An Interpretative Phenomenological Analysis exploring lived experiences of Bulimia Nervosa

Geraldine Bishop

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Abstract

Background Bulimia nervosa is defined as a clinically recognised disorder, the key diagnostic features of which are eating an 'abnormally' large amount of food within a short space of time and compensatory behaviours such as abusing laxatives, vomiting and excessive exercising. Research within the area of eating disorders has been mostly concerned with anorexia nervosa and studies have been primarily conducted with the female population. Predominant aims of this study were centred on understanding participants lived experiences of bulimia, drawing attention to the stigma associated with bulimia, exploring how this may impact on the process of seeking support, and highlighting the challenges found in the pathologizing of bulimia.

Method This qualitative study explored the lived experiences of seven female participants aged between 21-34 years old who identified with bulimia nervosa. The research utilised semi – structured interviews to facilitate participants to talk about their experiences and understandings of bingeing and purging processes, recovery from bulimia and the emotional impact of bulimia. The study also explored participants' relationships with food, body image and the role of bulimia specifically in relation to identity. Interpretative Phenomenological Analysis (IPA) was used to analyse to data.

Findings The findings of this study provides a rich source of material which details the participants' experiences and understandings of bulimia nervosa. Whilst participants' experiences varied, there were a number of commonalities evident throughout the analysis relating to the concept of control, the experience of feeling caught in a cycle, inner conflict and experiences of recovery. The analysis suggested that participants' experiences of bulimia introduced difficulties in emotion regulation, experiences of shame, and fears of being misunderstood. The concept of control was frequently highlighted throughout the analysis and was associated with experiences of feeling caught within a repeated cycle of bulimia. All participants spoke about the feeling of being caught in a cycle, emphasising the impact of secrecy in bulimia. Both fears of being misunderstood and secrecy in bulimia were seen as being partly a result of stigma and highlighted a need to move away from the pathologizing of bulimia. Bingeing and purging were both presented as behavioural attempts to cope with distress. The findings of this study contribute towards the existing literature in the area of eating disorders and to the field of Counselling Psychology by offering insights into how participants understand and experience bulimia nervosa. This understanding has the potential

to inform practitioners when working therapeutically with clients experiencing eating disorders.

Introduction to the study

The current study aims to understand how the participants make sense of their experiences of bulimia nervosa. A key focus of this study has been to offer alternative perspectives that challenge the idea of pathologizing bulimia and to evidence the sense of pathologizing that already exists within the current body of literature. The paper considers the impact of pathologizing on the individual and how this can be seen as contradictory of the philosophy of counselling psychology, considering that one of the central aims of the profession is centred on developing models of practice which are firmly based in the primacy of the therapeutic relationship, without assuming any one way of experiencing, feeling or knowing is superior (Kasket, 2017).

The study attempted to explore lived experiences through the use of interpretative phenomenological analysis. The fundamental aims of this research has been to consider the stigma associated with bulimia and call attention to how this may further impact on individuals' experiences, specifically their experiences of seeking and accessing support. Whilst highlighting the challenges that can be found in use of the medical model and the pathologizing of eating disorders, the study attempts to offer alternative perspectives that challenge the idea of pathologizing bulimia.

Throughout the process of conducting this research it has been of heightened importance to reflect on my own position as a researcher. In addition to this, it has been important to acknowledge my own previous experiences that relate to eating disorders, any expectations that relate to the findings of this study, and any assumptions that I held at the beginning, and throughout the process of conducting this research. Whilst interpretative phenomenological analysis is seen as being predominantly an inductive process, it has been key to recognise the detective aspects of this research. When initially formulating the research idea, I already had the experience of having had a close friend who had experienced an eating disorder (anorexia nervosa). Whilst my friend did not have experience of bulimia, I remain very aware of how this experience has influenced my interest in this field and impacted on my own views of the support available to individuals experiencing an eating disorder. My friends' experience was one in which she struggled to seek support and feared negative judgment from others. It has been key to acknowledge that whilst I have used a reflective journal throughout the process of this research, and engaged with regular supervision, my personal experiences will undoubtably have impacted on the data. According to Willig (2008) a key aim of

interpretative phenomenological analysis is for the researcher to work towards develop an understanding of the participants' views and the meanings that they attach to their experiences. This process involves adopting an 'insider perspective'. As highlighted by Braun and Clarke (2013) the research is a dynamic process with the researcher role being viewed as both descriptive as it attempts to describe how phenomena appear, and interpretive as there is an acknowledgement that there is no such thing as a phenomenon which is not interpreted (Braun & Clarke, 2013). In consideration of my own position as a researcher which includes having had my own experiences of not only having a friend with an eating disorder but also working therapeutically in the field, it should be acknowledged that the findings of this study are dependent on my own perceptions and interpretations as a researcher.

A key factor in formulating this research has been conducting a review of the already existing literature. When engaging with the literature search, frequent use of pathologizing language became evident. Examples of this can be seen within the literature review where terms such as 'diagnostic criteria' 'abnormalities' 'problematic behaviours' and 'a lack of control' are all terms that are frequently used throughout some of the previous research. As the researcher, it has been important for me to remain aware, and to acknowledge my own use of any language within the study that may be perceived by the reader, as being of a pathologizing nature.

Within the literature review attention is called to the definitions of bulimia documented within the DSM V. This is closely followed by highlighting the pathologizing of bulimia which can be seen within the 'diagnostic criteria' which focuses solely on 'symptoms of bulimia'. Alternative approaches to understanding bulimia are discussed within this, which can be seen to fall closer in line with the philosophy and ethos of counselling psychology as a profession.

In addition to highlighting potential challenges associated with the pathologization of bulimia, the literature review provides insight to the previous literature presented within the field of eating disorders, and more specifically documents a number of studies that have been conducted with individuals experiencing bulimia. These studies include the exploration of bulimia and the role it plays within an individuals' identity (e.g. Broussard, 2005) and the discourses surrounding bulimia, evidencing how historically bulimia has been commonly judged as 'unusual behaviour' and has been historically regarded as 'abnormal' and 'uncommon' (Huon et al, 1988). The literature review includes studies that have focused on

individual experiences of recovery highlighting the role of control, and how facilitating a persons need for control can be seen as a central aspect of supporting an individual in recovery from an eating disorder (Reid et al, 2008). In addition to this, studies focusing on recovery has called attention to the concept of self-acceptance as being a key factor within the recovery journey (Lindgren et al, 2014). Leading on from the focus on recovery, is literature surrounding therapeutic interventions, calling attention to the guidelines proposed by the National Institute for Health Care Excellence. Research is presented focusing on cognitive behavioural therapy for eating disorders (Fairburn, 2008), family based therapies (Hurst et al, 2015), and compassion focused therapy (Gilbert, 2012). In addition, evidence supporting the use of a more contemporary group based intervention (CFT-E) is documented (Gale et al, 2014).

The methodology chapter details the epistemology of IPA highlighting the origins of this methodology and its unique features. The rational for using IPA is documented, clearly justifying the choice of methodology. Within this chapter the process of interviewing for the study is documented and participant demographics are presented.

The results chapter presents a table of themes, created following the analysis of data obtained from seven semi - structured interviews. Themes relating to issues of control, feeling caught in a repeated cycle of bulimia, a fear of being misunderstood, and the use of bulimia as an attempt to emotionally regulate emerged. The role of emotion was viewed as being central to the development and maintenance of bulimia. The results of this study further evidence the need for practitioners to employ a holistic approach to working therapeutically with bulimia and to consider the surrounding issues associated with bulimia, moving away from medical models of practice and the use of diagnostic labels.

The findings of this study are further documented within the discussion, in line and consideration with the already published literature in the field. The discussion documents how the findings of this study can be seen to compliment some of the already existing research such as literature highlighting bulimia as an attempt to gain control (e.g. Patching and Lawler, 2009) and studies that have evidenced the impact of secrecy within the maintenance of bulimia (e.g. Broussard, 2005). Further suggestions are made for research and practice.

Introduction to the Literature Review

This literature review explores the current body of research relating to eating disorders, placing a specific focus on Bulimia Nervosa (BN). It will present an overview of existing qualitative studies that have been carried out within the area of eating disorders. Definitions of bulimia nervosa will be provided, whilst documenting challenges to the pathologizing of bulimia in mental health categorisation systems such as DSM V. The negative impact of pathologization on individuals with experience of eating disorders will be explored and alternative ways of understanding bulimia will be put forward. The review will highlight the prevalence of bulimia, whilst acknowledging the difficulties found in obtaining accurate statistics relating to presentations of bulimia. Previous qualitative studies which have focused on lived experiences of bulimia will be documented within this review. Psychological co – morbidities associated with bulimia will be discussed. The review will focus on the current evidence based treatments used when working with bulimia, documenting potential challenges. Primary aims of this research will be outlined, drawing attention to the relevance of this research within the field of counselling psychology.

Defining Bulimia Nervosa

Bulimia nervosa can often be difficult to identify and for some individuals can remain undetected for substantial periods of time. The majority of individuals experiencing bulimia maintain an average weight (Hurst et al, 2015). According to the American Psychiatric Association (2013) Bulimia nervosa is defined as a clinically recognised disorder, the key diagnostic features of which are eating an 'abnormally' large amount of food within a short space of time and compensatory behaviours such as abusing laxatives, vomiting and excessive exercising. The official diagnostic criteria for bulimia, according to the DSM V is:

- Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
- Eating, in a discrete period of time (e.g., within a two hour period), an amount of food that is definitely larger than what most people would eat during a similar period of time and under similar circumstances.
- Lack of control overeating during the episode (e.g., a feeling that you cannot stop eating, or control what or how much you are eating).

- Recurrent inappropriate compensatory behaviour to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications, fasting, or excessive exercise.
- The binge eating and inappropriate compensatory behaviours both occur, on average, at least once a week for three months.
- Self-evaluation is unduly influenced by body shape and weight.
- Binging or purging does not occur exclusively during episodes of behaviour that would be common in those with anorexia nervosa.

When considering DSM V official diagnostic criteria, it can be seen that the language used is of a pathologizing nature. Terms such as 'abnormally large' 'larger than what most people would eat' 'lack of control' and 'inappropriate compensatory behaviours' can all be seen to pathologize and disregard the number of factors that can be seen as contributing to the development of eating disorders, such as environmental factors and early experiences (Cooper et al, 1998).

Alternative approaches to understanding Bulimia Nervosa

The DSM V categorises bulimia from mild – extreme depending on the amount of times in a week an individual exhibits bingeing, purging or purging behaviours and can be seen to pathologize a state of emotional distress involving food, eating and body image. Offering an alternative view when working with disordered eating patterns may be more helpful to individuals with an experience of bulimia. The Power Threat Meaning Framework (Johnstone & Boyle, 2018) provides a model that suggests "what may be called psychiatric symptoms are understandable responses to often very adverse environments and that these responses, both evolved and socially influenced, serve protective functions and demonstrate the human capacity for meaning-making and agency." (Johnstone & Boyle, 2018, p.4)

Individuals experiencing bulimia often find themselves with psychological co – morbidities such as anxiety disorders, depression, substance abuse, obsessive compulsive disorder and personality disorders (Rikani et al, 2013). Bulimia is commonly portrayed as an attempt to regain control when one feels it is lost, such as when experiencing a mental health challenge, or in the experience of adverse environments (Patching & Lawler, 2009). Helping an individual with bulimia understand this in a non – pathologizing manner, has the potential

to support and individual in finding alternative ways of gaining control and agency in their lives whilst finding a sense of safety and belonging (Johnstone & Boyle, 2018).

Regardless of the widespread acceptance of medicalisation and psychiatric diagnosis, it is not uncommon for individuals having received diagnoses to have testified to the negative impact of this on their lives and identities (Johnstone, 2018). Criticisms of the medical model have focused largely on the low levels of agreement found amongst clinicians making diagnoses (unreliability) and the lack of usefulness or validity found in diagnostic categories (Boyle, 2013; Moncrieff, 2008). By presenting both emotional and behavioural problems as 'symptoms' of mental disorders; locating 'problems' primarily in the brain and body, diagnosis and medicalisation work towards obscuring the evidenced role of interpersonal and social factors in distress, making it considerably more difficult to make sense of people's difficulties in the context of their lives and relationships.

'A diagnosis can be seen to change what people feel or do into something they have or are' (Johnstone & Boyle, 2018 pp 27). In literature presented by Johnstone and Boyle (2018) it has been emphasised that diagnosis can also be seen to remove any meaning attached to feelings, thoughts and actions, creating an identity which can be very challenging to resist or change. Little exists within contemporary literature exploring the experiences of receiving an eating disorder diagnosis and there is a potential value in exploring the impact of this on the therapeutic relationship. Research of this nature has potential to further inform professionals working with this client population and to enable further understanding relating to the impact of pathologizing. When working with bulimia, taking an approach which prioritises understanding an individual's experience over pathologizing has potential to be a key aspect of successful treatment. It is better suited to the philosophy of counselling psychology, with a predominant aim of the profession being centred around developing models of practice which are firmly based in the primacy of the therapeutic relationship, without assuming any one way of experiencing, feeling or knowing is superior (Kasket, 2017).

Prevalence of bulimia

The experience of bulimia is suggested to be more common in females than males with statistics presented by Anorexia and Bulimia Care (2020) suggesting that eight percent

of women will experience bulimia nervosa at one stage in their lifetime. Whilst bulimia can occur at any age, it is suggested to mostly affect women between the ages of sixteen and forty. Beat (2020) has proposed that around 1.25 million individuals in the United Kingdom experience an eating disorder and that 25% of this population are male. Research from the National Health Service has concluded that up to 6.4% of the adult population present signs of an eating disorder. Figures published in 2014 demonstrated an 8% rise in the amount of inpatient hospital admissions in the year previous to October 2013 and it has been further documented that this is indicative of the trend in an increasing prevalence over time, with statistics highlighting a 34% increase in hospital admissions since 2005, making the increase approximately 7% each year (Beat, 2020). The exact prevalence rate of bulimia is difficult to gauge due to the number of cases that remain unreported. This can be linked to the issues of secrecy and shame that surround bulimia and is often due to symptoms of bulimia not being as apparent as those found in anorexia presentations. Therefore, it should be considered that such figures are only based on those cases that are reported and may have sought support.

Co-morbidities

A number of psychiatric co – morbidities have been associated with eating disorders such as anxiety disorders, depression, substance abuse, obsessive compulsive disorder and personality disorders (Rikani et al, 2013). In addition to this, suicidal ideation, suicide attempts and death by suicide are comorbidities that are frequently identified within this client group. It is estimated that around 10% - 20% of individuals with anorexia nervosa and 25% - 35%, of those with bulimia, have a history of attempting suicide, at least once in their lifetime (Sullivan et al, 2002). It can be challenging to get an accurate rate of death by suicide in eating disorders due to difficulties in discovering the exact cause of death, the unreliability in suicide statistics in general and because of the undiagnosed cases of eating disorders that result in death by suicide. In addition to the psychiatric co – morbidities, the range of medical complications associated with eating disorders are frequently highlighted within the literature such as; endocrine system dysfunction, cardiovascular diseases, anaemia, amenorrhea and electrolytes disturbances. The severity of the medical complications is typically dependent on the speed and severity of weight loss, age range, duration of the disorder and with bulimia the intensity of purging (Dalle-Grave et al, 2007).

When considering the above literature highlighting co – morbidities, it should be acknowledged that not all individuals experiencing bulimia will identify with these co –

morbidities. The literature fails to provide any statistical evidence relating to how many people may experience such co – morbidities, other than suggesting that 25% - 35% of individuals with experience of bulimia have a history of attempting suicide, at least once in their lifetime (Sullivan et al, 2002). It is of importance to remain mindful that the concept of 'psychiatric co – morbidities' is not one that can be generalised to every person that experiences bulimia. In addition to this, it should be acknowledged that there are many other factors that contribute to suicidal ideation and suicidal attempts, that may not necessarily be the result of a person's experience of bulimia.

Obsessive Compulsive Disorder

The results of a study carried out by Bulik et al (2004) explored the prevalence of anxiety disorders in both anorexia and bulimia. The results showed that the prevalence of anxiety symptoms and obsessive compulsive disorder (OCD) were considerably higher in individuals with eating disorders than in nonclinical groups of females. It was concluded that these presentations are approximately three times greater in those with bulimia nervosa. Within the study two thirds of participants with an eating disorder had one or more anxiety disorder with the most common being OCD (N=277) (41%) The majority of participants reported the onset of their anxiety being during childhood years, prior to the development of an eating disorder. These results support the idea that anxiety is a vulnerability factor for the development of both anorexia and bulimia nervosa. The study however only consisted of female participants. Ninety seven participants had a diagnosis of anorexia, 282 had received a diagnosis of bulimia and 293 had a diagnosis of both anorexia and bulimia.

Whilst it seems of importance to consider the suggestion of anxiety as a vulnerability factor for the development of both anorexia and bulimia nervosa when working therapeutically with individuals experiencing an eating disorder, it is of equal importance to acknowledge that the experience of each individual will differ and anxiety management should be incorporated only into therapeutic work with those identify with this. Whilst it was the majority of participants that identified with anxiety in the above study Bulik et al (2004) it should be considered that the study was conducted with individuals experiencing both anorexia and bulimia, and the results should not be generalised to all individuals with experience of bulimia.

The relationship between Obsessive Compulsive Disorder (OCD) and bulimia has been documented by Altman et al (2013) and it has been evidenced that bulimia and OCD share a number of phenotypic features (e.g. Altman & Shankman, 2009; Godart et al, 2002). Eating disorders and OCD typically share worries for orderliness, rigidity and excessive compliance (Tchanturia et al, 2004). In addition to this, family and longitudinal research has indicated that bulimia and OCD potentially have shared mechanisms of dysfunction which partially account for the co – occurrence. The nature of these however has yet to be elucidated (Kaye et al, 2004; Milos et al, 2002). A study carried out by Wilson and colleagues (2017) explored the potential association between bulimia and a maladaptive inductive reasoning style characterised by the over investment in possibility based (as opposed to reality – based) information. In their study twenty- five female participants with experiences of bulimia were invited to complete the Inference of Process Task. This is an ecological indictive reasoning task validated in OCD samples and the Fear of Self Questionnaire which is designed to evaluate investment in a feared possible identity. The findings of their study suggested that the development and maintenance of bulimia may be linked to maladaptive inductive reasoning processes characterised by over-investment in possibility-based feared outcomes and identities (Wilson, Aardema & O'Connor, 2017).

More broadly, contemporary literature put forward by Mandelli and colleagues (2020) has indicated that globally between 15% - 18% of all individuals with an eating disorder had a comorbidity with OCD (Mandelli et al, 2020). Whilst the relationship between OCD and bulimia has been highlighted, research has yet to clearly evidence the link between the two. The presence of OCD symptoms has been hypothesised as a predisposing factor for eating disorders (e.g. Thornton & Russell, 1997; Anderluh et al, 2010; Buckner et al, 2010) and it has been further suggested that the development of eating disorder symptoms can lead to exacerbation of pre – existing predisposition to obsessive compulsive symptoms (Kaye et al, 2012).

Social anxiety

Social anxiety has been closely linked to eating disorders (Godart et al, 2000). Whilst there have been consistent research findings pointing towards elevated levels of social phobia and social anxiety in women with experiences of eating disorders (e.g. Bulik et al, 1991; Godart et al, 2002; Hinrichsen et al, 2003), there still appears to be conflicting opinions in relation to the precise role these may play within the aetiology of eating disorders. A number

of scholars have discussed social anxiety as being a precipitating factor in the development of anorexia and bulimia, and others have taken the view that it is a secondary affect which results from the underlying psychopathology of eating disorders (Wenzel & Holt, 2001). Generally, within the literature It can be seen that there is agreement about the central role social anxiety takes in a number of mental health issues (Ingram et al, 2001). From a cognitive perspective, it has been suggested that individuals who are socially anxious excessively worry about negative public scrutiny (Crozier & Alden, 2001). With regards to individuals with experience of eating disorders, Striegel – Moore and colleagues (1999) have proposed that a persistent preoccupation relating to dieting strategies and body image is the reflection of an attempt to lessen interpersonal anxiety by projecting a positive self – presentation. In addition to this, in conflict – eliciting social encounters, women with experiences of eating disorders have been reported to engage with avoidant behaviours (McClintock & Evans, 2001). This behaviour has been interpreted as a means to escape fear of rejection or criticism by others. Grabhorn et al, 2006) have proposed that this suggests an underlying psychopathological mechanism in which eating disorders and social anxiety can be linked.

The above literature highlighting associations between OCD, anxiety and bulimia can be useful when considering factors that may contribute to the development of bulimia, however, aspects of this literature can be seen to maintain the stigma associated with bulimia and the pathologizing of the experience. Proposing the idea of bulimia and OCD having 'shared mechanisms of dysfunction' could be interpreted as something being 'wrong, or abnormal' which neglects the idea of a person having an understandable response to adverse early experiences or challenging environments. Presenting literature that suggests abnormalities in bulimia has potential to contribute to the stigma associated with bulimia and further impact on an individual's process of support seeking, serving as a barrier to accessing support. As someone who has worked in the field of eating disorders, and as a result of conducting this research, I view it as being of heightened importance to recognise and highlight how the concept of stigma and a fear of being viewed as having a 'problem' remain as a central factor in limiting individuals in their process of support seeking.

Within the literature specifically focusing on anxiety, it is important to acknowledge that findings are not consistent, there are still conflicting views surrounding the role of anxiety in the development and maintenance of bulimia, and it should not be assumed that

because an individual has an experience of eating disorders that it will be companied by anxiety. As previously highlighted social anxiety can be seen to take a central role in a number of mental health conditions (Ingram et al, 2001) and this is not specific to the presentation of bulimia. Literature presented by Striegel – Moore and colleagues (1999) point towards preoccupation relating to dieting strategies and body image as the reflection of an attempt to lessen interpersonal anxiety by projecting a positive self – presentation. Whilst this is helpful to consider in therapeutic practice when attempting to identify potential maintaining factors of anxiety, for those who may be experiencing anxiety, this idea should not be generalised. When working therapeutically with individuals experiencing bulimia, it should remain a priority to work collaboratively with the person based on their own individual needs.

Substance Misuse

Many clinical observation studies have reported the association between substance misuse and eating disorders (Holderness et al, 1994) supporting the notion that specifically adolescents engaging with binge purging behaviours have higher rates of substance use and greater psychological distress (Ross & Ivis, 1999). The results of a study conducted by Stock and colleagues (2002) has suggested that substance misuse is significantly higher in those presenting with bulimia when compared to individuals with a diagnosis of anorexia. In an earlier study carried out by Braun and colleagues (1994) it was concluded that individuals with anorexia were significantly less likely to develop alcohol or drug dependencies than those with bulimia. When considering the specific co-morbidities of anxiety disorders and substance misuse, literature mostly suggests that it is more likely for the onset of eating disorders to predate the onset of substance misuse disorders and more typical for the onset of anxiety disorders to predate the development of eating disorders (Agras & Robinson, 2018).

The prevalence of alcohol use disorders (AUD) have been explored by Bulik and colleagues (2004) as an attempt to identify the nature of the co-morbid relation between eating disorders and addiction. Their findings suggest that AUD was significantly more prevalent in females identifying with both anorexia and bulimia, with the majority of individuals reporting the primary onset of an eating disorder and only one third reporting the onset of AUD first. Whilst these findings indicate a relationship between the misuse of alcohol and eating disorders, they do not determine specific addictive properties that may be

found in bulimia presentations, these findings can be seen to point more towards alcohol being used as an attempt to cope with eating disorder symptoms.

It has been repeatedly highlighted that bulimia nervosa commonly coincides with substance abuse disorders, with evidence suggesting between 30% - 50% of individuals identifying with bulimia either abuse or are dependent on drugs or alcohol (Beary & Lacey, 1986; Striegel-Moore et al, 1999; Ranson et al, 2002). In addition to this, it has been suggested that up to 35% of individuals identifying as dependent on drugs or alcohol (or both) have an eating disorder diagnosis (Holderness et al, 1994). Both drug addiction and bulimia nervosa exhibit mood altering effects, compulsion, cravings, reinforcement and ultimately a loss of control (Rogers & Smith, 2000).

It can be seen that a number of studies have attempted to highlight associations between eating disorders and substance misuse. Some authors suggest substance misuse being more common in individuals identifying with bulimia as opposed to anorexia (e.g. Stock et al, 2002). However, there seems to be minimal evidence pointing towards why this may be the case. Less research has been carried out in the attempt explore experiences of addictive thought processes and behavioural manifestations of these in individuals with experience of bulimia. Research proposed by Umberg and colleagues (2012) has explored how the specific eating patterns associated with bulimia can be seen as being particularly addictive. These researchers discussed the addictive properties found in bingeing and purging behaviours being a central factor in differentiating bulimia from other eating disorders. The recognition of bulimia as having possible associations with addictive processes potentially has ramifications for the development of new therapeutic treatment targets for practitioners working with individuals experiencing bulimia nervosa.

Previous research within the field of eating disorders

Qualitative research within the field of eating disorders is a developing area, with researchers mostly showing interest in how qualitative research is able to assist in understanding experiences of eating disorders, barriers to care, recovery experiences and treatment needs. When reviewing literature within this field, it can be seen that considerably more qualitative research has focused on experiences of anorexia as opposed to bulimia (e.g.

