Finding a “fit” between narratives: A framework for meeting the needs of people struggling with non-clinical disordered eating

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Table of contents

List of figures 6

List of tables 7

Acknowledgements 8

Abstract 9

References 10

Chapter 1 Introduction to doctoral research project 11

1.1 Overview of thesis 11

Personal Reflexivity 11

References 14

Chapter 2 Critical literature review 15

2.1 Introduction 15

2.1.1 Defining disordered eating 16

2.1.2 Recovery from eating disorders 17

2.1.3 What this literature review hopes to achieve 17

2.2 Reviewing theories of eating disorders 18

2.2.1 Cognitive-behavioural theory 18

2.2.2 Psychoanalytic perspectives 19

2.2.3 Self-psychological perspectives 19

2.2.4 Psychosomatic theories of obesity 20

2.2.5 Attachment theory 21

2.2.6 Feminist perspectives 21

2.3 Examining literature on emotional processes of disordered eating 22

2.3.1 Escape Theory 22

2.3.2 Restraint Hypothesis 24

2.4 Models of emotion regulation in disordered eating 24

2.5 Reflection on the literature and rationale for the current study 26

2.5.1 Implication of using diagnostic categories 26

2.5.2 Inclusion of men with disordered eating 27

2.5.3 What would support people to seek help? 28

2.5.4 Moving away from diagnostic categories and inclusion of disordered eating experiences among a non-clinical population 28

2.6 Relevance to Counselling Psychology 29

2.7 The current research study aims ... 29
References ... 31
Chapter 3 Methodology ... 41
3.1 Introduction to Methodology ... 41
3.2 Research Question Development ... 41
3.3 Relevance to Counselling Psychology ... 42
3.4 Assumptions about the Nature of Knowledge ... 43
3.5 The Researcher's Epistemological Stance ... 44
3.6 Introduction to Grounded Theory ... 45
3.6.1 Rationale for Constructivist Grounded Theory Methodology ... 46
3.6.2 Rationale for choosing abbreviated version of Grounded Theory ... 46
3.7 Using semi-structured interviews ... 47
3.8 Grounded Theory Method: Principles of Analysis ... 48
3.8.1 Coding ... 48
3.8.2 Memo writing ... 49
3.8.3 Theoretical Sampling ... 49
3.8.4 Theoretical Saturation ... 50
3.8.5 Data collection and Analytic Process ... 50
3.9 Recruitment Strategy ... 52
3.10 The Participants ... 52
3.10.1 Table I: Participant information ... 53
3.11 Interview Structure ... 54
3.11.1 The Interviews ... 55
3.11.2 Invitation for a follow-up conversation ... 55
3.12 Evaluating the Quality of the Study ... 56
3.13 Transferability of Results ... 57
3.14 Ethical Considerations ... 57
References ... 60
Chapter 4 Results ... 64
4.1 The Grounded Theory and Model ... 64
4.1.1 Table II: A table with categories and corresponding sub-categories ... 65
4.1.2 The Grounded Theory Model: A Framework for making sense of experiences of disordered eating and understanding decisions to seek help ... 66

4.2 Presenting the Results 67
4.2.1 Using Quotations 67
4.2.2 Including Researcher Reflections 67
4.3 Core category: Experiencing emotional distress, shame, anxiety and depression 67
4.3.1 Situating experiences in relation to trauma 67
4.3.2 Contextualising one's 'disorder' 68
4.3.3 Managing problems in life 71
4.4 Core Category: Managing the uncertainty of experiences against the certainty of service provisions 73
4.4.1 Factors affecting decisions to seek help 74
4.4.2 Meaning of help-seeking 77
4.4.3 Processing attitudes towards helping relationships 80
4.5 Emerging Central Category: Finding a 'fit' between narratives 82
4.5.1 Taking the 'disorder' out of the 'eating' 82
4.5.2 The role of the other 83
Chapter 5 Discussion 84
5.1 Discussion of results 84
5.1.1 Conclusions 84
5.2 Linking results to existing research 85
5.3 Reflecting on differences in decisions to seek help 87
5.4 Linking findings to existing theory 89
5.4.1 Attachment Theory 89
5.4.2 Psychoanalytic perspectives 90
5.4.3 Narrative Theory 92
5.5 Summary of unexpected results 93
5.6 Reflecting on research participants 93
5.7 Reflections on using semi-structured interviews 95
5.8 Suitability of Social Constructivist Grounded Theory 95
5.9 Transferability of Findings 96
5.10 Credibility and trustworthiness of the Grounded Theory Model 97
5.11 Implication for practice and counselling psychology 97
5.11.1 Increasing awareness, offering training and consultations 98
5.11.2 Therapists accommodating a "fit" within the organisational context 98

5.12 Limitations and suggestions for future research 99
5.13 Locating disordered eating, mental health and treatment within the current context 101
5.14 Food for thought 102
References 103
Appendices 108
Appendix 1: Ethics certificate London Metropolitan University 108
Appendix 2: Introductory email to organisations to advertise 109
Appendix 3: Research poster 110
Appendix 4: Information sheet 111
Appendix 5: Consent form 113
Appendix 6: Interview questions 114
Appendix 7: Debrief sheet 116
Appendix 8: Distress protocol 117
Appendix 9: Sample of interview memos 118
Appendix 10: Transcript extract: a worked examples of data analysis 120
Appendix 11: Sample of database detailing line codes, focused code, subcategories and categories 125
Appendix 12: Sample of memos on emerging categories 128
Focused codes emerging after 5 interviews (05/07/2018) 128
Processes identified so far (01/08/2018) 128
Novel focused codes emerging across interviews (07/10/2018) 128
Experiencing emotional distress, shame, anxiety and depression (19/07/2018) 130
Managing uncertainty of experiences against certainty of services (11/02/2019) 131
Appendix 13: Examples of models and revisions 133
Figure II: Model 1 Created on 10/06/2018 134
Figure III: Model 2 Created on 09/02/2019 135

List of figures

Figure I: The Grounded Theory Model 65

Figure II: Model 1 Created on 10/06/2018 134

Figure III: Model 2 Created on 09/02/2019 135

List of tables

Table I: Participant information 53

Table II: A table with categories and corresponding sub-categories 64

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Abstract

Disordered eating is becoming increasingly prevalent among the general population and patterns are said to have substantial emotional, physical and psychosocial problems. This study examined emotional processes and helping relationships among people with experiences of disordered eating. Disordered eating as a way of regulating negative emotional states (e.g. Ganley, 1989), resulting from a misinterpretation of hunger signals (e.g. Bruch, 1973), or disinhibited and restrained eating during negative emotions (e.g. Herman & Polivy, 1984) are mechanisms highlighted and cited within the eating disorder literature. Qualitative studies focus on phenomenological and interpretative perspectives (e.g. Fox & Power, 2009; Cooper et al., 2004), and research among a nonclinical sample often selects participants on the basis of weight categories or diagnoses which are developed and implemented by researchers and clinicians (e.g. Hernandez-Hons & Woolley, 2012). However, there is an absence of theory of sufferers' experiences and dated examination of processes involved in help-seeking behaviours that also considers the social, cultural and economic factors influencing the problems in the person's life (e.g. Anderson, 1999; Raisanen & Hunt, 2014). Eight self-selected individuals were interviewed and their narratives were analysed using Charmaz's (2006, 2011) social constructivist adaptation of Grounded Theory. Finding a 'fit' between narratives emerges as a core category, supported by taking the 'disorder' out of the 'eating' and the consideration of the social context in which problems occur. The Grounded Theory Model also identifies the role of the other in creating the context for having a 'therapeutic conversation'. Relationships between categories and subcategories are examined and quotations are presented across participants' narratives. Attention is paid to the researcher's and participants' reflexivity in this intersubjective process. The research findings are explored in relation to existing psychological theory and positioned as guidance for those working with people with disordered eating experiences that do not meet diagnostic criteria. The research implications are positioned within the current context of access to psychological therapy and suggest a framework for meeting client needs.

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Chapter 1 Introduction to doctoral research project

1.1 Overview of thesis

The thesis focuses on the phenomenon of disordered eating, a term used to refer to patterns of eating behaviours, but it can also be used to describe subjective experience associated with eating related concerns. The intention of this thesis is to develop an understanding of disordered eating through the voices and perspectives of the people struggling with eating disorders, rather than categorising experiences based on classifications developed and implemented by healthcare professionals. The phenomenon of disordered eating and relationship to help remains underexplored, and there is to date little research to inform practice. The aim of this thesis was to examine emotional processes and identify factors affecting decisions to seek help from a sufferer's perspective. In line O'Neill's (2005) suggestions, this research makes use of critical and constructivist methodologies and draws from a social justice perspective in order to move away from the more individualistic frameworks of distress. As such, this study aims to examine narratives using a constructivist grounded theory approach (Charmaz, 2006).

This thesis includes a critical literature review, examining the range and types of existing research on emotional processes and disordered eating. The focus of the review identified that sufferer's experiences of disordered eating are missing and that there is a gap in identifying social, cultural and economic factors involved in decisions to seek help among people who do not have a diagnosis of an eating disorder. Within the methodology section, the researcher details the use of constructivist grounded theory, its ontological and epistemological underpinnings and the analytical process used within the process of coding through to theoretical construction. The results section presents theoretical categories which were developed through the analytic processes detailed within the methodology section and includes researcher reflections to demonstrate the co-constructed meaning of this grounded theory investigation. Finally, discussion of results includes information about the usefulness of the model and its clinical implications and identifies scope for further research.

Personal Reflexivity

Qualitative researchers have a great influence in the research process. Therefore, it is important that I reflect on my relationship with this topic in my personal and professional capacity (Dwyer & Buckle, 2009). Engaging in reflexivity is important to try and understand how my own views, values and assumptions (conscious or not) may influence the questions I ask. It could also influence the direction that I take in engaging with research and interpreting the data. My hope is that by being more transparent about my relationship to the research, it will become clearer to the reader how I have influenced the process…

Personal reflexivity continued…

…I have always been slim. "I am thin, but I am not anorexic. And I do not have an eating disorder", was something that I often said to defend myself against comments about my eating patterns and weight. I refused to acknowledge that I had an unhealthy relationship with food and yet I was drawn to this topic, professionally and personally.

On reflection, I have engaged in disordered eating for a long time. The training course's emphasis on reflexivity has enabled me to think about my own assumptions, values and beliefs, and reflect on my own emotional processing. This continues to be a relentless, uncertain and somewhat new territory for me. In my work with clients who identify with "emotional eating", some described a real sense of "deprivation" if they were unable to eat. Others described food as an outlet for managing and escaping from difficult feelings. I noticed parallel processes with my own eating patterns. At times, I would restrict or deprive myself of food as a way of managing difficult emotional states; at other times, I would engage in overeating high-calorie, high-fat snacks to dampen difficult emotions, especially during stressful periods. Although I did not look anorexic, I realise that I also had a disordered relationship with food.

Upon embarking on this research project, I worked as a support worker in a mental health charity organisation, where I often come across clients who presented with eating-related concerns as well as low mood, problems with self-esteem and body image issues. I also volunteered at Beat, an eating disorders charity, where I was part of a pilot project facilitating an emotional overeating support group. Clinically, I was less engaged with psychodynamic principles, preferring to use a more CBT, solution-focused approach to understanding client distress. On reflection, this stance also influenced how I approached and presented the literature in the early stages of the research process. I am aware that this was partly related to own perceived competence as a first year trainee. I believed at the time, that by providing basic psycho-educational information, loosely guided by CBT principles, I could separate the client's experiences from my own emotional 'stuff'. However, my world-view and approach to client distress has since changed. In my current clinical work, I am informed by an integrative framework and draw from principles of Narrative Theory to make sense of clients' presenting problems.

My experience of working with self-identified emotional eaters pointed me in the direction of looking at disordered eating among a nonclinical sample - those who do not have a formal diagnosis of an eating disorder. Kiselica and Robison (2001) "urge counsellors to identify some human condition that moves them so deeply it inspires a personal moral imperative to make this world a better place by advocating for others" (p. 396). As a rather naïve student, eager to learn and develop my clinical skills, I found myself unable to respond to a client who shared "I was not good at being anorexic so now I emotionally eat". I discovered that other self-identified emotional eaters held similar experiences, and that those who sought help were often told to lose weight or eat more healthily by healthcare professionals. Counselling psychology values subjective experience over notions of diagnosis; however, we also work within mental health teams where notions of disorders continue to be applied to mental health problems (Bury & Strauss, 2006). I now realise my lack of response to client experiences reflected the dilemma that I currently face, where access to psychological interventions can depend on receiving a clinical diagnosis or presenting with specific symptoms.

Taking the issue of body weight: more or less everybody would agree that it is 'unhealthy' to be obese. Some people may develop disordered eating patterns, for example, starting 'clean eating diets', initially motivated by the desire to eat more healthily, but leading to be diagnosed with anorexia nervosa if behaviours become severe or extreme…

Personal reflexivity continued…

…It is possible that another person with a 'healthy' body weight also engages in disordered eating without necessarily looking anorexic. This person might potentially not receive appropriate support because they present with a healthy weight. I am interested in understanding people's decisions to seek help and explaining non help-seeking behaviours and why a person who engages in disordered eating may or may not receive a diagnosis. Is it the context in which a person finds themself, or is their experiences different from the more formal eating disorders? This research is fuelled by my on-going interest in meeting the needs of the clients I see, and also to gain insight into my own emotional processing and disordered eating patterns.

It is important to acknowledge that we live in a society where we are bombarded by messages about healthy eating and curbing obesity. We also live in a culture where it is socially acceptable to engage in weight control behaviours. Thus it was unsurprising to read that around two-thirds of the adult population of the UK appear to be concerned with weight control behaviours (Wardle et al., 2000). Yet only a small proportion of people are diagnosed with eating disorders.

My belief is that disordered eating acts as a temporary solution to its underlying cause. If a person's motivation is to overeat and/or restrict food, their eating patterns can become psychologically and sometimes physically unhealthy. There may be a hidden group of sufferers who may not seek help for an eating disorder but may nevertheless experience its impact upon their life (Beat, 2015). Formal eating disorder diagnoses may only capture a small proportion of disordered eating in the general population.

I am not neutral in relation to this topic. I acknowledge that I have my own assumptions about the reasons why people may use food as way of managing emotions, and my own ideas as to why people are not accessing services. I therefore intend to manage this by keeping a personal notebook to document my own ideas and thoughts during the research process. I will try and remain open to different possibilities. I will also try to be more transparent in discussing my thoughts about the research process and emerging data in supervision.

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Chapter 2 Critical literature review

2.1 Introduction

Eating disorders are debilitating syndromes characterised by disordered eating and pervasive problems with self-esteem and body image (Brown & Keel, 2012). These disorders represent a significant public health problem because they are associated with significant distress, disability and increased risk of death (Klump, Bulik, Kaye, Treasure & Tyson, 2009). A report from the UK charity Beat (2015) estimates that more than 725,000 people in the UK are affected by an eating disorder. Research from the National Health Service (NHS) information centre also found up to 6.4% of adults show signs of an eating disorder (McManus et al., 2009). A nationally representative sample study in the UK found two-thirds of the adult population appeared to be concerned about their weight (Wardle, Griffith, Johnson & Rapoport, 2000). People in this study report using weight control behaviours such as induced vomiting, using laxatives, diuretics and diet pills as well as fasting and skipping meals (Wardle et al., 2000; Jeffrey & French, 1996).

Disordered eating has been found among students (Hay & Mond, 2005; Eisenberg, Nicklett, Roeder & Kirz, 2011), as well as among specific groups of people including athletes (McLester, Hardin & Hoppe, 2014) and clients accessing psychological services (Campbell, 2012). In a study of a large sample of college students, Lipson and Sonnerville (2017) concluded smaller gender difference in the prevalence of disordered eating symptoms than previously suggested. Eisenberg et al. (2011) found 80% of students with clinically significant symptoms of disordered eating do not receive treatment. Yager et al. (2006) found students with subclinical symptoms are even less likely to seek treatment. Unfortunately, it is recognised that behaviours can develop into more serious and debilitating eating disorders, with poorer prognosis and increased likelihood of relapse (Klump et al, 2009). Early prevention strategies have focused on minimising stigma, increasing awareness and improving access to services (Biddle, Donovan, Sharp & Gunnell, 2007). However, Lipson and Sonneville (2017) identified reasons for not seeking treatment among students in their study, including the lack of time, inability to recognise symptoms and the desire to deal with the issues “on my own”.

Furthermore, in a society where health and thinness is promoted, people increasingly report engaging in a ‘clean eating’ diet (Bratman, 2015). This change to healthy eating is said to be motivated by health, and for some this involves entirely restricting particular food groups. A person may be said to have ‘orthorexia’ when this quest for health becomes an ‘unhealthy obsession’ (Bratman, 2015; Dunn & Bratman, 2016). A person, who develops orthorexia may initially be driven by health but have underlying motivations such as a need for control, a drive to be thin or the improvement of self-esteem. As Dunn and Bratman (2016) urge, if left untreated symptoms can become entrenched and can lead to the development of more formal eating disorders.

However, extrapolating statistics from prevalence studies to the general population becomes difficult because people may not seek treatment and not all sufferers are captured within the clinical setting (Beat, 2015). Sufferers who do seek treatment do not always meet diagnostic criteria (Beat, 2015). A recent study suggests that mental health disorders including disordered eating are more common than previously realised (Duke University, 2009). If we factor in the broad range of behaviours that could be construed as disordered, the prevalence of disordered eating may in fact be higher. Furthermore, the fact that eating disorders have high comorbidity with depression, anxiety and substance use disorders (Hudson, Hiripi, Pope & Kessler, 2007) means clinicians are likely to meet people suffering with disordered eating while treating them with other presenting problems (Brown & Keel, 2012).

2.1.1 Defining disordered eating

According to the National Eating Disorders Collaboration (2016): "Disordered eating is a disturbed and unhealthy eating pattern that can include restrictive dieting, compulsive eating or skipping meals". It can refer to a range of behaviours that reflect symptoms of eating disorders (APA, 2013), problematic eating attitudes and body image distortions that adversely affect physical and mental health. Unhealthy eating patterns could relate to the amount of calories consumed as recommended for an adult man or woman; however a body builder may consume considerably more calories yet be considered as a non-disordered. This would suggest that there are different constructions of "disordered eating".

Distinctions between diagnoses of anorexia and bulimia are often related to body weight and associated medical problems (Walsh & Garner, 1997; Russell-Mayhew, 2007). Implicit to these definitions is the presumption that people with anorexia are underweight and people with bulimia are not. However, people with medical conditions may experience disordered eating which is not necessary reflected in their weight. In cases of hyperthyroidism, having an overactive thyroid can result in increased appetite and food intake; people may also present with significant weight loss due to increased metabolism. Fonseca and colleagues (1990) present a case where the onset of hypothyroidism affected the patient's ability to control her weight through food restriction and dieting resulted in significant psychological distress. This would suggest that focusing on weight as an indicator to an eating disorder would automatically invalidate the diagnostic criteria because a person's weight may fall within 'normal' range, even as they struggle with their relationship to food.

Increasingly people are engaging in weight control behaviours, such as using laxatives and other behaviours. However, as Wardle et al. (2010) acknowledges, this is not always indicative of disordered eating. Framing subjective experiences and mental processes with diagnostic labels would therefore become limiting when experiences do not match these frameworks. However it is of relevance to both the epistemological stance of this thesis and its findings to consider when disordered eating becomes 'disordered'.

2.1.2 Recovery from eating disorders

According to Jacobson (2001), recovery from an eating disorder varies depending on the definition of recovery, its context, interpretations and meaning. Historically, recovery from mental illness was linked to the elimination of physical symptoms such as weight restoration in anorexia (Morgan & Hayward, 1988) and behavioural symptoms such as the absence of compensatory behaviours, dietary restriction and binge-eating (Bulik et al., 2000). Currently elimination or a reduction of psychological factors such as body image concerns is relevant to recovery (Couturier & Lock, 2006). Jarman and Walsh (1999) suggest that psychosocial functioning should also be incorporated in the definition of recovery.

Studies of subjective experiences of sufferers of eating disorders in recovery revealed diverse experiences, some were unique to individuals (e.g. unconsciously lying to themselves and others about being in recovery) and others supported existing findings (e.g. "the turning points" of recovery; Lamoureux & Bottorff, 2005). The study by Pattersen and Rosenvinge (2002) investigated the experiences of recovery from suffers perspectives' who previously accessed treatment for their eating disorder. Participants said that admitting and accepting that they suffer from an eating disorder as a first step towards recovery – related to a desire for a better life, intimate relationships with others and increased self-acceptance. Similarly, Lamourex and Bottorff (2005) found that participants' accepting the eating disorder represented a turning point, which was often incited by an event that made them acknowledge the severity of the problem.

This study is interested in the investigation of sufferers' experiences of disordered eating and decisions to seek help therefore, a definition of recovery based on the subjective is deemed most appropriate. Anthony defines recovery from eating disorders as "a deeply personal, unique process … [and] a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness" (Anthony, 1993, p.527). This pluralistic definition views recovery as a subjective and personally meaningful process and places emphasis on psychological aspects rather than symptoms, which is relevant to this study. A person struggling with disordered eating would need to accept or identify disordered eating; a person might experience symptom distress and impairment in psychosocial functioning.

2.1.3 What this literature review hopes to achieve

As Toporek, Kwan and Williams (2012) suggest, for research to be valid, culturally relevant and meaningful individual perspectives need to be examined and integrated through the research process. The researcher understood that the validity of her current study would rely on the validity of research questions, which would reflect her own understanding of the phenomenon of disordered eating as well as the reality of participating individuals.

The researcher cites theories, psychological models and perspectives of eating disorders and emotional processes. She predominantly includes research on eating disorders published in the UK and US but it is

not her intention to suggest that experiences of eating disorders are the same across different social and cultural contexts; her intention is rather to communicate the types of psychological research and knowledge that exist. The researcher includes relevant research on eating disorders irrespective of diagnosis because the researcher agrees with Neimeyer and Raskin (2002) that using one type of scientific enquiry to understand disordered eating would be limiting and only valid within certain contexts. In line with Bury and Strauss (2006), a counselling psychology perspective would "focus on the full extent of the experience of the client (rather than splitting the client into diagnostic categories)". The researcher will also discuss tendencies within psychological research on eating disorders and hopes that this review will stimulate conversations about meeting client needs.

2.2 Reviewing theories of eating disorders

2.2.1 Cognitive-behavioural theory

Cognitive-behavioural model (Fairburn et al., 1993) proposes that people with a rigid dietary regime binge eat because of dichotomous thinking toward dieting and food. For example, consumption of "forbidden" foodstuff triggers an all-or-nothing thinking style (such as, "I have completely blown my diet") and then a person temporarily breaks their diet, which leads to episodes of uncontrollable binge eating. According to this model, compensatory behaviours (such as self-induced vomiting) happen after these episodes of binge eating which act as an attempt to prevent weight gain. Concerns with body shape and weight are also exacerbated following these episodes of binge eating, which maintain the pattern of dietary restraint and becomes a self-perpetuating cycle (Fairburn et al., 1993). More recently, cognitive behavioural therapy (CBT) treatment for eating disorders has been modified to address additional factors (such as, interpersonal difficulties; perfectionism; mood intolerance and low self-esteem) which are believed to maintain and exacerbate eating disorders (Fairburn et al., 2003; Faiburn, 2008). There is now substantial evidence that CBT is applicable to, and effective in the treatment of eating disorders (Fairburn, 2008).

Cognitive behaviour therapy (CBT) treatment protocols for eating disorders have often been used alongside nutritional and medical support (Shapiro et al., 2007). CBT is a term used to describe a range of therapies; all based on the premise that by changing how we think, we can change how we feel and act, despite the situation (Wright, 2006). CBT provides cognitive techniques for individuals to assess and modify their thought process with the goal of change in the problematic behaviour. CBT models that address emotions refer to "dysregulation" (e.g. Corstorphine, 2006, reviewed within section 2.4) which under this framework, emotions can be understood as a type of excess - like unhelpful thinking styles resides in the person and needs to be changed. This research project challenges such cognitive models of eating disorders because it provides a medicalised perspective and a disorder-specific outlook on subjective experiences. As stated earlier in this chapter, disordered eating can be understood as a

subjective phenomenon rather than a set of behaviours and experiences might not always be motivated by cognitive processes.

2.2.2 Psychoanalytic perspectives

Early psychoanalytic theories considered disordered eating in relation to the child's ambivalence towards the mother (Caparrota & Ghaffari, 2006). The child's unmet needs during the early experience of feeding (Orback, 1993) and through the child living such a way to please their parents (Bruch, 1978), leads to ambivalence towards the mother. It is suggested that this ambivalence results in 'separation-individuation', where the child wants to separate their identity from that of their mother's (Mahler, Pine & Bergman, 1973). Winston (2009) writes that the relationship between mother and child is often described as both engulfing and distant, but never fulfilling. The mother is often experienced as preoccupied and not empathic towards the child's needs. Farrell (2000) explains that when the mother fails to receive projections from the child (for example, comforting a child who cries in order to get rid of painful and conflicted feelings) then the child is left to introject the anxiety. At the same time, the child also receives projections from its mother which are experienced as intrusive objects. Conflicted emotions towards the mother are transferred onto food and result in the development of disordered eating.

According to Farrell (2000), where the mother is recognised as separate and also thought to have nothing to offer, the anorexic becomes omnipotent in order to survive difficult feelings. By not eating they do not experience separation from the mother but unconsciously equate food with the mother. Food is restricted because it is perceived as dangerous (Farrell, 2000), resulting in psychic destruction (Pearlman, 2005). Conversely, bingeing is an attempt to reunite with the mother and food becomes the substitute for the absent or longed-for mother. While food provides comfort and satisfies the need to have it, bingeing has been associated with being overpowered by the mother and vomiting occurs as an attempt to destroy the internalised bad object (Farrell, 2000).

Earlier psychoanalytic theories of eating disorders have been criticised as 'mother-blaming' (Hepworth, 1999). Furthermore, the focus on relationships between female children and their mothers also fails to account for eating problems among males. However, more contemporary theories recognise the role of critical fathers, boyfriends and experiences of sexual abuse in the development of eating disorders (Bordo, 2003). Specifically, a self-psychological perspective sheds light into the internal dynamics of sufferers' experience.

2.2.3 Self-psychological perspectives

According to Kohut's (1971) Self psychology model, narcissistic psychopathology is a result of parental lack of empathy during development. A child needs to be cared for emotionally and physically, and initially the mother functions as a 'selfobject' (Kohut, 1971). The concept of 'selfobject' refers to the

subjective, intrapsychic experience of reinforcing and maintaining 'healthy narcissism' (Krueger, 1988). According to Kohut, a responsive selfobject would provide an experience that enables the child to build on self-esteem and develop emotional regulation strategies, leading to the development of a cohesive sense of self (Kohut & Wolf, 1978).

Eating disorder symptoms have been viewed as attempts to restore the sense of self in an effort to move away from painful early experiences. In line with Bruch's (1982) observations about the deprivation that her patients suffered as children, Farrell (2000) explains that when the mother-child relationship is not well established it results in several developmental arrests, including the inability to recognise the self and others and regulate emotions. Within the eating disorder literature, a person is said to be 'alexithymic' because they are unable to vocalise feelings and instead rely on other ways to regulate emotions (Nowakowski, McFarlane & Cassin, 2013).

It is suggested that the child attempts to self-regulate by attuning herself to the mother to create the experience of being together (Farrell, 2000) - in psychoanalytic terms, an act of defence against the "fear of breakdown" (Winnicott, 1965). Food which equates to the mother provides omnipotence and comfort (Farrell, 2000). The use of food to regulate painful emotions such as anger, anxiety, depression and shame is often cited as an explanation for the development of obesity and overeating.

2.2.4 Psychosomatic theories of obesity

Since the experience of hunger is learned and organised into patterns, Bruch (1973) suggests something has gone wrong within this system among people who are obese. According to Bruch (1973), overeating is the result of faulty hunger awareness and overeating is a response to "emotional tensions" and "uncomfortable sensations and feelings". It is suggested that due to early experiences, people are unable to differentiate hunger (and the urge to eat) from other signals unrelated to food deprivation. As such, people who are obese cannot recognise when they are hungry or satiated (Slochower, 1976; Ganley, 1989).

Herman & Polivy (1975, proposed restraint-hypothesis, which is presented later) suggest overeating is not specific to those who are obese. Other researchers suggest that emotions and environment are factors affecting overeating (e.g. Wardle, 1985). More recently, emotional eating or the tendency to eat in response to negative emotional states has been used to explain the rise in obesity. Buckroyd (2011) identifies predisposing factors to emotional eating including early attachment problems, childhood abuse, neglect, poor mental health and household violence. Researchers suggest a strong correlation between childhood trauma and eating disorders, and studies show that people who struggle with disordered eating have a higher incidence of physical, emotional and sexual abuse and neglect (Ward et al., 2001). Attachment theory offers another framework for understanding eating disorders.

