was part of this group and you could just be yourself and it was all about the lift and it was pretty neat...But it was the same thing as

belonging to organized crime. It runs your life. If you dare go to leave there is a huge amount of peer pressure not to leave. “What do you mean you’re not training?” “What do you mean you don’t want to compete again?”

Participants were disappointed to find out that the sense of camaraderie and belongingness was only a façade. If they could not trust people who had similar goals and interests as they did, who could they trust?

No One Understands Me

Most participants believed that no one understood them, and therefore they believed they were not cared for by others:

My mom doesn’t understand me...because I do steroids and I sometimes take recreational drugs and I’m not scared to fight...we just don’t understand each other on a lot of levels. I’m starting to become cold in life just because of a few experiences...I don’t know why I’m that cold, I am. I don’t care. (Josh)

Some participants reported becoming apathetic and uncaring towards other people. Past hurts, disappointments, and experiences of rejection had reinforced the notion that others were not to be trusted, and therefore they believed they needed to protect themselves. Most participants learned to rely on themselves and committed to an intense training program where weight training, dieting, and steroid use took up most of their time, leaving little room in their lives for other people. Thus, a cycle of self-imposed isolation began.

Most participants believed that people closest to them had repeatedly betrayed their trust in a number of ways. They described family members as being physically, mentally, and/or or emotionally abusive. They reported that friends did not approve of

their training, training partners attempted to sabotage their programs, doctors did not approve of their excessive training and steroid use, and other gym members were competitive and not trustworthy. Participants believed that their own bodies had betrayed them because they were far from perfect and would not respond to training without assistance from supplements and/or steroids. Their bodies' needs for food, rest, socialization, and relaxation were not to be trusted because they interfered with training. There was literally nothing and no one to trust.

Participants, especially those who used steroids, believed that they were judged unfairly by individuals who were "uninformed" about bodybuilding and steroid use, including medical doctors. They often believed that such individuals had no basis for their beliefs, and often responded to them defensively. Josh felt harshly judged by other people and said he 'did not care' what their opinions were:

I hate people who form opinions and have no fact to back it. They just grab it out of the air. They have no facts...Shut the fuck up. I don't want to talk to you about your opinion because your opinion means nothing to me because you have nothing to back your opinion....You want to know about steroids? You want to ask me? I'll tell you. Flat out. Don't form your opinions about shit you have no idea why people do them. I hate that. Opinions formed about nothing.

Most participants reported becoming self-reliant and independent because they did not trust other people. However, because they also did not fully trust themselves, they focused on training, which became a cycle in itself—the harder they trained, the more isolated they became, and vice-versa. Some participants stopped caring for others because their training took over their lives. Anything that interfered with training was to

be avoided at all costs. Bob recognized that training took over his life; “I was an asshole...I was so focused on my contest that I totally neglected [my girlfriend]. I [was] very cold-hearted and uncaring”. He also said he quit socializing because other people interfered with his training:

I basically had no friends...all I did was eat, sleep and drink...I couldn't go out for supper with anybody. I couldn't very well go to a movie because I had to eat. I couldn't do anything...because I needed to eat certain food and certain amounts of food and it all had to be weighed out...I would go to family dinners and bring my own food because that was part of my diet and I had to do it and I felt like if I ate one meal that I shouldn't then I would be jeopardizing the goal that I had set for myself and wouldn't get the results that I wanted and then...[I would] beat myself up for doing it.

Using steroids was another huge secret that further perpetuated the cycle of self-imposed isolation. Steroid users reported that they did not want other people, especially family and friends, to know that they were using. The exception to the secret was wives or girlfriends, who had to be on board otherwise they would be asked to leave; “if they don't like who I am they can leave and I'm not going to quit doing what I am, who I am to make them happy” (Jake). Steroid users said they wanted other people to believe that they were obtaining their results ‘naturally’ through hard work and dedication to training. For example, Bob did not want his dad to know he was using “out of respect.”

Not only did steroid users not want family and friends to know they were using steroids, but they said they could not concentrate on the activities they were doing with family and friends anyway because they were preoccupied with thoughts about training,

dieting, and steroids. Bob remembered being in a counselling appointment with his girlfriend and his “thought process [was] totally being sidetracked” by whether or not he was going to take a testosterone to increase his results. While on a holiday in Mexico, Jake stopped at nearly every pharmacy he saw:

[My wife] was getting sick out of her mind because every time we went for a walk I had to stop at a different pharmacy or talk to a merchant who was selling steroids or if he knew where I could get them. And I loved it. She didn't understand. I said, “Why do you think we're in Mexico? ...It's one of the only countries you can buy it off the shelf.”

It appeared that participants were able to protect themselves and shield their secret by discussing their steroid use only with other steroid users and/or individuals who were interested in becoming steroid users. Even then, only certain individuals were allowed in on the secret. For example, Josh stated that he was able to speak with this researcher about his steroid use because “I don't know you from a hole in the ground,” although his first question for the researcher was “are you a cop?” By maintaining secrecy over something that they may have intrinsically known was a problem, they attempted to maintain a belief that they had control over their lives.

Control

Participants believed that weight training would give them control over their lives, which they reported often feeling were ‘out of control.’ Participants often described their workouts as an avenue to deal with depression, aggression, hyperactivity, and addictions. They reported that they often “felt better” after a heavy workout, were able to relax, and often experienced a better sleep than when they did not work out. These men believed

that a high amount of physical activity, particularly heavy weight lifting, would help them to deal with intense mental and emotional issues. However, they often found that they required longer and more intense workouts to obtain the same calming effects.

Most participants identified that they had a tendency towards depression, although Kyle, who reported working out moderately, reported little difficulty with depression. Participants recognized that the intensity of their training and the depth of their depressive symptoms were interrelated. They reported training more intensely when they felt depressed and believed that training would make them feel better. At the same time they began to feel more depressed because training harder made them feel worse. Individuals who had become very involved in weight training, dieting, and steroid use, especially competitive bodybuilders, reported experiencing suicidal depression.

Depression strongly affected the men after they experienced injuries that interfered with training, when they went off a cycle of steroids, or after completing a major competition. Jake, a competitive bodybuilder, was forced to take eight months off training due to a shoulder injury, which he found “discouraging” and “absolutely sickening” because it had seriously interrupted his training schedule and caused him to lose a tremendous amount of strength. Bob experienced a ‘yo-yo effect’ every time he cycled off steroids where he stated “I’m on [steroids] and I’m big and I’m strong and then I’m off [steroids] and I’m depressed” which he reported to worsen after each cycle. David described his experience of depression following power lifting competitions in the following manner:

After a [competition] I’m a complete physical wreck and a complete emotional wreck.... I’m depressed almost to the point of...[almost being] suicidal...it’s just

anticlimactic... You've accomplished your goal.... You have a goal but heaven forbid you said that you were going to pull 501 and you pulled 501 and now you're laying there on the couch going "Now what? What am I going to work on?" And you're done. Your goals are done and it is so absolutely wearying.

Participants believed that the only way to combat their feelings of depression was to "get your oars back in the water, man. Get back in here. Keep the habit of coming to the gym" (David). Participants reported that it was important for them to maintain the 'positive' habit of going to the gym on a regular basis so they did not allow themselves to resort to a different, potentially 'negative' habit of becoming 'lazy.' It appeared that they did not allow themselves transition time to recover physically, mentally, or emotionally from their injuries, cycling off steroids, or the intensity of competing, but immediately believed they had to return to their training. As David said, "leisure did not exist in my world."

Some participants reported dealing with aggression and hyperactivity in the same manner they dealt with depression—by taking their frustrations and excess energy out in the gym. Ryan and Josh reported focusing their aggression and hyperactivity in the gym in order to help them avoid trouble with the law. Ryan found that going to the gym became a "conscious decision" to keep himself occupied rather than "being an idiot" and getting into trouble. Josh, who reported being diagnosed with Attention Deficit Disorder (ADD) as a child because he was a "right out of control retard," used his anger from a hard day at work to focus on his training:

After work, after the day's gone retarded and I'm already pissed off at the world, I can take my aggression out on [name of employer] and just want to pound his

head in at work, I go to the gym and use that aggression and that steam and that fucking hate-work-and-hate-life, and I'll go to the gym and I'll come out smiling. Now I can go home and relax.