Williams & Reid, 2012; Verschueren et al 2014; Rance et al, 2016). Research seems to have been mostly carried out with White British female populations, with qualitative studies highlighting experiences of shame, loneliness, and identity conflict. From a review of the literature it can be seen that studies exploring individual's experiences of living with bulimia nervosa are sparse. The studies that have focused on bulimia mostly show that feelings of shame, fear of stigma and low self-esteem are all common factors in bulimia nervosa (Goss & Allan, 2009; Daley et al, 2008).

When conducting a review of the already existing literature within this field, it can be seen that little attention has been paid to the pathologizing of eating disorders, the stigma associated with the experience and the potential challenges that may exist for individuals when they attempt to seek support. Research that has concentrated specifically on bulimia has highlighted difficulties in emotion regulation, internal conflicts and experiences of shame. A study conducted by Broussard (2005) focused on women's lived experiences of bulimia. The researcher used an interpretative phenomenological methodology to analyse personal diary entries and interview transcripts from women aged 18-36. The four themes identified during the analysis were 'living in fear', 'pacifying the brain', 'being at war with the mind' and 'isolating self'. Broussard (2005) emphasised the importance of understanding the experiences of bulimia, stating that an awareness of participants' perspectives who have and continue to experience bulimia has the potential to promote a comprehensive understanding in relation to the aetiology of bulimia, and treatment options.

Broussard (2005) acknowledges throughout her work that it is already common knowledge that individuals experiencing bulimia often experience a loss of control and have constant thoughts about eating and food. Research findings presented by Broussard (2005) can be seen to provide further insight into the phenomenon of bulimia from individuals that have lived experience, which this current study seeks to build on. In addition to this, Broussard's work provides an understanding in relation to why some individuals may be reluctant to seek treatment and why treatment may not always be successful in the long-term, with participants in the study highlighting an 'emotional attachment' to their bulimia, emphasising fear of living without it, which further serves as a barrier to support seeking. The results of Broussard's study also highlighted challenges found in attending clinical assessments that do not incorporate questions which are sensitive to bulimic behaviours.

In my own experience of working therapeutically with bulimia, and having had the experience of conducting clinical assessments within eating disorder services, clinical assessment is an issue that I have become aware of. Through my own experiences, I have been able to recognise the impact of this on the individual and hold the view that assessments should be more carefully tailored to specifically suit the needs of individuals with experience of bulimia as opposed to assessing symptoms of 'disordered eating' more broadly. Whilst it is of importance to remain mindful that individuals' experiences of bulimia will differ, it is of equal importance to acknowledge the distinct differences between eating disorders (e.g. anorexia and bulimia) are clear and there is a need for clinical assessments to incorporate this. In my own experience, the process of assessment can be seen to play a central role in an individual's experience of seeking and receiving support as it can be one of the initial steps to engaging with services, seeking support and making the decision to begin a process of recovery. Both my own experiences and consideration of the literature focusing on the process of recovery influenced my decision to incorporate questions relating to support seeking and recovery into the interview schedule for the current study.

Bulimia and identity

Research by Broussard (2005) has discussed bulimia as becoming part of a person's identity. It can provide a sense of security in life and therefore creates an ambivalence towards intervention. Whilst an individual's will to recover may be strong, it can be edged with a fear of what life will be like without bulimia and without the sense of security it provides (Broussard, 2005). Williams and Reid (2012) suggest that the existence of a critical voice is common during the onset and maintenance of eating disorders. They suggested the application of dialogical theory which proposes a new model of anorexia that involves addressing critical aspects of the self in the attempt to develop a new dominant position which is accepting of the individual's core values and sense of self. The experience of internal critical voices is frequently documented within eating disorder literature, highlighting this concept in both anorexia and bulimia presentations. However, more studies have focused on this in individuals experiencing anorexia than bulimia and within the literature it is often referred to as the 'anorexic voice'. Research has attempted to explore the core characteristics of this. A study carried out by Pugh and colleagues (2018) has indicated that different voice characteristics are often associated with the duration of participants' eating disorders, body mass index and eating cognitions. In their study, two subgroups emerged with 'stronger' and 'weaker' voice experiences. Participants evidencing stronger critical voices were

characterized by having more severe compensatory behaviours, more negative eating attitudes and the likelihood of having the binge-purge subtype of anorexia. Addressing the existence of this critical part of the self when working with eating disorders, by identifying the content and how individuals relate and respond to it, has the potential to enhance treatment outcomes.

The concept of exploring participants experiences of bulimia in relation to their identity has the potential to shift the focus towards acknowledging each individual experience as unique, as opposed to the focus being on an individual 'meeting a diagnostic criterion' and therefore being 'categorised' as having bulimia which fails to acknowledge the individual within this process. In my own experience of working with individuals experiencing bulimia, I have witnessed the beneficial impact of collaboratively formulating treatment plans which consist of addressing the individual as opposed to working solely with diagnostic labels. The ways in which a person identifies with their bulimia is unique and specific to their own distinctive experience. Research surrounding identity and inner dialogues seems to have mostly focused on experiences of anorexia, therefore, the concept of identity is explored within this study to contribute to the developing literature focusing specifically on this in relation to experiences of bulimia.

Discourses surrounding bulimia

A review of the literature suggests a clear difference in the ways anorexia and bulimia have been discussed within psychological research throughout history. The oppositional constructions of bulimia and anorexia and their complex link to femininity (Malson, 1998; Squire, 2003; Saukko, 2000) have been highlighted by Foucauldian informed critical scholarship within the field of women's eating disorders. Burns (2004) has focused on the ways anorexia and bulimia are constructed using language in opposition to one another and how cultural discourses of femininity play out in these constructions, suggesting that some women who fit the criteria for bulimia may be positioned and regulated in relation to them. Burn's work brings attention to psychological research surrounding lay beliefs about anorexia indicating the 'symptoms' (excessive dieting and the pursuit of slimness) are often viewed as normal female concerns (Polivy & Herman, 1987; Levitt, 1997). However bulimia has been commonly judged as 'unusual behaviour' and has been historically regarded as 'abnormal' and 'uncommon' (Huon et al, 1988).

These representations can also be seen historically in the accounts of health experts who associate 'self – control, perfectionism and high achievement' with anorexia (Butler et al, 1990) characterizing self-starving girls as 'obedient, academic, hardworking, perfect children' (Whyte & Kaczkowski, 1983). Contrary to this, women with bulimia have been documented as 'breaking common rules of honesty' and 'practicing a rebellious selfishness' (Riebel, 2000). These oppositional constructions of bulimia and anorexia and the interweaving of notions of femininity within their construction have been documented (e.g. Eckermann, 1997; Hepworth, 1999; Malson, 1998; McKinnley, 1999; Saukko, 2000; Squire, 2003). The work has revealed that anorexic behaviours are often interpreted as indicative of ultimate control (Bordo, 1993; Garrett, 1998; Malson, 1998) whilst bulimia is constructed as being 'abnormal, disgusting, out of control and risky' (Brooks et al, 1998; Lupton, 1996, 2000). Eating disorders have been repeatedly suggested to be more common in females and generally characterised by the presence of body image concerns and disordered eating patterns often, but not always, aimed at weight loss. As a result of these characteristics studies have shown that individuals have felt stigmatised by the general population and by professionals (O'Connor et al, 2016). The discourses surrounding bulimia, suggesting it is more common in women could be a contributing factor to less men coming forward and seeking support. They are therefore likely to be missed within eating disorder statistics.

Whilst it is evident from the literature (e.g. Huon et al, 1988) that bulimia has historically been referred to as 'abnormal' 'uncommon' and 'unusual behaviour'. There is little research exploring how this may impact on an individual's experience of bulimia. It has been documented by O'Connor et al (2016) that individuals who identify with an eating disorder have felt stigmatised, by both professionals and the general population. It could be suggested that the use of such terms to describe bulimia, the comparison of bulimia with anorexia, and the beliefs around it being 'out of control and risky' (Brooks et al, 1998; Lupton, 1996, 2000) only contribute to the pathologizing of an individual's experience and further contribute to the stigma associated with bulimia. Further exploration of the stigma attached to bulimia, and the possible impact of this on support seeking has the potential to inform practitioners working with bulimia. Providing insight to this from individuals who have their own lived experience of bulimia can work towards challenging the idea of pathologizing by making literature available that evidences a negative impact of stigmatizing and pathologizing experiences of bulimia.

Experiences of recovery

Experiences of recovery have been explored, and it can be seen that most qualitative enquiry has been concerned with individuals experiencing both anorexia and bulimia. Literature focusing on this specifically with bulimic populations is less apparent. Qualitative research presented by Reid and colleagues (2008) has explored the experiences of individuals receiving outpatient treatment for eating disorders. These researchers used thematic analysis to analyse the data obtained from twenty interviews conducted with female participants receiving NHS treatment for both anorexia and bulimia. Their findings suggest that participants experienced a sense of ambivalence relating to whether their eating disorder was a way of exerting control or a disorder that controlled them which left women uncertain about seeking treatment. The researchers suggested that when supporting an individual in recovering from an eating disorder there is a need to facilitate a person's need for control by striking a balance between empathetic and practical approaches which can provide authoritative guidance and involve the client in treatment decisions.

A study that focused more specifically on recovery from bulimia in young adult women (Lindgren et al, 2014) utilised qualitative content analysis to analyse the data obtained from interviews conducted with fourteen women aged between 23 – 26. The analysis generated four themes in recovery from bulimia 'getting ready to change' 'grasping a new reality' 'feeling stuck in bulimia nervosa' and breaking free of bulimia'. The results of this study highlighted the process of recovery as not being linear, rather one that went back and forth between progress and relapse. The participants in this study discussed the ability to accept themselves as being an essential part of their recovery from bulimia, and support being a central aspect of this. The researchers argue that effective treatment should strive to strengthen clients' beliefs in their own abilities to instil hope for recovery from bulimia and therefore strengthen their self – efficacy.

When reviewing the literature concerned with recovery from bulimia, it seems there is little focus on exploring individuals' experiences of seeking or receiving support. Exploring individuals' experiences of psychological therapy, barriers to support seeking and the experience of recovery more broadly, has the potential to highlight key aspects of the recovery process, further informing practitioners working with bulimia, and providing insight to the challenges an individual may be faced with when support seeking. When focusing on

this part of the current study it has been important for me to remain mindful of my own experiences of having had a friend who struggled with seeking support for her eating disorder due to a fear of negative judgment. This personal experience is a factor that I view as contributing to my interest in recovery experiences and curiosity surrounding potential barriers to support seeking.

The role of shame in the development and maintenance of bulimia

Literature presented by Goss and Gilbert (2002) discussed the experience of shame in bulimia as occurring in a cycle that involves various factors that evoke shame, such as body shame, feelings and thoughts, which then lead to a behavioral response such as binge eating or purging, these behaviors are then thought to create further shame which then in turn restarts the shame cycle. According to Potter – Efron (2002) a key contributing factor to this re-occurring cycle is negative self-appraisal, which in turn is suggested to maintain the eating disorder. According to Dayal et al (2014) shame facilitates the secrecy around eating disorders. This idea has been complimented by Skarderud (2007) and has been documented as a factor that postpones the individual in seeking treatment. The results of studies conducted with populations worldwide, suggest that individuals experiencing bulimia experience heightened levels of shame, when compared with those experiencing other forms of psychopathology (Cook, 1994; Frank, 1991; Goss & Gilbert, 2002; Grabhorn et al, 2006). The shame which is associated with bulimia presents as the strongest predictor of severity of symptoms and is suggested to develop as both a cause and a consequence of unhealthy beliefs about the self (Skårderud, 2007; Geller 2006).

In contemporary literature presented by Berkiaris and Koletsi (2019) it has been suggested that systematic reviews and quantitative studies have supported the notion of emotions playing a key role in the development and the maintenance of both anorexia and bulimia. However, less can be seen in the way of qualitative research focusing specifically on the role of shame. Emotional functioning has been considered to play a key role in the development of bulimia (Schmidt & Treasure, 2006). In literature presented by Harrison and colleagues (2010) it has been highlighted that individuals with an experience of eating disorders find difficulty in regulating their emotions, which leads on to maladaptive behavioural strategies. Studies that have focused specifically on the subject of shame in eating disorders have used trait shame measures. Examples of these are the Internalised Shame Scale (ISS; Cook, 1994) and the Personal Feelings Questionnaire (PFQ; Harder,

1987), which also addresses experiences of guilt. External shame has been addressed using scales such as the Other as a Shamer Scale (Allan et al, 1994) which focuses on how individuals believe others perceive them. Internal shame involves self-generated criticism and negative self-evaluation, whereas external shame involves a distressing awareness that others view the self negatively (Gilbert, 1998). The role of shame in binge eating disorder (BED) seems to be documented more frequently (Masheb et al, 1999) with the research findings indicating that shame within this population is mostly internalised and often associated with shape and weight concern.

The work of Cooper et al (1998) has indicated that restricting is an attempt to manage emotional difficulties arising from early experiences and as a way of trying to avoid rejection or abandonment. This work has highlighted how the restrictive behaviours in anorexia can be seen as an attempt to help people feel in control and more successful, whilst bingeing behaviours in bulimia can serve as a distraction from negative self – beliefs, unpleasant thoughts and emotional states. These findings have informed a number of the developments in Cognitive Behaviour Therapy in more recent years (Fairburn, Cooper & Shafran, 2003). However, it can be seen that these developments and new treatment models have been primarily concerned with addressing the meaning attached to size and shape as opposed to directly addressing the experience of shame in eating disorders therapeutically.

Shame can be seen as an important aspect of the core beliefs that may be associated with eating disorders. Research by Waller and colleagues (2000) explored the beliefs of females with experiences of bulimia. The researchers used the Young Schema Questionnaire (Young, 1999) and identified 'insufficient self – control' 'defectiveness/ shame' and 'failure to achieve'. Fear of losing control was found to predict the severity of bingeing and defectiveness/shame beliefs predicted frequency of vomiting (Goss & Allen, 2009).

Therapeutic interventions

Research by Williams & Leichner (2006) suggests that practitioners may be faced with clients experiencing an eating disorder regardless of having had very little or no specific training relating to the issues that commonly surround eating disorders. Bulimia Focused Guided Self Help is currently documented within the NICE Guidelines as being one of the first in line treatment options for a person experiencing bulimia. A practice based study carried out by Vermes (2011) has pointed towards guided self-help as being a cost – effective

treatment with rapid access and high acceptability for individuals with experience of bulimia and Binge Eating Disorder (BED). Within her work Vermes (2011) has highlighted that guided self-help offers significantly shorter waiting times when compared to waiting lists for individual therapy, and that this form of intervention is particularly effective for individuals who do not have a concurrent mood or anxiety condition. Enhanced cognitive behavioural therapy (CBT-E) is one of the leading treatment models for adults experiencing bulimia nervosa and is recommended in the event of Bulimia Focused Guided Self Help being ineffective, unacceptable or contraindicated (NICE, 2021). CBT- E is suggested to be an effective treatment for all eating disorders (Fairburn, 2008). A model for younger people has been developed, however, the evidence base for children and adolescent therapies is still limited and NICE Guidelines still recommend Bulimia Nervosa Focused Family therapy (FT-BN) when working with children and young people. If this is ineffective, the practitioner is recommended to consider CBT-E.

When working with individuals who are not considered to be 'significantly underweight' CBT-E typically involves an initial assessment which is followed by up to twenty treatment sessions, whilst a person who is underweight receives up to forty sessions. Studies have already evidenced that in comparison to anorexia, bulimic behaviours very rarely result in any significant weight loss (e.g. Gendall et al, 1999; Carter et al, 2004) therefore, patients with anorexia would potentially be most likely to receive the intensive version of the model as they are most likely to present as underweight. Within the model there is a central focus on weight and BMI, in session weighing has been suggested by (Fairburn, 2008) as being a key component of the model.

Within his work Fairburn (2008) discusses the in – session weighing, claiming that it has a number of purposes. These include; educating the client about their body weight and body weight generally, providing the client with week by week data on their weight, addressing body checking behaviours, providing an opportunity for the therapist to interpret the number on the scales, which is suggested to be often misinterpreted by the client, addressing avoidance of weighing and challenging fears about weight gain. It is recommended that the client is weighed weekly, the client and therapist both check the client's weight together and that the number on the scale is obtained, agreed on then spoken out loud in units (Fairburn, 2008). Whilst these are valid points relating to factors that need to be addressed in bulimia, the model can be seen to disregard any possibilities of bulimia not

being rooted in weight concerns and introduces a rigid central focus on weight and body shape (Fairburn, 2008).

The transdiagnostic theory (Fairburn, 1997) underpins the CBT model for bulimia and suggests that individuals may move between eating disorders throughout time and that eating disorders have more commonalities than differences between them. The theory further suggests that all eating disorders share a distinctive 'core psychopathology'. Fairburn (2008) highlights the central cognitive disturbance as a 'dysfunctional schema for self-evaluation' which is characterised through controlling and over – evaluating shape and weight. Cognitive behavioural therapy for eating disorders is designed to challenge thoughts and attitudes around weight and body shape, formulate coping mechanisms for resisting binge and purging behaviours and replace the individuals dieting with 'normal' eating habits (Fairburn, et al 2009). Whilst the transdiagnostic model has been shown to be effective in the treatment of eating disorders, it is important to acknowledge that the model itself has only undergone limited testing (Dakanalis et al, 2014). In addition to this, the language used to describe 'symptoms' of bulimia within the transdiagnostic theory can be seen to have a pathologizing nature. A study conducted by Lampard et al (2012) attempted to determine if relationships between core eating disorder maintaining mechanisms and additional maintaining factors outlined in the cognitive behavioural model were transdiagnostic. The researchers used a quantitative methodology and 1,475 participants diagnosed with an eating disorder completed the Eating Disorder Inventory-2, the Eating Disorder Examination Questionnaire and the Personality Assessment Inventory. The results suggested that factors such as low self-esteem, mood intolerance process and over evaluation of shape and weight were transdiagnostic. However, dietary restraint was only associated with binge eating in bulimia nervosa and some differences between diagnostic groups were observed. The researchers suggest the need for longitudinal research in this area to validate results.

The aims of cognitive behavioural therapy for eating disorders appear to be clearly defined and are highlighted within practitioner manuals (Fairburn, 2008). A qualitative study conducted by Onslow and colleagues (2015) focused on individuals lived experiences of CBT-E. Participants in this study were eight females with a diagnosis of bulimia. The findings of the study highlighted that whilst cognitive behaviour therapy is commonly used, individuals in their recovery process found difficulties in challenging their behaviours, describing them as 'compulsive' and 'automatic'. Shame was identified during the analysis,

with all participants talking about the lengths taken to conceal their difficulties from those around them. The researchers suggested that a third generation therapy such as Mindfulness (Kabat Zinn, 1990) may be beneficial in assisting clients in being more accepting of their unhealthy cognitions and behaviour patterns. The results of the study indicated that the most helpful aspects of the treatment were gaining an understanding of maintenance cycles and experiential learning. The key criticisms of CBT for bulimia (CBT-BN) are that only approximately 50% of patients receiving the treatment make a full lasting recovery and that attrition rates are high (Vanderlinden, 2008). However two research trials of patients with varying eating disorder classifications receiving CBT-E have presented promising results with reports suggesting that 53-66% of patients make a considerable improvement which is maintained at follow-up (Bryne et al, 2011; Fairburn et al 2009).

The use of family – based treatment for eating disorders is increasing (Hurst et al, 2015). A variety of interventions have been formulated during recent years with cognitive – behavioural therapies, group and individual psychotherapies (Ball & Mitchell, 2004), multi – dimensional approaches, family therapies (Folse & Krawzak, 2013) and feminist psychotherapies (Maine & Bunnell, 2008) being practiced within the area of eating disorders. Attention has been paid to the evaluation of bulimia treatments for adults, including nutritional (Salvy & McCager, 2002), cognitive behavioural therapy and interpersonal psychotherapy (IPT) (Fairburn, 1997). The National Institute for Clinical Excellence guidelines propose that cognitive behavioural therapy is superior to alternative psychological treatments for the adult population (NICE, 2021).

A study conducted by Toto-Moriarty (2012) focused on the effectiveness of psychodynamic psychotherapy for the treatment of bulimia nervosa. The author suggested that there are few empirical studies exploring the aspects of this specific intervention. The researcher used grounded theory to analyse data from fourteen interviews with women ranging in ages 22-46 who identified as recovered from bulimia nervosa. Five major themes were identified as being beneficial to the individual's recovery, 1) the psychological meaning of the symptom, 2) building the therapeutic alliance, 3) signs of progress, 4) the nature of the therapy, 5) adjunctive treatment approaches. The findings of this study appear to underscore the relational field in psychotherapy and the researcher suggests that clients identifying as recovered from bulimia nervosa may view psychodynamic therapy as effective when it is integrated with behavioural and adjunctive interventions such as journaling and keeping food

diaries. This view has been complimented by a number of researchers (e.g. Davis, 2009; Hamburg, et al 1996; Zerbe 2008).

A review of the literature surrounding the role of emotion in bulimia suggests that difficulty in emotion regulation may be a central maintaining factor in bulimia nervosa, specifically the experience of shame with a number of studies indicating that individuals with an eating disorder experience considerably higher levels of shame than other clinical groups (e.g. Masheb et al, 1999; Frank, 1991; Cook, 1994). In addition to this, it has been documented that a person with an eating disorder experiences high levels of self – directed hostility (Williams et al, 1993) and are often highly critical of themselves (Goss, 2011). Two forms of self-criticism have been identified one which is focused on feelings of self-disgust and the other which is overly concerned with a sense of inadequacy and making mistakes (Gilbert et al, 2004).

Literature presented by Barrow (2007) has evidenced that individuals experiencing an eating disorder criticised themselves more for the purposes of self – persecution/self – harming and reported considerably lower levels of self – compassion than a student comparison group. In addition to this, shame has been found to mediate the relationship between higher levels of eating disorder pathology and self-criticism (Kelly & Carter, 2012) . Contrary to self – criticism and shame is openness to compassion from the self and others. A study conducted by Kelly and colleagues (2013) found that fear of compassion and self – compassion were related to higher levels of eating disorder pathology, heightened levels of shame and poorer responses to treatment. Self – compassion has been negatively associated with external shame and eating psychopathology in females with experience of an eating disorder (Ferrieira et al, 2013).

Compassion – focused therapy (CFT) was developed as a model to specifically target self – criticism, shame and self-directed hostility (Gilbert, 2012). These are seen as processes to be addressed through the practice of compassion. The initial use of compassion focused therapy with eating disorders has made additions to the NICE (2005) guidelines for working with eating disorders (CBT in group format) (Goss & Allan, 2010). This was first developed to enhance the effectiveness of the already existing approaches to working with eating disorders by introducing interventions used to stimulate and cultivate affiliative processing. Over time, the model has developed into a comprehensive approach with its own specific

treatment protocol and theoretic model in which compassion cultivation is at the centre of the programme. CFT-E has proposed that the treatment efficacy of the existing therapies designed to work with eating disorders is potentially being limited to the client's inability to use the affiliative soothing system (Goss & Allan, 2010).

CFT-E is a group based intervention that can be seen to expand on the model of CFT in the way that it is designed to address the biopsychological factors that play a role in the aetiology and maintenance of eating disorders, including chaotic eating, the biological effects of restricting and implications associated with weight change and the function of eating disordered behaviours in regulating threat and drive systems (Goss & Allan, 2010). Within this model, particular attention is paid to developing the ability to work with eating disorders from a compassionate orientation. Whilst a number of interventions have been adapted from the original CFT model, CFT-E has maintained a number of interventions taken from the CBT model such as guided discovery, diary keeping, the use of Socratic dialogue, graded exposure and learning emotional regulation strategies. In addition to this, meal planning, exposure to specific foods and eating situations alongside working therapeutically relating to issues of weight and shape have all been retained which are elements from CBT protocols specific to eating disorders.

Goss (2011) has highlighted that food is usually experienced as a comforting experience by humans and therefore the soothing system and eating are closely related. He further argued that responses to eating and food itself, have the potential to become an issue if they are the only ways in which an individual is able to access their soothing system. Within CFT-E, the role of food and eating in the regulation of emotions is introduced within the psychoeducation stage of the model which allows space for the client to explore their experiences during the second stages of the model (capacity – building and recovery). The central aim within this is to enable the client to develop compassion for their eating habits and recognise the relationship between this and their emotions. The model further aims to generate different ways of thinking about the self as opposed to thoughts centred around shame and self-criticism, which may be linked to the body's normal need for food. Clients are able to work with alternative ways of activating their soothing system, developing an ability to differentiate between hunger and eating as an attempt to manage distress.

Evidence supporting the use of CFT-E is encouraging. Studies show that individuals with eating disorders make considerable improvements on a wide range of self – reported eating disorder symptoms over the duration of the treatment programme with individuals experiencing bulimia benefiting the most (Gale et al, 2014). It has been suggested that individuals with eating disorders experience a particularly dominant voice of a critical nature that is often experienced as a necessary and powerful part of the individual's identity (Tierney & Fox, 2010). As previously noted, research seems to have focused on this more specifically in relation to anorexia as opposed to bulimia, therefore an extended group based version of CFT-E model has been developed for individuals with particularly low weight (BMI 14.5 – 17.5) with a total duration of 40 weeks.

