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Research Dossier

An Investigation into the Individual Experience of Seeking Help for Bulimia Nervosa, and the Process of Integrating and Searching for Identity Following Recovery from Bulimia

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Statement of Anonymity

To ensure the confidentiality and anonymity of all clients, supervisors and research participants, all potentially identifying information has either been omitted or replaced with pseudonyms throughout this portfolio.

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<table>
<thead>
<tr>
<th>Contents</th>
<th>Page Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preface</td>
<td>4</td>
</tr>
<tr>
<td>Introduction to the Research Dossier</td>
<td>5</td>
</tr>
<tr>
<td>Literature Review - Eating Disorders: A Review of the Literature with the Emphasis on an Individual's Experience of Bulimia Nervosa and the Help-seeking Process</td>
<td>8</td>
</tr>
<tr>
<td>Research Report 1 - The Individual Experience of Seeking Help for Bulimia Nervosa – Qualitative Research Report</td>
<td>44</td>
</tr>
<tr>
<td>Appendices:</td>
<td></td>
</tr>
<tr>
<td>Appendix 1- Self-reflection</td>
<td>88</td>
</tr>
<tr>
<td>Appendix 2- Transcript-first page</td>
<td>91</td>
</tr>
<tr>
<td>Research Report 2 – 'The Search for Identity'</td>
<td>92</td>
</tr>
<tr>
<td>The Narrative Analysis Approach to Exploring the Self-concept of Individuals with Bulimia Nervosa</td>
<td></td>
</tr>
<tr>
<td>Appendices:</td>
<td></td>
</tr>
<tr>
<td>Appendix 1- Self-reflection</td>
<td>139</td>
</tr>
<tr>
<td>Appendix 2- Transcript-first page</td>
<td>142</td>
</tr>
</tbody>
</table>
Preface

This research dossier was developed as an integral part of the practitioner doctorate degree in counselling psychology, and has evolved over the last three years. It contains three pieces of research: one literature review and two empirical studies. The literature review particularly focuses on the available help for bulimia nervosa and the process of seeking help for this type of human distress. By exploring the current trends in the eating disorders field and implications for individuals who experience bulimia nervosa, this literature review aimed to set the scene for future research projects. The first empirical study was a qualitative study, which explored the individual experience of seeking help for bulimia nervosa using interpretative phenomenological analysis. Conclusions from this study contributed to the development of the second empirical study. This second empirical study was also a qualitative study. It used a narrative analysis approach to explore how individuals who experienced bulimia nervosa made sense of themselves and their experiences after recovery.
Introduction to the Research Dossier

The Research Dossier contains three pieces of research conducted over the past three years. First is the literature review, which explores the issue of eating disorders, its diagnosis and predominant medical discourse that, not only dominates research, but is also present in the everyday understanding of eating disorders. In this context, the literature review explores the issue of individuals not seeking help for their eating disorder, and further explores the help-seeking process by particularly focusing on individuals with bulimia nervosa. This literature review focuses on seeking help for bulimia nervosa, as this type of distress seems to carry a lot of social stigma, secrecy and most individuals do not seek help for this condition. Therefore, it often goes unnoticed for years as these individuals ‘do not appear ill’. This is concerning as, the longer an individual engages in bulimia, the more difficult it is for them to stop (National Health Service, 2015).

Conclusions based on the conducted literature review became a base for the first empirical project. This piece of empirical research aims to explore individual experiences of seeking help for bulimia nervosa. It applies interpretative phenomenological analysis in order to develop an in-depth understanding of the individual meaning of the help-seeking process. This piece of research contributes to the field by emphasising the aspect of the internal struggle between wanting help and not wanting to let go of bulimia. It also indicates that help-seeking seems to be an ongoing process where individuals might encounter different types of help from different professionals. This process has also been characterised by the fluctuations between awareness and denial of their bulimia. Despite many setbacks and unsuccessful treatments, individuals continue to search for help that would bring meaningful change. This indicates an internal determination and resilience amongst these individuals to get better. The help-seeking process has also been characterised by internal changes to the perception and understanding of oneself which emerge in the process of encountering different types of help.

Findings from this empirical study have become a base for the second empirical project. In the previous study changes within self were described as emerging in the relational contexts. Therefore, the following study focuses in more depth on the relational and societal contexts of individual experiences of themselves. This
has been explored using narrative analysis of life story interviews. Furthermore, this study contributes to the knowledge by emphasising the unique aspect of bulimia which is as an integral part of an individual’s identity. This aspect of identity perceived by individuals emerges to counterbalance constant societal expectations of them being perfect. In this respect, bulimia becomes the only part of their identity which is allowed to be ‘imperfect and ugly’ and is kept private. This private ‘imperfect self’ allows individuals to maintain ‘the perfect self’ which is presented to the world. These findings and its implications to the practice are discussed in the final parts of the research report from that study.

All these pieces of research, not only contribute to the field of eating disorders, but, most importantly, they bring the concept of bulimia nervosa and the experiences associated with bulimia more openly onto the counselling psychology scene. This seems to be particularly important as studies exploring eating disorders still appear to be scarce in the counselling psychology journals. The development of a strong counselling psychology voice in the eating disorders field has the potential to, not only raise awareness and alert counselling psychologists to this growing social problem, but, most importantly, it carries the potential to open an alternative to the dominant medical discourse way of talking and thinking about eating disorders.

Conducting this research has alerted me to the importance of listening to the individual voices and different meanings of distress. It has made me reflect on the often reductionist nature of diagnosis and treatment packages with guidelines which seem to promote an idea that one way of helping would suit everyone. I started embracing the individual, multidimensional nature of human existence where bio-psychosocial dimensions are interrelated and equally valid. I became more critical when approaching, not only research findings, but also while reflecting on ‘diagnostic labels’ with which my patients came to see me. It made me reflect more deeply on my own practice as a therapist practising within a medical setting, and allowed me to start posing questions regarding practical aspects of helping individuals with their uniquely experienced distress. In this way, conducting my own research has supported and enhanced my personal and professional development as a counselling psychologist and a reflective scientist practitioner.
Reference
Eating disorders: A review of the literature with the emphasis on an individual’s experience of bulimia nervosa and the help-seeking process.

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Abstract
This literature review explores the current state of knowledge in the eating disorders field with particular emphasis on the bulimia nervosa and help-seeking process. This seems important as, despite the efforts in improving treatments for eating disorders, there are a large number of individuals for whom treatment still proves unsuccessful. Therefore, this literature review aims to explore what might be standing behind this lack of success. What are the current views in the literature on this issue? What are the experiences of those who experience bulimia nervosa and seek help for it?

By focusing on these aspects of bulimia nervosa, this literature review does not aim to give justice to all voices and understandings present in the field. However, as ‘eating disorders’ with ‘bulimia nervosa’ are diagnostic categories located firmly within the medical tradition, this review will set the background by initially presenting this understanding. Furthermore, after setting the background, this review will embark on the exploration of qualitative studies and the personal meaning of bulimia nervosa with personal views and experiences of currently available help. This will further lead to suggestions of possible avenues for future research.

As eating disorders are a growing social problem, the issue of seeking help amongst individuals with bulimia nervosa, particularly in the context of small therapeutic success, is of interest to counselling psychology. Counselling psychology aims to promote individual wellbeing and empower individuals who struggle with their distress. Therefore, deepening the understanding of issues surrounding seeking help for bulimia nervosa might go a long way in improving available support and developing greater therapeutic understanding of this type of distress amongst counselling psychologists.

Key words: ‘bulimia nervosa’; ‘eating disorders’; ‘help-seeking’; ‘literature review’
Introduction

Currently, eating disorders are perceived as a significant public health problem (Palmer 2005), as complex disorders (Schmidt, 2005) and as “multifactorially determined phenomena” (O’Brien, & Vincent, 2003, p. 57). They are also associated with particularly high rates of suicide and self-harm (Kostro, Lerman & Attia, 2014). Research has indicated that eating disorders are present in all age groups, ethnic backgrounds and social classes (Broussard, 2005). More so, according to the National Health Service (2013a), it is estimated that as many as 8% of women in the UK will have bulimia nervosa at some stage in their life. It is also estimated that a fifth of the 1.6 million Britons who are suffering from some form of eating disorder are male, and this number is constantly growing (National Health Service, 2013a). All these facts are indicating that eating disorders are a growing public and health problem which is complex and affects many people.

Commonly, eating disorders are regarded as one of the most difficult mental health disorders to treat (Capodilupo, 2012). This has been explained through eating disorder sufferers’ ambivalence and resistance to treatment with their prominent denial of illness and resistance to change (Hart, Granillo, Jorm & Paxton, 2011). They require long and intensive treatment with as many as 40% of eating disorder sufferers dropping out of treatment and over 60% relapsing (Schoen et al., 2012). On the other side, it has been shown that long waiting times – 18 weeks on average - impact on individual motivation, and this is seen as one of the factors contributing to the lack of success in eating disorders treatment (BEAT, 2013). Furthermore, according to the results from a study by Cachelin & Striegel-Moore (2006), only 28% of women with eating disorders sought treatment for their eating problems and only 17% had received treatment. This seems to highlight a rather problematic issue of, not only current ways of supporting individuals with eating disorders where the small success of evoking meaningful change seems to be the norm, but, more so, the small number of people who experience eating disorders actually seeking help.

Therefore, it seems understandable that something will need to change in order to more effectively help those who experience eating disorders. There are extensive
studies which utilise quantitative methodologies with an aim to find ‘the most effective’ treatment. Also, advances in neurosciences (Scherma, Fattore, Paola Castelli, Fratta, & Fadda, 2014) and neuroimaging (Gearhardt, Boswell & Potenza, 2014) have explored brain functioning, hoping to discover a source of disordered eating. In this respect, the medical model focuses on disordered eating as an illness and searches for a definite cure that would fight this illness.

This way of thinking about personal suffering does not resonate with counselling psychology which promotes individuality, values personal experiences and, by doing so, refrains from any form of pathologising individual experiences. In the psychological literature, next to the dominant voice of pathology and disorder, there have been present views on eating disorders which resonate closely with counselling psychology and promote individuality. A growth in qualitative studies in the eating disorders field has been observed. These studies focused specifically on individual experiences, perceptions and personal meanings of disordered eating (Espíndola & Blay, 2006). However, despite these efforts, the medical model, with quantitative research methods, continues to dominate.

As the attempts of medical science to find ‘a cure’ have so far been unsuccessful, it might be time to start focusing more closely on the individual meaning of this complex type of distress. In this respect, it becomes a question of ‘when’ rather than ‘how’ the changes in the way eating disorders are thought of and treated will happen. It is understood here that this change in perception might allow for more successful and beneficial ways of supporting those who are affected by this complex type of distress. By stating this, it is asserted here that such change might come from shifting the focus of our research from quantitative, epidemiological studies to focusing on the individual and their experiences. This appears necessary as this imbalance in research can be thought of as the major weakness of the eating disorders’ theory and clinical practice (Hepworth, 1994).

Therefore, to address such issues, this literature review will, 1) briefly outline what eating disorders are within the dominant medical model, 2) further focus on the concept of bulimia nervosa in the dominant medical model and the available
help, 4) reflect on the current ways of supporting individuals with bulimia, 5) explore the qualitative studies’ contribution to the understanding of bulimia nervosa and the help-seeking process, where possible, and, 6) reflect upon these and suggest possible avenues for research. The relevance of the highlighted issues to counselling psychology will be presented throughout this review.

In this review, the terms ‘bulimia nervosa’ and ‘bulimia’ will be used interchangeably. Furthermore, to encompass a wide range of studies, this literature review will employ an understanding of help-seeking behaviour for any health problem, developed by Cornally & McCarthy (2011). This understanding states that help-seeking is a process which involves any planned action undertaken by an individual to solve their problem. This action involves the interaction with a health professional that is able to provide help (Cornally & McCarthy, 2011).

What are Eating Disorders?
This part aims to ‘set the scene’ and give a brief account of what eating disorders are. At first it will briefly explain the historical context of eating disorders and bulimia nervosa. This brief explanation will lead to the current understanding of bulimia nervosa within the dominant medical perspective.

Brief Historical Overview
From the historical perspective, eating disturbances were primarily seen as a symptom of other medical conditions (Caparotta & Ghaffari, 2006). The first medical descriptions of anorexia nervosa focused on the neuroendocrine causes and biological mechanisms underlying this condition, and can be found in the nineteenth century medical records (Miller & Pumariega, 2001). Following this recognition, anorexia nervosa and eating disturbances became the focus of attention of professionals from medical and psychoanalytical professions. At that point, bulimia nervosa, with its binge-purge pattern, was seen as a part of anorexia nervosa (Miller & Pumariega, 2001). Bulimia nervosa was formally recognised as a separate diagnostic category by Russell (1979) who focused on its psychiatric symptoms: overeating and vomiting. He described bulimia as a preoccupation with food, weight and body shape. He also indicated that the
majority of patients with bulimic-type behaviour had a previous history of anorexia nervosa. As a separate diagnostic category, bulimia nervosa has been identified in the DSM–III-R (American Psychiatric Association, 1987). Since then there have been a large number of studies exploring different aspects of bulimia nervosa. Throughout the years its diagnostic criteria have been refined in order to distinguish different subtypes of bulimia, but the core diagnostic features have not changed (Palmer, 2004). Therefore, to create an understanding of the current concept of bulimia nervosa, the existing diagnostic criteria are outlined in detail below.

The Definition of Bulimia Nervosa within the Medical Tradition

Within the Diagnostic and Statistical Manual of Mental Disorders (5th ed., American Psychiatric Association, 2013) eating disorders are classified within the category of ‘Feeding and Eating Disorders’ and further divided into five different types: Anorexia Nervosa (AN); Bulimia Nervosa (BN); Binge Eating Disorder; Other Specified Feeding or Eating Disorders; and Additional Eating and Feeding Disorders, which all further contain specific subtypes (5th ed., American Psychiatric Association, 2013). In this respect, eating disorders are classified as psychiatric disorders and, by definition of this classification, are characterised by their essential behavioural and physiological features. One significant characteristic of bulimia nervosa is that individuals restrict their food intake in an aim to lose weight, but they find themselves unable to sustain this food restraint and engage in uncontrollable binges during which they consume large quantities of food (Davey, 2008). After the binge, the bulimia nervosa sufferers will engage in compensatory behaviours such as: self-induced vomiting; use of laxatives and/or diuretics; and excessive exercise, in order to prevent the weight gain (Palmer, 2005). This behaviour often leads to serious health problems such as erosion of dental enamel and electrolyte abnormalities (Carr & McNulty, 2006). According to DSM V, this cycle of binging and purging must occur at least once a week and be present for at least three months to be recognised as bulimia nervosa (American Psychiatric Association, 2013).
Next to these diagnostic categories, the medical profession has been attempting to identify causes of disordered eating. However, despite the vast amount of research, there has not yet been conclusive evidence pointing towards a single cause. Across the literature it has been widely acknowledged that it is a combination and unique interplay of interpersonal (familial, cultural and social) and intrapersonal factors (psychological, biological and genetic factors) that lead to the development and maintenance of eating disorders (Garner & Myerholtz, 1998; Polivy & Herman, 2002). This, however, does not bring any clarity as to what might be responsible for the development of eating disorders and how to help individuals and also prevent others from developing an eating disorder.

Furthermore, although bulimia nervosa is a distinct category, studies have revealed that a lot of anorexia nervosa sufferers often start from severely restricting their food intake only to develop bulimia nervosa in the later stage of their anorexia (Palmer, 2005). Palmer argued that eating disorders can be understood, not as separate categories, but as two opposite dimensions with anorexia sufferers on the one side and bulimia sufferers on the other. Palmer described eating disorders’ categories as ‘archetypes’ (Palmer, 2005, p. 6) which often fail to create a clear distinction between bulimia sufferers and anorexia sufferers, and also place many individuals who experience symptoms of eating disorders outside these two categories.

The new diagnostic criteria outlined in the DSM V (American Psychiatric Association, 2013) aimed to address this issue by altering some of these criteria to allow more individuals to receive a full diagnosis of an eating disorder and, consequently, receive appropriate treatment. These changes brought a reduction in the number of individuals placed outside diagnostic categories and brought an increase in anorexia nervosa diagnoses. However, it did not result in changes in the number of individuals diagnosed with bulimia nervosa (Mancuso et al., 2015). This might be indicating that there are no more individuals who would receive a diagnosis of bulimia nervosa irrespective of expanding inclusion criteria for the diagnosis of bulimia. On the other hand, this might be related to the fact that bulimia nervosa is ‘invisible’ to the naked eye (Bulik, Sullivan, Fear & Pickering,
1997) and its diagnosis solely relies on the individual’s self-disclosure, as opposed to anorexia nervosa which can be diagnosed based on the severity of weight loss and emaciated body.

In this respect, over the years the diagnostic classification of eating disorders has received a lot of criticism from within the medical field, as well as from elsewhere. This criticism has pointed towards the limitations of diagnostic categories due to its constructed and reductive nature.