Addictions to alcohol and/or drugs often preceded and co-existed with the participants' involvement with weight lifting and steroid use. Five participants openly admitted that they struggled with drug and/or alcohol addiction. They often found weight lifting as a "positive addiction" that helped them combat their "negative" addictions, although some individuals reported continuing to use drugs and/or alcohol to deal with depression. Josh and Scott reported struggling with depression for a many years and initially used alcohol to cope with life, then turned to drugs, and finally "discovered" weight training. David reported struggling with alcohol abuse for many years and found that power lifting helped him overcome his addiction:

I was looking for a tool to help me do it and power lifting, in a number of different ways, kind of helped me bridge that gap...it gave me something positive to focus on at a time and [surround myself with] people who weren't [drinking].

Some participants found that they needed to choose between one addiction (e.g., drugs or alcohol) or the other (e.g., weight training), and they chose the gym. They were very aware that they were addicted to the 'high' they got from lifting, but believed it was a more positive choice than drugs and alcohol. However, participants realized that going to the gym only gave them the illusion of having control over their lives.

It's All an Optical Illusion

It appeared that participants sought to create strong, muscular image that may have been equal and opposite to how weak and insignificant they felt as children by

changing their physical bodies through weight lifting. Participants reported that they wanted to be noticed as individuals. They wanted women to notice how attractive they were, and they wanted men to notice how strong and tough they were. For example, David wanted “to be the biggest, flashiest peacock in the bunch.” However, this image was an optical illusion that literally disappeared when they did not have the admiring eyes of others to reflect back to them who they wanted to be.

Participants believed that they received more attention from women when they were ‘bigger’ as opposed to when they were ‘smaller.’ They could not identify whether this was due to their actual size or because they felt greater confidence in themselves.

Matt believed that women wanted to ‘feel protected’ by a man:

Once I hit 200 pounds, I noticed I got a lot more attention from girls. I don’t know if it is just that I got to an age that I was a lot more confident, because I was really shy when I was a kid...A lot of my girlfriends...say that they feel, because I’m a little bit bigger, and that I’m stronger, that they feel safe when they are with me. It’s something girls look for...I don’t think most girls want skinny little wimps. They want somebody who they can feel protected by.

Many participants wanted to develop an imposing physical presence. David stated that he wanted his large, strong bodies to speak for him and “show off a little bit,” “walk in and act like the biggest dog in the room,” “be noticed,” and say “Here I am and don’t fuck with me.” It appeared that participants wanted to express through their muscular bodies that they were individuals to contend with, who owned their own lives, demanded respect from others, and could easily defend themselves, or other vulnerable individuals, in any situation.

Participants reported revealing their imposing physical presence through the clothing they wore. It was common for participants to own specific bodybuilding clothing (e.g., clothing with a barbell or ‘muscle guy’ label). Jake was “pissed off” if people who were not bodybuilders wore bodybuilding clothing because they had not earned the right to do so.

Some men preferred to train with small muscle shirts on, while others enjoyed taking their shirts off in order to reveal their sculpted muscles:

My shirt’s usually soaked by about 45 minutes, and at that point I take my shirt off, sweating all over the gym, shirt off, I don’t care who’s face I’m in about me having my shirt off. I look good, I’m sweating, I can’t have my shirt on, forget it.
(Josh)

Despite his size and muscularity, Jake felt uncomfortable revealing his body to others, including his wife:

Even when I was in contest shape around the house or going to the pool I hated it, I couldn’t take off my clothes but I could stand on a stage in front of a thousand people....But the second I’m off stage I cover up. Even to this day I hate it....I’m not fully comfortable walking around the house with my shirt off if my wife is [there].

Participants may have been attempting to construct a strong self-identity through creating an imposing physical image. Where many individuals identify themselves with their profession, these men identified themselves with their choice of exercise—“bodybuilders” (Bob, Jake, Josh, Matt), or “powerlifters” (David, Scott). Others further defined themselves as “hardcore” (Jake) or a “freak” (Josh). Some of these men were

able to create identities that they were proud of, where they were individuals in a marginalized group in society. They stood out from the majority of people and were driven to succeed; “It’s who I am. I’m not me without the size and without the muscle and without being big” (Jake). They enjoyed being noticed for their size and muscularity; “That’s my sport and I love it” (Jake).

However, participants also admitted that their size, muscularity, and confidence in their bodies was all an optical illusion:

[It was]definitely...a false image. I saw myself as, the only way I can describe it is as I’m me but I could see myself as the Incredible Hulk, like I’m some big tough guy and nothing can stop me and it’s definitely a false image and on more than one occasion I had the point proven to me. (Ryan)

Beneath their imposing physical presence were men who felt uncomfortable in their own skin. Participants admitted that they often put on an act to hide how weak, vulnerable, and scared they felt; “I don’t want to be scared because a lot of times I’m really scared...then I think, ‘No, no no. You’re [Josh] and you never get scared.’ I never want to be weak, ever” (Josh). Participants revealed that they often felt shy around women, intimidated by other men, insecure in their relationships, and very depressed many times throughout their lives. They had used weight lifting, dieting, and steroid use to cope with difficult relationships, betrayed trust, depression, aggression, hyperactivity, and addictions. When they took a good look in the mirror at the naked truth about how they felt about themselves, they were still not happy with the reflection. No matter how big they were on the outside, most participants still felt like weak, insignificant, scrawny, or fat little children inside.

After years of obsessing about their bodies, most participants began to question their efforts and attempted to overcome their obsession with achieving an ideal body.

Overcoming the Obsession

Attempting to achieve the ideal body through heavy weight lifting appeared to be an issue that two individuals were no longer obsessed with, four individuals were struggling to overcome, and two individuals remained extremely committed to. Most participants recognized that attempting to achieve the ideal body was a ‘phase’ they were going through. The participants who were no longer obsessed with changing their bodies realized that weight training had helped them bridge adolescence with adulthood, and as they began to develop their independence, establish their own identity, examine their priorities, and establish relationships they were comfortable with, their obsession with achieving an ideal body began to dissolve.

Individuals began to question whether all their efforts to achieve an ideal body were “worth it” (Bob). After all, they had tried “everything” and still not obtained the results they wanted or the happiness they desired. Participants also became seriously concerned about their health. Their years of ignoring injuries and ingesting ‘natural’ and chemical substances had begun to take a toll on them. They began to worry if they had seriously damaged their bodies.

Although some participants were still obsessed with changing their bodies through heavy weight lifting, all participants recognized that they were not likely to remain committed to, or obsessed with, weight lifting indefinitely. Josh, who wanted to become a “freak,” recognized that even he would slow down one day:

At one point a guy has to decide, okay, this has got to stop, I want to do something else with my life. I think I'll still always be physically active and always wanting to do something and maybe be a coach or something later on in life so I'm involved in sports or involved in something....But later in life, maybe my dogs will become more important, maybe my kids probably will become more important so I'll be spending less time in the gym. But even [then], I don't think I could ever go away from the gym.

Some participants chose to end their obsessive behaviors at specific times in their lives. For example, Josh intended on using steroids until he was "man size" at age 30. Ryan wanted to train intensely until he reached 280 pounds. Other participants found that they were forced to slow down due to injuries, or chose to slow down and allow other priorities to take precedence over their training.

After years of focusing on training, many participants realized that their lives were out of balance and required a shift in priorities. They began to allow family, friends, and careers to begin to take precedence in their lives:

I think all that time in the gym affected all my other things, like my studies, my schooling, maybe, potentially relationships with friends, with girlfriends, or whatever. Now I spend less time in the gym but, which is upset[ting]. I'm upset about it, but my work habits have improved, I'm trying to improve on them, my study habits in terms of my clients and spending time with my clients and focusing on other things, I'm trying to find a better balance. (Scott)

Although Scott was trying to find a better balance with his workouts, he also recognized that he was becoming unbalanced with his work; "I know now I work more

than I ever have...for the last year and a half or so I've been working seven days a week in one capacity or another.”

All of the participants that quit training intensely and using steroids believed they would not return to their previous obsession:

I never have, I have never, ever gone back on any [steroids]....You know, there are other things in my life now that are more important things. After the contest or towards the end of it I wrote down things that I wanted to do, things that I wanted to buy, and things that I wanted to accomplish before I used steroids again...It's not for me to spend \$1500 on drugs to do a cycle and eat, sleep and train and do nothing else. It really isn't worth it to me....That's just what was important to me at the time. (Bob)

Although he did not want to risk the psychological effects of using steroids anymore, Bob was not quite willing to give up all preoccupations with achieving an ideal body. He continued to use other 'natural' muscle building supplements and longed for the muscle size he once had. This appeared to be a pattern with all other participants who were no longer as obsessed with training as they once had been. Even though they accepted a more moderate training schedule and no longer spent hours at the gym, they were still involved with weight training.

