Chapter Four: Body Image

The third aspect of the present research is the notion of body image. While the specific understanding of this variable for the present research will be embellished later, it can be introduced here as “the picture we have in our minds of the size, shape and form of our bodies; and to our feelings concerning these characteristics and our constituent body parts” (Slade, 1994, p. 497). While there has been a strong emphasis on researching body image dissatisfaction and disturbance in women (Metcalf, 1985; Thomas, 1990), the present research was interested in looking at body image in men, as inspired by the work of Pope, Phillips and Olivardia (2000). The body image concerns found in this research have been placed under the umbrella term the Adonis complex, which is neither an official medical name, nor one particular sign of body image disturbance (Pope et al., 2000). Rather, it is used to describe secretive and potentially obsessive concerns that some men have towards their bodies, which range from being mild to extremely severe. These may manifest in several ways, including excessive exercise and weightlifting, steroid abuse, and eating disorders such as anorexia nervosa and bulimia nervosa (Pope et al., 2000). Given the expansive signs of the Adonis complex, the present research decided to focus predominantly on one manifestation known as muscle dysmorphia.

4.1 Muscle Dysmorphia

Previously known as reverse anorexia, the term muscle dysmorphia denotes a body image disturbance characterised by an excessive preoccupation with muscularity, where men perceive themselves as being very thin and weak, when in fact they are highly muscular (Pope et al., 2000). To compensate for the perceived inadequacy, the man may compulsively attempt to build a more muscular body through weightlifting and other kinds of exercise (Pope, Katz & Hudson, 1993), or engage in more destructive behaviours, such as taking steroids or continuing to exercise though injury (Blouin & Goldfield, 1995). While muscle dysmorphia does exist in varying degrees of severity, it should cause the person at least some distress in their daily functioning in order to be considered a disorder (Pope et al., 2000).

While “undue influence of body weight or shape” are key features of eating disorders (APA, 1994, p. 544), muscle dysmorphia is not an eating disorder, as the focus is not
on a “fear of fat”, but rather a belief that one is not muscular enough (Pope et al., 2000). In this way, the preoccupation with perceived levels of muscularity in muscle dysmorphia resonates more closely with another condition in the *Diagnostic and Statistical Manual of Mental Disorders* (fourth edition) (DSM-IV), namely body dysmorphic disorder (BDD) (APA, 1994). BDD is one subtype of the broader category of somatoform disorders in which a person has physical symptoms that have no known physiological basis (APA, 1994).

BDD denotes a condition wherein a person suffers from a debilitating preoccupation with an imagined defect in their appearance (APA, 1994; Veale, Kinderman, Riley, & Lambrou, 2003). If a slight anomaly is present, the person’s concern is markedly excessive (APA, 1994). While the perceived defects may relate to any aspect of appearance, including facial features such as the nose, skin blemishes, stomach, buttocks and so on (Veale et al., 2003), the perceived inadequacies should be seen in light of cultural factors which determine ideal physical attributes (APA, 1994). In Western culture, for example, particular forms of the body are attributed more social significance and beauty than others, and so not embodying these ideals may amplify concerns with the perceived defect (Pope et al., 2000). However, the essence of BDD is not the location in which the person sees the defect, but rather that they are pathologically preoccupied with it (Rosen, Reiter, & Orosan, 1995). Pope et al. (2000) have argued that muscle dysmorphia is one subtype of BDD specifically related to preoccupation with muscularity.

To fulfill the diagnostic criteria for BDD in the DSM-IV, the preoccupation must cause clinically significant distress or impairment in occupational or other important areas of functioning (APA, 1994). This includes an avoidance of social situations where the person may feel self-conscious due to a feeling that their body is being scrutinised. However, according to Rosen, Reiter and Orosan (1995), “most patients are capable of at least limited social and vocational functioning, using ways to avoid full exposure of their appearance in public by wearing clothes, grooming, or contorting body posture and movements in such a way as to hide the defect” (p. 263). This is true of muscle dysmorphia as well, as individuals have been noted to wear several layers of clothing to give the appearance of greater muscularity, or may avoid public places where their body will be seen, such as beaches or public change rooms.
(Pope et al., 2000). BDD and muscle dysmorphia may also lead to compulsive, excessive and time-consuming scrutinising of the body (Veale et al., 2003). Muscle dysmorphia also resonates with BDD in that there are attempts made to improve the imagined defect, for example, through excessive exercise and dieting (Pope et al., 2000). Blouin & Goldfield (1995) have associated the growing preoccupation with musculature to the increased use of both legal and illegal supplements designed to boost musculature such as Creatine, Ephedrine and anabolic steroids. While there is some suggestion that these behaviours may be confused with vanity or even attempts to exhibit a socially desirable appearance, the key difference lies in the notion that the behaviour needs to be excessively time consuming and bring about significant distress and impairment in important aspects of functioning (APA, 1994; Veale et al., 2003).