Concluding from this, it has become clear that current diagnostic criteria are characterised by many weaknesses. More so, although constructed in the twenty-first century, they closely resemble the first medical descriptions of anorexia and bulimia nervosa. As much as one would anticipate similarities between the way individuals experience this type of distress, particularly within its behavioural and physiological symptoms, it might be interesting to consider how and whether its meaning, feelings and values it evokes have changed over the years, particularly as receiving a diagnosis of an eating disorder carries certain consequences in society. Most importantly, in contemporary society the diagnosis opens the possibility of accessing treatment and help.

**Implications of Diagnosis - Receiving Treatment**

Within the National Health Service, a person who experiences distress and seeks help receives a diagnosis, which becomes ‘their passport’ to treatment and any future help. However, in the context of the information presented above, it appears that the understanding of eating disorders proposed by the medical tradition appears to be unclear and confusing. The lack of distinctiveness within diagnostic categories and their fluidity creates the possibility of individuals receiving different diagnoses depending on the disorder identified at the time (Davey, 2008). More so, psychopathology literature often associates eating disorders with other psychiatric conditions (O’Brien & Vincent, 2003). This issue of multiple diagnoses compounded by the co-existence of other psychiatric conditions has been widely acknowledged in the psychiatric literature as the major limitation of the diagnostic classification system and a challenge to possible treatment recommendations (Palmer, 2004).
Current guidelines for eating disorder treatments (NICE, 2004) list self-help programmes, groups, cognitive behavioural therapy and interpersonal psychotherapy as effective and recommended treatments in helping individuals with bulimia nervosa. More so, nowadays there has been an emphasis on utilising online self-help programmes for eating disorders, which has been perceived as helpful (McClay et al, 2014). Additionally, as bulimia nervosa often occurs alongside depression, psychological therapy is usually combined with antidepressants. The majority of patients suffering from bulimia nervosa are treated as outpatients. However, when the individuals with bulimia pose the risk of suicide or self-harm, the inpatient or more intensive outpatient treatment is considered (NICE, 2004).

Although cognitive behavioural therapy is regarded as the most effective treatment for bulimia nervosa (Davey, 2008), the meta-analysis of different treatments available for bulimia nervosa has provided little support for any specific treatment to be more effective than others (Spielmans et al, 2013). More so, although many studies suggest significant improvements amongst individuals who received cognitive behavioural therapy for bulimia nervosa, they also reported around 40% attrition levels (Knott, Woodward, Hoefkens & Limbert, 2014). A recent study (Wagner et al, 2015) highlighted that factors which predicted dropout from treatment amongst individuals with bulimia nervosa were associated with higher depression and lower self-directedness (Wagner et al, 2015).

To exacerbate the problem of treatment for bulimia nervosa, the study by Rotenberg, Bharathi, Davies & Finch (2013) concluded that bulimia nervosa sufferers expressed low trust, even in people close to them, low disclosure levels and high loneliness which imposed further challenges to effective treatment for these individuals. This secrecy amongst bulimia sufferers corresponds with other research conducted in the community which have shown that only 40% of women who met the criteria for an eating disorder, according to DSM IV, had ever sought professional help (Hay, Mond, Owen & Rodgers, 2007). The majority of bulimia sufferers sought help for a general mental health problem (74.2%) and/or weight
loss (72.8%), which further indicates that there is a large number of women who suffer symptoms of an eating disorder but do not seek or receive professional help specifically for these problems (Hay et al., 2007 p. 4).

Other studies also highlighted ‘poor mental health literacy’ (Mond et al., 2010) as one of the reasons for not seeking help. What also appears to impact help-seeking behaviour amongst individuals with bulimia nervosa is the stigmatising attitudes and beliefs towards bulimic eating disorders which are present in different societies (Rodgers et al., 2015). Similarly, socially held beliefs about eating disorders being a female phenomenon have been shown to negatively impact on recognition and help-seeking for eating disorders amongst men (Raisanen & Hunt, 2014). All these studies bring valuable knowledge, highlighting general tendencies amongst people who experience eating disorders.

Reflecting on the dominant medical approach and its understanding of bulimia nervosa and treatment guidelines, I acknowledge that, although a dominant way of conceptualising this phenomenon is as an illness with its distinct cognitive and behavioural characteristics, this is not the only way. There are also alternative ways of understanding eating disorders: psychodynamic, phenomenological and existential theories which address the individual meaning of food, eating and body shape. These alternative conceptualisations closely resonate with the counselling psychology philosophy and values. Closer exploration of these goes beyond the scope of this literature review as its concern rests with the experience of help amongst individuals with bulimia nervosa. Nevertheless, it is important to remember that, although the medical model shaped most of the current understanding of eating disorders and is part of the everyday discourse (Palmer, 2004), it is also strongly disputed and cannot be seen as definite. As Palmer highlighted, there is a debate within the eating disorders field which questions whether these diagnostic categories should be used to inform the treatment. This is particularly so, as the current transdiagnostic approach to eating disorders states that all eating disorders are essentially cognitive in nature and that they all have similar characteristics and underlying psychopathology (Fairburn, Cooper & Shafran, 2003), focusing on what people with eating disorders have in common.
rather than their individual aspects and needs. This way of conceptualising individual distress has provided an unclear understanding of what bulimia nervosa actually is and the person with bulimia nervosa. In this context, low treatment outcomes, high dropout rates and the small number of individuals seeking help posed a lot of questions as to how individuals with eating disorders, and more specifically with bulimia nervosa, can be helped so that this help brings a meaningful change to their lives and promotes their wellbeing.

Studies conducted within a quantitative paradigm bring valuable knowledge about common factors shared by people with eating disorders, but, because of their nature and design, they do not explore the individual meaning behind identified common factors. This furthers the discussion within the medical field that, while professionals can access and utilise multivariate analyses, randomised controlled trials and molecular medicine, there is still a need for more clinical observations and detailed studies of personal experiences of eating disorders to deepen this understanding (Palmer, 2004).

The emphasis on individuality and personal experience is in line with the counselling psychology discourse and its phenomenological stance. Counselling psychology opposes categorising individuals into pre-established categories according to a set of criteria, seeing it as reductive and posing the risk of losing the individual’s unique experiences and perceptions. Therefore, in order to gain a better and more complete understanding of eating disorders, particularly bulimia nervosa, one should also focus on the individual understanding, meaning and experience of their eating disorder within their specific context. Exploring these aspects has been in the domain of qualitative research, which focuses on individual experiences and meanings. This way of exploring eating disorders has the potential to enrich our knowledge and understanding of the different aspects of this complex type of distress and shed some light onto the individual experiences of treatment available and possible ways of supporting individuals who experience eating disorders. Hence, this literature review will focus on the contribution of qualitative studies that explore individual meaning and experiences of bulimia nervosa and the help-seeking process.
The Meaning behind the Diagnosis - Individual Experience of Bulimia Nervosa

As demonstrated throughout this literature review, much of the knowledge about eating disorders and bulimia nervosa has been based on the clinicians’ and researchers’ perspectives, which are firmly grounded within the medical model framework. However, this way of conceptualising eating disorders serves only as a partial view of this complex phenomenon. The missing part is the personal aspect of bulimia. The search for meaning behind individual distress and the focus on the individual experience closely resonates with the counselling psychology ethos. This way of understanding seems to be crucial here as “Bulimia is not what one has; it becomes who one is, shaping perception of self, others and the world at large” (Orbanic, 2001, p. 35). Therefore, by adopting a phenomenological framework and listening to the individuals who have experienced life with bulimia nervosa, can be far more meaningful when compared with clinicians’ definitions and measures, and can go a long way in considering possible ways of supporting individuals with bulimia nervosa.

Since Russell (1979) identified bulimia nervosa and described its dominant features, there have been several qualitative studies focusing on life with bulimia nervosa. Maddocks & Bachlor (1986) analysed a series of interviews with a bulimic patient and elicited four phases which characterised her bulimic behaviour. These phases encompassed a subjective perception of loss of control (mother’s death, father remarried, more responsibility and university); a desire to regain this control; looking for information about bulimia; feeling that this binge-purge cycle needs to stop; and seeking help (Maddocks & Bachlor, 1986). Despite the questionable methodological side of this study, in which the process of data analysis appears unclear with its lack of information, its findings seem to be in line with the contemporary understanding of bulimia nervosa and the impact of major life events instigating the onset of bulimia.

A study by Berge, Loth, Hanson, Croll-Lampert & Neumark-Sztainer (2012) focused on different family events and their role in the onset of eating disorders, concluding that the family events, compounded by the lack of support within the
family, might contribute to the development of eating disorders. The events were: 1) school transitions; 2) death of a family member; 3) relationship changes; 4) home and job transitions; 5) illness/hospitalisation; and, 6) abuse, sexual assault, or incest (Berge et al., 2012, p. 1357). In light of this, it becomes clearer that families who are lacking in support in the face of critical events might act as a catalyst and, in addition to other factors, might further contribute to the development of an eating disorder (Lampis, Agus & Cacciarru, 2013).

The other study which focused on exploring the experience of life with bulimia nervosa was conducted by Orbanic (2001). From the analysis of her findings, the experience of life with bulimia appeared to be marked by the continuous preoccupation with food and the emotional and physical exhaustion. The ‘perpetual cycle’ of binging and purging was perceived by bulimia sufferers as habitual and an inevitable part of their daily routine, with the underlying mechanism of self-criticism. In this context, bulimia sufferers claimed to use food to detach from strong feelings, to stop feeling sad, panicky and to push the emotions down. According to this study, life with bulimia nervosa required some elaborate planning with regard to purchasing food, purging and, at the same time, avoiding being caught. The thought of being caught by someone while binging or purging was associated with fear of other peoples’ negative judgements, disgust and shame. Binges were seen as being perpetuated by these feelings of shame, isolation and loss of control, to then experience gaining control by purging and getting rid of food. Orbanic also wrote about the feelings of ‘calmness’ and ‘satisfaction’ after the binge. Findings from this study bring an invaluable insight into the lived experience of bulimia nervosa. The main line of criticism towards Orbanic’s study is the lack of information about the participants’ ethnic backgrounds and history of bulimia. However, the study was also one of the first in the field and is claimed to have made a significant contribution to the understanding of the experience of bulimia nervosa within the nursing profession.

Findings from a similar study by Broussard (2004) confirm some of Orbanic’s (2001) findings. The Broussard study showed that bulimia nervosa sufferers perceived others to judge them negatively as ‘sick’, ‘disgusting’ or having
something ‘mentally wrong’ with them. Furthermore, as much as participants feared others’ judgements, they also expressed a fear of life without bulimia and a fear of becoming fat. They described the internal struggle with bulimia, as they considered themselves to be ‘normal’, but held the belief that others would think they were abnormal.

All this seems to strongly influence individual experiences and shape their perceptions and thoughts of themselves. In this context, this study also highlighted the individuals’ experience of living a double life - as bulimic and non-bulimic, with the bulimic life being kept secret from other people. The other study, which specifically focused on this experience of double life (Pettersen, Rosenvinge & Ytterhus, 2008) confirmed Broussard’s findings. According to these authors, the ‘double life’ was perceived by bulimia sufferers as a way of balancing between shame and dignity and a constant fear of being exposed. More so, the actual experience of the binge and purge cycle received attention from researchers and confirmed what most previous studies had emphasised with regard to the sense of relief and experience of control gained through binging and purging (Eli, 2015; Jeppson, Richards, Hardman & Granley, 2010). Furthermore, a recent study by Beaumont (2014) highlighted the individual’s perception of drifting in and out of awareness during binges.

Although these studies bring a valuable insight into life with bulimia nervosa, their findings do not encompass feelings and experiences of seeking and receiving help for bulimia. They seem to predominantly focus on the individual experiences of the course of development and maintenance of bulimia nervosa. The study by Maddocks & Bachlor (1986) highlighted seeking help as one of the characteristics of a bulimic person’s behaviour. However, its unclear methodology makes it difficult to evaluate its findings. Therefore, this literature review will focus more deeply on the experience of help and help-seeking, which has been investigated in the qualitative studies.
The Qualitative Studies’ Contribution to Understanding Different Aspects of Help

As it was mentioned at the beginning of this literature review, the help-seeking process can be defined as any planned action undertaken by an individual to solve their problem. Furthermore, this action involves an interaction with a health professional with an aim to solve the problem (Cornally & McCarthy, 2011). In this respect, help is considered here as any type of therapeutic intervention or other support received to help alleviate individual distress associated with the eating disorder.

There have been a great number of qualitative studies within the eating disorders field which have explored different aspects of help, types of therapeutic interventions and, subsequently, the recovery process. These studies predominantly focused on issues such as satisfaction and experience of different types of treatments (Leung, Ma & Russell, 2012; Moreno, Fuhriman & Hileman, 1995; Onslow, Woodward, Hoefkens, & Waddington, 2015; Sánchez-Ortiz et al., 2012). Other studies explored the therapists’ perceptions of the key turning points in therapy for individuals with bulimia nervosa (Mysliwiec, 2014) or the individual experience of relapse (Wasson, 2010) and recovery from bulimia nervosa (Lindgren, Enmark, Bohman & Lundström, 2015). The systematic review of qualitative studies conducted by Bell (2003) highlighted that individuals who received help for their eating disorder highly valued and perceived the experience of the supportive, empathic relationship and the feeling of being understood, as particularly helpful. On the other hand, ‘medical interventions’ and the exclusive focus on food and weight were generally perceived by those individuals as unhelpful (Bell, 2003). More so, individuals who experienced treatment for eating disorders concluded that aspects such as the treatment environment, the relationship with staff and the therapeutic method all played a role in their experience of treatment (Sheridan & McArdle, 2015). Also, some individuals with eating disorders described experiencing psychosocial barriers which prevented them from accessing and continuing their treatment (Leavey, Vallianatou, Johnson-Sabine & Gunputh, 2011).
Other qualitative studies have explored the experiences of those who looked after a person with bulimia nervosa: the emotional impact of caring (Perkins, Winn, Murray, Murphy & Schmidt, 2004) and the carers' needs and experiences of services and support (Winn, Perkins, Murray, Murphy & Schmidt, 2004). More so, other qualitative studies have explored differences in treatment for bulimia nervosa amongst individuals from different ethnic backgrounds (Cachelin & Striegel-Moore 2006; Ma, 2007) and the need for culturally specific adaptations of therapy (Shea et al., 2012).

Furthermore, currently there seems to be a growing trend of implementing computer-based treatments for bulimia nervosa. A qualitative study by McClay, Waters, McHale, Schmidt and Williams (2013) showed that the previous negative experiences of seeking help worked in favour of online self-help programmes amongst bulimic-type disorder sufferers (McClay et al., 2013). This seems to be in line with the findings of another study: “A computer isn’t gonna judge you”: A qualitative study of users’ views of an internet-based cognitive behavioural guided self-care treatment package for bulimia nervosa and related disorders” (Sánchez-Ortiz et al., 2011), which indicates the popularity of internet-based help. More so, the current thoughts of creating apps to reduce binge-eating behaviours seem very helpful and are met with positive feedback from individuals (Juarascio, Goldstein, Manasse, Forman & Butryn, 2015).

All these advances in improving and encouraging help for individuals who experience eating disorders might bring some much needed help and relief from distressing symptoms. However, by being internet-based, it may reinforce the secrecy and alienation of the person who experiences an eating disorder and further increase their withdrawal into secrecy. This seems to be a particularly relevant criticism as the study conducted by Skoufalos (2011) identified feelings of deep loneliness and isolation and a pervasive fear of being rejected as one of the origins of bulimia nervosa. In this respect, the computerised form of help seems to be missing the important role of loneliness and the fear of rejection in eating disorders.
More so, the other qualitative studies, by exploring individual experiences and different aspects of help amongst individuals with bulimia nervosa and eating disorders in general, bring a valuable contribution to the existing knowledge. They give an overview of treatments and interventions which have been perceived as helpful or unhelpful, allowing clinicians to reflect on these findings and consider supportive and meaningful ways of helping individuals who experience this type of distress.

Whilst all of these studies contribute to our understanding of the different aspects of the individual experience of eating disorders, they appear to miss the very first step, which is reaching out for help, the process of seeking help and the experience of accessing these different types of help.

**The Experience of Seeking Help**

The help-seeking process seems to be an important aspect in the individual experience of eating disorders as "the road to eating disorder recovery starts with admitting you have a problem" (Segal & Smith, 2013).

Exploring what led individuals to seek help seems to be particularly important, as individuals who have experienced eating disorders expressed a level of apprehension towards seeking help and engaging in treatment, despite the distress caused by their eating disorder (Cachelin, Veisel, Barzegarnazari & Striegel-Moore, 2000). People who experienced an eating disorder described profound social and psychological difficulties and the ambivalent feelings towards confronting or losing their relationship with food (Leavey et al., 2011). This relationship with food was described by these individuals as both comforting and debilitating. This ambivalence was shown as one of the reasons for not engaging in therapy and not seeking help (Leavey et al., 2011).