Participants who had begun to end their obsession with attaining an ideal body began to realize the importance of relationships and learning to trust other people again. When they began to seek greater balance and meaning in their lives, they focused on relationships, rather than isolating themselves in the gym. Participants who previously had been involved in bodybuilding or power lifting competitions did not want to

jeopardize their current relationships by once again becoming competitive. They believed that competing would put a strain on their personal lives that they were not willing to deal with now that they had developed stronger relationships with friends and loved ones.

In addition to learning how to trust other people, some participants had begun the task of learning how to trust themselves again. David began to realize that he no longer required the façade of strength and intimidation because he was developing greater confidence in himself:

Now I can walk into a room and I guess I'm more confident in who I am. I don't have to be the most intimidating guy in the room, or have to act like it. There are very few things that actually scare me but before I used to promote that much more, whereas now I can hang in the back and still feel as competent as, not that I don't feel fear... but I don't have to flaunt it the way I used to flaunt it. I don't know if it's more of a confidence issue now but I would say, probably for me, is probably what it boils down to. I have more self-esteem and self-confidence so that I don't have to be that visible presence anymore. (David)

Some individuals reported that they had received previous counselling. David had received previous counselling with the Alberta Alcohol and Drug Abuse Commission (AADAC) for alcohol addiction and Bob had attended couples counselling. Other individuals, Kyle and Matt, reported having strong spiritual beliefs. In comparison to individuals that did not report previous counselling or having strong spiritual beliefs, these individuals reported to have achieved greater balance in their lives in the areas of work, relationships, and leisure.

Summary

The results of this study suggest that there may be a developmental progression for men who attempt to achieve an ideal masculine body. The participants in this study resolved to change their bodies through weight training because of insecurities stemming from messages they heard about their bodies as children or adolescents. Some individuals lifted heavy weights, dieted, and used ‘natural supplements’ moderately, while other men engaged in more extreme behaviors. Others pushed the limits of their physical bodies and attempted to become “huge” or “freaks” by using steroids. Most participants realized that their efforts at achieving an ideal body were an “optical illusion,” and desired to overcome their obsession by seeking greater balance in their lives. The following chapter compares these results to existing literature, examines the implications of these results for counsellors, discusses the limitations of this study, and suggests directions for future research.

Chapter 5: Discussion

The goal of this thesis was to explore the phenomenon of attempting to achieve an ideal masculine body. The results of this thesis reflect all aspects of existing literature related to this phenomenon, which suggests that men who attempt to achieve an ideal masculine body may be dealing with a variety of complex issues. The results of this thesis combined with the literature suggest the following conclusions. First, men who attempt to achieve an ideal masculine body may be vulnerable to external messages about their bodies, as seen by all the research participants who heard negative messages about themselves as children, cited movie stars and bodybuilding icons as their role models, and relied on ‘fitness’ and bodybuilding magazines for their exercise, diet, and supplement information. Second, it appears that most of the research participants may have had pre-existing personality traits and/or mental health issues (e.g., substance dependence/abuse, symptoms associated with mood disorders, etc.) that may have contributed to this vulnerability, while developing traits of other mental health issues (i.e., eating disorders, muscle dysmorphia, depression, etc.) as a result of becoming engaged in extreme exercise, dieting, and steroid use. Third, most of the research participants appeared to try to deal with complex mental health issues (e.g., substance dependence/abuse, symptoms of depression and/or hypomania, etc.) by taking their ‘frustrations’ and ‘aggression’ out in the gym, rather than seeking counselling. Each of these conclusions are discussed in detail, followed by implications for counsellors, limitations of the study, directions for future research, and the implicated researcher.

External Messages

The results of this study correlate to the literature that suggests that external messages may contribute to the phenomenon of attempting to attain an ‘ideal’ masculine body (Klein, 1993; Marzano-Parisoli, 2001; Weigers, 1998; Wendell, 1996). All participants in this study cited bodybuilding and fitness publications as influential on the way they perceived their bodies, and nearly all the participants cited movie stars and bodybuilding icons as their physical role models. Their desire to become as well-known as individuals with supposedly ‘perfect’ bodies may be summed up in Scott’s response to becoming a research participant—“Are you going to make me famous?” It appears that a desire for an ideal masculine body as portrayed by media images may have provided impetus for the men in this study to begin lifting weights.

Results of this study also correlate to Russell & Ryder’s (2002) ideas that exercise and diet behaviors lie on a continuum that ranges from mild to extreme, and that engaging in mild behaviors may spiral into obsessive behaviors that may lead to a diagnosable disorder. Most participants began exercising to “lose a little weight” or to “gain a little muscle,” however, and found that they required greater commitment to exercise and dieting as well as greater amounts of supplements and/or steroids to obtain and/or maintain their results. One participant in this study was able to exercise and diet at a moderate level to maintain his health while the other seven participants engaged in extreme exercise and diet behaviors that would likely be considered obsessive and unhealthy.

The research participants' stories about heavy weight lifting, rigid dieting, excessive supplement use, and for some, steroid use, revealed symptoms similar to those associated with mental health issues.

Mental Health Issues

The writer is not attempting to diagnose these individuals, but wishes to speak to the correlations between the participants' stories and mental health issues that were presented in the literature review.

Eating disorders. A correlation between heavy weight lifting, steroid use, and eating disorders was strongly indicated by the literature (Klein, 1993; Marzano-Parisoli, 2001; Monaghan, 1999; Pope et al., 2000; Russell & Ryder, 2001). Research participants cited many behaviors that interfered with daily functioning that would meet the diagnostic requirements for an eating disorder. For example, lifting weights twice a day; training every muscle every day; and planning out seven meals per day based on the "right" combination of protein, carbohydrates, and fats would be considered obsessive behaviors. In addition to revealing symptoms similar to those associated with eating disorders, participants also revealed symptoms associated with muscle dysmorphia. For example, all participants described "feeling small" or inadequately muscular, and some participants reported the excessive use of mirrors.

Substance dependence. Substance dependence/abuse was revealed by most research participants. This finding correlates with Phillipott & Shephard's (1998) assertions that individuals with eating disorders often have co-occurring substance addiction. Most participants reported the excessive use of supplements and/or steroids to "get results," and five of the eight participants also reported the excessive use of drugs

and/or alcohol to “get through the day.” Two individuals reported that they chose not to use steroids because they were afraid of their potential for addiction as their past experiences with drug and alcohol addiction revealed. Two participants who used steroids stated that they had “addictive personalities.”

The participants who used steroids described many of the physical and psychological effects that were evident in steroid literature (Klein, 1993; Wright et al., 1991; Haupt & Rovere, 1984). All participants who used steroids reported massive physical gains, disturbing psychological side effects (e.g., depression and aggression), and withdrawal effects after discontinuing the use of steroids. All participants who used steroids observed that their own personality traits became ‘enhanced’ while they were using steroids. For example, individuals who reported aggressive tendencies prior to steroid use noted increased aggression while using steroids, and an individual who reported a tendency towards shyness noticed that he became more withdrawn while using steroids.

Mood disorders. Traits associated with mood disorders were noted by most research participants. For example, most participants reported having experienced periods of depression throughout their lives. There appeared to be four different reasons for depressive symptoms described by research participants: (a) they may have been attributed to a pre-existing mood disorder; (b) they may have been attributed to the individual’s reaction to stress at certain times in his life; (c) they may have been attributed to malnutrition or semi-starvation, as is often seen in individuals with eating disorders (American Psychiatric Association, 2000); or (d) they may have accompanied steroid withdrawal (Pope & Katz, 1998). Individuals reported that their symptoms of

depression worsened after they engaged in heavy weight lifting, dieting, and/or using steroids.