2.2.5 Attachment theory

Bowlby (1969; 1980) postulates that all babies are predisposed to form attachment relationships based on the instinct to seek protection, safety and comfort. The nature of the attachment is determined by interactions between the infant and caregiver. Bowlby further suggests that early experiences lead to the development of 'internal working models' of relationships which influence and are influenced by later relationships (O'Shaughnessy & Dallos, 2009). Internal working models are predictions that a child develops about themselves and others, based on their early experiences with the primary caregiver.

Insecure attachment has been found to be common among eating disorders (Ward, Ramsey & Treasure, 2000). Felitti (2003) observed a 55% dropout rate on a weight loss programme among people who were losing weight. Following subsequent interviews Felitti (2003) interpreted overeating as unconscious "protective solutions to unrecognised problems dating back to childhood" (p. 2). O'Shaughnessy and Dallos (2009) discuss the significance of the 'unresolved' attachment style that is often reported in attachment and eating disorder research. Ward et al. (2001) found 50% of the patients and 67% of the mothers rated high for 'unresolved' status in terms of their experiences of 'loss' or 'trauma'. Researchers also found only half of the mothers agreed to participate in the subsequent part of the study. With reference to Bruch's ideas, Ward and colleagues (2000) suggest that the mother's avoidance attachment style would have limited her ability to be responsive and attentive to her daughter's needs growing up. As such, the child never learns to differentiate between her own needs and feelings. O'Shaughnessy and Dallos (2009) interpret the findings as an 'unconscious statement' resulting from the mothers' feeling fearful or unable to engage in discussions about their past, and their daughters' mental wellbeing.

2.2.6 Feminist perspectives

There is an expectation for women to achieve in all areas – to be feminine as well as ambitious and career driven (Griffin & Berry, 2003). This intense pressure among woman in relation to their role within a patriarchal culture creates anxiety and a fear of failing. MacSween (1993) considered the development of disordered eating as a way of managing this conflict. In line with Landwerlin's (2001, p.1) writings, the "intense pressure on women to conform to the ultra-thin beauty ideas of the media has led to dramatically low body image in women and an epidemic of eating disorders". The "thin ideal" is said to have the greatest impact during puberty when sexual attractiveness becomes important and changes in physical appearance increase the discrepancy between actual and ideal body image (Malson, 1992).

Orbach (1993) and Bordo (2003) question the relevance of pathology of eating disorders and suggest most women within a Westernised society measure self-worth based on their body weight. Bordo (2003) believes there is a "blurry" line between normality and pathology when looking at issues associated with disordered eating. Hepworth (1999) argues that the psychiatric definition of anorexia is socially constructed from a patriarchal Western perspective. Furthermore, psychiatric diagnosis is said to have

developed as a way of exerting power, control and "governmentality" (Hepworth, 2010; Foucault, 1978). A feminist perspective adopts a critical stance on diagnosis, and suggests notions of "disease" and "illness" are constructions developed by authoritative medical institutions. Kleinman (1988) would argue that disordered eating qua socially constructed reality needs to be understood in this context.

However, the argument that eating issues are used to keep women in their place does not account for the increasing number of males coming forward with eating disorders (Babusa et al., 2015; Beat, 2015). Malson (1992) argues against the commonly held identification of eating disorders as a consequence of cultural pressures to attain thinness. She writes, with reference to sufferers who are often labelled as "super-dieters" and who adhere to the pervasive cultural ideology of "feminine beauty equates thinness", that this undermines the functional role of the illness for those that are affected.

2.3 Examining literature on emotional processes of disordered eating

The relationship between emotions and disordered eating is well documented. Numerous studies have provided evidence that bingeing episodes in both bulimia and binge eating disorder are preceded by the experience of negative emotions (Agras & Telch, 1998; Hilbert & Tuschen-Caffoer. 2007).

2.3.1 Escape Theory

Escape theory (Heatherton & Baumeister, 1991) postulates that overeating is an attempt to distract or 'escape' from an ego-threatening stimulus that causes unwanted self-awareness. Emotional eating is suggested as a strategy used to manage difficult emotions. Bingeing may be considered an extreme form of emotional eating, where episodes are motivated by the desire to escape from aversive self-awareness (Heatherton & Baumeister, 1991; van Striern, Frijters, Bergers, & Defares, 1986).

Emotional eating has been defined as "… the tendency to overeat in response to negative emotions such as anxiety or irritability" (van Stiern et al., 2007; p. 106). This tendency is also represented in the media. For example, in television a woman may be shown to eat a whole tub of ice-cream after a relationship breakup or when she is experiencing painful emotions. Emotional eating is often associated with weight gain, and more recently, it has been used as an explanation for the rise in obesity (Buckroyd, 2011).

In an early review of studies, Ganley (1989) concluded that "emotional eating" patterns were very common in "massively obese persons". Ganley (1989) found emotional eating was consistently precipitated by negative emotions including anger, loneliness, depression, boredom and was related to stressful life events. Disordered eating was also found to be prevalent across various social classes and sexes. The validity of self-report measures have been criticised due to demand characteristics in studies among obese persons, where participants were exposed to treatment conditions. Allison and Heshska (1993) argue for the possibility that obese persons were complying with a social role in these studies.

However, when people were given the opportunity to talk about their subjective experience, participants talked about the stress, anxiety and loneliness associated with disordered eating in a study by Davis, Rovi and Johnson (2005).

Hernandez-Hons and Woolley (2012) adopted a method of inquiry to explore the experience of emotional eating in relation to attachment and cultural influence among obese women. Participants spoke about using food as a substitute and a distraction from difficult memories, and findings are interpreted as a defence against intolerable emotions. The researchers discuss findings in relation to the fear of relating to another which would involve emotionally allowing another person in. This can seem too painful to bear and so emotional eating becomes a comforting activity. Hernandez-Hons and Woolley (2012) suggest that food becomes something people could turn towards because it symbolises an object (or a person) that does not reject them.

The role of positive emotions in eating patterns is often neglected in research, yet we receive diverse messages around food growing up. Lupton (1994) suggests that food may also become the symbol for love or acceptance, internalised from early life. Hamilton-Wasson (2003) explored the experiences of binge-eating and purging processes among people with a diagnosis of bulimia. Participants described negative emotions of depression, anxiety, loneliness and a sense of powerlessness in relation to their eating patterns and its role in relapse prevention. Hamilton-Wasson (2003) found that positive emotional states also triggered relapse because they “enhance positive feelings such as excitement and enjoyment” (p.80); but the positive emotion was soon overridden by feelings of guilt and remorse about binge eating. Patel and Schlundt (2001) suggest that positive emotions increase food intake via an associative learning mechanism. As such, ‘happiness’ reported in the Hamilton-Wasson study may have been associated with eating more food.

Geliebter and Aversa (2003) looked at the experiences of positive and negative emotions among overweight, underweight and normal weight participants. Findings showed that underweight participants ate significantly less during negative states. However, they ate significantly more during positive states compared to overweight and normal-weight participants. Participants’ restrictive behaviours whilst experiencing negative emotions were significantly more than overeating during positive emotions which would explain their low weight. Contrary to popular belief, findings suggest emotional eating was not limited to negative emotions and that people may use various strategies at any one time. As Waller and Osman (1988) point out, emotional eating may not necessarily be disordered, that in fact it is “normal” for people to be concerned with their body shape and weight, and this has been termed “normative discontent” (Rodin, Silberstein & Striegel-Moore, 1985).

Researchers in the field of obesity have also observed that participants who habitually restrained their eating were more likely to overeat. However, unrestrained eaters were more likely to adapt their intake to refrain from overeating (Herman & Polivy, 1980).

2.3.2 Restraint Hypothesis

The restraint hypothesis was originally developed by Herman and Mack (1975) and further elaborated by Herman and Polivy (1980). Restrained eaters worry about what they eat and chronically restrict their food intake in order to avoid becoming fat, whereas unrestrained eaters eat without worrying about their food intake or related consequences. Herman and Polivy (1984) postulate that in restrained eaters, specific cognitions (the perception of having overeaten), using alcohol and experiencing strong emotional states leads to 'disinhibited eating'. This results in temporary decrease in motivation to diet leading to overeating.

Numerous correlational studies among clinical and non-clinical samples have found support for the restraint hypothesis (for a review see Davey, Buckland, Tantow & Dallos, 1998). However, other studies suggest that restrained eating is not due to disinhibited eating. Wallis and Hetherington (2004) found that emotional eating was linked to increased intake following an ego-threatening stressor only, whereas restrained eaters increased their intake regardless of the type of stressor. Sheppard-Sawyer, McNally & Fischer (2000) also found exposure to sad film segments increased food intake in restrained eaters compared to unrestrained eaters. The researchers therefore conclude that restrained eaters do not show a disinhibited eating pattern when exposed to stimuli that does not threaten their self-esteem.

Lindeman and Stark (2001) believe that emotional eating may be a characteristic of some dieter subtype. Classification was based on scores on the Dutch Eating Behaviour Questionnaire (van Striern et al., 1986), with two subscales measuring emotional and restrained eating. Findings showed that normal weight women who were classified as 'emotional dieters' showed no bulimic tendencies but displayed signs of an eating disorder compared to 'normal dieters'. They also found that emotional dieters reported more feelings of ineffectiveness, depression, and inadequacy compared to normal dieters. People who are at risk of developing eating disorders have been found to suffer from depression, low self-esteem and body-image issues (Luppino et al., 2010). Therefore, it is possible that 'emotional dieters' are more susceptible to various self-image threats which can lead to disordered eating. Lindeman and Stark (2001) conclude that their findings hold significant clinical implications, and suggest emotional eating as a psychological vulnerability related to eating disorder psychopathology rather than a "normal" tendency which is observed in the general population (as suggested by Waller & Osman, 1998).

2.4 Models of emotion regulation in disordered eating

The works of Cooper, Wells and Todd (2004) suggest that specific eating disorder symptoms are used to regulate and manage strong emotional states. Individuals with eating disorders are said to experience or perceive negative emotions as particularly difficult and unmanageable. Corstophine (2006) proposed an affect regulation model (based on Dialectic Behavioural Therapy; Linehan, 1993) which considers an individual's subjective understanding of their emotional states. According to the model, as a result of growing up in an invalidating environment, a person comes to believe that specific emotions are "bad" or "dangerous" and should not be expressed. The model identifies primary and secondary emotions. Anger and sadness are initially suppressed through disordered eating but then guilt and shame arise, exacerbating the distress, which interferes with the person's ability to cope. Bingeing or restricting then becomes a way of managing painful emotions.

Anestis, Selby, Fink and Joiner (2007) found that high scores on the distress tolerance scale predicted bulimic symptomatology among a non-clinical sample, after controlling for depression and anxiety. The distress tolerance scale (Simon & Gaher, 2005) assesses the degree to which the experience of negative affect is deemed unbearable. Findings revealed that distress intolerance mediated the relationship between anxiety sensitivity and bulimic symptoms. Anestis and colleagues (2007) conclude that it is not simply the presence of negative affect that predicts disordered eating but whether the negative affect is perceived as intolerable. This would suggest a more complex relationship between emotions and eating.

Earlier research on emotions and eating disorders has been criticised for being simplistic. Models have tended to consider the role of emotions in isolation, which may have prevented the development of theoretical understanding of emotional processing within eating disorders (Fox & Power, 2009). One model that has started to be applied to eating disorders is the schematic propositional analogical associative representation, a cognitive model of emotion (Power & Dagleish, 1997, 2008). According to the model, emotional disorders derive from the coupling of two or more basic emotions (e.g. sadness, happiness, anger, fear and disgust). This is where the experience of one emotion is used to inhibit or dissociate from the other, more "toxic" or intolerable emotion (Power & Dagleish, 2008).

Using a grounded theory approach, Fox and Power (2009) explored how people with anorexia understood and managed their emotions. Researchers' specifically asked participants about experiences of sadness, anger, fear and disgust and discovered that anger was experienced as most problematic for participants. Participants experienced anger as highly "toxic", where the higher the levels of anger experienced, the more likely they would be to engage in bingeing and vomiting behaviours. Fox and Power (2009) identified differences in the way participants understood their emotions and eating disorders. For example, anger was believed to be "dangerous" to both the participant and other people, whereas sadness meant "weakness". In line with other studies, participants also discussed a high level of disgust towards their bodies due to body dissatisfaction (e.g.Hayaki, Friedman & Brownell, 2002).

Ester and colleagues (2012) extended these findings to explore how anorexics related their emotional experience to their eating disorder behaviours. Findings showed that participants linked emotions in a specific way. There was a tendency to inhibit sadness and anger in interpersonal relationships, with high levels of disgust and anger towards themselves and their bodies. This was then expressed through restrictive, purging and body checking behaviours.

2.5 Reflection on the literature and rationale for the current study

There appears to a wealth of quantitative research on emotional eating, a term which has more recently been used to explain the rise in obesity (Buckroyd, 2011). Existing qualitative studies have identified more complex, specific relationships between disordered eating and emotions (e.g. Power & Dagleigh, 1997). Studies using a grounded theory methodology have enabled the development of specific models of emotions in relation to eating disorder symptomatology (Fox & Power, 2009). Methodological limitations within existing research (such as drawing conclusions from self-report measures, generalisability from analysis of case studies, and inconsistent use of measures in quantitative studies) cannot be overlooked. Furthermore, research investigating men's experiences needs to be addressed. Similarly, the balance of the research included within this review reflects the researcher's finding that the majority of the literature exploring experiences of disordered eating and emotions proposes developmental frameworks (predominately focusing on internal processes with little attention paid to the social context) and often select participants on the basis of weight and eating disorder symptomology.

Furthermore, existing research on disordered eating mostly reflects the medical model, which is the dominant framework and typically locates problems and distress within the individual (Williams, 2009 Russell-Mayhew, 2007). However, the use of diagnosis often carries assumptions about aetiology and treatment and informs service provisions which often hinge on accepting or receiving a diagnosis. The medical model has been criticised for locating mental illness in the individual and consequently ignoring the impact of larger sociocultural factors (Jacobs & Cohen, 2010. As Wilkinson (1997) contends, a model that finds 'causes' and 'cures' places responsibility on the individual for the problems that they are facing, and using diagnostic categories further stigmatises people who may already experience marginalisation from society. Bemak (1998) identifies a need for psychological models and contemporary paradigms to be deconstructed and integrated with new models in order to move away from frameworks that fail to acknowledge social, cultural, political and economic contexts and their implications.

2.5.1 Implication of using diagnostic categories

Eating disorders are often diagnosed when a sufferer or a carer seeks medical help, and healthcare professionals are said to play a central role in recognising symptoms and making referrals to specialist services (Currin et al., 2007). However, the reality is that clients that we meet may struggle with

disordered eating and counsellors would find themselves working within primary mental health services where notions of diagnosis and symptoms associated with psychological distress prevail (Bury & Strauss, 2006). Diagnostic labels can have profound implication for sufferers.

Firstly, diagnostic labels potentially confines the thoughts, feelings and behaviours of individuals as an expression of psychological distress (Williams, 2009). However, Russell (1995) argued the influence of social factors such as "today's cult of thinness' in the development of eating disorders; but given that everyone is exposed to these social factors this would suggest the problem resides in the person who then develops an eating disorder while others do not.

Secondly, the conceptualisation of eating disorders as a psychiatric condition instead of a representation of behaviours that most people are preoccupied with means there is a degree of expertise within the psychiatric community who are already invested in the development of treatment (Hays, Prosek & McLeod, 2010). Although it may be helpful to sufferers who would want their experiences to be formulated within a medical framework and to receive the recommended treatment, it may be unhelpful to sufferers who feel invalidated and marginalised because of the medicalisation of their personal suffering (Reed, 2010). As demonstrated earlier within the introduction section, people with medical conditions may experience disordered eating which might not necessary be reflected by their weight.

Thirdly, diagnostic labels have been criticised for being too specific. There is also no "global consensus" as to how recovery from eating disorders is defined (Williams, 2009). For example, outcome measures for the treatment of anorexia often focus on weight gain (APA, 2006) allowing quantifiable outcomes but fail to account for the subjective experience of an eating disorder (Russell-Mayhew, 2007). Fairburn, Cooper and Shafran, (2003) suggests that in practice there is an overlap in eating disorder symptomology, with some individuals moving between diagnoses over time. Rather than assume recovery from one types of eating disorder and development of another type of eating disorder, researchers describe eating disorders on a continuum (Fairburn, 2008). Although this transdiagnostic perspective is influential, there is still a tendency to cluster symptoms in relation to diagnostic classifications which might not be applicable to all cases of eating disorders (Schwitzer et al., 2008; Andersen, 1999). For example, Schwitzer and Choate (2014) found that students with eating-related concerns often showed symptoms of disordered eating indicative of "clinically significant distress or impairment" but would not meet the diagnostic criteria. As Rhodes (2003) writes: "It became clear to me that this disorder lacked a proper name … [I] might not fit all the criteria for [anorexia or bulimia], but have a unique and very real problem that needs to be addressed … referred to as an 'in-between' disorder'" and therefore a different approach would be needed to "[understand] the exact problem I was struggling with". .

2.5.2 Inclusion of men with disordered eating

Berry and Howe (2005) suggest that men are increasingly affected by eating disorders as cultural norms shift to include more lean and muscular male bodies in mass media. A commonly cited estimate is that 10% of clinical eating disorder cases occur in men (Beat, 2015). However, some data suggest that this prevalence could be as high as 25% (Hudson et al., 2007), which may also be an underestimate of the prevalence of eating disorders among men. Raisanen and Hunt (2014) urge that eating disorders are often considered as a "female problem" and are more commonly diagnosed in women. It is suggested that current diagnostic categories which are aimed at body shape, weight and weight control methods are more relevant to women (e.g. thinness and dieting) than men (e.g. masculinity/low body fat and exercise) (Jones & Morgan, 2010; Wade, Byrne & Bryant-Waugh, 2008). Phillips (2009) writes that the perception that their body is scrawny may underlie bodybuilders' quest for masculinity. This has been referred to as 'bigorexia' (e.g. Pope et al., 1997). Babusa et al. (2015) suggests that the disparity between ideal body image and the reality results in a preoccupation with using steroids, dieting and weight lifting among men which is linked to poor mental health (Mishkind, Rodin, Silberstein & Striegel-Moore, 1986).

2.5.3 What would support people to seek help?

Although processes involved in decisions to seek treatment was not the focus of this review, researchers in some of the studies reviewed identified a theme of ambivalence (e.g. Eisenberg, Golberstein & Gollust, 2007). Williams and Reid (2009) found both women and men reported a reluctance to seek treatment due to ambivalence towards recovery. Participants in a qualitative study by Raisanen and Hunt (2014) recounted an inability in themselves and others to recognise their behaviours as symptoms of eating disorders. Men in the study detailed stories of explicit dismissal of their symptoms which was linked to challenges in accessing relevant and gender-appropriate information about eating disorders (Robinson, Mountford & Sperlinger, 2013). Participants reported fears of dismissal by healthcare professionals and not wanting to be a "burden on services". Raisanen and Hunt (2014) discuss the implications of cultural constructions of eating disorders as a "female problem" leading to sufferers delaying seeking medical advice. Furthermore, the culturally prevalent views that eating disorders largely affect teenage girls mean that sufferers fail to recognise their behaviours as symptoms of eating disorders, which limits the opportunities for early intervention and improved prognosis of the problem.

2.5.4 Moving away from diagnostic categories and inclusion of disordered eating experiences among a non-clinical population

Existing qualitative research exploring the experience of people with disordered eating is often conducted in the context of weight, obesity and an eating disorder diagnosis. In line with Russell-Mayhew's (2007) writings research "rarely considers both (eating disorders and obesity) as part of the continuum". There is growing awareness of increasing prevalence of disordered eating (BEAT, 2015; Raisanen & Hunt, 2014; Latzer, Azaiza & Tzischinsky, 2014; Gibbons, 2001) and so exploring experiences of disordered eating

and helping relationships is essential. It is well documented that disordered eating can have a significant impact on mental and physical health, and in some cases patterns become life threatening (Klump et al., 2009). As Raisanen & Hunt (2014) suggest, more research on men and eating disorders is needed in addition to raising awareness more widely in order to enable people to recognise and seek help before patterns become entrenched and less tractable to intervention (Beat, 2015). It is therefore crucial that early identification and intervention is provided for people experiencing emotional distress in relation to disordered eating.

However, current approaches to treatment and prevention of disordered eating are said to reflect medical models of mental health. The increasingly individualistic view of disordered eating implicitly blames sufferers for failing to take responsibility for the problems in their life and for choosing instead to engage in problematic behaviours (Toporek et al., 2012; Jacobs & Cohen, 2010). As Young (2011) writes, clinical practice that focuses on internal processes and places responsibility for change on the person implies that change resides within the individual irrespective of environment. This is arguably incompatible with Government initiatives on health promotion and illness prevention models.

2.6 Relevance to Counselling Psychology

It is of great importance that counselling psychologists and mental health professionals look at issues of social justice, because our clients do not exist as individuals independent of their social, cultural and political context (Crethar & Ratts, 2008). The psychology of social justice research is relevant to counselling profession and places emphasis on "giving voice" to the people (Goodman et al., 2004; Morrow & Smith, 2000); this is particularly critical when working with a vulnerable group of people whose voices are often dismissed, ignored or supressed (Toporek et al., 2012). As Comstock et al. (2008) state, practitioners who are not guided by a sense of social justice potentially perpetuate the oppression and silencing that their clients experience. With our responsibility to be skilled and competent, counselling psychologists are at an advantage in identifying sources of problems including access to services, stigma and prejudices. Counselling psychologists are consequently equipped with the knowledge and understanding to help them respond to the needs of the people that we see (Fouad, Gerstein & Toporek, 2006).

2.7 The current research study aims

In line with Palmer and Parish's (2008) writings, the researcher aims to move away from the individualist models of disordered eating that dominate psychological research towards a more integrated framework that considers wider social, economic and political contexts within which disordered eating occurs (Russell-Mayhew, 2007; Prilleltensky & Nelson, 2002). The research study that follows aims to explore people's experiences of disordered eating and identify factors affecting decisions to seek help. To the best of the researcher's knowledge, the topic of experiences of disordered eating as well as helping

relationships is neglected within existing eating disorder literature, especially among a non-clinical population. Furthermore, favouring the person's subjective experience allowed the opportunity for a potentially hidden group of people suffering from eating disorders to be heard, who would otherwise be missed within the current eating disorder literature.

One of the strengths of this research project is the inclusion of men's experiences, which will contribute to the understanding of "a hard to reach group" (Raisanen & Hunt, 2014; Williams & Reid, 2009). Semi-structured interviews are used to explore narratives and the researcher aims to create a grounded theory which will contribute to counselling psychology knowledge and guide clinical practice. Other professionals (including mental health practitioners) can also use the model as a framework for understanding the needs of people struggling with disordered eating, and the barriers identified could inform helping relationships and service provisions in order to meet client needs.

Reflexivity: Introduction to research

It is suggested that researchers should avoid engaging in literature prior to conducting constructivist grounded theory inquiries. However, I engaged with the literature for the purposes of producing a critical literature review as per the university requirement and to support the early stages of the research processes (gaining ethical approval and developing initial interview questions). Throughout the grounded theory process, I strived to put existing knowledge of psychological theory to one side in the hope that a grounded theory would emerge entirely from the participant narratives and the way that I was making sense of them. However, I found that this was indeed a "constraining exercise" (Ramalho, Adams, Huggard & Hoare., 2015) as it was not always possible, which created a challenge when I moved towards data collection and began to write up the finalised grounded theory research.

I wanted to present enough background information on current perspectives of eating disorders and potentially relevant psychological models to facilitate the reader's understanding of the current disordered eating literature on emotional processes. I also believe that introducing the research in this way, providing my reflections and including implications of diagnostic categories would provide the reader with a clear understanding of how this research might fill the gaps within the current disordered literature and would also provide a good foundation for the discussion section.

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Chapter 3 Methodology

3.1 Introduction to Methodology

The researcher applies a social constructivist framework to qualitative research to gain an in-depth understanding of how people make sense of experiences of disordered eating and to ascertain factors affecting decisions to seek help. Cutcliffe (2000) suggests that qualitative research prioritises depth over breadth of inquiry and captures the complexities of individuals' lived experiences within their social context. The researcher explores participant narratives using semi-structured interviews and analyses them using Grounded Theory method, adapted by Charmaz (2006).

3.2 Research Question Development

Across disordered eating literature, little qualitative, experiential data exploring experiences among people not selectively sampled on the basis of diagnosis, weight or gender, was found. Given the increasing prevalence of disordered eating among the general population (Beat, 2015), exploring sufferers' experiences is essential. It is widely accepted that disordered eating patterns become entrenched and less tractable to intervention if unrecognised or left untreated, and can in some cases be life threatening (Klump et al., 2009; Beat, 2015).

Cutcliffe and McKenna (2004) acknowledge that research interest often develops from personal and professional experiences. The researcher identified the topic of disordered eating years ago through her observations across different settings. Whilst working with clients with experiences of disordered eating during her training to become a counselling psychologist, the researcher became interested in issues of social justice. The researcher began to question whether experiences of people who identify with disordered eating qualitatively differed from people with a diagnosis of an eating disorder; whether ambivalence about seeking treatment related to actual or perceived barriers; how wider social structures influence experiences; and what would need to be done to meet people's needs within a clinical setting when presenting issues are not disordered eating.

The researcher met with her research supervisor at London Metropolitan University to refine and focus the research question and to think about what methodology would best fit this research question. As Pandit (1996) advocates, the researcher wanted the research question to be general enough to promote flexibility, but specific enough to focus attention on the phenomenon under scrutiny. The researcher also wanted to produce work that would be relevant and applicable to readers in the years to come. As Glaser and Strauss (1967), and Corbin and Strauss (2008) both acknowledge, during the course of the research data collection, analysis and the researcher's own reflexive process, the research question became modified. The current research questions: "how do people make sense of their experience of disordered eating" and "what factors promote or hinder people to seek support" subsequently emerged.

Reflecting on the research question

In this research project I was aware that I made assumptions, and as such I proposed the concept of "disordered eating" within the research question as a concept understood by all. This is also linked to the second part of the question, where I assume that people who experience distress would seek treatment in the form of counselling. However, as I interacted with the participants, their narratives helped me realise that each person was making sense of the concept of disordered eating in a different way depending on their experiences: how they defined disordered eating; its impact on areas in their life; as well as the context that they were coming from and interacting with. As such, what was considered helpful support became apparent as the data collection progressed.

In terms of constructing experiences, almost all participants appeared to define disordered eating in relation to patterns and behaviours, with reference to the context of diagnoses of anorexia and/or bulimia. Making references to symptoms would suggest that participants define experiences in terms of a reality 'out there'. However, the subjectivity of experiences suggests that disordered eating was also being constructed as a relational phenomenon within a particular social context. I also observed changes in the way participants defined disordered eating at the start of the interview and how a recognition of 'eating distress' emerged through deep exploration of their experiences.

I speculated that, by nature, asking people to define disordered eating automatically positions them to talk about specific symptoms and behaviours which would mirror the social context and the way we use language. I realise that this automatically negates any experiences that do not match social constructions of disordered eating, the very things that I was trying to move away from by 'giving voice' to a group of people who are often missed within the eating disorder literature because researchers would typically assign specific inclusion and exclusion criteria on the basis of symptoms or behaviours. I realise that my initial research question, which was "how do people use food to manage emotions?" implies cause and effect and a directional relationship to food. As such, this generated more symptom-focused narratives of experiences in the early interviews, where the problem or disordered eating was being located within the person's control and potentially reinforcing the shame and sense of failure already experienced among this group of people. However, acknowledging my assumptions, biases and beliefs and constantly interrogating taken-for-granted meanings through the use of supervision, I could step back and join participants in the discovery of "fits" between the narratives.

The different ways in which each participant defined disordered eating demonstrated to me the importance of defining the research question ("the 'it' that we take apart is seldom something so concrete and tangible that everyone views it from the same starting point and standpoint" (Charmaz, 2009, p. 146)). This meant accepting the multiple realities of experiences, which would allow me to attend to the variation in how research participants and I construct meaning, and to adapt and amend the research question and focus accordingly.

3.3 Relevance to Counselling Psychology

According to Fassinger (2005), constructing a theory out of lived experiences integrates theory and practice and would reflect the science-practitioner model of counselling psychology practice. As Fassinger (2005) suggests, Grounded Theory methodology offers the discovery of experience-near theory, and its applicability to a variety of issues is relevant to counselling psychologists interested in diversity

and issues of social justice. Furthermore, giving voice and empowering a marginalised group of people would help others suffering with disordered eating.

3.4 Assumptions about the Nature of Knowledge

The researcher was aware of holding multiple assumptions about the nature of knowledge. As suggested by Ponterotto (2005), by making these assumptions explicit, the researcher hopes to: (i) show that the assumptions held fit with the epistemological stance taken, and (ii) acknowledge the potential impact of the following assumptions on the planning, conduction and analysis of this research project.

Within this research, the researcher assumed that:

- participants' definitions of disordered eating varied and were socially constructed due to interactions with others and the social context to which they belonged;
- people (the researcher included) hold their own subjective truths, meanings, and experiences of the processes involved;
- people were able and willing to explore and reflect on experiences verbally with the researcher;
- the researcher's identity in terms of her professional identity and the way she looked would impact how interviewees verbalised their experiences, and the theory that would emerge;
- the processes observed within the theory would be of interest and relevance to healthcare professionals in contact with people with disordered eating across multiple settings;
- the resultant theory would be consistent with the early prevention model of eating disorders with a focus on understanding the needs of people struggling with disordered eating and identifying gaps to accessing support.