If one accepts Pope et al.’s (2000) assertion that muscle dysmorphia can be understood as a subtype of BDD for the reasons considered previously, then it is sensible to further suggest that factors relevant to BDD could also be relevant to muscle dysmorphia, such as its onset, duration and aetiology. The DSM-IV has suggested that while BDD typically originates in early or late adolescence, the great reluctance to express these concerns may mean that BDD will only be diagnosed much later (APA, 1994; Phillips, 1991). Rosen, Reiter and Orosan (1995) corroborate that the person’s preoccupation is likely to have started during adolescence when concerns regarding physical and social development were at their peak. For example, it is suggested that a person who was teased about some aspect of their appearance would internalise the comments and begin to automatise the negative thoughts about their appearance. This could lead the person to believe that the teasing was correct and hence become self-conscious about that aspect of their appearance. Similarly, it can be inferred from the work of Pope et al. (2000) that muscle dysmorphia typically peaks in late adolescence and early adulthood, though the roots of the disorder may be traced to early adolescence. While BDD is a useful corollary in understanding muscle dysmorphia, the causes of BDD are not clear (Rosen, Reiter and Orosan, 1995), and so it is difficult to extrapolate its aetiology to muscle dysmorphia. As such, in considering factors that could explain the development of muscle dysmorphia, it is necessary to draw on BDD as well as other comparative disorders.
4.2 Factors Causing Muscle Dysmorphia

The identification of risk factors for the development of both body image dissatisfaction and disturbance is an active area of inquiry, particularly regarding women (Thompson & Smolak, 2001). However, given the relative recency of research in muscle dysmorphia and the Adonis complex more broadly, the aetiology of these concerns is not well understood (Pope et al., 2000). Nevertheless, there is growing consensus that their cause can be attributed to a complex array of external and internal factors. While external factors include elements in the person’s environment that may contribute to the feeling of discontent (such as the media) (Barlow & Durand, 2001), internal factors could include personal experiences (such as being teased about one’s appearance) or internalised concepts of masculinity (Pope et al., 2000). The degree to which each of these factors contributes to the body image concerns will vary with respect to each individual, with some individuals’ showing any number or combination of factors, while others show no similarity (Palmer, 2000). In order to build an account of why men specifically may develop body image dissatisfaction or disturbance, this chapter will first look at external factors that can account for body image concerns in men, and thereafter turn to internal factors that could account for why only some men develop more acute distress.

4.2.1 External factors

The media is one powerful environmental factor that brings to life tangible representations of masculinity and femininity, and much empirical research has assessed the differential portrayal of men and women in the media, and the implications of these images for masculinity, femininity and sexuality (Burr, 1998). One area that has received a large amount of attention is the depiction of men and women’s bodies. For example, early work by Berger (1972) suggested that men are positioned in more active, dynamic poses which convey a sense of power, while women’s bodies appear strategically placed in more passive positions that make them a visual spectacle. This was corroborated by a recent South African study by the Media Monitoring Project (2005), which found that men occupied a greater diversity of roles than women in the media. The images of men were noted to be “active, most commonly represented in sports stories as heroes and ‘doing things’. This is in stark comparison to women, who are often represented passively in posed or sexualised images” (Media Monitoring Project, 2005, p. 7).
The media also brings to life body images that a particular culture perceives to be desirable at any given time, and so provides a platform for men and women to engage with the ideal body for their sex (Rutherford, 2003). In the case of women in Western culture, for example, a large body of research has been dedicated to the way in which the media has portrayed a consistently thinner and hence more unachievable ideal for girls (Barlow & Durand, 2001; Palmer, 2000). The power of these thin images lies in their juxtaposition with suggestions of perceived positive qualities, such as being in control of oneself, and being successful and happy (Nasser, 1997). Women and girls with eating disorders are believed to draw on this cultural interest in weight and dieting as a means to cope with personal distress (Nasser, 1997). This has led to the media being implicated in the increased diagnoses of eating disorders such as anorexia and bulimia nervosa (Barlow & Durand, 2001).

Flowing from this, Pope et al. (2000) have argued that, as with girls who are bombarded with glorified images of extreme thinness, so too are men influenced by recent shifts in the media representation of the ideal man. For example, Hollywood icons from the 1930s, 1940s and 1950s such as John Wayne and Clark Gable were significantly less muscular than later stars of the 1990s such as Sylvester Stallone and Arnold Schwarzenegger, who have been described as hypermuscular. Again, attached to these “super-male” images is the appearance of social, financial and sexual success (Pope et al., 2000). This recent shift in representation may also allude to why men who are now over 40 are less likely to be concerned specifically with fitness and muscularity, given that the role models for the youth of the time were more realistic (Pope et al., 2000). Pope et al. (2000) consequently attribute the development of muscle dysmorphia to the increasingly unattainable muscular ideal represented in the media, and the review will now discuss empirical research which has corroborated their assertion.