In order to address the issue of individuals not engaging in treatment and dropping out of treatment, a specialist drop-in service was introduced for eating disorder treatment. To explore its effectiveness, semi-structured interviews were conducted with patients who used this service (Clinton, Almlöf, Lindström, Manneberg, & Vestin, 2014). Based on these interviews it was concluded that the
service was received positively by individuals and was thought of as an encouraging engagement in treatment. However, what seems also important, next to the availability of service, is the individuals’ ambivalence and apprehension towards engaging in treatment, which has been indicated by studies mentioned earlier in this review. Additionally, a recently conducted literature review of qualitative and quantitative studies revealed that the internalised stigma, as well as the treatment stigma, was most often associated with reduced help-seeking (Clement et al, 2015). As well as the individual ambivalence and perceived stigma, the ethnic or racial stereotypes held by healthcare professionals have also been described as impacting on an individual’s attitude to seeking help for their eating disorder (Becker et al, 2010).

All of the experiences and individual perceptions mentioned above highlight a complex interplay of emotions, experiences and beliefs. Furthermore, they seem to play an important role in an individual not seeking help, which goes beyond the issue of the accessibility of the service.

What has also been highlighted to impact on the individual help-seeking process and acceptance of help is the aspect of control and the ambivalence towards treatment because of the fear of losing control (Reid, Burr, Williams & Hammersley, 2008). A study (Reid et al., 2008), which explored the individual’s perception of their eating disorder and the outpatient service, highlighted that the individual’s need to feel in control of some aspect of their lives was one of the most important facets of their eating disorder. The eating disorder itself was also described by these individuals as a coping mechanism for stress. The struggle to retain control over their eating disorder led to the individual feeling desperate and suicidal and to, subsequently, seek help. On the other hand, what was preventing some individuals from engaging in treatment was the concern that, by receiving treatment, their control would be completely removed or that treatment would centre upon their weight gain (Reid et al, 2008). This pointed towards the important role of preconceptions and fears experienced by individuals with eating disorders. It also highlighted the function of the eating disorder and the important aspect of control which prevented them from seeking help.
One qualitative study specifically focused on barriers to help-seeking amongst young women with eating disorders (Evans et al., 2011). Women, in this study, described experiencing a compromised quality of life and psychological distress caused by their eating disorder. If these women decided to seek help and disclosed their eating problems to a health professional, the positive experiences of feeling understood, listened to and being able to talk freely and openly, had a positive impact on them. On the other hand, participants in this study also described negative experiences of feeling judged, which prevented them from talking about their eating disorder. They felt disappointed for not being taken seriously; not being understood. More so, the cost of treatment was an important barrier to seek and engage in treatment.

These studies bring a valuable contribution to the existing literature by emphasising the ambivalent feelings, role of control, personal beliefs and negative and positive experiences as important aspects which might influence a person seeking help for eating disorders. However, the major weakness seems to be the fact that they do not distinguish between different eating disorders, but treat all eating disorders under one category. This misses the important fact that there are different treatment recommendations available for different types of eating disorders. Therefore, individuals with different types of eating disorders might encounter contrasting responses from professionals, which might impact them differently. More so, the study by Evans et al. (2011) indicated the cost of treatment as one of the barriers. This seems to be understandable as the study was conducted in America where the health sector is private and treatments can be expensive, unlike the UK where the National Health Service offers a free service. Furthermore, as valuable as all these studies are, they do not explore the actual individual experience of seeking help in depth.

A qualitative study conducted by Shoen et al. (2012) explored the help-seeking process in young women with eating disorders. These authors interviewed 14 college-aged women who suffered from anorexia nervosa, bulimia nervosa or an eating disorder not otherwise specified. They used a grounded theory approach to develop a model of the help-seeking process amongst college-aged women. Their
results indicated a gradual shift from what the authors interpreted as ‘denial’ to increased awareness of the self and the impact of the eating disorder. However, as valuable as Shoen et al.’s findings are, the study can be observed to have two major weaknesses. Firstly, its work focused only on college-aged women and did not recognise the variability of people’s perceptions of their eating disorders. Secondly, it made no distinction between different eating disorders; the authors approached all eating disorders regardless of possible variations.

Recently, a qualitative study was conducted which specifically focused on the experience of seeking help amongst women with anorexia nervosa (Gulliksen, Nordbø, Espeset, Skårderud & Holte, 2015). This study suggested that individuals who sought help for anorexia nervosa did not feel particularly motivated in the initial stages. More so, their motives for help-seeking indicated a wish to feel less depressed, get rid of somatic symptoms and a wish to get rid of the problematic aspects of their eating. This last aspect related to individuals who were diagnosed with a bulimic subtype of anorexia nervosa. These individuals wanted to stop their binge-purge behaviour, but wanted to continue significantly restricting their food intake. Findings from this study seem to be in line with other qualitative studies, which focused on experiences of help-seeking. However, as it specifically focused on anorexia nervosa, it could be missing some aspects of experience that might be more specifically related to individuals with bulimia nervosa.

There seems to be a large number of qualitative studies either approaching eating disorders regardless of different variations of disordered eating or specifically focusing on anorexia nervosa and recovery from anorexia (Lindgren et al, 2015). The lack of distinction in different eating disorders seems to stem from quantitative literature where many similarities have been described amongst individuals with different types of eating disorders. This literature pointed towards behavioural and cognitive similarities in mechanisms maintaining different eating disorders (Fairburn, Cooper & Shafran, 2003). Therefore, it seems that, in line with this dominant thinking, many researchers treat eating disorders as one large category, despite the fact that other research clearly shows important
differences between experiences of individuals who have bulimia nervosa and those who have anorexia nervosa.

According to Serpell & Treasure (2002), strong feelings of ambivalence towards their eating disorder differed in some important way between individuals with bulimia nervosa and individuals with anorexia nervosa. This seems to be particularly important as significant differences have been described in the way individuals with different eating disorders think of themselves. Within a group of people with different eating disorders, these individuals viewed the diagnoses as a hierarchy, with anorexia nervosa and bulimia nervosa subscribed to the ‘gold and silver’ positions. More so, those who had anorexia nervosa associated bulimia nervosa with a loss of control. In this respect, anorexia nervosa was admired and glamorised by individuals with other eating disorders, whereas bulimia was thought of as disgusting (Ison & Kent, 2010). These contrasting self-perceptions might further influence individuals’ actions and different help-seeking experiences.

Recognising this difference in the perception of the self and of others seems to be particularly important, as seeking help is a process whereby an individual discloses to another individual their distressing experiences which they had previously kept secret (Pettersen et al., 2008). Additionally, bulimia nervosa, unlike anorexia nervosa, often stays hidden, not only because of the generally secretive nature of all eating disorders, but also because the individual’s weight tends to stay normal, so problems with food and weight are often well hidden even from close family members (Pettersen, Thune-Larsen, Wynn & Rosenvinge, 2013). Therefore, the help-seeking process needs to be particularly internally-driven in bulimia nervosa sufferers as, without their self-disclosure, no one would know of their distress.

An investigation into pathways to seeking help amongst individuals who experienced bulimia nervosa and binge-eating problems, Hepworth & Paxton (2007) focused on three factors relating to the help-seeking process: problem recognition, barriers to help-seeking, and prompts to help-seeking. Moreover, it
pointed towards specific barriers to help-seeking such as: fear of stigma, low mental health literacy, shame, fear of change, and financial cost of treatment (Hepworth & Paxton, 2007, p. 493). Their findings bring a valuable contribution to the understanding of what might be preventing individuals with bulimia nervosa from seeking help. However, this study also has several weaknesses, one of which is that the authors used the Leximancer software to conduct a qualitative analysis and identify themes. It did so by defining concepts as collections of words relating to a central theme. This way of analysing qualitative data risks missing subtle meanings which can only be picked up by close reading, re-reading and in-depth analysis of individual narratives. Also, it may have missed some peculiarities in the individual use of language and the more personal, contextual use and meaning of words.

Furthermore, what can also be seen as the main limitation of this study is its exclusive focus on the female experience of life with bulimia. Although eating disorders affect fewer men than women, they are present amongst men, and the number of men being diagnosed with eating disorders is increasing. The study by Robinson, Mountford & Sperlinger (2012), which explored the experiences of men in contact with specialist services for eating disorders’ treatment, found possible similarities between the experience of life with bulimia nervosa between men and women. A systematic qualitative literature review (Thapliyal & Hay, 2014) further highlighted the general lack of consensus as to whether sex is relevant in the treatment for eating disorders. This highlights the fact that the experience of bulimia nervosa might not be gender-specific, but be experienced similarly and independently of gender.

Concluding from the studies presented in this literature review, there seems to be no known qualitative research exploring the individual experience of seeking help for bulimia nervosa amongst men and women of different ages in the UK. Exploring this issue seems to be relevant as eating disorders affect people of all ages (National Health Service, 2013b). Furthermore, the experiences of different individuals seeking help within the National Health Service in the UK might
slightly differ from experiences of individuals in America or other continents, where the organisation of the health service differs.

In addition, this topic is of particular relevance to all counselling psychologists as it is our responsibility to deepen our knowledge and understanding of this highly complex personal distress. This also seems important as an increased number of individuals who access primary care services present with symptoms of bulimia nervosa (Micali, Hagberg, Petersen & Treasure, 2013). Therefore, developing an in-depth understanding of experiences of seeking help amongst these individuals might help counselling psychologists to offer more meaningful ways of supporting these individuals.

Exploring seeking help for bulimia nervosa in a diverse group of individuals seems also relevant in the light of findings from the qualitative studies discussed in this literature review. The authors of some studies highlighted the feelings of shame and guilt and secrecy amongst individuals with bulimia nervosa, which signifies the great importance of building trust and relationships as the base for therapy. They pointed to the value of a non-judgemental attitude; an empathy and personal warmth which would encourage disclosure and lessen the experienced feelings of shame. These clinical implications particularly resonate with the counselling psychology philosophy which emphasises the importance of the therapeutic relationship as the main source of therapeutic change (Cooper, 2008).

**Final Conclusions**

As it has been presented in this literature review, in the field of eating disorders there seems to be dominance in the medical discourse with regard to pathology, illness and the person being viewed as having something disordered about them. A growing number of qualitative studies focus on aspects of individual experiences of different types of treatments, barriers to seeking and/or accepting treatments or seeking help amongst college-aged students. The majority of these qualitative studies focused on eating disorders by treating them as one large category and, by doing so, not acknowledging possible differences amongst individuals experiencing different types of distress around food and eating. One
study, which focused specifically on pathways to help-seeking amongst individuals with bulimia nervosa, has been shown to have several important weaknesses which may compromise the value of its findings.

More so, the current emphasis on promoting computerised treatments for bulimia nervosa seems to be missing the very important relational aspect of this type of distress. Computerised self-help aims to support those who struggle with shame and secrecy and/or lead busy lives and struggle to find time to engage in treatment (McClay et al., 2013). This appears to be the most persistent dilemma in the eating disorders field: the large number of individuals that do not seek help. As was shown, reluctance to seek help amongst individuals who experience bulimia nervosa is a complex and multifactorial issue. Although the help-seeking process has been explored from different angles, there has not yet been a study which has solely focused on exploring the actual lived experience of seeking help for bulimia nervosa amongst individuals of different ages in the UK.

In this respect, this literature review identified a gap in the understanding of the help-seeking process. Therefore, I argue that the research implementing qualitative phenomenological methodology and exploring the individual experience of seeking help for bulimia nervosa may enable professionals to gain a better understanding of the individual experience of seeking help and, by doing so, extend our understanding of the possible ways of supporting the process of seeking help and facilitating a successful therapeutic change. This seems crucial, not only because of the secrecy and the destructive nature of bulimia nervosa, but, most importantly, because of the current turn to computerised forms of help at the expense of personal contact. Additionally, what appears to be rather concerning is the small number of qualitative studies investigating an individual’s experience of life with bulimia nervosa conducted in the UK. Similar suggestions came from a systematic literature review carried out by Hart et al. (2011), which concluded that future research needed to focus on treatment-seeking in the young and elderly, for both males and females in countries outside of Australia and the United States. Furthermore, all the questions mentioned throughout this literature review correspond with the counselling psychology epistemology and
idiosyncratic, phenomenological view on human distress. It is my belief that, by adopting a phenomenological framework and exploring the experience of the help-seeking process from individuals who have gone through these experiences, this may go some way to expand our knowledge about bulimia nervosa and about the individual experience of seeking help. This knowledge might enable us to develop more meaningful ways of reaching out to individuals and also bring a greater understanding of the journey these individuals might have encountered before entering the therapy room. This has the potential to highlight some specific meanings of bulimia in the context of individual life and everyday challenges. This further brings the potential for more appropriate understanding of bulimia and more appropriate directions for treatment.
References


The Individual Experience of Seeking Help for Bulimia Nervosa –

Qualitative Research Report

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Abstract

This qualitative study explored the individual experience of seeking help for bulimia nervosa. Interviews were conducted with eight individuals. Interpretative Phenomenological Analysis (IPA) was used to analyse data. Three superordinate themes were identified: ‘Wrestling with Control’, ‘The Experience of Readiness to let go of Bulimia’ and ‘Changes within Self’. These three superordinate themes consisted of further subordinate themes. ‘Wrestling with control’ consisted of three subordinate themes: ‘The experience of Control’, ‘Reaching Breaking Point, Losing Control and Reaching For Help’ and ‘Paradox of Control: Accepting Help = Loss of Control’. ‘The Experience of Readiness to let go of Bulimia’ consisted of four subordinate themes: ‘Ambivalence about help’, ‘Feelings of Not Being Heard’, ‘The Experience of Inadequacy of Help’ and ‘Taking Help into One’s Own Hands’. ‘Changes within Self’ further consisted of four subordinate themes: ‘Wanting to be Someone Different’, ‘Fear of Rejection’, ‘Denial - Pushing Bulimia Out of Awareness’ and ‘Searching for the Lost Self - Re-evaluating and Integrating’. These results highlighted that help-seeking was an ongoing process of internal change and transformation and was characterised by an oscillation between awareness and denial of bulimia. This study also highlighted the central role of subjectively perceived control and its impact on the help-seeking process. Furthermore, it explored some of the gradual intrapersonal changes experienced throughout the help-seeking process. The findings from this study seem to be particularly important for counselling psychologists as eating disorders and distress experienced around food seem to be becoming more and more prevalent in society. More so, counselling psychology, by promoting personal experience of eating disorders, has the potential to encourage discussions other than the ones focused on pathology, illness and behavioural symptoms. Results from this study are discussed in the context of existing literature. Implications for clinical practice are explored.

Key words: ‘bulimia’, ‘eating disorders’, ‘seeking help’, ‘qualitative study’, ‘control’
Introduction
This study employs an existential phenomenological perspective to examine women’s lived experience of seeking help for bulimia nervosa. Applying this paradigm implies that this study is concerned with subjective human experience as it reflects individuals’ values, ideals, intentions, emotions, and relationships (Jun, 2008). The understanding here is that human beings and their lives are grounded in the surrounding world in so much that individuals make sense of themselves and others through the context of their lives and their interactions with the world (van Deurzen-Smith, 1990). In this way, the study aims to understand individual subjective experiences of seeking help for bulimia nervosa, its various forms and its relational and contextual nature.

Initially, this paper will provide a brief overview of the relevant literature regarding bulimia nervosa and the help-seeking process. Firstly, the focus will be placed on the research investigating the individual experience of bulimia nervosa. Subsequently, the focus will move onto research exploring the process of seeking help for bulimia, to then further discuss the rationale for this particular study. Following on from this, the method and research analysis will be outlined, and the findings will be described. In the penultimate stage, findings will be discussed in the context of existing literature. Finally, the limitations and suggestions for future research will be discussed.

Background Information
Currently, eating disorders are perceived as complex mental health problems which often co-occur with other mental health conditions (O’Brien & Vincent, 2003) and require long and intensive treatment (Schoen et al., 2012). They are present in all age groups, ethnic backgrounds and social classes (Broussard, 2005). The conducted literature review (Turek & Brown, 2013) indicated that, although there has been considerable research carried out on bulimia nervosa, much of this has focused on bulimia as an illness predominantly located within the individual and described through behaviour and symptoms which are disordered and need to be ‘fixed’ or ‘cured’. This way of understanding individual distress seems to be reductionist and follows the Cartesian dualism by seeing the mind as a substance which is distinct from
the body and which can influence the body but which cannot be influenced by the body. In this respect, the brain has the power to govern the body and make it ‘normal’. This view becomes problematic in the context of eating disorders where the individual experience of the body seems to be influencing the mind and this influence is central in this type of distress. Therefore, existential, phenomenological philosophy seems to be much more suitable in understanding this type of distress as it sees individual consciousness and the body as inextricably linked and mutually engaged in the process of perceiving and experiencing the reality. The primacy of perception and the embodiment of experience was emphasised by Merleau-Ponty (1945/1996). He emphasised that the body is the primary site of knowing the world - we perceive and experience the world through and within our bodies using all our senses and our bodies are central to all perceptions. In this understanding, the body and the mind are inseparable and, therefore, “the body may express the otherwise inexpressible” (Schneider & Fitzgerald-Poole, 2005, p. 59). This way of understanding eating disorders closely resonates with counselling psychology as it emphasises the possible personal meanings of individual distress, highlights the unity of body and mind in the individual experience and situates the distress, not only on a personal, but also on an interpersonal level.