Reflexivity: being an active researcher

I believe that I played an active role throughout the research process. I recognise that my assumptions about disordered eating had an impact on how participants' constructed their experiences, and as Charmaz (2009) notes, this also influenced the interpretative lenses that I used in generating the grounded theory model.

There were several times during research data collection and analysis where I was reminded about "being thin". This was either through explicit comparisons or in the context of examples where "losing weight" was celebrated and being thin was idealised. I was aware of the potential impact of holding this "thin ideal" and its perceived privilege and wondered how participants might be experiencing me. *I believe that I played an active role throughout the research process. I recognise that my assumptions about disordered eating had an impact on how participants' constructed their experiences, and as Charmaz (2009) notes, this also influenced the interpretative lenses that I used in generating the grounded theory model…*

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It was apparent that I was playing an active role in how participants' constructed knowledge and meaning, and that removing or "bracketing" myself from the data would be impossible and potentially limiting. In line with Pazella, Pettigrew and Miller-Day's (2012) writings, embracing researcher characteristics provided the opportunity to develop rapport and build trust by offering reassurances, validating experiences and highlighting strengths and resources. At times, I was aware of providing an interpretive summary intended to demonstrate active listening and facilitate further reflection.

I expected that the people participating whose lives I am interested in might experience distress while giving voice to their experiences and I struggled to negotiate what Fine (1994) refers as the "ethics of involvement and the ethics of detachment" (p75). It was tempting to offer therapeutic responses to participants' content. However, I struggled to reconcile my need to gather 'good enough' data unbiased by my assumptions about what was important and my beliefs about giving support, reassurance and validation. One of the ways I managed this conflict was by allocating enough time during debriefing and by explaining to the participant that even though I needed to continue questioning, I would return to the emotive issues at the end of the interview. I offered time to discuss painful issues after the tape recorder was turned off and ensured that participants had helpful resources.

3.5 The Researcher's Epistemological Stance

The researcher's assumptions were seen to run most in line with the social constructivist view of how knowledge is generated by research participants and researchers alike. As Willig (2012) and Maly and Cott (2009) concur, this position is based on the tenets of relativism. Rather than focusing on finding one absolute truth, the social constructivist researcher looks to understand how individuals continually construct meaning, and as a result, constantly adjust their behaviour within the social interactions and situations they encounter.

According to Charmaz (2006), rather than viewing one ultimate version of reality that can be directly observed and described by numerous social actors, the social constructivist researcher believes in multiple realities constructed moment-to-moment and dependent on where the individual comes from. Willig (2008) positions the social constructivist researcher as also being interested in how his or her own identity impacts on ways in which individuals narrate the meaning underlying the social processes of interest. Charmaz (2005) writes that what the researcher sees and hears depends on their interpretative frame, history and interests as well as the research context and their relationship to their research.

The social constructivist perspective also draws from the tenets of symbolic interactionism, viewed by Blumer (1969) as assuming that language and communication are the tools that people use to make sense of their social realities. Rather than simply responding to stimuli, individuals are viewed as active, reflective players within the realities they create (Charmaz, 2006, 2009). Charmaz (2005) writes that constructivist grounded theory offers a "systemic approach to social justice inquiry that fosters integrating subjective experiences with social condition", which the researcher believes is relevant to the research inquiry on disordered eating and help-seeking.

3.5.1 Reflexivity: epistemological stance

Choosing the "right" Grounded Theory methodology required me to think about my epistemological position which Crotty describes as "how we know what we know" (Crotty, 1998, p8). After reading a lot about the different philosophical underpinnings of different versions of Grounded Theory methodology, I came to realise that the Constructivist version was most compatible with my own philosophical beliefs about the nature of reality. As I reflect on my epistemological stance, I can appreciate the research design and identification of the research problem was based on my own experiences, prejudices, philosophical views and the theories that I was drawing from. I have also come to accept that my perspective of reality is not fixed and that my views of the nature of reality have changed from a critical realist to a constructivist perspective. Critical realism understands that there is an objective reality "out there" to be investigated and that adopting a relativist stance would place emphasis on the multiple interpretations of subjective experiences. However, I believe that we do not leave behind our socially based constructions and I would agree in "placing priority on the phenomenon of study and seeing both data and analysis as created from shared experiences and relationships with participants and other sources". Constructivism assumes that reality or an aspect of reality is constructed and that a different person would interpret the data differently and would develop a different set of codes and categories. As such, I also believe that the development of the theory is relative to the context within which the Grounded Theory inquiry is taking place.

3.6 Introduction to Grounded Theory

Grounded Theory methodology was first introduced by Glaser and Strauss (1967) in radical contrast to the hypothesis-led, positivist claims of research designed to capture an objective truth. Grounded Theory is viewed as inductive in nature with, as Wilson, Hutchinson and Holzemer (2002) states, theory emerging from data rather than data being tested against established, pre-existing theories. The approach was positioned as applicable to both qualitative and quantitative data, its aim, as Glaser (1999) writes, being the discovery of meaningful theory specific to the context in which data is collected. The term 'grounded' refers to the desire for theory to be steeped in the narratives of individuals with first-hand experiences of the phenomenon under investigation.

Glaser brought positivist ideas from his research background whereas Strauss took a pragmatist stance based on his interest in language, action and meaning. Differences in epistemological underpinnings led to the development of alternative versions of grounded theory from the more positivist (Glaser, 1992),

through to post-positivist (Strauss & Corbin, 1990) and constructivist versions (Charmaz, 2000). Charmaz (2006) states that positivist epistemology assumes that the truth of the phenomenon is there to be discovered by the researcher who adopts a neutral stance. As such, classic grounded theory has been criticised for failing to attend to social processes that influence the data and for ignoring the role of the researcher (Hall & Callery, 2001).

3.6.1 Rationale for Constructivist Grounded Theory Methodology

A review of the literature revealed a small selection of qualitative studies examining people's experiences of disordered eating and help seeking processes among a non-clinical population. There are studies examining experiences among people with defined eating patterns, specific groups of people, or which exclusively looked at men's experiences. To the researcher's knowledge, there is a lack of theory-driven research exploring emotional processes as well as help-seeking decision making among people struggling with non-clinical disordered eating. Therefore, as Glaser and Strauss (1967) state, developing a Grounded Theory attended to the absence of existing theory within the relevant literature.

Grounded theory provides flexible and systemic methods for collecting and analysing data in order to develop frameworks or theories grounded in the data. Constructivism begins with the phenomenological experience and examines how members construct the phenomenon under investigation. The approach assumes a relative ontological position, and suggests the world consists of multiple realities. As Charmaz (2006) states, the constructivist researcher gains multiple views of the phenomenon to the extent that she or he is able to, and discovers it in its complexities. This means that the interpretation in itself is considered a construction.

Constructivist grounded theory provides an opportunity to explain and situate social and organisational processes and as Charmaz (2006) writes, has the potential to transform practice. As such, the approach provides a suitable ontology for this research project, which seeks to understand people's experiences and places emphasis on subjectivity as experienced by the people participating. Charmaz (2011) writes that this approach is also useful in a social justice inquiry that "attends to inequalities and equality, barriers and access… [which has] implication for suffering." This is in line with the intention of the research to 'give voice' to a group of people that may otherwise be missed within the eating disorder literature. However, as Clarke (2005, p15) acknowledges, giving "unmediated 'voice' to the unheard – from 'their' own perspective(s)" also means the researcher considers the extent to which different perspectives were given a voice, and to who or what is omitted, intentionally or unintentionally, during the research process.

3.6.2 Rationale for choosing abbreviated version of Grounded Theory

The researcher was aware that finite resources, in terms of money and time, would limit her ability to utilise the full Grounded Theory methodology (Pidgeon & Henwood, 2004). This meant that the researcher employed what Willig (2008) defines as an 'abbreviated version' (pp. 38) of the Grounded Theory methodology, the end point of which was an imposed deadline, rather than true saturation as explored below (in the full version). As Willig (2008) further writes, the research was also abbreviated by the researcher's desire to concentrate data purely on a semi-structured interview strategy. Principles of grounded theory analysis were only applied to interview transcripts to identify meaningful categories and experiences (Willig, 2012).

3.6.3 Reflexivity: Grounded Theory

I tried to maintain an openness and flexibility in relation to the contents of participant narratives. A key part of my reflexive process was managing my own anxiety regarding whether I was doing Grounded Theory 'right'. The approach felt somewhat ambiguous to me compared to hypothesis-led, positivist research that I have completed in the past. Suddaby (2006) writes that it is important for those new to Grounded Theory research to be both patient and tolerant of uncertainty when conducting research. At times I was concerned that I wasn't generating theory, but I now realise that the moment I began to collecting data and immersing myself in the process, theory generation was also happening.

Throughout the research, I was aware of the limitations of using semi-structured interviews as the only source of data collection. As such, I missed the opportunity to gather information from four people who were unable to participate due to other commitments, time constraints, location and reluctance to have a face-to-face conversation. On reflection, collecting data by means of structured skype or telephone interviews would have still created relational contact and could have resulted in the discovery of additional information. Allocating more time to data collection and analysis would have afforded opportunities for theoretical sampling, constant comparisons and theoretical sensitivity. This would have resulted in the emergence of a more robust, comprehensive theory concluding at the point of saturation rather than at an imposed deadline using an abbreviated version of Grounded Theory.

3.7 Using semi-structured interviews

It is suggested that interviewing is most appropriate where the focus of research is gaining in-depth meaning and understanding (Newton, 2010). Gilham (2000) acknowledges face to face interviewing is most suitable where contextual and relational aspects are deemed significant to further understanding. As such, this research investigation used face-to-face semi-structured interviews. Use of open-ended questions aimed to cover a wide range of experience while being specific enough to generate data relevant to this research investigation (Charmaz, 2006). As suggested by Luker (pp. 168-171; 2008), the questions moved "from the more general to the more specific and from less emotionally threatening to the more emotionally threatening … [and at the end] the cool down" to "finish up and let go of the interview". During the course of data collection and analysis, the interview schedule questions and the overall

research question evolved in line with the discovery of new data and development of the emergent theory. In line with Strauss and Corbin's (1990) suggestions, the researcher's openness to changing the interview schedule questions demonstrated sensitivity to the emerging theory.

3.8 Grounded Theory Method: Principles of Analysis

This research followed Grounded Theory principles first explored by Glaser and Strauss (1967) and later adapted by Charmaz (2006) for data collection and analysis, outlined below. The linear presentation show not suggest that data collection and analysis was conducted in that fashion, but rather that the principles are explored in this way to provide clarity to the reader. In reality, analysis began as soon as possible and continued along with data collection to allow for theoretical sampling (Ward, Gott & Hoare, 2016). Glaser and Strauss (1967) propose that analysis begins after the first data is collected, with subsequent data collection and analysis intertwined and led by theoretical sampling, as outlined below.

3.8.1 Coding

Coding is the first step of analysis, involving taking the data apart. Coding is used to capture what is in the data, to learn how people make sense of their experiences and act on them. Charmaz (1996) writes, "Coding is a pivotal link between collecting data and developing an emergent theory to explain these data". The researcher sought to break the data into analysable fragments and name each fragment. Initial line by line coding involves short, analytic labels that the researcher defines. Charmaz (2006) suggests that codes are active, short, specific and spontaneous. An example of an open code was "food as a symptom to managing things".

Focused coding is the next stage where codes are more directed, selected and conceptual, and applied to several lines or paragraphs in the transcript (Charmaz, 2006). Here, the researcher selects significant initial codes that appear more frequently and which are pertinent to the research question to "sift, sort, synthesise and analyse large amounts of data" (Charmaz, 2006, p138). As such, the researcher can identify emerging categories and interpretative ideas without losing the detail captured during the initial coding phase (Charmaz, 2009). Focused coding led to the development of tentative, process-focused categories, viewed by Pandit (1996) as analytic connections between related initial codes. Taking the above example, the initial codes "identifying relational triggers" and "punishing self with use of food" were viewed as related to the initial code "food as a symptom to managing things" all of which, through focused coding, were seen as examples of the category "behaviour as a communication".

The final stage of coding looks to explore relationships between categories identified during focused coding. Relationships between and across categories are explored and hierarchical relationships developed, similar to Glaser's (1978) theoretical coding. Grounded theory uses constant comparison methods where the researcher moves back and forth and looks at similarities and differences between

emerging categories. The researcher compares codes with codes, recorded memos with memos in order to understand and explain variation in the data. Willig (2008) writes that the researcher would be able to link and integrate categories so that all instances of variation in the data are captured by the emerging theory. This would include identifying instances that do not fit in order to capture the full complexity of the data, adding detail and depth to the emerging theory (Willig, 2012).

As Corbin and Strauss (2008) states, as categories and subcategories began to emerge, the researcher moved towards creating an interrelated theory. For example, the category "contextualising one's disorder" was seen to be related to the category of "taking the disorder out of the eating" where "recognising eating distress" was seen as a subcategory. How participants were constructing their experiences of disordered eating was seen to be connected to the process of "contextualising one's disorder" which influenced decisions to seek treatment. At this stage the core category deemed central to the emergent theory was identified as "finding a fit between narratives". A table of codes and development of categories in an extract from an interview transcript can be found in appendix 11.

3.8.2 Memo writing

The researcher produced several memos throughout the data collection and analysis process as suggested by Charmaz (2006) and Grounded Theory researchers before her. These memos detailed her ideas about the data collected and the rationale for the next steps of data collection through theoretical sampling. Memo writing was done at the beginning of data collection and continued throughout the research process. Early memos were partial, exploratory and tentative, recorded with questions and hypotheses to pursue (Charmaz, 1995). Later memos become abstract, conceptually robust and sophisticated to show relationships between theoretical categories.

As Willig (2008) acknowledges, memos ranged in length, detail and depth and were used to record in-the-moment discoveries in words or diagram format. Memos also detailed the development of the research question, and also the content of newly emerging, as well as established categories. The researcher utilised suggested questions from Charmaz (2014) on memo writing to maintain the focus and direct the research process. As Willig (2008) writes, over time memos were returned to and built on to allow more elaborate exploration of categories. A selection of memos exploring the development of codes and categories can be found in Appendix 12. Reflexivity memos developed over time have also been included in the form of text boxes and included in the research write-up.

3.8.3 Theoretical Sampling

Theoretical sampling was used following the development of tentative, analytic categories. The researcher used constant comparison methods and negative case analysis to examine new data in order to elaborate, refine and develop the emerging grounded theory. Memos were also used to alert the researcher to gaps or hypothesis requiring elaboration or testing. The researcher asked herself questions relating to

the voices that are not represented in the development of the tentative categories and selected interviewees who possessed knowledge that would shed light on those categories (Charmaz, 2006). For example, the researcher interviewed and included the experiences of one participant (pseudonym, Samantha) who expressed a willingness to participate in research, but was not initially interviewed because of a ‘historic’ diagnosis of an eating disorder.

3.8.4 Theoretical Saturation

Saturation is upheld as the ideal of Grounded Theory. It is suggested that theoretical sampling of new material outlined above, continues until saturation is reached and there can be no further development of the theory through gathering additional data (Glaser & Strauss, 1967). However, in the context of this research, and with finite resources available, the researcher was aware that moving towards saturation was an ideal (Willig, 2012). Therefore, as suggested by Henwood and Pidgeon (2004), the resultant theory was a compromise between meeting the ideal of Grounded Theory method and availability of resources.

3.8.5 Data collection and Analytic Process

A total of nine interviews (with one participant agreeing to a second interview) were completed during this investigation. The full dataset was collected over the seven month period between November 2017 and July 2018. The first three interviews were conducted within the first month of data collection. The researcher, new to Grounded Theory research and methodology, wanted to immerse herself in the data to gain insight into diverse experiences with potential for theory development (Henwood & Pidgeon, 2004). The researcher paused after each interview to transcribe the audio recording, verbatim (with all identifiable information omitted) and code their content.

Transcribing straight away allowed the researcher to familiarise herself with the data and code for ‘nuances’, as suggested by Charmaz (2006). The researcher also recorded memos detailing initial reflections and themes emerging within each participant narrative as well as researcher reflections on the interview process. Rennie (1998) acknowledges that researchers hold knowledge and a sense of what is occurring within the data after each interview. Treating initial data in this way allowed the researcher to gain confidence with the data and developed her style for conducting subsequent interviews. It also led to a more robust and informed approach to subsequent theoretical sampling. Constant comparisons were performed, as suggested by Henwood and Pidgeon (1996), where newly emerging codes were compared to existing codes. As indicated by Willig (2012), theoretical sampling led to an ongoing development of the interview schedule reflecting required changes in the direction of data collection. The researcher contacted people expressing interest in participation for interviewing and collected data guided by a systematic, theoretical sampling approach using process-led questions suggested by Charmaz (2006).

Reflecting on the research process

This quote taken from Pandit (1994) bears relevance to my experiences: "thankfully there did come a time after much patience, persistence and perspiration when things became clearer" (p. 11). Despite the need to complete my thesis, there was almost a year-long delay in completion due to conflicting demands, procrastination and questioning of decisions taken in the process of analysis.

One of the challenges for me was to negotiate the endless options for coding and subsequent comparisons between codes and categories. I had to trust in the fact that my choices during the analysis process were led by the questions that arose directly from the data in the moment. As such each choice was an appropriate construction that would capture the richness of the data of that particular point in time. As I look back over the interviews, I see how each played a significant role in the theory that I am now able to present. At the time, I recall feeling anxious as I was unsure of how the final Grounded Theory would come together. I remember questioning the usefulness of the interview transcripts that did not "fit" the emerging theory. I also remember questioning whether I was gaining rich enough data. However, as the data collection and analysis continued and I reflected on the assumptions held, I realised that my assumptions about the nature of "relevant" or "correct" data were blocking my ability to remain open to the differences and diversity of the data gathered. Acknowledging these assumptions and beliefs and using questions suggested by Charmaz (2011) at different stages of analysis allowed me to move beyond them.

With time, theoretical sampling increased my openness and allowed me to interrogate the emergent theory more closely and confidently. For example, my decision to include the narrative of a person with a historical diagnosis of an eating disorder who expressed interest in participating in the research early in the recruitment phase and inviting some participants for a second interview allowed me to approach and fill the theoretical gaps with the new data. Although true saturation was not reached, data collection was concluded at a point when few new categories were emerging within the areas of exploration that I had followed to that point.

In line with Charmaz's (2006) view, I believe that reflexivity was the best way for me to think about the assumptions I have made in the course of the research. I also believe that the way in which I interacted with the data and conducted its analysis would always be a reflection of my own subjectivity and identity as a researcher-practitioner. Reflecting on ways in which my values and experiences have shaped the research and also how the research has affected and changed me as a person and a researcher supported the process of determining the outcome of the Grounded Theory (Willig, 2012). Thinking about the assumptions made in the course of the research, supervision and conversations with others allowed me to step back and consider what the constructed findings show and for whom the theoretical model is for. See appendix 13 for examples of earlier models and revisions.

Reflecting now on the data collection and analysis process, the openness and flexibility of Grounded Theory which had originally been perceived as daunting became an empowering, liberating shift beyond the positivist research paradigm. I allowed myself to become submerged in the creative, iterative process of data collection and analysis and am now able to reflect on this having been a challenging but enjoyable experience. I would have liked, time allowing, to the return to all participants for follow-up-interviews later into the research. This would have allowed me to gain additional data confirming or refuting the categories emerging within the Grounded Theory in its later stages, thus increasing theoretical sensitivity. I realise however, that this is a compromise of any abbreviated Grounded Theory.

3.9 Recruitment Strategy

A research poster was placed across counselling organisations, GP surgeries, universities and community locations and on Facebook. Initial contact to organisations was made via email (see appendix 2 for an example of an introductory email) asking permission to advertise the research poster (see appendix 3). At the initial stage of data collection, the researcher was interested in the subjective experiences of people who do not have a current diagnosis of an eating disorder; later, with purposive sampling the research included participants irrespective of diagnosis of an eating disorder.

To uphold the voluntary nature of the research and avoid coercion, potential participants opted into the research by contacting the researcher by telephone or email (BPS, 2010; 2008). Once contact was established, an information sheet (which detailed the informed consent, research purpose, study procedures, efforts to protect privacy and maintain confidentiality, benefits and potential risks and how these would be minimised, and complaint procedure as seen in appendix 4) and also a consent form (see appendix 5) were sent to the potential participant via email. Once agreement was established, the researcher confirmed with the participant details of the interview, including location, time, date and duration of the interview.

3.10 The Participants

In total eight individuals participated in this research; and the age range of participants was 29 to 47 years. Six participants were female and two were male. Of the eight who participated, two participants contacted the researcher after seeing the poster in the waiting room of a counselling organisation; three participants saw the poster on a notice board; one participant was recruited from social media; two participants following word of mouth; and one saw the poster from a shop window. Five participants expressed interest in participation and did not participate due to demands on time, or having withdrawn their consent or contacted the researcher following data collection. Table I below provides demographic details of the final sample, and include the age and relevant information to contextualise the findings.

As Raisenen and Hunt (2014) identify, there is a cultural construction of disordered eating as a “female problem” when in fact findings suggest increased prevalence of disordered eating among men. This research was interested in recruiting men and women. It was also hoped that this would maximise the recruitment potential. Inherent to the research questions were the researcher’s inclusion criteria that all participants should struggle with disordered eating and wish to talk about subjective experiences. All participants were fluent and fully conversant in English. Being over 18 years of age and able to read, speak and understand English were also inclusion criteria to ensure that all participants were able to give informed consent (BPS, 2010; 2008). Excluding people who were not fluent in English was based on the

assumption that exploration of the phenomenon under scrutiny would be limited by the potential language barrier.

Through theoretical sampling, an individual with a historical diagnosis of an eating disorder who struggled with her relationship to food was contacted following her expression of interest in participation in the early stage of data collection. Three participants who expressed openness to support and implied a desire seek support were invited (with consent to further contact obtained following the interview).

3.10.1 Table I: Participant information[1]

Participant number	Pseudonym	Gender	Age	Previous therapy	Relevant information
01	Adam	Male	42	No	Adam is a medical doctor working within cosmetic industry.
02	Jane	Female	22	Yes	Jane is a psychology graduate and currently works in an unrelated industry.
03	Cindy*	Female	42	Yes	Previously nicknamed as a "butterfly" in Greek because of her free-spirited nature before becoming a mother. Interview took place at her home, and the researcher witnessed interaction between Cindy and her mother, who also according to Cindy has a long-standing disordered relationship to food.
04, 07	Peter*	Male	47	Yes	Peter identifies as a carer for his elderly father. Peter adds that he particularly dislikes cooking for himself and eating when he is at his father's house.
05	Anna	Female	33		Anna is a mother of two young children. Anna does not meet criteria for bariatric surgery including counselling, However, she is currently on a programme for consideration of NHS-funded bariatric surgery because of unrelated long-term chronic condition and pain.

[1] Please note participant number reflects the order in which the interviews took place and asterisks against pseudonyms identified participants who were invited for a second interview, which was informed by theoretical sampling. In the interest of confidentiality, pseudonyms have been assigned. These pseudonyms are used throughout the methodology, results, discussion chapters and the appendices 9 and 12, where segments of participant narratives are included and references to participants are made.

06	Rose*	Female	36	Yes	Rose received psychiatric diagnosis following an inpatient admission. She reported to have been denied bariatric surgery from NHS due to psychiatric diagnosis and the rationale that disordered eating patterns were a healthier coping strategy. Instead, Rose accessed bariatric surgery privately with financial help from friends and family members.
08	Samantha	Female	51	Yes	Received a diagnosis of an eating disorder following repeated admission to inpatient and community services which were privately funded. However, past psychiatric interventions were not specific to eating disorders rather for addiction such as excessive use of weight loss tablets. Samantha was also a part of a "faith community" that was anti-psychiatry for a period of three years.
09	Mandy	Female	29	Yes	Mandy was working within primary care service at the time of the interview and was accepted onto a psychology doctoral programme.

3.11 Interview Structure

At the beginning of each interview the researcher thanked the participants for agreeing to participate and provided a copy of the information sheet to re-read. Once the researcher had invited and answered participant questions and participant had signed the consent form, the interview commenced. All interviews were conducted by the same researcher and took place at agreed location that was confidential. In depth one-to-one semi-structured interviews were conducted, each lasting between approximately one hour and one and half hours. Although an interview schedule with set questions (see appendix 6) was used to guide the flow of the interview, questions were incorporated gradually and the researcher responded to the interviewee's subjective narrative rather than disrupting the conversational flow by interrupting (Luker, 2008). Before the end of the interview, the researcher invited reflections and answered any questions posed by the interviewee. As suggested by Miller, (2006), attention was paid to debriefing interviewees using a standardised debrief sheet (see appendix 7) which was read out and given to each participant to keep. This debrief sheet explained the purpose of the interview in relation to theory generation aimed at exploring experiences of disordered eating and decisions to seek help. As suggested by Willig (2008), the researcher did not take notes within the interview which may have deterred her from active listening. All interviews were audio recorded. Written memos reflecting on the interview

experience and emerging themes started immediately after completion of each interview (see appendix 9 for a selection of post-interview memos).

3.11.1 The Interviews

The interview schedule was initially designed to be open and became focused, and in-line with theoretical sampling as the research process progressed (Charmaz, 2006). As Fylan (2005) acknowledges, interview questions were often answered during the participants' narrative. When this happened, the researcher reacted and reframed the questions to enable the flow of conversation; this also reflected the researcher's confidence in conducting interviews.

The researcher used counselling skills to create a safe space and to foster trust; she explained the purpose of the interview, reiterated to all participants that they did not have to answer any questions that would make them uncomfortable and reassured them of confidentiality which aided detailed exploration. Verbal and non-verbal prompts such as nodding were used to encourage further exploration and verbal prompts such as, "could you give me an example of when you would do that ?" were used to specify the more abstract concepts in the narratives communicated.

Interviews predominately took place in a private room at the university however, two interviews were conducted at the participants' respective homes. The researcher acknowledges that this would have had an effect on the data collected. For example, it was possible to gather additional data in the early stages of the research process following an interview with Cindy, which took place in her home. This allowed the researcher to hypothesise about the context participants were coming from, infer about relationships with others and bear witness to participants' experiences of disordered eating such as the empty, large Nutella jar consumed. As the data collection and analysis progressed, the interview schedule as well as the overall research question evolved to search for novel data and expand the emergent theory (Morrow, 2005).

After the third interview, questions were added to and removed from the interview schedule so that the data could further develop the emergent theory. This reflected the change in researchers' initial focus on broad data collection to gain insight into the diversity of experiences within the data before utilising more focused questions guided by theoretical sampling. On reflection, removing questions about specific eating patterns allowed for a more spontaneous narrative on disordered eating and relationship to help. On completion of this thesis, the researcher also wondered about the possible effect on recruitment, data collection and analysis had the interviews been conducted during the summer.

3.11.2 Invitation for a follow-up conversation

Purposive sampling was used to select three participants to invite for a follow-up conversation to reflect on the interview experience. One participant agreed to meet for a follow-up conversation.

Reflexivity: conducting interviews

I believe that the way in which the participants and I interacted impacted what, how and why I asked, or refrained from asking, the questions that I asked. Engaging in reflexivity throughout the research process allowed me to observe and refine my questioning style. I was aware that my interview style evolved and improved with practice. I noticed that taking the position of a "naive researcher" and allowing the interviewee to take the lead rather than being wedded to the interview schedule helped to establish rapport and build trust. It also created a relaxed space and facilitated a more conversational interview experience. I realise that this supported the interviewee's ability to narrate their experiences in their own way.

Six of the eight participants described the interview experience as 'therapeutic', likening the experience to a 'counselling session'. Peter indicated that the nature of the interview questions allowed him to share his narrative with ease. I wondered about the significance of the research context in relation to decisions-making processes and recognising the "eating distress", identified as a subcategory to taking the "disorder" out of the eating. Could counsellors be a catalyst to finding a fit between narratives? I was aware of the risk of becoming a 'therapeutic-researcher', which according to Haverkamp (2005) is where clinical researchers intervene from a therapeutic rather than from a researcher stance. I became aware that this was something that I was doing in earlier interviews. My summarising and empathic feedback demonstrated active listening and helped to regain the focus when the content was moving off topic. However, I also noticed that it generated a lot of material in earlier interviews that was not necessarily explaining the phenomenon under investigation. I was aware of needing to move away from a more therapeutic questioning model, linked to asking about participant feelings, to a more process-led questioning style, more conductive within Grounded Theory methodology.

3.12 Evaluating the Quality of the Study

According to Charmaz (2009), the social constructivist researcher aims to create a Grounded Theory that is both credible and relevant. The researcher acknowledges that this Grounded Theory could not capture all aspects of the phenomenon under investigation and can only hope to explain the processes experienced and narrated by those who have contributed to the Grounded Theory development.