The starting point for this discussion is to engage with the changes in representation of men in the media, and to then surmise the possible effects of these representations. Liet, Pope and Gray (2001) took the lead from a series of studies conducted on the increasing thinness of the female Playboy centrefolds (e.g., Garner, Garfinkel, Schwartz & Thompson, 1980) and assessed the changes in representation of the male centrefold in Playgirl magazine over the last 25 years. The results showed that since
the 1970s, the *Playgirl* centrefold had become increasingly leaner and more muscular. In a different context, action toys for boys, such as *G. I. Joe* and the *Star Wars* figurines, were found to have changed from being “realistically” proportioned to “unrealistically” muscular, while newer action figures such as *Wolverine* from *X-men* are staggeringly hyper-muscular (Pope, Olivardia, Gruber & Borowiecki, 1999). 

Pope, Olivardia, and Borowiecki (2001) also examined two best-selling women’s magazines, namely *Cosmopolitan* and *Glamour*, and looked at the growing market value of men’s bodies by comparing the number of undressed men and undressed women. The state of undress was defined as any clothes (or lack thereof) that would be deemed inappropriate to be seen walking in the street. It was found that while the number of undressed women fluctuated back and forth over time, the percentage of undressed men increased consistently, particularly after the 1980s. While there may be several explanations for these results, including the particular readership of these magazines, for Pope et al (2001), the results imply that the undressed male body has become increasingly more important and marketable.

In order to test the effects of media images on men’s attitudes toward their body appearance, Liet, Gray and Pope (2001) conducted a study in which undergraduate men were divided into two groups. One group was shown 30 advertisements of muscular men taken from popular magazines, while the control group were shown 30 neutral advertisements with no human images or human images focusing on the body. Immediately thereafter, participants performed a computerised test of body image perception known as the Somatomorphic Matrix, and were asked to choose the figure that they believed best represented, for example, their current and ideal body shape. The results showed that even after only brief exposure, students who were shown the muscular images showed a significant discrepancy between their current and ideal body shape. This led the researchers to surmise that if even brief presentation of media images can impact on men’s views of their bodies, then consistent bombardment could have an even more powerful effect (Liet, Gray & Pope, 2001).

The work by Pope and his colleagues suggests that the ideal male body promoted in the media may be a factor in the aetiology of muscle dysmorphia. This is because men who believe that they do not embody the ideal image of masculinity may feel dissatisfied with their body image or develop more severe concerns seen in muscle
dysmorphia. There are, however, at least two issues that need to be raised with respect to this argument. Firstly, despite their emphasis on the hypermuscular representation of men and its effects, the ideal image of men in contemporary society is not necessarily hypermuscular, and the ideals are known to shift and change. Secondly, while the power of the media cannot go underestimated, questions are raised over the extent to which images in the media are actually internalised by people, as there are likely to be factors which mediate whether or not one acts upon the messages to which they have been exposed (Bandura, 1986; Edwards, 2003). Indeed, some authors argue that “the media are used and read in different ways by different individuals and that we cannot make assumptions about their effects” (Burr, 1998, p. 100). It is beyond the scope of the present report to engage with the various processes that may influence the internalisation of media images, but it is the present researches position that body image disturbance in men cannot be exclusively linked to idealised media images.

The second external factor that Pope et al. (2000) use to account for the rising body image concerns in men is the broader societal shifts and changes in gender roles mentioned in chapter two of the literature review. Prior to feminism, men asserted their masculinity through, for example, their status and wealth, but the progression of women into the workforce and broader social-political sphere has made it difficult for some men to find ways to exude traditional masculinity (Rutherford, 2003). For Pope et al. (2000), this predicament has led to a feeling of “threatened masculinity,” and a subsequent search for alternative ways of displaying masculinity. One solution is argued to be exaggerating or emphasising the male body, as “true masculinity is almost always thought to proceed from men’s bodies- to be inherent in a male body or to express something about a male body” (Connell, 1995, p. 45). This interpretation holds that the designation of the ideal male body as increasingly muscular is not random. Indeed,