Exploring the individual meanings and experiences of distress has been central to the qualitative research inquiry. Therefore, to set the background for this study, this paper will now focus on the concept of bulimia nervosa as it is experienced by an individual and has been captured in the qualitative studies. The studies which are briefly outlined below have been previously analysed in the literature review conducted by the author and, therefore, only the most relevant aspects of these studies are going to be presented here (Turek & Brown, 2013).

**Individual Experience of Bulimia Nervosa**

The conducted literature review (Turek & Brown, 2013) highlighted a number of qualitative studies which explored the individual experience of bulimia nervosa. These studies emphasised distinctive features of bulimia such as the preoccupation with food and body weight, and the experience of depression and increased risk of suicide.
(Orbanic, 2001; Russell, 1979). More so, what has also been mentioned is the individual’s perceived loss of control (mother’s death, father remarried, more responsibility, and university) and the desire to gain control over one aspect of life – weight (Maddocks & Bachlor, 1986). Different family events, such as death of a family member, relationship changes, and illness/hospitalisation have been found to contribute to the development of bulimia nervosa (Berge, Loth, Hanson, Croll-Lampert & Neumark-Sztainer, 2012). In response to the stress brought on by such events, individuals described feeling ‘unsupported’, ‘lost’, ‘alone’, ‘out-of-control’, ‘horrible’, ‘unimportant’, ‘worthless’ or ‘depressed’ (Berge et al., 2012). In this context, the binge-purge cycle was found to be a way of managing their emotions and detaching from feelings (Obranic, 2001). Several studies also talked about the binge-purge cycle emerging as a response to stressors and being an individual way of managing stress and feeling in control of emotions (Reid, Burr, Williams & Hammersley, 2008).

However, at the same time bulimia has also been said to evoke strong fears of being negatively judged by others (Broussard, 2005; Orbanic, 2001). Individuals suffering with bulimia described trying to hide it from everyone around them and, by doing so, leading ‘a double life’ (Pettersen, Rosenvinge & Ytterhus, 2008) with bulimia being kept a secret. Consequently, individuals were isolating themselves from others and living in fear of others finding out about their bulimia, being at war with the mind and pacifying the brain through the binge-purge cycle (Broussard, 2005).

These studies of the individuals’ experiences of bulimia nervosa gave a much needed insight into the complexity of these experiences and bulimia’s multi-layered nature which goes beyond the diagnostic categories. They uncovered some of the internal struggles within the individuals and with the world around them, and their strong fear of being negatively judged by others. However, these studies, while exploring the individual experience of bulimia, did not explore the help-seeking process, which seems to be an integral part of the experience of distress and further recovery. Therefore, this study will now focus on presenting qualitative studies which have explored the help-seeking process amongst individuals with bulimia nervosa.
Help-Seeking Process amongst Individuals with Bulimia Nervosa

As presented in the literature review (Turek & Brown, 2013), this study will also use the definition of help-seeking behaviour for health problems developed by Cornally and McCarthy (2011). This definition states that it is “a problem-focused, planned behaviour, involving interpersonal interactions with a selected health-care professional” (Cornally & McCarthy, 2011, p. 286).

The conducted literature review (Turek & Brown, 2013) highlighted a large number of qualitative studies exploring individual experiences of different types of help, various aspects of that help and others’ perceptions of helping individuals who experience different types of eating disorders.

The studies which looked at individuals with different eating disorders and encompassed the help-seeking aspect in their findings emphasised an individual’s experience of apprehension and ambivalence towards seeking help and engaging in treatment despite the experienced distress (Cachelin, Veisel, Barzegarnazari & Striegel-Moore, 2000; Leavey, Vallianatou, Johnson-Sabine, Rae & Gunputh, 2011). Other studies highlighted the role of control and the ambivalence towards treatment because of the fear of losing control (Reid et al., 2008). The loss of control over the eating disorder was described as resulting in an individual seeking help. At the same time, the fear that receiving treatment would mean taking the control away from these individuals or that accepting treatment would mean gaining weight resulted in their withdrawal from help (Reid et al., 2008).

Furthermore, the barriers to help-seeking have been explored by Evans et al. (2011). This study indicated that, not only do individuals with eating disorders most often seek help for conditions other than their eating disorder, it also highlighted that the fear of judgement and stigma prevented many individuals from seeking help for their eating disorder. This study also pointed towards the cost of treatment as an important barrier to seeking help (Evans et al., 2011), and brought a valuable understanding of the help-seeking process by exploring barriers to seeking help. At the same time, by focusing on specific aspects of seeking help might have led to the actual individual
experience of seeking help being missed. This specific focus may have restricted individuals’ accounts of their experiences that may go beyond positive and negative aspects and contain different experiences which are not clearly defined by these two categories. More so, the study indicated that the cost of treatment was one of the barriers, which does not resonate with the experiences of people in the UK, where NHS healthcare is free.

The study by Shoen et al. (2012) focused on the internal help-seeking process for eating disorders amongst college-aged girls. Authors used a grounded theory approach to develop a model of this process. Their results showed a gradual shift from what was interpreted as ‘denial’ of their eating disorder amongst participants, to increased awareness of the self and the impact of the eating disorder. Furthermore, this study identified several aspects which influenced the individual help-seeking process, such as: feedback from peers, professionals and own bodily reactions; pre-conceived attitudes towards help-seeking and perceptions of treatment and increased awareness of the eating disorder and experience of strong negative emotions. However, as it has been highlighted in the conducted literature review (Turek & Brown, 2013), Shoen et al’s findings, although valuable, have two main weaknesses: they make no distinction between eating disorders and focus only on college-aged women; and, by doing so, do not recognise the variability of people’s perceptions of their eating disorders (Turek & Brown, 2013). To date there seems to have been little research specifically focused on seeking help amongst people with bulimia nervosa.

The study by Hepworth and Paxton (2007) specifically focused on exploring pathways to help-seeking amongst individuals with bulimia nervosa and binge eating. Their study focused on three factors relating to the help-seeking process: problem recognition; barriers to help-seeking; and prompts to help-seeking (Hepworth & Paxton, 2007). According to their study, ‘problem recognition’ was associated with noticing changes in one’s behaviour, bulimia interfering with life roles, comments about changes from friends or family and experiencing psychological problems such as increased anxiety or depression. ‘Salient barriers to help-seeking’ which prevented individuals from reaching out for help included fear of stigma, low mental health literacy/perception of need, shame, fear of change and cost. On the other hand,
‘prompts to help-seeking’ constituted increased symptom severity, psychological distress, interference with life roles, health problems and the desire to get better.

As much as this study brings a much needed insight into the individual experience of seeking help for bulimia nervosa, it has one major weakness: it used software to analyse the interview data. By doing this, it risked missing the depth and richness of personal accounts and experiences which can only be derived through the informed use of subjectivity and in-depth interaction with the collected data (Smith & Osborne, 2007). Only by such close engagement with individual accounts, the researcher is able to capture “the chain of connections between verbal report, cognition and physical state” (Smith, Jarman & Osborne, 1999, p. 221) and attempt to understand the individual meanings behind the words which are not easily available and cannot be obtained through measuring the frequency of words (Smith & Osborne, 2007).

Based on the literature review (Turek & Brown, 2013) and the brief outline of the most relevant studies above, which, amongst many others, were also presented in the literature review, it becomes clear that there seems to be a gap in the understanding of the help-seeking process. Presented studies have tended to focus generally on all eating disorders. Furthermore, some of them have included only young female students or explored specific types of help-seeking experiences and, by doing so, limited the possible understandings that can be derived from the variety of individual accounts and the richness and depth of these accounts. Therefore, there is a gap in the knowledge and understanding of the experience of the help-seeking process for bulimia nervosa amongst men and women of different ages who have sought help for bulimia nervosa in the UK (Turek & Brown, 2013). Deepening the knowledge in this aspect seems particularly relevant as individuals with bulimia nervosa do not often seek treatment and they tend to exhibit low trust, even in people close to them, and high levels of loneliness (Rotenberg, Bharathi, Davies & Finch, 2013). Consequently, the distress of these individuals can go unnoticed for a long time and they often seek treatment after years of battling in secret with bulimia. The research shows that, the longer the history of bulimia is, the harder it seems to be for individuals to change and to recover (National Health Service, 2014). Therefore, it seems crucial to develop a greater understanding of an individual experience of seeking help for bulimia as this
understanding might help to support these individuals in a more meaningful way.

Rationale for this Study
In the light of the studies mentioned above, the purpose of the proposed study is to explore, in-depth, how a varied sample of people diagnosed with bulimia nervosa experienced seeking help for their condition. To this end, the proposed study aims to acknowledge the individual voices of people who have experienced bulimia nervosa and have sought help. The objective here is to widen the literature on the eating disorder topic, deepen our understanding of bulimia nervosa and its individual experience and explore the help-seeking field. To achieve the aim and objective of this research, the study will ask:

‘How do bulimia nervosa sufferers experience seeking help for their condition?’

To help answer this research question, the method of data-gathering will be semi-structured interviews and the method of data analysis will be Interpretative Phenomenological Analysis (IPA) (Smith, 2008). The semi-structured interview appears to be the most suited method for the purpose of this research as this method allows the researcher and participant to equally engage in the act of dialogue. That is, the researcher does not impose his/her views on the interviewee but follows the participant on what he or she regards as relevant to the topic under investigation (Smith & Osborne, 2007, p.57). Furthermore, IPA will be the chosen method of data analysis as this method allows the researcher to gain an insight and attempt to interpret the internal world of the individual participating in the research (Smith & Osborne, 2007). To deepen our understanding of the individual’s internal world seems particularly important as there is a large body of qualitative research indicating that, in many cases, bulimia nervosa strongly relates to the subjectively experienced distress. This distress is often experienced in the context of the individual’s life events and appears to be strongly related to the meaning that individuals ascribe to those incidents. In this way and for this reason, Interpretative Phenomenological Analysis (Smith, 2008) seems particularly suitable as its main aim is to understand the meanings that the individual ascribes to their experiences in their interactions with the
environment. This, further, has the potential to help counselling psychologists “understand what it is like, from the point of view of the participant, to take their side” (Smith & Osborne, 2007, p. 53). This would allow for the development of more holistic and alternative views of bulimia nervosa to the one advocated by the medical model. The in-depth understanding of seeking help for bulimia nervosa, therefore, has the potential to bring valuable changes to the current ways of helping and, by doing so, encourage individual engagement. Therefore, findings from this research might have wider implications for future support of individuals seeking help for bulimia.

Method
This section describes the process of recruiting participants and their characteristics and contexts. It then explains the data collection and analysis process, and provides the rationale for the method used. Furthermore, it presents ethical considerations and briefly explains the ways in which the researcher ensured adherence to the ethical standards.

Participants - Sampling Strategy and the Inclusion Criteria
The study followed an IPA sampling strategy which is known as a purposive sampling strategy (Smith, 2008). In this respect, this study searched to find a closely defined group of individuals who had direct experience of the phenomenon under investigation and for whom the topic of this study was relevant. This means that people who took part in this study ‘represented’ a perspective rather than the general population (Smith, 2008).

This study was concerned with the individual experience of seeking help for bulimia nervosa. Therefore, in line with the sampling strategy, the main criteria for selecting participants in this research study was that they had to have the experience of seeking help for bulimia nervosa in the UK and were able to talk openly and freely about this experience with the researcher.
To ensure that participants had experience of bulimia nervosa and sought help for this particular type of distress, the researcher decided to use the criterion that participants in this study had to have received a diagnosis of bulimia nervosa. The rationale behind this decision was that, in contemporary society, seeking help for bulimia nervosa or any other eating disorder or health condition is often closely related to, and follows, a diagnosis. Receiving a diagnosis of bulimia nervosa, therefore, can be understood as an integral part of the help-seeking process which often determines what type of help is available to an individual, if any. Furthermore, receiving a diagnosis of bulimia nervosa when seeking help seems particularly important in this study, as previous studies have indicated that many individuals who experience bulimia nervosa seek help for issues other than their eating disorder (Hay, Mond, Owen & Rodgers, 2007). Therefore, to ensure that all recruited individuals had direct experience and could offer an insight into the phenomenon under investigation - the help-seeking process for bulimia nervosa - the researcher used the diagnosis of bulimia nervosa as one of the criterion.

Furthermore, this study required participants to be at least 18 years old. It was decided that an adult sample would have greater experience of the help-seeking process for bulimia nervosa and would be able to provide independent consent to participate in this study.

Finally, the decision to recruit participants irrespective of their gender was made as many recent studies have emphasised the lack of distinct differences between experiences of eating disorders amongst men and women (Thapliyal & Hay, 2014).

Participants in this study were between the ages of 21 and 44 and their experience of bulimia varied between two years to 27 years. Two of the participants suffered with anorexia nervosa before developing bulimia. All participants sought help for bulimia nervosa from various sources: NHS, individual therapy, group therapy, private hospitals, private therapy, recovery clinics, memberships of independent fellowships which support recovery from food addiction, and charities such as BEAT or ABC, helping individuals with eating disorders. Six participants were in paid employment, one was a student and one participant was a full time mother. All participants were
white British and were born and lived in the UK (Kent, London area, Midlands, North, North West, and Surrey) (please see Table 1 for details).

<table>
<thead>
<tr>
<th>Participant Alias</th>
<th>Age</th>
<th>Approximate length of bulimia</th>
<th>Marital status</th>
<th>Ethnic origin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Louise</td>
<td>22 years old</td>
<td>11 years (had anorexia for 3 years prior to bulimia) - recovered for 3 years</td>
<td>In a relationship</td>
<td>White British</td>
</tr>
<tr>
<td>Mark</td>
<td>29 years old</td>
<td>2 years - was being helped/in recovery while interviewed</td>
<td>Single</td>
<td>White British</td>
</tr>
<tr>
<td>Annie</td>
<td>44 years old</td>
<td>27 years - recovered for 5 years</td>
<td>In a relationship</td>
<td>White British</td>
</tr>
<tr>
<td>Vicki</td>
<td>26 years old</td>
<td>12 years - recovered for 3 years</td>
<td>Married with two children</td>
<td>White British</td>
</tr>
<tr>
<td>Pauline</td>
<td>36 years old</td>
<td>20 years - recovered for 4 years</td>
<td>Single</td>
<td>White British</td>
</tr>
<tr>
<td>Caroline</td>
<td>26 years old</td>
<td>13 years - recovered for 2 years</td>
<td>In a relationship</td>
<td>White British</td>
</tr>
<tr>
<td>Julia</td>
<td>24 years old</td>
<td>8 years - recovered for 1 year</td>
<td>Married</td>
<td>White British</td>
</tr>
<tr>
<td>Monica</td>
<td>21 years old</td>
<td>4 years (had anorexia for 2 years prior to developing bulimia) - recovered for 1 year</td>
<td>In a relationship</td>
<td>White British</td>
</tr>
</tbody>
</table>

*Table 1 – Participant characteristics and demographics*
Participants’ Context: 
Five out of eight participants were recruited through the charities BEAT and ABC, one participant was recruited through the advertisement placed at the University of Surrey and two participants were recruited through word of mouth. Three out of eight participants identified themselves as coming from a working class background and five other participants thought of their background as being middle class/well-educated. The length of the bulimia was an individual self-reported estimation. The length of seeking help was also self-reported and varied amongst participants from over a year, in Mark’s case, to nearly 25 years in Annie’s. For all participants, help-seeking was an ‘on-and-off’ process and they all sought help from various sources: the NHS, where they received individual therapy and group therapy; private hospitals and private therapies; recovery clinics; membership of independent fellowships which support recovery from food addiction; and charities such as BEAT and ABC. Initially, all participants sought help from their GPs. In their contact with the NHS, participants received a diagnosis of bulimia nervosa from a mental health professional. They all talked about looking for help from more than one source at any one time, and often finding information on the internet. Individuals who found NHS help inadequate/unhelpful and could afford private treatments sought help from private health providers/recovery clinics/private therapists. Other participants used the internet and charities for support, alongside or instead of the NHS.

The Issue of the Homogeneity of the Sample
As was previously mentioned, the experience of seeking help for bulimia nervosa in the UK was the main criteria for selecting participants in this research study. In this respect, the criteria defined the homogeneity of the selected group of individuals. The researcher decided to base homogeneity solely on the participants’ experience of seeking help for bulimia nervosa in the UK, as this understanding of homogeneity stands in line with that proposed by Smith, Flowers & Larkin, (2009) which states that participants should “represent a perspective rather than a population” (Smith, Flowers & Larkin, 2009, p. 49). Stating this, the researcher also acknowledged that the recruited group of individuals may have shared some other characteristics such as age or geographical location, which would have increased the homogeneity of the selected
sample. However, at the same time, the issue of homogeneity is a complex one as differences amongst individuals will always exist; every person, even if similar in age, length of particular experience or geographical location, will differ in their family circumstances, life experiences, feelings, thoughts and personal history. Therefore, complete homogeneity can never be guaranteed or achieved and, thus, in this study homogeneity based on the actual lived experience of seeking help for bulimia was felt to be sufficient.