When considering the quality of the research, Hammersley (1992) pointed out the importance of asking whether findings accurately capture features of the phenomenon that they are intended to explain and describe. Pandit (1996) suggests examining the internal validity of qualitative research; however, from a social constructivist perspective, the researcher was unsure how she would approach this. Having the analysis verified by a second researcher was dismissed because the second researcher would bring their own identity, meaning, and interpretation to all elements of the analysis (Madill, Jordan & Shirley, 2000). As such, it would be difficult to resolve differences in researchers' versions of the analysis.

Sbaraini et al., (2011) suggests asking participants to check their transcript or the findings to manage any misinterpretation. However, as communicated by Elliot and Lazenbatt (2005), the researcher believes that this would add another procedure needing additional analysis. Instead, the researcher utilised the opportunity presented by the follow-up interview (the only one agreed to by any of the participants) to

present the preliminary model and invite suggestions and amendments. In line with Charmaz's (2006) writings, the researcher would be prepared to amend findings as new information emerges.

As Wilson et al. (2002) suggest, an audit trail of procedures taken was maintained and observational memos were made directly after each interview to supplement the interview data in order to enhance the credibility and trustworthiness of the data. Ongoing memo-writing, the inclusion of researcher's reflexivity and consideration of how the researcher's assumptions shaped the data collection, decisions and analysis was incorporated to increase transparency and trustworthiness of research findings (Sikolia et al., 2013).

The analysis of interviews was supervised and emergent categories were explored in supervision to uphold the quality and validity of the data and its analysis (Elliot & Lazenbatt, 2005). The research supervisor also oversaw the emerging theory, commenting on categories and their relationships as they emerged, to ensure that the categories accurately reflected the data they proposed to represent.

3.13 Transferability of Results

As Drisko (1997) states, transferability of qualitative findings is an area requiring attention, especially in terms of explaining the limitations of generalisability of findings within qualitative research. As previously stated, the researcher acknowledges that from a social constructivist perspective, the Grounded Theory presented in this research was the result of mutual construction of the narratives of those who participated as well as the identity and beliefs of the researcher reporting it (Charmaz, 2006). As such, the subjectivity of knowledge and subsequent theory development would limit the transferability of a theory beyond the narratives of those who participated in grounded theory discovery (Mandill et al., 2000). However, this does not mean that the emergent theory would not be transferable to the experiences of other people experiencing disordered eating at this current time. As with any theory, there will be parts that will be more or less useful to some readers than others (Cutcliffe & McKenna, 1999). Nonetheless, the researcher hopes that this Grounded Theory will give a voice to a group of people struggling with disordered eating experience and stimulate conversations among clinicians within the mental health community who are in contact with people with disordered eating experiences.

3.14 Ethical Considerations

Before the research commenced, the research proposal was reviewed and approved by London Metropolitan University, Research Ethics Committee (see appendix 1). Subsequently, all aspects of the research were supervised by an experienced researcher-practitioner at London Metropolitan University.

In line with the British Psychological Society's (BPS) code of ethics (2010) and practice guidelines (BPS, 2008), the following ethical considerations were considered in planning, data collection, data analysis, and writing up of this research.

Informed consent and right to withdraw: An information sheet and consent form was designed to explain the content of the research without coercion to participate. Potential participants were advised to take time before making the decision to participate. The right to withdraw was also explored within the information sheet, consent form and again discussed prior to the interview to ensure participants had adequate understanding of what the research involved.

Anonymity and data protection: All participant data were kept secure, protected and accessible only to the researcher. All recordings were kept on an encrypted hard drive and interview transcripts anonymised after transcription, with identifiable information omitted to ensure confidentiality. Paper copies of consent forms were stored securely in a lockable cabinet. Participants were made aware of the fact that electronic files and hard would be maintained and then destroyed in line with London Metropolitan University archiving policies for doctoral research materials.

No deception: At no point during this research were participants deceived regarding the true nature of their participation. The researcher tried to be as transparent as possible in communicating the purpose of the research and research involvement.

Debriefing: After the interview, a standardised debrief information sheet was read out to the participating individuals and a written copy was given to them to take away, if they chose to. All participants were encouraged to ask questions and the researcher answered all questions with openness and transparency. This was not recorded. Participants were also asked if they would be happy to be contacted for a second interview or for further information.

Protection from possible psychological harm: The researcher tried to be as transparent as possible about the potential risks of participation including the potential distress from talking about experiences. The researcher followed the participant distress protocol (see appendix 8) adapted from Cocking (2008), identifying signs and actions to take in managing participant distress during research participation. No participants showed moderate or severe distress. Participants requesting advice for support were referred to signposting information and advised to speak to their GP, family and social network for support. During interviews the researcher also tried protect participants from exploration that might have left them emotionally affected. Participants were assured that they did not have to answer questions they felt uncomfortable about and were given time before moving onto subsequent questions.

Participant and researcher safety: To ensure safety of both participants and researcher, research predominantly took place at London Metropolitan University. Interviews were only scheduled during the hours of operation to ensure that in the event of an emergency, there were people in the building to intervene. The researcher also contacted a trusted person prior to arriving and directly after the interview

taking place. There were two participants who requested that the researcher interview them at their respective homes. Participant and researcher safety was deemed paramount and again a trusted person was provided with details of the location in a sealed envelope to be opened if they were not contacted by the researcher after an estimated time allocated to each interview. This safety measure was not required and the sealed envelope was destroyed after the researcher left the premises. In retrospect, an additional safety measure would have been to provide the research supervisor with a copy of the interview dates and location so that an intervention could be made in the event of an emergency.

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Chapter 4 Results

4.1 The Grounded Theory and Model

The Grounded Theory that follows explores a framework for healthcare professionals working with people who present with disordered eating and seeks to i) understand where this group of people are coming from; ii) identify opportunities for early prevention; iii) suggest ways to support people to manage problems in life. To enable comprehension, a table with categories and corresponding sub-categories is presented in Table II, and this is followed by a graphical representation of the Grounded Theory Model, presented in Figure I.

The central circles of the two flowers capture core psychological and social processes involved in the construction of disordered eating and helping relationships. Related categories are presented as separate flower petals and include feedback loops to represent maintenance cycles. The model includes the wider context influencing participant experience, which is depicted as a flower bed. The researcher suggests that trying to 'fit' experiences perpetuates the confusion and ambivalence and furthers the suffering and exclusion experienced among this group of people. Finding a 'fit' between the narratives is presented as the outcome of this research inquiry, and is depicted as a flower pot.

Looking at disordered eating as a subjective phenomenon permits the inclusion of contextual factors having an effect on experiences and identifies ways for promoting a positive relationship to help. The interrelation of categories means that taking the disorder out of the eating in order to include diverse stories allowed participants to readily recognise the eating distress. The application of the social constructivist perspective allowed the inclusion of the diagnostic context, and suggests that where the socially constructed notions of disordered eating do not reflect experiences, confusion and uncertainty result, which further the vulnerability and suffering experienced among this group of people.

Appendix 11 includes a synthesis of the full dataset and appendix 12 details memos from which this Grounded Theory has been constructed.

4.1.1 Table II: A table with categories and corresponding sub-categories

Core Category	Category	Subcategory
Experiencing emotional distress, shame, anxiety and depression	Situating experiences in relation to trauma	Disclosing early trauma, emotional neglect and bullying
		Beliefs about self
	Contextualising one's 'disorder'	"Then and now"
		Individual, family and social context
		"as a symptom" of life problems
	Managing problems in life	'Disorder' as a communication *"Increasing negative emotions"*
		Food as a comfortable buffer
Managing the uncertainty of services against the certainty of service provisions	Factors affecting decisions to seek help	Impact of early trauma
		Individual, external and contextual factors
		Fallacy of seeking treatment
	Meaning of help-seeking	"Managing overeating"
		Seeking counselling
		Contributing to research
	Processing attitudes towards helping relationships	Ambivalence towards support
		Negotiating costs of 'giving up' the 'disorder'
	Taking the 'disorder' out of the 'eating'	Recognising the eating distress
		Having a therapeutic conversation
	The role of the other	Creating context
		Assessing eating lifestyle

4.1.2 The Grounded Theory Model[2]: A Framework for making sense of experiences of disordered eating and understanding decisions to seek help

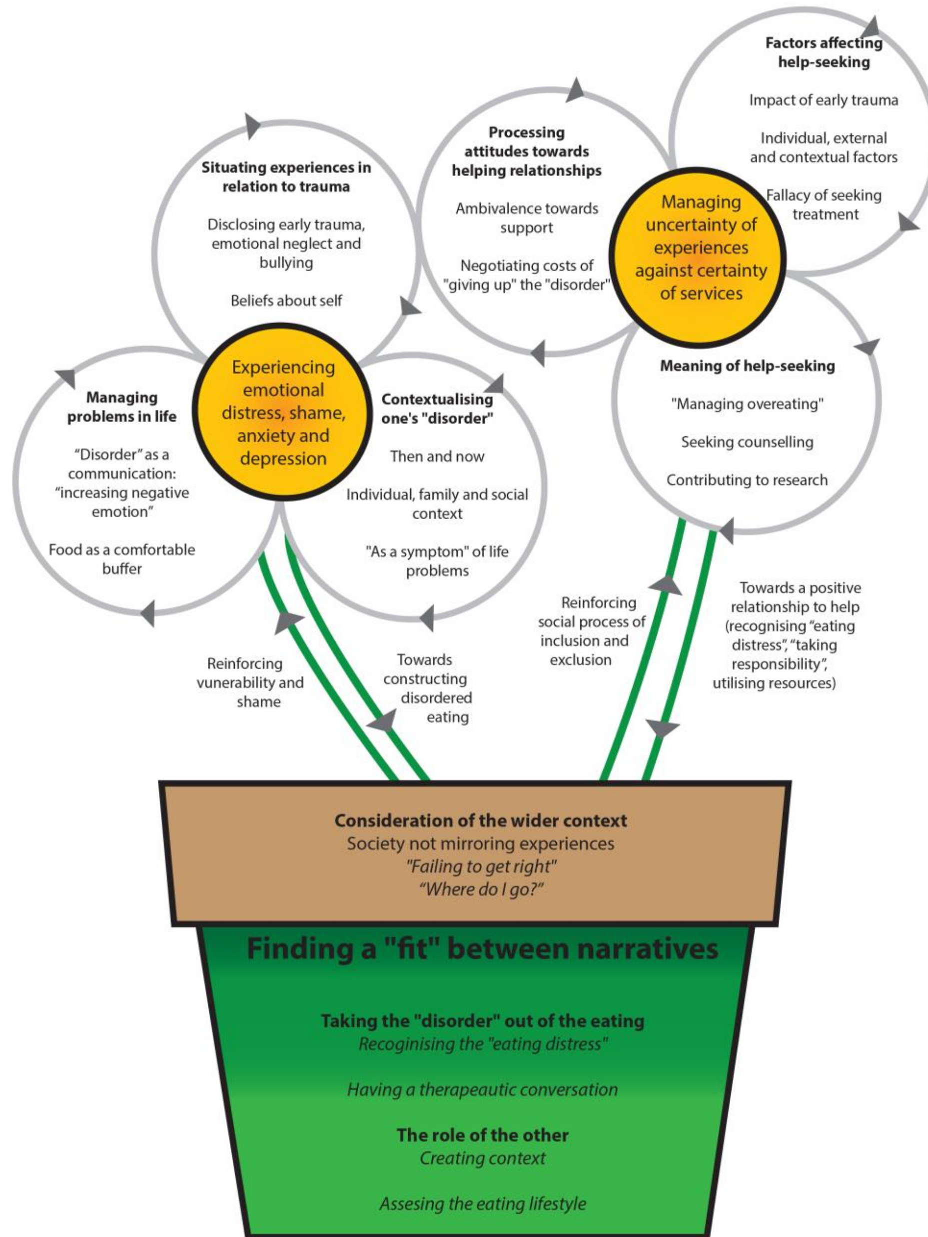


Figure I: Grounded Theory Model: Finding a "fit" between narratives: A framework for making sense of experiences of disordered eating and understanding decisions to seek help

[2] Each flower captures processes involved towards constructing experiences of disordered eating and decisions to seek help. Flower petals include feedback loops to represent maintenance cycles. Petals can be used to provide a framework for understanding the needs of sufferers. The plant pot represents the resultant theory which looks at disordered eating as an experiential phenomenon and suggests opportunities for a positive relationship to help.

4.2 Presenting the Results

4.2.1 Using Quotations

Quotations are shown in *italics.* To facilitate the flow, utterances such as "err" and "umm", and repetitions have been removed. Within the quotations parentheses, "*[…]" or "[//]*, are used where the researcher omits a portion of the participant's narratives which do not add further information or which combine different parts of the participant's transcript, respectively. The researcher underlines parts of the quotations that best capture the intersubjective process of finding a "fit" between the narratives, presented as the outcome of this research inquiry.

The researcher acknowledges that some categories have more quotations than others. For example, the category "disclosing early trauma, emotional neglect and bullying" and "beliefs about self" does not offer original new knowledge and so it was given less space within the results section.

4.2.2 Including Researcher Reflections

The researcher has included reflections which are italicised and in colour, intended to provide the reader with insight into the research process and understanding of the data.

4.3 Core category: Experiencing emotional distress, shame, anxiety and depression

4.3.1 Situating experiences in relation to trauma

Situating experiences in relation to significant early experiences provided i) a context for understanding where this group of people are coming from; ii) a lens for hypothesising about the impact of trauma on the development of the self and for interpreting beliefs about the self; iii) a framework for making sense of participants' relationship to the problem.

Disclosing early trauma, emotional neglect and bullying: It was common for narratives about problematic eating patterns to be located within the person and any resolution was assumed to reside within the person's control. Separating from these symptom-focused descriptions allowed Rose to identify and relate to painful early experiences:

> *"After I got out of the relationship, there was a period of two years where the therapist said that I was making a concerted effort to make [myself] ugly. That I was- [becoming tearful] that it's apparently common in rape survivors to make yourself unattractive to men to make yourself feel safer."*

Beliefs about self: Examples entering participant narratives relating to upbringing included parental disordered eating, poor eating patterns in the home, and growing up in an invalidating environment. Jane describes low self-esteem and body-image issues at the "root" of her experiences of emotional distress:

"I have low self-esteem and that causes me to worry all the time, which gives me anxiety. It causes me to feel horrible about myself and I eat more which makes me get fatter which makes me feel worse about myself"

Reflective comment: It was not uncommon for participants to describe a vicious cycle between behaviours, emotional response, physiological sensations and thoughts. Participants' refer to vicious cycle of their relationship to food. I wondered about the relevance of psychologically informed formulation models and maintenance cycles in this Grounded Theory.

4.3.2 Contextualising one's 'disorder'

Experiences of disordered eating had more or less of an influence depending on the context that the person was coming from. How problematic disordered eating was deemed to be was related to contextual factors; who responded to the 'problem' was also significant.

"Then and Now": The context of time was discovered across all participant narratives. Participants refer to the impact, frequency and intensity of behaviours over time. Samantha identifies a long-standing disordered relationship to food:

"I've never made myself sick or used laxatives, but in every other way, I think <u>I've experienced all forms of eating distress</u>."

For Jane, eating patterns have become "*worse over time"*. Most participants identify times when disordered eating was at its worst. In the context of becoming a single parent, Cindy refers to the loss of freedom contributing to her eating distress:

"I was very free [but now] it's really difficult because at night I may want to go and see a friend.... And you can't do it when you've got kids. And I resent it. And I suppose it's resentfulness that makes me... internalise and implode and that's when I eat"

Reflective comment: I wondered about the significance of participants' context in relation to disordered eating becoming recognised as problematic. Cindy identifies disordered eating over time but it seems that experiences have become intensified now. This may be due to a range of factors including transitions and becoming a single mother, reacting to weight gain, boredom and inactivity, and having little freedom. Cindy commented, like the researcher she "used to be thin" and "it [disordered eating] wasn't obvious" to others. Across participant's narratives, "putting on weight" was an indicator of a problem and others reacting to the weight is outlined below.

Adding context enabled people to identify exceptions to disordered eating which included fewer work stressors, having "healthy" interpersonal relationships and maintaining good mental health. As Mandy explains, being offered a training contract alleviated worries about the future:

"I was thinking well I don't need to comfort eat anymore, there nothing really to stress about [...] and I felt I could do other things in my life [... because for me] it was this constant worry about where I'm going in life, what I'm doing"

Individual, family and social context: There were similarities in participants' examples about triggers for disordered eating. It was also common for participants to identify an awareness of disordered eating patterns in relation to their weight and body-image issues from a young age. Cindy links current distress to feelings of "oppression" in childhood:

> *"Emotions were absolutely were not allowed to be expressed as a child. I was abused quite badly, physically and the emotions were not allowed to be expressed [and] it's the same really. For me it's a form of abuse living in a place that I'm completely tied down to having no freedom […] the common link is the feeling of oppression maybe propels me to want to self-harm… really this is the first time I'm talking about it. So it's more like a counselling session for me"*

Reflective comment: I wondered whether the context of research created a space for "having a therapeutic conversation". Attending to participant's relational style in conversation, I noted with interest participant's shift in their position in relation to the way they were constructing their relationship to food. This led me to further wonder about the 'role of other' and the clinical implication of this. I noted that Peter, Cindy and Rose explicitly make references to seeking treatment in the form of talking to a counsellor, speaking to a GP and requesting signposting information from the researcher.

Peter and Adam discuss cultural traditions that have an influence on their relationship to food. Peter recounts a situation of *"eating four burgers"* provided by his mother as an expression of love, common within his Italian background. Peter recalls *"feeling disgusted with myself"* for feeling hungry and reports similar feelings of disgust when he is presented with *"huge"* portion sizes which become intensified in social situations and where others prepare his food:

> *"I remember looking back at it, just horrified and feeling very hungry after and I just felt quite disgusted with myself [and now] when I'm with people, I suddenly think, I don't want all of that in my stomach – I just don't want that inside me. I'm just really careful not to overeat. If I see a huge quantity of food on the plate, it feels quite disgusting"*

Reflective comment: Participant narratives about trauma and upbringing made me wonder about the relevance of Attachment Theory and psychological models of trauma in this Grounded Theory Model. I wondered about how emotions were expressed growing up, and the influence of culture and parental mental health influencing experiences of disordered eating. I was aware of my curiosity to understand by asking for specific experiences but was also mindful about the potential impact to participants in terms of (re)traumatising and triggering. I noted with interest the level of disclosure. As a result, I became more aware of differences in participants' relational styles and noted instances when participants were sharing too much or too little, halting or changing the subject during emotive parts of the conversation.

Other examples entering participant narratives included the social context and diagnosis that influence experiences. Jane discusses the impact of social pressures and unrelenting standards:

> *"Reading magazines and seeing pictures of people that are smaller than me […] throughout my life it's always made me feel bad because I think I don't look like that and then I don't look the way a woman is supposed to look […] I think that we are all affected by what we see in society and what we are told we have to be"*

Notions of *"being thin*" and *"managing overeating"* which entered participants' narratives then became one way of building up self-esteem and measuring their sense of worthiness. Continuing with Jane's narrative, despite *"having a boyfriend"* and successfully transitioning into adulthood (by moving out and going to university), she continues to place an emphasis on her weight and body-image. Denying hunger through the means of restriction and controlling food intake becomes an attempt to overcompensate for underlying problems of low-self-esteem.

Rose refers to changes in definitions of disordered eating over time and discusses the impact of socially constructed disordered eating:

> *"There are turns of phrases that are now so commonly used that they've lost the essence and power of their original meaning. [//] It's been a very recent discussion to talk about compulsive eating – if that's even what I have – overeating. Yet anorexia and bulimia and other controlled eating have always felt that they were taken very seriously [//] I don't feel like I'm allowed to talk about my disordered eating because it doesn't sit well with people who have suffered or do suffer from managing controlled eating, in terms of very strict controlled eating and I don't think eating in such an uncontrolled way as I do is taken very seriously"*

Changes in the way society constructs what is problematic highlights the influence of wider systems imposing one way of thinking about problems. Cindy frequently refers to the context of diagnosis and later alludes to barriers to getting help because her experiences would not meet diagnostic criteria:

> *"Growing up [my mum] would take laxatives and – for me that it's a form of bulimia or whatever you want to call it. She used to live off laxatives because she wanted to lose weight for wearing an outfit for the night so for the whole week she wouldn't eat and just take these laxatives […] in the 70s-80s […] So I disagree with what she just said [when her mother walked into the room] I think her relationship to food is not good"*

"As a symptom" of life problems: The dominant story entering participant examples emphasised a sense of failure and lack of willpower in relation to disordered eating. Despite insight and awareness of relationship triggers, Rose describes the circularity of her relationship to food which keeps her isolated and furthers emotional suffering:

> *"…it probably isolates me a lot from other people because as I said I eat in secret a lot… it's such a circular problem as all self-abuses in terms of mental health because the shame and frustration, I feel at the fact that I am in my mid-thirties and this is something I still haven't got a handle on [//] I know exactly what it is, I see exactly why I do it and to not be able to stop doing it – there's something so much more shameful in that than just the behaviour – like the shame in knowing and that I am not stopping"*

Participant descriptions of problems seemed to place them within the person's control. There was a theme of "feeling rootless" and lacking in interpersonal connectedness in the narratives communicated. Furthermore, experiences were not independent from the contextual factors presented above. Peter expresses a sense of hopelessness:

"… home is like a place to sleep, a place to get up and wash in the morning […] It feels like a place I do stuff and not a place that I live in [//] I'd rather not be here sometimes [four second pause] because life can feel actually overwhelming at times [//] [becoming tearful] I haven't had the courage to say that to the people in the counselling thing but maybe I'll start doing that"

Reflective comment: Peter identifies his father as a protective factor; "needing to be there for him". Being in clinical practice and conducting research meant that I was able to recognise psychological distress, assess any risks and signpost appropriately. I wondered whether Peter's internal world mirrored his current eating lifestyle. This led me to wonder about the circularity of problems within Systemic Thinking where problems are communication to others with feedback loops and processes. From this perspective, problems are maintained and move him further away from the connection he needs. This is explored within Discussion section.

The researcher appreciates that showing vulnerability within the context of research may be difficult. While Cindy readily expresses feelings of "*resentment*" and "*rage*" towards her situation, it may be easier to minimise experiences instead of relating to painful, unexpressed emotions. Controlling intake, neglecting needs and avoiding cooking become easier disclosing failing relationships, eating distress, dissatisfaction with life and aggression. Peter offers additional context in a follow up interview:

"My life and my work and my girlfriend and you know a lot of things … work isn't really what I want to do to be honest with you […] and then I got my own stuff going on with my dad … my girlfriend is okay but I don't feel that close to her … when we meet up it feels more about friendship … not a very close and bonded relationship with somebody"

Reflective comment: While unpacking the different ways that participants were making sense of their relationship to food, I noted the different ways behaviours and patterns have changed or remained the same as well as points of "feeling stuck". I also noted the influence of transitions such as moving out, getting married, and change in roles on participant's relationship to food. This observation led me to further wonder about experiences that might be shared and experiences that are context specific. I began to think about the influence of other contexts that participants may find themselves in, having effect on their experiences.

The researcher listened to exceptions and invited discussion about the different contexts in order to generate alternative stories that influence the problems in the person's life. The researcher noted differences in how participants were relating to the problem which were in line with the dominant stories that participants were bringing into the research context. Some participants were adopting a disconnected stance towards recognition of the "eating distress", from denying problematic relationships to food and holding onto the "disorder", through to glamorising and defending eating patterns. Some participants also moved between these positions.

4.3.3 Managing problems in life

The researcher wondered about the communicative function of behaviours and eating patterns, especially in the context of early trauma and where there were no opportunities to be listened to. Identifying the function of disordered eating would acknowledge the contexts that people were coming from and allow participants to relate to painful experiences. As such, the researcher deemed it relevant to hypothesise about gains of the disorder to further understand where this this group of people are coming from. The researcher later infers about potential losses to 'giving up' the 'disorder' in decisions to seek help.

'**Disorder' as a communication:** Rose describes using food as a way of communicating distress and ***"increasing negative emotions".*** It was a way of asserting control and escalating behaviours when Rose experienced loss of control which resulted in being sectioned under the mental health act:

> *"Because you have an overreaction and you don't have a better way of saying I'm lonely, I'm sad, I'm scared ...I was trying to get them to notice that I wasn't okay and I was so worried about getting into trouble... That I didn't tell them what was happening [//] I don't want to use the words that are always used with disordered eating but I think probably the sense of control – this is the thing that's mine, nobody knows but me and I was secretly getting away with it [...] and then the control was further taken away from me by you know these kids... [Becoming tearful and sniffing] making me miserable all day and every day and my parents and teacher being unable to stop it [...] So I just disappeared into this world in my head and then because people don't notice you, it's very common I think to escalate your - until they can't ignore it anymore"*

There is something powerful about eating in secret, overeating or refusing to eat in what it communicates to others and the responses that it elicits. Continuing with Rose's narrative, escalating behaviours would remind others to remain vigilant:

> *"Getting a wakeup call [from my GP] [//] [saying] you did that, that's all on you. That is because you ate too much [and with all conditions] you might die in your sleep for eating too much [//] So it's not like I refused to talk about it but my response [to others] was so violent that it was indicative of that in itself that it was a massive problem"*

Food as a comfortable buffer: Taking into account disclosures of early trauma, it is possible that when participants experience similar problems in life disordered eating becomes a comfortable buffer to manage painful experiences. This was discovered in participant narratives about functions of disordered eating. Rose ascribes relational triggers to disordered eating: *"All my destructive behaviours are related to interpersonal issues".*

Samantha also describes using food as a way of managing problems in interpersonal relationships:

> *"If I'm in a stressful situation, particularly socially, like work, I find it easier to manage but interpersonally, where I may be feeling overwhelmed by the number of people there or there is somebody there that I don't get along with too well then that's a classic example of when I might feel my mood really sink and then my first instinct is always to medicate it. In the past, it's often been with undereating but at the moment, it's with overeating."*

Reflective comment: I noted similarities and differences in participants' constructions of disordered eating. Functions of disordered eating such as "filling a void" and disordered eating as a form of "self-harming" were unique but also mirrored existing studies.

Examples of having too much or too little control in areas of life would also explain the development and maintenance of disordered eating. In defining disordered, Mandy suggests:

> *"[Using] food to try and cope with whatever they are going through and it's a way of maybe controlling life that can feel quite chaotic or maybe control an aspect of life when everything else feels like it's crumbling"*

Food then comes to represent an *"emotional crutch"*. Rose describes experiencing anxiety at the thought of having "too little" food:

> *"I feel actually anxious when there's not a snack next to me [...]I would walk half a mile in that snow to make sure that I had sugar specific but like sugary carb, disgusting food to hide in my room. [With reference to groceries bought before the interview] I don't even typically hide them in the cupboard but because you were here when I arrived with my groceries I was really self-conscious about getting them out of the cupboard – because I bought like five donuts which I know that I'm going to eat, by myself tonight, in hiding and I still do that despite the medical intervention to control my eating"*

Reflective comment: In listening to participants' journey of disordered eating, I was struck by the level of strength that this group of people possessed. I noted stories of survival, resilience and efforts to seek help. It can be said that participants have come to reach a bad resolution, in terms of their eating patterns, to managing problems in life. Disordered eating can be understood as a strategy that has stopped being helpful and some participants may be finding themselves in situations where they are negotiating the costs of giving up the disorder and finding a "fit" between normal and dysfunctional eating patterns because the strategy is no longer working. I was also aware that this was a group of people who are already marginalised and excluded because of the social context that we are a part of. This would suggest implications for targeting wider systemic factors rather than focusing on individual experiences. Ideas from Narrative Theory and Practice will be explored within Discussion Section that could complement this Grounded Theory.

4.4 Core Category: Managing the uncertainty of experiences against the certainty of service provisions

Having an understanding of where this group of people are coming from supported the discovery of the complex, interconnected processes involved in decisions to seek help. The researcher acknowledges that the sample consisted of self-selected individuals choosing to participate in research on disordered eating and help-seeking behaviours. As such, the researcher assumes that there is an identification of

disordered eating as problematic and sought to unpack factors contributing to decisions to do something about it. This section suggests opportunities for facilitating *a shift towards openness about support and considers potential costs to seeking support.*

4.4.1 Factors affecting decisions to seek help

Impact of early trauma: The researcher acknowledges the possibility that participants may be suffering with the emotional sequel to undisclosed or unprocessed trauma. Participants reflect on experiences of asking for and receiving support from others growing up. Rose describes the implication of disclosure in the context of early trauma and abuse:

> *"It was always about hiding something […] so now I got really good at keeping secrets and I understood the importance of keeping them, the power of keeping them and not making yourself [vulnerable] and telling people"*

Anna describes turning to food when she experienced distress growing up:

> *"[My mum] couldn't give me the emotional support […] So when I was on my own that's when I would turn to food* [//] *I couldn't really talk to my mum about most things really she would kind of shut it down … I suppose in a way I didn't really know how to explain things to myself or build up the courage to speak to anyone … about how low I felt about how I looked".*

It is possible that such experiences influence later relationships towards help. Peter describes having learned to "*problem solve*" difficulties due to earlier experiences of lack of support:

> *"I would say that I am self-sufficient. I find answers to problems myself all the time […] I talk a bit to friend about it … it's very difficult, it's hard to share stuff. It's very difficult [//]I think there is something really wrong about [my eating patterns and behaviour]… but I haven't … It's not okay really. <u>I mean I realise that</u> but I don't really know what to do about it"*

It is also possible that the uncertainty of experiences reinforces the underlying sense of helplessness. Equally, people may feel that they do not deserve support because of issues with low self-esteem and feelings of unworthiness. Feelings of defectiveness, shame and unworthiness would then influence attitudes towards any type of support in the future, creating the same belief that help is desperately wanted but could not be relied upon. People would then be rejecting others before being rejected themselves. Mandy describes a typical conversation with her partner:

> *"I do tell him quite often that I do feel quite fat […] I think it's because I want to just make him aware that I know that I'm bigger maybe trying to reassure him, maybe that this isn't going to stay like this [quietly] <u>which is a really not nice thing to say about myself</u>"*

It would make sense that people would repeat early experiences in interactions with others. Participants identified using general phrases and skirting around the subject of disordered eating in conversations with others. Adam readily seeks practical advice and strategies instead of emotional support from his peers:

> *"[asking my peers] what regime should I be following [and] what kind of things should I be avoiding".*

Reflective comment: I inferred that some participant may be repeating earlier experiences of "being forgotten" or "ignored" in interactions with others including services. I noted a push/pull style of relating in the interview space. I also noted that some participants would disclose very painful experiences, relating and showing vulnerability and soon after use humour to minimise and detract the conversation. I wondered if this interactional style also mirrored the types of conversation that people were having in their relationship with others.