In consideration of the encouraging evidence supporting the use of CFT-E in group settings, it could be suggested that there is potential benefit to further research focusing on incorporating the use of CFT to work with eating disorders in a one to one setting. In my own therapeutic practice I take a preference to utilizing the CFT model, dependent on the individual needs of the client, and view this as being an effective way to work with issues such as shame, self-criticism and anxiety.

Rationale for the study

This qualitative study will make a contribution to the field of Counselling Psychology by offering an understanding of how participants make sense of and experience bulimia nervosa. This understanding has the potential to inform practitioners when working therapeutically with clients experiencing eating disorders. Within the field of eating disorders, literature focusing on bulimia is sparse when compared with the studies that have been carried out with individuals experiencing anorexia, suggesting a clear gap in the literature, evidencing a need for more research to address bulimia and the issues surrounding it more specifically. A review of existing research shows a key focus on the medicalisation of eating disorders, with frequent reference being made to signs, symptoms and diagnosis. In contrast, there is a limited amount of literature considering, the impact of pathologizing eating disorders and the stigma attached to experiences of bulimia. It is expected that the study will offer insight relating to the underlying aspects of bulimia that would benefit from therapeutic attention. Literature has evidenced that practitioners may be faced with clients experiencing an eating disorder regardless of having had very little or no specific training relating to the issues that commonly surround eating disorders (Williams & Leichner, 2006).

It is therefore essential for there to be contemporary literature available to practitioners that can assist in the understanding of eating disorders and provide insight into client experiences. This study will also consider ideas for future research relating to the understanding and treatment of bulimia.

Aims of the research

The research attempts to bring attention to the ways in which bulimia has been discussed in previous literature, the stigma associated with bulimia and consider how this may further impact on individuals' experiences, specifically their experiences of seeking and accessing support. The research considers how counselling psychologists may be positioned to work with eating disorders, whilst highlighting the challenges that can be found in use of the medical model and the pathologizing of eating disorders, attempting to offer alternative perspectives that challenge the idea of pathologizing bulimia.

Methodology

Design

The study employed qualitative methods to explore the lived experiences of individuals with a history of bulimia nervosa. Interpretative phenomenological analysis (IPA) was used to analyse the data obtained from interview transcripts. IPA has been described by Smith and colleagues (2009) as a qualitative methodology developed to examine the ways in which an individual makes sense of their own lived experiences. The approach can be seen as phenomenological with its interest in meaning making and interpretative with its recognition of the analysis as a hermeneutic process (Smith, 2011). IPA takes an ideographic approach as it focuses on the detailed analysis of individual participants. This research focuses specifically on exploring the ways in which individuals make sense of their experiences of bulimia. Throughout the process of conducting this research my key interests have been in understanding the meanings that participants attach to their experiences, and interpreting these findings as the researcher.

Epistemology of IPA

IPA has developed from a branch of philosophical thinking called phenomenology (Smith et al, 2009). This particular style of thinking is concerned with the ways in which individuals experience the world within particular time periods and contexts (Willig, 2008). From this philosophical standpoint, the concept of oneself and the world cannot be seen as separate from the meanings derived from them (Zahavi et al, 2014). IPA has been defined as a method that can be used to unravel the meanings that are held in individuals' accounts through a process of interpretative engagement within transcripts and text (Smith, 2011). IPA uses a series of tasks that enable the researcher to identify and integrate themes which are clustered within and between transcripts.

IPA has its origins in health psychology (Smith et al, 1997) and is theoretically rooted in the social cognition paradigm (Fiske & Taylor, 1991) and critical realism (Bhaskar, 1978). Critical realism acknowledges that there are enduring and stable features of reality that exist independently of human conceptualisation (Fade, 2004). The differences that are found within the meanings that individuals attach to their experiences are considered possible due to them experiencing different parts of reality. This research accepts that there are stable and enduring features of reality that exist independently of human conceptualisation. Differences

in the meanings that participants in this study attach to experiences are considered possible because they experience different parts of reality. The social cognition paradigm is grounded in the assumption that human speech and behaviour reflects these differences in meaning, either indirectly or directly. Therefore the analysis of interview data is viewed as being a reasonable method to develop an understanding of and access these differences.

The study aimed to understand how the participants had subjectively experienced and made sense of bulimia. Therefore a critical realist stance is congruent with the aims of this research, as it is concerned with the participants' experiences of reality, not the reality itself (Fade, 2004). The participants' accounts that have been gathered in this study are seen as being truthful accounts of their individual experiences, as a critical realist stance would accept the notion of multiple equally credible truths. If the participant provides what they consider to be a truthful account of their own experiences, this is accepted as truth. Utilising IPA to conduct this research, I became aware of a number of differences in participants' experiences, particularly when participants discussed the onset and development of their bulimia. It was important for me to remain mindful that each participants' account was to be viewed as their individual experience of reality. For example, for Lisa, an awareness of body shape was what she described as being a key factor in the development of her bulimia. Whereas Claire associated the onset of her bulimia as being triggered by the experience of stress and depression. When utilising IPA it is of importance to remain aware that neither of these were a representation of truth, or a reality in itself, rather a description of how each participant had subjectively experienced their own reality.

The primary goal of interpretative phenomenological analysis is for the researcher to develop an understanding of the participants' views and the meanings that they attach to their experiences, adopting an 'insider perspective' (Willig, 2008 p66). Braun and Clarke (2013) argue that this is never entirely possible, due to access to participants' experiences being dependent on the researchers own perceptions. The work of Braun and Clarke (2013) emphasise how this is a dynamic process with the researcher role being viewed as both descriptive as it attempts to describe how phenomena appear, and interpretive as there is an acknowledgement that there is no such thing as a phenomenon which is not interpreted (Braun & Clarke, 2013).

Once the researcher has made sense of the participants' accounts a second process is then suggested to take place in which the researcher attempts to make sense of the participants' sense making. This is described as a double hermeneutic process (Braun & Clarke, 2013) which calls for interpretation by the researcher who holds their own beliefs and assumptions which are brought to the process (Smith, 2011). Therefore, as IPA recognises the role of the researcher in attempting to make sense of the participants experience (Smith, 2003), it has a strong relationship with the hermeneutic or interpretative traditions, which emphasise how prior knowledge shapes the interpretative process (Denzin & Lincoln, 2005). Unravelling the meanings held in the participants' accounts within this study is a process that has involved a significant amount of reflection. This has been in order to make sense of my own sense making of participants' experiences. Due to my own experience of practicing therapeutically within the field of eating disorders, my own sense making of participants' accounts has been especially important to consider at times in which participants discussed their experiences of therapy and engagement with eating disorder services. At some points during the interview process, I found myself recognising particular services mentioned by participants and was already familiar with the specific pathways and procedures followed within these services. The use of a reflective journal and utilising regular supervision with my research supervisor has been a key factor in my own ability to hold boundaries between my two roles as a practitioner and as a researcher, whilst acknowledging my own experience of working within the field and making sense of this in relation to my interpretations of the data.

IPA is viewed as having three characteristic features, one of these being its strong ideographic focus, as it is concerned with a detailed case by case examination. The cross – case analyses which look for the emergent themes, which the participants share and those that are distinctive to the individual, are only attempted once this has been achieved (Smith, 2003). IPA is inductive as it uses techniques that are flexible enough to allow unexpected discussions to emerge throughout the data collection and the analysis process. Therefore, IPA does not seek to confirm any hypotheses, instead, it aims to collect expansive data. Finally, IPA is seen as being interrogative, as the findings of the analysis aim to make a contribution to the already existing literature by interrogating the current research base (Smith, 2004).
It was important to acknowledge that whilst this research was mostly inductive, welcoming new discussions and themes to emerge within the data, not testing any theories or hypotheses. There was a deductive aspect of the research in which a preconceived expectation was that

participants would respond with answers relating directly to the topics that were highlighted in the interview schedule. In consideration of the deductive aspect of this research, it was important to acknowledge my own experiences of having worked in the field of eating disorders and having a friend with an experience of anorexia. Whilst these experiences will have impacted on the entire process of conducting this research from the initial planning to the interpretation of the data, I particularly became aware of this when creating the interview schedule and recognised my own pre-conceived expectation that participants would have longer responses in relation to the question 'can you tell me about the emotional impact of bulimia?'

Rationale for using IPA

IPA is suggested to be at an advantage in terms of exploring the ways in which individuals make sense of or find meaning in their experiences (Smith, 2011). When first deciding on the most appropriate methodology for this study both IPA and thematic analysis (TA) were considered. Following careful reflection on different aspects of this research such as the participant sample, the philosophical paradigm underpinning the study and the research question TA was rejected. IPA and TA follow a completely different procedure. In addition to this, TA is a method used for the collection and analysis of data as highlighted in the work of Braun and Clarke (2013) and IPA is an approach which is theoretically informed (Larkin et al, 2006). TA can be seen as flexible around some of its different features such as the ontological and epistemological underpinnings, in that it can be used for studies across the spectrum, where as a study utilising IPA is specific to the underpinnings of critical realism and contextualism (Larkin et al, 2006). Within IPA research participants are asked questions about their experiences and their perspectives which falls in line with the research question of this study being centred on 'lived experiences of bulimia nervosa'.

Data collection

After careful consideration of the most appropriate methodology for the study, it was important to remain mindful that the key aim was to gather data directly from participants, resulting in a singular method of data collection through semi – structured interviews. Literature presented by Smith and colleagues (2009) supports the idea of this research instrument being the most suitable when exploration is the primary aim.

A semi – structured interview schedule was designed following engagement with the current body of qualitative literature available and the specific areas that the researcher hoped to explore with the participants. The first question provided participants with an open invitation to tell the researcher about themselves and how they have come to identify as a person with bulimia and further questions focused on individual meanings of bulimia, lived experiences of bingeing and purging behaviours, the physical feelings associated with bulimia, perceptions of body weight, the emotional impact of bulimia, goals with regards to recovery and hopes for the future. At the end of the interview participants were also offered the opportunity to add anything that they felt may not have been covered throughout the interview. Interviews lasted between forty five minutes and one hour.

Interview process

The importance of good interviewing skills is highlighted by Smith (2011) who suggests that the interviewing skills used by the researcher are key to obtaining high quality data. The interview schedule for this study consisted of sixteen questions and prompts (see appendix B). I asked the participants if they had any further questions before starting the interview. One participant expressed concerns around exactly who would have access to their personal information i.e. name and email address. The participant was informed of this and reassured by myself that none of this information would be documented in the study. Once ensuring that participants had no further questions, I started the interview process and began working through the semi – structured interview schedule. I was particularly interested in the participants who shared their feelings of being more comfortable with telephone interviews, associating this with the experience of anxiety and shame relating to being visible during the interview. The first interview which was a face to face interview was originally designed to be a pilot interview, however, the interview went well generating high quality data, therefore, I made the decision to include this in the study. All interviews were conducted by following the same procedure of ensuring consent had been obtained, asking the participant if they had any further questions and then working through the semi – structured interview in the convenient order. The only times in which question(s) were missed was if the participant had already answered the question(s) in a previous response.

Participant sampling and recruitment strategy

Seven female participants for this study were recruited through the use of a University participant pool, an eating disorder charity, an Eating Disorder Peer Support Group and Social Media Advertisements. Three participants came forward via the University participant pool, two participants made contact with me through the eating disorder charity and the remaining two made contact via social media. Smith and colleagues (2009) focus on the process of recruiting the correct number of participants for an IPA research study, specifically suggesting between six and ten participants being sufficient for research being conducted on doctoral programmes. I was aware throughout the process of recruiting participants for this study that a key aim of each interview was to gather meaningful in-depth data, holding this in mind, seven participants were recruited for this study.

The inclusion criteria for this study was anyone over the age of 18 who self identifies as bulimic or as having current or previous experiences of bulimia. Four participants who had received a formal diagnosis and three that self- identified with bulimia came forward. I decided not to exclude participants that had not received a formal diagnosis as I was interested in their experiences of accessing support and curious as to how receiving a diagnosis may have impacted on this. An advertisement was sent out to the eating disorder charity, the peer support group the University and posted on social media pages. Participants were provided with the option of face to face, Skype or telephone interviews. Demographic information was collected prior to the interviews taking place and all participants were provided with information sheets (see appendix C) prior to participating. Two of the participants shared via email communication that they would feel less anxious talking over the telephone. One interview was conducted via Skype and three interviews were conducted face to face. Two of the face to face interviews were carried out in a one to one setting within a University setting and one was carried out at the participant's home. The three participants who were interviewed face to face shared that they were made to feel comfortable and at ease throughout the interview process, two of the participants who chose to be interviewed via telephone emphasised how the use of telephone would ease the anxieties they were experiencing in relation to meeting with the researcher face to face, one telephone interview was chosen due to practical issues with meeting in person. Unfortunately during the skype interview there were technical complications at the start of the interview, however, I was able to collaboratively solve this problem with the participant and we successfully completed the interview at a later time.

Participants in this study

Basic demographic information 1.1

Participant	Age	Occupation	Ethnicity	Diagnosis status	Marital status	Experience of therapy
1 Victoria	23	Student	White British	Diagnosis received	Single	No
2 Lisa	27	Employed	White British	Diagnosis received	Single	No
3 Jess	31	Employed	White British	Diagnosis received	Married	No
4 Claire	21	Student	White British	Self - identified	Single	Yes
5 Sam	34	Employed	White British	Diagnosis received	Married	No
6 Sally	30	Employed	Mixed heritage (White and Asian)	Self - identified	Single	Yes
7 Sarah	24	Student	White British	Self – identified	Single	Yes

Rationale for interview only

Semi – structured interviews are a well – established method of data collection for qualitative studies (DiCicco-Bloom & Crabtree, 2009). The interviews enabled participants to explore and make sense of their understandings of bulimia nervosa. Willig (2008) has emphasised the ways in which interviews can also enable participants to challenge the researcher's beliefs and assumptions about the relevance and the meaning of the concepts being explored within the research. In addition to this, it has been suggested by Smith and colleagues (2009) that interviews enable the development of rapport, allow participants time to process and be heard. I decided to use semi - structured interviews for this study in order to support the attempt to build a strong rapport with my participants whilst considering the sensitive nature of the topics being discussed. Semi – structured interviews were favoured over structured interviews as it allowed for participants to speak freely about what they felt was relevant to the interview questions and for the interviews to feel less formal, encouraging the participants to feel more at ease throughout the interviews. Novick (2008) has suggested

that telephone interviews are neglected within the field of qualitative research and that they are commonly viewed by researchers as being a less attractive alternative to face to face interviews. This suggestion is based on assumptions that telephone interviews put the researcher at a disadvantage when attempting to build rapport with the participant and that the absence of visual cues can result in loss of non-verbal data and further impact on the researcher's interpretation of responses. However, it seems of importance to consider that telephone interviews provide flexibility for the participant and may allow the participant to feel better able to disclose sensitive information that they may be reluctant to disclose when face to face with a researcher. Following consideration of this literature, I decided to proceed with three telephone interviews. When conducting the interviews, it was important to remain mindful that the interview schedule consisted of sixteen questions in total, and prompts. Each interview was different, and whilst some participants were asked all sixteen questions, others had answered more than one question in one of their responses. In this case, it was unnecessary to ask all of the questions listed. I was able to be flexible with this aspect of the research due to the interviews being semi – structured. I managed time throughout the interviews by monitoring the amount of time spent on each question, and encouraging participants to elaborate on their responses if it seemed the participant may have had more to say in response to the question. Interview prompts were effective when I decided to use them to encourage participants to elaborate, to manage time and to avoid any diversions away from the research topic.

Ethical considerations

Ethical approval for this project was first sought from my University. The risks of this study were assessed as being relatively low. Risk identified with regards to the myself visiting participants in their homes to conduct interviews was managed through the use of a 'buddy system' in which the researcher made another person aware of their time of arrival and time of leaving the participants home, ensuring safety of myself throughout the interview process. Richards and Schwartz (2002) has highlighted risks inherent in qualitative research and suggests that qualitative research, brings with it the risk of causing participants anxiety and distress. This is due to qualitative research often being used to explore sensitive topics and being probing in nature. In order to minimise any possible distress I ensured that I engaged with regular supervision with the supervisor of this research to ensure that any

challenges were avoided or resolved in order to ensure care of the participants. I aimed to develop a strong rapport with the participants in the hope of reducing any anxiety that participants may have been experiencing, prior to gathering the data. Participants were informed of their right to terminate the interview at any point should they wish to do so. Throughout the interviewing process I was able to utilise basic counselling skills including adopting a non – judgemental and empathetic approach to conducting the interviews, this was in the attempt to provide a sense of safety in which participants felt comfortable to share their experiences.

I ensured that all participants were reminded at the start and during the interview process that they could refuse to answer any questions that they felt uncomfortable with. In addition to this, I was aware throughout the duration of the interviews to monitor all participants for signs of distress. In this study, none of the participants opted to pause or terminate the interview, however, if this had happened, I would have offered a debriefing session to the participant in the hope of alleviating any distress prior to leaving the interview. All participants were provided with the details of the research supervisor in case they had any complaints relating to any part of the research process.

Informed consent

Informed consent was obtained from all participants in the study, through explaining what to expect from the interview process and informing participants of the topics covered in the interview. Participants were informed of how the information that they provided would be used (this was explained verbally and documented in the participant information sheet). It was clearly explained that participants had the right to withdraw their consent at any time until the write up and submission of the research (consent form can be found in appendix D).

Confidentiality and Data Protection

I gained consent from participants to use verbatim extracts from the interviews in any write up with the reassurance that any identifiable information would be removed in order to ensure anonymity. Any identifying data was only accessible to me and any data that I shared

with the research supervisors was anonymised (confidentiality statement can be found in appendix C).

Data Analysis

Interviews were transcribed verbatim as soon as possible after the interview. The initial analysis process started during transcription. This ensured that the interactions between myself and the participant were captured in detail and that my own initial interpretations were documented. I was then able to draw on these initial interpretations and subsequent identification of themes for the final analysis. Throughout the analysis process I was aware of holding my research questions in mind. I was able to acknowledge how this can influence the analysis of the data. I ensured that I was using my reflective journal to document this part of the process throughout, acknowledging the double hermeneutic process, and acknowledging my own beliefs and assumptions which are brought to the analysis.

Reading and re – reading the transcripts

The process of data analysis started by noting initial ideas in the first interview. This began informally during the interviewing process in which my initial interpretations were later recalled and continued through the process of transcription and reading and re-reading the transcripts. A key aspect of IPA is the researcher's ability to 'totally immerse themselves in the data' (Pietkiewicz, & Smith, 2012, pp. 6). During the initial stages of the analysis I aimed to do this through reading and re-reading the transcripts. When making my initial comments in the left hand column I was also able to take a reflexive position as suggested by Pietkiewicz and Smith (2012). In this, I considered how my own characteristics as the researcher may have impacted on the rapport with the participant, further influencing the process of the interview. Three participants in this study were of similar age to me, all participants identified as the same gender and five identified with the same marital status.

Initial noting

When reading the transcripts I made comments in the left-hand column regarding any interesting and significant issues. Following this, I then used the right-hand margin to document the emerging theme titles. An example of this can be found in appendix G which evidences initial notes made in the left hand column of Sally's transcript. Notes highlighted 'a way of gaining control in other aspects of her life' this later contributed to the development of the superordinate theme 'Control' and subtheme 'a sense of empowerment through

bulimia'. When making initial notes, the secretive aspect of bulimia emerged with all seven participants discussing their experiences of this.

Developing emergent themes

When working towards the process of transforming notes into emergent themes on a case by case basis, the concept of 'feeling trapped' continuously emerged and was initially going to be a superordinate theme, however, following further analysis and discussion with my supervisor, this concept was seen as being closely linked to feelings of wanting to escape. I specifically focused on these aspects of the data in an attempt to identify what the participants were attempting to 'escape' which further led to identifying a 'cycle' bringing attention to experiences of feeling trapped within this. When analysing the data case by case, it was clear that there were aspects of control within this cycle and feelings of guilt and shame.

Searching for connections across emergent themes

When I moved to considering connections across the emergent themes and developing the clusters for each case, the connections could be seen in participants' experiences of attempting to gain control, feelings of guilt and shame and ultimately the loss of control as a result of bingeing and purging. The challenges found in breaking this cycle were evident within the data that highlighted the feelings of being 'caught in a repeated cycle of bulimia' which then became a superordinate theme.

Repeating the process by moving on to the next case

The above process was repeated for the analysis of seven transcripts. Throughout the process of analysis I had carefully selected the quotes which best reflected the themes that emerged. This process was repeated during the write up of the results when the themes were finalised, I then revisited all interview data to highlight any further quotes which illustrated the themes. I ensured that I utilised supervision throughout the process of analysis.

Looking for patterns across the data

The use of bulimia as an attempt to cope with conflicting parts of the self was present across the data. Participants talked about identifying with two parts of the self (one that was caught in the cycle of bulimia and one that wanted recovery, and to escape). At first this conflict was going to be a sub theme of superordinate theme 'control' however, when I focused more specifically on these parts of the data, it could be seen that five out of seven participants likened it to an addictive process using terms such as 'fixing cravings' 'feeling addicted' and 'being hooked' to describe their experiences. When noting that this association was made by five participants, it was important to be mindful of not generalising this process to experiences of bulimia and to focus on the sense making of each individual participant which is a central factor of IPA.

Creating the table of themes

During the earlier stages of analysis, I initially identified three superordinate themes, however, as a result of continuous engagement with the data and a sense of curiosity relating to how the participants who identified as 'recovered' or 'in recovery' had reached that point, I identified a fourth superordinate theme 'The journey in recovery'. This theme highlighted aspects of participants experiences in psychological therapy that pointed towards the role of self-discovery and acceptance within their recovery from bulimia (a draft table of themes, which was constructed during the earlier stages of this research can be found in appendix F). Following this I created the final list of sub – themes and super – ordinate themes.

Reflexivity

Throughout this research I have kept a reflective journal. This has highlighted a number of feelings and automatic responses to the research material which originate from my own views surrounding eating disorders, the effectiveness of treatments and access to support. The journal has also brought attention to my original reasons for wanting to conduct research in this area.

My interest in the subject of eating disorders has stemmed from an early experience of having a close friend with a diagnosis of anorexia nervosa. Whilst this research has focused on bulimia, when carrying out an initial literature search it became evident that there was a lot less in the way of literature focusing on experiences of bulimia and that there is a stronger focus on anorexia. I believe the experience of witnessing my friend's journey from the onset of her eating disorder and hearing her version of events which highlighted feelings of being misunderstood and pathologized encouraged me to further explore the experiences of others and left me with the desire to contribute to the developing knowledge within this field.

Witnessing my friend's experience of identifying with anorexia unquestionably influenced my personal opinions relating to the issue of pathologizing eating disorders. Prior to conducting this research and throughout the process, I have been able to recall a number of experiences in which my friend shared with me the feeling of 'there being something wrong with her' which was a result of how she had been approached by others (i.e. professionals, family members and friends). I was at the time aware of how powerful her need was to feel understood by those around her.

Whilst I chose Interpretative Phenomenological Analysis due to it being well suited to counselling psychology and the most suitable for exploring lived experiences, I also decided to use this method due to its reflective nature and to bring awareness to my own sense making of the data.

Interpretative Phenomenological Analysis can be seen as a dual interpretive process, also known as the double hermeneutic process, whereby participants are attempting to make sense of their world and the researcher is attempting to make sense of the participants' sense making (Braun & Clarke, 2013). This was an important factor to consider throughout all

stages of the research. My reflective journal particularly highlighted times throughout the research whereby the accounts of participants were very similar to those of my friend. I believe these accounts have contributed to my own already existing views about the dangers of pathologizing eating disorders and my perspectives surrounding the need to adopt an alternative, more understanding approach when working therapeutically with clients presenting with eating disorders.

It has been important for me to consider my own positioning as a trainee counselling psychologist, who during training has worked clinically practicing CBT-E within an eating disorders outpatient service. Whilst working in this setting, a compulsory component of 'treatment' was to weigh clients prior to their therapy sessions. Clients were weighed on a weekly basis. I personally found this challenging. At times I struggled to understand the reasoning behind this being a mandatory aspect of treatment and was not surprised to hear a number of participants in the study also struggle with this. There seems to be very little in the way of literature documenting the impact of this on treatment outcomes. My own experiences of this process as a practitioner has been negative as I hold the view that it can contribute to shame in this client population and fails to compliment the idea of developing models of practice based in the primacy of the therapeutic relationship, a key aspect of counselling psychology.

Whilst working clinically with this client group I was always interested in the client's experiences and how the idea of being weighed may have impacted on the therapeutic relationship, further impacting on their experiences of therapy. My experience of working in this setting led me further to incorporate questions for this study, which allowed for an exploration of participants' experiences of receiving support for their bulimia and a space for them to share their thoughts around what may be missing from current treatment approaches.