More so, as Smith (2008) states, sometimes choosing a sample is guided by more pragmatic criteria of availability or individual willingness to take part in the study. The population of individuals who experience bulimia nervosa is relatively small, (NHS, 2013) and it has been documented that individuals who experience bulimia nervosa often keep it hidden from people even close to them (Rotenberg, Bharathi, Davies & Finch, 2013). They are also reluctant to take part in studies where they are required to talk openly about their experiences (i.e. Nunn, 2009). This posed an additional challenge to the recruitment process. Therefore, taking these challenges into consideration, the researcher decided to base homogeneity on the actual experience of seeking help for bulimia nervosa rather than using any additional criteria.

**The Tensions between Using Diagnostic Criteria for Recruitment Purposes**

The existential phenomenological philosophy which underpins this research project arose as a criticism towards the objectivity of science and diagnostic categories. The chosen paradigm criticised science for its disconnection from individual experiences, and from culture and history (Sadler, 2005). In this respect, the decision to use diagnostic criteria in the recruitment process created an ethical and professional dilemma, and the researcher reflected on this in the context of the paradigm chosen and method of data analysis.

As much as existential phenomenological philosophy has grown in opposition to the medical model and diagnostic categories, it also acknowledges the individual “situatedness” in the world (Sadler, 2005, p. 191). The individual ‘being in the world’ (Heidegger, 1927/1996) embraces, not only the person’s embodiment of the
experience, but also the individual embeddedness in the world, within their sociocultural and historical context. In line with this understanding, an individual experiences bulimia nervosa and seeks help while being embedded in the cultural and relational matrix of contemporary meanings and experiences (Manafi, 2010). Diagnosis, therefore, can be understood as part of an individual ‘being in the world’ (Heidegger, 1927/1996) - “the situation of doctor and patient” (Sadler, 2005, p. 192) whereby “diagnosis occurs in a context-dependent interpersonal field” (Sadler, 2005, p. 192).

In this respect, while using the criterion of the diagnosis of bulimia nervosa in the recruitment process, the researcher attempted to stay true to the paradigm chosen. The researcher did so, by placing the main focus of this research not on the diagnosis itself but on an individual’s meaning and experience of bulimia nervosa and the help-seeking process, putting personal memories, sensations, and thoughts at its centre (please see the interview schedule, Appendix 7, for examples).

**Ethical Considerations**

Full ethical approval for this study was obtained from the Faculty of Arts and Human Science Ethics Committee at the University of Surrey and resulted in a favourable ethical opinion (for a copy of the Ethical Approval Letter Please see Appendix 1). The researcher achieved this approval by presenting academic integrity and transparency of the presented study and also by ensuring full respect for the people involved in the project.

More so, this research adhered to the *BPS Code of Human Research Ethics* (The British Psychological Society, 2010) and *HPCP Guidance on Conduct and Ethics for Students* (Health and Care Professions Council, 2012). The researcher informed participants about the anonymity and confidentiality and also about their right to withdraw from this study at any point until the end of the interview. Furthermore, all participants were treated with equal dignity and respect and they were informed about the ability to refuse to answer a question should they feel uncomfortable without any negative consequences. All aspects of the research were explained and further questions answered before the start of the interview. Participants were also given the
information sheet about the research and they were advised that, in case they experienced any distressing feelings after the interview, they were given the information about available support from the BEAT helplines. They were also invited to contact the researcher should they wish to clarify some issues which emerged after the interview or to ask any questions. The researcher also asked if participants were interested in receiving the copy of the research report. All participants expressed their interest.

**Procedure**

The recruitment process comprised the use of posters distributed around the University of Surrey premises. The advertisement was also published on the National Eating Disorders Charity’s website (BEAT) and listed in the ‘Take Part’ section of their website (please see Appendix 2 for the content of the advertisement). The information about this research was also sent to its members via the BEAT research email. Furthermore, recruitment was supported by the ABC (Anorexia and Bulimia Care) charity and the same advertisement that was published on the BEAT website was also published on the ABC website and distributed amongst its members via a monthly newsletter. This enabled the information about this study to reach individuals across the UK. In these circumstances the researcher proposed to reimburse potential participants for travel expenses should they choose to meet for an interview at the University of Surrey. This aimed to enable all individuals who wished to participate in this study to take part irrespective of their financial situation or area they lived in. However, participants were willing to meet the researcher at their respective homes or nearby locations, so no financial reimbursement for travel expenses was necessary. Five out of eight interviews were conducted at the participants’ own homes; one was in a hotel room; one in the pre-booked room at the University of Surrey; and one in a private location chosen by the participant. The ability for participants to choose a place for the interview may have helped them feel more comfortable and relaxed during the interview and positively influenced their openness.

When individuals contacted the researcher, they were asked questions to ensure they met the research criteria. These questions included whether they were 18 years or
older, whether, at some point in their life, they had received a diagnosis of bulimia nervosa, and whether they were happy to talk openly about their experiences of seeking help for bulimia. If the participants met all these criteria and expressed an interest in taking part in this research study, the researcher then went on to ask if there were any distressing experiences that might be triggered during the interview.

If individuals responded positively to all questions and declared that no distressing experiences could be triggered by participating in the interview, the researcher then sent these potential participants the Participant Information Sheet (Appendix 5) to help them gain a better understanding of this study. This also aimed to allow individuals to have time to think and reflect on their decision to participate in this study. In this respect, the informed consent to participate was ensured by providing individuals with clear and concise information about the study. There was no time limit and individuals could take as long as they needed before deciding to contact the researcher again should they wish to proceed. Those individuals who contacted the researcher after receiving the information sheet were asked if they had any further questions. After any emerging questions were clarified and individuals expressed their willingness to participate in the study, the researcher agreed a place and time for the interview and, following this agreement, sent them a letter with this information (date, time and place of the interview, plus the researcher’s contact details) (please see Appendix 6). At this point the researcher also reminded participants that they were able to withdraw from the study without the need to give any reason up until the end of an interview.

Upon meeting with participants at their chosen locations, the researcher greeted participants and explained the study once more. The researcher also clarified whether there were any emerging questions and whether individuals were still happy to proceed with the interview, and, if so, they were asked to sign two copies of the consent form for participation in the research (one for the participant and one for the researcher) (Appendix 3) and for the recording of the interview (Appendix 4).

Participants were recruited between February and May 2014. Eight individuals were accepted for the research: seven women and one man. All the participants’ names and
details were changed for the purpose of confidentiality and participants in this study were under names: Louise, Mark, Annie, Monica, Vicki, Pauline, Caroline and Julia.

The research interview was planned as a semi-structured interview containing five open-ended, non-leading questions. In this respect, the interview schedule followed a technique called ‘funnelling’ (Smith & Osborne, 2007, p. 67) which starts with a more general question to then move onto more specific ones later. All interviews started with the question: ‘What is your experience of life with bulimia nervosa?’ In this respect, areas of inquiry involved: the meaning of bulimia for participants; their motivation; and the help-seeking process for bulimia nervosa (for the detailed interview schedule please see Appendix 7). This technique was chosen to give participants the opportunity to express themselves freely and openly. Prompts were used flexibly and individual experiences always took precedence over pre-planned questions. All interviews lasted approximately 70 minutes each and were all audio-recorded.

**Potential Distress and Participants’ Safety**

Taking part in the study and talking about personal experiences always carries the risk of evoking distress. To minimise this risk, the researcher gave detailed information about the topics that would be covered prior to conducting the interview by providing participants with the Participants Information Sheet and also by clarifying all emerging questions. Participants were also informed that, if at any point during the interview they felt uncomfortable, did not wish to answer some of the questions or felt that they needed a break, they had the right to do so without any consequences. They were also informed that they could withdraw from the study without having to give a reason for doing so at any point up until the end of the interview.

After the interview was completed, the researcher spent approximately 10 minutes debriefing the participants. During this time the researcher asked each participant about their experiences of the interview, such as their feelings, thoughts, and impressions. The researcher also offered a follow-up telephone call a month after the interview to ensure that participants did not have any residual feelings. No participant
expressed the need for a follow-up call. Participants were also invited to contact the researcher should they experience any distress following the interview, and were also encouraged to contact the research supervisor, Dr Dora Brown, should they have any comments/complaints regarding the research project or the interview process. Furthermore, participants were advised to contact the BEAT and ABC helplines should they wish to discuss any issues related to their eating disorder (all this information was included in the Participation Information Sheet - for details please see Appendix 5).

Furthermore, to reduce participants’ potential anxiety, the researcher agreed to meet at places chosen by participants, so that they felt comfortable in a familiar space. Interviews were planned during the day at a time convenient for participants. To ensure that no confidential materials were lost or stolen, the researcher travelled to all meetings by car and kept the minimum amount of necessary materials with her at any time. The researcher parked in public car parks and, as much as possible, avoided carrying confidential materials with her at all points.

Furthermore, participants’ safety was ensured by storing all the collected data - recordings, transcripts, and personal details - on a secure and password-protected computer. Following the interview, the raw, unedited data was only seen by the researcher and the research supervisor. Any data used in the report was edited for confidentiality and any identifiable details were edited.

**Credibility**

In order to establish the credibility of this research, the researcher reflected on the use of the self in this analysis (please see Appendix 8). The researcher also acknowledged her own assumptions towards the topic through a process called ‘bracketing’ (Husserl, 1913/1999, 63-65), which attempts to suspend one’s own assumptions before and during conducting the interviews and also during the process of the data analysis. The researcher also followed Yardley’s (2000) guidelines on establishing validity in qualitative research. The researcher expressed sensitivity to the context by showing awareness of existing literature, empirical data, the socio-cultural setting and the
relationship between the researcher and participants. The researcher also expressed commitment, transparency, rigour and coherence during data-gathering and data analysis by strictly following the pre-planned schedule of data analysis and also by presenting findings within the actual interviews. Presenting findings in this way allowed the reader to track the interpretations back to its source, present the logic behind interpretations made and ensure transparency of findings. Furthermore, the impact and importance of the research findings were presented in the discussion section by placing the research in the context of existing studies and the understanding of bulimia nervosa (Yardley, 2000).

**Data Analysis**

The data analysis followed a pre-planned schedule of transcribing each interview whilst adhering to IPA guidelines for data analysis (Smith, Jarman & Osborne, 1999) (please find an example of an interview transcript in Appendix 9). Along with following Smith’s guidelines (Smith, Flowers & Larking, 2009), the analysis was divided into four steps: step 1 - initial reading and re-reading transcripts; step 2 - initial coding; step 3 - developing emerging themes; and step 4 - looking for connections across themes. Each stage is described in more detail below:

Initially, the researcher transcribed the collected interviews. Once the interviews were transcribed, the researcher read each transcript several times. After this, the researcher began the initial stage of analysis, which required the researcher to read each line of transcript and develop an initial ‘coding’ (Smith, Flowers & Larking, 2009). This reflected unfocused notes and comments which captured participants’ unique experiences present in the transcript. Generally, it is believed that this initial coding should be written in the left-hand margin of the transcript. However, the researcher found it much easier to note the initial codes in the right-hand margin. This is regarded as correct as the analysis does not have to be followed rigidly and the researcher should apply analytic steps flexibly. Furthermore, it has been stated in texts on analysing IPA data that the order of placing initial comments in the left-hand margin was guided by the fact that Smith was left-handed, so it would have been natural for him to move from right to left while making notes after reading the text.
(Smith, Flowers & Larking, 2009, p. 84). The researcher is right-handed, so it was easier for her to note her immediate thoughts on the right-hand side after reading the passage of transcript. More so, Smith, Flowers and Larkin (2009) emphasised that there is no right or wrong way of conducting this sort of analysis and that IPA is a dynamic process of engagement with the collected data and involves the researcher to think flexibly and creatively.

The next stage of analysis involved the researcher looking for emerging themes based on the initial codes produced in the previous stage. This process aimed to capture important aspects present in the transcript and the meanings of the experiences described in those sections by using thematic labels. The intention was to reduce the volume of detail, as important aspects present in data are interpreted in relation to the entire transcript (Smith, Flowers, Larkin, 2009). In this respect, themes can be thought of reflecting descriptive and interpretative aspects of analysis. These themes were noted on the other margin of the text. Furthermore, the researcher created a table of themes by listing them chronologically according to the order they came up in the text.

The next stage of analysis required the researcher to look for connections across emergent themes. The list of themes created earlier served as a basis for this process. The researcher moved themes around forming clusters of similar meaning and reflecting how the identified themes fitted together. While looking for patterns and connections between themes, the researcher aimed to highlight the most important and interesting aspects of the individual's account. At this point the researcher created a table of themes accompanied by the actual quotations from the transcript (Smith, Flowers, Larkin, 2009).

While analysing subsequent transcripts, the researcher aimed, as far as possible, to bracket the ideas from the previous analysis and treat each new case on its own. With each transcript, the researcher systematically followed all the steps of analysis outlined up until this point. In the light of new data emerging, the researcher reviewed earlier transcripts for the presence of similar data (Smith, Flowers, Larkin, 2009).
Once all the transcripts were analysed, the researcher embarked on searching for connections and patterns across all the transcripts. This process aimed to, while representing individual unique experiences and meanings, also reflect a higher level of shared qualities across cases. In order to do so, the researcher created a table of all themes which were identified in all transcripts. At this point studying these themes allowed the researcher to look for further connections and, therefore, further reduce the number of themes by clustering them into subordinate themes. These subordinate themes were further clustered according to their shared meaning, relationships and references, and these clusters formed three main superordinate themes: Wrestling with Control, The Experience of Readiness to let go of Bulimia, and Changes within Self. In this respect, each of these superordinate themes reflected general, as well as more specific, shared idiosyncratic qualities (Smith, Flowers, Larkin, 2009).
**Findings**

Albeit the participants in this study varied in demographic characteristics and backgrounds, the data yielded some commonalities. These were grouped under three superordinate themes: ‘Wrestling with Control’ ‘The Experience of Readiness to let go of Bulimia’ and ‘Changes within Self’. These three superordinate themes consisted of further subordinate themes (please see the table below).

<table>
<thead>
<tr>
<th>Superordinate Theme</th>
<th>Subordinate Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wrestling with Control</td>
<td>The Experience of Control</td>
</tr>
<tr>
<td></td>
<td>Reaching Breaking Point, Losing Control and Reaching for Help</td>
</tr>
<tr>
<td></td>
<td>Accepting Help = Loss of Control</td>
</tr>
<tr>
<td>The Experience of Readiness to let go of Bulimia</td>
<td>Ambivalence about Help</td>
</tr>
<tr>
<td></td>
<td>Feelings of Not Being Heard</td>
</tr>
<tr>
<td></td>
<td>The Experience of Inadequacy of Help</td>
</tr>
<tr>
<td></td>
<td>Taking Help into One’s Own Hands</td>
</tr>
<tr>
<td>Changes within Self</td>
<td>Wanting to be Someone Different</td>
</tr>
<tr>
<td></td>
<td>Fear of Rejection</td>
</tr>
<tr>
<td></td>
<td>Denial - Pushing Bulimia Out of Awareness</td>
</tr>
<tr>
<td></td>
<td>Searching for the Lost Self - Re-evaluating and Integrating</td>
</tr>
</tbody>
</table>

*Table 2: Themes with their superordinate themes identified in the study*

The results in this study also highlighted that help-seeking was an ongoing process of internal change and transformation and was characterised by an oscillation between awareness and denial of bulimia. More so, the entire process of seeking help for
bulimia was described by participants as full of ups and downs, which eventually led participants to a perceived increase in their self-awareness and an internal transformation.

The themes that depict different aspects of the individual experience of seeking help for bulimia nervosa are described below:

**Wrestling with Control**
Participants retrospectively thought of their bulimia and the help-seeking process as an experience of gaining and losing control over self, food and life. Participants talked about the difficulties they experienced with their need for control over feelings through the binge-purge cycle; their subsequent difficulty in letting go of this control; and, at the same time, the difficulty in letting help and changes in.