Individual, external and contextual factors: Discovering differences in the narratives communicated suggests the subjectivity of experiences and also invites diverse positions and conversations about help-seeking. Participants identified context-specific factors as well as the wider social context that they were interacting with, which influence decisions to seek help. The researcher hypothesised that the professional background participants were coming from would also influence their relationship to help. Adam positioned overeating in relation to problems with willpower and self-control, closely linked to the "macho" mentality of medical training:

> *"You ought to know the answers so you are less likely to ask for help or to seek help for something like that. Often until you know the problem is quite some way down the line [//]It's a view I used to have. Now I don't. I think it's probably a more destructive one than a constructive one"*

Although Mandy reports positive experiences of seeking counselling, she did not disclose the frequent bingeing despite patterns being at their *"worst"* during that time:

> *"We didn't talk about the food [because] I just think it's not that big of a thing. Although it is something ... maybe because I've had it for so long, it's just… its just a way - I don't even know, I just think it wasn't important to mention because other things felt more important*"

Reflective comment: I acknowledged that participants were acting into the context of research and entering a new relationship with me. I was also aware that participants were coming from specific backgrounds (e.g. professional background) with assumptions and ideas about what was important for me to know which would influence the narratives and examples that they communicated. Attending to participant's relational style in conversation (e.g. talking too much or too little) and hypothesising about how I may be positioned (e.g. in the role of the helper) provided information about participant's relationship to help (in relation to interpersonal relationships, professionals and services).

Acknowledging participants' individual contexts provided insight into decisions to seek help. Cindy also considers that her experiences of fertility treatment, which involved following a rigid eating plan, and where food restriction and healthy eating is commonly suggested in cases of weight management, would mirror her current situation, perpetuating the feeling of "*being restricted*":

"I had to follow a programme and I hate it - hated it. It was like, restrictive again so it was almost following like a diet sheet and I just binned it. I couldn't deal with it. It's restrictive again. Maybe I've got an issue around being restricted."

Feeling invalidated and dismissed were common examples entering participant narratives about experiences of seeking support. Mandy describes needing to justify her experiences to others:

"I've got to justify how I feel [....]. I feel like it would match somebody who is physically a lot heavier [//] [and when I talk about it [the] response I usually get is, you are not fat"

Rose imagines her experiences are more likely to be dismissed than when she was obese, with others and professionals reacting to her weight. Rose specifically refers to responses from significant others:

"If I talked about compulsive overeating at my larger size then I would've been taken more seriously, but saying I eat every day in the dark by myself when you are a size 14, nobody is taking that seriously [//] thinking about my family, about my parents [becoming tearful] that they would know that it was a serious problem, they would see the behaviours that were problematic and I'm thinking about my girlfriend and my friends if I tried to talk to them about it they would suggest like diet options or like 'let's eat healthy together'"

Decisions to seek treatment were not in isolation from the social context that we are all a part of. Jane draws comparisons on how people might respond depending on the presenting weight:

"If someone is underweight then they kind of have more pity for people who are anorexic because they just look at them and think 'why would you think that, you look fine or you're too skinny' but if they look at someone that is fat they won't think 'this person shouldn't see themselves as fat'. They think this person should see themselves as fat and they should start controlling what they eat"

Previous experiences and who was responding to the weight featured within participant narratives about helping relationships. Rose discusses feeling failed by the mental health system, with professionals reacting to her weight and more life-threatening behaviours at the expense of exploring her relationship to food.

"It's so hard talking about this because I've literarily never had this conversation before and that is really frustrating because I have been in the mental health system for 20 years and I've never had this conversation [becoming tearful] I mean there's something wrong with that . Everything else was so important, I get that more immediately life threatening behaviours that has to take precedence but why has this conversation never come up. That's what's so frustrating"

Fallacy of seeking treatment: Cindy considers what 'support' would look like in the context of not having an *"identifiable eating disorder":*

"Now that I kind of really identify that I've got an issue, what do I tell the doctor, what do I say? That I've got a weird relationship to food, and with the knowledge to give advice so who they send me to, a dietician? - an eating disorder clinic? It wouldn't be would it? Because it wouldn't be identified as a serious risk, do you know what I mean? ... Would it be a nurse? Or even a psychologist – or psychiatrist even?"

Reflective comment: I noticed a shift in Cindy's position in relation to seeking support for disordered eating. Initially, she positions support as having an expert in the field of disordered eating, dismissing the expertise and knowledge of her counsellor who does not hold this "specialist" knowledge. In conversation she begins to negotiate what support would look like, having come to recognise the "eating distress". Having a therapeutic conversation may have influenced this shift and towards the end of the interview Cindy considers doing research on available support. Participant's positioning is explored further in processing attitudes towards helping relationships, within Results section below.

Despite recognising the eating distress, the unavailability of services in the context of diagnosis and meeting eligibility was one of the identified barriers to seeking treatment. This subsequently contributed to the fallacy of help-seeking communicated by Cindy.

Samantha describes her journey to receiving psychiatric care following deterioration in her mental health. Like Rose, who was also able to afford bariatric surgery, Samantha was *"blessed"* having had the opportunity to access private healthcare in the context of budget constraints and not meeting eligibility:

> *"As I've grown older I've just gotten more pragmatic that you know it's not a perfect world and huge budgetary constraints and if somebody is 5 stones rather than 9 stones you can imagine why they might take priority. But at the same time, it's been devastating and I just feel blessed that I could go to rehab twice - each time I was left with some money by somebody who passed away and each time I decided to use it and honestly, it didn't fix things but it was huge steps for me"*

4.4.2 Meaning of help-seeking

Reflective comment: Examining my assumptions about help-seeking, I became aware that they might be getting in the way of discovering participant's relationship to help. I began reflecting on the different contexts that I was coming - my role as a practitioner was perhaps exerting more of an influence at different stages of the research process. Engaging in reflexivity enabled me to become more attuned to the different ways of help-seeking done in this group of people that was not necessarily limited to seeking counselling. Reframing support in relation to whether it was experienced as helpful or unhelpful was relevant in discovering participant meaning of help-seeking which was important in the process of making the decision to seek help.

"Managing overeating": Putting on weight featured in the majority of the narratives communicated and was an indicator for uncontrolled disordered eating for Cindy:

> *"It wasn't obvious before" [//] I'm like a size 6-8 and now I'm a size 16"*

For Adam**,** gaining weight initiated conversations with others and supported the process of "managing overeating":

"It was because I was struggling with my heath [and weight gain] that I realised I had to do something about it. That was the point of change for me [//] Now I tend to use food more as a

Reflective comment: Adam and Mandy were the only participants to describe to be successfully "managing overeating". Psychodynamic perspective may formulate this as denial, a defence against overwhelming anxiety. However, Mandy's disclosure of past trauma, showing vulnerability and connecting with painful experiences, generating alternative perspectives, and considering the impact would suggest reflexive capacity and openness.

way of trying to make my body healthier rather than trying to use it as comfort mechanism because I feel that it's making me healthier then I don't feel guilty about it which improves my mood [//] I think it's an achievement of food restriction [...] I try to use limitation of food as a comfort"

It was discovered that where problems were located within the person, then disordered eating experiences were viewed as something that could and should be managed with greater willpower and self-control. Participants suggest losing weight and changing their eating lifestyle as an indicator to "managing overeating". Mandy suggests making healthier choices, eating "*more mindfully*", reframing her relationship to food as a source of "*fuel*" and "*nourishment*", actively challenging disordered eating thoughts and reassuring herself that *her "weight won't fluctuate massively in a day"*. Furthermore, surrounding herself with positive role models *"who eat for nutrition*" helps her manage the intensity and frequency of bingeing experiences.

Rose discusses the continual process of instituting changes to improve her mental health and wellbeing:

"For the first time in my life when I'm doing really well, food is something that I push myself to doing better at [//] I think it's been fundamental to me to be doing better is realising that there are other ways to get that experience than hiding in the dark and eating"

Praise and acknowledgement of her efforts from the researcher enabled Anna to recognise her strengths, which included being resourceful:

"*Only just now, from talking to you ... everything has been supressed for a while... it's like life has been passing me by lately"*

Reflective comment: Using the Systemic conceptualisation of "problems" being in relation to a context is relevant in this Grounded Theory. I began thinking about individual differences including participant characteristics, strengths and resources. For example, Rose shows vulnerability in her narrative. She describes working hard to maintain her emotional wellbeing by surrounding herself with others and cooking for others instead of "hiding" and eating in secret. These observations are noted within the Discussion Section on implication and recommendation for professionals working with this group of people.

However, when management strategies were closely linked to weight and the body, then losing weight was often equated to success, increased confidence and happiness. Mandy concludes:

> *"If I was able to lose weight, to become comfortable in my body then I wouldn't have this unhealthy relationship to food because there wouldn't be anxiety of good and bad foods"*

Samantha reflects on her experiences of "managing overeating" when in fact such weight control behaviours have been masking her distress:

> *"I've become very reliant on them [diet pills] and the ironic thing - about a year ago they stopped keeping me thin. And yet, I still haven't been able to get rid of the habit."*

Reflective comment: Samantha's narrative highlighted to me the importance of exploring the meaning behind management strategies.

Seeking counselling: Almost all participants report having had contact with health care professionals. In the context of accessing statutory mental health services where a "fit" of symptoms is relevant to assessing needs, it influences the types of conversations people have. Peter describes his journey to accessing counselling:

> *"I think I said I was feeling quite lonely to my GP and then she got me to go to [a counselling organisation]"*

However, it was common for people to not disclose or have the opportunity to explore disordered eating experiences in the context of accessing counselling. Disordered eating was often deemed as separate, due to the factors affecting help-seeking presented above as well as participant attitudes about helping relationships presented later in the results section.

Reflective comment: Hearing participant narratives about help-seeking made me wonder about my assumptions about support. I noted with interest that Peter and Cindy were accessing counselling at the time of the interview, bringing themselves to counselling to talk about their difficulties but also choosing to not talk about their experiences of disordered eating. Participants provided different reasons for this when questioned. I also wondered about the context of research inviting a different space to have a conversation about disordered eating. After unpacking my own assumptions, I was able to make sense and discover participant meaning of help seeking which was linked to individual, external and contextual factors. Engaging in self-reflexivity and acknowledging my own assumptions enabled me to discover and better understand barriers and facilitators to seeking help among this group of people.

Contributing to research: Participants' narratives about their experiences of the interview process would indicate that the research context creates an opportunity to seek support. According to Peter, seeing

the research advert prompted his decision to speak to his counsellor about his eating patterns for the first time:

> *"I have been aware about [my disordered relationship to food] but this actually gave me a prompt to actually think about it. I go once a week to counselling and I actually talked to the*

Reflective comment: Peter tentatively describes his relationship to food that is separate from more formal eating disorders. As the interview progresses, Peter comes to recognise the "eating distress" and eating patterns and behaviours as "a symptom" of life problems.

> *counsellor about it. [//] I spent the hour discussing it with my counsellor actually"*

Rose navigates routes to seeking treatment:

> *"I would love if there is any access to support that you think would be useful if you could let me know where I can get that because I think this conversation has made me realise that maybe this needs addressing more than I want to think about how much it needs addressing. [//] This is turning into therapy."*

Participants readily impart advice for people struggling with disordered eating. Cindy suggests the importance of identification of problematic eating patterns:

> *"Well the first thing if they identify themselves with [the eating distress] – because a lot of people use it like, "oh I pigged out last night" but it isn't pigging out, its self-harming. […] I wonder how many people sat in [counselling waiting area] the way I did and looked across at that and think that it didn't apply to them and they are overweight or obese"*

4.4.3 Processing attitudes towards helping relationships

Ambivalence towards support: It was not uncommon for participants to start the interview by asserting that their experiences might not be relevant and then subsequently find that they are tearfully relating to the distress not long into the interview. Peter becomes sure of the validity of his experiences of disordered eating as the interview progresses, eventually empowering him to speak further with his counsellor:

> *"I didn't think it's worth [talking about my experiences] – it only suddenly occurred to me when you put your [poster] … it was something worth speaking about. [//] If I was to tell people, I am quite ashamed about it, so I don't say things to people. I'm sure there are other people that live like that – that don't cook and that – I am doing it for another reason [//] I understand about anorexia and overeating but there's probably a spectrum of things, that I don't know about. I'm sure about this"*

However, in a follow-up interview Peter suggests significant changes would impel him to consider seeking treatment for disordered eating:

> *"I don't know it would have to be something quite traumatic I would have thought. Because I can just keep going on like this"*

Reflective comment: I wondered about possible factors influencing the shift towards recognising the eating distress, discovered in the research process. I noted that participants were generating multiple perspectives and meanings in conversation. Peter discloses a difficulty in opening up to others and suggests, experiencing "safety" during the research process in a follow-up interview. Peter attributed this to feeling validated about his experiences and because I was asking specific questions and building up to facilitate exploration. The benefits of having therapeutic conversation are explored within Discussion Section.

Cindy suggests that a specialist is better equipped to explore eating-related concerns:

> *"I didn't think [my counsellor] will be equipped to know. I think it's a specialist area and counsellors are more paraphrasing back so you can work through what the issues are. So a psychiatrist, psychologist and somebody who specialises in food disorders would be a better option [//] I suppose for years I didn't really identify with having an eating disorder […] it is only now really that I've acknowledged that there's an issue"*

While ambivalence about support was linked to the fallacy of help-seeking, which is presented above, seeking counselling for eating distress would mean relating to painful experiences and as suggested by Cindy, it is easier to receive a diagnosis with a prescribed treatment pathway:

> *"I would love to fit into a pattern of disordered eating – eating disorder actually. Now since I've been talking to you, since reading your advert and thinking about it myself I actually think more and more that I have something – not enough to hospitalise me but I have, I think there is a serious issue. But I'd rather go into a hospital and sort me out than do the whole thing for me and deliver it rather than me doing it myself – the preparation"*

Samantha and Rose identify the need for taking responsibility for problems in life. Samantha reflects on changes in her attitudes towards helping relationships:

> *"I think early on I was very naive and trusting and thought all the answers were in the hands of the professionals […] without me having to make any changes or any efforts. And I learned that wasn't the case. […] I went sort of through a phase of feeling rather angry and almost over-reliant - this notion that professionals should be able to fix it you know - work miracles without me having to go through a process. And now, I just think I've got a healthy relationship, or a healthy attitude towards professional input which I think is something really useful but you don't put all your reliance on it, you don't expect miracles with it but you work in partnership."*

Reflective comment: I wondered about the impact current diagnostic systems imposing a linear way of looking at problems which influence participant's experiences. I was aware that participants describe feelings of "shame" and a sense of "failure" in relation to their experiences of disordered eating. As such the inclusion of social process of inclusion and exclusion within this Grounded Theory Model was fundamental. It was also useful to hold in mind different schools of thoughts around diagnosis, disorder and dysfunction/functional. Debates around usefulness of diagnosis, relevant in this Grounded Theory Model are reviewed within the Discussion section.

Mandy echoes potential risk of talking about experiences:

> *"[Its] almost like putting someone in a vulnerable position to start talking about it and you aren't taken seriously anyway so you might as well not talk about it in the first place"*

Negotiating costs of 'giving up' the 'disorder': Using participant narratives about functions of behaviours, the researcher infers that seeking treatment may mean giving up perceived gains of disordered eating. Although this was not explicitly communicated within participant narratives, Rose identified costs in relation to her autonomy:

> *"I'm not very good at accepting help [...] because of how far I went with my autonomy was something I fought tooth and nail to get back and my ability to have secrets and keep secrets is something now I'm very protective off so yeah I don't like telling people about the stuff that's been going on in case my freedom is taken away [//] remember a friend of my telling me that it's better to be fat and alive than skinny and dead right? And [becoming tearful] I used that argument with everyone that's brought it up"*

Reflective comment: This highlights the usefulness of asking about previous therapy in assessing the person's relationship to help. Suggestions for clinical practice are reviewed within Discussion.

Clinically, examining potential costs to "giving up" the disorder and challenging ambivalence at the outset would be beneficial.

4.5 Emerging Central Category: Finding a 'fit' between narratives

The researcher drew on the strengths of Grounded Theory methods to develop a framework for understanding sufferers' experiences of disordered eating and identify processes involved in decisions to seek help. An interpretation of the data suggests that moving towards finding a "fit" between narratives was central to sufferers' experiences of disordered eating and would support working with people who identify with problematic relationships to food where experiences do not fit a clinical diagnosis. This intersubjective process occurred when participants were articulating their experiences, with the researcher extracting and constructing meaning from the narratives communicated.

4.5.1 Taking the 'disorder' out of the 'eating'

The exploration of subjective experiences supported the process of recognising the "eating distress". It also allowed for the experience of having a therapeutic conversation, which emerged from participants' reflections on the interview process, with underlined examples presented throughout the results section. Where participants dismiss their experience at the start of the interview, they go on to begin relating to painful experiences and generate alternative narratives through the process of contextualising their experiences. The researcher suggests that this also supported a shift in participants' positions towards helping relationships. This was observed in four participants who expressed an intention to access services and requested information about resources and signposting services.

4.5.2 The role of the other

The model highlights the crucial role of healthcare professionals working with or in contact with people who are struggling with disordered eating. It is suggested that creating the context for having a conversation and assessing eating lifestyle rather than looking at behaviours and weight as indicators of a problem, would support the process of finding a "fit" between narratives. It would also give people permission to explore their experiences and would support meeting the needs of this group of people.

Reflecting on results section

As I reflect on the process of creating the results section, the first emotion that comes to mind is a feeling being overwhelmed. I had been worried about creating something that would be novel, relevant and respectful of the participants' narratives. I also worried about creating a piece of work that was 'good enough'. This feeling of paralysis kept me from writing up the results section for some time after I considered myself ready to proceed onto it. Writing up the results felt like a huge, unmanageable task. The amount of data collected was overwhelming. Whilst reviewing the transcripts I was reminded of the strengths and resources that this group of people possess. I was grateful for and respectful of their honesty in relating to painful experiences and was impressed by their willingness to share and impart their knowledge and expertise to others. However, I worried about doing justice to the rich data and allowing each of the participant stories to be heard.

There was a period of time between data collection, analysis of the data and the writing up of the results section. I experienced difficulty in putting words onto paper. I realise that I had become so immersed in the dataset that I needed the time to digest and consolidate the information. I was aware of the restrictions in the word count that would require me to be selective in presenting the results section. I realise that part of this 'paralysis' in writing up the results was the process of integrating what was coming out of participant narratives but also accepting that what I was observing was the function of my own experiences and identity, which influenced what I hoped to see. However, when I strived to strike this balance, I found that the grounded theory was pouring out of me. I made several revisions before the decision to present my reflections throughout this section, which I hoped would show the reader the development of the intersubjective process of "finding a fit between narratives "that was deemed relevant and important to the people who participated in this research investigation.

Examining earlier models, I realise they reflect the more phenomenological focus of the early stages of the research. Unfortunately, paying attention to the subjective experiences meant that the codes generated and questions asked would invite conversations that locate problems within the person. As I conducted more interviews, I grew less focused on the individual subjective experiences and my attention was directed to how these experiences can be used to hypothesise about the relationships between participants. This allowed me to understand the processes by which participants and I construct meanings, which is different to phenomenology research where the focus is on subjective experiences of lived experiences. I was fascinated by the parallel process that occurred during the interview process. I noticed that when I was focusing less on the behaviours, participants more readily positioned me in the role of the helper. This enabled the process of recognising the 'eating distress' instead of defending or dismissing experiences which often occurred at the start of the interview. Looking at my earlier memos, recorded following each interview, I realise that in the early stages of the research process, I also failed to recognise the 'eating distress' communicated. In listening to participant stories, I was also finding a "fit" between narratives and moving away from my preconceptions based on my knowledge at the start of the research and what I was constructing during the research process and development of theory.

Chapter 5 Discussion

5.1 Discussion of results

This research inquiry fulfils its aims of exploring an under-researched topic, examining experiences of disordered eating among a non-clinical sample and unpacking factors affecting help-seeking behaviours. The research proposes a framework for meeting the needs of people struggling with experiences that do not "fit" with current constructions of disordered eating. It attends to the absence of theory and includes subjective experiences of a group of people that might otherwise be missed within the current eating disorder literature. Attention is drawn to complex and interrelated processes underlying people's experiences of disordered eating and decisions to seek help. Examples are accompanied by suggestions for professionals working with people who identify with disordered eating.

5.1.1 Conclusions

The model provides the reader with a framework for understanding where this group of people are coming from and captures complex interrelated processes involved in decisions to seek help. It aims to identify the needs of people experiencing disordered eating and identifies gaps in their support.

In constructing experiences of disordered eating, participants were situating their experiences in relation to trauma, disclosing early childhood sexual abuse, physical and emotional neglect and bullying experiences. Narratives about experiences were related to the individual, cultural, family and social context that participants' belonged to. Examples entering participant narratives included beliefs about the self, informed by early experiences. However, examples of 'societal pressures' were found to influence the individual's relationship to the problem, where disordered eating becomes located within the individual, and in relation to 'control' and 'willpower'. Unpacking the function and meaning behind behaviours provided a lens to infer about gains and losses to 'giving up' one's disorder, where food was identified as a strategy for managing problems in life.

It was discovered that the process of contextualising one's disorder generated multiple perspectives including the issue of diagnosis influencing problems in the person's life. Where participants connected similarities, differences and exceptions to disordered eating the researcher noted a shift away from the position of blaming the self or others towards recognising the eating distress "as a symptom" of life problems. The researcher suggests that "fitting" experiences perpetuates the shame and vulnerability found among this research group, and subsequently reinforces social processes of inclusion and exclusion. Where experiences do not "fit" a diagnostic framework and experiences fail to reflect cultural notions creates the dynamic of balancing the uncertainty of subjective experiences against the certainty of services due to service availability, accessibility and eligibility criteria.

The dynamic becomes apparent in conversation about help-seeking decision making. Examples entering participants' narratives included individual, external and contextual factors affecting decisions to seek help. Participants communicated different ways of coping with the eating distress, which again was informed by the individual's context as well as the wider social context that they were interacting with. Consideration of the relationship between the different contexts provided a lens for understanding differences found within participants' attitudes towards helping relationships. Seeking counselling would suggest openness to support. However, participants also express ambivalence towards seeking treatment due to early trauma resulting in distrust in others, compounded by later experiences of dismissal and potentially negative experiences with services. The researcher suggests understanding and working with the communicated ambivalence fosters a positive relationship to help. Specifically, recognising the eating distress, "taking responsibility" and seeking support (which was not necessarily limited to seeking counselling) for disordered eating was found to be relevant in supporting proactive decision-making. Rose and Samantha explicitly refer to elements of responsibility being held within the person experiencing the eating distress as well as the professionals. Furthermore, unpacking costs to giving up one's disorder would be another way of managing and working with the ambivalence.

By taking the 'disorder' out of the 'eating', disordered eating can be viewed as a subjective and experiential phenomenon. Professionals working with people who identify with disordered eating can support people to generate alternative meanings, buttress narratives of strength and resilience to enable people to identify alternative ways of coping. We are all responsible for creating the context for having a 'therapeutic' conversation, where a person can experience 'safety' while finding a 'fit' between narratives.

5.2 Linking results to existing research

Whilst reflecting on the Grounded Theory findings, areas of overlap with existing research were found: for example, experiences in relation to early attachment issues and fear of relating to others (Hernandez-Hons & Wooley, 2012). This finding was supported by Cindy, Anna, Rose, and Samantha who acknowledge that turning to food as a way of managing painful experiences with others was linked to attachment failures and inability to express emotions in childhood. Findings were also consistent with research from Buckroyd (2011) who discovered predisposing factors to disordered eating connected to early experiences including childhood abuse, neglect and poor parental mental health. Rose links undisclosed childhood trauma to the development of disordered eating and self-harming behaviours. Her narrative of protest in interactions with others was in line with Fellitti (2003) who interpreted dropout rates in weight management programmes as an effort to protect painful experiences connected to early trauma.

Mandy and Jane would agree with Landwerlin (2001) and other feminist researchers who suggest that the pressures on woman and cultural notions of beauty give rise to body-dissatisfaction, depression, anxiety and issues with body image and disordered eating. Furthermore, the view that disordered eating is a way

of managing this tension was supported by Jane in her narrative about "societal pressures". However, Rose would agree with Malson (1992) that such explanations negate important aspects of people's experiences such as the social, political and systemic context where the eating distress occurs. This explanation also fails to account for experiences of disordered eating among males.

Across all participant narratives, disordered eating was less about food and weight, and more a 'symptom' of managing life problems. Consistent with findings in a study by Davis et al. (2005), participants identified the function of food as a distraction and an "escape" from painful experiences. Participants within this inquiry also talked about stress, depression, anxiety, and loneliness in relation to disordered eating. Samantha and Rose would agree with Hernandez-Hons and Wooley's (2012) interpretation that food symbolises a person who is not experienced as rejecting. Whilst findings were consistent with commonly cited explanations for disordered eating as a way of regulating negative emotional experiences (Waters, Hills & Waller, 2001, Copper et al., 2004), asking participants to talk about experiences revealed complex emotional processes that were relational, 'circular', and context-specific with examples of differences and exceptions and reference to 'then and now'.

While eating too much or losing weight attempts to reduce anxiety, at least in the short term, disordered eating also provides a feeling of control, a sense of achievement, an expression of distressing emotions and a communication to others. Therefore it is not surprising to find that participants express ambivalence about support because of the invested need for control, maintaining the behaviour that protects people from the problems that they are experiencing in life. It is suggested that ambivalence is common among people with long-standing and entrenched patterns of disordered eating. Rose and Samantha share stories of denial of experiences and resisting input from services related to ambivalence towards recovery.

There are a number of studies that support the finding of ambivalence felt by people with experiences of disordered eating (e.g. Raisanen & Hunt, 2014, Reid, et al., 2008, Eisenberg et al., 2007, Serpell et al., 1999). For example, Adam (see page 71) denies experiencing eating distress in his narrative and instead describes a sense of achievement gained from food restriction. Similarly, as discovered in a study conducted by Reid and colleagues (2008), Samantha expressed ambivalence towards treatment and recovery because using diet pills provided a feeling of control. However, as behaviours became more entrenched, Samantha began to feel less control and the loss of control led to help seeking in the form of joining a faith community. As suggested by Dunn and Brattman (2016), Samantha added that exploring the underlying function for disordered eating behaviours (e.g. disordered eating in relation to the need for control, loneliness, lacking in connectedness and improving self-esteem) would have been helpful in treatment *then*.

Relevant to this research inquiry are consistent research findings that men express dissatisfaction with their physical appearance (Pope et al., 2000). However, in comparison to women, men are less likely to be diagnosed with eating disorders. As Anderson (1999) suggests, men are often hesitant to allude to the possibility of struggling with disordered eating for fear of dismissal and stigma. Peter echoes a similar

story of dismissal of symptoms to that found in a study of men's experiences of contact with services (Raisanen & Hunt, 2014). Peter initially disregards eating patterns as symptoms of disordered eating, but having a therapeutic conversation within the research context enables Peter to recognise the "eating distress". However, in a follow up interview Peter explains that his experiences were attributed to symptoms of irritable bowel syndrome in conversation with his counsellor. As Robinson et al. (2013) suggests, challenges to accessing relevant and gender-appropriate information mean men often delay seeking treatment due to professionals remaining uninformed (Anderson, 1999). Although the counsellor's intentions in their response to Peter's disclosure of experiences of disordered eating are unknown, Cindy alludes to the lack of expertise and knowledge among clinicians.

