

'Bad Boys' Bodies: The Embodiment of Troubled Lives. Body Image and Disordered Eating Among Adolescents in Residential Childcare Institutions

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ABSTRACT

Children residing in care (hereafter referred to as childcare residents) are a risk-group for emotional disturbances and behaviour problems. Based on existing knowledge of risk factors one would also expect this population to be a high-risk group for eating disorders and related body-image disorders. The objective of this study was to describe pathological eating behaviour, dysfunctional body focusing and psychological symptoms in a sample of childcare residents compared with a non-clinical sample. Sixty-one childcare residents (aged 14–21 years, mean 16.2) and a non-clinical comparison group ($n = 196$) completed the Eating Disorders Inventory – Child version (EDI-C). The childcare residents also completed an extended questionnaire, including questions regarding the use of anabolic-androgenic steroids. Our main findings were high scores on EDI-C symptom scales for boys in the childcare resident group; few differences between girls in the two samples; and a high frequency of having used anabolic-androgenic steroids among boys in care. Body-image problems among boys have hitherto been given little attention. The results call for increased efforts in describing and detecting pathological cognitions, emotions and behaviour concerning the body in males in general and, more specifically, in high-risk male groups, such as childcare residents.

KEYWORDS

body image, childcare institutions, eating disorders, embodiment, metaphor

THIS IS A study of children residing in care (hereafter referred to as childcare residents) and their relationship with their own bodies. Most of the adolescents in this type of care have experienced troubled lives; deprivation, loss, abuse or parental neglect. More specifically this study addresses the *embodiment of troubled lives*.

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What is 'embodiment'? Linguistically, it tells us that something becomes body. In religious contexts this may stand for the *incarnation* of something mental or spiritual. In a secular culture we are more concerned with the fact that it is the psychological, social and cultural conditions that are turned into something bodily. Paul Ricoeur (1977), the philosopher of science, speaks about the body as 'a text': It can be read. It tells tales about the culture, its norms, boundaries and aesthetical ideals.

We communicate with others through the cultural body, and we also communicate with ourselves. Psychological phenomena such as *identity* and *self-esteem* are central references in the symbolic interaction between body and culture. The external, such as size and form, is used to promote internal life. Body image and self-image are closely linked (Cohane & Pope, 2001). Changes in the body by means of pathological and non-pathological methods such as training, slimming and medication are used in psychological and social games. Eating disorders illuminate ways in which people, through training, slimming and medication, may lose control over body practices that originally should have increased their self-esteem (Faibburn, Shafran, & Cooper, 1999).

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Previous research

This study is part of a larger research project investigating the relationship between the educational training of professionals in the health and social welfare field, and the demands confronting these professionals in their practice. Childcare residents are one important group of clients that these professionals meet in their practice. There is increasing concern as well as empirical knowledge about a high prevalence of emotional disturbances and behaviour difficulties among these clients (McCann, James, Wilson, & Dunn, 1996; Richardson & Joughin, 2000; Rosenfeld et al., 1997). They constitute a risk group for psychic illness and subsequent criminality (Pilowsky, 1995). The fact that the parents may have grave psychiatric problems and/or are drug abusers, may be due to both biological and psychological factors (Graham, Turk, & Verhulst, 1999). In addition to this, these vulnerable adolescents are faced with having to adapt to the additional strain of being placed outside their homes.

Based on the knowledge of risk factors for eating disorders and related body-image disorders, such as negative self-evaluation, physical and sexual abuse and psychological failure of care (Fairburn, Cooper, Doll, & Welch, 1999; Fairburn, Welch, Doll, & O'Connor, 1997; Fairburn et al., 1998; Kent, Waller, & Dagnan, 1999), we hypothesize that our sample might, in addition, also be at risk for these disorders. We have not been able to find solid empirical studies of this particular population that address the research questions explored here.

Eating disorders

Extensive research into eating disorders has gradually been carried out, the three diagnostic categories being anorexia nervosa, bulimia nervosa and binge eating disorder (DSM-IV). The main research here is on girls and women, owing to a far higher prevalence. In the reported studies, the female-to-male ratio for anorexia is usually around 11 to 1. For bulimia this ratio is even higher (Van Hoeken, Seidell, & Hoek, 2003).

Here we would like to point to a couple of factors that are relevant to our study.