“By having and using power, men have based their self-esteem, at least in part, on power. Loss of power causes men to feel insecure in their masculinity, especially if they have failed to adequately fulfil other aspects of their gender role. Being powerless places them in the position of women, a position considered inferior. Since they do not have actual accomplishment from which to derive legitimate power, they fall back on the most superficial aspects of the masculine gender role, physical strength, to give them a sense of power and maintain self-esteem” (Steinberg, 1993, p. 140).
Thus despite the loosening of boundaries between masculine and feminine characteristics, one area that can still clearly distinguish men from women is their physique. This is not simply to say that men and women are anatomically different, but it acknowledges that men are capable of achieving much higher levels of muscularity and strength than women. As Pope (2005) somewhat crudely stated “some men, consciously or unconsciously, may see their bodies as a last refuge; women can have equal rights in every wake of life, but they cannot bench-press 300 pounds” (para.12). Moreover, the muscular body is intimately tied to typical cultural views of masculinity, which prescribe that men be powerful, strong, efficacious, and even domineering (Connell, 1995). Through building a body that pushes the limits of what a muscular physique can achieve, a man can show a great deal of self-control, discipline and restraint, and can also hold in check any hint of emotional weakness or other factors associated with femininity (Glover & Kaplan, 2000). A muscular physique may then serve as a visual representation or embodiment of masculinity (Pope et al., 2000). As such, the present research holds that the body, specifically the body’s muscularity, may be used as a symbolic attempt to assert traditional and powerful male norms, such as strength and power, as well as “ensuring first that masculinity and femininity are readily distinguishable from each other and cannot be confused” (Burr, 1998, p. 110).

4.2.2 Sexual Orientation and Body Image Concerns

The idea of the muscular male body acting as a symbol of traditional values of masculinity is interesting in light of sexual orientation, as the hegemonic form of masculinity excludes homosexuality (Connell, 2000). As mentioned earlier in the review, sexual orientation can be understood as a person’s preference for their sexual partners to be members of his or her own sex (gay men and lesbian women), members of the opposite sex (heterosexual) or both sexes (bisexual) (Tyson & Tyson, 1990). While pre-Oedipal or Oedipal object relations may begin to channel one’s sexual object choice, it is only later in adolescence that the choice becomes more salient (Tyson & Tyson, 1990). It is beyond the scope of this report to detail the development of sexual orientation, but it does beg the question of how body image concerns will play out in an individual who does not have a heterosexual orientation or who may not adopt a traditional masculine orientation.
The role of sexual orientation in body image dissatisfaction is an active area of research, but it is also fraught with inconsistencies. On the one hand, gay men have been shown to have greater body image dissatisfaction and higher levels of bulimic and anorexic symptoms compared to heterosexual men (Russell & Keel, 2002). This is typically attributed to the belief that gay men identify more strongly with femininity, which in turn is associated with greater emphasis on appearance and hence a predisposition to body image concerns (Andersen, 1990; 1999; Boroughs & Thompson, 2002; Silberstein, Mishkind, Striegel-Moore, & Timko, 1989).

While there is some evidence to suggest that gay men are more effeminate, and that they are also more prone to body image problems and eating disorders (Boroughs & Thompson, 2002), Zlotnick (2002) found that gay men were no more likely to be feminine in orientation than heterosexual men, and similarly that heterosexual men were no more likely to be masculine. Russell and Keel (2002) also found that identification with femininity was not a factor associated with gay men or eating pathology in men. Similarly, Olivardia, Pope, Mangweth, and Hudson (1995) and Schneider, O’Leary and Jenkins (1995) found no significant differences between rates of homosexuality in eating disordered and non eating disordered men. Russell and Keel (2002), however, still maintain that the majority of studies support a significant association between eating pathology and homosexuality in men. Given that there is some debate regarding sexual orientation and body image concerns, the present research inquired into whether gay men were more likely to have a feminine orientation, and whether sexual orientation was related to body image dissatisfaction or disturbance.

4.2.3 Internal factors causing BDD

While some aspects of the quest for muscularity may be attributed to the influence of the media, or even to an attempt to reclaim masculinity, it does not explain why only a few men become severely affected by muscle dysmorphia. Veale et al. (1996) consequently suggest the following:

“any model of BDD needs to be integrated with other body image disorders to account for why one individual may be emotionally well adjusted to [for example] severe burns….whilst another patient with a small hump on his nose is emotionally disturbed and can psychologically benefit from cosmetic surgery” (p. 717).
Accordingly, if one could hold that social factors account for why there is increased interest in the male body, one could further submit that there must be other factors that discriminate between those who are more or less vulnerable to these social influences (McLaren, Gauvin & White, 2001). For example, BDD is suggested to have a biological basis, as it has been linked to a genetic inheritance, obsessive and compulsive traits, and a predisposition toward anxiety (Veale et al., 2003). However, such biological factors are likely to manifest in BDD and muscle dysmorphia only through an interaction with social and cultural influences (Veale et al., 1996). The review will now draw on theories of cognitive distortions and eating disorders to add a psychological account of the development of muscle dysmorphia.