In addition to symptoms of depression, episodes of hypomania and/or mania were recounted by two participants. Both individuals recalled impulsive spending (e.g., Ryan received \$30,000 in traffic fines and Josh spent \$9000 on an aquarium), impulsive behavior (e.g., Ryan was pulled behind a truck going 85 kilometers an hour while on rollerblades), rapid speech, and an inability to sleep when they were on a cycle of steroids. During Josh's interview, when he reported to be using steroids, the researcher noted psychomotor agitation, fast speech, and flight of ideas. Pope & Katz (1988) noted that manic or subthreshold manic symptoms may be present in individuals while on a cycle of steroids, however, both of these individuals also recalled similar behaviors when they were not using steroids. For example, Ryan reported impulsive behavior, moodiness, and having difficulty holding a job when he was not using steroids. Josh reported that he had been an "out of control retard" as a child and had been diagnosed with Attention Deficit Disorder. Pre-existing mental health issues and personality factors cannot be ignored when looking at individuals who engage in heavy weight lifting and steroid use in an attempt to achieve an 'ideal' masculine body.

Personality traits. Participants provided numerous examples of personality traits associated with a number of personality disorders as cited in the literature. For example, obsessive-compulsive traits were suggested by most participants' disclosures of extreme devotion to their training, preoccupation with the details of their programs, diets, supplement use, and steroid use; perfectionism; desire for control; rigidity about weight training and dieting 'rules'; and the exclusion of leisure and friendships. Individuals who

had reportedly overcome their obsession with weight training also continued to display obsessive-compulsive traits (e.g., Scott reported working seven days per week).

Borderline traits were suggested by most participants' disclosures of brief but intense relationships with training partners, impulsivity, mood lability, and inappropriate anger and aggressiveness. Narcissistic traits were suggested by most participants' statements of self-importance; preoccupation with fantasies of success, power, and beauty; beliefs or desires to be "individual"; desire for excessive admiration; envy of others or beliefs that others were envious of them; and demonstration of arrogant or haughty attitudes. For example, Josh stated, "If you live in [name of city] and you haven't heard the name of [Josh], you must be living on crack....Everyone knows who I am." Avoidant traits were suggested by one participant's disclosures of fears of disapproval, criticism, and rejection; restraint with close relationships; and viewing himself as unappealing.

Participants also revealed traits associated with personality disorders that were not listed in the literature. For example, paranoid traits were suggested by most participants' difficulty trusting other people, quick and angry reactions to others, reluctance to confide in others, and two participants' self-reported feelings of "paranoia" (e.g. Josh's first question to the researcher was "Are you a cop?"). Histrionic traits were also suggested by some participants' style of language and description of their behaviors. For example, some participants used very descriptive language (e.g., David described wanting to be the "biggest, flashiest peacock in the bunch"). Others described using their physical appearance to draw attention to themselves (e.g., wearing tight-fitting clothing to accentuate their bodies), and some individuals stated that they did not want to recommend anyone else they knew for this research because they wanted to be "special."

All research participants also spoke about being “individual” and “independent,” which may suggest why they attempted to deal with complex mental health issues on their own.

Dealing with Mental Health Issues

The results of this study indicate that most of these participants actually may have been attempting to deal with complex mental health issues on their own rather than by seeking counselling. Some individuals with drug and alcohol addictions stated that they choose to go to the gym instead of going to the bar in order to overcome their addictions on their own; the gym was reported to be a “positive” addiction instead of a “negative” addiction. Participants reported that they used heavy weight training as an outlet for releasing aggression, a means to channel fears and anxieties, and a way to deal with frustrations stemming from work and relationships. Some participants reported that they were not able to sleep unless they engaged in intense physical activity. It appears that most participants in this study used intense physical activity as a means of relieving symptoms of mental health issues. When queried as to whether or not they sought counselling for these issues, only two participants reported that they had—one for relationship issues and one for alcohol dependence. When queried as to why he had not sought counselling for mental health issues, Josh stated the following:

I don't need a psychologist [to tell me] why I am who I am, why I do what I do. I don't need a psychologist to know why I'm angry at the world and violent. It's because my biological father was abusive and an asshole. The fact that...they say I [have] addictive disorder, I don't know. That's just floating in the air bullshit. Those doctors aren't gonna tell me something about myself that I don't already know.

These results suggest many implications for counsellors.

Implications for Counsellors

Implications for counsellors are discussed in terms of prevention, intervention, and treatment.

Prevention

Prevention efforts target populations that may be at risk of developing a mental illness and focus on reducing associated risk factors (Russell & Ryder, 2002). The results of this study indicate that individuals who may be at-risk for engaging in extreme behaviors in an attempt to obtain an ideal body may have received negative messages about their bodies as children and adolescents. Implicit or explicit messages from the media (e.g., television or magazines) or intentional or unintentional comments about one's body size, shape, or athletic ability from influential individuals (e.g., parents, teachers, or peers) at a vulnerable age may have contributed to these beliefs. Lowen (1985) asserts that children and adolescents do not have the developmental ability to question the validity of such messages, and therefore may believe them to be true. Almaas (2001) believes that sensitivity to negative messages may continue into adulthood, leaving individuals vulnerable to self-doubt and lowered self-esteem.

Russell & Ryder (2001) suggest that body image and disordered eating prevention and intervention efforts need to target children and adolescents. However, this researcher suggests that prevention and intervention efforts also need to include parents, teachers, coaches, and any individuals working with children and adolescents. Individuals who work with children need to understand how their own values and attitudes toward body-related issues (e.g., weight, dieting, exercise, etc.) may impact the children they work

with. For example, coaches and parents of adolescents involved in team sports need to be aware that adolescents may feel pressured to begin using steroids to enhance their athletic performance in order to reach 'star' status. In this study, 'average' athletes who wished to become 'star' athletes, and 'star' athletes who believed they may have had a chance to go professional began lifting weights and using steroids to increase their athletic abilities. Individuals working with children may wish to examine the purpose of practices such as weighing children and adolescents in school classes or in team sports; comparing athletic ability; and may need to be extremely cautious of implementing weight loss, weight training, or diet programs for children and adolescents. Such practices may impact children's and adolescents' body image, as was suggested by the participants in this study. Adults working with children and adolescents also need to be aware that some individuals may be more vulnerable to suggestion than others. Such individuals may be at greater risk for developing unhealthy attitudes and beliefs as well as engaging in unhealthy exercise and dieting practices (Russell & Ryder, 2001).

When an at-risk individual is identified, intervention strategies need to be employed.

Initial Intervention

Counsellors need to be aware that initial intervention strategies are likely to be met with denial and resistance (Rogers & Petrie, 2001; Vitousek et al., 1998). The results of this study indicate that individuals who engage in extreme weight lifting, dieting, and steroid use in an attempt to achieve an ideal body may be extremely resistant to outside intervention. Even the suggestion of counselling was met with high resistance by most research participants. Individuals may insist that everything is fine and that their

behaviors are rational and/or necessary (Vitousek et al., 1998). Symptoms may be defended out of fear because the possibility of losing size and gaining body fat is terrifying. Malnutrition and rigid thinking also makes it impossible for such individuals to be rational about their condition (Vitousek et al., 1998). Counselors need to recognize that denial and/or resistance is directed against the fear of losing control, feelings of helplessness, and fear of change (Vitousek et al., 1998).

Knowing that denial will likely be the individual's first response when initially confronted about their extreme behaviors should not stop people from expressing their concerns, as well as referring the individual to a professional trained in the assessment and treatment of these issues. People who do not express their concerns may be creating a conspiracy of silence which enables the individual with a serious problem to continue with unhealthy behaviors and thus prolong the disorder, potentially endangering his life (Thompson & Sherman, 1993).

Treatment begins once an individual has been identified as being at-risk and agrees to seek help.

Treatment

The participants in this study presented with similar behaviors (i.e., heavy weight lifting, rigid dieting, excessive supplement use, and for some, steroid use). However, they also revealed a tremendous variety of motivations for engaging in these behaviors, as well as mental health issues and personality traits, that would require an in-depth assessment and an accurate diagnosis before specific treatment could begin. Once an accurate diagnosis is achieved, a model of eating disorder treatment may be used in order

to decrease extreme exercise and dieting behaviors, examine underlying issues and prevent inevitable relapses.