The use of my own reflective journal has been crucial to processing my own feelings towards a number of responses from participants when questions were centred on participants' experiences of services. I felt myself empathise with their comments surrounding frustrations that they experienced with regards to feeling misunderstood by others (professionals and family members).

I believe that I was able to develop rapport with my participants through the use of counselling skills and an ability to communicate an understanding of some of the issues involved in the area of eating disorders. It has been important throughout the research, specifically the interviewing process, to remain mindful that the focus is research and not therapy. When reviewing the content of my reflective journal I have been able to identify points during the interview in which I found participants demonstrating an increasing depth of disclosure as the interviews progressed as opposed to limited responses that were apparent at the start of interviews, which I believe evidences the building of rapport throughout the duration of the interviews.

Results

The study was carried out with seven female participants ranging between ages 21 – 34. All participants except one identified as White British. Four of the participants had received a formal diagnosis of bulimia and the remaining three participants self-identified. Three of the participants identified themselves as students, four participants were in full – time employment.

Findings from the interview data 1.2
Super – ordinate and sub – ordinate themes

Super-ordinate Themes	Sub-ordinate Themes
Super-ordinate theme 1 The search for control	**Sub-theme 1a** Feeling controlled by others
	Sub-theme 1b A sense of empowerment through bulimia
	Sub-theme 1c Feeling powerless as a result of bulimia
Super-ordinate theme 2 Caught in the repeated cycle of bulimia	**Sub-theme 2a** Bulimia as a secret lifestyle
	Sub-theme 2b Keeping the cycle going; a fear of incorrect assumptions and misunderstandings
Super-ordinate theme 3 Inner conflict; ‘fighting a battle mentally'	**Sub-theme 3a** Bulimia as an attempt to regulate emotion
	Sub-theme 3b Addictive properties of bulimia
Super-ordinate theme 4 The journey to recovery	**Sub-theme 4a** Release and self-discovery through psychological therapy
	Sub-theme 4b The shift from fighting to acceptance

Super-ordinate theme 1: The search for control

The first super-ordinate theme considers different aspects of control experienced by all participants. Every participant discussed the concept of control. The ways in which the participants talked of their understandings and experiences of this varied. A number of participants talked about feeling that they had lost their sense of control at a young age, with some participants specifically highlighting the early experiences of feeling controlled by family members. For some the emphasis was on drawing attention to their need to feel in control of their own life, other participants discussed feeling 'controlled' by their bulimia. The analysis identified that associated with bulimia is a state of feeling out of control and the behaviours associated with bulimia were seen as an attempt to regain control in the areas of their lives in which they felt it had been lost.

> *'I have always been scared of not being in control I didn't really have any control in my life until I was a teen and now my only control comes from me controlling what I eat I was controlled a lot when I was young by my mum she was a good mum and loved us but she was controlling in so many ways' (Victoria)*

> *'I was trying to feel OK with myself it was a very bad time in my life with a lot of depression and it was all spiralling out of my control I just wanted to feel more able to manage my own life' (Sarah)*

These extracts can be seen to capture the experiences of feeling out of control and the desire to regain it. Sarah communicates a sense of desperation to be in control of her own life, highlighting a particularly difficult time in her life when she was experiencing depression. It was evident from her accounts that bingeing and purging were used as attempts to cope with this. Sarah emphasises her wish to feel more able to manage her life and feel more comfortable with herself. Victoria discussed control from a different standpoint, focusing more on the experience of being out of control, identifying with a sense of fear in relation to this. Victoria seemed to have lost her sense of control at a young age through an early experience of feeling controlled by her mother, this evidently impacted on her adult life and seemed to further influence factors associated with the development and maintenance of her bulimia. Victoria made it clear that she had always feared being out of control. It can be seen

from her narrative that her attempt to gain a sense of control was through controlling her foods.

Following analysis it became evident that the re-occurring theme of control mostly presented at times when participants were answering questions about the onset of their bulimia, focusing on the initial stages and the ways in which bulimia developed over time. It was clear during the fourth interview with Claire that she had prior experience of feeling out of control and during her interview she was able to consider the experience of attempting to meet the need of regaining this control through her eating habits. There was a sense of desperation evident in the way that she discussed this. From a reflective position Claire seemed able to recognise that she was not in control during this time even though at the time she believed she was. There was a repeated pattern evident throughout Claire's interview in which she found herself in positions where she felt that she was being controlled. Bulimia presented as an attempt to regain control and agency in her life.

> *'I felt so out of control the whole time but was trying to get control through my eating I desperately just wanted to be in the driver's seat, but I never was' (Claire)*

The concept of control appears to be one of heightened importance in relation to bulimia, however it seems that some of its dimensions are more consistently associated bulimia symptoms than others. Determining the dimensions of control that are most central with bulimia is important as it has the potential to assist practitioners in understanding the specific aspects of control (if any) that need to be assessed and possibly addressed within interventions, however only very few studies have explored this (Tiggemann & Raven, 1998; Donovan & Penny, 2014). The concept of control is frequently highlighted within eating disorder literature, however, research focused on bringing attention to early experiences of feeling controlled by others is less apparent. Insight to early experiences has the potential to highlight factors that may contribute to the development of bulimia and further inform therapeutic interventions.

Sub-theme 1a: Feeling controlled by others

Three participants in this study specifically highlighted the feeling of being controlled by others in their lives. Participants described these experiences as being overwhelming. Lisa, Claire and Sally highlighted this within their interviews. They referred to childhood experiences and clearly emphasised the impact that feeling controlled by others had on their eating habits. The ways in which these participants' communicated their experiences suggested that bulimia had been an attempt to regain control.

> *'Like at home both my mother and my older brother try and control like what I do and can get really bossy but like it's done in a controlling way' (Lisa)*

> *'because I was living with my boyfriend, I would only be sick when he was out he was very controlling as well I couldn't do much without his say so I had to lie to him about it all which made me feel more guilty' (Claire)*

Lisa and Claire both described in depth experiences of feeling controlled. During the second interview with Lisa she frequently referred to her teenage years, at home as being a time that she felt controlled by her mother and brother. These feelings were presenting during the time that she started to engage with bulimic behaviours, suggesting that they may have contributed to the onset of her experience. It seemed that Lisa's experience of feeling controlled were endured and further influenced her behaviours during the time she struggled with bulimia. Claire talked about the experience of feeling controlled within her relationship, sharing her experiences of feeling controlled by her partner and using bulimia as an attempt to manage her feelings and to regain a sense of control that she felt had been taken from her at that time.

> *'I already had to lie about everything, I couldn't do anything or have anything of my own he was so obsessed and would control everything I would do' (Claire)*

'That must've been really hard for you'

> *'Yeah it was a really tough time I lost everything in that relationship when I was down I would just binge, being sick was my way of controlling it all really and having something of mine, it was one thing he didn't know, not in the beginning anyway' (Claire)*

Whilst it seemed that Claire was using bingeing as an attempt to manage the uncomfortable feelings that would arise as a result of the dynamics within her relationship, it was evident within her accounts that the concept of control was closely linked to bingeing and purging behaviours. It seemed that Claire experienced a sense of control from holding her bulimia as a factor in her life that her partner remained unaware of, in addition to this it appeared that other areas of Claire's life were out of her control as a result of her relationship and that she was attempting to regain this control through her bulimia. Within Claire's narrative there was also a sense of loss, Claire seemed to have experienced the loss of various factors in her life that had previously brought her happiness. The concept of loss was reoccurring, presenting at various points throughout Claire's interview. It seemed that whilst Claire had experienced loss, her bulimia was the one factor in her life that remained a constant, that she evidently felt she had taken ownership of describing it as 'something of mine' Whilst Claire's bulimia seemed to serve as a constant factor in her life, Claire was able to recognise the loss that presented as a result of her bulimia, discussing this in a way that implied her bulimia took away from her a sense of happiness, and brought with it the experience of loneliness.

> *'I didn't realise that my obsession with exercise was making me lonely at the time, I was really isolated I only see that looking back though I didn't see it at the time but I was happier with myself before I got into all this then it was just like anything positive was gone because all I could really think about was this' (Claire)*

Lisa's experience of feeling controlled centred around feeling controlled from an early age. Her narrative suggested that she had previous experiences of feeling that she had very little control over her life and emphasised that when she moved away from home, she felt she was able to gain a sense of control. This seemed to be a result of separation from the members of her family whom she described as controlling. During Lisa's interview she talked about feeling controlled at home by her mother and her older sibling, describing them as 'bossy' and often attempting to control aspects of her social life. The extract below suggests that the experience of growing up in an environment in which she felt controlled may have contributed to the development of her bulimia. Individuals having had previous experience of feeling a lack of control and attempts to gain this through eating behaviours, is something that I have seen in my own experience of working therapeutically with this client group. Therefore it was important for me to remain aware of this during analysis, ensuring that I reflected on these experiences through reflective writing and utilised regular supervision to

focus on the separation of client and participant experiences and my own experiences of understanding and interpreting both.

> *'there have been times I have had no control over it but like when I moved from home to the city umm it really was loads better because I could control everything, I had a plan with eating and things were going well. I definitely think that my environment has a relationship with my bulimia, like the people that I am around' (Lisa)*

During interview six with Sally, she also talked about having experience of a challenging relationship with her mother. Sally's descriptions of her mother implied that she was controlling and indicated conflict within the relationship. Sally's account suggested that this further left her feeling separate from her family stating 'my whole family were against me'. At multiple times throughout the interview Sally indicated she was 'unhappy' from a young age, associating this with the development of her bulimia, further suggesting the impact of feeling controlled by others and the links between this and the development of bulimia as an attempt to gain a sense of control.

> *'so it all just came at once I was I think around 14 I wasn't a happy person at that age and like I said I was very depressed I had issues with my mum she always wanted me to just do what she wanted, never really what I wanted and like yeah I felt like my whole family were against me at the time' (Sally)*

Similar to Lisa, Victoria highlights her experiences of feeling controlled by her mother from a young age.

> *'Yeah so just like always controlling what I did and not really letting me go out with friends and stuff I didn't have any brothers and sisters so it was just me and her, I made friends at school wanted to be out of the house more and she didn't really like that, I mean it meant her being alone she was controlling in many ways that's just part of it but like yeah I remember feeling scared about not having any control over my own life and like that's how I feel about bulimia like I get scared that it will control me forever' (Victoria)*

There was an evident conflict found in the link between bulimia and control for Victoria. It seemed that she described it as a way of attempting to gain a sense of control in her life when she felt that she was being controlled and restricted by her mother, something that she felt

fearful of, however, Victoria expressed similar fear in relation to bulimia becoming the a factor that controls her, clearly presenting the same state of fear. It seemed evident that the role of bulimia switched from becoming the perceived solution to not having control and later became the controller, highlighting the vicious cycle set up within this pattern. The sense of fear experienced by Victoria seemed to be rooted in her early experiences, and a factor that remained present prior to, during and following the onset of her bulimia.

Sub-theme 1b: A sense of empowerment through bulimia

Five out of seven participants emphasised the need to be in control of their own lives, whilst this related closely to the discomfort found in feeling controlled by others, participants drew on other aspects control such as feelings of empowerment. Within this sub-theme the underlying emotional factors, often driving the behaviours became evident. Sally captures this in her narrative when she describes being in what she termed as her 'happy place' being a time that the desire to engage with bingeing and purging subsided, she links this to the concept of gaining control.

> *'when I was in a happy place I didn't want to do it I think like when everything was going good for me but then when I wasn't my bulimia was my way of trying to get some control something only I could do with nobody interfering' (Sally)*

There was a sense of sadness when Sally shared this part of her experience, as she recognised that she was using her bulimia as an attempt to cope with underlying feelings that were perceived as being unmanageable for her at that time. It seemed that Sally was able to identify the feeling of being out of control as a trigger for her bulimia. She was able to identify bulimia as part of a cycle in which she was attempting to fix one problem with another, recognising how bulimia was dependent on her emotional states. Within her interview Sally was able to reflect on her experiences, evidencing a compassionate approach towards her younger self. Within this Sally was able to associate her bulimia with self-destruction.

> *'I can really see how much of a hard time I was having and I was just trying to fix all my problems with another problem in itself it is hard to really say exactly what it means to me because like I said it has meant so many different things over the years*

and now it just means destruction to me, I know when I am having my bulimic thoughts I am being destructive' (Sally)

Like Sally, Sam shared her understanding of needing to be in control as part of a cycle, Sam identified as 'being in recovery' at the time of her interview. She specifically brought attention to feeling the need to gain control of her body weight as being part of a repetitive cycle and identified with a hope that 'the state of being in control' would transpire into other areas of her life. Sam talked frequently about needing control and recognised the need for control a maintaining factor of her bulimia.

'it felt very much like being out of control and a real cycle of needing that control and losing it' (Sam)

Similar to Sam's account, Claire was able to recognise her bulimia as an attempt to gain control and identify with losing control as a result of this, clearly highlighting the vicious cycle evident within this pattern. This was particularly presented when she discussed the attempt of gaining control through her eating, whilst at the same time identifying with being out of control. There was a sense of desperation present when Claire discussed her experiences of this, implying that it felt like a continuous battle.

'I felt so out of control the whole time but was trying to get control through my eating I desperately just wanted to be in the drivers seat but I never was' (Claire)

Throughout her interview, Claire shared her history which consisted of being bullied during primary and secondary school, alcoholism within the family and the experience of her parents separating when she was a teenager. It was clear how all of these events were out of her control and that she had experienced a sense of powerlessness in relation to these experiences. Claire discussed her previous experiences of self-harming behaviours (cutting and burning) as attempts to cope with these events, specifically the separation of her parents. Claire shared that the onset of her bulimia was at the time she stopped harming through these methods, suggesting that her bulimia was an alternative attempt to cope and possibly regain the control that she felt she had lost within other areas of her life. Literature by Wonderlich and colleagues (2002) have questioned the associations between bulimia nervosa and self-harming behaviours and suggested that research in this area is sparse. According to Zanarini and Frankenburg (1997) the question of what causes self-harming behaviour in individuals

with a diagnosis of bulimia is multi-determined with social, psychological and biological factors implicated (Paris, 1997). A study conducted by Deep et al (1999) has suggested that self-harming behaviour in individuals experiencing eating disorders is associated with histories of childhood trauma, this research has been complimented in a study carried out by Favaro and Santonastaso (1998) and studies of both children and adults who have experiences of trauma suggest that childhood mistreatment may promote both an increased risk of impulsive and self – harming behaviour and disturbances in eating (Wonderlich et al 2001). Such literature evidences the importance of bringing attention to the early experiences of individuals identifying with bulimia.

Similar to Claire, Sarah reflected on times that she felt out of control and clearly described a need to feel in control of her own life. Sarah discussed the attempt to feel OK with herself during her experiences of depression, suggesting that her bulimia presented as an attempt to regain control of her own life during a time in which she felt this had been lost.

> *'I was trying to feel OK with myself it was a very bad time in my life with a lot of depression and it was all spiralling out of my control I just wanted to feel more able to manage my own life' (Sarah)*

Sarah associated the existence of her bulimia with the events taking place in her life during the onset and the duration of her experience, clearly making the association between the underlying feelings that presented as difficult to manage and the use of bingeing and purging as an attempt to gain control. Sarah talked at a depth about her experiences of losing control introducing a sense of powerlessness.

> *'During it and before I had just completely lost all control of everything, nothing was going the way I needed to and it felt like I couldn't do anything about it at the time' (Sarah)*

'And do you remember what sort of triggers you might experience before engaging with the behaviours?'

'I think main triggers would be like anything bad happening in my day so like getting a bad mark in a test or you know falling out with a friend or even feeling low in that day that would trigger it' (Sarah)

It seemed that as a result of making the associations between gaining control and bingeing and purging, when something difficult would arise in her life, she would revert back to these behaviours which were part of her familiar pattern in attempting to cope. This is something Sarah discussed as being challenging throughout the process of her recovery. Sarah found it difficult to identify alternative methods of attempting to gain control in her life when this need would present itself. In the above extract Sarah describes this as being one of her main 'triggers' when we discussed the concepts of recovery and relapse in her interview.

'it makes me feel more empowered, I just like, I like being in control' (Lisa)

Lisa discussed the need to be in control of her own life from a different position to the other participants presenting this theme. Lisa shared her understanding of being in control as being empowered. It became clear that Lisa had experienced a number of events in her life that had left her feeling powerless and that her bulimia provided her with a sense of independence, control and empowerment. The need for control of her own life was a matter that had presented early on in Lisa's life, prior to the onset of her bulimia, however, throughout her interview she discussed her bulimia in a way that suggested it had served as an attempt to fulfil this need.

Sub-theme 1c: Feeling powerless as a result of bulimia

The idea of bulimia being consuming and taking over the lives of the participants was a theme that presented for six of the seven participants in this study. This subtheme can be seen to capture feelings of loss, obsession and powerlessness. Experiences of these can be seen within Lisa's narrative when she likened her experience of bulimia to the idea of being 'obsessed' with a person and highlighted her awareness of this as being out of her control.

'Yeah so it's like out of my control, it reminds me of like when you are crazy about a person, like mad about them and then you realise you're obsessed that's the only way

I can really describe my reaction to it all its obsessive it's like something that feels out of my control at the time just that thought of purging after a binge' (Lisa)

Lisa shared this experience in a way that implied there was a realisation of developing an obsession, which she felt that at the time was out of her own awareness, a sense of powerlessness was reflected in the reference she makes to feeling that she held no control with regards to the thoughts of bingeing and purging, highlighting how she felt these thoughts had taken over and had an obsessive nature to them. There was a sense that the thoughts had become increasingly consuming for Lisa, a similar narrative was presented in Sam's interview who also emphasised a state of being consumed with the focus of her bulimia and feeling incapable of managing this.

'that focus just got out of control, I really couldn't manage it anymore I was way out of my depth with it' (Sam)

In the above extract from Sam she refers to being 'out of her depth' with her bulimia, reflecting the impact of bulimia on the other aspects of her life, this was evident as she moved on to discuss her relationships and work.

'everything was affected because all my attention was there it was horrible' (Sam)

The sense of feeling consumed by bulimia was also acknowledged by Claire, who referred to the wider impact of her bulimia on the other areas of her life, Claire referred to the idea of bulimia 'taking over her brain' as a way of describing the experience of being controlled by her bulimia and the negative spiral of feeling a loss of control in relation to separate parts of her life. Within her narrative Claire captured the ways in which bulimia affected all aspects of her life, and how the feeling of being out of control transpired.

'it completely takes over your brain it makes you feel like you can't control anything else in your life' (Claire)

The idea of bulimia taking control was discussed from a different position by Jess when she explained the impact of her bulimia on her thinking styles and further described this as a barrier to support seeking. Jess was able to reflect on what she called an 'old mindset' and

recognised that her thinking in relation to seeking support was centred around the concept of control, specifically the fear of losing it.

> '*it's because in my head getting help meant someone else taking control from me' (Jess)*

During her interview Jess considered this further and within her account it was clear that she recognised this thinking was a part of feeling controlled by her bulimia, the below passage captures this in a way that evidences Jess' processing of her past ways of thinking as a comparison to where she positioned herself at the point of her interview, communicating her ongoing learning in relation to the concept of control.

> *'I knew it would mean changing I also knew it would mean someone trying to make me gain weight I just didn't think I really wanted any help at the time anyway.. but then again yeah'*

'Were you going to say something else then?'

> *'Umm yeah I was just thinking really that was all part of my bulimia too I did want help but something in my head told me I didn't and that it was wrong my head was just really full up with it all you know'*

It seemed that at this point Jess realised the extent to which her bulimia was impacting on her way of thinking which further impacted her ability to seek support, this was specifically highlighted when she referred to her head being 'full up' when reflecting on that particular time in her life. At this point in the interview with Jess she was able to observe her own thinking and identify with her processing at the time of being caught in a cycle of attempting to gain control and battling with the idea of receiving support and what this may entail for her. It can be seen from her narrative that she had perceived the idea of support seeking and gaining weight i.e. losing control.

Super-ordinate theme 2: Caught in the repeated cycle of bulimia

Feeling caught in a cycle of bulimia was an experience that all participants identified with, specifically highlighting the feeling of being trapped in a cycle. For many participants it seemed that they had a sense of being somewhat heavily invested in keeping secrets and framing this as a lifestyle, leaving them feeling emotionally distanced from those around them. Participants identified a repeated ongoing cycle consisting of obsession, shame and loneliness. The interview questions encouraged participants to become curious about their own attempts (if any) of breaking this cycle and during analysis it became apparent that a barrier to this was the dread of incorrect assumptions and misunderstandings. This subtheme highlights the difficulties participants had in feeling understood by others. The idea of an individual having lived experience of bulimia seemed central to having an understanding of what bulimia consists of with a number of participants emphasising the feelings of being misunderstood by 'others' referring to people who did not have any experience of bulimia.

Sub-theme 2a: Bulimia as a secret lifestyle

The secretive aspect of bulimia was highlighted in a way that brought attention to the impact of bulimia on relationships and the barriers found between individuals and their close others. The experiences of shame and loneliness were repeatedly brought to light within this sub-theme with participants relating their experience of shame to hiding their behaviours and emotions from others, creating an emotional distance. Participants talked about their fears of others finding out about their bulimia.

Sally emphasised the 'hidden feelings' she experienced during the development and the maintenance of her bulimia sharing her experience of how this further brought the feeling of loneliness. The extract below from Sally's interview captures the experience of being caught in the cycle of bulimia which left her feeling emotionally distanced from those around her. Sally brought attention to the lack of awareness she feels exists in relation to bulimia and the emotions associated with it, highlighting how this has a further impact on the experience of loneliness and isolation. Within her account, Sally highlights how she 'doesn't think bulimia is talked about enough'. A lack of awareness in relation to bulimia can be viewed as being a result of the stigma attached to the experience, further influencing the process of support

seeking. Throughout her interview Sally talked frequently about the emotional impact of bulimia and how she felt this was not a part of her bulimia that was recognised or understood by others.

> '*bulimia is a tricky one I don't think it is talked about enough I suppose when I think about how it actually feels sometimes it can just feel very lonely like people don't talk about it it's a hidden feeing no one really knows what you're going through at the time' (Sally)*

Sarah shared her experience of fear, it was evident throughout her interview that Sarah felt the need to hide her behaviours. During the time she was experiencing bulimia Sarah was living at home with her parents, it was clear from her responses that she was fearful in relation to her parents discovering her bulimia. Sally talked about underlying emotional processes relating to the idea of her parents 'finding out' and what this would mean in relation to her positioning within her family dynamic, very much focusing on the importance she placed on the views of others i.e. her parents.

> *'I used to get scared my parents would hear me it would always be when my parents were out mum caught me once but I told her I had a stomach bug and that's why I threw up' (Sally)*

What would it have meant if she had known?

> *'It would have completely fucked up her view of me, and everyone in the house really like I know they would have thought I was mental and never really understood it because I was always the person who had my shit together and had no reason to be doing what I was doing' (Sally)*

This extract can be seen to shed light on how important the views of Sally's family were to her, it seemed that she felt the discovery of her bulimia would be accompanied by a change in how others perceive her which made sense when attempting to explore the reasons Sally felt the need to keep her bulimia as a secret. It was interesting to note how Sally used the term 'mental' to describe how her mother may have perceived her if she had discovered her purging. This narrative can be seen to highlight a fear of being pathologized whilst also bringing attention to the stigma associated with bulimia, which potentially contributed to Sally feeling the need to maintain the secrecy around her bingeing and purging. This extract

also captured a critical part of Sally which seemed to suggest that there should have been a specific root cause for her behaviours, further suggesting a possible difficulty in relation to the acceptance of her own individual experience of bulimia.

Victoria also discussed the idea of what it would mean for others to discover the existence of her bulimia, it was evident from her accounts that she found a discomfort in holding her bulimia as a secret. Throughout Victoria's interview there was a reoccurring theme of suppression which was communicated through her approach to close relationships which repeatedly consisted of relationships where she would only reveal parts of herself, the part of self that Victoria would present to her close friends and family members seemed in no way consistent with the part of herself she presented to me throughout the interview when openly discussing her lived experiences of bulimia, instead it was evident she felt the need to hide this from 'others' it seemed that Victoria viewed this as a factor of her bulimia that she had little choice in.

> *'with being sick it's just such a secret for a start no one even knows you're doing it unless you get caught so yeah I just got real comfortable with it and it was easy, well I mean it's not easy but it is at the same time if you get me like easier to hide is what I mean yeah and like it was just easy to not tell people, horrible to have to lie about it but it was just what I had to do really yeah' (Victoria)*

Sam talked from a different perspective clearly demonstrating an awareness in relation to the differences she found between her experience of anorexia and bulimia, linking this to the secretive aspect of bulimia. There were many occasions throughout the interview that Sam seemed to glamorize anorexia and often compare this to her experience of bulimia. This comparison is a factor which can be seen in previous literature and further points towards the stigma associated with bulimia. In relation to the concept of support, it was interesting to note how Sam felt comfortable to be 'open' in discussions with her friends, which allowed her to receive support. Whereas in her experience of bulimia, Sam felt unable to do this due to feelings of shame. It seemed inevitable that this would further influence the dynamics within her friendships as her bulimia progressed to becoming a secret kept from the people who she identified as being closest to her. Sam also shared the sense of pride that she experienced alongside her experience of anorexia which significantly contrasted her experiences of bulimia.