4.2.3.1 Theories of cognitive distortions

Theorists have suggested that conditions such as depression, social anxiety and eating disorders can be attributed to maladaptive thought and belief systems (e.g. Ellis, 1962; 1974). Indeed, Ellis (1962) suggested that “we are not made disturbed simply by our experiences; rather, we bring our ability to disturb ourselves to our experiences” (p. 3). In particular, inflexible, all-or-nothing and self-defeating beliefs can lead to an unhealthy sense of self and psychological disturbance (Dryden, 1987). Bentall, Kinderman and Kaney (1994) have applied this theory to BDD and attribute this condition to a conflict between what the person believes they should look like relative to what they actually look like.

While there are variable definitions of actual, ideal and should selves, the key for the present research is the interaction between how the person perceives they actually look, compared to how they believe they should ideally look. Distortions in body image will result when a person shows a large discrepancy between their ideal and actual self, specifically where the ideal self is regarded more highly than the actual self (Veale et al., 2003). Despite being a useful supposition, however, there is limited theoretical argument as to the origins of these disordered thought patterns, and the theories are usually applied in intervention (e.g. Veale et al., 1996). As such, the theory is more useful to the present research in reconfirming that men who feel that they do not embody the prescribed ideal may develop body image problems.
4.2.3.2 The usefulness of eating disorders

Eating disorders, such as anorexia and bulimia nervosa, refer to cases of abnormal eating patterns broadly associated with the intense pursuit of thinness and the morbid dread of becoming fat (Thompson, 1995). There is a strong emphasis on weight and dieting in these disorders, but these behaviours are more correctly understood as symptoms of underlying mental distress communicated through the person’s nutritional habits (Palmer, 2000). While it was stated earlier in this chapter that muscle dysmorphia is not an eating disorder, the symptoms of BDD and eating disorders are both strongly linked to body image disturbance (Pope, Kats and Hudson, 1993). Given that much research has been conducted on body image disturbance with respect to eating disorders, it was deemed appropriate to draw on psychological explanations for these disorders to embellish the understanding of muscle dysmorphia. While eating disorders are likely to stem from a complex interplay of social, biological, and psychological factors (Costin, 1996), this discussion will focus almost exclusively on intra-psychic explanations.

Early psychoanalytic theories explained eating disorders as “fixations at the oral level of psychosexual development, regression in instinctual drives from the genital level of development, and symptom formation around oral conflicts” (Garfinkel & Garner, 1982, p. 177). Later psychodynamic formulations focused on the nature of parent-child relations, oedipal conflicts, and deficits in the ego. For example, Bruch (1973) explains that these conditions develop from ego disturbances that include a sense of ineffectiveness and distortions of body image. Her central idea is that the search for autonomy and a sense of self is maladaptively pursued through control over the body (Bruch, 1973). Indeed, for Mushatt (1992), anorexia is an “expression of defective ego development arising from varying degrees of failure to resolve the separation-individuation process and of failure to develop a sense of individuality” (p. 302).

Bruch’s (1973) emphasis on the weakness of the ego in eating disorders is elaborated by Laufer and Laufer (1984) who attribute the vulnerability of the ego to a domineering super-ego. This latter structure represents the moral component of personality, and “acts to control sexual and aggressive impulses through the process of repression” (Feist & Feist, 1999, p. 28). An individual with a domineering superego will feel strong feelings of guilt and inferiority, and will experience much
conflict due to the ego’s inability to mediate between the demands of the super-ego and another structure known as the id, or *pleasure principle*. The ego’s ability to arbitrate these forces becomes increasingly pertinent during puberty, as this stage is associated with changes in body shape and genital maturation (Laufer & Laufer, 1984; Polansky, 1991). Indeed, “at puberty, the relationship of the super-ego to the ego becomes disrupted and the ego has to find a means of re-establishing that relationship to include a sexual identity acceptable to the super ego” (Laufer and Laufer, 1984, p. 75). However, where the individual is unable to do this without “the ego deforming itself,” a distorted body image may be internalised that “represents a compromise between the pre-Oedipal, idealised body image and the reality of the sexual body” (Laufer and Laufer, 1984, p. 75).

These sentiments locate the development of eating disorders in the re-emergence of an unresolved conflict of gender identity formation that began at the Oedipal stage. In adolescence, this conflict is represented by difficulties in dealing with the psychic conflict around physical sexual maturity and in finally adopting a feminine identity (Gordon, 1992; Hook & Fuller, 2002). As such, the severe weight loss and onset of amenorrhea in anorexia may symbolically represent a return to the pre-pubertal body which lacks “feminine” curves (Palmer, 2000). As stated by Laufer and Laufer (1984):

“*The image the adolescent had of [her]self before puberty may have contained the unconscious fantasy of having a body different from the one [s]he knew [s]he had in reality, and it is only at puberty, when [her] body has become physically, sexually potent, that the efforts to repudiate what is true (either being male or female) fails them. That is, the adolescent rejects [her] sexually mature body and perpetuates instead a relationship to a fantasised body different from the one [s]he actually has*”

(p. xii).