Assessment and diagnosis. In order to inform case conceptualization and provide specific interventions, counsellors need to determine (a) what an individual's specific behaviors are in order to determine the severity of the disorder; (b) what motivated the individual to begin engaging in the behavior; and (c) what is sustaining the behavior. When the research participants' profiles are revisited, each individual describes very different motivating and sustaining reasons for their behavior. For example, David engaged in competitive power lifting, began weight lifting to "get in shape," and said he was replacing his "negative" alcohol addiction with a "positive" power lifting addiction. Jake engaged in competitive bodybuilding and steroid use, said he still felt like the "shy fat kid" he remembered from his childhood, and alluded to dealing with grief issues surrounding the loss of his mother at age 16. Josh began using steroids to be the "golden boy" in hockey, vowed "never to be weak," and intended on "becoming a freak" by using steroids until he was "man size" at age 30. These individuals presented with similar behaviors yet reported completely different motivating and sustaining factors for their behaviors.

The diagnosis of Axis I and Axis II disorders according to the DSM-IV-TR combined with the issues the individuals bring to each therapy session will inform treatment and interventions. For example, one individual may be diagnosed with an eating disorder as well as present with traits of obsessive-compulsive disorder, while another individual may present with symptoms more closely associated with muscle

dysmorphia and traits of avoidant personality disorder. Accurate assessment and diagnosis calls for individualized treatment.

A model of treatment. A model of treatment for eating disorders may be appropriate because it addresses three areas that appear to be related to obtaining an ideal masculine body: (1) normalization of eating and exercise habits, (2) significant changes in thought and behavior, and (3) relapse prevention (Garner et al., 1997; Russell & Ryder, 2001; Vitousek et al., 1998).

Phase one treatment for eating disorders consists of weight stabilization and the normalization of eating and exercise habits. This may be a very lengthy process for individuals who have been engaged in extreme behaviors for a long period of time. As previously stated, these individuals may be highly resistant to change. As well, participants in this study reported having difficulty trusting others, particularly individuals who appeared to be judging them or wanting them to change their behaviors. This implies that developing a strong therapeutic relationship will likely be of utmost importance in order to engage these individuals in long-term therapy.

Once an individual's body becomes stabilized, other issues may begin to take precedence over exercise and diet behaviors, thus moving the treatment into Phase Two. This is where accurate assessment and diagnosis will inform treatment. For example, one individual's grief issues would likely be addressed, whereas another individual's rigid thinking (e.g., beliefs about becoming "man size" at age 30) may be challenged. There are a number of approaches that may be effective. Cognitive-behavioral therapy is a widely researched and effective treatment for eating disorders (Garner et al., 1997; Wilson, Fairburn, & Agras, 1997). Cognitive-behavioral therapy addresses the

behavioral, cognitive, and affective areas of the person. It examines specific purposes of eating disordered symptomatology, contradictions in thought and behavior, and advantages and disadvantages of change (Vitousek et al., 1998). A psychoeducational approach may provide objective information to challenge irrational thinking and teach problem solving skills and new coping strategies. Self-esteem, self-concept, perfectionism, impulse regulation, affective expression, family conflicts, and interpersonal functioning are issues that are likely to be addressed during this phase (Garner et al., 1997; Wilson et al., 1997). This researcher would not recommend group therapy at the beginning of treatment because the results of this study indicate that these individuals may be more likely to perceive themselves as solitary individuals, as most of them preferred training alone. However, these individuals also implied that they were moving towards trusting others as they moved away from obsessive exercise, which suggests that group therapy may be more effective towards the end of treatment.

Counsellors should be aware that body image issues may be difficult to overcome in a society where images of the 'ideal' masculine body continue to be presented every day in media and entertainment (Marzano-Parisoli, 2001) at the same that these individuals are trying to stop achieving an 'ideal' body. This is why relapse prevention and intervention strategies are important in Phase Three of eating disorder treatment (Garner et al., 1997; Wilson et al., 1997). Relapse is common in eating disorders, even four to twelve years after recovery (Schneider & Irons, 1997). Individuals may continue to show signs of weight and dieting preoccupation, obsessive thoughts and behaviors, emotional restraint, psychopathology related to eating habits, perfectionism, and negative affect (Kaye, Klump, & Strober, 2000; Pike, 1998). Symptoms may be less intense after

recovery, but many concerns may remain the same. In this research, most individuals who had overcome their obsession with weight lifting indicated that they still experienced many of the same thoughts and beliefs after they had significantly decreased their training and were attempting to obtain balance in their lives.

Limitations of the Study

The limitations of this study are related to the phenomenological-hermeneutic research methodology and the small sample size. In regards to the phenomenological-hermeneutic research methodology, the nature of the research questions allowed the researcher freedom to explore a broad range of experiences related to the topics of heavy weight lifting and steroid use with each research participant. The difficulties that resulted from this approach were limited in that the participants presented such a broad range of experiences that themes could be subject to other interpretations. Although precautions were taken to limit researcher bias and ensure reliability and validity of the results, other individuals may provide further insights into the findings. This implies that further research on this topic is necessary.

Conclusions drawn from this research must be interpreted cautiously because the small sample size cannot be assumed to represent all individuals who engage in heavy weight lifting and steroid use, nor can they be generalized to the public (Priest, 2002). As well, the personal and individual nature of the interviews must be taken into account, as well as the fact that participants were purposively selected in order to fulfill the needs of this study. As well, although every effort was made to maintain rapport with the participants and despite their willingness to disclose drug use and other sensitive information, they may have withheld information from the interviewer that they would

have reported in a self-administered questionnaire. These limitations are taken into account in the directions for future research.

Directions for Future Research

It would appear that there are many possible areas of further research as a result of this study. As an extension of this research, themes generated from this study may be compiled into a questionnaire or survey and presented in a quantitative format in order to obtain greater numbers and check to see if the results may be applicable to a broader population. Any similarities may lend weight to the validity of the method developed and described in this study. Further research may include: (a) exploration of personality factors of individuals who attempt to attain an 'ideal' masculine body through heavy weight lifting and steroid use, and (b) further exploration of the relationship between intense exercise and mood disorders.

Grilo et al. (2003) assert that the co-occurrence rates between eating disorders and personality disorders are sufficiently high to warrant careful consideration during assessment and treatment planning stages, although it is notable that the literature primarily focuses on women. There was a significant amount of data in this research that suggests that personality traits may play an important part in a man's desire to attain an ideal body. Further research in this area is needed, specifically, the design of instruments that link body image to personality.

Another area for further research may be an exploration into the relationship between intense physical activity and mood disorders. Exercise is often associated with mood enhancement (Berger & McInman, 1993, as cited in Motl, Berger, & Leuschen, 2000). However, no research has been found that explores the intensity of physical

activity that individuals with mental health issues may require to achieve mood-elevating effects. As well, no research was found that discusses the implications of exercise contributing to rather than alleviating symptoms of mental health issues. For example, some participants in this research reported experiencing severe depressive symptoms after they decreased the intensity of their training. Some research participants also revealed symptoms similar to mania and/or hypomania, which suggests that investigation into the phenomenon of heavy weight lifting and steroid use and mood disorders (i.e., bipolar disorder) also may be warranted.

The Implicated Researcher

The researcher's personal orientation to this phenomenon was made evident in the introduction to this research. Van Manen (1990) asserts that one cannot engage in the process of phenomenological research without the research having an impact on one's views and beliefs. Throughout the process of this research, the researcher's views moved from a surface level that focused on presenting behaviors and misguided assumptions to a more in-depth analysis of the participant's stories and a consideration of core themes. The researcher's beliefs were affected in three main areas: (1) media influence, (2) similarities and differences between this phenomenon and eating disorder symptomatology, and (3) increased compassion and empathy for individuals who experience this phenomenon.

The researcher recognized that her initial views towards the research participants and muscular men in general had been strongly influenced by the media. She too had been (mis)led to believe that muscular men were healthy, strong, confident, independent, self-assured, and happy, as this was the image that had been portrayed by the media. The researcher came to the realization that external images about 'healthy' and 'fit' bodies,

especially those portrayed in sports, entertainment, and/or 'fitness' magazines, may have a tremendous impact on the way she (and others) view their bodies. By exploring the literature pertaining to media influence on body image and the participant's experiences with believing external messages about their bodies, the researcher's views changed tremendously in this area. She began to question the misguided assumption that individuals who were attempting to achieve the media's image of the supposedly 'ideal' masculine (or feminine) body were indeed as 'happy' or 'confident' as they were portrayed by the media to be. When the researcher examined the research participants' stories, she found contradictory evidence; it appeared that these individuals actually inflicted physical pain and ill-health upon themselves by attempting to achieve an ideal body. It also appeared that some of these individuals may have been attempting to overcome a great deal of emotional pain and/or mental distress by engaging in obsessive weight lifting, dieting, and steroid use.