**The Experience of Control**
The important aspect of seeking help for bulimia was influenced by the actual function of bulimia in the individual’s life. This gave the necessary context to internal dynamics and future experiences. To begin with, all participants pinpointed experiencing difficulties around food which developed in a background of subjectively experienced life difficulties, stresses and/or critical life incidents (parents’ divorce, death or illness of a significant other, hospital admission of a parent/grandparent). In those circumstances participants remembered feeling anxious, struggling with unpredictability and loss of control over what was happening. Participants reflected that, at those times, food seemed to have become an escape from the difficulties and uncertainty and gave them a new focus in life. Pauline said:

“(…) [bulimia] was a good distraction from my real problems. So if I felt anything it would be ‘I’m fat,’ and the answer to that was always to lose weight. So rather than be like, ‘I’m stressed, I need to do this’, I would create this artificial construct of a problem with my weight.” (Pauline)

In this respect, food and controlling food became a way of controlling feelings.
Vicki’s words echoed how all the participants described bulimia and managing emotions:

“(…) if I made myself sick I’d feel better. It did, for that short term and it would lift my mood, and it was fine…It brought me this comfort that my life would be fine as long as I had this bulimia. I’d use food to feed my emotions and then vomiting would be like getting them out of my system and feel relaxed, it would make me thin. It was almost like every worry I had would be gone, because I’d thrown them up.” (Vicki)

Vicki described how, in her perception, her worries would become embodied in food and, by gaining control over food, she was gaining control over her problems. In this way, it became apparent that, for participants in this study, bulimia and its binge-purge cycle was more of a symbolic process where food and eating played a highly personal function of symbolically or metaphorically not digesting or processing problems, but getting them in as food and getting rid of them by vomiting the food out. By engaging in this process, all participants talked about feeling in control of their emotions, worries, anxieties and feeling relieved.

**Reaching Breaking Point, Losing Control and Reaching for Help**

For all participants the actual experience of seeking help started at the point when the binge-purge cycle and its consequences became unbearable and out of control. They talked about bulimia gradually replacing and taking over more and more of them and their lives. When describing these experiences, participants used words such as “life falling apart”, and “feeling exhausted”, “feeling hopeless”. Louise’s words captured, in detail, what other participants also described:

“(…) it all started to escalate to the point where, if I ate something, my body naturally just wanted it to be sick. It just, kind of, became a, that’s when I felt like I was out of control, ‘cos I couldn’t stop myself. It wasn’t like I was going, ‘Right, I’m going to do this now,’ it was like an almost knee-jerk reaction any time I ate anything (...) and… I was just feeling really crappy and I realised I was no longer in control and it wasn’t actually… doing what it had done before. I was start, I
started to feel out of control and, because I started to feel out of control, and that’s something I don’t like, that’s what caused me to go, ‘I need to find a way of stopping this I need to get help’ because I no longer felt that the security it had given me….and that’s why I used it in the first place, because I felt so unstable and it gave me a way to outlet.” (Louise)

Louise’s account depicts how, primarily, bulimia served a purpose of asserting control in her life and how, within time, she lost the control over bulimia and felt desperate to regain this control. She described this experience further:

“’I was the smaller, I was the smaller bit and I was the weaker bit and I had no control over this thing that had just, kind of, consumed completely everything…erm, and it was affecting, like, social stuff as well (…)’” (Louise)

**Accepting Help = Loss of Control**

Participants talked about wanting to regain control over their bulimia at times when it was getting out of their control. However, participants also described that, as much as loss of control drove them to seek help, the same fear of loss of control pushed them away from accepting this help. Louise describes this internal struggle:

“(…) I knew doing something about it for me, doing something about it equated putting weight on, it equated getting bigger, it equated, weirdly enough, not being in control anymore… it would mean giving up something that had given me control.” (Louise)

All participants pointed towards this conflicting, internal dynamic which they went through when they were thinking of seeking help for bulimia. Bulimia was something that had given them control and they wanted to regain this control but not necessarily to let go of bulimia. In these initial stages of seeking help participants talked about wanting to stop “feeling exhausted”, “feeling hopeless” and “out of control”, but described feeling frightened of completely stopping the binge-purge cycle and letting go of bulimia. At this point, the participants’ ability to accept help was synonymous with having to stop the binge-purge cycle.
The Experience of Readiness to let go of Bulimia

Within this superordinate theme individuals described the gradual process of feeling ready to let go of bulimia. This experience was described as needing to come from within individuals and could not be forced by others. More so, individuals highlighted that they were only able to feel ready to let go of their bulimia after they reached ‘rock bottom’ and felt that they could not continue with their bulimia any longer. The themes that describe this experience of readiness are outlined in more detail below:

Ambivalence about Help

Initially, individuals described experiencing mixed feelings about accepting help and letting go of bulimia. Julia’s words depict this experience:

“As much as I desperately wanted help I just could not imagine facing life on my own, without it, I was not ready to do that.” (Julia)

Further, Vicki talks about her experience of feeling pressurised and not ready to let go of bulimia when being helped by health professionals:

“I was angry with all of them for trying to take it away from me. This was mine. I just felt so scared without it, to be honest.” (Vicki)

Vicki’s experience emphasised the important aspect of the help-seeking process, which was indicated by all participants - the lack of ability to make changes at their own pace.

However, at the same time participants also talked about their own lack of willingness to engage in the help offered to them. They, retrospectively, reflected on some of the aspects of help being particularly useful. Pauline talks about it:

“CBT made me aware I had a problem, made me aware of things like the importance of normal eating. It introduced me to the concept, but I wasn’t willing to take them on board and live them.” (Pauline)
Feeling of Not Being Heard
When participants described feeling ready to receive help, they talked about being faced with what they regarded as ‘dismissive’ reactions from the health professionals. Participants talked about stereotypical views that they encountered while seeking help from their GPs. The quotes participants brought up as examples of opinions about bulimia amongst their GPs were: “this is just stress” or “bulimia and eating disorders are just about being depressed”. Moreover, Vicki’s account echoed almost every participant’s experience of seeking help:

“(…) I went to my GP and I told her I was throwing up 20 times a day and exercising a lot. She asked me my age and I said, ‘I’m 15.’ She said, ‘It’s a phase that young girls go through.’(…)It reassured me that it was OK what I was doing but later I realised it just put me more into my bulimia than ever.” (Vicki)

Participants described feeling angry and frustrated with services and felt that people who should be helping them did not understand or did not take their distress seriously. Vicki expressed this further:

“It’s still classed as a choice. I think certain bits are choice – I think recovery is a choice – but being ill is not a choice whatsoever.” (Vicki)

The Experience of Inadequacy of Help
Participants emphasised that often help for bulimia was unsuitable and did not respond to their individual needs. Mark’s words captured other participants’ opinions:

“You can’t have bulimic people together and then anorexic people together (...) If you want to help me, you treat me as an individual or I’m not interested (...) I’m not a book, you can’t read out of a book to help me. You ask me questions and decide in your head what you’re gonna do and suggest it to me. If I agree to it, that’s, you know, then all well and good. If I say, ‘No, don’t force me,’ then let me get on with it.” (Mark)

Mark’s opinion was present amongst all participants. He talked about his desire to be seen as ‘Mark’ and the help to be in response to his needs, not generally prescribed as ‘one size fits all’, which participants had indicated was often the case when they
sought help for bulimia. More so, he emphasised the aspect of wanting to be involved in making decisions about his treatment.

Furthermore, participants who had received help in the past talked about being exposed to the same type of help despite the fact that this way of support did not work for them. Pauline described this aspect of experience:

“So, I went to that therapist and she said, ‘Write down everything you’ve eaten,’ and I said, ‘No, I don’t want to,’ because I was trying to get away from that. They wanted to do meal plans with me again and normalise my eating, and I said, ‘No, that hasn’t worked. I don’t want to do that, I want to do what I’m doing on the internet.’ Anyway, I wrote down what I’d eaten and she saw I’d eaten three chocolate bars and she said, ‘If you could just eat one chocolate bar and have a banana instead,’ and I was like, ‘No f****** sh**, you’re talking to the expert. Don’t give me tips on how to restrict my food! No! Actually I wanted three chocolate bars.’ And she said, ‘OK, if you do that you will put on weight.’ I was like, ‘REALLY? Thanks for the advice!’” (Pauline)

Pauline’s and Mark’s accounts highlighted what other participants described as finding difficult when seeking help for bulimia. They talked about not being heard, not being listened to and the experience of being fitted into a particular model or treatment plan without their unique individual needs, problems and/or stories being considered. The importance of acknowledging individuality was emphasised by Caroline, who, after a number of difficulties in accessing help for bulimia, was refused treatment for bulimia but was offered more general counselling which focused on her and her difficulties. She described this experience:

“[therapist] she was lovely, she said to me ‘I cannot, I don’t, this is not my thing’ but she really, really did the best she could, and we talked through it and she helped, she really helped, we talked and she kind of concentrated on why I did it, with things being like stress and anxiety a lot of it was like based on guilt, I held a lot of guilt for the stuff that I did not need to have guilt about.” (Caroline)
Taking Help into One’s Own Hands

After ups and downs and disappointments of seeking help, participants described looking for help for bulimia independently. All participants showed their relentless determination to find their way out of bulimia regardless of the disappointments and negative experiences they had had. Louise talked about this:

“(…) I then did… some hypnotherapy (…) I saw a nutritionist (…) I have yet to find anything particularly, I would say, 100% helpful.” (Louise)

She described accessing various types of help in order to find something that met her individual needs. Participants talked about using different sources of help including the internet, alternative medicine and private treatments. Unfortunately, most participants were not able to access private treatments, and they talked about using internet and charities as a main source of support.
**Changes within Self**

This superordinate theme describes how participants retrospectively thought of the changes that happened within them throughout the process of seeking help for bulimia. This included what participants described as ‘the void’ within the self that initially bulimia filled in and the gradual process of realising it and of finding one’s own way of filling in that void without bulimia.

**Wanting to be Someone Different**

“With bulimia I could be someone different, I did not have to think of all my problems, I was X with bulimia…I had something that could define me because I did not feel I had anything about me that was special or important…It just gave me a different identity.” (Julia)

Julia’s words capture the overarching theme amongst participants, which was a desire to become different; a different version of the self which, presumably, would be better - a self that would not have the undesirable parts of the experience. More so, bulimia was seen by participants as something that was making them feel special and unique. The life they presented to everyone else would be designed to meet outside expectations. Whilst seeking help and accessing help, participants talked about carefully managing the perception of them that the helper would create. Louise described this:

“I was just… showing her what she wanted to see, which has always been my approach anyway. I always, if I do something normally, it’s… it does tend, I don’t often do things for me.” (Louise)

**Fear of Rejection**

When seeking help, participants also talked about minimising their symptoms of bulimia and underplaying the extent of their bulimic behaviour. Participants talked about experiencing strong emotions of fear if the truth about them was to be exposed. For participants the full honesty about their bulimia equated to rejection by everyone and shame. Julia’s account depicted this experience:
“Bulimia was such a weird illness of mine, because I wanted help so badly...you beg for help, but at the same time I did not want anyone around me, you just don’t want anyone near you, you don’t want friends...because you are afraid that they will see what you really are and then they would be horrified and then they would leave you.” (Julia)

This fear of rejection expressed amongst participants was often driving them away from seeking help. In this way, participants found themselves in an inescapable dilemma, having to choose between equally unsatisfactory alternatives – exposing themselves and risking rejection or lying and risking receiving help that was not suitable. Participants described that this situation made them feel hopeless and, at times, made them withdraw further into bulimia.

**Denial - Pushing Bulimia Out of Awareness**

The experience of denial seems to be dynamic in nature. Participants talked about times in their lives when they were in complete denial of their bulimia and its seriousness. Vicki talked about making herself believe that everyone else was bingeing and purging but no one was talking about it. By doing so, she described making herself believe that it was not really a problem. Also, Louise described her internal belief that, if others did not know of her bulimia or binges, then it was less real; it was not so bad. Participants stated that at those times they would not think of seeking help. Retrospectively, they talked about not feeling ready to receive help and, even if such was offered to them, they would not engage in it. In this respect, participants described fleeting moments of awareness of their bulimia and the distress, when they would seek help. These moments, however, were quickly overridden by denial. Louise depicted this experience:

“(…) although I was feeling out of control… in that moment… that I told her, I did feel out of control, but in the morning it felt very different, ‘cos I was not in that state anymore. I guess it’s, kind of, like if you go out and you, you have a few drinks and you just, you’re just having a good time and then you might say a few silly things, or whatever, but in the morning everyone’s forgotten about it, it was just a good night out and you’re not so bothered about it anymore. So, I would go
in swings and roundabouts: if I felt fine and I felt, ‘No, I’m alright today I, kind of, thought, ‘Why did I tell my mum, ‘cos she’s gonna keep asking me about it and I’m going to feel like she’s watching me and… I don’t really want to deal with it.” (Louise)

Searching for the Lost Self - Re-evaluating and Integrating

“I’ve been running away from myself all my life.” (Caroline)

Caroline’s words represent what other participants expressed as the result of their help-seeking process for bulimia - the realisation of bulimia being an escape from much deeper problems within the self. The process of seeking help was described by participants as eventually leading to a better knowledge and understanding of themselves and bulimia in the context of their lives and, subsequently, this understanding was enabling them to let go of bulimia. Annie described her help-seeking process for bulimia:

“I tried and tried and tried with my bulimia to stop being bulimic, but until I was able to address my issues around relationships (...) I couldn’t actually let go of the bulimia.” (Annie)

Participants described that this focused on their internal, individual self-discovery through the process of seeking help for bulimia. Through engagement in the help-seeking process, they would become aware of their individual reasons behind bulimia and its function in their lives. Louise’s words expressed this internal transition:

“(…)...I can feel... I’m getting a sense of who I am back, who I am rather than this eating disorder.” (Louise)

Louise’s words also highlighted the central role that bulimia used to play in her life and in her sense of herself. This brings back the previously mentioned ‘void’ within the self that bulimia initially filled, and the gradual process of recognising and addressing it. Participants talked about the process of seeking help being also a process of re-evaluating and finding a new focus in life instead of food and bulimia.
Monika’s words captured these experiences of change within oneself throughout the process of seeking help for bulimia:

“(...) for me to help the most was to know what was happening in my body physiologically and to know other people's stories so I can anticipate what is going to happen (...) but ultimately to recover I needed to get different priority into my life.” (Monica)

Furthermore, at the point when participants let go of bulimia, they described being faced with having to integrate and make sense of themselves before, during and after bulimia. Pauline described this experience:

“I’m a totally different person. It’s weird. Now I’m in this town, I’m working, at the moment, to try and build a bridge between who I was before recovery and who I am now, because it just feels like two different people and that’s quite disturbing, because that’s 10 years of my life.” (Pauline)

In this respect, the entire process of seeking help was a process of letting go; getting to know oneself with all its aspects, which further led to internal integration.
Discussion
This study set out to ask the question: ‘how do people with bulimia nervosa experience seeking help for their condition?’ The results from this study build on the findings from previous qualitative research which explored the help-seeking process amongst people with eating disorders (Shoen et al., 2012) and people with bulimia nervosa - binge-eating (Heworth & Paxton, 2007). In this context, the findings confirmed the centrality of the denial/awareness dynamic throughout the entire help-seeking experience amongst people with bulimia nervosa, as was shown by Shoen et al’s (2012) study. The individual experience of seeking help was prompted by the increased severity of symptoms, increased awareness of bulimia and the increased desire to seek help. This study confirms some of the Hepworth & Paxton (2007) findings where ‘prompts to help-seeking’ constituted increased symptom severity, psychological distress, interference with life roles, health problems and a desire to get better.

This study also highlighted the great extent to which people with bulimia would go to in hiding their bulimia. This has been previously researched as a phenomenon of the 'double life of bulimia’ (Pettersen et al., 2008) and ‘living a façade’ (Obranic, 2001) and was also present throughout the help-seeking process. This was accompanied by feelings of shame, guilt, and denial of bulimia and the fear of rejection if the bulimic behaviour was to be exposed. More so, this study also pointed towards the central role of the experience of control in the process of seeking help for bulimia. This experience of gain and loss of control in the experience of eating disorders has been previously highlighted (Maddocks & Bachlor, 1986), and in the help-seeking process (Reid et al., 2008). The current study confirmed findings from the previous studies; the aspect of control has been shown to play an important role in the individual experience of seeking help. This seems to have been absent or marginal in the findings of both previous studies, which specifically focused on investigating help-seeking behaviour amongst bulimia and eating disorders sufferers (Hepworth & Paxton, 2007; Shoen et al., 2012).

This study, in a unique way, brought together aspects of help-seeking with the individual complexity of the lived experience throughout this process. Furthermore, it
described that letting go of bulimia was a gradual process marked by subjectively experienced readiness to live without bulimia. In this way, the help-seeking process had a continual and gradual nature rather than being a one-off episode. Therefore, the help-seeking process can be described on a continuum with individual consciousness oscillating between awareness and denial of bulimia and the need to get help, seeking help and withdrawing from help (please see Picture 1 below for details).

**Awareness of Bulimia and its Consequences**

Reaching breaking point - loss of control - seeking help, feelings of not being heard, withdrawing from help, searching for help on their own = staying in control, gradual increased awareness of self, developing new understandings and new meanings in life

The self that seeks control, wanting to be someone different, subjective denial of reality/experience of control over self/others/life through bulimia

**No awareness of bulimia – denial**

*Picture 1 - The individual experience of seeking help for bulimia - ‘fluidity of awareness in seeking help for bulimia and ongoing process of becoming’*

Picture 1 presents the fluidity of awareness during seeking help for bulimia nervosa. It highlights that seeking help is an ongoing process marked by individuals experiencing moments of awareness and denial of bulimia. Initial greater fluctuation between these two states highlights the individual’s increased denial of their bulimia, of it being a problem, and the disconnection from the reality of life. However, this was transient
and individuals, after some time of being in this state of denial, were becoming aware of the impact bulimia had on their lives and were experiencing feelings of being out of control. This experience of being ‘out of control’ instigated help-seeking behaviours which further led to the experience of receiving help. At this point individuals experienced increased self-awareness. This awareness, however, was something they felt uncomfortable with and they often escaped from this back into their bulimia and denial of its destructiveness. Within time, as individuals sought and engaged in various types of help from different sources, their awareness of self, bulimia and its impact gradually increased. In this process, individuals highlighted a gradual development of a greater self-awareness and acceptance of themselves. They described feeling much more in touch with reality, feeling ‘connected’ and began reflecting on their lives and the role of bulimia. This process is illustrated by the gradual decrease of oscillation between awareness/denial.