Bruch (1973) also holds that unresolved feminine identifications contribute to eating disorders, and suggests that many girls with anorexia fantasised about growing up to be boys, but that the dream was shattered by the onset of puberty. The yearning to be a boy can be traced back to the phallic stage in which girls were argued by Freud (1933) to feel a sense of lack at not having a penis. Anorexia can then be explained as a regression to a pre-Oedipal body where boys and girls were oblivious to anatomical sex distinctions.
While there are links between aspects of muscle dysmorphia and eating disorders, it is necessary to keep in mind that eating disorders are still far more prevalent in women (APA, 1994), and that the frustration that these women are argued to have with femininity cannot be neatly extrapolated to men with muscle dysmorphia. With these cautions in mind, however, the present research argues that certain adaptations to the theories can link muscle dysmorphia with masculinity. For example, if girls with anorexia avoid the realisation of femininity by regressing to a distinctly non-feminine body, men with muscle dysmorphia may do the reverse by displaying a hypermuscular body that represents a “defence against regression to pre-Oedipal identification with the mother” (Connell, 1995, p. 33). In so doing, these men may actually show signs of reaction formation against appearing feminine. Craib (2001) described reaction formation as follows:

“[Reaction formations are] one step beyond denial- where the feared impulse is so strong that it can only be fought by consciously embracing its opposite with all the strength at one’s disposal. It is as if the strength of the repressed wish is so great for the ego that it breaks through to consciousness and the only course left for the ego is to embrace it with as much energy as it once suppressed”

(p. 44).

For Freud (1926), a reaction formation can be identified by its exaggerated character and by its obsessive and compulsive form. The present research suggests that by exemplifying the muscular ideal as the symbol of masculinity, men with muscle dysmorphia may be symbolically exaggerating their muscularity in an attempt to disguise their fear of not being sufficiently masculine. It is also possible that when a man seeks to build a muscular body that is convincingly masculine, he is actually playing out a rejection of anything associated with femininity, while embodying the masculine ideal (Osgerby, 2003). This could be attributed to a breakdown in the negotiation of the Oedipal crisis. While the successful resolution of the Oedipal complex does require the boy to identify with the father, the hypermasculine body may represent an over-identification with masculinity, and hence a reaction formation against femininity. This suggests that muscle dysmorphia is a symbolic attempt to reject femininity. Given the limited knowledge on the intra-psychic foundations of muscle dysmorphia, however, the present research’s suggestion must be treated as exploratory.
4.3 The Anticipated Links between Body Image and Gender Identity

This chapter will now look at the anticipated relationships between body image, gender identity, and ego strength, starting with body image and masculinity. Masculinity has been found to have varying associations with body image concerns. On the one hand, men have been found to be less dissatisfied with their bodies (Meyer, Blisset & Oldfield, 2001), and to experience fewer cases of eating disorders than women (Barlow & Durand, 2001). Recent research has also found masculinity to be associated with a broader health or adjustment factor, and has led some authors to conclude that the endorsement of masculinity may be a kind of protective factor against psychological concerns (Long, 1989; Markstrom et al., 1997). In the case of body image, however, the failure to find significant relationships between body image concerns and masculinity could be attributed to the failure of the measures used in such research to tap into concerns found specifically in men (Rosen & Reiter, 1996). Indeed, evidence of relatively new kinds of body image concerns that seemed to be exclusively targeting men was presented in this chapter, and are broadly known as the Adonis complex. While its aetiology is complex, Pope et al. (2000) have attributed these concerns to the increasingly insecure and unstable definition of masculine identity, and the rise of the muscular body as the ideal of masculinity.

Despite the blurring of the polarity between masculine and feminine traits, Pope et al. (2000) argue that a prominent medium through which gender distinctive traits can be asserted is the body. For example, traditional (stereotypical) versions of masculinity as espoused on the BSRI focuses on dominance and independence, and an orientation to the world which is active and assertive (Frosh, 1994). By linking this hegemonic definition of masculinity with the media and cultural representation of masculine men as muscular, the man can visually portray a masculine gender identity (Osgerby, 2003; Pope et al, 2000). This will not only lead to an external portrayal of power and strength, but will serve to keep any hint of femininity in check. In this regard, a man satisfied with his level of embodiment of the masculine ideal will likely score high on the BSRI Masculinity scale, but low on the scales of body image concerns.

However, because the ideals are largely unattainable, the correlation may actually work in the reverse. Indeed, men who fail to uphold this ideal are not likely to feel
adequately masculine, and so may become more dissatisfied with their body image. As such, men who aspire to define themselves as masculine may have more body image dissatisfaction in view of the increasingly unattainable images of ideal masculinity. In some men, this dissatisfaction may translate into a desire to combat the perceived body inadequacy by engaging in compulsive exercise or other behaviours that could lead to muscle dysmorphia (Pope et al., 2000).