The researcher anticipated similarities between the participant's exercise and steroid use behaviors, eating disorder symptomatology, and muscle dysmorphia. However, she did not anticipate research participants to reveal a wide variety of traits associated with other mental health issues, substance dependence/abuse, and personality disorders. This changed the researcher's belief that men who attempt to achieve an ideal body through heavy weight lifting and steroid use may be doing so for a single purpose (e.g., the narcissistic pursuit of a physical ideal). Research participants revealed a number of motivations for their exercise and steroid use behaviors that appeared to stem from mental health issues and specific personality traits. The discovery of these similarities to,

yet differences from, eating disorders and muscle dysmorphia increased the researcher's empathy and compassion for these individuals.

As the researcher listened to each participant's story, her compassion and empathy for individuals struggling with body image and mental health issues increased. The research participants presented as strong, confident men, yet most of them revealed painful issues that they appeared to struggle with on their own. As a researcher engaged in phenomenological research, she recognized how humbling this experience was—who was she to assume to be an expert on these men's experiences with weight lifting and steroid use? As a beginning counsellor, she recognized the importance of a thorough exploration of each individual's history and the development of a strong therapeutic alliance in order to enhance treatment and healing. As a human being, she allowed the shared element of truth in each participant's story to resonate with her, and came to the realization that there truly is much more to a person than meets the eye.

Conclusion

The purpose of this thesis was to research the phenomenon of attempting to achieve an ideal masculine body. It utilized a phenomenological-hermeneutic methodology to gather stories from eight different individuals who willingly revealed that they were engaged in this phenomenon. Previous research reveals that this phenomenon may result from a combination of cultural and media influences, eating disorders, addictions, and other mental health issues. This study reveals that individuals who attempt to achieve an ideal masculine body may internalize negative messages about their bodies as children; engage in a continuum of obsessive exercise, dieting, and steroid use behaviors that ranges from mild to extreme; have difficulties trusting other people; and

attempt to overcome their obsessions through time. The results of this thesis combined with the literature suggest the following three conclusions. First, men who attempt to achieve an ideal masculine body may be vulnerable to external messages about their bodies. Second, it appears that pre-existing personality traits and/or mental health issues that may contribute to this vulnerability. Third, some men may attempt to deal with complex mental health issues by taking their ‘frustrations’ and ‘aggression’ out in the gym, rather than by seeking counselling. Counsellors may be able to help these men find the strength they are seeking by providing accurate assessment, diagnosis, and treatment that is designed to meet the specific needs of each individual.

References

- Almaas, A. (2001). *The point of existence: Transformations of narcissism in self-realization*. Boston: Shambhala.
- American Academy of Pediatrics Committee on Sports Medicine and Fitness. (1997). Adolescents and anabolic steroids: a subject review. *Pediatrics*, *99*, 904-909.
- American Academy of Pediatrics Committee on Sports Medicine and Fitness. (2001). Strength training by children and adolescents. *Pediatrics*, *107*, 1470-1473.
- American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders (4th Ed., text revision)*. Washington, DC: Author.
- Andersen, A. (1999). Eating disorders in males: Critical questions. In R. Lemberg (Ed.), *Eating disorders: A reference sourcebook*, (pp. 73-79). Mahwah, NJ: Lawrence Erlbaum Associates.
- Anderson, A., Bowers, W., & Watson, T. (2001). A slimming program for eating disorders not otherwise specified: Reconceptualizing a confusing, residual diagnostic category. *Psychiatric Clinics of North America*, *24*, 271-280.
- Barke, M., Yesalis, C., & Wright, J. (1996). Psychological and behavioural effects of endogenous testosterone and anabolic-androgenic steroids: An update. *Sports Medicine*, *22*, 367-390.
- Bouchard, C., Shephard, R., & Stephens, T. (1994). *Physical activity, fitness, and health*. Champaign, IL: Human Kinetics.
- Brooks, C., Taylor, R., Hardy, C., & Lass, T. (2000). Proneness to eating disorders: Weightlifters compared to exercisers. *Perceptual and Motor Skills*, *90*, 906.

- Burkes-Miller, M., & Black, D. (1988). Male and female college athletes: prevalence of anorexia nervosa and bulimia nervosa. *Athletic Training, 23*, 137-140.
- Burnett, K., & Kleiman, M. (1994). Psychological characteristics of adolescent steroid users. *Adolescence, 29*, 81-90.
- Campbell, J. (1973). *The hero with a thousand faces*. Princeton, NJ: Princeton University Press.
- Carnes, P. (1997). *Sexual anorexia: Overcoming sexual self-hatred*. Center City, MN: Hazeldon.
- Chilibeck, P., Sale, D., & Webber, C. (1995). Exercise and bone mineral density. *Sports Medicine, 19*, 103-122.
- Claude-Pierre, P. (1997). *The secret language of eating disorders*. Toronto: Random House.
- Cochran, L. (1985). *Position and the nature of personhood*. Westport, CT: Greenwood Press.
- Cochran, L. (1986). *Portrait and story*. Westport, CT: Greenwood Press.
- Cooper, C., Noakes, T., Dunne, T., Lambert, M., & Rochford, K. (1996). A high prevalence of abnormal personality traits in chronic users of anabolic-androgenic steroids. *British Journal of Sports Medicine, 30*, 246-250.
- Cover photograph. (2002, May). *Gentleman's Quarterly*.
- Cusamano, D., Thompson, J. (1997). Body image and body shape ideals in magazines: Exposure, awareness, and internalization. *Sex Roles: A Journal of Research, 37*, 701-722.

- Davis, C. (2000). Exercise abuse. *International Journal of Sport Psychology*, 31, 278-289.
- Davis, C., & Fox, J. (1993). Excessive exercise and weight preoccupation in women. *Addictive Behaviors*, 18, 201-211.
- Davis, C., Claridges, G., & Cerullo, D. (1997a). Personality factors and weight preoccupation: A continuum approach to the association between eating disorders and personality disorders. *Journal of Psychiatric Research*, 31, 467-480.
- Davis, C., Katzman, D., Kaptein, S., Kirsh, C., Brewer, H., Kalmbach, K., et al. (1997b). The prevalence of high-level exercise in the eating disorders: Etiological implications. *Comprehensive Psychiatry*, 38, 321-326.
- Davis, C., Katzman, D., & Kirsh, C. (1999). Compulsive physical activity in adolescents with anorexia nervosa: A psychobehavioral spiral of pathology. *The Journal of Nervous and Mental Disease*, 187, 336-342.
- de la Torre, J. (1995). Mens sana in copore sano, or exercise abuse? Clinical considerations. *Bulletin of the Menninger Clinic*, 59, 15-31.
- Douglas, C. (2000). Analytical psychotherapy. In R. Corsini & D. Wedding, (Eds.), *Current psychotherapies*, (pp. 99-131). Itasca, Ill: F.E. Peacock Publishers, Inc.
- Epling, W., & Pierce, W. (1996a). An overview of activity anorexia. In W. F. Epling & W. D Pierce (Eds.), *Activity anorexia: Theory, research, & treatment* (pp. 3-77). Mahwah, NJ: Lawrence Erlbaum Associates.

- Epling, W., & Pierce, W. (1996b). Theoretical developments in activity anorexia. In W. F. Epling & W. D. Pierce (Eds.), *Activity anorexia: Theory, research, & treatment* (pp. 23-41). Mahwah, NJ: Lawrence Erlbaum Associates.
- Evans, N. (1997). Gym and tonic: A profile of 100 male steroid users. *British Journal of Sports Medicine*, *31*, 54-58.
- Fox, K. (2000). Self-esteem, self-perceptions and exercise. *International Journal of Sport Psychology*, *31*, 228-240.
- Gabbard, G. (1989). Two subtypes of narcissistic personality disorder. *Bulletin of the Menninger Clinic*, *53*, 527-532.
- Gabbard, G. (1994). Cluster B personality disorders: Narcissistic. In G. Gabbard (Ed.), *Psychodynamic psychiatry in clinical practice: The DSM-IV edition* (pp. 497-526). Washington, DC: American Psychiatric Press.
- Garner, D. M., Vitousek, K. M., & Pike, K. M. (1997). Cognitive-behavioral therapy for anorexia nervosa. In D. Garner & P. Garfinkel (Eds.) *Handbook of treatment for eating disorders* (2nd Ed., pp. 94-144). New York: The Guilford Press.
- Glassner, B. (1992). Men and muscles. In M.S. Kimmel & M.A. Messner (Eds.) *Men's lives*. (pp. 287-298). New York: Macmillan.
- Gordon, R. (2000). *Eating disorders: Anatomy of a social epidemic* (2nd ed.). Malden, MA: Blackwell.
- Haupt, H. & Rovere, G. (1984). Anabolic steroids: A review of the literature. *The American Journal of Sports Medicine*, *12*, 469-484.