First, there has been a one-sided feminine gender perspective on eating disorders. The scientific literature is now beginning to make the male gender visible, although boys and men represent a small group in an epidemiological sense (Andersen, 1990, 1999; Andersen, Cohn, & Holbrook, 2000; Andersen & Holman, 1997; Braun, Sunday, Huang, & Halmi, 1999; Carlat, Camargo, & Herzog, 1997; Schneider & Agras, 1987; Williamson & Hartley, 1998). We have clinical experiences of boys who have refrained from revealing their problems and from seeking help because they suffer from a 'girls' illness'. The literature presents eating disorders among boys as being phenomenologically similar to eating disorders in girls. In a clinical-therapeutic context, similar traits are more striking than differences. However, there is one crucial difference, namely that the original motivation for boys to change their bodies has often not been slimming in order to become thin, but to achieve a different body composition, or their motivation has been guided by ideas about health and purity in food intake. The cultural pressure on the boy-body for change and modelling is perhaps not so much less than it is for girls (Andersen & Di Domenico, 1992; Pope, Phillips, & Olivardia, 2000), but the aim is different. Whereas the aim of girls is often reduction, the aim of boys is both reduction (less fat) and the expansion of muscles.

Second, there is growing clinical and scientific knowledge about atypical and sub-clinical forms of eating disorders. This is also expressed in DSM-IV as the category 'Eating Disorders Not Otherwise Specified' (American Psychiatric Association [APA], 1994). Clinical experience indicates a phenomenological diversity of forms of illness, both within the diagnostic categories and outside them. With the sub-clinical forms in

mind, which do not fully satisfy the diagnostic criteria, we speak not only of eating disorders, but also of 'disordered eating'. There are reasons to expect a high prevalence of such problems in our sample. Kent et al. (1999), for example, point to a fairly clear connection between parents' psychological failure to provide care and an anomalous attitude to food and body among their children.

Body dissatisfaction and dysmorphic disorders among boys and men

A relatively new field of research has turned towards the problems of boys and men in regard to food, weight, sexuality, body form and looks. If one is to 'discover' body problems among boys, one has to search for more than the traditional eating disorders. The literature provides us with reports from fitness studios about boys and men who lose control over their bodily practices; muscularity run amok, training dependency, fat phobia, cosmetic surgery, body image disorders, etc. (Neumark-Sztainer, Story, Falkner, Beuhring, & Resnick, 1999; Pope, Gruber, Choi, Olivardia, & Phillips, 1997; Pope, Katz, & Hudson, 1993). Cohane and Pope (2001) outline 17 studies on body image in boys. Even though, in general, the boys displayed less body dissatisfaction than the girls, most studies report that a significant number of boys of all ages were dissatisfied with the form and size of their bodies. While the girls mostly wanted to become thinner, there was variation among the boys. Some wished to become thinner, others heavier and stronger. Body satisfaction correlated positively with self-esteem.

Previous study of a childcare population

In 1999, one of the authors (Kjelsberg & Nygren, 2004; Nygren, 2000, 2001) conducted a study of 1106 children and adolescents in Oslo who at that time were clients in public childcare and public child- and adolescent psychiatric services respectively (the double-client project). This sample was examined with the aid of the Achenbach's Child Behavior Checklist (CBCL) and Youth Self Report (YSR) (Achenbach, 1991a, 1991b, 1991c). The childcare sample had a high prevalence of emotional and behavioural problems. Results indicated that 51% of the clients in the childcare institutions were in need of psychiatric health services, hence they were defined as 'double-clients'. Fifty-six per cent of these double-clients qualified for the psychiatric diagnosis of conduct disorder (DSM-IV; APA, 1994). The prevalence of psychiatric disorders, defined by total CBCL scores with a 'cut-off' of 32, was 82%, compared with 10% in a non-clinical sample (Nøvik, 1999). For 60% of the double-clients aged above 10 years, there were reports of substance abuse during the last 12 months, alcohol and/or narcotic drugs. Forty-one per cent had first abused substances before the age of 13 (Nygren, 2001). Boys in childcare institutions had problem scores on the same level as boys in child- and adolescent psychiatric institutions. Girls in childcare institutions did not reach the same problem level as girls in psychiatric institutions, but the level was significantly higher than in the non-clinical population (Kjelsberg & Nygren, 2004).