In contrast to masculinity, the endorsement of femininity has been associated with a disproportional amount of eating disorders and body image concerns (Meyer, Blisset & Oldfield, 2001). This has been attributed to the greater emphasis on thinness, the preoccupation with dieting, and the importance of appearance for women (Palmer, 2000). If femininity is indeed a factor that predisposes one to body image concerns, then a cross-typed (feminine) man may also be dissatisfied or even disturbed with his body image. Importantly for the purposes of this research, however, the operational definition of both body image dissatisfaction and disturbance (discussed in section 4.6) relates to concerns with muscularity, which is possibly not a feminine concern. As such, it was anticipated that the relationship between femininity and body image concerns would likely be negative or not significant. However, should femininity be positively related to either dissatisfaction or disturbance, then one could surmise that femininity may in fact be globally related to body image concerns.

Finally, if one accepts the assertion that the body has become an increasingly tangible means to assert distinctively gendered characteristics, then the androgynous person who does not dichotomise these traits is far less likely to require their body as an outlet to exude their gender identity. Moreover, given that androgyny has typically been associated with flexibility, integration and the fullest range of coping strategies (Bem, 1974), it was anticipated that androgyny would be negatively correlated with both body image dissatisfaction and disturbance. However, while it is highly unlikely that androgyny would be positively associated with body image concerns, one possible explanation could account for this. The discursive construction of the “new man” espoused by Gill (2003) takes on both typically masculine and feminine traits, but also has a tendency toward narcissism and a keen interest in his body. In this light, despite having the more healthy orientation, an androgynous man may develop a strong preoccupation with body image and show a propensity to body image
dissatisfaction if his perception of himself differs from what he aspires to look like. However, given the consistently strong support for androgyny as the key to health, it is unlikely that this individual would develop a more disturbed body image.

4.4 The Anticipated Links between Body Image and Ego Strength

The discussion of the aetiology of eating disorders earlier in this chapter suggested a link between poor ego functioning and body image distortions (Bruch, 1973). As higher ego strength is typically associated with an overall resilient orientation towards life, and implies a more integrated individual (Markstrom et al, 1997), it was anticipated that higher ego would be associated with lower body image concerns, and that lower ego strength would be associated with higher body image concerns.

4.5 Predicting Body Image Dissatisfaction using Gender Identity and Ego Strength

While the individual links between the variables in the present research have been suggested, the arguments in the literature review further imply that there is a core interrelationship between gender identity (whether masculine, feminine or androgynous), level of body image satisfaction and ego strength. To engage with the complexity of how these variables interact, a fourth research question was posed, namely whether there are particular combinations of gender identity and ego strength which predict higher scores on body image concerns.

In view of the previous discussion in this chapter, body image concerns in men have been linked to the repercussions of the unattainable male ideal and to weak ego strength. If these suggestions are put together, it is possible to surmise that where a man does not feel adequate in his gender identity, and hence has low ego strength, then the two combined could lead to greater body image dissatisfaction. The reverse of this may also be true, as a person with a more comfortable and established sense of their identity, who implicitly also has higher ego strength, may show fewer body image concerns (Gordon, 1992). While the individual links discussed in the previous section suggested that masculinity and femininity could have varying associations with higher body image concerns, it was anticipated that when masculinity, femininity, or androgyny was combined with high ego strength, lower body image dissatisfaction would be predicted than when these gender identity dimensions were combined with low ego strength. This was in view of Markstrom et al.’s (1997)
findings that all three of these gender roles had high ego strength. Finally, while the undifferentiated group were not considered in previous analyses, the multiple regression used allowed this dimension of gender identity to also be drawn into the combinations. Given that low ego strength has been associated with body image concerns (Bruch, 1973), and the undifferentiated group have poor ego strength and poor endorsement of a gender identity (Markstrom et al., 1997), it was anticipated that the undifferentiated would have higher body image concerns given their generally poor mental health status.

4.6 Operationalising Body Image Concerns
While the notion of body image is popular in much research, it is somewhat elusive to define as it relates to behavioural, perceptual and cognitive ways a person perceives their physique (Thompson, 1995). It can also denote feelings toward one’s weight, overall body shape or specific parts of the body, as seen in the DSM-IV criteria for BDD (APA, 1994). While this makes the assessment of body image difficult, Thompson (1995) argued for the usefulness of a distinction between body image dissatisfaction and disturbance. While many people may be dissatisfied with some part(s) of their body, a person with a body image disturbance has a pathological preoccupation with an imagined defect that causes severe distress and loss of freedom (Thompson, 1995). This resonates with Rosen and Reiter (1996) who hold that in measuring BDD, it is important to be able to distinguish between “normal” body image dissatisfaction from body image problems that would be found in clinical populations. It should be noted that the term body image concerns was used in the present research as a generic grouping for both body image dissatisfaction and disturbance.