'then I had this secret with myself which reinforced that shame, with the anorexia I was open about it and able to discuss that with friends and I guess that's because I still felt that pride whereas with the bulimia it became a secret and something that I didn't talk to anyone about because I was feeling so shameful about it' (Sam)

In Jess' interview she discussed the development and maintenance of her bulimia as a way of life, highlighting how it became a 'secret lifestyle'. It was clear in this extract that Jess was acknowledging the unseen parts of her bulimia and focusing on the impact this had on her life as a whole, not just her body image. Jess highlighted how the secretive aspect of bulimia brought its own additional challenges.

'it goes from making yourself sick to try and lose weight to being a lifestyle, a secret lifestyle which is what makes it even harder' (Jess)

Both Claire and Lisa used the word 'secretive' to describe their experiences of bulimia, Claire brought attention to the invisible aspect of bulimia. Reflecting on a time where she lost weight through disordered eating prior to the development of her bulimia. Claire highlighted the differences found in the experience of weight loss and compared this to her experience of bulimia, identifying the two as separate. Lisa used the term 'secretive' to discuss her process around consuming food.

'that kind of continued for quite a while I was very secretive about it nobody knew anything about it um obviously people noticed before that like I was really thin when I wasn't eating properly' (Claire)

'some days eating is still a really secretive thing for me' (Lisa)

Sub-theme 2b: Keeping the cycle going; a fear of incorrect assumptions and misunderstandings

This sub theme presented in five out of seven of the interviews, in which participants expressed fears of being misunderstood. A number of participants further discussed how they feel this impacts on the process of seeking support whilst other participants linked this to the lack of awareness people have of bulimia in comparison to anorexia nervosa.

'I still have that gut feeling that they won't get it or like they will make an assumption or misunderstand me, I just dread it, I don't know that people don't really get it unless they are a professional like with experience or like they have their own lived experience of bulimia it's just one of those things' (Jess)

In Jess' interview when she discussed the idea of support seeking and therapies, she seemed to place heavy focus on the feeling of being misunderstood, highlighting the stigma associated with bulimia and the impact of this on support seeking. Jess particularly related this to the idea of seeing professionals suggesting that there is a lack of understanding from anyone that does not have lived experience of bulimia. The dread of being misunderstood seemed to serve as a block to Jess seeking any kind of support for her bulimia.

Lisa reflected on previous times that she had talked about her bulimia with friends, there was a sense that she felt misunderstood, and indicated a need for a more compassionate approach. Throughout her interview Lisa talked about the experience of having seen a friend experience anorexia and witnessed the responses from others, highlighting that they were critical and lacking empathy. It seemed that this may have possibly influenced Lisa's approach to talking about her experiences of bulimia, introducing a fear in relation to how others may respond. Lisa claimed that there is a need for more awareness with regards to bulimia and a call for further education. Lisa felt this would be specifically beneficial to 'the older generation'. Within her narrative she highlighted how the media has changed over the years, possibly implying this has a role to play in the lack of understanding she describes as being with the 'older generation'. Lisa's narrative points towards the pathologizing of bulimia, highlighting how 'we' referring to people with experience of bulimia, are made to feel there is something wrong. She discussed how this served as a barrier to feeling able to talk about her experience, which can be seen to further impact on the extent to which people seek support.

'*people with bulimia are like radicalised, we are like made to feel there is something wrong and then that stops people talking I've seen how people react' (Lisa)*

'it's really hard to talk about so I just feel that there needs to be like yeah more respect and more education on the topic'

'That's interesting could you say a little more about that?'

'Well I think young people know more about it, like they know that it's a problem and its prevalent, but I feel like the older generation don't really understand because maybe they've not been exposed so much to stuff like that, I mean the numbers have increased with the media and stuff, and the media is different now to years ago, and I'm not saying that like all young people understand but like I think they have a better idea than the older generation' (Lisa)

Within Sally's accounts she brought attention to a lack of understanding in relation to the underlying and associated aspects of bulimia, indicating that people often tend to focus on the behavioural symptoms of bulimia, evidencing a disregard for the emotions attached to this.

'I think people often see bulimia as something it's not, for me there is a lot more to overeating and being sick but it feels like people just don't get that' (Sally)

Similar to Lisa, Claire highlighted a lack of awareness around bulimia, echoing Sally when claiming that 'there is more to it' than what is seen by others. Whilst Claire points towards there being 'more to' bulimia than what others see, she did not elaborate on this. Her narrative highlights her own views on the 'stereotype' and stigma surrounding bulimia and how it fails to be a true representation of her experiences. There was a sense that Claire was also pointing towards the lack of awareness relating to the emotional impact of bulimia, she used a typical stereotype to communicate her experiences of how she feels bulimia is understood by others.

'because it's not really talked about I reckon for most people its seen as like a gross kind of thing which it is but I think in society it is seen as you know depressed teenage girls and just like there is a stereotype about it and just yeah there is more to it than that its over simplified' (Claire)

Sarah focused on the concept of awareness and shared her views on the invisible aspect of bulimia, highlighting how this can often lead to misunderstandings or assumptions of 'normality'. It was evident within Sarah's account that she felt there was a lack of understanding in relation to what having a lived experience of bulimia meant. However, Similar to Claire, Sarah did not describe at a depth what her experience of bulimia truly consisted of using the words 'what it is' to describe her experiences. Sarah highlighted the

role of body image in this, indicating the impact weight loss has on the awareness of eating disorders, therefore suggesting that eating disorders are often identified and understood through a person's weight. Sarah discussed bulimia as being unseen visually and therefore often remains concealed as a result of feeling misunderstood and through the fears of assumptions being made.

> *'I think there isn't enough awareness around bulimia in the groups because people seem to know more about anorexia and its more visible, whereas we look normal or can look normal I think there are a lot of assumptions that are just so far from the truth and people just struggle to get their head around what this really is' (Sarah)*

Super-ordinate theme 3: Inner conflict; 'fighting a battle mentally'

The third superordinate theme considers the concept of inner conflict and its association with bulimia. Four participants (Victoria, Lisa, Sam and Sally) all seemed to identify with their bulimia as being a separate part of the self, within their accounts they refer to the messages received from these parts of themselves and at times describe this as an experience that reflects process battling and conflict. The subthemes highlight the ways that a number of participants identified with two different parts of themselves and described the challenges found in managing this, describing the struggle participants found in emotion regulation and the use of bingeing and purging as an attempt to block emotions that felt difficult to cope with. Five out of seven participants linked both the thought processes and the behaviours associated with their bulimia to aspects of addiction.

Sub theme 3a: Bulimia as an attempt to regulate emotion

Six out of seven participants identified with the use of bingeing and purging as an attempt to regulate difficult emotions. There were a number of occasions where participants touched on finding particular emotions difficult to cope with and recognised their bulimia as a way of trying to escape from/cope with these. Feelings highlighted across participants accounts included anger, powerlessness, guilt, frustration and 'emptiness'. In Victoria's interview she talked about the association she created between being empty and feeling powerful. There was a clear cycle identified in her narrative.

'happy because I am empty and like I said that can be like a feeling of being powerful but then that night you go to bed and you think about what you have done and you feel controlled again and start thinking you have no power to fight this and yeah then you just do the same to get rid of that feeling' (Victoria)

Sarah presented the concept of emptiness in a different light, Sarah discussed emptiness in emotional terms suggesting that she was using bingeing as an attempt to cope with this state of emptiness she was experiencing. On reflection Sarah was able to see that bingeing did not fulfil her needs long term and that the feeling of emptiness would always return, this extract captured a similar cycle to what had been identified by Victoria, however Sarah's behaviours seemed to be driven more by feelings of guilt, however both of these participants described an emotional drive eventually leading them back to the familiar behaviour of bingeing and purging.

'I have blocked a lot out I suppose before a binge I felt like this strong need to consume something and a load of emptiness in me that I needed to fill I was just filling the emptiness within me and I think that's where the bingeing came into it then afterwards I would have the guilt and I would need to purge then the emptiness would come back the hole was never filled' (Sarah)

Lisa identified as being in recovery and recalled times that she had experienced feelings of being angry and recognised that this is when old ways of thinking would resurface, leaving her with urges to engage with previous bulimic behaviours.

'if I am feeling really down or I am angry about something that is when I get the urge to go back to my old behaviours part of me thinks it will get rid of it sometimes' (Lisa)

Jess identified with the use of bulimic behaviours as an attempt to block the unwanted feelings, Jess discussed how her repetitive thoughts would lead to anxiety and the belief that purging would work as a way of calming herself, easing states of anxiety. She talked about this as though it was factual, indicating it had become an automatic response to feeling anxious.

'I just kept thinking of the calories and I just wanted them out, it would make me so anxious and I knew being sick would just calm me' (Jess)

Claire shared her experience of being driven by the feeling of guilt when purging. Claire highlighted the concept of weight loss and suggested that it was associated with feeling 'positive'. She highlighted the guilt that presents as a result of bingeing which seemed to further encourage purging. Claire had convinced herself that purging meant losing weight. Her narrative captured her lack of ability to escape feelings of guilt with this presenting regardless of whether or not she purged. Highlighting guilt as a result of bingeing, however guilt would also be a result of purging afterwards.

> *'it felt so good to know that I was losing weight so if I had just purged there would be a positive feeling for me because I would have cleared the guilt of bingeing but like I would also be filled with guilt because I knew I shouldn't be doing it' (Claire)*

Sally talked through her experiences of constant attempts to supress her emotions, she emphasised the existence of anger and frustration and shared that she used bingeing and purging as a way of attempting to block these feelings. Throughout her interview Sally discussed a history of depression and feelings of anger towards her mother.

> *'I think that made a big impact on me always looking for ways to try and I don't know just like hide my feelings well like block them you know and I think when I started bingeing and purging it was something that did that for me in a way it took away all the feelings of anger and frustration' (Sally)*

'Anger and frustration?'

> *'Yes I was very angry growing up mostly um with my mum like I blamed her a lot for the fact I didn't have a dad' (Sally)*

> *'I always felt depressed as a teenager, I never felt normal I think from a young age I had problems in my family, like um I grew up without my dad around, I know loads of people do but like I look back and think it really did affect me growing up I never felt I could really show that though I would always pretend I didn't care' (Sally)*

It seemed that Sally had adopted the behaviour of masking her feelings from a young age. Throughout her interview she described a complex relationship with her mother, indicating that she may not have felt able to communicate her feelings and further struggled with

validating them. Sally talked through her experience of feeling anger towards her mother and feeling affected by the absence of her father. Sally's narrative suggested that the onset of her bulimia provided a way in which she was able to temporarily supress these feelings of anger and sadness as opposed to processing them in a healthy way.

Sub-theme 3b: Addictive properties of bulimia

Five out of the seven participants likened the existence of their bulimia to an addictive process, using terms such as 'fixing cravings', 'being hooked on it', and 'needing more' a key commonality across the interviews seemed to be identifying the challenges found in stopping the engagement with bulimic behaviours and participants feeling out of control in their attempts to activate behaviour change. Sarah talked about her behaviours as primarily developing as a habit and then feeling like an addictive process, she highlighted how this process felt out of her control.

> *'the bingeing and then the behaviours that would come afterwards it started like a habit and then it was so out of my control I couldn't stop' (Sarah)*

Sally used the word addicted to describe her understanding of her relationship with her bulimia, specifically focusing on a particular time period, she emphasised throughout her interview that this was the most difficult time for her. Sally was able to recognise that during that particular time she was unaware of the extent to which bulimia was affecting her life. Her narrative suggested that she felt addicted to her experience of bulimia, and on reflection was able to recognise this as a process out of her own awareness.

> *'I would say that between sixteen and twenty it was at its worst like I was probably addicted to it for those years I didn't know that then though' (Sally)*

Claire associated her experiences of bingeing with the experience of fixing a craving. She suggested that there was always the need for more, it seemed throughout Claire's interview that there was a reoccurring theme of satisfaction seeking and Claire seemed to have used bingeing as an attempt to experience a sense of feeling satisfied. During her interview she talked about the challenges of trying to satisfy herself with food and her experiences of craving food prior to a binge.

'I think binging was like really satisfying and like every mouthful was like I needed to have more and it just tasted so good, it was like fixing a craving, it was hard to satisfy myself my body wasn't used to it' (Claire)

Sam described the experience of being 'hooked', similar to Sarah suggesting that it felt very much out of her control. In her interview Sam talked about her engagement with bulimic behaviours as being driven by automatic thoughts, her narrative suggested that once she started engaging with these behaviours it became extremely challenging to stop which again emphasised the lack of control she experienced. In addition to this, Sam highlighted a sense of ownership of her bulimia describing it as 'her thing' possibly pointing towards challenges that may be found in letting go, and highlighting the powerlessness associated with this.

'it never felt OK or good in any way but equally it was so hard to stop because I was so hooked on it, I just couldn't stop it became my thing' (Sam)

Super-ordinate theme 4: The journey to recovery

The fourth superordinate theme considers the various factors participants associated with the process of recovery from bulimia nervosa. During the study participants discussed their experiences of therapy, highlighting what they had found helpful to their recovery and parts of therapy they experienced as unhelpful. Four participants described a sense of liberation through therapy and shared their experiences of this. Participants described experiences of letting go of the urge to battle with the self and to shift toward self-acceptance, for some participants this was with the support of professionals and for others it was through support from friends, family and 'the eating disorder community'. All participants that identified as being in recovery from their bulimia brought a focus to the concept of self-discovery, specifically highlighting the continued learning about parts of themselves in recovery that they were unaware of before starting their journey to recovery.

Sub-theme 4a: Release and self – discovery through psychological therapy

This sub-theme particularly highlights the participants' experiences of therapy and support. Sally, Sam and Sarah had experiences of therapy (CBT, Music therapy and Integrative

therapy) and talked about this in relation to their recovery journeys. Participants discussed their experiences of receiving CBT-E and finding the weighing element of this treatment unhelpful. Sally talked about her experiences of engaging with a music therapist whilst at hospital, there seemed to be a sense of relief evidenced in Sally's account when she focused on her experiences of feeling heard.

> *'Um so I actually was fourteen when I first went to hospital and they had a music therapist she really helped me just express myself there' (Sally)*

> *'I was so amazed by like what she was doing I didn't really do music therapy as such but she would sit with me and I just felt she got me '(Sally)*

It was clear that Sally felt understood by the music therapist that she met whilst at hospital. It seemed that simply feeling heard aided Sally in her recovery journey, which further influenced her decision to train in a similar job role, this communicated the impact of the experience and presented as a pivotal part of Sally's process in recovery, this was evidenced in her heightened emotions when she discussed the experience of feeling heard by a professional. In later years Sally sought private therapies and discussed her experiences of these, highlighting what she found helpful and unhelpful about the process.

> '*Um I quite like CBT in that it has like this homework element rather than like coming back next week and reasoning with you so it's like using evidence to go against what you are thinking and that was really helpful for me because my thinking was not helpful at all and it explained how my thinking influences my behaviour but I also like just like word vomiting you know just getting it all out and I didn't really get to do much of that in CBT and I think that can be like a really nice release' (Sally)*

Both Sam and Sarah spoke about how they found the requirement to be weighed in CBT-E unhelpful, describing thoughts of being weighed as overwhelming and anxiety triggering. Sam talked about the shame she experienced when receiving her diagnosis and the concept of being weighed being a significant influencing factor when considering treatment, it seemed that Sam recognised the possibility of this process re-triggering her shame, in her account it was clear that the idea of being weighed was unknown and brought with it a sense of being overwhelmed. Sarah had lived experience of this and discussed it as being unhelpful, she

talked about her experience of being weighed as one that triggered anxiety. Sarah discussed at various points throughout her interview a discomfort with knowing her own weight and found it challenging to understand the reasoning behind this being a compulsory part of the treatment.

> *'I found it so shameful to receive that diagnosis and um I was offered treatment with them but from what I remember you had to be weighed at every session and that was part of the treatment, I said I couldn't do it, it was too much for me like I had never weighed myself even when I had anorexia' (Sam)*

> *'I do remember being weighed in some of my sessions but like I said I was never underweight if anything my BMI would be high and she would tell me that and I was like well yeah I know this I weigh myself every morning I don't know what this is achieving you know? I can understand if people are underweight they need to be weighed but I didn't get why I was being weighed it caused me more anxiety by stepping on the scale' (Sarah)*

> *'it's such a learning curve recovering because you get to a point where you think oh I am alright and then a month or so later something may change its just such a non-linear process the recovery thing and it's kind of amazing because you learn so much about yourself like I feel like I have learned a lot about myself so in terms of what it means it's a journey to me' (Sam)*

Within the above extract, Sam captures the experience of her process in recovery, specifically highlighting the learning she has taken from her experiences. Sam discussed thought processes that were taking place during this time and emphasised the changes that take place throughout the journey in recovery. Sam presented her experiences of recovery in a positive light describing the process of learning about the self as being 'amazing' .

Sarah shared her experiences of recovery and learning about the self through focusing on the parts of herself she was unaware of when she was caught in the cycle of bulimia, Sarah's account demonstrated how she was able to see things differently in recovery, when reflecting on her experiences she was able to identify with the emotional process taking place during

her battle with bulimia, and acknowledged that she was unable to recognise that part of herself prior to being in recovery.

> *'I think the best way of trying to describe it is as a hole that you need to fill but that's something I have learned about myself only through recovery I was just so unaware before' (Sarah)*

Both Jess and Claire talked about the changes they recognised in themselves throughout their journeys in recovery. Jess talked about the development in her relationship with food, clearly documenting how this has changed in comparison to when she was engaging with bulimic behaviours. Jess communicated the changes she found in cooking, sharing how she was previously unaware that this was an activity that she was able to find enjoyment in. Claire talked from a different position identifying as being 'at the start of her recovery journey' when discussing what the concept of recovery meant to her individually, there was a clear focus on the concept of compassion and discovering different parts of the self.

> *'food so like I enjoy cooking, I enjoy making healthy foods and stuff and that's all new to me like I didn't know it was something I could actually enjoy doing' (Jess)*

> *'so yeah to focus more on the feelings I get when I eat and be kinder to myself about it, keep getting to know myself and what this is all about' (Claire)*

Sub-theme 4b: The shift from fighting to acceptance

The shift from fighting to acceptance was present in five out of seven interviews, Participants reflected on the process during their journeys in recovery specifically highlighting the concept of acceptance. Within all participants accounts that discussed this, it seemed that there had been an end to the idea of battling with the self and a shift towards self – acceptance. Victoria who identified as being 'on her way to recovery' highlighted this idea of self – acceptance as one of the key factors when contemplating what it would mean to be 'in recovery' she describes the idea of being 'OK' with herself indicating a discomfort with part of the self throughout her experience of bulimia.

'I would like to just be OK with me and what I have done I suppose' (Victoria)

Jess talked about her experiences of recovery and linked this to perceptions of body image. Jess discussed having friends with similar experiences and beginning the process of recovery together. Jess pointed to a shift in relation to the way she viewed her body image, describing how this changed over time, particularly highlighting the concept of acceptance. It seemed that a lot of Jess' bulimia was rooted in a dissatisfaction with how she looked, at various points in her interview she talked about this, when focusing on her experiences of recovery from bulimia she highlighted the concept of accepting her own body.

'*we all just started to like see our body image in a different way and we all like started to accept our body image together' (Jess)*

In Sam's interview she linked the concept of recovery to acceptance of self and focused on her experience of having to look at various parts of the self. Throughout her interview it seemed that there were many aspects of herself that she seemed unaccepting of and it seemed that she would often attempt to mask this discomfort through bingeing and purging. Sam shared how her experience of volunteering in the field of eating disorders benefited her recovery and emphasised the benefits of 'giving back' throughout her interview.

'I feel fully recovered I think the volunteering is one of the best things I have ever done, it took a lot of effort to look at who I really am, stop the judging and just accept that person' (Sam)

Sally talked from a different position about the concept of acceptance and brought this when she was discussing the links between bulimia and her sense of identity. It was clear in Sally's accounts that she viewed bulimia as being part of her identity and it seemed that she had faced previous challenges in accepting this part of herself. When Sally talked about her experiences of recovery, she emphasised the importance for her, in accepting the bulimia and focusing more on how to manage it as opposed to battling with it. When discussing this, she referred back to the cycle of bulimia and the feeling of wanting to escape, discussing this as being a battle in itself, it seemed that throughout her recovery Sally had found alternative ways to manage the emotions associated with her bulimia.

> '*I see it as something I can't escape from and something that will always be there so instead of trying to escape it I just try to accept it when I think of it, bulimia will always be a part of who I am and nothing is going to change that or take it away' (Sally)*

Similar to Sally, Sarah discussed the concept of acceptance in relation to her body image, she talked through her past views of her body image and compared this to how she felt about her body at the time of taking part in the study. The extract below captures the changes Sarah experienced in the ways she felt about her body image, highlighting a sense of acceptance of her body. Her account indicated that she identifies with being on this 'journey in recovery' with her discussing the differences between self-love and acceptance. It seemed that Sarah was able to be less critical of herself. She compared her past views of her body with the view she held at the time of her interview. Emphasising the value in being able to be 'OK' with her body. It seemed that Sarah was reassuring herself when seeing the sight of her own body and that this was a key factor in her recovery from bulimia.

> *'I think I am in a position where I don't really love my body but I am really accepting of it now I think compared to where I was with it I used to look at myself and hate myself and breakdown at any sight of myself naked whereas now I see it and I think OK this is me this is my body' (Sarah)*

The results of this study put forward the ways in which participants experienced bulimia as both a search for control and by contradiction, a road to being out of control. The experience of bulimia is evidenced through participants narratives and was discussed as having an obsessive quality. As a result of the stigma attached to bulimia and the experience often being perceived as being 'gross, unusual or abnormal', there was a fear for participants of being misunderstood by others, this further contributed to bulimia being experienced as a 'secret lifestyle'. Secrecy can be seen to further maintain the continuation of bulimia as it left participants feeling unable to seek support. For some participants in this study the journey to recovery was one that depended on acceptance of self which was highlighted in experiences of psychological therapy.

At times when participants were questioned about support seeking, they identified with a fear of being pathologized as can be seen in Lisa's nattative. Participants drew on past experiences of being misunderstood and having assumptions made by others. Participants

spoke of a lack of understanding in relation to bulimia and 'what it really is' using terms such as 'there's more to it than that' and 'people don't get it' despite interview prompts and encouragement from the researcher to discuss this concept further, participants did not identify exactly what is missed by people when they attempt to comprehend bulimia. Participants discussed this 'lack of understanding' as a barrier to support seeking, however other than further education, little indication was made as to how participants felt this barrier may be eliminated.

When reflecting on my own material in relation to the findings of this study, and how this will have impacted on the process of analysis it has been important to consider my previous experiences within the area of eating disorders. Throughout the analysis process and documenting the findings of this study I have kept a reflective log and engaged with regular supervision. This has been important to consider and separate my two roles when conducting this research. One role as a researcher and one as a practitioner, with experience of working with bulimia. Remembering that the aim in this study has been to explore and interpret lived experiences as opposed to responding to the data from a therapeutic position, has been useful in aiding this process. The conflicting role of control is one that I have witnessed in therapeutic practice, and one that emerged during the analysis. The fear of incorrect assumptions and misunderstandings is not an experience I have seen in previous work with this client population, however, in this study it has been a key finding pointing towards the stigma associated with bulimia and the impact of this on support seeking. My own experience of witnessing eating behaviours as an attempt to regulate emotion is one that I have been exposed to through having had a friend who experienced anorexia. It has been key to remain mindful of the double hermeneutic process (Smith, 2011) and to recognise how my own prior knowledge and experience will have featured within the analysis.

Discussion

Predominant aims of this study were centred on understanding participants' lived experiences of bulimia, drawing attention to the stigma associated with bulimia, exploring how this may impact on the process of seeking support, and highlighting the challenges found in the pathologizing of bulimia. The interview data provides a rich source of material which details the participants' experiences and understandings of bulimia nervosa. Whilst participants' experiences varied, there were a number of commonalities evident throughout the analysis relating to the concept of control, experience of feeling caught in a cycle, inner conflict and experiences of recovery.

A key theme that remained present throughout the analysis was 'control'. Narratives highlighting the concept of control were present across all seven interviews. The concept of control and the ways in which it manifests within presentations of bulimia has been evidenced in a number of studies (e.g. Reid et al, 2008; Broussard, 2005; Jepson et al, 2010) This study has complimented previous literature highlighting the role of control within bulimia whilst bringing attention to participants' early experiences relating to a loss of control and attempts to gain control through bulimia. The concept of 'control' within the development and maintenance of bulimia is one that I have felt familiar with through therapeutic practice. However it was interesting to note the conflicting role found within control with participants moving between feeling empowered through their bulimia and feeling powerless as a result of their bulimia.