In this study, no detailed questions were asked about eating disorders, although the adolescents were asked the following questions: 'Do you have eating problems?' and 'Have you had eating problems?' The adolescents' professional contacts were also asked to make a professional judgement about whether at the time of the investigation their client had 'eating problems', answering 'yes' or 'no'. The results from this study indicated a high prevalence of eating problems. It is also interesting that the question of whether the adolescents considered themselves as having eating problems was answered with 'yes' almost equally in boys and girls, 13.6 and 13.3% respectively (Nygren, 2000). The question about having 'eating problems', cannot be used to estimate the prevalence of eating disorders in respect to diagnostic criteria. In addition, one found a discrepancy

between the adolescents' self-report and the staff report. This discrepancy is striking in the case of the boys; 13.6% of the boys responded that they had an eating problem, whereas the adolescents' contact among the staff responded that 3.1% of the boys had an eating problem (Nygren, 2001). The results were considered interesting, in particular, the high rate reported for boys, and led to the initiation of this study.

Aim of the study

The main aim of the study is to describe patterns of pathological eating behaviour, dysfunctional body focusing and psychological symptoms in a sample of childcare residents compared with a non-clinical sample. Of particular interest was the investigation into gender differences and ethnic differences.

Method

Subjects

Childcare residents This study deals with the total population of adolescent clients above the age of 14 in residential childcare institutions in the municipality of Oslo, the capital of Norway. Inclusion criteria for participation in the study were as follows: all adolescents aged 14 years or more and who were in public residential childcare institutions in Oslo, or who were connected to the institution in terms of active follow-up care. The total number of adolescents fulfilling the inclusion criteria was 89. In total, 66 agreed to participate in the questionnaire study. Of these, 5 were rejected on account of incomplete questionnaires, so that the number of analysed questionnaires was 61, giving a total response rate of 69%. In the sample, 36 (59%) were boys and 25 (41%) girls. The mean age was 16.2 years (SD 1.7) (range 14–21). Split on gender, the mean age was 16.6 years (SD 1.7) for girls and 16.1 years (SD 1.9) for boys. Sixty-four per cent had a Norwegian ethnic background, whereas 36% were defined as first- or second-generation immigrants. In the 'double-client-project', see earlier, the screening of the total childcare population in Oslo was carried out in September 1999. At the time of the present study in May 2001, 30 (49%) belonged to the group of clients who had also been more broadly studied in 1999. The results from the first study give a picture of problems that are usually found in this particular sample (Kjelsberg & Nygren, 2004; Nygren, 2000, 2001).

Non-clinical sample In order to compare our results with a representative sample, using EDI-C, our childcare data were compared with a sample of a Swedish urban non-clinical population from Uppsala (Edlund, Halvarsson, Gebre-Medhin, & Sjöden, 1999). Edlund et al. collected data from 401 students, with a response rate of 87.5%. For the purposes of our analysis we eliminated those younger than 14 years and questionnaires that had not been filled out satisfactorily, which left us with 196 respondents; 78 boys and 118 girls. The mean age of the non-clinical group was 15.5 years (SD 1.1); 15.4 years (SD 1.1) for girls and 15.5 years (SD 1.9) for boys.

Procedures

Those in charge of the childcare institutions were informed about the project, and they informed the adolescents. All data were collected over a period of one week in May 2001. The collection of questionnaire data was administered by the institution staff in a way that safeguarded the anonymity of the participants.

Instruments

A self-report questionnaire consisting of three parts was used in the study:

1. Eating Disorders Inventory, Child Version (EDI-C).
2. Three special questions with set-response alternatives to elucidate attitude to food and body.
3. Use of doping agents.

Eating Disorder Inventory, Child Version (EDI-C) (Garner, 1991) The inventory consists of 91 items with 6 set-response alternatives. This inventory assesses psychological characteristics and symptoms common to anorexia and bulimia nervosa. The original EDI (Garner, Olmsted, & Polivy, 1983) has 64 items and 8 subscales. Three of the subscales assess attitudes and behaviours in regard to weight, body shape, and eating. The scales are named Drive for Thinness, Bulimia and Body Dissatisfaction. They are called the symptom scales. The other five scales assess more general psychological characteristics: Ineffectiveness, Perfectionism, Interpersonal Distrust, Interoceptive Awareness and Maturity Fears. The revised edition (EDI-2) added 27 items which formed three additional scales: Ascetism, Impulse Regulation and Social Insecurity. EDI-2 can be used as a screening instrument to detect at-risk populations, and for diagnosis, as well as a treatment outcome measure. It can be useful for differentiating levels of severity and subtypes of anorexia and bulimia nervosa. All items are formulated as statements from 'Never' to 'Always'. Responses are scored from 0 to 3, with a score of 3 assigned to the response farthest in the 'symptomatic' direction, depending on whether the item is keyed in a positive or negative direction. It is worth mentioning that the EDI was originally made with reference to women. This is expressed in some of the items, particularly some of those constituting the symptom scale Body dissatisfaction, referring to female aesthetic ideals. Hence, there is a possibility of boys and men under-reporting, but it has been shown that the EDI-C could well be used for both boys and girls (Thurfjell et al., 2004).