4.6.1 Measures of body image and the Adonis Complex Questionnaire
While there are few validated measures or diagnostic schedules that are specifically designed to measure BDD, Rosen and Reiter (1996) attempted to develop and validate the Body Dysmorphic Disorder Examination (BDDE), which is a clinical interview consisting of 28 questions. Despite its application to the present research, it is fairly time consuming to administer and hence impractical for a large sample. Body image dissatisfaction and disturbance can, however, be measured in other ways. For example, figural stimuli are used to assess current as opposed to ideal size, and body
satisfaction scales can quantify the degree of satisfaction felt with one’s body (Thompson, 1995). These measures do not, however, account for concerns with muscularity specifically. Indeed, existing questionnaires like the Eating Attitudes Test (EAT-26) or the Eating Disorders Inventory (EDI) measure restrained eating and drive for thinness rather than a desire for muscularity. Consequently, while research may find that women are more likely to have unhealthy attitudes to weight and eating and are more dissatisfied with their bodies (Meyer, Blisset & Oldfield, 2001), these results may be explained by the fact that the measures used do not tap into the kinds of concerns found in men (Rosen & Reiter, 1996).

Owing to the concerns raised above, an inventory known as the Adonis Complex Questionnaire (ACQ) was developed by Pope et al. (2000) to assess general body image concerns and how these affect the individual’s daily life, while the Muscle Dysmorphia Questionnaire (MDQ) was designed by the same authors to look more specifically at preoccupation with muscularity. For reasons that are clearly discussed in the methodology chapter, a combined version of these two scales was used in the present research. This new scale was termed the Adonis Complex Questionnaire-Revised (ACQ-R) and inquired into two dimensions of body image, namely body image dissatisfaction (measured by the ACQ-R_Image) and behaviours that may potentially signal body image disturbance (measured by the ACQ-R_Dysmorphia). Consequently, the operationalisation of the body image variable for the purposes of this research were the scores obtained on the ACQ-R subscales. Higher body image dissatisfaction is seen in higher scores on the ACQ-R_Image, while evidence of body image disturbance is noted with higher scores on the ACQ-R_Dysmorphia subscale. While body image disturbance was included in the present research, the particular sample used was unlikely to show symptoms of more pathological body image disturbance, and so the research was primarily interested in dissatisfaction.

4.6.2 The FFMI and the BMI
While the ACQ-R was used to measure body image disturbance and dissatisfaction, it did not provide a sense of the person’s actual body shape and muscularity. One measure of muscularity created by Pope et al. (2000) is known as the “fat-free mass index” (FFMI), and was inspired by the belief that the male body cannot exceed a certain level of muscularity without the help of steroids or other chemicals. The FFMI
formula uses a man’s height, weight and body fat percentage as an estimate of his degree of muscularity. A level of muscularity that exceeds 26 is argued to be unattainable without steroids, while a score between 20 and 25 suggests the person is noticeably muscular, but that this is not attributed to drugs. The FFMI can, however, give inaccurate results when a person is very fat (Pope et al., 2000), as the more fat that the body has, the more potential it has for muscle (Rosser, 2001).

Given the logistical problems with deriving FFMI s with a large sample, these were not calculated in the present research. However, to gain a sense of their body shape, respondents were asked their weight and height so as to calculate their Body Mass Index (BMI). This assesses whether the person is average weight, overweight or underweight, but does not take into account age and build (Gorman & Allison, 1995). The present research was primarily interested in how BMI scores were related to body image disturbance, as it was hypothesised that individuals with a higher BMI would either be overweight or extremely muscular. Indeed, an overweight person may feel more self-conscious about their appearance and so be more obsessed with behaviour that could reduce their weight or improve their tone (Pope et al., 2000). Higher BMI would then be associated with higher disturbance, defined on the ACQ-R_Dysmorphia subscale as compulsive attempts to improve a perceived inadequacy. However, a higher BMI can also be created by higher muscle tone from vigorous exercise in an attempt to cope with a body image disturbance (Rosser, 2001). Higher BMI scores could then also be associated with a person who is not technically overweight, but rather highly obsessed with muscularity. As such, while not a direct variable of interest, the BMI was included in the correlation analyses as an additional control dimension of body image. While there may be slight variation in interpreting the BMI scores, the following is a breakdown of how BMI scores are conventionally understood as adapted from Abraham and Llewellyn-Jones (1997).

- A BMI above 30 is classified as obese
- A BMI between 25 and 30 is classified as overweight
- A BMI between 20 and 25 is classified as healthy
- A BMI less than 20 is classified as underweight
- A BMI less than 15 is classified as emancipated