The search for control

The results of this study can be seen to compliment the literature put forward by Patching and Lawler (2009) which suggests that bulimia often presents as an attempt to gain control in one's life during a time in which they felt this has been lost. Within the data it can be seen that participants in this study talked at a depth about the 'need to be in control' however experienced fear in relation to being out of control. At times, participants referred to early experiences of being out of control and linked this to the onset of their bulimia. In addition to this, participants associated more recent experiences of feeling out of control with relapse. Such narratives evidence the destructive cycle linked to control which can be found within the maintenance of bulimia. Similar findings have been evidenced by Broussard (2005) which point to the lack of control experienced by individuals with bulimia,

highlighting how the experience of constant thoughts relating to food and eating leave an individual feeling controlled by their bulimia.

The conflicting thoughts about being in control and being controlled by bulimia were consistently present throughout the analysis of this study. This conflict has been highlighted in literature presented by Reid and colleagues (2008) and is suggested to leave individuals with bulimia hesitant to seek support. From the accounts of participants in this study it can be seen that the attempt to gain control through bulimic behaviours (bingeing and purging) results in ultimate loss of control, in which the individual feels out of their depth and returns to what could be seen as the safety behaviour of attempting to regain the control that is perceived as being lost. This points towards the need for practitioners to support clients in finding more helpful ways of gaining control over their lives. The concept of control and its relation to bingeing and purging has been highlighted by Jepson et al, 2010) who discussed the act of purging as an attempt to gain control and bingeing as an attempt to cope. Within the findings of this study, purging was identified as a behaviour used as an attempt to regain control when participants felt out of control, specifically in relation to thought processes linked to bingeing. Participants frequently referred to the loss of control being rooted in the inability to manage thoughts surrounding bingeing. Issues of personal control have repeatedly been suggested to play a central role in the maintenance of eating disorders (Froreich et al, 2016) however, more literature can be seen to focus on the role of control in cases of anorexia as opposed to bulimia (e.g. Tan et al, 2003; Jarman et al, 1997). When considering the concept of control in relation to the act of bingeing and purging behaviours, it seems there would be a benefit in future research focusing on the nature and functions of the binge and purge process and its links to control.

Some participants in this study were able to share their early experiences of being controlled by others, in particular, early experiences of controlling parental relationships and experiences of teenage relationships in which they felt controlled by their partners. Participants were able to link this to their attempt to seek control through bulimia. It seemed important throughout the analysis to consider the early experiences of participants. Early experiences and interactions with primary caregivers significantly influence the ways in which an individual learns to identify, manage and express their emotions. Emotional dysregulation, occurring when a person experiences invalidating interactions from significant others as a child and is suggested to be common in individuals with experiences of eating

disorders (Monell et al, 2015). Such experiences can lead to an inability to express emotions and instead the individual adopts negative strategies as an attempt to cope Findings of this study emphasise the importance of practitioners exploring the early experiences of their clients, in an attempt to determine the origins of control seeking patterns. A number of participants attempted to cope with feelings of being controlled by others through bulimia, which at first enabled participants to feel a sense of control over their own lives. However, bulimia could be seen to further bring conflicting thoughts introducing the experience of fear in relation to being controlled by the bulimia.

The experience of feeling controlled by bulimia was captured in the sub theme 'it completely takes over'. Six out of seven participants brought attention to the feelings of powerlessness and obsession relating to aspects of their bulimia that left them experiencing an inability to manage. Within their account's participants talked about the obsessive nature of bulimia and specifically referred to the onset of 'obsessive thinking', identifying particular thoughts that were described as being 'consuming', 'automatic' and perceived as being out of the individual's control. Literature has evidenced that approximately two thirds of individuals experiencing an eating disorder have a co-occurring anxiety disorder (Kaye et al, 2004). However literature exploring the relation between the two still seems limited and outdated. Literature presented by Anderluh et al (2003) has revealed that women who experienced OCD in their childhood were at greater risk of developing an eating disorder later in life. Participants in this study did not share any experiences of OCD, instead narratives described obsessive thoughts relating to bingeing and purging.

The role of shame

When participants in this study discussed their experiences of feeling caught in the repeated cycle of bulimia, they identified shame as being both internal and external. A number of participants described a sense of fear relating to how they may be viewed by others, with the predictions of this being only negative. It could be suggested that this fear is partly a result of the stigma associated with the experience of bulimia and can further impact on the process of support seeking. Previous research has highlighted a fear of stigma for individuals identifying with bulimia (Goss & Allan, 2009). However, research is still limited with a specific focus on the stigma associated with experiences of bulimia. There would be a

benefit to qualitative research exploring this further, specifically addressing how stigma impacts on support seeking. Participants also shared feelings of shame with regards to how they judge themselves and their own sense of identity, particularly after purging. The role of shame within eating disorders has been explored (Blythin et al, 2018) and findings suggest that shame plays a central role in the development of both anorexia and bulimia. A study carried out by Troop and Redshaw (2012) differentiated between the roles of shame in both anorexia and bulimia presentations with their findings pointing towards externalized shame being uniquely predictive of anorexia and internalized shame being predictive of bulimia. It has been suggested by Masheb and colleagues (1999) that shame in eating disorders is predominantly concerned with weight and body shape. However, within the findings of this study participants did not relate their experiences to weight or body image. Instead shame was discussed as being related to purging, an inability to manage emotions, holding secrets, comparison of self to others and the experience of receiving a bulimia diagnosis. The results of a study conducted by Kelly and Tasca (2016) has suggested that shame can worsen the severity of disordered eating, indicating that following periods of increased shame, an individual's eating pathology becomes worse than usual (Kelly & Tasca, 2016). These findings are important in relation to understanding the role of shame in bulimia, specifically when considering the experience of shame following purging behaviours which were highlighted by participants in this study.

Whilst the role of shame has been explored in relation to the development of bulimia (Levinson et al, 2016) there seems to be less in the way of literature exploring shame as a maintaining factor, and there has been less of a focus on how much of the shame experience results from stigma. Participants in this study discussed shame following purging behaviours and discussed an increase in shame over a duration of time. Within this study the act of purging was frequently associated with shame, future research may benefit from further exploration of this in order to determine the ways in which shame may contribute to the experience of feeling caught in a cycle of bulimia and further hinder the process of support seeking.

One participant shared her experiences of shame as a result of purging behaviour and compared this to her experiences of anorexia, highlighting the ways in which anorexia can be seen as a glamorised disorder, which is opposite to the way bulimia has been documented. Literature supports this idea (e.g. Habermas, 1992; Gordon, 2000) has highlighted the

glamorization of anorexia within the media. Literature put forward by McCarthy and Thompson (1996) has brought attention to anorexia bringing feelings of being in control and the existence of denial. This is suggested to stimulate perfectionism, a sense of achievement and pride. Whilst bulimia consists of feeling completely out of control and is suggested to be shameful in its 'indulgent excesses', stimulating self-disgust and guilt (McCarthy & Thompson, 1996). Such literature can be seen to contribute to the pathologizing of bulimia which could be suggested to further impact on an individual's experience of shame when identifying with bulimia.

Throughout this study, a number of participants discussed their experiences and understandings of anorexia in comparison to bulimia. Previous research in this area has revealed that anorexic behaviours are often interpreted as indicative of ultimate control (Bordo, 1993; Garrett, 1998; Malson, 1998) whilst bulimia is constructed as being 'abnormal, disgusting, out of control and risky' (Brooks et al, 1998; Lupton, 1996, 2000). Only one participant in this study identified with having a past experience of anorexia and did point towards the experience of pride associated with this in comparison to the shame associated with receiving a diagnosis of bulimia, which further influenced secrecy. Within the accounts of other participants, the experiences of feeling misunderstood by others was identified and closely linked to the understandings of anorexia in comparison to bulimia. Participants linked this to a lack of awareness in relation to bulimia and indicated that within the field of eating disorders, there is a stronger focus on anorexia and better understandings surrounding this. Participants discussed this in a way that communicated the visible aspect of anorexia, indicating that the existence of anorexia it is evidenced through weight loss and body image, whereas bulimia is often invisible and as a result can be easily missed by others (professionals, friends and family members). When participants talked about their experiences of attending eating disorder support groups, their narratives supported the idea of there being more recognition of anorexia. Participants shared their experiences of peers having a better understanding of this, presenting as less knowledgeable about bulimia if they did not have their own lived experiences of it. The focus on the role of shame within this study has allowed for me to reflect on past experiences of working with this client group and recall how working with shame was a constant factor found in the therapeutic work. Following the analysis, I have been able to consider how the experience of shame may be closely associated with the stigma attached to the experience of bulimia.

The impact of secrecy in bulimia

Participants in this study discussed the secretive aspect of their bulimia with one participant labelling it as 'a secret lifestyle'. Analysis of this specific aspect of the participants' experiences called attention to the loneliness, shame and changes in relationships. Experiences and the impact of secrecy in bulimia has been highlighted in the results of a study carried out by Broussard (2005) the results emphasised how bulimic practices are almost always carried out in secret which further leads to isolation. The findings of this study can be seen to compliment these results with participants in this study frequently referring to the experience of loneliness, highlighting the feelings of being isolated as a result of separating themselves from close others in order to hide their bulimia and maintain the secret. Whilst association between bulimia and secrecy has been explored, the impact of this factor in bulimia has been less documented. Within this study the impact of secrecy could be seen to further impact on relationships and contribute to feelings of guilt, shame and anxiety. The concept of secretive behaviour was also discussed in relation to secretive eating and from this perspective was associated with the experience of shame.

Research has indicted that there may be a variety of secretive behaviours and thoughts that contribute to the onset and maintenance of eating disorders (Smart & Wegner, 1999). Related to secrecy, literature by Evans and Wertheim (1998) has focused on a lack of openness within relationships which has been found to correlate with eating disorders. Their study found that women with eating disorders experienced greater difficulties within their intimate relationships, experiencing less satisfaction and less comfort in close intimate relationships. In addition to this, their analysis indicated that individuals with eating disorders experienced difficulties in relating to parents, friends and romantic partners. Difficulties found in intimacy were most prevalent in individuals with experiences of bulimia as opposed to anorexia. The findings of this study can be seen to coincide with the results put forward by Evans and Wertheim (1998) with participants discussing the impact of their bulimia on relationships, highlighting feelings of loneliness which originated from the secretive aspect of their bulimia. Participants discussed how holding secrets reinforced feelings of shame and left them feeling an emotional distance from others. Within the study participants emphasised the state of loneliness that occurs as a result of this. These findings are similar to those presented in the work of Broussard (2005) who highlighted how secrecy in bulimia leads to isolation and loneliness. This study did not focus specifically on the secretive aspect of

bulimia, therefore the experience of holding secrets, the impact of this on relationships and the need to maintain bingeing and purging as secret behaviours was not explored at a great depth. However, further research may benefit from exploring this and the links between stigma and the pathologization of bulimia. It could be suggested that the stigma associated with bulimia and a fear of being pathologized has potential to affect how comfortable and willing an individual may feel in being open with close others about their experience, which has potential to further impact on their experience of seeking and receiving support.

Addictive properties of bulimia

A number of participants in this study discussed the concept of feeling addicted to the process of bingeing, describing their experiences using terms such as 'fixing cravings', 'being hooked on it', and 'needing more'. When focusing on the addictive aspect of bulimia, analysis of this study can be seem to compliment the findings of Umberg and colleagues (2012) which has suggested that addictive patterns can be seen as being somewhat related to eating disorders, these researchers highlighted that this association is greater for bulimia which echoes the results of earlier studies (e.g Welch & Fairburn, 1998; Bulik, 1987), specifically highlighting the addictive aspects found in the 'binge-purge' pattern.

The experience of addiction in relation to the bingeing aspect of bulimia was discussed by participants in this study as being linked to cravings and satisfaction seeking. When participants talked about their purging experiences, they associated it with addictive thoughts and behaviours, linking this to feelings of being trapped within this way of thinking. Research linking bulimia to addictive processes has explored the neurobiology of bulimia and its links to addiction, focusing specifically on factors such as reinforcement, dependence, tolerance, withdrawal, cravings, peripheral hormones and dopamine and reward sensitivity (Umberg et al, 2012). This study did not make any attempts to explore the neurobiology of bulimia. The recognition of bulimia as potentially having addictive properties could possibly have ramifications for the development of new therapeutic treatment targets for practitioners working with bulimia nervosa. Five out of the seven participants in this study likened the existence of their bulimia to an addictive process. It is important to highlight that whilst participants made associations between addictive processes and their bulimia, these findings are not to be generalised and whilst participants made reference to addictive thought

processes throughout their interviews, associating this with bingeing and purging, none of the participants disclosed having experience of addiction to alcohol or other substances.

Work presented by Lacey and colleagues (1993) has suggested that both substance addictions and bulimia may be related to a common mechanism of difficulty in managing impulsive behaviours. The study evidenced that in women experiencing bulimia, there was a statistical association between addictive and self-damaging behaviours. The authors further suggested that when an individual with bulimia moves from abusing food to other damaging behaviours, impulsive behaviours rapidly escalate which encompass further addictive or behavioural problems (Lacey et al, 1993). Whilst the results of this study did not make indications towards this, participants did discuss having past experiences of other self-damaging behaviours such as cutting and burning and whilst it is commonly recognised that addiction can be seen as a self-damaging behaviour in itself, it seems that further research would be needed to explore the links between bulimia and self-harming behaviours, which may further evidence associations with addictive thinking and behaviours.

Bulimia as an attempt to regulate emotion

Typically bulimic behaviours were used to have a function of reducing or blocking distressing or unpleasant feelings. The results of this study specifically highlighted participants' experiences of anger, powerlessness, guilt, shame and frustration. Natenshon (2019) has discussed bulimia as being a 'disorder of the self', predominantly characterised by an individual's diminished self-regulation, self-reliance, self - trust, self - worth and self - perception. In an attempt to escape the conscious self Natenshon (2019) has suggested that an individual with bulimia uses bingeing and purging behaviours as an attempt to dissociate from the experience of painful feelings and thoughts. It seems there is a need for more research in order to determine the role of dissociation within this area to explore its potential impact on the maintenance of bulimia. Within the present study the use of bulimic behaviours as an attempt to manage emotion was present with a number of participants describing the use of bulimic behaviours as an attempt to escape feelings of anger, powerlessness, guilt, frustration and 'emptiness'. Bingeing was described by one participant in this study as a way of filling the emptiness she felt within herself, through the over consumption of food. Purging was commonly referred to as an attempt to manage the experience of guilt that presented as a

result of bingeing, the analysis identified the repeated cycle of feeling caught in and controlled by these emotions as a result of engaging with bingeing and purging as an attempt to regulate emotion. The work of Schmidt and Treasure (2006) has considered emotional functioning as central component in the development of bulimia. In addition to this Harrison et al (2010) has highlighted that individuals with an experience of eating disorders are suggested to experience difficulty in emotional regulation which was evident in the accounts provided by participants in this study. The findings of the current study highlight the importance of practitioners working with clients to establish healthy ways of identifying and regulating uncomfortable emotions.

Within this study, some participants shared their early experiences of anger and described bulimia as an attempt to escape feelings of anger in teenage years and adulthood. The role of anger in both the development and maintenance of bulimia has been explored (e.g. Amianto et al, 2012) and it has been suggested that amongst psychopathologic traits explored in eating disorders anger is a relevant core (Fava et al, 1995; Fassino et al, 2001). Individuals with experiences of bulimia are characterised by higher propensity to anger (Miotto et al, 2008) and it has been further suggested that anger makes significant contributions to the severity of symptoms within this population (Fava et al, 1995; Krugg et al, 2008). Authors have linked this to the association with self-harming behaviours (Truglia et al 2006; Krugg et al, 2008) which have also been evidenced in this study. Literature proposed by Leombruni et al (2006) has suggested that anger significantly decreases following therapeutic intervention. In consideration of this, it seems of importance to acknowledge the role of anger in relation to both the development and the maintenance of bulimia when working therapeutically with this client group.

Research carried out by Waller et al (2003) has focused more specifically on anger and core belief systems in bulimia, suggesting that the cognitive factors driving this affect are not fully understood. Their research aimed to determine if the participants' anger was linked to negative core beliefs. Results of their study evidenced that women with experiences of bulimia had higher levels of state anger, anger suppression and unhealthy core beliefs which were all associated with higher levels of trait anger. Whilst it seems of importance to develop a clear profile of different aspects of anger in bulimia, it is of equal importance to call attention to understanding the cognitive bias of this emotion. The schematic level of cognitive representation (unconditional core beliefs) has been cited (e.g. Young, 1994) as

being responsible for phenomena such as rapid mood swings (a result of the triggering of unconditional core beliefs) and mood suppression (caused by activation of emotional inhibition beliefs). Whilst schema level representations can be seen to have received more attention in relation to their capacity to explain personality disorder pathology, it could be suggested that they can be understood as playing a specific role in disorders with an impulsive component, such as bulimia (Leung et al, 1999).

The results of this study can be seen to compliment some of the findings presented by Waller and colleagues (2003) with the analysis suggesting that feelings of anger contributed to bingeing and purging behaviours. It has been suggested by Waller et al (2003) that belief systems potentially play a central role in bulimia and therefore can increase the individual's likelihood of both experiencing and attempting to suppress anger. This work can be seen to highlight a need to address these factors within the treatment of bulimia. Whilst her work is not in the field of eating disorders, Linehan (1993) has made a number of suggestions relating to the ways in which emotional control and anger control mechanisms can be valuable in such cases. Treatment plans may have the goal of assisting clients in replacing emotion focused coping strategies with more adaptive problem – focused approaches, whereby anger is able to be directed adaptively to change the environment in a way that it is no longer incapable of expression.

The experience of guilt in the maintenance cycle of bulimia was frequently highlighted by participants and was primarily described as a feeling that would trigger purging behaviour. The role of guilt as a characteristic within eating disorders has been explored (e.g. Allen et al, 2007) with research findings suggesting that women who experience bulimia score higher on feelings of guilt in comparison with other eating disorders. Guilt has been strongly associated with a number of psychological difficulties including psychosis, depression and post-traumatic stress disorder (e.g., Andrews et al, 2002; Kim et al, 2011; Pugh et al, 2015). Guilt is commonly associated with the existence of shame which has been evidenced as playing a central role in the development of bulimia (Levinson et al, 2016). It could be suggested that experiences of both guilt and shame are closely associated with the stigma surrounding bulimia. In addition to this, it seems important to recognise that an individual experiencing shame related to their experience of bulimia may be more hesitant to seek support.

Literature put forward by Blythin et al (2018) has suggested that shame may have a stronger association to the development and maintenance of bulimia than guilt. In this study participants discussed their experiences of guilt as being central to the maintenance of their bulimia, describing the ways in which guilt would enforce the feeling of needing to purge, repeatedly. For most participants the feeling of guilt seemed to be triggered by bingeing, serving as both a trigger and consequence of purging. More attention seems to have been paid to shame than guilt within literature focusing on bulimia. It could be suggested that there is a need for further research to determine the role of guilt in the development and maintenance of bulimia. The results of this study suggest that affect regulation (specifically regulation of shame and guilt) may be implicated in the maintenance of bulimia. It is therefore important to consider this when developing interventions tailored specifically for this client group. Whilst current approaches to treatment can be seen to typically target maladaptive behaviours and cognitions, literature indicates that emotions such as shame and guilt may benefit from therapeutic attention (Blythin et al, 2018).

Literature by Ruscitti and colleagues (2016) has highlighted difficulties with emotion regulation as a defining characteristic of eating disorders. Research findings indicate that individuals with experiences of bulimia show greater difficulties in regulating emotion (Svaldi et al, 2012). One study has indicated that binges are triggered by a breakdown in emotion regulation, highlighting the food itself as the regulator, regardless of there being no improvements in mood following a binge episode (Munsch et al, 2012). Interventions with an emotion regulation focus are beneficial to the treatment and outcomes for individuals with bulimia (Bankoff et al, 2012). The analysis in this study suggested that participants found difficulty in regulating their emotions with a number of participants highlighting the use of bulimia as an attempt to cope with distress. Difficulties in emotion regulation can be addressed through a number of therapeutic interventions. Acceptance and Commitment Therapy can be seen to emphasise acceptance of distress and works towards improving an individual's ability to manage and tolerate their emotions (Hayes et al, 2012). Similar to this Dialectical Behaviour Therapy provides modules that relate specifically to learning to effectively tolerate distress and regulate emotions (Linehan, 2007). In addition to this, psychoeducation focusing on emotion regulation and how it relates to bulimia symptoms seems crucial in assisting individuals to better understand their emotional states.

The idea of incorporating third – wave contextual emotion regulation strategies has been supported by Goss and Allen (2010). It has been evidenced that many individuals with experiences of eating disorders show partial improvements following cognitive behavioural therapy (Fairburn, 2008; Wilson et al, 2007). Previous research has indicated that central aspects of emotion regulation dysfunction in eating disorders consist of a lack of emotional awareness, acceptance, clarity, problem solving and reappraisal (Prefit et al, 2019) and highlighted how only the latter two are directly targeted by classic cognitive behavioural interventions, such as cognitive reappraisal, which places focus on challenging cognitions. Within contemporary research Hessler – Kaufmann et al (2020) aimed to compare the impact of cognitive restructuring, mindfulness and self-compassion in the treatment of bulimia. The results of their study revealed that overall, self – compassion was more effective than cognitive restructuring in relation to perceived control over current emotions in participants with psychological comorbidities. Overall, it was suggested that self – compassion appeared to be the most effective emotion regulation strategy in comparison to the others and with regards to affecting multiple aspects of emotion regulation. These findings support preliminary research indicating that the introduction of self – compassion to the treatment of eating disorders has potential to improve the outcome (Gale et al, 2014). This further emphasises that self-compassion has the potential to advance the treatment of bulimia (Goss & Allen, 2010; MacBeth & Gumley, 2012; Wilson et al, 2019).

The development of treatment interventions that support the regulation of emotions is essential to successful treatment outcomes as a review of the literature indicates that the difficulties found in managing and regulating emotion is potentially at the core of bulimia. The results of this study suggest that both emotions and thought processes were driving the behaviours of bingeing and purging. Within this study there was an evident fear in relation to the experience of emotions, with participants referring to the suppression of emotions that they perceived as being unable to manage. A study carried out by Via et al (2014) focused on the expression of emotion during and following recovery from experiences of bulimia. Their results pointed to emotional dysregulation in bulimic participants, suggesting a specific strategy of supressing anger. Such findings are consistent with the SPAARS model (schematic, propositional, analogical and associative representation systems) of emotional processing, which suggests that eating disorders develop as an attempt to manage negative emotions by redirecting the emotion onto the body and self (Fox & Power, 2009). The researchers further suggest that the expression of anger has possibly been linked to rejection

from others, as a form of emotional invalidation, possibly learned through classical conditioning. They concluded that individuals with experiences of bulimia have learned the behaviour of suppressing anger which possibly has an outlet through restriction/bingeing and purging (Via et al, 2014). Within the present study the suppression of emotions was evident, however, the idea of participants redirecting their negative emotions onto their bodies was not supported.

The analysis identified states of internal conflict. Within this, participants talked about recognising different parts of the self as being in conflict with one another, often referring to 'fighting battles' and 'the other part of me'. Participants shared experiences of presenting the self to others in a way that did not reflect their true identity. Participants also referred to parts of the self when discussing their experiences of challenging bulimic behaviours. This conflict also relates to the notion of true-self (Winnicott, 1965) and to Rogers' (1961) theory of self in which a state of incongruence is experienced by the individual. The conflict between two contradictory parts of the self has perhaps been best discussed within psychodynamic literature (e.g. Reich & Cierpka, 2009). From a psychodynamic perspective bulimia is understood as an 'elaborated habitualized impulsive action' (Habermas, 1992) and has previously been described as a form of impulsive neurosis by Fenicihel (1994). This impulsive action is suggested to be an attempt to manage internal psychic tension by means of physical objects and lies between an involuntary symptom, an unconscious intrapsychic defence and a sanctioned cultural technique. The alteration between ego dystonicity and ego syntonicity is proposed to arise from the intense identity conflict that individuals with bulimia typically experience (Reich & Cierpka, 2009). One part of the individual's identity is suggested to represent independence, activity and self-control (the part that is revealed to others) and the alternative identity is suggested to consist of weakness, a lack of control and neediness which is experienced as defective and therefore hidden away (Reich & Cierpka, 2009). This idea relates to the participant accounts in this study which highlight the secretive aspect of bulimia and aspects of internal conflict identified throughout the study whereby participants discussed identifying with two different parts of the self.

Psychological intervention

In addition to the experience of internal conflicts, this study brought attention to the concept of identity within the theme 'self-discovery', in which participants talked about experiences of getting to know the 'true self'. Highlighted within participants' experiences of

recovery was the feelings of release, this was specifically related to experiences of psychological intervention and self-discovery. Reindl (2001) discusses bulimia as 'a disorder of the self', that involves an individual's inability to sense self-experience. Within her work Reindl documents the accounts of individuals in recovery from bulimia that have reported accuracy in "sensing their own voice" "sensing curiosity about their subjective experience" and "sensing they matter as human beings". Participants in this study talked about their experiences of feeling 'heard' and 'understood' in therapy and drew on the ways in which this aided their recovery process. CBT was described as being helpful in challenging negative thoughts.