EDI-C is a further development from EDI-2 (Garner, 1991). This children's version is approximately similar to the adult version. A few items are changed, linked to the subscale Maturity fear.

Three extra questions After interviewing the staff at the childcare institutions we added three 'extra' questions, designed to reflect some aspects of the institution culture relevant to our study:

I am scared of not getting enough food.

I am being told that I help myself to more food than I need.

I want to have a fit/strong body in order to be able to defend myself.

The response categories are the same as in EDI-C.

Doping agents Four questions with two fixed-response alternatives, yes or no, about the use of and being offered anabolic-androgenic steroids and other doping agents were included. These were taken from a Norwegian epidemiological study of adolescents (Pedersen, 2000). The questions are:

Have you been offered anabolic-androgenic steroids during the last four years?

Have you used anabolic-androgenic steroids during the last four years?

Have you been offered other doping agents during the last four years?

Have you used other doping agents during the last four years?

Statistical methods Data were analysed in the statistical programme SPSS, version 11.0. Owing to skewed data, a non-parametric test was used to compare the means for the subscales in EDI-C, comparing childcare residents and non-clinical sample, and comparing girls and boys within the samples. More specifically, we performed a log-rank test with adjustment for age. Linear regression analysis was used to explain variances in the EDI-C symptom scales from scores in EDI-C psychological subscales. We used a block-wise procedure, including the psychological subscales as predictor variables. In these analyses, the residuals were less skewed, and the assumption of normality was deemed to be satisfactory. Significance was set at $p < .05$.

Results

We presented the results of comparing the two samples split by gender, due to expected differences between boys and girls. We examined gender differences within the two samples, and ethnicity as a variable within the groups of childcare residents. Finally, regression analysis was used to investigate which are the variables that explain variance.

EDI-C: Childcare resident sample versus non-clinical sample

Boys – Childcare residents versus non-clinical sample The analyses demonstrated significant between-group differences for all three of the symptom scales: Drive for Thinness (DT), Bulimia (B) and Body Dissatisfaction (BD); and four of the eight psychological scales: Ineffectiveness (I), Interoceptive Awareness (IA), Ascetism (A) and Impulse Regulation (IR). On all these scales the childcare resident boys scored higher.

Girls – Childcare residents versus non-clinical sample The analyses demonstrated significant between-group differences on only one of the psychological scales – Impulse Regulation (IR). Childcare girls scored higher.

EDI-C: Gender differences within the two samples

Non-clinical sample There were significant gender differences on all three symptom scales: Drive for Thinness (DT), Bulimia (B) and Body Dissatisfaction (BD), with girls scoring higher than boys. On the psychological scales, girls scored higher than boys on Ineffectiveness (I), Interoceptive Awareness (IA) and Impulse Regulation (IR). Boys scored significantly higher on Interpersonal Distrust (ID) and Ascetism (A).

Childcare residents In childcare residents there were significant differences between boys and girls on only one scale. This is due to the overall high scores among boys. The scale is the psychological scale Ascetism (A), where girls scored lower than boys (Table 1).

EDI-C: Ethnicity differences within childcare residents

We compared first- and second-generation immigrants and Norwegians. For girls, we did not find any between-group differences within the child resident group. For the boys, there was a significant difference on only one scale, Perfectionism, with scores of 6.7 for immigrants and 2.6 for non-immigrants ($p = .01$).

EDI-C: Psychological factors as predictors of eating disorder symptoms

Linear regression analysis was used with the symptom scales Drive for Thinness (DT), Bulimia (B) and Body Dissatisfaction (BD) as dependent variables in relation to the