Although in Picture 1 the help-seeking process is presented in a linear fashion, it can also be understood as participants going full circle from initially engaging in bulimia to disconnect from feelings and from oneself, to then, gradually, through the process of seeking help, experiencing changes within the self and, subsequently, experiencing a reconnection with life and with feelings, in an aim to make sense, find a new meaning and a new way of integrating their experiences. Consequently, this process seems to bring a new and unique experience and understanding of themselves.

Limitations
This study has several limitations. It might be important to take into consideration that six out of eight participants in this study had been in recovery for their bulimia. Therefore, their experience of seeking help might have been viewed from a more reflective perspective than it might have been if they were at the earlier stages of seeking help.

Also, the context of the relationship between researcher and participant needs to be acknowledged and taken into consideration (Yardley, 2000). Being a young female might have, in some cases, helped participants to open up, but in others might have
made them feel more self-conscious about their bulimia, particularly in the case of the male participant. The success of this study relied upon the individuals’ willingness to talk openly about their experience and disclose personal information in front of a newly met person. This further might have increased the experience of anxiety and apprehension amongst participants towards sharing intimate details. Equally, interviews took place at the participants’ convenience and in places chosen by them, which met the research and confidentiality criteria. The ability to choose a place of interview aimed to minimise individual discomfort experienced while sharing intimate and often highly sensitive details.

**Implications for Clinical Practice**

This study highlighted the importance of individuality when offering support and attempting to understand this very personal type of distress – bulimia nervosa. It highlighted that the treatments available are suitable in offering people with bulimia the ability to learn skills to manage their eating disorder. However, the downfall of this, perceived by participants, is its mechanical application by health professionals. In the light of this research it seems important for counselling psychologists to remain open to the individual needs and readiness to make changes, rather than slavishly following the dominant medical discourse of implementing pre-planned treatment protocols and pushing individuals to make changes.

Faced with disappointing experiences of receiving help, participants felt prompted to find their own ways of helping themselves. Unfortunately, most participants could not afford private treatments. This raises a concerning issue of inequality where only wealthy people can afford help that meets their needs. In this respect it is the responsibility of counselling psychologists and all mental health professionals to place greater emphasis on hearing unique individual needs and responding to these. Thus, mental health professionals need to stand alongside the individual who tries to find their own way out of bulimia and their own individual meaning of it, rather than implementing pre-prescribed treatments, plans and protocols.
Future Research
It appears that there is a need for future research focusing on the experience of individual readiness to receive help and to make changes, which have been highlighted in this study. Furthermore, thinking of the individual experience of seeking help for bulimia, it also feels necessary to explore experiences of those bulimia sufferers who did not seek help and explore the thoughts and attitudes they hold which may prevent them from seeking help.
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Appendix 1

Self-reflection

My experience of bulimia nervosa is multidimensional and includes my friends, family and my own experience of food and eating. Last year my motivation to write the literature review and choose this topic was influenced by my very personal experience of a very close friend who suffered from bulimia and did not receive help and, consequently, still struggles with recovery. Furthermore, during my year of working in a secondary care NHS setting, I have encountered many individuals who have struggled with and around food, overeating at times of stress and throwing up, feeling low and depressed. In fact, a couple of my own patients had experienced this. They came to me with a diagnosis of recurrent depressive disorder. Their distress around food became apparent as our therapy progressed. They told me that ‘they were not ill enough’ to seek treatment from eating disorder services and that this situation was making them feel hopeless, depressed and, at times, suicidal.

I started exploring research focused on the help-seeking process amongst eating disorder sufferers. My attention was particularly drawn to the current state of support for eating disorders and the situation that sufferers are left with. In the report made by BBC1 in Autumn, 2013, Susan Ringwood, the chief executive of the eating disorder charity Beat, said that, according to current research "eating disorders are fatal in up to 20% of cases". One of the patients interviewed by BBC1 commented on the situation: "You're just left stranded"; "You think, 'If I make myself worse they might take more notice’" (Burns, 2013). These made me think more deeply and question the individual experiences of those who are actually ‘left stranded’.

Reflecting on these experiences, I made the decision to focus my research specifically on the individual experience of seeking help for bulimia nervosa. I was guided by my own frustration that there are so many people who are not helped and for whom the current treatment does not work, or who are not able to access it for various reasons. Therefore, it is for that reason, together with my personal experience, that has led me to focus on and select a considerable amount of qualitative literature and research exploring an individual’s experience of seeking help for bulimia nervosa. Also, because of these experiences I came to the conclusion that people who have experienced bulimia nervosa are the experts and their opinion should be the leading
one in shaping our understanding of help for bulimia and informing others of the future ways in which they would like to and can be supported to meet their needs. When I embarked on this research I reflected on my own assumptions and expectations regarding results of this study. My thoughts were oscillating around shame and stigma which were preventing people from seeking help. Then, after reading the BEAT report ‘Waiting Times Survey’, which highlighted particularly long waiting lists and difficulties in accessing treatment by individuals with eating disorders, I made some expectations as to the results of my study. I was expecting that participants in my study, while talking about their experience of seeking help for bulimia, would point to the long waiting lists. I expected participants to talk about feeling frustrated and angry with services. I assumed participants would talk about their bulimia as a struggle and internal battle with self, wanting to stop but not having any support; feeling frustrated with bulimia and frustrated with themselves. I knew there was already a lot of literature focusing on the difficulties in helping eating disorder sufferers and their denial of the illness, but in my mind I thought that, surely, if someone is desperate to get help, they must be fully aware of what is happening to them. At that time, I did not understand the nuances of this experience.

While conducting research interviews, at times I felt my therapeutic side was emerging. While listening to a few of my participants, I caught myself creating mini formulations of their problems. Luckily, as I was aware of this process, I was able to suspend those thoughts while keeping a curious and explorative attitude during interviews. Also, during the analysis of these interviews, my therapeutic side was at times taking over, particularly while putting down final conclusions regarding research implications for practice. My supervisor kindly reminded me that I needed to remain in my researcher role, using evidence from research and participants’ voices rather than letting my counselling psychologist side speak. With this close support from my supervisor I was able to acknowledge those moments and remain sensitive to the research evidence rather than my personal stance.

Conducting this research made me more aware of the subjectively experienced distress and the crucial aspect of openness and listening to the individual internal struggle rather than making assumptions. I noticed how, throughout this year, I became more open and more in tune with my patients and I noticed how this improved my therapeutic work. I believe I became more present and open to the individual
experience and subjective feelings which significantly improved my patients’ wellbeing.

Reference
Appendix 2

Research interview

The interview has been edited for confidentiality: names and any significant details have been changed. I-Interviewer; P- Research Participant

I: So, this is the start of our interview. This research is about your experience of seeking help for bulimia nervosa. And, before we get onto that and talk about it, I would like to ask you; actually, what is your experience of life with bulimia?

P: Erm, long and very… tricky and got really bad at one point. It… ‘cos, it started initially ‘cos I hated school and I was in my teens then...before it became, sort of, image-related, it was very much, ‘I don’t want to go to school.’ And I realised that if I could be physically sick, then my mum’s going to believe that I’m ill, so she’ll let me stay off school. So, that’s how it started. And then, as I got older, erm, my parents divorced, various things happened that made me very stressed, started doing GCSEs, much more pressure. And then that behaviour that I’d learnt when I was younger suddenly became a way of, well, I think of coping. It started to come into play a lot more and became a lot more image-related.

I: Right.

P: … ‘cos I needed something to… control, ‘cos I’m a very, very much a control freak; I don’t like things that I can’t control. It really, really annoys me. And I planned for everything. So, it, it’s very difficult when things rock, that even just, for example, the work on the house at the moment, just the fact that everything is a mess, you’ve got stuff all over the place... So, that makes it harder for me to feel settled and secure. So, anything that rocks the boat with me… makes… those feelings come back and, although I’m at a point now where I’m… I don’t purge anymore, but it doesn’t mean I don’t feel like I want to sometimes [half laugh]. And, actually, anything that rocks my… my world or makes, or any change, change of any kind is just a real trigger, anything that’s stressful…

I: Right.

P: … just instantly makes me go [thump noise] and I can’t… erm, I have to work really hard to not fall back into old habits, because it has adapted and changed. I am much better now…I know my triggers so I feel I can control it better because before…before I was a mess, my life was a mess. I thought I was in control but I wasn’t. It controlled me…totally controlled me, my life…everything!
‘The Search for Identity’

The Narrative Analysis Approach to Exploring the Self-Concept of Individuals with Bulimia Nervosa

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Abstract

This qualitative study is situated within the social constructivism paradigm. It aims to explore how individuals with past experiences of bulimia nervosa narrate their present selves. For this purpose, life-story interviews from six participants were obtained and analysed using narrative analysis as outlined by Murray (2008a). The findings from this study suggest that individuals who recover from bulimia nervosa narrate their identity through the meanings and knowledge they acquire within the society and culture they live in. The common patterns across all narratives were: 1) The Family Context: a Formative Ground; 2) Developing a Mask; and 3) Redefining the Self. Each of these three patterns consists of further patterns which reflect individual narratives. Bulimia was seen as an integral part of identity that allows participants to counterbalance social pressures, demands of perfection and a sense of responsibility. The identities they took on from an early age appeared fixed and demanding. In this respect, bulimia became their ‘secret escape’ and their ‘imperfect self’ over which they felt they had ‘perfect control’ and which was ‘theirs’ as opposed to all other identities. Individuals narrated their stories as stories of struggle and confusion which led to triumph and victory over bulimia. In relation to this, these stories had a progressive and optimistic tone. The findings are presented in the context of existing literature. The contribution of this study to counselling psychology is in its emphasis on the social and interpersonal aspect of bulimia. Deepening this understanding might improve the type of support counselling psychologists can offer to those who experience this type of distress, particularly as bulimia and eating disorders are a growing social problem and it is the obligation of counselling psychologists to develop an in-depth understanding of this unique type of distress.

Key words: ‘bulimia’, ‘self’, ‘identity’, ‘society’, ‘qualitative'
**Introduction**

This paper presents a narrative analysis of the life stories of six individuals - five females and one male - who experienced bulimia nervosa. Theoretically, this study is situated within the social constructivism epistemology which views that everything we know about ourselves is socially constructed and dependent on the context and language. This implies that there is no single reality or truth but that there are multiple meanings which are dependent on the context, language and people involved in the interactions (Burr, 2003). Therefore, this research does not aim to examine or find out the ‘true’ way in which individuals with past experiences of bulimia narrate their present selves. Rather, it aims to analyse, through the use of life stories, the possible ways in which individuals narrate their present selves and make sense of their experiences. In this way this research aims to add, to the existing literature, possible meanings and ways that the self of those who have recovered from bulimia might be narrated. By doing so, it, not only aims to contribute to the current scientific research, but it also aims to promote the voices of those who consider themselves as recovered and, through this, encourage and bring hope to the ones who still struggle with their experiences of bulimia.

The inspiration for this research came from the findings from the previous study conducted by authors Turek & Brown (2014a). This research identified that, in the process of seeking help for bulimia, individuals experienced significant ‘changes within the self’ which were closely related to: the context they lived in; others’ reactions to their bulimia; and the fact that bulimia constituted an important aspect of their identity. However, this former study did not explore these aspects in detail. Therefore, the proposed study aims to focus on this personal meaning in the societal context in more depth.

This paper starts with briefly setting out the background of existing studies which further influenced the idea for the presented study. Furthermore, it outlines the rationale for this study and the method used. Subsequently, the findings are presented and discussed. The final part of this report presents the findings in the context of existing literature. The importance of this to counselling psychology will be present
throughout this report. Limitations and implications of this study, together with suggestions for future research, are highlighted at the end of this report.

**Background Information**

The field of eating disorders has received a lot of attention from researchers over the years. This has resulted in a large number of findings and important advances in science. However, despite this extensive research, professionals seem far from understanding this complex phenomenon. The report commissioned by BEAT (2015), an eating disorders charity, estimated that more than 725,000 people in the UK are affected by an eating disorder (BEAT, 2015). More so, Smolak’s (2011) research revealed that girls as young as six expressed concerns about weight or shape and, for many, these concerns about weight or becoming too fat continue through life (Smolak, 2011). The study by Micali (2013) looked at the incidence of eating disorders in primary care in the UK over a ten-year period (2000-2009) and found an increase of 60 per cent in females and 24 per cent in males reporting symptoms of eating disorders which met most criteria associated with anorexia or bulimia (Micali, 2013).

All this data shows that distress around food and eating is not an alien concept but a constantly growing social problem which requires the urgent attention of counselling psychologists and other professionals. In this respect, it is the responsibility of counselling psychologists to attend to such distress and deepen their understanding of its individual meaning, if counselling psychology is to remain open, sensitive, and responsive to changing social contexts and issues.

**The Phenomenon of Bulimia Nervosa**

Nowadays the dominant discourse in the eating disorders field is of ‘abnormality’, ‘symptoms’, ‘disorder’ and ‘pathology’ (Theander, 2002). Bulimia nervosa is a diagnostic category which belongs to a group of ‘Feeding and Eating Disorders’ and is characterised by recurrent binge-purge cycles which occur at least once a week for three months, according to the Diagnostic Statistic Manual 5th ed. (American Psychiatric Association, 2013). In this respect bulimia is defined through its
behavioural symptoms located in the individual who is perceived as disordered and ill. Over the years researchers have made numerous attempts in finding ‘a cure’ for this ‘disorder’ by measuring the efficacy of various treatment protocols or by looking into genetics and brain functioning with an aim to locate the source of the disorder and find a way of alleviating this distress (Kings College London, 2015). For this reason the majority of studies are quantitative and explore various aspects potentially responsible for the development and maintenance of an eating disorder. In this context the eating disorder becomes solely located within the individual who presents with disordered symptoms and the prospective failure or success of recovery is dependent on this individual.

This way of thinking, not only emphasises the Cartesian dualism of body and mind, but also decontextualizes the personal distress by locating it within an individual whose eating is ‘disordered’, ‘abnormal’ and, therefore, classed as ill. Although this seems to be a dominant discourse within the eating disorders field, it is not the only way of understanding this type of distress. There is a substantial body of research emphasising the social and cultural influences, not only on the development of eating disorders (Becker, Burwell, Herzog, Hamburg, & Gilman, 2002; Miller & Pumariega, 2002), but also its maintenance (Becker et al, 2002; Palmer, 2008). This seems understandable as an individual’s life is inextricably linked and is influenced by social and interpersonal aspects (Gergen, 1985). In this understanding, human existence starts and is maintained within and through interactions with others (Owen, 1995). Thus, it seems impossible to understand the phenomenon of bulimia without thinking of its context. However, despite these findings, in the eating disorders field there is a strong dominance of psychiatric discourse which classifies it as a medical problem and situates it within the individual.

This dominant construction of bulimia, which is maintained in social awareness, carries important real-life implications and evokes certain social actions. Through this construct of bulimia as pathology, individuals who engage in bulimic behaviour create their sense of self, make sense of their feelings and behaviours and, by doing so, make certain actions possible and close down others (Burr, 2003). The view of bulimia as an
illness might open the possibility of accessing treatment and help, but, equally, it can evoke repulsion, disgust, rejection and blame from the community which carries the opinion that those individuals who experience an eating disorder are responsible for their condition (Churruca, Perz & Ussher, 2014; Crisp, Gelder, Rix, Meltzer & Rowlands, 2000). This can create strong feelings of shame which, subsequently, drives many individuals to increased secrecy, alienation (Pettersen, Rosenvinge & Ytterhus, 2008) and continuation of their bulimic behaviours (Turek & Brown, 2014a).

In this respect, while exploring the personal aspects of bulimia nervosa, it seems vital to examine the way current social meanings affect subjective experience. This way of approaching the topic employs the theoretical basis of social constructionism which postulates that all meanings are constructed within different social interactions which are socially and historically situated and co-exist with other equally valid and important understandings, and which are present in culture (Burr, 2003).