A growing body of literature supports the use of CBT in the treatment of bulimia (Mitchell et al, 2007; Murphy et al 2010). According to the cognitive behavioural theory of bulimia, the individuals core psychopathology: their dysfunctional scheme for self-evaluation, is central to the maintenance of bulimia (Murphy et al, 2010). Whilst one participant in this study shared her experiences of finding CBT helpful. Participants in this study shared their experiences of CBT-E (Fairburn, 2008) and discussed the 'in – session weighing' as being challenging. For one of the participants in this study the idea of being weighed introduced a state of fear which further impacted on her engagement with treatment. Another participant shared her struggle with understanding the reasoning behind being weighed and the anxiety that would follow after being told her weight and BMI by the practitioner.

Literature surrounding the role of therapeutic interventions when working with bulimia nervosa can be seen to vary. Two participants in this study had experiences of CBT-E. Both of these participants brought attention to the 'in – session weighing' aspect of the treatment model. One participant shared her experience when being diagnosed with bulimia and being informed that she would need to be weighed as part of her treatment. It was clear from her accounts that this was a significant influencing factor with regards to making the decision of whether or not to engage in treatment. Analysis suggested that the participant declined treatment based on the fear of re-triggering experiences of shame, which she linked to the idea of having to be weighed. Within her accounts the participant shared how the thought of being weighed felt 'too much' to manage. Another participant who did engage with the CBT-E treatment model described the onset of anxiety as a result of being weighed during her sessions and found the requirement to know her own weight challenging.

Fairburn (2008) has discussed the need for clients to be made of aware of their weight whilst receiving treatment in order to educate clients about their own body weight and body weight in general, to address avoidance of weighing and to provide an opportunity for the therapist to interpret the number on the scales, which is suggested to be commonly misinterpreted by the client. Within this study the participant who had experience of receiving CBT – E shared finding it unhelpful to have both her weight and her BMI communicated with her and described how the purpose of this was not explained. For this participant, the concept of being weighed as part of therapeutic treatment was perceived as being unhelpful in relation to recovery from bulimia. Having had my own experience of working within an eating disorder service and having to weigh individuals when working within the CBT-E model, I have witnessed clients find this experience difficult. Whilst the rationale behind weighing clients is clearly documented by Fairburn (2008) it seems important to approach this sensitively, explaining the reasoning behind this process to the client, allowing them to decide when they wish to be weighed (at what point during their session) and allowing for time following the weigh - in for further reflection with the practitioner, ensuring that the client has space to regulate any emotion that may have presented as a result of weighing and becoming aware of their own weight.

The experience of therapy was mostly discussed as being helpful. One participant shared her experience of having a music therapist, whilst she did not highlight specific aspects of music therapy as being beneficial to her recovery, it was evident that the of feeling being heard and understood was a significant aspect of her experience in therapy.

The feeling of being misunderstood has been highlighted within this study as a central aspect of the participants' experiences. One participant discussed her fears of feeling misunderstood by professionals and how this impacted on her experiences of seeking support. Another participant shared her experience of recognising a lack of understanding from others when she witnessed her friend experience an eating disorder. It could be suggested that the fear of being misunderstood is partly a result of the stigma attached to bulimia. The need for a compassionate approach within therapeutic intervention seems central to successful treatment outcomes and further emphasises the need to step away from a pathologizing approach which can be seen to mostly concern itself with body shape and weight concerns.

The results of this study and others (e.g. Schmidt & Treasure, 2006; Harrison and Tchanturia, 2010; Broussard, 2005) have evidenced the need to address the role of emotions

in the development and maintenance of bulimia. Critical parts of the self have been identified in this study as playing a key role in participants' experiences of bulimia which complement the findings of Pugh and Waller (2018). Critical aspects of the self within this study further introduced barriers participants found in relation to acceptance of bulimia and the acceptance of the emotions presenting during their experiences. Shame has also been considered as taking a central role within participants' experiences suggesting a need for therapeutic intervention to be tailored in a way that specifically addresses these concepts and consider the stigma attached to bulimia.

CBT-E has a rigid manual in which practitioners are required to follow that outlines the four stages of treatment. Stage one is centred on engaging the client in treatment, educating the client about weight and introducing the idea of in – session weighing. Stage two is a brief transitional change whereby both the practitioner and the client review the clients progress, identify barriers to change, modify the formulation and plan the third stage of treatment. Stage three is suggested to be the main body of treatment in which the factors that can be seen to maintain the eating disorder are addressed. The final stage of treatment focuses on the future, the two central aims of this stage are concerned with maintaining change and minimizing the risks of relapse (Fairburn, 2008). The broad form of CBT-E (Fairburn, 2008) has been designed in order to address issues that can be seen to be maintaining an eating disorder, it is determined if this form is appropriate at the end of stage two in the focused model of CBT-E. The broad form of CBT-E can be seen to document modules focusing on issues such as clinical perfectionism, interpersonal problems and low self – esteem. Whether or not a client will receive this form of CBT-E is dependent on if a client presents with interpersonal problems, clinical perfectionism or core low self-esteem that appear to be maintaining the eating disorder (Fairburn, 2008). Participants in this study did not have experience of the broad form of CBT-E, however it seems worth considering that this form of the CBT-E model seems better able to address potential underlying aspects of bulimia, particularly within the core low self-esteem module, which can be seen to address client views of self-worth.

When discussing experiences of recovery participants shared learning about the self with sense of self-acceptance emerging within the data provided by participants that identified as being 'in recovery' from their bulimia. Two participants shared their experiences of self-acceptance and linked this to feeling better able to accept their bodies. Participants'

accounts captured the ways in which they perceived their bodies whilst struggling with bulimia and compared them to the views held at the time of participating in the study. Other participants shared their experiences of self – acceptance in a way that highlighted aspects of their identity. For one participant discussing this, it was clear that she viewed bulimia as being part of her identity. Within the analysis this further reflected a shift from battling towards acceptance. Participants' narratives clearly emphasised that in recovery they were able to reflect on being caught in a cycle of bulimia and identify healthier ways of managing the emotions associated with this.

This further highlights the fundamental need to focus on addressing the underlying emotional components of bulimia within treatment and challenges the idea that bulimia is primarily rooted in weight and body image concerns. CBT-E places a heavy focus on both weight and body image and less attention is paid to working with aspects of shame, identity, anger, and guilt which have all been highlighted within this study. Whilst weight and body image concerns may be present during the onset of bulimia, participants in this study paid very little attention to this aspect of their experiences with only the minority of participants talking about body image and considerably more emphasis on the impact of early experiences and the difficulties found in emotion regulation.

In consideration of the shame, guilt, challenges found in self-acceptance and low levels of self – worth that can be seen to be attached to experiences of bulimia, Compassion focused therapy (CFT) could be suggested as being a beneficial intervention when working with this client group, specifically when working with experiences of guilt and shame, due to its focus on developing self-compassion, distress tolerance and affect regulation which has been found to be beneficial in the treatment of other presentations characterized by high levels of shame (e.g. Leaviss & Uttely, 2015).

Compassion focused therapy can offer new ways for formulating and conceptualizing some of the self-critical and shame based challenges that can be associated with bulimia. A key factor in compassion focused therapy is enabling clients to understand their experiences, allowing them to accept these experiences and work towards being more compassionate towards themselves. CFT is able to be combined with standard therapies such as CBT. CFT could be suggested as a beneficial approach to use within eating disorder group settings, where the relationships between group members can become increasingly validating, compassionate, supportive and encouraging (Gale et al, 2014).

In consideration of the research findings which suggest that individuals identifying with bulimia make considerable improvements over the duration of engagement with CFT-E (Gale et al, 2014), it could be of benefit to incorporate CFT-E training within clinical training programmes that are designed specifically to train practitioners work therapeutically with eating disorders.

Contributions to counselling psychology and concluding comments

Literature can be seen to evidence the pathologizing of eating disorders, and the negative impact of receiving diagnosis has been documented (Johnstone, 2018). However, little remains within contemporary literature exploring the experiences of receiving an eating disorder diagnosis and there may be a potential value in exploring the impact of this on the therapeutic relationship. Clinical psychology can be seen to work closely with medical models of practice and some practitioners may find themselves experiencing a conflict as a result of this, research has evidenced that clinical psychologists are primarily based within systems that are dominated by the medical model (Sidley, 2015) and within such systems Boyle (2002) has suggested that psychological practitioners often reluctantly start to use medicalised concepts and language when working with clients. This could be suggested to further contribute to the pathologizing of bulimia. Less has been documented in relation to how the use of medicalised language affects the individual identifying with bulimia. It could be suggested that counselling psychologists may find challenges when working in such systems, with the principles of counselling psychology being closely related to the application of interventions that focus primarily on challenging the pathologizing of mental health, and the emphasis on working towards the development of models that are firmly based in the primacy of the therapeutic relationship (Kasket, 2017). Within this study the experience of feeling misunderstood and pathologized was highlighted, such feelings may contribute to the shame experienced in relation to identifying with bulimia and further impact on seeking support.

Counselling psychology takes a holistic approach to human distress and provides diversity with regards to therapeutic approaches (Vermes et at, 2014). Counselling psychologists work to understand lived experiences, working collaboratively with clients to explore underlying issues that may have contributed to their experience within a relational framework. The results of this study have highlighted a need to work with the underlying issues associated with bulimia nervosa and work towards alternative ways of understanding

this that move away from the pathologizing of bulimia, challenging the stigma attached to the experience and shift away from the view of bulimia being primarily concerned with weight and body image. Incorporating aspects of third wave approaches within the therapeutic work such as compassion focused therapy (CFT) and acceptance and commitment therapy (ACT) could be suggested as a way of allowing clients to address these aspects of bulimia, which could potentially be missed in therapy that has a primary focus on body image and weight concerns. The findings of this study highlight a need to move towards taking an integrative approach within therapeutic work that enables the client to work with issues of control, inner conflict, relational dynamics and the challenges that can be found in self-acceptance.

It was of importance to complete this study using interpretative phenomenological analysis, this allowed for an in-depth exploration of participants experiences, acknowledging that individuals with experiences of bulimia can often remain unrecognised and are therefore unheard as a result of often maintaining what is considered as a 'normal weight'. This study is relevant to the field of counselling psychology due to its interest in stigmatised groups, a review of the already existing work in this area suggests that bulimia is often stigmatised. This can be seen in the way bulimia has been negatively constructed throughout history (e.g. Huon et al, 1988; Burns, 2004). The idea of bulimia being stigmatised and pathologized has been supported in the findings of this study. Within this study, stigmatization and pathologizing has been considered in relation to the process of seeking and receiving support. Participants' accounts have pointed towards a fear of being misunderstood and the secretive aspects of bulimia which both impact on the process of support seeking and could be seen as partly a result of the stigma attached to bulimia. Statistics presented by The Mental Health Foundation (2016) suggests that 80% of individuals with an eating disorder report feeling stigmatised in the workplace and did not feel that their employers were 'informed' about eating disorders, the impact of them, or how they were managed. The report further suggested that the stigma attached to eating disorder diagnosis had a considerable impact on 40% of individuals recovery.

Limitations of this study

A review of the psychological literature on bulimia suggests a shortage of studies that include the accounts of individuals who do not identify as White British. Six out of seven participants in this study identified as White British and one participant identified as having mixed heritage. Therefore, future research may benefit from accessing the accounts of

individuals from ethnic minority groups as this is still missing from the literature within this field. One of the key limitations of this study is that it did not provide many accounts from individuals who identify as being from ethnic minorities. In addition to this a limitation was that only three participants in this study had received psychological therapy, whilst other participants talked about alternative support, they could not discuss experiences of therapy in their interviews, this limited the amount of data that was able to be gathered focusing specifically on therapy experiences. This study has highlighted the stigma associated with experiences of bulimia and the pathologization of bulimia which can be seen in the literature, considering how this may impact on the process of support seeking. It could be suggested that there would be a benefit to further qualitative research focusing on the role of the therapeutic relationship in a person's recovery from an eating disorder, exploring how stigma, in – session weighing and receiving a diagnosis may impact on this.

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Appendix A – Ethical approval

Application title: A discourse analytic exploration of self-constructions of lived experiences of bulimia

I am writing to confirm that the Faculty Research Ethics Committee are satisfied that you have addressed all the conditions relating to our previous letter sent on 1 October 2019 and the study has been given ethical approval to proceed.

The following standard conditions also apply to all research given ethical approval by a UWE Research Ethics Committee:

1. You must notify the relevant UWE Research Ethics Committee in advance if you wish to make significant amendments to the original application: these include any changes to the study protocol which have an ethical dimension. Please note that any changes approved by an external research ethics committee must also be communicated to the relevant UWE committee. Amendments should be requested using the form at http://www1.uwe.ac.uk/research/researchethics/applyingforapproval.aspx
2. You must notify the University Research Ethics Committee if you terminate your research before completion;
3. You must notify the University Research Ethics Committee if there are any serious events or developments in the research that have an ethical dimension.

The Faculty and University Research Ethics Committees (FRECs and UREC) are here to advise researchers on the ethical conduct of research projects and to approve projects that meet UWE's ethical standards. Please note that we are unable to give advice in relation to legal issues, including health and safety, privacy or data protection (including GDPR) compliance Whilst we will use our best endeavours to identify and notify you of any obvious legal issues that arise in an application, the lead researcher remains responsible for ensuring that the project complies with UWE's policies, and with relevant legislation https://intranet.uwe.ac.uk/whats- happening/sites/gdpr/updates/pages/research-and-gdpr-compliance-update-08-may- 2019.aspx. If you need help with legal issues please contact safety@uwe.ac.uk (for Health and Safety advice), James2.Button@uwe.ac.uk (for data protection, GDPR and privacy advice).

Please note: The UREC is required to monitor and audit the ethical conduct of research involving human participants, data and tissue conducted by academic staff, students and researchers. Your project may be selected for audit from the research projects submitted to and approved by the UREC and its committees.

Please remember to populate the HAS Research Governance Record with your ethics outcome via the following link: https://teams.uwe.ac.uk/sites/HASgovernance.

We wish you well with your research.

Interview Schedule

- Can you tell me a bit about yourself and how you have come to identify as a person with bulimia?
- Can you tell me what bulimia means to you?
- How would you describe the place bulimia has in your life and your sense of identity?
- Can you explain a little bit about how it feels to experience bulimia?
- Can you tell me a little about your body weight and what this means to you?
- Can you describe your relationship with food?
- Can you tell me about your experiences of binging and purging?
- Could you describe the physical feelings that you experience when you binge and purge?
- What emotions do you feel are linked to these physical feelings?
- What sorts of triggers and feelings do you experience before you binge and purge
- How do you feel afterwards?
- Could you tell me about the emotional impact of bulimia?
- What kinds of support have you had to help you manage your bulimia/how have you found this?
- Is there any support that you feel is missing for people with bulimia?
- Can you tell me a bit about your goals in regard to recovery and your hopes for the future ?
- is there anything else you'd like to add

- Prompts
- *That's interesting could you tell me a little more about that?
- *What does that mean to you?
- *How do you feel about that now?
- *Are there any ways you could elaborate on that?
- *Support – types of therapy? (if any)

Participant Information Sheet

My name is Geraldine Bishop and I am a trainee counselling psychologist in the Department of Health and Social Sciences, University of the West of England, Bristol. I am collecting this data for my doctoral thesis. My research is supervised by Associate Professor Dr Helen Malson. If you have any queries about the research you can contact her at the Department of Health and Social Sciences, University of the West of England, Frenchay Campus, Coldharbour Lane, Bristol BS16 1QY, Tel: (0117) 328 2164; if you have any queries about the research.

Who are the researchers and what is the research about?
Thank you for your interest in this research. The focus of this research is to explore individuals' lived experiences of bulimia nervosa.

What does participation involve?
You are invited to participate in a qualitative interview – a qualitative interview is a 'conversation with a purpose'; you will be asked to answer questions in your own words. The questions will focus on your experience of bulimia, you will be asked a series of questions relating to your own identity, your experiences of binging and purging, recovery and your relationship with food. The interview will take place in a quiet location of your choosing. It will be audio recorded and I will type-up (transcribe) the interview for the purposes of analysis. On the day of the interview, I will ask you to read and sign a consent form. I will discuss what is going to happen in the interview and you will be given an opportunity to ask any questions that you might have. You will be given another opportunity to ask questions at the end of the interview.

Who can participate?
Anyone over the age of 18 who self identifies as bulimic or as having current or previous experiences of bulimia.

How will the data be used?
Your interview data will be anonymised (i.e., any information that can identify you will be removed or changed) and analysed for my research project. This means extracts from your interview may be quoted in my thesis and in any publications and presentations arising from the research. The information you provide will be treated confidentially and personally identifiable details will be stored separately from the data.

The personal information collected in this research project (e.g., the interview audio recording and transcript and the consent form, will be processed by the University in accordance with the relevant data protection legislation (please see the privacy notice below).

You will get the opportunity to participate in a research project on an important social and psychological issue.

How do I withdraw from the research?
If you decide you want to withdraw from the research, please contact me via email [geraldine.2bishop@live.uwe.ac.uk]. Please note that there are certain points beyond which it will be impossible to withdraw from the research – for instance, when I have submitted my thesis. Therefore, I strongly encourage you to contact me within six weeks of participation if you wish to withdraw your data.

Are there any risks involved?
It is possible that discussing your experiences of bulimia may raise uncomfortable or distressing issues for you. We don't anticipate any particular risks to you with participating in this research; however, there is always the potential for research participation to raise uncomfortable and distressing issues. For this reason, we have provided information about some of the different resources which are available to you.
If you are a UWE student you can also use the university counselling service, see: http://www1.uwe.ac.uk/students/healthandwellbeing/wellbeingservice.aspx or email wellbeing@uwe.ac.uk, or telephone 0117 3286268.
If you are not a student at UWE or you would prefer an off-campus counselling service, the website of the charity **Mind** enables you to find free or low-cost counselling in your local area via the Local Mind services. Search for your local mind: https://www.mind.org.uk/information-support/local-minds/

Then, search for low-cost counselling via the website of your Local Mind (e.g. Local Mind for Bristol is: http://www.bristolmind.org.uk/bsn/counselling.).

The **British Association for Counselling & Psychotherapy** (http://www.bacp.co.uk/) **It's Good to Talk** website enables you to search for an accredited counsellor or psychotherapist in your area: http://www.itsgoodtotalk.org.uk/

The website of the **British Psychological Society** enables you to 'find an accredited psychologist' in your area: https://www.bps.org.uk/public/find-psychologist

Beat is the UK's leading charity supporting those affected by eating disorders and campaigning on their behalf. Information and the number of helplines can be found on their website https://www.beateatingdisorders.org.uk

Anorexia and Bulimia Care provide emotional support and practical guidance for anyone affected by eating disorders, those struggling personally and parents, families and friends. ABC works tirelessly to increase awareness and understanding of eating disorders through talks, training and campaigns for change.
http://www.anorexiabulimiacare.org.uk/about/research

If you would like to take part in this research please make contact with myself via email or by telephone 07983179735

If you have any questions about this research please contact myself or my research supervisor: Dr Helen Malson, Department of Health and Social Sciences, Frenchay Campus, Coldharbour Lane, Bristol BS16 1Q.

Appendix D – Interview consent form

Interview Consent Form

Thank you for agreeing to take part in this research on what it is like to live with bulimia nervosa.

My name is Geraldine Bishop and I am a trainee counselling psychologist in the Department of Health and Social Sciences, University of the West of England, Bristol. I am collecting this data for my doctoral thesis. My research is supervised by Associate Professor Helen Malson. If you have any queries about the research you can contact her at the Department of Health and Social Sciences, University of the West of England, Frenchay Campus, Coldharbour Lane, Bristol BS16 1QY, Tel: (0117) 328 2164.

Before we begin, I would like to emphasise that:

- your participation is entirely voluntary
- you are free to refuse to answer any question
- you are free to withdraw at any point up until one month after the interview. After this point it may be difficult to separate the information that you provided from the overall analysis.

You are also the 'expert'. There are no right or wrong answers and I am interested in everything you have to say.

Please sign this form to show that you have read the contents of this form and of the participant information sheet and you consent to participate in the research:

_____ (Signed)

_____ (Printed)

_____ (Date)

Please return the signed copy of this form to me.
This research has been approved by the Faculty Research Ethics Committee (FREC)

Call For Research Participants

A Qualitative research study exploring individuals' experiences of living with bulimia.

The study is open to anyone over the age of 18 who self identifies as bulimic or as having current or previous experiences of bulimia.

Participating in this study will involve taking part in an interview that will last for approximately 45minutes – 1hour. Questions will be focused on participants experiences of bulimia nervosa.

If you are interested in taking part in this study, please contact the researcher via email geraldine2bishop@live.uwe.ac.uk or via telephone **07893179735.**

Appendix F – Previous draft of theme table

Emergent Themes	**Master table of themes**			**Participants contributed Page/line**			
	Victoria	Lisa	Jess	Claire	Sam	Sally	Sarah
1. *Control*							
- Feeling controlled by others	6.7	3.25		4.24			
- The need for control		2.24		3.20	3.3	2.10	8.25
- Experiences of losing control	6.5	8.18	9.18	4.17	5.12		9.4
2. *Inner conflict*							
- A battle with two parts of the self	7.18	7.20			3.21	5.4	
- The use of bingeing and purging to block unwanted feelings	4.12	5.4	8.12	8.9		6.16	8.12
- Bulimia as an addictive process	2.9			7.1	4.3	1.14	3.17
3. *The feeling of being trapped in a cycle of bulimia*							
- The desire to escape	8.8		5.1		3.28	13.9	
- Bulimia as a secret lifestyle	1.22	5.26	2.8			4.20	
- Obsession	2.7	2.8	4.22	2.27	4.8		8.4
- The feeling of being misunderstood			4.1	2.10		10.24	3.12
- Shame			3.25	10.18			10.5
	11.6	9.25		6.20	8.19		2.19
4. *The journey in recovery*							
- Finding a release through therapy			10.1			12.10	
- The experience of self-acceptance			9.23	11.21	9.8	10.16	
- Self - discovery	11.4		11.10		11.13		5.7
				11.19	2.12		3.25
							8.21

Appendix G – Annotated transcript

Interview 4 – Claire

	And this is when you were around sixteen seventeen?	
Loneliness Became obsessive with exercising at first 'Obsession' with calorie counting and exercise Hx of anorexia Hx of self-harm, Purging without bingeing first Onset of secretive behaviours	Yeah um in years 10 and 11 and then I think the eating issue probably kicked off as I was going in to college so I would have been umm sixteen umm and I didn't really have any friends it was around that time, I didn't realise that my obsession with exercise was making me lonely at the time, I was really isolated I only see that looking back though I didn't see it at the time but I was happier with myself before I got into all this then it was just like anything positive was gone because all I could really think about was this yeah so I was filing up my spare time with a lot of exercise, so I think it started with umm with exercise because my mum is quite active and I always did a lot of exercise with her so um yeah it started with me doing that every day and then it got to an unhealthy point where I was doing like two hours every day in the gym and like umm running um even when I didn't want to I would force myself and then umm then it started to play into my eating, so I started with having anorexia so I basically started just cutting down my foods then I just became consumed with thinking about calories and making sure that I was burning everything off when I was exercising and um I would be like counting everything on my phone and just keeping track of absolutely everything and it went down to me having um I think 300 calories a day was my lowest count so yeah I was getting really thin by then but I had never binged or anything or purged, I think I tried to but I don't think I was able to like I couldn't make myself sick so just stuck to cutting down my food and exercising, and then um and then I started to get into a relationship at the end of college so when I was 18 I think and that's when I started gaining weight again, because my boyfriend knew that like I had problems I was self-harming before my bulimia as well so he obviously knew something was wrong and then he tried to help me with my eating problems, um, and just like making sure I was eating properly everyday um and then as I got into my relationship, I think because I put on weight so quickly I was really um just I think it freaked me out a bit and that's when I was like oh my gosh I need to lose weight again fast um and that's when I started purging my food so yeah it started with um me just	

Interview 6 – Sally

	OK thank you and could you tell me a bit about what bulimia means to you?	
Sally's experience of bulimia used to be her everyday normality. Perspective has shifted to seeing it as destructive and negative Impulsive behaviours Guilt, shame and regret Behaviours driven by feelings underneath the surface that are difficult to identify (bulimic behaviours as a block?avoidance?) A way of trying to gain control in other aspects of her life. Perspective (younger self)	Um well I think it has kind of changed over time so like what it was to me before which was just a normal part of my everyday life, it isn't anymore so for me now it is kind of like a cycle of destructive and negative eating behaviours, for me that starts with feeling negative and impulsive and that leads to bingeing and then the sort of cycle of regret comes after and it brings like guilt and shame this is when I would engage with purging behaviours. Like for me it is a feelings based problem I think it all comes from feeling a particular way its hard to pinpoint the feeling that causes it but it was definitely linked to my emotions it was like my way of taking back control you know, like only something I really knew, so when I was in a happy place I didn't want to do it I think like when everything was going good for me but then when I wasn't my bulimia was my way of trying to get some control something only I could do with nobody interfering but I wasn't like that on a good day I didn't want to ruin it with all these shitty thoughts and behaviours I was just enjoying being well, but then when something didn't go to plan in my life or I felt that things were spiralling for me like I was losing control it would be my way of coping, well I thought I was coping anyway but like yeah I was depressed anxious just a wreck at times really I still get emotional when I think about it if I am honest because I look back and really I was just a young girl going through a really hard time, I suppose doing anything I could to make it better but the whole time I was just making it worse for yourself, like all of those behaviours a voice in your head tells you it think will make you better but all along I was just making myself worse the whole time so yeah I suppose that's kind of sad when I look back now I can really see how much of a hard time I was having and I was just trying to fix all my problems with another problem in itself it is hard to really say exactly what it means to me because like I said it has meant so many different things over the years and	

Appendix H - 5000 word article

A Qualitative study exploring lived experiences of bulimia nervosa

Abstract

Background Bulimia nervosa is defined as a clinically recognised disorder, the key diagnostic features of which are eating an 'abnormally' large amount of food within a short space of time and compensatory behaviours such as abusing laxatives, vomiting and excessive exercising. Research within the area of eating disorders has been mostly concerned with anorexia nervosa and studies have been primarily conducted with the female population, evidencing a clear need for more research to address bulimia and the issues surrounding it. A review of existing research evidences a key focus on the medicalisation of eating disorders, with frequent reference being made to signs, symptoms and diagnosis.