Table 1. EDI-C. Mean values (SD) on symptom and psychological scales

					Differences between study samples			
	Childcare residents		Non-clinical sample		Between samples ^a		Between genders ^b	
	Boys	Girls	Boys	Girls	In boys	In girls	In childcare residents	In non-clinical sample
	N = 39	N = 25	N = 78	N = 118				
Symptom scales								
Drive for Thinness (DT)	1.5 (2.6)	3.7 (6.0)	0.2 (0.9)	3.4 (5.1)	p = .001	p = .5	p = .1	p < .001
Bulimia (B)	1.1 (1.6)	1.3 (2.4)	0.3 (0.8)	0.6 (1.5)	p = .01	p = .9	p = .06	p = .05
Body Dissatisfaction (BD)	5.3 (7.3)	7.4 (7.6)	2.6 (2.7)	9.3 (7.6)	p = .007	p = .3	p = .5	p < .001
Psychological scales								
Ineffectiveness (I)	3.1 (3.6)	3.2 (3.0)	0.7 (1.1)	3.4 (4.3)	p < .001	p = .9	p = .5	p < .001
Perfectionism (P)	3.9 (3.7)	3.5 (2.7)	3.0 (3.0)	2.5 (2.8)	p = .3	p = .8	p = .2	p = .4
Interpersonal Distrust (ID)	3.8 (3.5)	3.7 (3.6)	4.2 (3.1)	2.5 (2.5)	p = .7	p = .3	p = .9	p < .001
Interoceptive Awareness (IA)	3.4 (4.0)	4.2 (3.9)	1.0 (1.5)	2.8 (3.8)	p < .001	p = .4	p = .7	p < .001
Maturity Fears (MF)	6.4 (4.3)	6.8 (4.3)	5.2 (3.6)	5.3 (3.9)	p = .2	p = .1	p = .2	p = .1
Ascetism (A)	8.2 (3.6)	6.0 (3.0)	6.2 (3.0)	5.0 (2.7)	p = .01	p = .3	p = .03	p = .003
Impulse Regulation (IR)	5.0 (7.1)	4.5 (3.4)	1.6 (2.5)	3.0 (3.3)	p < .001	p = .03	p = .9	p = .005
Social Insecurity (SI)	3.1 (3.7)	2.1 (2.0)	2.8 (2.0)	2.8 (2.7)	p = .5	p = .1	p = .2	p = .5

Note. In the analysis a Logrank test was used with adjustment for age.

^a Differences between childcare resident sample and non-clinical sample, for boys and girls respectively. ^b Differences between boys and girls within the two samples, childcare residents and non-clinical sample.

psychological subscales as independent variables. Owing to low *n*, this procedure could not be repeated with all the independent variables for the childcare sample. As a first step, all the psychological subscales were used in the analysis of the non-clinical sample. As a second step, we chose to run the analysis for the childcare sample with the three strongest predictors found in the analysis of the non-clinical sample. These were Ineffectiveness (I), Interoceptive Awareness (IA) and Impulse Regulation (IR). To reduce the risk of overlooking important predictors for the childcare sample, we analysed, undivided, each of the psychological scales separately, giving no indications of other important predictors.

Non-clinical sample Predictors were different for boys and girls. Interoceptive Awareness (IA) predicted all three symptom scales in boys. In girls, Ineffectiveness (I) predicted all three symptom scales. Also, Impulse Regulation (IR) predicted Drive for Thinness (DT) and Body Dissatisfaction (BD).

Childcare residents Among childcare resident boys, Ineffectiveness (I) predicted the symptom scales Drive for Thinness (DT) and Body Dissatisfaction (BD); Impulse Regulation (IR) predicted Bulimia (B). In accordance with the results for the boys, Ineffectiveness (I) predicted the symptom scales Drive for Thinness (DT) and Body Dissatisfaction (BD), for the girls. No psychological factors were associated with Bulimia (B) in girls (Table 2).

Use of doping agents in the childcare sample

Among the boys, 6.5% reported the use of anabolic–androgenic steroids during the last four years. No girls gave a positive report. Among the boys, 19.4% had been offered anabolic–androgenic steroids during the last four years, whereas none of the girls had. There were lower scores among immigrant boys, but the differences were not statistically significant.

Defending oneself

There was a high percentage of positive answers to the statement: ‘I want to have a fit/strong body in order to be able to defend myself’: 44% of the boys and 8% of the girls answered ‘always’. If we add the categories ‘usually’ and ‘often’, the positive answers increase to 55% for boys and 42% for girls. There were no significant differences between immigrants and non-immigrants.

Discussion

Conclusion

The major findings in this study are as follows.

1. Surprisingly high scores on EDI-C scales for boys in the childcare resident group. They scored significantly higher on 8 of 11 scales, compared with boys in the non-clinical sample. The gender differences on the symptom scales in the non-clinical sample, where girls scored higher than boys, is as expected within our contemporary culture of body ideals (Anderson & Di Domenico, 1992). But these differences seem to disappear in the group of childcare residents. Here the boys approach the levels of the girls.
2. Another interesting result is the surprisingly few differences between childcare girls and girls in the non-clinical sample. Based on the knowledge about risk factors for eating disorders and dysfunctional body preoccupation, such as trauma, neglect and other psychiatric symptoms, one would expect higher symptomatic levels in the childcare group.