5.3 Reflecting on differences in decisions to seek help

Reflecting on the completed Grounded Theory, the researcher concludes that participants' definitions of seeking help were not equivalent. For example, seeking counselling, "managing overeating" or contributing to research all link participants to having the ability to identify a problem with their relationship to food. However seeking counselling and engaging in self-reflexivity suggests recognition of the "eating distress" and would support the process of taking responsibility for being part of the problem. The researcher acknowledges processes discovered within help-seeking decision making may be specific to the people participating.

One suggestion highlighted within this research inquiry was the need to recognise the "eating distress". Contextualising one's disorder would enable people to find a "fit" and adjust their position in decisions to seek help, which was relevant across participant narratives, irrespective of their understanding of help-seeking. However, processes underpinning ambivalence towards support were context-specific and related to participants' unique experience, beliefs and assumptions. While having 'therapeutic' conversations with others allowed people to express openness towards support, attitudes towards helping relationships were revealed to be multifaceted. As such, considering the meaning of help-seeking was key in unpacking participants' relationship to help. As Mandy suggests, accessing counselling in the context of a relationship breakdown was useful then; but she dismisses the usefulness of seeking treatment now because her experiences do not "fit" with the socially constructed disordered eating. Despite this, Mandy identifies strategies in "managing overeating". It is possible that her attitude towards helping relationships and her understanding of help-seeking was influenced by her professional identity. Specifically, working as an allied mental health practitioner in a setting where distress is understood with reference to specific symptoms, thoughts and behaviours may create or reinforce the uncertainty and ambivalence. Adam suggests that his knowledge of service provisions and pathways to identified problems as a medical practitioner allowed him to establish alternative ways of "managing overeating" in order to promote positive emotional wellbeing.

However, it is possible that Mandy and Adam are denying current eating distress, and such management strategies could be conceptualised as disordered and may become problematic, as in Samantha's case. Similarly, among patients with eating disorder, Goodsit (1997) writes, the denial of an illness and resistance in therapy needs to be dealt with immediately. As Rose suggests, placing responsibility among healthcare professionals to challenge resistance would helpfully integrate and validate people's experiences. As such, this research enquiry identifies the role of the other in creating the context for having a therapeutic conversation.

Within this research inquiry, participants refer to changes in the definition of disordered eating over time. In line with Hepworth's (1999) writings, medieval women were regarded as Saints because they detached themselves from physical nourishment and the pleasures of the world, and instead preserved themselves for heaven; these women might not relate their experiences to 'anorexia'. Rose upholds the importance of acknowledging changes in social constructions of disordered eating and the impact of imposing a specific way of viewing problems. As such, Cindy's desire for her experiences to "fit" a diagnosis is not far from stories among people with an undiagnosed eating disorder. Undoubtedly, being fat has an obvious fit of a problem or disorder compared to experiences that are hidden, such as underlying feelings of shame, fear and distress communicated across all participant narratives. Where there was a more obvious fit, professionals and families were reacting to the weight. However, rather than identifying who has a disorder and who does not, diagnoses and definitions of disordered eating can be interpreted as being more or less helpful for people.

To the best of the researcher's knowledge, the reasons why people would express a wish to fit experiences within a diagnostic framework and how this would then influence the narratives about disordered eating and decisions to seek treatment are yet to be formally investigated. However, the desire to fit experiences would suggest the impact of the wider social context imposing on people's experiences. Cindy identified the fallacy of help-seeking, and questions pathways and accessibility to services. Further research could seek to substantiate these potential relationships to understand barriers to seeking treatment.

While the issues explored by Peter (for example, problems in his interpersonal relationship, work stressors, low mood and anxiety in the context of caring for his elderly father) may have been salient within a therapy context, such conversation could also have emerged within another supportive context. Creating the context of having a "therapeutic" conversation would create opportunities for feeling validated and experiencing a sense of safety, as indicated by Peter in his reflection of the interview process. It is also possible that talking about disordered eating for the first time in the context of research permits people to explore their experiences without having to take the responsibility to do something about it. Brown and Keel (2012) recognise that clinicians and counsellors may be working with people with experiences of disordered eating while treating other presenting problems. As Bell (2003) suggests,

empathy and understanding are imperative in effecting change, but unfortunately this was not always the case across all participant narratives in conversations with others at different times in their life.

It is well documented that experiences or perceptions of stigma are positively correlated with greater psychopathology and longer duration of disordered eating (Griffiths, et al. 2015) which then becomes a barrier to seeking help, highlighted as one of the factors affecting help-seeking behaviours within this inquiry. In light of the stigma surrounding eating disorders, particularly among men, sharing stories about experiences shows strength and courage. It can also help raise awareness of disordered eating and weaken the stigma attached. Future research could also seek to hear more stories from a non-clinical population and would include narratives from men, to improve the outcomes of people struggling with disordered eating.

5.4 Linking findings to existing theory

5.4.1 Attachment Theory

The researcher believes that the key premise of Attachment Theory bears relevance to this Grounded Theory. The term 'attachment' is used to describe the emotional bond, or lack thereof, between infants and their early caregivers (Bowlby, 1969; 1980). According to Sonkin (2005), consistent, stable and predictable care encourages children to become secure, autonomous adults who not only value themselves, but trust that they can seek and reliably receive support from others; whereas inconsistent, unstable and unpredictable care leads children to develop insecure and anxious attachment styles which can persist in adulthood.

When children learn that the attachment figure is not always there for them, their internal working model of availability of an attachment figure changes (Tesca & Balfour, 2014). When the child sees that the figure is unavailable, they find ways to maintain the feeling of security. The development of disordered eating has been understood in relation to attachment styles (Salcuni, Parolin & Colli, 2017). Bowlby's attachment theory suggests that a person with an insecure attachment pattern often views attachment figures as unpredictable, and therefore seeks to have control over their life through how much (or how little) they eat. People with an avoidant attachment pattern often perceive others as rejecting, and compensate by rejecting them first. According to Tesca & Balfour (2014), people struggling with eating-related issues may also believe that they are worthless and often show increased sensitivity to rejection, compensating by striving to be socially acceptable by living up to the "thin ideal".

Within the context of this research enquiry, Attachment Theory offers a lens for making sense of the interpersonal and psychological difficulties communicated. Examples of trauma and abuse entering participant narratives would suggest that in the absence of corrective experiences, situations that trigger feelings of "failure" and inability to cope activate and reinforce early attachment patterns. Food then becomes a way of managing problems in life.

The ambivalence about support would also evidence the maladaptive early attachment patterns. Within this research inquiry, the findings suggest that this group of people are coming from a position of loss of trust in others; they may not be convinced that there will be support. Equally, people may feel that they do not deserve support because of underlying issues of self-esteem and feelings of unworthiness. Such feelings of defectiveness, shame and unworthiness would then influence participant's attitudes towards any type of support. Furthermore, feeling dismissed and invalidated would leave the person wary of disclosing to others.

It is suggested that the context of research creates a neutral ground for exploration. Therapeutically, creating an environment where the person feels safe and understood enables trust to build. With trust comes expression of vulnerability and an opportunity to make sense of negative emotions and discuss behaviours, shameful thoughts and conflicted relationships. The potential role of the other as a safe haven was supported by Peter coming to recognise disordered eating 'as a symptom' of life problems in conversation. It is likely that people feel stigmatised and marginalised because society does not mirror their experiences of disordered eating and so contributing to research would create hope for an alternative experience.

5.4.2 Psychoanalytic perspectives

The findings from this study bear relevance to self-psychology perspective which provides a subjective view of experiences, links problems in early relationships and disordered eating, and explains the use of food as a way of maintaining self-cohesion. As Caparrota and Ghaffari (2006) summarise, faulty attunement, inadequate mirroring and lack of empathy in the early mother-child relationship results in developmental arrests. This early relationship becomes internalised and influences how the person relates to others (Miller, 1991). Disordered eating symptoms may represent a frantic struggle to supply missing self-object functions. It is suggested that food is chosen because it is a transitional object between the mother and child (Krueger, 1988), and food would correspondingly represent everything the mother is, or should have been. Food is real and tangible, and represents a self-object that is predictable and reliable instead of a disappointing or unreliable human self-object (Krueger, 1998). That is, food symbolises care and love.

Within the eating disorder literature, 'bingeing episodes' are said to be compulsive: a means of survival in order to tolerate and numb experiences in the moment. Turning to food temporarily alleviates stress, leaving the person feeling intact, sated and in control in the moment. According to self-psychology perspective, food does not adequately fulfil the missing selfobject functions. In bulimia, Bacher (1998) writes, what goes in must come out. While Rose and Mandy's narratives shed light on what happens during the bingeing episode it remains unknown what helps this group of people if for example they do not vomit to feel better. Future research could explore the complexity in the eating process and the strategies people use to support clinicians' understanding of disordered eating, which may be different to more formal eating disorders.

Johnson (1985) writes about the "wish –fear dilemma [which] revolves around the patients' wish for someone to identify and respond to her needs, which is juxtaposed against her fear that allowing someone to see the needy and dependent side will collapse the self-esteem and self-organisation" (p 33). The need for a sense of connection, love, safety and trust within the context of a relationship also facilitates a fear of loss, disconnection, rejection and abandonment. In her book, Savelle-Rocklin (2016) refers to this dilemma playing out in the therapeutic relationship, with patients wishing for the analyst to understand and approve of them, but simultaneously harbouring fears of discovering a harsh, judgemental critic in their analyst. Difficulties in the interpersonal relationship documented within the eating disorder literature are also found within this Grounded Theory inquiry. It can be interpreted that Rose was ravenous for something relational, but expresses her desire by turning to food, in secret. Rose identified the circularity of the problem where turning to food keeps her further away from the love and connection she needs.

Savelle-Rocklin (2016) documents clinical observations in the therapeutic relationship in relation to themes around attachment, ambivalence, and anticipated anxiety about depleting self-object functions should separation occur and the individual let go of the disorder. In therapy, clients often rely on the therapist to regulate this tension, but when this happens the person also feels overwhelmed, without an identity. Furthermore, the split client is often mirrored in the therapist (Sands, 1989). Upon reviewing the research memos, the researcher recognised that she was holding conflicted feelings during the interview process. The researcher noted herself feeling connected and empathic but then frustrated and confused by the stories told which provided a clue into participants' experience. Attending to participants' emotional responses to topics, coding for changes in conversation and noting what was being communicated (or avoided) in conversation was useful. Participants minimising or dismissing the eating distress, skirting around the subject (or speaking more generally about experiences) and laughing may be understood as a defence against showing vulnerability. The researcher, by actively taking a curious position, was able to hear and make sense of psychological defences, which are described as protective psychological processes that help the person to maintain integrity in the face of threat and danger. Bruch (1988, p. 8) promoted a "fact finding noninterpretive approach", where the therapist listens closely and positions the clients as collaborator rather than acting from a superior position. The use of an empathic stance closely resembles the self-psychology perspective (Bacher, 1998) and is appropriate among clients with problems with self-regulation (Goodsit, 1997).

Although self-psychology is relevant and includes subjectivity of experiences, like attachment theory it fails to explain other factors. Taking a developmental perspective that focuses on the aetiology of the problem is not always fitting. It also does not support the narratives about strength, resilience and resources discovered within this research inquiry. By focusing on the development of disordered eating or the function and unconscious motivations of behaviours which are said to be deeply rooted in an individual's early history, it assumes that the problems are located within the person. This would suggest that it is within the person's control to change their relationship to food. However, this would reinforce experiences of shame and stigma that are already experienced among this group of people.

5.4.3 Narrative Theory

Although literature on Narrative Therapy for eating disorders is not reviewed within the introduction section, drawing ideas from the theory and practice offers a better "fit", and is deemed to be most relevant to this Grounded Theory. The premise of Narrative Therapy is that the telling of the experience through questioning and scaffolding facilitates change and generates alternative perspectives. As such, this provides an opportunity for the person seeking help to position themselves more helpfully in relation to the issues that they bring. Narrative therapists may also work with clients to create "anti-anorexia" and "anti-bulimic" stories, externalising and separating the individual and the disorder. By creating alternative stories, individuals are positioned as active members in their treatment (White & Epson, 1990).

The idea that "The person is not the problem, the problem is the problem" is both useful and relevant within the context of this research inquiry where experiences may not necessarily "fit" diagnostic classifications for an eating disorder (Lock, Epson & Maisel, 2005). According to White (2000) people often tell 'problem saturated' stories of their life which represent the dominant narrative of their life experiences. However, such stories often omit experiences, leaving little room for identifying exceptions and contradictions which may call into question the person's distress. Within the context of this research inquiry, participants echo the dominant narrative within the eating disorder literature of lack of control, issues of willpower and low self-esteem. It was discovered that the telling of participants' narratives revealed an alternative part of the story that was not readily available (White & Epson, 1990).

White (2000) suggests problems are constructions created through the narratives that people tell, and are related to the assumptions and "truths" of the social and cultural context. As Payne (2000, p.14) writes: "through deconstruction the person gains a wider perspective on her experience and 'writes a richer story'". Translated to this inquiry is the process of contextualising one's 'disorder' and recognising the 'eating distress' enabling a shift in position in relation to the participant's view of the problem and their relationship to help. Rose recounts a story of a traumatic childhood but also remembers a critical relationship with her GP who reacted to her weight, which activated her decision to accept and later seek treatment, although privately. The researcher asking about exceptions to problems highlighted hidden experiences and generated alternative narratives of strength, resourcefulness and courage. The researcher suggests creating a context for having a "therapeutic" conversation would support the deconstruction of experiences, where people can generate alternative meanings that do not "fit" with their dominant story.

Stories about upbringing and attachment would still be relevant in Narrative Therapy. This perspective acknowledges Bowlby's internal working model, which is said to be laid down in infancy and influences the way a person navigates distressing experiences. Furthermore, self-esteem issues, an identified marker for disordered eating within the literature, would also be relevant. However, the therapist would encourage people to look at the broader sociocultural context and consider the effects of different roles, and the effects of different roles, and the effect of power, as suggested by Foucault (1998). Payne (2000) suggests narrative therapy helps people to counteract the effects of power because problems are seen as

socially constructed and arise from the "practices of power"; as a result people define their lives in narrow ways. Therefore, systemic informed practice would address the social and political issues which have an influence on people's experiences.

5.5 Summary of unexpected results

A surprising and unexpected finding for the researcher was the complexity of the processes underlying participants' experiences of disordered eating and their decision to seek support. Finding a "fit" between the narratives of disordered eating and the ways this was managed also surprised the researcher. Participants recalled specific examples of talking about disordered eating influenced by the context that they were coming from as well as the wider context that they were interacting into. Participant reflexivity and openness allowed the exploration of political and systemic issues reinforcing the shame and vulnerability experienced among this group of people. It allowed the discovery of the tension between the uncertainty of experiences as against the certainty of services in the context of undiagnosed disordered eating. Participant narratives about seeking treatment highlighted the disparity in treatment availability and accessibility linked to treatment pathways and eligibility, the time of contact with services, and who was reacting to the weight. Although the exploration of experiences of treatment offered was not the focus of this grounded theory, the need for follow-up appointments following disclosure of disordered eating, having pre and post bariatric surgery psychological support, and a de-emphasis on weight as an indicator of a problem or as a resolution to a problem were unexpected barriers identified in participants' experiences of seeking treatment.

Participants' candidness about the fallacy of seeking treatment demonstrates strength and resilience in utilising the strategies and resources available to them as a way of managing problems in life, despite limitations and barriers to seeking support. Similarly, participants who deployed the interview space as a 'therapeutic' opportunity to reflect on their experiences were showing vulnerability and recognising the 'eating distress' was an intriguing finding. The number of people who contacted the researcher about participation within a short space of time would suggest the need for a space to talk about experiences of disordered eating.

Another finding that the researcher did not consider was the link between disordered eating and long term conditions such as irritable bowel syndrome. The identification of the impact of diet, nutrition, lifestyle and physical activity on mental health and wellbeing in managing disordered eating was also unexpected. A systematic review conducted by Lassale and colleagues (2019), exploring the role of diet shows a promising link between diet quality and depressive symptoms, and findings from this research offer support to nutrition-orientated approach to disordered eating.

5.6 Reflecting on research participants

The researcher noted variations within seemingly similar processes underpinning participants' experiences of disordered eating and decisions to seek help. This had an impact on how participants positioned themselves in relation to disordered eating with context-specific factors identified in decisions to seek treatment.

Examining participants' profiles within the researcher's reflective memos revealed difference and diversity in the sample, with each individual bringing their own unique journey of disordered eating to the research process. Experiences of loss, transitions, familial patterns, individual stressors and circumstances were observed to underpin the uniqueness of each individual who participated in the research and the way in which they responded to the research and the researcher. The experiences of people who contacted the researcher but did not participate may also vary from participating individuals within this inquiry. While we cannot be certain about motivations for participation, the people that responded to the research advert would have identified themselves as struggling with disordered eating. Almost all participants identified with current experiences of disordered eating, with Adam providing a retrospective account of his experiences. The majority of the participants who were making sense of experiences in the here-and-now reflected the outcome of this research inquiry of finding a "fit" between narratives.

Research participants were credible experts in their experiences whose interest in the subject matter was evidenced by their participation. People often bring their own agenda to the research (Raheim et al., 2016) and detailed disclosures of trauma accompanied by strong emotions made it difficult for the researcher to interrupt participants. This challenged the researcher's ability to maintain her position as a researcher rather than adopting a more therapeutic stance in the interview process. However, participant openness and disclosure of painful experiences signalled trust and collaborative alliance (Karnieli-Miller, Strier & Pessach, 2009). It would also suggest that participants were seizing the opportunity to talk to someone who had the time to listen, highlighting the need for creating a context for having a 'therapeutic' conversation. On completion of the interview, all participants expressed gratitude for the opportunity and reported a positive experience of research participation. The researcher also felt privileged to hear narratives of struggles and strength which gave her a greater understanding of the context that this group of people were coming from.

As acknowledged within the introduction and methodology section, there was a gender imbalance with five females and two males participating. The under-representation of males within the sample would reflect the under-representation of men in research on disordered eating (Anderson, 1995). Pope and colleagues (2000) suggest that fewer men with experiences of disordered eating seek treatment due to issues of stigma, feelings of shame and embarrassment and fear of being considered "effeminate". The gender imbalance would also reflect the general assumption that men are less willing than women to participate in psychological research (Woodall et al., 2010).

While experiences of men are under-represented within this research inquiry, the researcher does not believe that this had a negative impact on the data obtained and the resultant theory development. In

defining the focus of the research, the researcher did not intend to explore gender differences within people's experiences of disordered eating and help-seeking behaviours, and as Morse (2007) acknowledges, the researcher did not intentionally seek to recruit individuals on the basis of gender, as in existing research (e.g. Schwitzer & Choate, 2014; Robinson et al., 2013; Hernandez-Hons & Woolley, 2012). As Charmaz (2009) states, when sampling participants, the researcher should focus on gaining diverse accounts from knowledgeable informants of the phenomenon under scrutiny. Therefore, attempting to gain a balance across participant demographics or suggesting that people's experiences would vary considerably on the basis of gender, may have limited the novelty of this study and overlooked the subjectivity and heterogeneity of experiences underpinning this social constructivist research inquiry. The researcher believes this would fit within a more positivist framework and could potentially reinforce the sense of exclusion already experienced in this group of people.

5.7 Reflections on using semi-structured interviews

As suggested by Flick (2009), semi-structured interviews complemented the Grounded Theory methodology and elicited the data underpinning the resultant theory. The researcher's questioning was appropriate and prompts facilitated lengthy interview narratives and allowed the researcher to amend and focus questions and prompts in line with theoretical sampling (Charmaz, 2006). All questions posed were answered, signalling participant engagement and sensitive use of questioning. Although participants were confident relaying their experiences, as acknowledged by Flick (2009) alternative data collection methods such as the use of focus groups may have jeopardised the acquisition of rich, honest and open narratives achieved within this research inquiry. The researcher believes the subjectivity of experiences would have further reinforce shame and vulnerability, especially among men who may already feel criticised, and as suggested by Pope et al, (2000) would be less likely to voice concerns about issues of body image and disordered eating.

5.8 Suitability of Social Constructivist Grounded Theory

Social constructivist Grounded Theory methodology allowed the researcher to create a novel theory grounded in the narratives and situated in the contexts of participating individuals (Glaser, 1999). Grounded Theory suited the exploration of subjective experiences, examining personal and social meanings of disordered eating and the ways people manage experiences. This inquiry confirms that the ways in which problems are defined can have an influence both on subjective experiences and behaviours, and affect how (and even if) society responds to the problem. This research provides a way of understanding how a group of individuals contribute to producing knowledge and gives a voice to people suffering. Constructivist Grounded Theory also suited the researcher's belief that her own experiences and the participants' narratives contributed to the research findings (Charmaz, 2006; 2009). The researcher observed herself playing an active role in the research process, the content of participants'

narratives, and the resultant theory (Willig, 2008). This is in line with her belief that another researcher would have constructed theory development in a different way.

The techniques proposed by Charmaz (2006) for social constructivist Grounded Theory were flexible and comprehensive. It gave the researcher a framework to work within and also the freedom to move back and forth between data collection and data analysis in response to the codes, categories and relationships that emerged within the data. The researcher's interest in social justice allowed for an alternative reading of the data, as suggested by Charmaz (2006). Through comparing stories the researcher gained a sense of the wider context contributing to the suffering and suggests how participants' unique experiences and understandings of help-seeking influenced the ways they managed their experiences. Comparisons also led to ideas about structure and accessibility of services. Constructivist Grounded Theory also allowed for diverse categories to emerge without interpreting the data to fit already discovered coding structures (Strauss & Corbin, 1998). The researcher made decisions about what content to include in the write-up based on the novelty of the findings and a clear demonstration of the processes underlying how people make sense of experiences and come to manage them.

Charmaz's (2006) social constructivist Grounded Theory fit the researcher's assumptions about knowledge, which were made explicit before embarking upon the research process. In accordance with the social constructivist framework, meanings of the phenomenon explored do not necessarily exist independently but rather develop in relation to a particular social, cultural and political context. Participants were also seen to hold subjective truths and definitions about the phenomenon, and were assumed to be able and willing to explore their experiences with the researcher. The research write-up also reflects Charmaz's (2006, 2009) beliefs about the importance of reflexivity, evidenced by the inclusion of the researcher's reflexivity.

5.9 Transferability of Findings

The researcher acknowledges that this Grounded Theory is not generalizable beyond the participants' subjective narratives, which were specific to those wishing to participate, as well as the time and the context within which the research was conducted (Madill et al., 2000). By including men and sampling across a variety of settings, the researcher hopes that the identified processes provides a useful framework for healthcare professionals. While this research inquiry represents one interpretation of the data it has a wider application beyond the small participating sample. As suggested by Sayer (2000), findings represent tendencies rather than absolute truth and could offer useful constructs that can be used to frame clinical work. Furthermore, finding a "fit" between narratives was also deemed to have sufficient explanatory power on the data collected from the last interviews.

Findings may be of interest to policy makers for early prevention, organisations offering support as well as researchers wishing to increase their understanding of disordered eating behaviours and their awareness of a group of people that may be otherwise be missed or disregarded due to presentation of

"mild" symptoms. Moving away from defining specific patterns that would otherwise reinforce exclusion, the finding of taking the 'disorder out of the 'eating' would be relevant among people whose experiences do not 'fit' clinical diagnoses. Readers can use this framework to build or gain an understanding of the needs of this group of people. Clinically, counsellors can explore a client's lifestyle of eating, which would be particularly useful among men who often fail to recognise eating distress (Raisanen & Hunt, 2014). Furthermore, the researcher believes findings evidence best practice within the counselling psychology field (discussed within implication for practice and counselling psychology).

5.10 Credibility and trustworthiness of the Grounded Theory Model

The researcher believes she was successful in creating a social constructivist Grounded Theory that was credible and relevant to those who participated (Charmaz, 2009; Chiovitti & Piran, 2003). Revising the interview schedule, the research question and areas of the emerging theory according to the information that participants were bringing meant that they were guiding the research process, which according to Chiovitti and Piran (2003) helps with credibility. Using participant' words and phrasing also adds to the credibility of findings (Strauss & Corbin, 1990). The researcher believes engaging in reflexivity, articulating her assumptions and acknowledging how these affected the resultant theory shows transparency and enhances credibility (Maxwell, 2013; Miller 2008).

The researcher did not strive to invite feedback from participants on the credibility and trustworthiness of the theory, as recommended by Drisko (1997). This was due to a number of factors, including the time between the interviews and sending the final theory, and her assumption that participants would not prioritise reviewing the theory because of other life commitments. This assumption was made due to the failure to respond to requests for a follow-up interview in two out of three participants contacted. The researcher interpreted non-response as an indication of opting out and so did not follow up. The researcher invited feedback at one follow-up interview and the participant cast the preliminary model in a positive light. However, it would not be appropriate to base an assessment of credibility and trustworthiness of the model on the basis of one response.

5.11 Implication for practice and counselling psychology

When considering the increased prevalence of disordered eating, the need for early recognition and treatment becomes essential. It is suggested that people struggling with disordered eating often do not recognise the severity of their illness and therefore may be reluctant to seek help. Throughout the years, early prevention strategies such as screening and increasing public awareness have been introduced, yet public health initiatives and treatment protocols continue to target more common eating disorders and have been criticised for focusing exclusively on women. As such, this leaves people whose experiences do not 'fit' with more commonly accepted symptoms of disordered eating to doubt the severity of their experience and their need for treatment. A recent position statement by the Royal College of Psychiatry

(2019) agrees that a lack of awareness, knowledge or skills among primary healthcare professionals leads to under-diagnoses and delays in treatment. Furthermore, the researcher believes that findings from this research inquiry are in line with the early prevention model and meets the needs of people struggling with experiences of disordered eating, who might otherwise be missed.

5.11.1 Increasing awareness, offering training and consultations

This study has demonstrated that people's experiences of disordered eating and decisions to seek treatment are both complex and protective. Sadly, as stated by Pope et al., (2000), for every person suffering from a diagnosed eating disorder, there are many more experiencing milder symptoms which are still distressing. It is recognised that offering continual training supports early detection and prevention. However, efforts that solely focus on behaviours and recognising symptoms of eating disorders are likely to increase the gap of exclusion, and further reinforce shame and vulnerability. The researcher believes that we must consider ways of taking the 'disorder' out of the 'eating', and include physical, emotional, social, interpersonal and contextual issues that contribute to and maintain disordered eating. Educational programmes should then address (though not necessarily be limited to): increasing awareness of disordered eating; barriers to seeking treatment; educating people about the effects of dieting and restricting; creating opportunities for supportive networks; and confronting societal standards, including views of men and disordered eating.

The results of this study and others alike could be incorporated within a consultation framework to stimulate conversations among healthcare professionals about disordered eating and contextual issues that may arise. Offering reflective spaces to think together would be beneficial. Unfortunately, because disordered eating is traditionally recognised in women, men may be disinclined to seek counselling, often denying or failing to recognise their eating distress, and those who do may be reluctant to talk. Research suggests that men are likely to cite food making them tired, abdominal discomfort, and feelings of nausea as reasons for disordered eating (Ficheter & Daser, 1987). Therefore, it remains the responsibility of healthcare professionals to readily ask about disordered eating. Assessing the eating lifestyle would assist people to learn about disordered eating and become aware of the resources available to them. It is of key importance to provide a setting for people to speak in confidence with competent professionals and for people to be able to receive support and specialist help for their experiences.

5.11.2 Therapists accommodating a "fit" within the organisational context

The fact that almost all participants in this study have had contact with services at some point suggests promising opportunities for promoting positive experiences towards helping relationships. Helping people to learn alternative strategies for managing problems in life would be beneficial. By creating a setting that is safe to talk about experiences, people will gauge the impact of having a therapeutic conversation and come to recognise the eating distress. Establishing trust is likely to foster self-disclosure and counsellors

may be presented with opportunities to normalise and validate experiences as well as address fears and ambivalence to treatment.

It would be helpful to assess a person's lifestyle of eating behaviour rather than focus on symptoms of disordered eating which may not necessarily be representative of the person's experience of disordered eating. Consequently, people may doubt the severity of their experience and their need for treatment. Therapists must be aware of the prevalence of disordered eating among the general population and feel equipped to implement (and refine) strategies to support people. One participant suggested that a group setting to explore her experiences would be helpful. Establishing eating-related groups may create opportunities for people to gauge the impact of their eating patterns and receive feedback. In addition to group factors such as universality, imparting of information and installation of hope, as suggested by Yallom (1995), developing eating-related psychotherapy groups may give permission to those who recognise eating distress and wish for individual therapy.

Reflexivity: Implication for clinical practice

Conducting this research has highly influenced my clinical work and enhanced my appreciation of the importance of contributing to social justice issues in the counselling profession. I was aware that I was attending more frequently to people's relationship to help and thinking of the ways in which I was affecting the helping relationship. I hope that I am taking my clinical and ethical responsibility seriously by considering how I may be unintentionally reinforcing negative experiences of seeking treatment for psychological distress (O'Neill, 2005).

I do this from initial consultation and assessment through to the end of treatment. For example, I take disordered eating concerns seriously and I attend to environmental factors that contribute to people's experiences. I realise that I am able to do more of this because of the context that I am working in which is informed by a systemic and integrative framework for psychological distress. As suggested in this research investigation, we are all responsible for enabling people to have "therapeutic conversation" about disordered eating experiences. I hope that readers reviewing this research project have a similar attitude.