Aims of the research The predominant aim of this research is to develop an understanding of bulimia based on the insights provided by participants who have their own lived experiences of it. The study attempted to explore lived experiences through the use of interpretative phenomenological analysis. The fundamental aims of this research was centred on understanding participants lived experiences of bulimia, drawing attention to the stigma associated with experiences of bulimia, exploring how this may impact on the process of support seeking, and highlight the challenges found in the pathologizing of bulimia.

Method Seven female participants aged between 21-34 who identified with bulimia nervosa were recruited for this study. The research utilised semi – structured interviews to facilitate participants to talk about their experiences of bulimia. Interpretative Phenomenological Analysis (IPA) was used to analyse to data.

Findings Four superordinate themes were developed from the analysis (1) The search for control; (2) Caught in the repeated cycle of bulimia; (3) Inner conflict; 'fighting a battle mentally' (4) The journey to recovery. Subordinate themes were developed for each of these superordinate themes. The findings of this study have highlighted a need to work with the underlying issues associated with bulimia nervosa and work towards alternative ways of understanding this that move away from the pathologizing of bulimia and the view of bulimia being primarily concerned with weight and body image. The concept of control was frequently highlighted throughout the analysis and was associated with experiences of feeling caught within a repeated cycle of bulimia. All participants spoke about the feeling of being caught in a cycle, emphasising the impact of secrecy in bulimia. Both fears of being misunderstood and secrecy in bulimia were seen as being partly a result of the stigma attached to experiences of bulimia and highlighted a need to move away from the pathologizing of bulimia. The study makes a contribution to the field of Counselling Psychology by offering insights into how participants understand and experience bulimia nervosa. This insight has the potential to inform practitioners when working therapeutically with clients experiencing bulimia.

Conclusion The findings of this study point towards the central role of control in both the development and maintenance of bulimia. Participants evidenced a fear of being misunderstood by others which further contributed to bulimia being experienced as a 'secretive lifestyle'. Fears presented in relation to how the individual would be viewed by others. This was interpreted as being a result of the stigma associated with bulimia. The secretive aspect of bulimia, which was closely linked to shame can be seen to further maintain the continuation of bulimia as it left participants feeling unable to seek support. For a number of participants the journey to recovery was one that depended on acceptance which was highlighted in experiences of psychological therapy. The findings of this study highlight a need to move away from the pathologization of bulimia and towards taking an integrative approach within therapeutic work that enables the client to work with issues of control, inner conflict, relational dynamics and the challenges that can be found in self-acceptance.

Introduction

When conducting a review of the already existing literature within this field, it can be seen that little attention has been paid to the pathologizing of eating disorders, the stigma associated with the experience and the potential challenges that may exist for individuals when they attempt to seek support. Research that has concentrated specifically on bulimia has highlighted difficulties in emotion regulation, internal conflicts and experiences of shame. Broussard (2005). A key focus of this study has been to offer alternative perspectives that challenge the idea of pathologizing bulimia and to evidence the sense of pathologizing that already exists within the current body of literature. The paper considers the impact of pathologizing on the individual and how this can be seen as contradictory of the philosophy of counselling psychology, considering that one of the central aims of the profession is centred on developing models of practice which are firmly based in the primacy of the therapeutic relationship, without assuming any one way of experiencing, feeling or knowing is superior (Kasket, 2017).

The study attempted to explore lived experiences through the use of interpretative phenomenological analysis. The fundamental aims of this research has been to consider the stigma associated with bulimia and call attention to how this may further impact on individuals' experiences, specifically their experiences of seeking and accessing support. Whilst highlighting the challenges that can be found in use of the medical model and the pathologizing of eating disorders, the study aims to offer alternative perspectives that challenge the idea of pathologizing bulimia.

Methodology

Design

Interpretative phenomenological analysis (IPA) was used to analyse the data obtained from interview transcripts. IPA has been described by Smith and colleagues (2009) as a qualitative methodology developed to examine the ways in which an individual makes sense of their own lived experiences.

Data collection

After careful consideration of the most appropriate methods to gather meaningful data , it was important to remain mindful that the key aim was to obtain data directly from participants, resulting in a singular method of data collection through semi – structured interviews being used for this study.

Participants

Seven participants were recruited through the use of a University participant recruitment system, an eating disorder charity, a peer support group and social media advertisements. Three participants came forward via the university participant pool, two participants made contact with the researcher through the eating disorder charity and the remaining two made contact with the researcher via social media. The study was opened to anyone over the age of 18 who self identifies as bulimic or as having current or previous experiences of bulimia.

Analysis

Interviews were transcribed verbatim as soon as possible after the interview and the initial analysis process started during transcription. This ensured that the interactions between the researcher and the participant were recalled in detail and that the researcher's initial interpretations were documented. The researcher then drew on these initial interpretations for the final analysis and subsequent identification of themes.

The process of data analysis started by looking for themes in the first case. This began informally during the interviewing in which the interviewer's initial interpretations were later recalled and continued through the process of transcription and reading and re-reading the transcripts. Comments were made in the left-hand column regarding any interesting and significant issues. Following this, the researcher then used the right-hand margin to document the emerging theme titles. The researcher then looked for connections between these themes. This was followed by a more analytical or theoretical ordering as the researcher noted a clustering of themes. As these clusters emerged, they were checked in the transcript to make sure that they matched the actual words of the participant as suggested by Smith and Osborn (2003). After all transcripts had been analysed a final table of super-ordinate themes was constructed following discussion with the research supervisor.

Results

Super-ordinate theme 1: The search for control

The first super-ordinate theme considers different aspects of control experienced by all participants. All participants discussed the concept of control. The ways in which the participants talked of their understandings and experiences of this varied. A number of participants talked about feeling that they lost their sense of control at a young age, participants specifically highlighted the experience of feeling controlled by family members.

> *'I have always been scared of not being in control I didn't really have any control in my life until I was a teen and now my only control comes from me controlling what I eat I was controlled a lot when I was*

young by my mum she was a good mum and loved us but she was controlling in so many ways' (Victoria)

'I was trying to feel OK with myself it was a very bad time in my life with a lot of depression and it was all spiralling out of my control I just wanted to feel more able to manage my own life' (Sarah)

These extracts can be seen to capture the experiences of feeling out of control and the desire to regain it. Sarah communicates a sense of desperation to be in control of her own life, highlighting a particularly difficult time in her life when she was experiencing depression. It was evident from her accounts that bingeing and purging were used as attempts to cope.

Sub-theme 1a: Feeling controlled by others

Three participants highlighted the feeling of being controlled by others in their lives. Participants described these experiences as being overwhelming. They referred to early experiences and clearly emphasised the impact that being controlled had on their eating habits, suggesting that bulimia had been an attempt to regain control.

'Like at home both my mother and my older brother try and control like what I do and can get really bossy but like it's done in a controlling way' (Lisa)

During the second interview with Lisa she frequently referred to her teenage years as being a time that she felt controlled by her mother and brother. These feelings were presenting during the time that she started to engage with bulimic behaviours.

'I already had to lie about everything, I couldn't do anything or have anything of my own he was so obsessed and would control everything I would do' (Claire)

'That must've been really hard for you'

'Yeah it was a really tough time I lost everything in that relationship when I was down I would just binge, being sick was my way of controlling it all really and having something of mine, it was one thing he didn't know, not in the beginning anyway' (Claire)

It seemed that Claire experienced a sense of control from concealing her bulimia, ensuring her partner remained unaware. It appeared that other areas of Claire's life were out of her control as a result of her relationship, and that she was attempting to regain this control through her bulimia.

Sub-theme 1b: A sense of empowerment through bulimia

Five out of seven participants emphasised the need to be in control of their own lives, whilst this related closely to the discomfort found in feeling controlled by others, participants drew on other aspects control such as feelings of empowerment.

> *'when I was in a happy place, I didn't want to do it I think like when everything was going good for me but then when I wasn't my bulimia was my way of trying to get some control something only I could do with nobody interfering' (Sally)*

There was a sense of sadness when Sally shared this part of her experience, as she recognised that she was using her bulimia as an attempt to cope with underlying feelings that felt unmanageable for her at that time.

Sub-theme 1c: Feeling powerless as a result of bulimia

The idea of bulimia being consuming and taking over the lives of the participants was a theme that presented for six of the seven participants in this study. This sub - theme can be seen to capture feelings of loss, obsession and powerlessness.

> *'Yeah so it's like out of my control, it reminds me of like when you are crazy about a person, like mad about them and then you realise you're obsessed that's the only way I can really describe my reaction to it all its obsessive it's like something that feels out of my control at the time just that thought of purging after a binge' (Lisa)*

Lisa shared this experience in a way that implied there was a recognition of developing an obsession, which she felt that at the time she was unaware of. The idea of bulimia taking control of her life was reflected in the reference she makes to feeling that she held no control with regards to the thoughts of bingeing and purging, highlighting how she felt these thoughts had taken over.

Super-ordinate theme 2: Caught in the repeated cycle of bulimia

Feeling caught in a cycle of bulimia was an experience that all seven participants identified with, specifically highlighting the feeling of being trapped and desires to escape. For many participants it seemed that they had a sense of being somewhat heavily invested in keeping secrets and framing this as a lifestyle, leaving them feeling emotionally distanced from those around them. Participants identified a repeated ongoing cycle consisting of obsession, shame and loneliness.

Sub-theme 2a: Bulimia as a secret lifestyle

The secretive aspect of bulimia brought attention to the impact of bulimia on relationships and the barriers found between individuals and their close others as a result of the hidden aspect of bulimia. The experiences of

shame and loneliness were repeatedly brought to light within this sub-theme. Participants shared their fears of others finding out about their bulimia.

Sarah shared her experience of fear, it was evident throughout her interview that Sarah felt the need to hide her behaviours. It was clear from her responses that she was fearful in relation to her parents discovering her bulimia. Sally talked about underlying emotional processes relating to the idea of her parents 'finding out' and what this would mean in relation to her positioning within her family dynamic.

> *'I used to get scared my parents would hear me it would always be when my parents were out mum caught me once but I told her I had a stomach bug and that's why I threw up' (Sally)*

What would it have meant if she had known?

> *'It would have completely fucked up her view of me, and everyone in the house really like I know they would have thought I was mental and never really understood it because I was always the person who had my shit together and had no reason to be doing what I was doing' (Sally)*

This extract can be seen to shed light on how important the views of Sally's family were to her, it seemed that she felt the discovery of her bulimia would be accompanied by a change in how others perceive her. It was interesting to note how Sally used the term 'mental' to describe how her mother may have perceived her if she had discovered her purging. This narrative can be seen to highlight a fear of being pathologized whilst also bringing attention to the stigma associated with bulimia, which potentially contributed to Sally feeling to need to maintain the secrecy around her bingeing and purging. Sally felt hesitant to talk about her experiences, further impacting on her process of seeking and receiving support. Within her account, Sally highlights how she 'doesn't think bulimia is talked about enough'. A lack of awareness in relation to bulimia can be viewed as being a result of the stigma attached to the experience of bulimia, further influencing the process of support seeking. Throughout her interview Sally talked frequently about the emotional impact of bulimia and how she felt this was not a part of her bulimia that was recognised or understood by others.

> '*bulimia is a tricky one I don't think it is talked about enough I suppose when I think about how it actually feels sometimes it can just feel very lonely like people don't talk about it it's a hidden feeing no one really knows what you're going through at the time' (Sally)*

Sub-theme 2b: Keeping the cycle going; a fear of incorrect assumptions and misunderstandings

This sub theme presented in five out of seven of the interviews, with participants expressing a fear of being misunderstood, a number of participants further discussed how they felt this impacted on the process of seeking support whilst other participants linked this to the lack of awareness people have of bulimia in comparison to anorexia nervosa. The fear of being misunderstood can be seen to closely relate to the stigma associated with bulimia and further influenced participants when contemplating seeking support.

'I still have that gut feeling that they won't get it or like they will make an assumption or misunderstand me, I just dread it, I don't know that people don't really get it unless they are a professional like with experience or like they have their own lived experience of bulimia it's just one of those things' (Jess)

In Jess' interview when she discussed the idea of support seeking and therapies, she seemed to place heavy focus on the feeling of being misunderstood, Jess particularly related this to the idea of seeing professionals, further suggesting that there is a lack of understanding from anyone that does not have lived experience of bulimia.

Super-ordinate theme 3: Inner conflict; 'Fighting a battle mentally'

The third superordinate theme considers the concept of inner conflict and its association with bulimia. The subthemes highlight the ways that a number of participants identified with two different parts of themselves, describing challenges found in managing this. A second subtheme describes the struggle found in emotion regulation and the use of bingeing and purging as an attempt to block emotions that felt difficult to cope with. Five out of seven participants linked both the thought processes and the behaviours associated with their bulimia to aspects of addiction.

Sub theme 3a: Bulimia as an attempt to regulate emotion

Six out of seven participants identified with the use of bingeing and purging as an attempt to regulate emotion. There were a number of occasions where participants touched on finding particular emotions difficult to cope with and recognised their bulimia as a way of trying to escape from these.

I have blocked a lot out I suppose before a binge I felt like this strong need to consume something and a load of emptiness in me that I needed to fill I was just filling the emptiness within me and I think that's where the bingeing came into it then afterwards I would have the guilt and I would need to purge then the emptiness would come back the hole was never filled' (Sarah)

Sarah presented the concept of emptiness in a different light, Sarah discussed emptiness in emotional terms suggesting that she was using bingeing as an attempt to cope with this state of emptiness she was experiencing. On reflection Sarah was able to see that bingeing did not fulfil her needs long term and that the feeling of emptiness would always return, this extract captured a similar cycle to what had been identified by Victoria, however Sarah's behaviours seemed to be driven more by feelings of guilt, however both of these participants described an emotional drive eventually leading them back to the behaviour of bingeing and purging.

'happy because I am empty and like I said that can be like a feeling of being powerful but then that night you go to bed and you think about what you have done and you feel controlled again and start thinking you have no power to fight this and yeah then you just do the same to get rid of that feeling' (Victoria)

Sub-theme 3b: Addictive properties of bulimia

Five out of the seven participants likened the existence of their bulimia to an addictive process, using terms such as 'fixing cravings', 'being hooked on it', and 'needing more' a key commonality across the interviews seemed to be identifying the challenges found in stopping the engagement with bulimic behaviours and feeling out of control in the attempts to change behaviours.

> *'it never felt OK or good in any way but equally it was so hard to stop because I was so hooked on it, I just couldn't stop it became my thing' (Sam)*

Sam described the experience of being 'hooked' when describing the act of bulimic behaviours. In her interview, Sam talked about the engagement with bulimic behaviours as being driven by automatic thoughts, her narrative suggested that once she started engaging with these behaviours it became extremely challenging to stop which again emphasised the lack of control she experienced.

Super-ordinate theme 4: The journey to recovery

The fourth superordinate theme considers the various factors participants associated with the process of recovery from bulimia nervosa. During the study participants discussed their experiences of therapy, highlighting what they had found helpful to their recovery and parts of therapy they experienced as unhelpful.

Sub-theme 4a: Release and self – discovery through psychological therapy

This sub-theme particularly highlights the participants individual experiences of therapy and support. Sally, Sam and Sarah had experiences of therapy (CBT, Music therapy and Integrative therapy) and talked about this in relation to their recovery journey. Participants discussed their experiences of receiving CBT-E and finding the weighing element of this treatment unhelpful.

> *'I found it so shameful to receive that diagnosis and um I was offered treatment with them but from what I remember you had to be weighed at every session and that was part of the treatment, I said I couldn't do it, it was too much for me like I had never weighed myself even when I had anorexia' (Sam)*

> *'I do remember being weighed in some of my sessions but like I said I was never underweight if anything my BMI would be high and she would tell me that and I was like well yeah I know this I weigh myself every morning I don't know what this is achieving you know? I can understand if people are underweight, they need to be weighed but I didn't get why I was being weighed it caused me more anxiety by stepping on the scale' (Sarah)*

Both Sam and Sarah spoke about how they found the requirement to be weighed in CBT-E unhelpful. Sam talked about the shame she experienced when receiving her diagnosis and the concept of being weighed being a significant influencing factor when considering treatment, it seemed that Sam recognised the possibility of this

process re-triggering her shame, in her account it was clear that the idea of being weighed was unknown and brought with it a sense of being overwhelmed.

Sub-theme 4b: The shift from fighting to acceptance

The shift from fighting to acceptance was present in five out of seven interviews, Participants reflected on the process during their journeys in recovery specifically highlighting the concept of acceptance.

In Sam's interview she linked the concept of recovery to acceptance of self and focused on her experience of having to look at various parts of the self. Throughout her interview it seemed that there were many aspects of herself that she seemed unaccepting of and it seemed that she would often attempt to mask this discomfort through bingeing and purging. Sam shared how her experience of volunteering in the field of eating disorders benefited her recovery and emphasised the benefits of 'giving back' throughout her interview.

> *'I feel fully recovered I think the volunteering is one of the best things I have ever done, it took a lot of effort to look at who I really am, stop the judging and just accept that person' (Sam)*

Sally talked about the concept of acceptance and brought this when she was discussing the links between bulimia and her sense of identity. It was clear in Sally's accounts that she viewed bulimia as being part of her identity and it seemed that she had faced previous challenges in accepting this part of herself. When talking about recovery she emphasised the importance of accepting the bulimia and focusing more on how to manage it as opposed to battling with it. When discussing this, she referred back to the cycle of bulimia and the feeling of wanting to escape, discussing this as being a battle in itself, it seemed that throughout her recovery Sally had found alternative ways to manage the emotions associated with her bulimia.

> '*I see it as something I can't escape from and something that will always be there so instead of trying to escape it I just try to accept it when I think of it, bulimia will always be a part of who I am and nothing is going to change that or take it away' (Sally)*

Discussion

Control

A key theme that remained present throughout the analysis was control. Narratives highlighting the concept of control were present across all seven interviews. The concept of control and the ways in which it manifests within presentations of bulimia has been evidenced in a number of studies (e.g. Reid et al, 2008; Broussard, 2005; Jepson et al, 2010) This study has complimented previous literature highlighting the role of control within bulimia whilst bringing attention to participants' early experiences relating to a loss of control and attempts to gain control through bulimia.

The role of shame

When participants in this study discussed their experiences of feeling caught in the repeated cycle of bulimia, they identified shame as being both internal and external. A number of participants described a sense of fear relating to how they may be viewed by others, with the predictions of this being only negative. It could be suggested that this fear it partly a result of the stigma associated with the experience of bulimia and can further impact on the process of support seeking. Previous research has highlighted a fear of stigma for individuals identifying with bulimia (Goss & Allan, 2009). However, there is still limited research with a specific focus on the stigma associated with bulimia. It seems there would be a benefit to qualitative research exploring this further, specifically addressing how stigma impacts on support seeking.

Whilst the role of shame has been explored in relation to the development of bulimia (Levinson et al, 2016) there seems to be less in the way of literature exploring shame as a maintaining factor and how much of the shame experience results from stigma. Participants in this study discussed the existence of shame following purging behaviours and evidenced an increase in shame over a duration of time. Within this study the act of purging was frequently associated with shame, future research may benefit from further exploration of this in order to determine the ways in which shame may contribute to the experience of feeling caught in a cycle of bulimia and further impact support seeking.

The impact of secrecy in bulimia

Participants in this study discussed the secretive aspect of their bulimia with one participant labelling it as ‘a secret lifestyle’. Analysis of this specific aspect of the participants’ experiences called attention to the loneliness, shame and changes in relationships. Experiences and the impact of secrecy in bulimia has been highlighted in the results of a study carried out by Broussard (2005) the results emphasised how bulimic practices are almost always carried out in secret which further leads to isolation. Further research may benefit from exploring this and the links between stigma and the pathologization of bulimia. It could be suggested that the stigma associated with bulimia and a fear of being pathologized has potential to affect how comfortable and willing an individual may feel in being open with close others about their experience, which has potential to further impact on their experience of seeking and receiving support.

Addictive properties of bulimia

The experience of addiction in relation to the bingeing aspect of bulimia was discussed by participants in this study as being linked to cravings and satisfaction seeking. When participants talked about their purging experiences, they associated it with addictive thoughts and behaviours, linking this to feelings of being trapped within this way of thinking. Research linking bulimia to addictive processes has explored the neurobiology of bulimia and its links to addiction, focusing specifically on factors such as reinforcement, dependence, tolerance, withdrawal, cravings, peripheral hormones and dopamine and reward sensitivity (Umberg et al, 2012). This

study did not make any attempts to explore the neurobiology of bulimia. The recognition of bulimia as potentially having addictive properties could possibly have ramifications for the development of new therapeutic treatment targets for practitioners working with bulimia nervosa. Five out of the seven participants in this study likened the existence of their bulimia to an addictive process. It is important to highlight that whilst participants in this study made associations between addictive processes and their bulimia, these findings are not to be generalised and whilst participants made reference to addictive thought processes throughout their interviews, associating this with bingeing and purging, none of the participants disclosed having experience of addiction to alcohol or other substances.

Bulimia as an attempt to regulate emotion

Typically bulimic behaviours were used to have a function of reducing or blocking distressing or unpleasant feelings. The results of this study specifically highlighted participants' experiences of anger, powerlessness, guilt, shame and frustration. The experience of guilt in the maintenance cycle of bulimia was frequently highlighted by participants and was primarily described as a feeling that would trigger purging behaviour. The role of guilt as a characteristic within eating disorders has been explored (e.g. Allen et al, 2007) with research findings suggesting that women who experience bulimia score higher on feelings of guilt in comparison with other eating disorders. Guilt is commonly associated with the existence of shame which has been evidenced as playing a central role in the development of bulimia (Levinson et al, 2016). It could be suggested that experiences of both guilt and shame are closely associated with the stigma surrounding bulimia. In addition to this, it seems important to recognise that an individual experiencing shame related to their experience of bulimia may be more hesitant to seek support.

Psychological intervention

In consideration of the shame, guilt, challenges found in self-acceptance and low levels of self – worth that can be seen to be attached to experiences of bulimia, Compassion focused therapy (CFT) could be suggested as being a beneficial intervention when working with this client group, specifically when working with experiences of guilt and shame, due to its focus on developing self-compassion, distress tolerance and affect regulation which has been found to be beneficial in the treatment of other presentations characterized by high levels of shame (e.g. Leaviss & Uttely, 2015).

Concluding comments

Literature can be seen to evidence the pathologizing of eating disorders, and the negative impact of receiving diagnosis has been documented (Johnstone & Boyle, 2018). However, little remains within contemporary literature exploring the experiences of receiving an eating disorder diagnosis and there may be a potential value in exploring the impact of this on the therapeutic relationship. Clinical psychology can be seen to work closely with medical models of practice and some practitioners may find themselves experiencing a

conflict as a result of this, research has evidenced that clinical psychologists are primarily based within systems that are dominated by the medical model (Sidley, 2015) and within such systems Boyle (2002) has suggested that psychological practitioners often reluctantly start to use medicalised concepts and language when working with clients. This could be suggested to further contribute to the pathologizing of bulimia, and less has been documented in relation to how this affects the individual identifying with bulimia. It could be suggested that counselling psychologists may find challenges when working in such systems, with the principles of counselling psychology being closely related to the application of interventions that focus primarily on challenging the pathologizing of mental health, and the emphasis on working towards the development of models that are firmly based in the primacy of the therapeutic relationship (Kasket, 2017). Within this study the experience of feeling misunderstood and pathologized was highlighted, such feelings may contribute to the shame experienced in relation to identifying with bulimia and further impact on seeking support.

Counselling psychology takes a holistic approach to human distress and provides diversity with regards to therapeutic approaches (Vermes et at, 2014). Counselling psychologists work to understand lived experiences, working collaboratively with clients to explore underlying issues that may have contributed to their experience within a relational framework. The results of this study have highlighted a need to work with the underlying issues associated with bulimia nervosa and work towards alternative ways of understanding this that move away from the pathologizing of bulimia, challenging the stigma attached to the experience and shift away from the view of bulimia being primarily concerned with weight and body image.

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