Table 2. EDI-C. Symptom scales Drive for Thinness (DT), Bulimia (B) and Body Dissatisfaction (BD) are dependent variables, and psychological scales are independent variables

	Drive for Thinness				Bulimia				Body Dissatisfaction			
	Childcare residents		Non-clinical sample		Childcare residents		Non-clinical sample		Childcare residents		Non-clinical sample	
	Boys N = 39 β	Girls N = 25 β	Boys N = 78 β	Girls N = 118 β	Boys N = 39 β	Girls N = 25 β	Boys N = 78 β	Girls N = 118 β	Boys N = 39 β	Girls N = 25 β	Boys N = 78 β	Girls N = 118 β
I	.7**	.7**	-.1	.6***	-.1	.2	.1	.5***	.5*	.9***	.2	.4***
P			.04	.03			-.1	.02			-.3	-.2
ID			.05	-.09			.1	-.04			-.1	-.2
IA	-.86	-.07	.3*	.1	-.05	.3	.3*	.1	-.3	-.4	.3*	.2
MF			-.1	-.07			.02	-.1			-.1	-.07
A			.004	.1			.1	.1			.1	.1
IR	-.2	-.4	.2	.2*	.6**	-.3	-.005	.1	.2	-.1	-.2	.2*
SI			.04	-.1			-.1	-.2			.3	.1

* $p < .05$; ** $p < .01$; *** $p < .001$.

β = Standardized beta.

I = Ineffectiveness, P = Perfectionism, ID = Interpersonal Distrust, IA = Interoceptive Awareness, MF = Maturity Fears, A = Ascetism, IR = Impulse Regulation, SI = Social Insecurity.

Predictors included in the analysis of childcare residents were chosen from the analysis of the non-clinical sample.

3. In regression analysis, the psychological subscale Ineffectiveness (I) was an important predictor for symptom scales for both boys and girls in the childcare sample.
4. With one exception, i.e. on the subscale Perfectionism (P) for boys, ethnicity is not a variable associated with significant difference within the childcare group.
5. There was a high frequency of having used anabolic-androgenic steroids among childcare boys.

Limitations of the study

Even if it can be argued that the relatively small number of cases in the childcare group ($N = 61$) supports the significant differences in our results, it also reduces the possibility of solid statistical analyses and perhaps contributes to obscuring differences that might have been disclosed with a larger sample.

Another limitation on further interpretations of the results is the lack of background data, such as case history, socio-economic data and psychiatric diagnoses. However, 49% of the participants also took part in the study from 1999 with more data on various relevant variables. These results (Nygren, 2000, 2001) point to a tendency to multiple problems, i.e. substance abuse and psychiatric comorbidity, i.e. conduct disorder. The lack of background data for many of the respondents in our sample means that we are not able to discuss the relative influences of background variables and the influence of the actual context as institutionalized adolescents.

Contribution to the knowledge and language relevant to the work with childcare clients

Because of the results presented, in this section, we place the main emphasis on boys. In order to contribute to the knowledge about this particular sample we first look into the results on the psychological subscales in EDI-C. From these results we wish to highlight the following four phenomena.

Low self-esteem The subscale Ineffectiveness (I) is central in these results. For the childcare boys it is significantly higher than in the non-clinical sample. In the linear regression analysis in childcare boys it is the only single significant predictor of Drive for Thinness (DT) and Body Dissatisfaction (BD).

The 10 single items constituting the scale Ineffectiveness (I), are strongly related to self-esteem. Our study underscores earlier research about eating disorders (Fairburn, Cooper, et al., 1999; Fairburn et al., 1997, 1998) and body-image disturbances (Cohane & Pope, 2001; Pope et al., 2000) as a concrete bodily expression of problems of low self-esteem.

Interoceptive awareness For the childcare boys, the psychological subscale Interoceptive Awareness (IA) is significantly higher than in the non-clinical sample. IA is a naming of 10 items dealing with being in contact with, having control over and being able to name inner feelings. High scores relates to the term *alexithymia*, which traditionally is referred to as crucial in the psychology of eating disorders (Cochrane, Brewerton, Wilson, & Hodges, 1993), as well as in other somatic and bodily expressions of psychological problems (Sifneos, Apfel-Savitz, & Frankel, 1977).