5.12 Limitations and suggestions for future research

Analysis was based on the narratives of sufferers' experiences, and at best, the findings represent the reconstructed actions and mental processes of the phenomenon under investigation. As Hussein and colleagues (2014) suggest, the end product of a grounded theory is its systemic replication requiring confirmatory evidence to support findings. Therefore, finding a "fit" between narratives would be confined to this research and not necessarily applicable to other contexts because there was no further testing of initial findings. However, Corbin and Strauss (1990, p. 15) write that "no theory that deals with social psychological phenomena is actually reproducible". Further testing would be useful to develop a robust theory with new insights to adapt existing theory and to reconceptualise the phenomenon of people's experiences of disordered eating and seeking treatment.

It can be argued that the framework aimed at professionals is flawed because it does not include perspectives of healthcare professionals working with people struggling with experiences of disordered eating. However, it was a purposeful exclusion in order to give voice to sufferers' experiences and explore an under-researched area. The development of theory does not claim an objective truth but rather aims to provide an explanation of how disordered eating is experienced and decisions to seek treatment in relation to the actions of those who contributed to it. It is acknowledged that the findings pertain to the experiences of the people participating in this research but would lend itself to further investigation. Future research exploring experiences of healthcare professionals working with clients presenting with eating distress could develop insight into the constructs identified. The current study offered limited scope to explore the individual experience and another methodology may offer new knowledge. Given the broad and exploratory nature of this research inquiry, there is scope to explore each component of the model. It may be of interest to researchers to unpack the meaning of help-seeking to develop literature in this area and to ask what people want or would consider helpful support. Implication for this Grounded Theory can be considered by using different methods of data collection and including clinicians' perspectives across different contexts for triangulation (Cohen & Manion, 2000). Nevertheless, the process between participants' telling their story and the researcher's efforts to select and construct meaning from the narratives was considered a privilege and as such has implications for the knowledge it can offer (Willig, 2012).

Reconsidering 'epistemological reflexivity'

I have tried to demonstrate personal reflexivity by considering the ways in which my own experiences, beliefs, values and identity have shaped this research investigation. I also consider the ways in which this research has had an impact on my clinical practice and as a researcher. According to Willig (2008), epistemological reflexivity broadly examines the research process and considers how the research questions may have defined or limited what could be "found", and how constructivist grounded theory methodology "constructed" the data and findings of this research project. Engaging in epistemological reflexivity helped me think about the assumptions I have made in the research process.

As O'Neill (2005) writes, our view of problems influences the way we approach and study them. I acknowledge that much of the research and psychological models of disordered eating presented within the critical literature review and introduction to the research project was informed by medical models of mental illness in relation to where problems are located. I realise that this influenced the way I was approaching this research in the early stages. For example, one of the research questions asked within my research proposal was certainly informed by my existing knowledge but also the kind of research that I was engaging in which perhaps limited the scope and aims of the literature review. I wonder if participant narratives and experiences of the interview process would have been significantly different if interview questions were less structured, and did not assume that disordered eating was a management strategy for emotional states…

Reconsidering 'epistemological reflexivity' continued

... Furthermore, if research questions were guided by the participant narratives rather than trying to fit experiences by generating interview questions from existing knowledge, perhaps this would have given rise to a different understanding of the phenomenon under investigation. It is possible that it would have influenced how I made sense of participant narratives. In writing up the results and discussion, I realise that I also neglect to present alternative perspectives on eating disorders and relevant psychological theories that would have introduced and guided the reader towards a more balanced and integrated conceptualisation of emotional processes within disordered eating literature.

5.13 Locating disordered eating, mental health and treatment within the current context

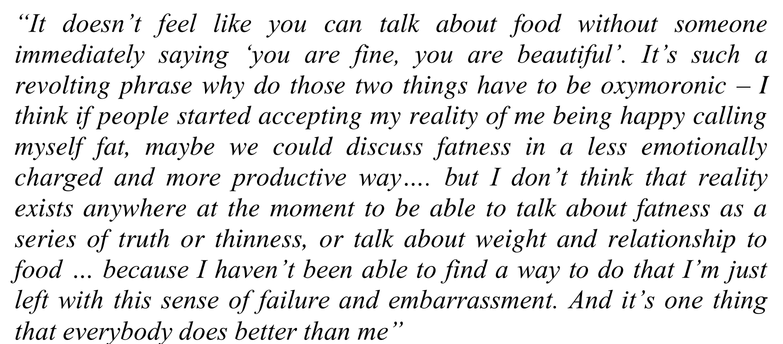
Reflecting on the completed Grounded Theory, the impact of its findings and avenues for future research explored above, it is important to consider the counselling profession, and the organisational, societal, and financial contexts within which this inquiry falls. Given the increasing prevalence and nature of eating disorders attracting concern, it would not only impact the types of research that might be conducted moving forward, but also the future general and specialist support and provisions made available. In 2014, the Government announced additional funding for provision of services for young people with eating disorders (NHS England, 2019). More recently, the UK, Royal College of Psychiatry (2019, p. 8) published a position statement in relation to early intervention for eating disorders urging that specialist services "should not deny people with eating disorders access to treatment based on arbitrary severity criteria … this is dangerous and demoralising for patients and is not in keeping with early prevention model".

The need for counsellors to incorporate social justice perspective in advocating and understanding the broader context within which disordered eating occurs becomes more relevant (Fouad et al., 2006). This would include acknowledging that the medical model contributes to the stigma associated with mental distress (Brackon &Thomas, 2010). As Wilkinson (1997) contends, it assumes that the problems people encounter are internal, and that any change would need to reside within the client. This internal focus on psychological distress according to Prilletensky (1994) is further reinforced by the dominant theory and treatment that focuses on thoughts, feelings and behaviours, with little attention to the social context (Young, 2011). As Prilletensky (1994) argues, it maintains the status quo and fails to meet client needs in supporting long term changes. In line with Szasz's (1972; 2010) writings, by attempting to use medical language to frame psychological distress we end up "fitting" people and problems into a framework that does not reflect their experiences.

Within the current field of mental health service provision, increasing access to psychological services is one of the strategies prioritised to meet the mental health needs of service users. As such, the likelihood

of people struggling with eating-related distress being seen within this setting will increase. In addition to exploring disordered eating among a non-clinical population, it will be important for researchers to explore both clients' and counsellors' experiences to identify gaps when meeting the needs of people struggling with disordered eating. However, from a financial perspective interventions offered within primary mental health settings are based on guidelines that deem what is "appropriate", and where meeting targets equates to funding for the services offered. However, for counsellors to challenge this system may mean not meeting targets and potentially risking employment, perhaps making them hesitant to work with problems that are not related to the presenting anxiety and depression.

5.14 Food for thought



So to conclude, what key messages would the researcher like the reader to take from this Grounded Theory inquiry? Concerns for body image and weight are not necessarily disordered but rather looking at disordered eating as a phenomenological experience would be helpful. Overall it would seem that whether or not a person recognises the eating distress, it is important for all of us to find a way to talk about disordered eating because we will undoubtedly come across people with concerns for body image and weight who are also trapped in a conflicting relationship with food, and struggle with disordered eating where 'symptoms' are a way of managing problems in life and provide a way of expressing anxiety, depression, low self-esteem and shame.

As summarised beautifully by Rose in the quote above, talking with each other and listening to people's stories in all contexts would be therapeutic. As therapists, we can empathise with our clients' experiences but we can never know what their experiences are like for them. However: (i) asking about a person's lifestyle of eating creates an opportunity for exploration; (ii) explicitly talking about disordered eating, raising awareness and giving accurate information is important and (iii) acknowledging the broader context in which disordered eating occurs would create the opportunity for people to share experiences and lessen the stigma, and hopefully support the needs of the clients that we work with who are struggling with disordered eating experiences

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Appendices

Appendix 1: Ethics Certificate London Metropolitan University

London Metropolitan University
School of Social Sciences
Research Ethics Review Panel

I can confirm that the following project has received ethical approval by one anonymous reviewer and the Head of School of Social Sciences Ms. J. Skinner to proceed with the following research project:

Title:	A grounded theory exploration of emotional processes in disordered eating among a non-clinical sample
Student:	Zarah Shariff
Supervisor:	Dr Athanasiadou-Lewis

Ethical clearance to proceed has been granted providing that the study follows the ethical guidelines used by the School of Psychology and British Psychological Society, and incorporates any relevant changes required by the Research Ethics Review Panel. All participating organisations should provide formal consent allowing the student to collect data from their staff.

The researcher is also responsible for conducting the research in an ethically acceptable way, and should inform the ethics panel if there are any substantive changes to the project that could affect its ethical dimensions, and re-submit the proposal if it is deemed necessary.

Signed: Date: 21 February 2017

Prof Dr Chris Lange-Küttner
(Chair - Psychology Research Ethics Review Panel)

Email c.langekuettner@londonmet.ac.uk

Appendix 2: Introductory Email to Organisations to Advertise

Address details
Date

Dear (name of manager)

Re: Research exploring the relationship between emotions and eating patterns
Emotional processes in disordered eating

I am a trainee Counselling Psychologist studying at London Metropolitan University. I am researching the experiences of people who do not have a formal eating disorder but struggle with their relationship with food and I was hoping to recruit participants from your [oraganisation]. The research will form part of my Doctoral thesis.

The aim of this research is to explore how people use food to manage emotions and to determine factors or barriers to accessing services. I am offering a £20 amazon voucher to participants. I enclose a participant information sheet which explains the study further. I also enclose a research poster which I hope can be advertised at your premises. If possible, in communal as well as private areas.

Yours sincerely,

Zahra Shariff
Trainee Counselling Psychologist

Department of Psychology
London Metropolitan University
Faculty of Life Sciences and Computing
166-220 Holloway Road
London N7 8DB

Appendix 3: Research Poster

PARTICIPANTS NEEDED FOR RESEARCH

DO YOU STRUGGLE WITH YOUR RELATIONSHIP WITH FOOD?

THIS STUDY IS INTERESTED IN THE EXPERIENCES OF MEN AND WOMEN.
IT IS INTERESTED IN HOW PEOPLE USE FOOD TO MANAGE EMOTIONS.

My name is Zahra Shariff and I am a trainee Counselling Psychologist. I am looking for people who do not have a formal diagnosis of an eating disorder to take part in a 60 - 90 minute interview exploring their emotional processes and relationship with food.
The study aims to gain insight into emotional processes of eating and to understand factors that influence help-seeking behaviours.

This study is part of the requiremnt towards a Professional Doctorate in Counselling Psychology at London Metropolitan University. It is supervised by Dr. Catherine Athanasiadou-Lewis. This study has received ethics clearance through London Metropolitan University, Psychology Department Research Ethics Committee.

All information will be kept confidential.

If you are interested in taking part or would like more information, please contact me on either:

ZAS0277@my.londonmet.ac.uk

or

07508 138644

Appendix 4: Information Sheet

Emotional processes in disordered eating

My name is Zahra Shariff and I am a Trainee Counselling Psychologist at London Metropolitan University. I am carrying out this study as part of a Doctoral qualification in Counselling Psychology. The research is being supervised by Dr. Catherine Athanasiadou-Lewis (senior Lecturer and Counselling Psychologist at London Metropolitan University).

Before you decide whether you would like to give consent to take part, please take the time to read the following information, which I have written in order to help you understand why the research is being carried out and what it will involve.

Please take the time to read the following information carefully and feel free to ask if there is anything that you do not understand.

What is the purpose of the research?

The study aims to gain an understanding of emotional processes in disordered eating and to identify factors involved, if any in accessing primary (or other) services in the United Kingdom. The study is interested in the experiences of those who do not have a formal diagnosis of an eating disorder but engage in disordered eating patterns. Disordered eating can be, but is not limited to overeating or restricting behaviours. It is hoped that findings of this study will enhance clinicians understanding of the problem and possibly inform service provision.

Do I have to take part?

Participation is voluntary, and even after agreeing to do so you may change your mind at any point without question. If you do choose to take part but later decide you do not wish for your information to be part of the study you may withdraw. You can contact the researcher at any point and ask to withdraw up to one month after the interview is conducted.

What is involved?

If you decide that you would like to take part, then please contact me using the details below. You can for some more information about the research after which you will have time to think about, or we can arrange a time and a place to meet to answer any questions.

If you are still happy to continue, we will agree on a convenient date, location and time to meet. The interview can be conducted in a private room at London Metropolitan University in Holloway Road. I will ask you to sign a consent form to agree to take part in this research. The interview will last approximately one hour to one and half hours. During this time we will discuss your relationship with food, your current and past experiences and your emotional life. The interview will be audio-recorded. I may take notes during the interview as prompts for myself.

After the interview, you will have an opportunity to discuss the interview and ask any questions you may have. You will be provided with a debrief sheet which outlines further information about the research and further support.

What will happen to this information?

The recording of the interview will be typed out so the information could be looked at in detail. The aim of this is to discover common themes that are important in understanding the experiences we have discussed. Both the recording and transcripts will be made anonymous and kept separately in a locked cabinet.

Anonymised sections of the interview will be looked at by my supervisor and other trainee counselling psychologists at London Metropolitan University, who are also bound by the ethical principles of confidentiality.

Will my taking part in this study be kept confidential?

Your name will not be used in connection with the results in any way. You will be given a pseudonym and all identifiable information will be anonymised. All information you provide will be used for this study only and responses will be made confidential unless there is evidence of risk to you or someone else. All data will be destroyed at the end of this study.

What are the possible disadvantages and risks of taking part?

It is possible that the research interview will bring up topics that you find distressing to talk about. You do not have to answer all questions and you can ask the interview to be stopped at any time without giving an explanation. It is important that you make the researcher aware of any discomfort you experience if at all possible.

If you feel distressed during the interview, the researcher may offer a break or alternatively ask if you wish to finish the interview at that point. You will be offered the opportunity to briefly discuss any issues that came up and you will be given details of any relevant services.

What are the potential benefits of taking part?

The study aims to give voice to people who struggle with their relationship with food. This will contribute to our knowledge and support people with eating-related concerns. It is hoped that findings will allow commissioners and practitioners to consider factors and barriers to seeking help. The interview process could also give you an opportunity to explore your own feelings and thoughts about your relationship to food.

What if I am unhappy or if there is a problem?

If you are unhappy, or if there is a problem please feel free to let us know by contacting Dr. Catherine Athanasiadou-Lewis (details below). If you remain unhappy or have a complaint which you feel you cannot come to us with then you should contact the Complaint Handler for the Faculty of Life Sciences and Computing Peter Chalk, Associate Dean on p.chalk@londonmet.ac.uk. Please provide details of the name or description of the study (so that it can be identified), the researchers involved, and the details of the complaint that you wish to make.

Contact details

Please contact the project researcher Zahra Shariff for further information and any questions you may have. If you would be interested in taking part, please complete the consent form.

Project researcher	Research supervisor
Name: Zahra Shariff	Name: Dr. Catherine Athanasiadou-Lewis
Telephone: 0750 813 XXXX	Telephone: 0207 133 XXXX

Thank you for taking the time to read this information sheet

Appendix 5: Consent Form

Emotional processes in disordered eating

Title: An exploration of emotional processes in disordered eating among a nonclinical sample.

Researcher: Zahra Shariff, Trainee Counselling Psychologist

Description of procedure: In this research you will be asked a number of questions regarding your eating patterns and emotional experiences using an audio recorded interview.

- ❏ I confirm that I have read and understand the information sheet. I have had the opportunity to consider the information and if needed ask questions that were satisfactory answered.
- ❏ I understand that participation is voluntary. I am free to withdraw at any point up to one month after my interview is conducted and that this would not result in being disadvantaged in any way.
- ❏ I understand that any information I provide is confidential. All information that may otherwise identify me or anyone else will be anonymised prior to transcription. I understand that confidentiality may be breached if any information that is disclosed indicates a risk to safety to myself or others.
- ❏ I give consent to the audio-taping and transcription of the interview, and the use of direct quotes in the write-up of the study (which I understand will be anonymised). I also understand that the results of the study will be accessible to others when completed.
- ❏ I understand that all data will be stored separately in a locked cabinet in accordance with the Data Protection Act (1998).
- ❏ I understand that I may find this interview upsetting and that it may evoke difficult and distressing feelings for me. I will be offered support and the opportunity to discuss these feelings after the interview with the researcher. The researcher will also give information on additional support.
- ❏ I understand that I have the right to obtain information about the findings of the study and details of how to obtain this information will be given in the debrief sheet.
- ❏ I understand that the data will be destroyed once the study has been completed.

Signature of participant: _______________ Signature of researcher: ___________________

Print name: _________________________ Print name: ____________________________

Date:______________________________ Date: _________________________________

Appendix 6: Interview Questions

This includes a list of initial semi-structured interview questions with prompts used to facilitate conversation and includes later interview questions introduced following theoretical sampling:

Opening questions:

Are there any questions you would like to ask before we begin?

What interested you in taking part in the study?

Main body:

1: Tell me about your relationship with food

- How do you make sense of it? [Are there any patterns?]
- How does it have an impact on your life?
- How, it at all, has it changed over time?
- When, if at all, did you first notice that it was a problem?
  - What was going on in your life then?
  - What, if anything, did you know about ----?
  - What was it like?
  - What did you think? How did you feel? What did you do?
  - How if at all, have your thoughts and feelings about this problem (or experience) changed since ----?

2: How do you manage your emotions through your eating patterns?

- What helps you to manage ----? What problems might you encounter? Tell me the sources of these problems?
- How do your eating patterns change?
  - How would they change as a way of expressing or avoiding your emotions?
- How do you feel emotionally when your eating patterns change?
- Describe a typical day for you when you are feeling ----?
  - [ask about different emotional states if participants are speaking more generally]
  - [probe for different emotional states and different times of the day]

3: A social justice perspective on disordered eating

- What do you understand by the term disordered eating? How would you define it?
- Do you feel this is different to how other people may define it? – if so how?
- What are your views about people with disordered eating?
- In your view, what has led you to struggle with disordered eating?
  - Ask about early and current experiences and include their current context

4: Help-seeking behaviours

1. Growing up who would you go to when you are distressed or hurt? How it was dealt with? What person? [being curious about early relationships]
2. How, if at all, have your thoughts and feelings about your relationship to food changed?
3. Do you talk to anyone about your eating? [Friends, family, professionals or organisations]
    - Who? When? Why?
    - If sought professional help: Who, if anyone, was involved in this decision?
        - What contributed to this decision [ask about other people, systems as well as personal factors that may have influenced this decision)
        - How have [they] been helpful [or unhelpful]?
    - If have no sought professional help, why not?
        - What stops you from doing this? [Probe for intrinsic motivation to seeking help]

Closing questions:

Is there anything else you think I should know to understand your relationship to food?

After having these experiences, what advice would you give to someone who is struggling with their relationship to food?

Is there anything you would like to ask me?

Later interview questions generated due to theoretical sampling:

1. Can you tell me what tended to happen when you felt hurt or distressed growing up?
2. How do you cope with problems in your life?
3. What are your thoughts on the impact of the context of diagnosis on your experiences/decisions to seek treatment?
4. Can you tell me any time when disordered eating wasn't a problem for you?
5. What would be different if the problem was not there? Who would notice if the problem was not there? What would they/you see/not see? What would be different or the same?
6. Who else have you spoken to in relation to your experiences?
7. What have you thought about what you said you will do? (e.g. speaking to your counsellor, looking for information, sharing experiences with others, seeking treatment).
8. What do you think it would take for you to seriously consider seeking treatment?

Appendix 7: Debrief Sheet

Emotional processes in disordered eating

Title: An exploration of emotional processes in disordered eating among a non-clinical sample.

Purpose: The interview you have given will be transcribed and analysed and used as part of the researcher's doctoral research. The purpose of the study is to gain insight into how people use food to manage emotions and to understand the contributing factors to accessing services for eating-related concerns. Your personal experience is valuable and by sharing it you have contributed towards the study, which will further our knowledge of disordered eating and potentials factors behind it. This could further improve in the way that we work with clients in therapy in addressing these issues.

Confidentiality: The information you have provided will be used for this study only. The recording will be transcribed and analysed and will be used for doctoral thesis write up and possible publication of the research. Any information provided is confidential, and no information that could lead to the identification of any persons will be disclosed in any reports of the study or to any other party or organisation. No identifiable information will be published.

Contact: Please feel free to get in contact with me should you have any questions or concerns about the study. If you wish to withdraw from the research, please contact me within one month of your interview. If you said you were happy to be contacted again after this interview you may be contacted again for clarification or be invited for a second interview. I can be contacted on: 07508138644 or ZAS0277@my.londonmet.ac.uk. Emails will be checked regularly.

Further support: If you feel you need further support around your eating, you can contact your GP or the following organisations:

Beat

National eating disorder charity

Information and support for eating disorder

Phone: 0845 632 1414 / Website: www.b-eat.co.uk

The Samaritans

Free 24 hour helpline service

Confidential support for people experiencing feelings of distress

Freephone: 116 123 within UK and Ireland / Website: www.samaritans.org

Counselling Directory

Pay for service

List of accredited counsellors or psychotherapist for psychological support

Website: www.counselling-directory.org.uk

Complaints

If you have a complaint regarding your participation, please contact the researcher Zahra Shariff or the research supervisor Catherine at London Metropolitan University on 0207 133 2669 or email on x.athanasiadoulewis@londonmet.ac.uk. If you have a complaint which you feel you cannot come to us with then you need to contact Complaint Handler for the Faculty of Life Sciences and Computing Peter Chalk, Associate Dean on p.chalk@londonmet.ac.uk, and inform them the name of the project is "Emotional processes in disordered eating".

Appendix 8: Distress Protocol

This protocol has been devised to deal with the possibility that some participants may become agitated and/or distressed during their involvement in the research into emotional processes and disordered eating. The principle researcher (Zahra Shariff) is a trainee counselling psychologist, and so has experience in monitoring and managing situations where distress may occur. It is not anticipated that extreme distress will occur, nor that the actions described below will be necessary. This is because the study excludes people with a formal eating disorder diagnosis, who would be considered vulnerable. Participants would also be reminded that they could stop the interview at any time or choose not to answer questions they did not want to. However, researchers will follow the three step protocol, detailing signs of distress to look out for and actions to take at each stage (Cocking, 2008).

This was adapted from Cocking (2008), distress and risk management protocol.

Mild distress:

Signs to look out for:

- Tearfulness
- Voice becomes choked with emotion/difficulty speaking
- Participants become distracted/restless

Actions to take:

- Ask participants if they wish to continue
- Offer a break from the interview, if needed
- Offer them time to pause and compose themselves
- Remind them that they can stop at any time they wish if they become too distressed

Severe distress:

Signs to look out for:

- Uncontrolled crying/wailing, inability to talk coherently
- Panic attack – e.g. hyperventilation, shaking, fear of impending heart attack

Actions to take:

- The researcher will intervene to terminate the interview
- The researcher will acknowledge and validate the participant's distress
- If appropriate, relaxation techniques will be suggested to regulate breathing to reduce agitation
- Debriefing will begin
- If any major issues arise during the interview, accept and validate their distress, but suggest that they discuss with medical professionals and remind participants that research is not designed as a therapeutic intervention
- Details of psychological and mental health services available will be provided to participants

Extreme distress:

Signs to look out for:

- Severe agitation and possible verbal or physical aggression

Actions to take:

- Maintain safety of participant and researcher
- If the researcher has concerns for the safety of the participant or others, she will ask participants to approach the GP and offer them information for other sources of support

Appendix 9: Sample of interview memos

Memos were handwritten in a notebook after completing each interview. I also noted initial thoughts on a post-it note in the process of transcribing the interview.

<u>Interview 1 - Adam</u>
Post interview conversation – interest in psychology of eating and positive psychology. Working towards publication of research. Did this affect how he was relating to me as a fellow researcher and student in psychology?
Medical doctor perspective – context of NHS and private cosmetic surgery, from patient experiences
Function of eating – achievement from restricting food intake
Patterns of eating – then and now, similarities and differences
Quality of the interview – my style and my position in trying to match experiences to existing knowledge, exploration of specific patterns, triggers and function may have limited the conversation
Examples used - socioeconomic status, poverty and diet affecting types of food
Relationship to the problem and position in relation to the problem
"macho" mentality of medical training – what is the significance of professional background?
"managing overeating"

<u>Interview 2 – Jane</u>
I felt that the quality of this interview was not good. I noticed that the stories being told were about pressures and media influence and role of dieting. It was difficult to focus on the questions about experiences
Generalising and blaming – I noticed that I was switching off at times. Jane was losing track of the conversation, but I was also losing track – parallel process? Is it significant? Advocating for "fat movements"
Attending to the relational style – talking too much or too little, what is the focus or direction of the stories?
Mismatch between who we are and what we want to be (ideal and real self?)
<u>Key Themes:</u>
Placing problems within the person – linked to confidence and low self-esteem
Parental mental health and early experiences
Narratives about societal pressures – blaming position
Disordered eating and stigma, reference to DSM-5 and new diagnostic category.

<u>Interview 3 - Cindy</u>
This was the first interview conducted in the home – showed me what she was eating. Significance of this – highlighting the level of distress?
Pervasiveness of the distress, and linked to experiences in life e.g. becoming a single parent. The relevance of context adding meaning.
Identified concepts of oppression, suppression? And restriction in relation to eating patterns
Circularity of the problem – vicious cycle
Psychological awareness of distress
Witnessed interaction between Cindy and her mother, and conversation about disordered eating. Link to parental disordered eating

<u>Key Themes:</u>
Function of disordered eating
Wanting to "fit" a diagnosis
Drawing comparisons (then and now, in relation to me, and her mother)
Disordered eating as a social construct – definitions, talking to others about it, expert versus non expert therapist
Relationship to help – seeking counselling and dismissing counsellor

<u>Interview 4 - Peter</u>
Link to eating disorder symptomology – similarities and differences

Accessing counselling – context of low mood and loneliness
Responsibility element – dismissing, minimising, denying
Selective eating disorder? – Physiological responses to food, preoccupation with weight and fear of fatness as indicators of eating disorder?
Relating to painful experiences
The role of the counsellor
I noticed that I was being pulled in different directions, and I was confused at times in the narratives communicated.
I was impressed by his realisation that his eating patterns are "symptom of something else"
Invitation for a follow up interview?
Change in definitions of disordered eating

Key themes:
The role of the helper – how was I being positioned in the interview process
Attraction to taking part in the research
Disordered eating on spectrum
Level of distress – experiencing shame, anxiety, low mood and hopelessness
Shift in position – how is this connected to decisions to seek help (or not)

Interview 6 – Rose
Another interview conducted in participant home. I was privy to information that I would not have had access to otherwise e.g. home environment. Disclosures about intentions of eating donuts after the interview – function of this?
The after the tape moments – and conversation about social context and impact
Intriguing reflexivity and openness about her narrative, requesting signposting information, disclosures
Confronted again with the reality that participants were also responding to me and elements of my identity in the interview process. In this case, explicitly asked about my relationship to food and the topic.
NHS context and private healthcare
Diagnosis and mental health – reference to diagnosis of borderline personality disorder. How is this related or not related to eating patterns – as function of communication of needs? Who is reacting to the weight? And what are people responding to? The weight or the psychological distress, is there a difference and should it matter?
Admitting costs of talking about experiences – and reference to previous psychiatric care.

Interview 8 - Samantha
Perspective of a person with historic diagnosis of an eating disorder – own reasons for participating
Interesting response on reflecting on her relationship to help – change in attitudes over time, linked to responsibility and working hard to manage experiences.
Reflexive capacity
Affordability of treatment – NHS versus feeling "lucky" to have been able to access support privately
Indicated the problem with defining disordered eating in terms of symptoms and behaviours, what happens when behaviours or subjective experiences do not match?

Appendix 10: Transcript extract: a worked examples of data analysis

This appendix presented a worked example of an interview transcript analysis. It contains a step-by-step overview of how the researcher moved from the raw data through to the phases of coding and creation of categories. I focused on analysing actions and processes rather than themes and prioritising construction of theory rather than application of existing theory.

Step1: Interviews transcribed from audio-files onto Microsoft Word.

Step 2: Initial line-by-line coding were applied to each printed interview transcripts.

Step 3: Relationships between initial codes were explored and most significant and frequent occurring initial codes became focused codes.

Step 4: Further exploration of the relationships between focused codes led to those focused codes with explanatory properties to hold category status. Categories were found to be connected, with subcategories identified.

Step 5: The core categories and central categories were identified and the sub categories were organised in a table. Sections of the interview narratives supporting each category were selected. This led to the generation of a cohesive Grounded Theory supported by direct quotations taken from participant narratives.

The pages that follow show a worked example, edited to show the steps above.

Rose – Interview 6

Initial line by line coding | Focused codes and categories

Participant - 6 Rose
Reflections: at the home, bought me food and went shopping. Projection. Knowing participant, colleague at one point. Apologetic. Before starting interview – asking about the number of interviewees so far (feeding to trying to please?)
Shame; Sexual survivor abuse; internalized shame
Theoretical sampling- interview again, questions about diagnosis? Whether sort help and what happened after the conversation?