- Henry, R. (2000). The effect of aerobic and aerobic/strength training on body image in females. (Doctoral dissertation, Middle Tennessee State University, 2001). Dissertation Abstracts International, 61, 07.
- Hickson, J., Jr., Johnson, T., Lee, W., & Sidor, R. (1990). Nutrition and the precontest preparations of a male bodybuilder. *Journal of the American Dietetic Association*, 90(20), 264-268.
- Humbert, M. (1990). Psychological effects of self-administered anabolic steroids on male athletes: Hostility, depression, vigor, fatigue, anxiety and confusion. (Doctoral dissertation, United States International University, 1990). Dissertation Abstracts International, 51, 04.
- Jardine, D. (1990). Awakening from Descartes' nightmare: On the love of ambiguity in phenomenological approaches to education. *Studies in Philosophy and Education*, 10, 211-232.
- Johnson, R. (1997). Examining the validity structure of qualitative research. *Education*, 118, 282-292.
- Kaye, W., Klump, K., Frank, G., & Strober, M. (2000). Anorexia and bulimia nervosa. *Annual Reviews of Medicine*, 51, 299-313.
- Keen, S. (1992). *Fire in the belly: On being a man*. New York: Bantam.
- Kernberg, O. (1975). *Borderline conditions and pathological narcissism*. New York: Jason Aronson.
- Kilpatrick, J. & Caldwell, J. (2001). *Eating disorders: Anorexia nervosa, bulimia, binge eating and others*. Toronto, ON: Key Porter Books.
- Klein, A. (1993). *Little big men: Bodybuilding subculture and gender construction*. New

York: State University.

Kleiner, S., Bazzarre, T., & Litchford, M. (1990). Metabolic profiles, diet, and health practices of championship male and female bodybuilders. *Journal of the American Dietetic Association, 90*, 962-968.

Kohut, H. (1971). *The analysis of the self: A systematic approach to the psychoanalytic treatment of narcissistic personality disorders*. New York: International Universities Press.

Laslett, B. (1999). Personal narratives as sociology. *Contemporary Sociology, 28*, 391-401.

Lowen, A. (1983). *Depression and the body: The biological basis of faith and reality*. New York: Penguin Books.

Lowen, A. (1985). *Narcissism: Denial of the true self*. New York: Macmillan.

Marzano-Parisoli, M. (2001). The contemporary construction of a perfect body image: Bodybuilding, exercise addiction, and eating disorders. *Quest, 53*, 216-230.

Masterson, J. (1981). *The narcissist and borderline disorders*. New York: Brunner & Mazel.

Monaghan, L. (2001). Looking good, feeling good: The embodied pleasures of a vibrant physicality. *Sociology of Health and Illness, 23*, 330-356.

Monaghan, L. (1999). Challenging medicine? Bodybuilding, drugs and risk. *Sociology of Health and Illness, 21*, 707-734.

Motl, R., Berger, B., & Leuschen, P. (2000). The role of enjoyment in the exercise-mood relationship. *International Journal of Sport Psychology, 31*, 347-363.

- Neuman, W. (1997). *Social research methods: Qualitative and quantitative approaches* (3rd ed.). Needham Heights, MA: Allyn & Bacon.
- Nixon, G. (1992). The quest for wholeness. (Doctoral dissertation, University of Calgary, 1992). *Dissertation Abstracts International*, 54, 09.
- Olrich, T., & Ewing, M. (1999). Life on steroids: Bodybuilders describe their perceptions of the anabolic-androgenic steroid use period. *The Sport Psychologist*, 13, 299-312.
- Osborne, J. (1990). Some basic existential-phenomenological research methodology for counsellors. *Canadian Journal of Counselling*, 24, 79-91.
- Packer, M. (1985). Hermeneutic inquiry in the study of human conduct. *American Psychologist*, 40, 1091-1043.
- Peräkylä, A. (1997). Reliability and validity in research based on tapes and transcripts. In D. Silverman (Ed.) *Qualitative research: Theory, method and practice*. Thousand Oaks, CA: Sage.
- Phillips, K., & Castle, D. (2001). Body dysmorphic disorder in men. *British Medical Journal*, 323, 1015-1016.
- Pike, K. (1998). Long-term course of anorexia nervosa: Response, relapse, remission, and recovery. *Clinical Psychology Review*, 18, 447-475.
- Pope, H., Jr., & Katz, D. (1994). Psychiatric and medical effects of anabolic-androgenic steroid use: a controlled study of 160 athletes. *Archives of General Psychiatry*, 51, 375-382.
- Pope, H., Jr., & Katz, D. (1998). Affective and psychotic symptoms associated with anabolic steroid use. *American Journal of Psychiatry*, 145, 487-490.

- Pope, H., Jr., Katz, D., & Hudson, J. (1993). Anorexia nervosa and 'reverse anorexia' among 108 male bodybuilders. *Comprehensive Psychiatry*, 34, 406-409.
- Pope, H., Jr., Phillips, K., & Olivardia, R. (2000). *The Adonis complex: How to identify, treat, and prevent body obsession in men and boys*. New York: Touchstone.
- Prokop, D., & Neveux, M. (1994). *The art of muscle*. London: Bison Books.
- Reisman, C. (2002). Analysis of personal narratives. J. F. Gubrium & J. A. Holstein (Eds.), *Handbook of interview research: Context and method* (pp. 695-711). Thousand Oaks, CA: Sage.
- Robson, C. (1993). *Real world research: A resource for social scientists and practitioner researchers*. Oxford, Blackwell Science.
- Rogers, C. (1961). *On becoming a person*. Boston: Houghton Mifflin Company.
- Rogers, R., & Petrie, T. (2001). Psychological correlates of anorexia and bulimic symptomology. *Journal of Counseling and Development*, 79, 178-186.
- Ruben, P. (2002). How I got my body. *Gentlemen's Quarterly*, May 2002, 190-197.
- Russell, S. & Ryder, S. (2001). BRIDGE (Building the relationships between body image and disordered eating graph and explanation): A tool for parents and professionals. *Eating Disorders: The Journal of Treatment and Prevention*, 9, 1-14.
- Sass, L. (1998). Humanism, hermeneutics, and the concept of the human subject. In S. Messer, L. Sass, & R. Woolfork (Eds.), *Hermeneutics and psychological theory: Interpretive perspectives on personality, psychotherapy, and psychopathology* (pp. 222-271). New Brunswick, NJ: Rutgers University Press.

- Schwerin, M., & Corcoran, K. (1992). What do people think of male steroid users?: An experimental investigation. *Journal of Applied Social Psychology, 22*, 833-840.
- Schlumberger, A. (2002). Strength training of athletes in rehabilitation. *Isokinetics and Exercise Science, 10*(1), 15-16.
- Schneider, J., & Irons, R. (1997). Treatment of gambling, eating, and sex addictions. In N. Miller, M. Gold, & D. Smith (Eds.), *Manual of Therapeutics for Addictions* (pp. 225-245). New York: Wiley-Liss.
- Schwitzer, A., Rodriguez, L., Thomas, C., Salimi, L. (2001). The eating disorders NOS diagnostic profile among college women. *Journal of American College Health, 49*, 157-167.
- Schwalbe, M., & Wolkomir, M. (2002). Interviewing Men. Handbook of Interview Research: Context and Method. In J. F. Gubrium & J. A. Holstein (Eds.), *Handbook of interview research: Context and method* (pp. 221-238). Thousand Oaks, CA: Sage.
- Sharp, M., & Collins, D. (1998). Exploring the “inevitability” of the relationship between anabolic-androgenic steroid use and aggression in males. *Journal of Sport and Exercise Psychology, 20*, 379-394.
- Tamaki, T., Uchiyama, S., Uchiyama, Y., Akatsuka, A., Roland, R., Edgerton, V. (2001). Anabolic steroids increase exercise tolerance. *The American Journal of Physiology, 280*, 973.