Impulse regulation For the childcare boys, the psychological subscale Impulse Regulation (IR) is significantly higher than in the non-clinical sample. IR is composed of 11 items about control of affects and behaviour. The experience of low impulse regulation may be expressed as low control over affects and/or uncontrolled behaviour.

The theme of control For the childcare boys, the psychological subscale Ascetism (A) is significantly higher than in the non-clinical sample; and the boys in the non-clinical sample also have a significantly higher score than non-clinical girls. Ascetism is composed of eight items covering more than the traditional spiritual–bodily concept of restriction. It also contains aspects of self-control, and the need to have control.

Chaos and control

We interpret these results as important information about main psychological dilemmas in this population: *It addresses self-esteem and internal and external control.*

‘Control’ is a wide concept, with many possible meanings. It refers to a subjective feeling, but there may be many references to life conditions which one does/does not actually control. There are many examples of theoretical models and phenomenological descriptions from the literature on eating disorders (Surgenor, Horn, Plumridge, & Hudson, 2002).

Many patients speak and write about their subjective need for control, and the feeling of ‘chaos’ when they are not in control. Crisp (1997) has used the concept of control to describe the central psychopathology of anorexia nervosa as a failure of mastery of biological and psychological changes in puberty. In psychodynamic models, the control issue in eating disorders is on a familial and interpersonal level. Bruch (1973) defines eating disorders as a ‘struggle for control, for a sense of identity, competence and effectiveness’. Affect theory emphasizes the lack of control of affects and emotions. Feminists refer to a gendered culture, in which adolescent women are left with ‘feelings of confusion, fear and powerlessness’ (Orbach, 1978). Nasser and Di Nicola (2001) discuss radical societal changes, which are out of control, proposing to rename eating disorders ‘social chaos syndromes’.

Loss of control is a very actual issue on a familial and societal level in the sample we are studying here, with its individual histories of phenomena such as child neglect, losses, conflicts, violence traumas and low socio-economic status. Although we lack data for non-clinical samples for comparisons on the statement ‘I want to have a fit/strong body in order to be able to defend myself’, the high positive response rate indicates that the members of this subculture are not only emotionally and socially insecure, but that they may also be physically threatened.

When comparing immigrant and non-immigrant boys there was only one significant difference; higher scores for Perfectionism (P) among immigrants. This scale consists of six items that cover not only the traditional understanding of psychological perfectionism as a personality trait, but also high expectations and demands from others. Hence, these higher scores among immigrants can be interpreted as internalized high expectations from hierarchical families and cultures.

Body metaphors

As described earlier, the body is both physical and metaphorical. Bodily qualities – such as size, weight, shape, muscles and ways of eating – are physical entities that also express non-physical phenomena. They are also expressions of psychological and normative meaning. In our own research we have found the striking explicitness of body metaphors in eating disorders and body image disturbances (Skårderud, 2000). When studying the body as a symbolic language – both in pathological and healthy cultures – there are numerous examples of how bodily metaphors are ‘mimics’ (Douglas, 1966/2002). An example in this context is how people experiencing emotional or interpersonal lack of control in their lives, attempt to gain control through controlling their appetite, or other bodily attributes. It is often striking how such body practices point to a basic and close

relationship between emotion and the physical body, a more or less immediate translation. In these ‘concretized metaphors’ (Enckell, 2002) there is a striking closeness, a direct analogy and primary relation between emotions and different sensorimotor experiences. Emotional experiences are organized, and felt, based on different domains of physical life, sensorimotor experiences and bodily attributes. Emotions are concretized.

With reference to the childcare sample in this study we propose that the high scores on the symptom scales EDI-C indicating chaotic ways of eating, bingeing and dieting are concrete messages about the problems of control in their lives. The troubled body embodies a troubled life lacking the necessary control over essential life conditions.

‘Bad boys’ bodies

The results confirm our hypothesis that this male sample is a high-risk group. Traditionally, girls are expected to have more problems concerning eating and body image. In the childcare sample, the differences on the symptom scales on EDI-C between the sexes are reduced. Another way of accounting for this is to claim that there is a tendency towards more eating and body dissatisfaction pathology among the childcare boys, a tendency to the same extent as for childcare girls. That does not necessarily mean that they fulfil the criteria for eating disorders. With reference to the DSM-IV diagnostic criteria for eating disorders (APA, 1994) we should look for ‘atypical’ and sub-clinical forms, as well as for other phenomenological expressions of psychological discomfort with the body.