Interviewer: Are there any questions you would like to ask me before we begin?
Participant: How many participants are in the study? How many participants have you spoken to?
Interviewer: So far I have spoken to six people and because of the method and the type of study I may need to speak to a few more people. And as a mentioned earlier, all data will be annonymised after our conversation today – so this includes if you mentioned any names or locations in the course of the interview. The recorder is password protected.
Participant: Yeah. I think I'll just be interested to hear about other people. One of the reasons I wanted to be involved in this is I think its probably a very widespread problem and I think it will be really interesting to just read – obviously it's a tiny source of data that you are coming at, like a very limited, a few people but it will be very interesting to read about if there are universal Reponses.
Interviewer: So that follow on to what interested you specifically in taking part in the study?
Participant: So I... um... I think ... I am just so specifically – my life journey has been so interestingly connected to what your study is about. I am somebody that was at one point in my life had a BMI of 42 and half, um I am now, have got a BMI of about 26ish, 27. And very lucky and tat took extreme medical measures and I am also somebody that's been sectioned four times and um, I don't, I don't know whether or not those two things were connected – I don't think they cant be, that's a really terrible, clumsy double negative. But I am not sure how they were never addressed. I have spoken at length with my family about this, thy accurately recall me saying to them "stop taking my food away or I'm going to kill myself" – like really violent aggressive—this is—my mum once said to me "this is how kids get anorexia because bitch mums like you, take away our food and make use self conscious about our weight!" and so it's like, it was an absolute no go discussion that I, I set that boundary for my limit but also it wasn't the fact that I refused to talk about it and that my response was to it was so violent that it was indicative of that in itself it was a massive problem. So, so yeah I'm really interested in sort of the dual diagnosis and cross diagnosis of eating disorders and other mental health diagnosis – I think its fascinating and I'm not sure I have an answer as to how useful it is to separate those things or to link them but I definitely feel like that I personally could have done with some intervention with food-related specifically like food-specific mental health problems that I was having. O yeah, that's why because of my personal experience.
Interviewer: Tell me a little bit about your relationship with food?
Participant: oh... it's terrible. I mean I'm well enough now for the most part – touch wood [*laughs*] I can objectively say my relationship with food is terrible. That um its something, there are turns of phrases that are now so commonly used that they've lost the essence and power of their original meaning. So like we talk about 'emotional eating' now and most people just think about stuff that we see in rom coms – when people are a bit hormonal and they just chow through a pack of biscuits that one day, from

Initial line by line coding	Focused codes and categories

that one month or something. Um, I... think that mines a very extreme force of that – I think mine was very much tied in with self abuse and self neglect... I think that food is still those things, not being in that I don't feed myself but that I am so deep in m'self loathing that I will, or unable to cook for myself. But sometimes it wasn't safe for me to cook in kitchens – there are dangerous places and psychosis and BPD meant that impulse control was a really massive issue for me. So being around flames and knives was simply not safe – I also didn't care enough about my life so I, I think one of the reasons that I got so obese was that I didn't think that I was going to live for the next six days, six months, let alone six years so why did it matter what %$$% size I was- sorry excuse my language, I didn't meant to swear [*laughs*] and um so I um, my relationship with food was that bad, now I work really hard to be better, but I still secretly eat by myself all the time. I have a very almost Freudian oral fixation, like I feel actually anxious when I'm not, when there's not a snack next to me. Its really weird, its become much more profoundly dangerous I think in the fact that I – like today its snowing right, if you, if my electricity key ran out, I would sit in the dark for the rest of the night rather than go out in the snow, if I knew that I didn't have no just some dinner, but something for after dinner and something for after that just in case and then maybe just something for even after for just, just in case – I would walk for a mile in that snow to make sure that I had sugar specific but like sugary carb-ary disgusting food to hide in my room. I don't even typically hide them in the cupboard – when, because you were here when I arrived with my groceries, I was really self conscious about getting them out in the cupboard – because I bought like five jam donuts which I know that I am going to eat, by myself tonight, in hiding and I still do that despite the fact that I've had very extreme medical intervention to control my eating – that's a very long winded way of saying my relationship with food is bad. And that even with the medical interventions, they never ever go to the root of that--

Interviewer: Have you noticed any patterns to it?

Participant: I think that it's a really good canary in the mind shaft for me to see that I'm getting really ill again. So when I—it's like never good but I know I'm having a really good time, or that I am doing well when I am buying fresh produce and cooking for myself. It does—that addition and replacement of ready meals and take away so say that's the bit that alters and I can tell when I'm doing much better mentally when I'm um, when I'm buying fresh produce, when I feel safe to be in the kitchen and I'm interested in cooking *for* people and I'm *with* people because I like communally and that's really nice – so for me its not like I notice so much patterns but it is a really good indicator of how honestly well I am doing. Um... I feel like I notice the food before I notice something else going on in life. Like you know how some people get lack of sleep because they are stressed, ill notice that I've not come out of my room to eat with other people because I've been hiding and eating just like really, really negative eating habits for a while and that I wont have noticed it because we can wrap it up in some kind of bow that it's "me self caring" and that "I'm hibernating, and I'm cozy" or whatever it is but actually more dangerous and insidious that that and it takes me seeing that to be like "oh maybe stuff isn't okay"

Interviewer: And how does this impact on your life – more generally?

Participant: um... I'm broke and I buy I million miles, food is my biggest expense and I'm not somebody that lives particularly um carefully in any area of my life. Um I'm not wealthy by any stretch but I spend probably $20-30 of food per day because I eat all this secret fast food crap and I'm constantly storing it like a squirrel in winter. And um... because I eat so much takeaway and readily available fast food crap, it's all really expensive

Contextualising ones disorder

Disordered eating over time, difference between then and now in terms of severity

Context of diagnosis influencing relationship to food

Individual and contextual factors

Adding Context of Diagnosis and mental health to make sense of experiences

Managing overeating

2

Initial line by line coding | Focused codes and categories

so it massively impacts on that, on my money. It probably isolates me a lot from other people because as I said I eat it in secret a lot. Um... its such a circular problem as all self-abuses in terms of my mental health because the shame and frustration I feel at the fact that I am in my mid 30s and this is something I still haven't got a handle on even with—is this something I am always going to do? Is this—to be so self-aware about it and not be able to stop the behavior. I know exactly what it is, I see exactly why I do it and to not be able to stop doing it – there's something so much more shameful in that than just the behavior – like the shame in knowing that I am not stopping.

Interviewer: And what would you say happens during this process?

Participant: mm... the scary thing is that I now know – its not even a measured amount but I know when I eat so much that I start to feel sick, or start to feel painfully, excruciately, painfully full or that I might even be sick, I mean I'm very—I'm not sick anymore but like even if I was that, that wouldn't stop me eating—that I'd know I'd just have to slow my pace down for a bit until the pain stops and then I can increase my pain again. That sensation or um—yeah that sensation of full is just absolutely absent from me and um its just simply the case of the speed in which I put things in my mouth and when it hurts I slow down – don't stop – slow down and when it doesn't hurt, I speed up again. And that um sometimes to the point that I'm literately, I have to take off m underwear because it means that I can get more food inside me and that um I'll sit here with my jeans unbuttoned, my bra off and um, like I'm physically hot and that I've got palpations because of eating too much – and that's a regular occurrence, that's how much that I eat. And its so hard talking about this because I've literature never had this conversation before and um, it and that is really, really frustrating because I have been in the mental heath system for 20 yeas and I've never had this conversation [*becomes tearful*] – I mean there's something wrong with that. That I- that they were—that everything else was so important, and I get that, that life—more immediately life-threatening behaviors that have to take precedence but why has this conversation never come up! That's what so frustrating.

Interviewer: and what was your experience of that – you mentioned that you had the medical intervention – what happened and what led to that?

Participant: Well um—I have arthritis in my right knee and um... I also developed sleep apnea and I had a GP – she was like a trainee or something, one of those that were doing a 6 month rotation at the surgery – when I happened to be one of the first patient she saw, when she arrived there and I'd come in to her in a really bad mental health episode and so she asked me to come back every week to see her to have like my meds adjusted and to check in on how, how I was doing. I think she was one of those GPs who was still optimistic and energetic before the NHS you know destroys your enthusiasm, happiness and energy, you overworks everybody. But she put in a lot of effort to me, and we became friends, hmm well as much as one can with a professional right, but it definitely crossed, it definitely crossed traditional very strict-like or steer conversational boundaries. So after a while, I say to her "I'm coming to see you every week anyway, I wanted to discuss my knee" and she was like "okay" and she goes and sends me to a specialist and results come back. And I don't know how it came up, but for some reason in the same appointment get results from her that I have got arthritis in my knee and that I've got sleep apnea and she said to me "you did that" and it was so bold and if it had been another human being in my life or any other professional, I would have probably punched her in the face but she went "you did that, that's all on you. That is because you ate too much. Both of those conditions, you might die in your sleep and that is because you ate

Experiencing shame and anxiety
Managing problems in life (Food as a comfortable buffer)
Communicating distress "Failing to get it right"

3

Reorganising quotes to include in the results section

As explained within the results section, to facilitate the flow of each quotation but also retaining the meaning, utterances, repetitions and researcher's responses intended to facilitate discussion were omitted. Below is an example of a part of the narrative in its original form and then reorganised for the inclusion in the results section:

Raw data

Peter: Well what interested me was the- I have got a strange relationship with food. I'm not sort of anorexic or obese and things like that but I've got…

Researcher: mmhm

Peter: I've got some issues about it which I'll discuss as we kind of go through about it. I have been aware about them but this actually gave me the prompt to actually think about. I go once a week to mind and I actually talked to the counsellor about it. I said I saw that and I told him I would like to investigate it"

Reorganised narrative

Peter: "I have got a strange relationship with food. I'm not anorexic or obese. I've got some issues about it which I'll discuss as we go through it. I have been aware but this actually gave me the prompt to actually think about. I go once a week to counselling and I talked to the counsellor about it. I said I saw that [research poster and I told him I would like to investigate it"

Appendix 11: Sample of database detailing line codes, focused code, subcategories and categories

Participants	Line Codes	Focused Codes	Subcategory	Category
Cindy, Samantha and Rose – narratives about early trauma Adam, Peter, Jane and Anna – examples of unmet needs and “lacking in emotional expression” (Cindy)	Disclosure of early trauma Parental mental health Witnessing abuse Bullying experiences Loss of control	Processing experiences Relating to painful early experiences	Disclosing early trauma, emotional neglect and bullying	Situating experiences in relation to trauma
All Rose: “shame for me is like a failure” Jane: “I feel rubbish about myself”	Identifying issues of low self-esteem issues, confidence and body image issues in relation to disordered eating	Locating disordered eating as a problems of willpower, low self-esteem and lack of control Positioning the self within the disorder	Beliefs about the self	
All Cindy: “turning to food” Jane: “[food] as an emotional crutch”	Identifying function of food (e.g. “increasing negative emotions”) Relational triggers	Communicating eating distress Compensating for relational needs	‘Disorder ‘as a communication	Managing problems in life
Rose: “all my destructive behaviours are related to interpersonal issues” Cindy, Jane, Anna and Samantha	Managing painful experiences with others Regulating emotions/distress	Coping with the distress (and anticipating threat) Turning to food management styles	Food as a comfortable buffer	
All adding context – with reference to different points of time Samantha: “I think I’ve experienced all forms of eating distress”	Becoming a single mother Identifying patterns, triggers and exacerbating factors Disordered eating over time	Adding context Development of disordered eating (longstanding disordered eating) Having too much or too little control	Then and now	Contextualising ones disorder
All – refer to formal eating	Referring to symptoms	Context of diagnosis, context	Individual, family and social context	

disorder diagnosis Peter, Jane, Anna, Mandy and Rose – comparisons with experiences	"fitting" symptoms to diagnosis "fitting" self within a diagnosis (drawing similarities and differences)	of time Narratives about "societal pressures" Context adding meaning Social constructions of disordered eating		
All report current eating distress, except Adam who was "managing overeating"	Adopting a disconnected stance Minimising the distress, glamorising eating patterns, denying eating distress Realising disordered eating as a current problem	Recognising the "eating distress" (versus uncertainty of experiences)	"as a symptom" life problems	
Rose: "value of keeping secrets" Adam: "macho" identity	"Learning to problem solve"	Distrusting of relationships Implication of disclosure Feeling unworthy of support	Impact of early trauma	Factors affecting help seeking
All Mandy - Problem is not "bad enough" to talk about Rose: others "reacting to the weight"	Fears of dismissal Feeling invalidated Reasons for non-help seeking – costs, time and commitment	Previous therapy experiences Not recognising the eating-related "distress" Diagnosis and mental health	Individual, external and contextual factors	
Cindy: "where do I go?"	Availability of services, meeting eligibility and accessing (and costs of accessing treatment privately)	Pathways to seeking support Influence of social processes of exclusion (and inclusion) Certainty of services (versus uncertainty of experiences)	Fallacy of help-seeking	
Mandy: "eating for nourishment" Adam: "talking to peers"	Success in losing weight	Building self-esteem, confidence	"managing overeating" (utilising own resources) (self-management strategies)	Meaning of help seeking

Cindy, Peter, Rose, Jane, Anna, Mandy and Samantha Current or historic experiences of seeking counselling	Partially disclosing experiences / sharing experiences Accessing support privately Going to the GP	Looking after wellbeing Assumptions about therapy	Seeking 'counselling'	
All participants shared positive research experiences e.g. Cindy: "having a therapeutic conversation" Imparting advice, sharing of knowledge	Identifying reasons for participation- add to knowledge, come to recognise, unsure, activating decisions to seek help	Benefits of research – generating alternative stories; context for seeking support	Contributing to research	
Mandy – viewed counselling as a "weakness" Samantha – change in attitude towards helping relationships	A shift in attitudes towards helping relationships	Relationship to the problem influencing help-seeking or non-help seeking Relating to others with hypervigilance	Ambivalence towards support	Processing attitudes towards helping relationships
Rose: "I'm not very good at accepting help … because of how far I went [to keep my] autonomy"	Protecting the eating Defending eating patterns Examining/reviewing the function of disordered eating	Inferring about costs to letting go of the problems	Negotiating costs to 'giving up' the 'disorder	

Appendix 12: Sample of memos on emerging categories

Focused Codes emerging after 5 interviews (05/07/2018)

- Adding context – life stressors, interpersonal relationships, early trauma
- Factors affecting decisions to seek help – previous therapy, attitudes towards support, early experiences
- Support system – what is helpful support? What is not helpful? Who helps? Who doesn't?
- Identifying function of behaviours
- Identifying triggers including problems in interpersonal relationships
- Positioning disordered eating within eating disorder terminology
- Drawing similarities/differences
- Barriers to seeking treatment
- Decisions to seek treatment
- Impact of early trauma – lack of emotional expression?
- Definitions of disordered eating – who's problem is it?
- Mental health, diagnosis and disordered eating
- Interview space – relational style, talking too much or too little.
- Interview space – relationship to the problem – skirting around the problem; minimising
- Interviewee reflexivity - level of insight, awareness and processing
- Interview space - Moving between positions/attitudes; 'like a counselling session'

Processes identified so far (01/08/2018)

- Locating problems within the person – e.g. lack of confidence, self-esteem issues
- Assuming resolution resides in the person – increase willpower, control and confidence
- Processing undisclosed/unprocessed trauma
- Relationship to the problem – e.g. dismissing the distress
- Negotiating whether disordered eating is bad enough
- Questioning validity of experiences
- Navigating the mental health system
- Processing attitudes towards help-seeking
- Managing interpersonal relationships
- Identifying the fallacy of help seeking
- Relationship to services – ambivalence about support, rejecting support
- Meaning of help seeking
- Communicative function of behaviours – symbolic meaning of food
- Social processes of inclusion and exclusion in relation to disordered eating experiences
- Social context – stigma, others reacting to the weight, diagnosis
- Managing experiences that do not "fit" diagnosis
- Searching for a label for experiences
- Being in conversation with the researcher / the role of the other
- Individual differences – context that people are coming from and acting into in conversation with the researcher.
- Having a therapeutic conversation – "like a counselling session"

Novel focused codes emerging across interviews (07/10/2018)

<u>Adam</u>

Managing overeating
Learning from peers
Situating experiences in relation to context – "macho" professional identity
Situating experiences in relation to context – Socio-economic status
Situating experiences in relation to context – Cultural influence

<u>Cindy</u>

Layers of disordered eating – symptoms, behaviours, eating too much or too little
Layers of disordered eating – lifestyle of eating; physiological responses to food; neglecting needs

Then and now – freedom, emotional expression
Then and now – identifying exceptions
The role of context – parental identity
The role of context – becoming a single parent
Themes – Oppression; Restriction; Self-harming; Shame/distress
"Like a counselling session"
The need for a diagnosis / "fitting" within an eating disorder (diagnosis)
Acknowledging changes in definition of disordered eating (social context)
Reacting to the weight
Interviewee reflections

Anna
Positioning success and confidence in relation to weight
Attending to the relational style – talking too much or too little; pleasing the researcher
Attending to the relational style – effect on the listener / researcher response to the participant
Attending to the relational style – function of behaviours
Therapeutic researcher – researcher characteristics
Lacking in interpersonal connectedness – missing functions (feeling connected, loved, self esteem); replacing or turning to food
Social context – diagnosis, society and cultural norms

Peter
Identifying layers to seeking help – feeling dismissed, failing to recognise the distress
Identifying layers to seeking help – men and eating disorders; stigma
The role of the other – interviewee reflectivity
Shift in positioning in identifying disordered eating (dismissal to recognising the distress)
Recognising the eating distress as a symptom of other conditions
Expressing vulnerability and sense of hopelessness
Medical context – knowledge and emphasis on weight
Feeling empowered to seek help

Jane
Positioning the self against dominant narratives – "what the hell effect", advocating for fatness movement
Fallacy of help seeking in the context of organisational structure – meeting eligibility
Social influences, expectations and meeting standards

Rose
Being obese – who is reacting to what?
Vicious cycle – unmet needs and behaviours keeping herself further away from connection she needs
Normal eating against disordered eating – thoughts about changes in definitions over time
Having too much or too little control – element of autonomy and losing autonomy with seeking help
Costs of giving up disordered eating
Taking accountability for disordered eating
Problem at individual level
Problem at systemic/organisational level
Both/and – recognising the eating distress and others reacting to the distress (responsibility in both)
Disclosing and relating to painful experiences
Function of disordered eating - Managing painful relationships with others
Disorder as a communication (of needs, distress, trauma)

Mandy
Tracking bingeing experiences – before, during, after
"Mindless" eating
Resourceful – personal skills and attributes
Role of diet, health and wellbeing

Samantha
Chronicity of the problem
Change in attitudes towards helping relationships – taking responsibility
Change in attitudes towards helping relationships – recognising the 'eating distress'
Change in attitudes towards helping relationships – seeking help, contributing to research

Peter (follow up interview)
The role of the other – feeling dismissed by counsellor
Experiencing distress, shame and anxiety in relation to disordered eating
Reinforcing isolation, vulnerability
Interviewee reflexivity – scaffolding, interview questions, feedback on model
Interviewee reflexivity – feeling empowered to talk to counsellor again

Experiencing emotional distress, shame, anxiety and depression (19/07/2018)

Towards constructing experiences → disclosing early trauma, unmet needs, impact of early experiences and relationship with others → strategies to managing problems in life → struggling with eating distress → "failing to get it right"

- Understanding where this group of people are coming from
- Using food as a communication
- Symbolic meaning of food – reliable, consistent, available
- How? What are the strategies used? → neglecting self-care needs; self-harming; distancing self from others/ normalising experiences/protecting the eating
- Contractions in stories about disordered eating - moving between positions e.g. acknowledging and dismissing experiences
- Context of trauma, context of psychiatric diagnosis → having unmet emotional needs, lacking in safety, expressed vulnerability, unexpressed emotions, undisclosed trauma, dismissive parents
- Discerning the relevance of significant experiences: Holding a secret that nobody knows → for power, control, and autonomy? The significance of losing control (e.g. in the context of becoming sectioned under the mental health act).
- Experiences of oppression as a woman, and in context of abuse, deprivation and social isolation

Q: Considering the context of when these stories/positions come to the forefront? Would the conversation be different if they were responding to another researcher or a person who isn't a trainee psychologist?

Q: Is looking at how "experiencing emotional distress, shame, anxiety and depression" might support or hinder (decisions to seek help or ways problems are constructed) a process-led category to include in this research?

Q: Moving on from the individual experiences, what are the social/structural/organisational factors that influence the problems that people are experiencing?

Q: Where do exceptions to problems fit? Are behaviours always problematic? Where is the middle ground or a fit of experiences between normal dieting experiences and distress?

Q: What happens after recognising the eating distress? → Depends on the meaning of help seeking and ideas about helping relationships → what activates decisions to seek treatment or not?

Strategies for managing problems in life (03/06/2018)

I noticed that people typically missed out on stories of success and often presented stories of the problems that they are experiencing. Reframing disordered eating as functional rather than disordered was useful as participants would describe a range of ways they were 'managing' problems in life. When the focus shifted from asking about specific symptoms, patterns and situations that triggered disordered eating

patterns then I noted that people started bringing in alternative narratives about their experiences. This included stories about success and exceptions to disordered eating.

Q: When do management strategies become problematic? Would looking at disordered eating as an experiential phenomenon be most useful? (Here, I refer to experiential to mean looking at subjective experiences of disordered eating , whether it was experienced as distressing or problematic to the sufferer rather than looking at behaviours that would be considered as disordered.)

Managing uncertainty of experiences against certainty of services (11/02/2019)

For the purpose of illustrating the development of this core category, I examined the data about experiences of disordered eating and used the notion of the social process of inclusion and exclusion as a concept to begin analysis. Peter was the fourth person I interviewed. Similar across participants' narrative, Peter focused on eating patterns that were similar or different to anorexia or obesity, presumably referring to binge eating behaviours in his examples of his experiences being different to obesity. As the interview progresses, Peter recounted symptoms as problematic and indicative of distress:

> "Food is just a symptom to manage things really. It's another thing of not taking care of myself [//] struggling to choose something […] thinking about what I'm prepared to eat on that plate and what I'm not prepared to eat on that plate. Looking at food combination on there, with concern. I think its disordered eating having to think about what to put in front of me and trying to analyse- or if I'm given a choice of things, trying to think about what I'm prepared to eat – that feels disordered to me – having a lot of concern about it".

In his first statement Peter is dismissive of his experiences of disordered eating, perhaps he believes that his experiences are not valid in the context of a diagnosis of an eating disorder. Peter's later statement illustrated above reveals the impact of experiences in different areas of his life, as he begins to make comparisons with peers and groups of people who are different from him. Peters infers about others definition of disordered eating, with reference to anorexia and obesity:

> "I think there loads of stuff going on in their life – I just think it's a symptom of other things. I think it's got very little to do with the food. It's something about their self-esteem, but I don't quite know, having low self-esteem and not taking care of themselves. I would say that for anorexia and obesity yeah both of those things. They think they are not worth it, or that they don't value themselves, Yeah I would say that definitely."

The realisation about the global impact of his eating lifestyle led him to recognise disordered eating "as a symptom" of life problems and Peter suggests that he would speak to his counsellor about his experiences.

As I coded and compared extracts with extracts, it became apparent that the differences between participant's subjective experiences in relation to their knowledge of symptoms of formal eating disorders excluded people from recognising the 'eating distress' and led to suffering in silence. But what did this exclusion mean? Through sorting and organising the data, I was able to show how people enacted this sense of exclusion – distancing themselves from others, struggling alone, feeling disempowered to talk about experiences and as a result minimising the 'eating distress'. Applying the concept of social processes of inclusion and exclusion to this grounded theory was relevant and identified that it was also related to the wider system and organisational context e.g. in terms of accessing services and how clinicians were making sense of people experiences. Using grounded theory strategies e.g. constant comparative methods and looking at the broader context helped to discern taken-for-granted assumptions and meanings and put them to the test in order to avoid generalising and reinforcing pervasive assumptions. People were not simply deciding to not access support because almost all the participants had access to psychological therapy at one point and presumably have had contact with services at different points in their life. How did this exclusion influence people's meaning and attitudes towards helping relationship? In continuing with Peter narrative, he explains that he has felt worse since speaking to me about his experiences. I wondered whether this was connected to his experiences of talking to his counsellor who attributed his eating patterns as symptoms of irritable bowel syndrome.

This led to the discovery of the core category of managing the uncertainty of experience against the certainty of services that could explain help seeking or non-help seeking among this group of people. It also moves away from assuming the resolution to a problem resides in the person and includes that the wider social, economic and political context that can influence the problems in a person's life. I learned that this group of people have learned to cope with their experiences and allowed me to uncover meanings and attitudes this group of people held.

Appendix 13: Examples of models and revisions

I present two models created in the early stages of the research process as an effort to present iterative process of this grounded theory research. Looking at the first model, I can see this reflects my initial interaction with the data and as novice researcher coding for all instances in the data. It shows actions and processes discovered in the examples communicated. Examining processes allowed me to refine the concepts/dilemmas using different analytical questions to see how the narrative about societal pressures for example were acted upon. This enabled me to become attuned to the processes that I was inadvertently missing by focusing on the subjectivity and attempting "fit" the findings with existing knowledge, assumptions and views. The second model reflects grounded theory emphasis on analysing psychological processes as well as social processes, and attempts to demonstrate grounded theory in practice.

Figure II: Model 1 Created on 10/06/2018

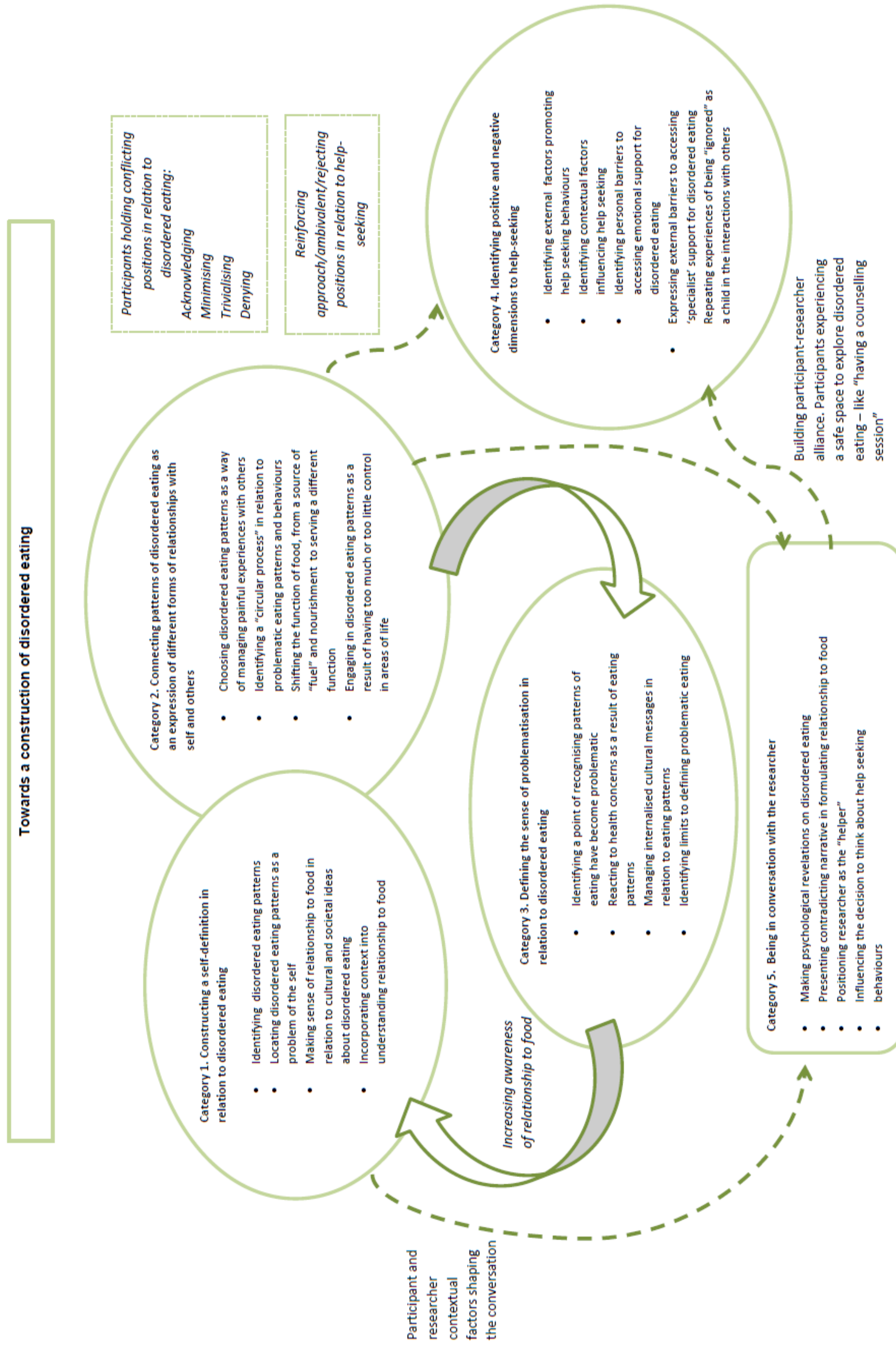

Figure III: Model 2 Created on 09/02/2019