- Taub, D., & Blinde, E. (1992). Eating disorders among adolescent female athletes: Influence of athletic participation and sport team membership. *Adolescence, 23*, 833-848.
- Taylor, W. (1991). *Macho medicine: A history of the anabolic steroid epidemic*. Jefferson, NC: McFarland & Company.
- Thompson, R., & Sherman, R. (1993). *Helping athletes with eating disorders*. Champaign, IL: Human Kinetics.
- Tomporowski, P. (2001). Men's and women's perceptions of effort during progressive-resistance strength training. *Perceptual and Motor Skills, 92*, 368-372.
- Van Manen, M. (1982). Phenomenological pedagogy. *Curriculum Inquiry, 12*, 283-299.
- Van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. London, ON: Althouse Press.
- Veale, D., & Riley, S. (2001). Mirror, mirror on the wall, who is the ugliest of them all? The psychopathology of mirror gazing in body dysmorphic disorder. *Behavior research and therapy, 39*, 1381-1393.
- Vitousek, K., Watson, S., & Wilson, G. (1998). Enhancing motivation for change in treatment-resistant eating disorders. *Clinical Psychology Review, 18*, 391-420.
- Von Eckartsberg, R. (1998). Introducing existential-phenomenological psychology. In R. Valle (Ed.), *Phenomenological inquiry in psychology: Existential and transpersonal dimensions* (pp. 3-20). New York: Plenum Press.
- Wendell, S. (1996). *The rejected body*. London: Routledge.

- Weigers, Y. (1998). Male bodybuilding: The social construction of a masculine identity. *Journal of Popular Culture*, 32, 147-161.
- Wiklund, L., Lindholm, L., Lindstöm, U. (2002). Hermeneutics and narration: A way to deal with qualitative data. *Nursing Inquiry*, 9, 114-125.
- Wilson, G., Fairburn, C., & Agras, W. (1997). Cognitive-behavioral therapy for bulimia nervosa. In D. Garner & P. Garfinkel (Eds.) *Handbook of treatment for eating disorders* (2nd ed., pp. 67-93). New York: The Guilford Press.
- Wright, S., Grogan, S., & Hunter, G. (2001). Body-builders' attitudes towards steroid use. *Drugs: Education, prevention, and policy*, 8(1), 91-95.
- Yesalis, C., & Cowart, V. (1998). *The steroids game: An expert's inside look at anabolic steroid use in sports*. Champaign, IL: Human Kinetics.

Appendix A

Letter of Introduction

Weight Lifting and Steroid Use in Men
Angela D. Bardick, M. Ed: Counselling Psychology student
University of Lethbridge

I am conducting a study about the experiences of men between the ages of 20 and 40 who lift heavy weights and use steroids. The purpose of this study is to research underlying motives and issues that influence choice of exercise and other issues affecting male body image, as well as to influence future interventions and programs in these areas.

If you know any men between the ages of 20 and 40 who may meet the following criteria, please mention this study to them, and inform them that all information is strictly confidential:

- a) Lift heavy weights 2-3 hours per day, 4 or more days per week
- b) Have been told that their exercise behaviors may be interfering with their social life or work life
- c) Are using steroids
- d) Are willing to speak about their experience.

You may provide them my card with my voicemail number and email address on it and instruct them to contact me within the next week to inquire about participation in this study. I may be contacted at (403) 581-8855 or weightliftresearch@monarch.net.

Your assistance is a tremendous help in order for me to complete my thesis requirement for the Masters of Education: Counselling Psychology degree at the University of Lethbridge.

Thank you for your assistance.

Sincerely,

Angela D. Bardick
B.FA, B.Ed., Graduate Student
University of Lethbridge

Appendix B

Poster

RESEARCH OPPORTUNITY

Do you know a man between the ages of 20 and 40 who:

- a) Lifts heavy weights 2-3 or more hours per day, 4 or more days per week?**
- b) Have been told that exercise may be interfering with his social life or work life?**
- c) May be using steroids?**
- d) Is willing to speak about his experience?**

**All participation is completely voluntary
and strictly confidential**

**Please contact (403) 581-8855 or
weightliftresearch@monarch.net
for further details:**

The purpose of this study is to research underlying motives and issues that influence choice of exercise and other issues affecting male body image, as well as to influence future interventions and programs in these areas.

Your participation in this study will assist me greatly in completing my thesis requirement for the Masters of Education: Counselling Psychology degree at the University of Lethbridge.

Thank you for your assistance.

A. Bardick
B.FA, B.Ed., Graduate Student
University of Lethbridge

Appendix C

Screening Questions

1. What is your current exercise program?
2. Has anyone ever told you that your exercise interferes with your work or your social life?
3. Do you use steroids?
4. What is your age?

Appendix D

Interview Guideline

1. Using a story format, where the beginning is when you began lifting weights and the end is the present, describe for me your experience with lifting weights and using steroids.
2. What factors encouraged you to lift weights and use steroids?
3. What are your reasons for lifting weights and use steroids?
4. What are your thoughts, feelings, and behaviours when you are not able to exercise?
5. Describe for me how others react to your weight lifting and steroid use.
6. How do others' reactions to your choice to lift weights and use steroids impact you?
7. Describe for me how lifting weights and using steroids impacts the following:
 - a) your work
 - b) your social life
 - c) your relationships
 - d) your health
 - e) how you feel about yourself
8. Are there any questions or areas I might have missed that you would like to expand on?
9. Is there anything you believe you need at this time to assist you in dealing with any of the issues that may have come up for you during this interview?

10. Would you be willing to refer other individuals who lift heavy weights and use steroids to me for participation in this research? If so, please give them my card and encourage them to contact me within the next week.

Appendix E

Letter of Consent

Weight Lifting and Steroid Use in Men
Angela D. Bardick, M. Ed: Counselling Psychology student
University of Lethbridge

I am conducting a study of weight lifting and steroid use in men. The purpose of this study is to research underlying motives and issues that influence choice of exercise, use of steroids, and other issues affecting male body image. I anticipate that you and others will benefit from participation in this study by influencing programs and interventions in the areas of male health, wellness, and body image.

As part of the research you are being asked to participate in an initial 1 ½ to 2 hour interview and a follow up interview of approximately 30 to 45 minutes. The interviews will be audio taped.

All information will be handled in a confidential and professional manner. When responses are released, they will be reported in summary and direct quote form with pseudonyms. No identifying information will be included in any discussion of the results. You will not be asked to reveal incriminating information (i.e., distribution of steroids) to the researcher. The only situation in which a researcher is legally obligated to release personal information is if subpoenaed by a court of law or a search warrant is obtained. You have the right to withdraw from the study without prejudice at any time (i.e., before and after interviews, after being given one's transcript, after reading summaries, and after reading a final copy of the material).

The results of this study, as well as being the basis of my MEd:Counselling Psychology thesis, also may be published in academic journals and a book, and/or presented at professional conferences and university classes. I will arrange a follow-up meeting with you after the data is examined and conclusions are drawn. You will receive a copy of your transcript, and also may request a one to two page summary of the study.

In accordance with the University of Lethbridge ethical guidelines, audio tapes, computer discs, and transcripts will be stored in the researcher's home and will be destroyed (i.e., shredded or erased) five years after publication of the research (i.e., December 31, 2008).

If you choose to do so, please indicate your willingness to participate by signing this letter in the space provided below.

I very much appreciate your assistance in this study. If you have any questions please feel free to contact me at (403) 581-8855 or weightliftresearch@monarch.net. Also feel free to contact the supervisor of my study (Dr. Gary Nixon, Assistant Professor, Addictions Counselling, University of Lethbridge, (403) 329-2644, gary.nixon@uleth.ca) and/or the chair of the University of Lethbridge Faculty of Education Human Subject Research

Committee if you wish additional information. The chairperson of the committee is Dr. Cathy Campbell, (403) 329-2271, cathy.campbell@uleth.ca.

Sincerely,

Angela D. Bardick
University of Lethbridge
(403) 581-8855
weightlifresearch@monarch.net

I have read the above information and agree to participate in this study and have the results published in the researcher's MEd:Counselling Psychology thesis, as well as any academic journals and book/s, and/or presented at any professional conferences and university classes the researcher deems suitable.

Signature _____ Date _____