The high figures for having used and have being offered anabolic–androgenic steroids confirm the severity of body image problems in this subculture. Among the boys, 6.5% reported using anabolic–androgenic steroids during the preceding four years. No girls gave a positive report. In a community study of 10,828 adolescents in Oslo, Pedersen and Wichstrøm (2002) found that the lifetime use of doping agents was 1.8% (2.3% of boys and 1.3% of girls), and 11.5% had been offered doping agents without using them (13.6% of boys and 9.4% of girls).

Hence, these results point to a doubly neglected phenomenon. First, psychiatric phenomena are under-reported in the childcare population (Nygren, 2000, 2001). Emotional problems in this population are seldom recognized because other aspects of their behaviour demand attention. Second, there really do exist problems concerning body image among boys, which have hitherto not been given sufficient attention.

Two contexts are relevant in the discussion of our results: (i) the childcare boys are representatives for masculinity in contemporary society; and (ii) they express their masculinity in the context of ‘childcare’, historically and in the present.

Modernity represents rapid changes. Masculinity, especially as a cultural and social role, is undergoing changes. In the past, boys and men had fairly natural arenas. In the course of a short period, women have entered many of these. Women have become both executives and fighter pilots. With anabolic–androgenic steroids is it relevant to ask: How does the boy/man, and the male body, react? A possible solution is to assert one’s masculinity by cultivating one’s body. For some males this may mean fitness and big muscles, which will make their masculinity more visible. Big muscles have become very important symbols in a post-industrial world in which, strictly speaking, they are not of so very much use (Bordo, 2000; Faludi, 2000; Pope et al., 2000). Exercise and fitness are also supported by the medical profession as a practice of good health, and as a sign of high morals. For some, this may mean a drive for thinness; the search for a sense of control via restrictive behaviour and weight reduction. And for others it may mean a more or less controlled mixture of these body techniques.

Childcare residents are a high-risk population. Their individual personal history has led to this caretaking. As a group, they represent stories of well-known risk factors such

as traumatic experiences, attachment failures, separation and loss. In addition to this, they are exposed to the possibly beneficial or non-beneficial effects of the role as childcare clients, and to living in multi-problem milieus and being institutionalized.

Clinical relevance

This research is clinically relevant in raising important issues about the prevalence of body dissatisfaction, eating disorders and related disorders in adolescent males, and, more specifically, the struggles and mental health needs of boys in institutional care. The childcare staff's knowledge about and focus on problematic and pathological body attitudes and behaviour is limited. Increased knowledge will contribute to an earlier and better identification, and to swifter and more adequate measures.

Based on our results, we can state that the boys in the childcare sample experience problems with body image and bodily behaviour, which are not satisfactorily perceived and understood by the dominating discourses about the body. Furthermore, our results indicate that the anticipated negative effects of living under conditions structured by a past and/or present 'childcare context', which manifest themselves, for instance, in terms of problems with body image and bodily behaviour, seem to be present only among the boys. Thus, while girls in the childcare sample do not show this type of problem to a significantly higher degree than girls in a non-clinical sample, the childcare context seems to address the boys in a way that can be described in terms of embodiment of troubled lives. This childcare contextual embodiment of the boys' troubled lives seems in a characteristic way to add its effect to the general societal pattern for embodiment of masculinity. This opens our eyes to new discourses about what could be called the 'societal body'.

There is an obvious need to initiate such new discourses, which may generate a more nuanced language and attention to male behaviour. The biased emphasis on the diagnostic criteria for eating disorders, and regarding these problems as primarily female phenomena, represents a gendered 'tunnel vision', with the probability of hindering us from seeing and understanding atypical, sub-clinical, and masculine ways of expressing troubled lives through bodily behaviour.

Future research

Our results call for:

- increased research efforts in describing and detecting pathological cognitions, emotions and attitudes concerning the body in males generally, and more specifically in high-risk male groups, like childcare populations;
- research on the body in the childcare system;
- we see an interesting and important challenge in some of these institutions, in the ways in which food is used as a symbolic expression of warmth, support, fellowship and emotional nurturing; with a risk of unwanted weight gain and obesity;
- gendered careers among childcare residents;
- developing professional competence in the fields of psychiatry, general medicine, social work and child welfare;
- to gain competence in *detecting* more than the traditional forms of eating disorders, including atypical and sub-clinical forms; 'impure' forms of pathology in addition to the 'pure' forms;
- To gain competence in *preventive* and *treatment strategies* in relation to the mentioned forms of pathology connected to the mechanisms producing the *embodiment of troubled lives among boys*.

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