**Societal View of the Person with Bulimia Nervosa**

There have been several studies which have employed the social constructionist theory while exploring the phenomenon of bulimia nervosa. The study by Brooks, LeCouteur & Hepworth (1998) used discourse analysis with an aim to identify different versions of bulimia and the self that were present in language. Their study included participants who, to various degrees, actively engaged in binge-purge and compensatory behaviours. The researchers identified the dominance of negative versions of bulimia and of individuals affected by it. Individuals described themselves as victims of bulimia, which was seen as a ‘thing’ that ‘overtakes, rules and destroys one’s life’. Bulimia was thought of as an individual defect which was abnormal and disgusting, and was an illness seen as “socially unacceptable” (Brooks et al., 1998, p. 202). This study gave a valuable insight into the cultural and social aspects of bulimia, examining the view of a negative and disempowering version of the self. However, the main weakness of this study is with the interview schedule, which included, not only participants’ descriptions of themselves and bulimia, but also other questions
which might have compromised the opportunity for participants to provide in-depth and extensive information about themselves and their view on bulimia.

**Qualitative Studies Exploring the Personal Aspect of Recovery**

Those who overcame bulimia contributed to the vast majority of qualitative studies, highlighting various aspects of bulimia. However, there is no agreement amongst researchers as to how recovery from bulimia nervosa or other eating disorders should be defined; different studies use different criteria (Noordenbos, 2011). The term ‘recovery’, according to the online Oxford Dictionary (2015), means: “*A return to a normal state of health, mind, or strength*”. The first criteria defining recovery from bulimia encompassed physical, behavioural, psychological, sexual, and social factors (Morgan & Russell, 1975). However, nowadays most studies conducted within the dominant medical model identify recovery from bulimia as a reduction in symptoms of binging and purging (Noordenbos, 2011). On the other hand, amongst qualitative studies it seems popular to use ‘self-reported recovery’, where individuals consider themselves recovered from bulimia nervosa. This promotes the value of the personal experience of recovery over external behavioural categories of ‘being recovered’. In this way, qualitative findings emphasise various aspects of individual transformation and changes within the self (Turek & Brown, 2014a) which contribute to individual recovery.

In many studies individual accounts of recovery were often depicted as a journey which led to a greater sense of self (Patching & Lawler, 2006). Other studies also explored the impact that this personal transformation had on relationships (Milstein, 2001) and highlighted various personal difficulties (Bjork & Ahlstrom, 2008; Keski-Rahkonen & Tozzi, 2005; Pettersen, Thune-Larsen, Wynn & Rosenvinge, 2013).

One study in particular, which explored narrative identity in women diagnosed with eating disorders (Bedoya-Hernández & Marín-Cortés, 2010), found that these women adopted the social model of slimness as a measurement of beauty which equated to them being successful. This study also identified that the body and the ‘other’ were the two main horizons in their identity construction. In this context recovery was seen
as the process of questioning this model of beauty which then led to a new identity construction (Bedoya-Hernández & Marín-Cortés, 2010). Another qualitative study (Nunn, 2009) also explored the experience of the self among individuals with eating disorders. This study made a valuable contribution to the field by highlighting the difficulties which individuals with eating disorders have in maintaining a coherent sense of the self and by exploring the role that traumatic events and the family play in the development of the self.

These and many other qualitative studies, which looked at recovery from eating disorders, bring a valuable contribution to our understanding of this process. However, their major weakness is the fact that they approach all eating disorders as one group irrespective of different variations. This issue has already been highlighted in the literature review conducted by this author (Turek & Brown, 2013). Furthering the discussion, this is particularly important as the cultural constructions of anorexia nervosa and bulimia nervosa seem to differ (Burns, 2004). Anorexia is seen as glamorised and admired whereas bulimia is perceived as disgusting and out-of-control. Consequently, these individuals think of themselves differently (Ison & Kent, 2010). Those with bulimia nervosa see themselves as ‘greedy pigs’ for which there is not much compassion in society and that helping them would be perceived as a waste of time (Ison & Kent, 2010, p. 479).

Apart from the various studies exploring eating disorders in general, there are also a substantial number of studies which focus solely on anorexia nervosa. As Lindgren et al (2015) indicated, research which specifically explores individual accounts of recovery from bulimia nervosa is scarce (Lindgren, Enmark, Bohman & Lundström, 2015). A study, which centred on a young woman’s experience of recovery, described it as a dynamic process marked by the individual growing self-efficacy and the ability to replace feelings of distress with feelings of wellbeing (Lindgren et al, 2015). Findings from this research, although important, also seem to emphasise values of autonomy, power and self-mastery by promoting the view of an individual’s recovery as being ‘in their own minds’ and independent of the social context. This view of the person is partial and misses the relational context of human existence; the context of language and interactions with the world (Burr, 2003).
A qualitative study conducted by Morrell-Bellai (1997) explored healing amongst individuals who experienced bulimia. This research indicated that the source of an individual’s recovery was in their ability to reject the false self-identity and to accept their true self based on true wants and needs (Morrell-Bellai, 1997). As much as this research brings a valuable contribution to our understanding of the personal experience of recovery from bulimia, it also has several weaknesses. The division of self into ‘false’ and ‘true’ seems to be an imposed construct that might not hold much relevance for many individuals who experience bulimia, particularly as a growing number of studies point towards bulimia being experienced as an integral part of personal identity (Broussard, 2005) with recovery being a process of integration rather than rejection of one of its aspects (Bulik & Kendal, 2000; Turek & Brown, 2014a). This study also implies that ‘the self’ can be seen as something that exists outside the language and has fixed attributes which are either ‘true’ or ‘false’, limiting the ways of understanding a person’s ‘self’.

Some other qualitative studies applied psychodynamic concepts to interpret their findings (Appledorn, 2000; Elran-Barak, Latzer, Buchbinder & Zubery, 2012). This can be perceived as standing in opposition to qualitative research as dynamic theories locate the source of individual distress within that individual and, by doing so, they assign the personal experience to a category that further determines its destiny (Kafle, 2013).

The personal experience of recovery from bulimia nervosa was also explored through analysis of individual narratives (Nakamura, 2012). This study identified two types of transformation: the transformation of action - stopping dieting and bulimic behaviour; and the transformation of cognition - dropping the desire to be thin (Nakamura, 2012). These results centred around two core characteristics of bulimia at the expense of personal and contextual experiences of recovery.

Therefore, exploring narrative accounts of people who have recovered from bulimia nervosa with an aim to explore their current views of themselves in their social context, might bring a valuable contribution to the existing literature.
The Rationale for this Study

Concluding from the overview of the literature presented above, existing qualitative research has predominantly explored the views of the self by focusing on personal attributes, motivations and attitudes, rather than the context and their social interactions. More so, the imbalance between the amount of quantitative and qualitative research in the eating disorders field has been pointed as “a weakness in developing theory and clinical practice” (Hepworth, 1994, p. 179).

Therefore, this proposed study aims to analyse the way individuals with past experiences of bulimia nervosa narrate their present selves. This seems particularly important as the dominance of the psychiatric discourse of ‘disorder’ and ‘pathology’, with the negative societal perception of a person with bulimia, often leads to the individual experience of shame and social stigma (Brooks et al., 1998; Ison & Kent, 2010). Thus, it seems crucial to gain a deeper understanding of how an individual makes sense of their experience and narrates their present selves in the context of recovery from bulimia. To achieve this, the proposed study will employ a social constructionist perspective (Burr, 2003).

By employing this epistemological stance, the researcher states that all the data and findings of this research are firmly situated in the people and their contexts (Mertens, 2010), and their lives are inextricably linked and impacted by social and interpersonal influences (Gergen 1985). This way of understanding seems to be particularly relevant in the case of bulimia, as it has been understood to have strong cultural and social roots (Becker et al., 2002; Miller & Pumariega, 2001; Palmer, 2008). This means that the categories and knowledge are not objective or real entities but are socially constructed and, therefore, are historically and culturally specific (Burr, 2003). Consequently, bulimia can have different meanings to different people in different contexts. All these meanings are treated as equally relevant and valid. In this respect it will be the researcher’s aim to develop an understanding of this personal knowledge (Mertens, 2010).

Furthermore, the objective of this study is to focus, not on the ‘disorder’, but on the person. This would aim to enable the researcher to embrace the personal perspectives
of bulimia nervosa situated within social practices and interactions. To achieve this aim and objective, the study asks:

‘How do individuals with past experiences of bulimia nervosa narrate their present selves?’ (Turek & Brown, 2014b, p. 3)

“To answer this research question the method of data-gathering will be open-ended interviews. This method is useful as it allows participants to express themselves freely and openly and provides extensive data for future analysis.” (Turek & Brown, 2014b, p. 3)

The chosen method of data analysis is narrative analysis, as described by Murray (2008a). This way of analysing data was thought of as particularly suitable for exploring the individuals’ views of themselves, as it is through narratives and the use of language that we actively produce the knowledge (Burr, 2003) and make sense of ourselves and the world around us (Murray, 2008a). In this respect, we, not only use language to reflect, but to actively construct our experiences in their historical and social contexts through the interactions with others (Burr, 2003).

**The Rationale for the Research Method Chosen**

In this section the rationale for choosing narrative analysis is presented. Before choosing this method the researcher considered several other methods of approaching this study: grounded theory, discourse analysis, thematic and structural analysis.

Narrative analysis (Murray, 2008a) was chosen over grounded theory (Charmaz, 2008) because grounded theory (Charmaz, 2008) predominantly focuses on developing theories which was not the aim of this study. Furthermore, as described by Charmaz (2008) grounded theory is mostly used to study individual processes and relations amongst different individuals, and relations amongst individuals and social processes and cultures. This was not in line with the aims and objectives of this study, which were focused on exploring the ways in which individuals who have
experienced bulimia nervosa talk about themselves in the context of their life experiences.

Discourse analysis in the form of discursive psychology was rejected because it predominantly looks at how individuals use discursive resources and with what effect. It emphasizes the role of psychological processes as discursive actions and the individual use of language as a way of managing personal interests (Willing, 2008). Furthermore, Faucauldian discourse analysis was rejected as its main concern rests with the use of language and its role in the social and psychological world. It examines positions of power, social processes and the availability of different discourses in different social contexts—what, when and by who can be said. It also focuses on the ways individuals’ position themselves in the social world and the implications this has on their experience and subjectivity (Willing, 2008) which was not the focus of this study.

Furthermore, thematic analysis was rejected because it predominantly focuses on the content rather than on the way the narrative is being said (Riessman, 2008). As much as the proposed study was interested in the content of the participants’ narratives, its main aim and objective was on the way individuals narrate their present selves. Similarly, Structural Analysis was also rejected because of its focus on the form, the way narrative was composed and its structure rather than the way an individual narrated their story (Riessman, 2008).

After considering different ways of approaching this study, the researcher chose narrative analysis as the most suitable method to explore the research question. Studying narratives has been increasingly recognised in social sciences as a way of understanding individual meaning-making in the ever changing world (Murray, 2008a). However, as there are several ways of analysing narratives, in the next step the researcher considered which method was the most suitable for the purpose of this research. The process and rationale for choosing narrative analysis, as described by Murray (2008a), rather than any other approach to collected narratives, is presented below.
The Rationale for taking the Narrative Analysis Approach

Prior to choosing the approach to narrative analysis, as described by Murray (2008a), the researcher considered other available approaches to analysing the narrative/autobiographical data.

Firstly, the researcher considered the approach to analysing narratives as described by Catherine Kohler Riessman (1993). However, this method was rejected as its main focus was on analysing why individuals tell the story in a particular way, and also focused more on the performative aspect of individual narratives. This approach to analysing data was different from the aims and objectives of this study, which focused on analysing the ways, rather than the performative character, of narratives.

The researcher also considered analysing the collected data using narrative analysis as described by McAdams (1993; 1988). However, this approach was also rejected because of its specific focus on particular features of individual narratives and, by doing so, limiting possible interpretations. By using this method of data analysis, the researcher is able to conclude the state, maturity and integrity of a person’s identity (Laszlo, 2008). However, drawing conclusions regarding the state or other attributes of individual identity from a story they told was not consistent with the aims and objectives of this study.

More so, the researcher considered Rosenthal and Fischer-Rosenthal’s (2004) way of analysing narrative data. This approach analyses the actual life events and the story as it is narrated by an individual in the ‘here and now’. It considers the formation of different types of narratives and the differences between the two levels of narrative - the actual story and the way the person narrates it (Rosenthal & Fischer-Rosenthal, 2004). This approach was thought to be unsuitable because it seeks to trace the process of the formation of life stories rather than focusing on the way a person narrates their present sense of their self and orients this to the listener/reader (Rosenthal & Fischer-Rosenthal, 2004).

After considering these three main ways of analysing narrative data, the researcher came to the conclusion that narrative analysis, as described by Murray (2008a), was
the most suitable way of analysing individual narratives and was in line with the aims and objectives of this study. It focuses on the person rather than the disorder, and on different ways in which individuals make sense of their experience of bulimia nervosa in the context of their lives. Furthermore, the main task of narrative psychology (Murray, 2008b) is to explore personal stories for the insight they provide into the actual experiences and into the identity of the storyteller. Murray (2008b) believed that people choose what stories to tell and what stories not to tell and, in doing so, they actively construct their own identities. In this respect, narratives have a crucial part in the construction and maintenance of self-identity (Murray, 2008b). Therefore, choosing narrative analysis, as described by Murray, enabled the researcher to develop a deeper understanding of how individuals with past experiences of bulimia nervosa make sense of their present selves in the context of their past and present experiences embedded within the cultural and relational context. Language, in this understanding, is a tool with which people actively construct their experiences through social exchange and within interactions.

Investigating various aspects of bulimia nervosa experiences seems to be particularly important to counselling psychology. This is because bulimia and distress around food is a social problem which has significant relational and social aspects, and might be seen as an individual attempt to express what is “otherwise inexpressible” (Shneider & Fitzgerald-Pool, 2005, p. 59). These aspects are at the heart of counselling psychology. Therefore, it is the counselling psychologist’s responsibility to deepen the understanding of this growing social problem and the impact it might have on individuals. In this respect, this study, by exploring the way individuals who recovered from bulimia narrate their identity, has the potential to impact counselling psychology practice by making professionals aware of multiple ways in which identity can be created in the social contexts and its different meanings (Kashubeck-West & Mintz, 2001). This further has the potential to develop more effective ways of supporting individuals affected by bulimia and promote their wellbeing.
Method
To recruit participants to this study the researcher employed a purposive sampling strategy to ensure that the recruited group of participants consisted of individuals for whom the subject of this study had personal significance (Smith & Osborne, 2007). The researcher aimed to recruit six participants. By focusing on a small number of participants, the researcher aimed to provide in-depth, detailed accounts of participants’ understandings of themselves in the context of their bulimia and, by doing so, to provide a useful insight into the subject under investigation (Smith & Osborne, 2007). The inclusion criteria for this study required participants to be recovered from bulimia nervosa and over 16 years of age. The criterion for ‘being recovered’ was defined as a self-expressed experience of recovery which was further clarified as not engaging in the binge-purge cycle and/or other obsessive behaviours that aimed to control weight. Participants took part in the study voluntarily and were informed about the subject and confidentiality of the research. They were also asked to sign a consent form agreeing to participate in this research and a consent form for the recording of the interview.

Six participants were recruited. Their age varied from 17 to 35 years old. They had been recovered from bulimia for between one and five years. There were five women and one man. Five participants had paid jobs and one was in full time education. Two participants lived with their parental figures and four participants lived with their husbands/partners. All participants were born, brought up and lived in the UK. They all came from different parts of the UK (London and outskirts, Midlands, north, northwest).

Ethical Considerations
The researcher applied for and received a favourable ethical opinion for this study from the University of Surrey, Faculty Ethics Committee (Appendix 1). This means that this study met the Faculty of Art and Human Science criteria for conducting research with human participants by presenting its academic integrity and ensuring full respect for the people involved in the project. It also achieved this by being explicit and transparent in all aspects of conducting this research.
More so, this research adhered to the *BPS Code of Human Research Ethics* (The British Psychological Society, 2010) and *HPCP Guidance on Conduct and Ethics for Students* (Health and Care Professions Council, 2012). At all stages the researcher ensured and informed participants about the anonymity, confidentiality and the right to withdraw from research right up until the end of the interview meeting. The researcher also ensured that all participants were treated with equal dignity and respect. Due to the nature of the topic, participants were informed about the ability to refuse to talk about anything they might find distressing or uncomfortable without any implications or negative consequences. The nature of the research was fully explained to the participants and any emerging questions were answered prior to conducting the interview. Participants were also informed about the possibility to contact the researcher after the interview should they have any further questions or concerns. After each interview, the researcher spent about five to 10 minutes debriefing the participants to ensure they felt happy with the way the interview had gone and that there were no residual feelings. The researcher also offered to share findings with participants, for which all participants expressed their interest.

**Procedure**

Initially, the researcher contacted people who had previously expressed their interest in participating in a study exploring bulimia nervosa. From this initial stage of recruitment, the researcher recruited two participants. In the next stage, the researcher contacted participants who had taken part in the researcher’s previous study (Turek & Brown, 2014a) and who gave their permission and expressed their interest in taking part in future research. From this process, the researcher recruited a further four participants. So, altogether, the researcher recruited six participants to this study: two new participants and four that had taken part in a previous research project. All participants voluntarily took part in this study and were interviewed between January and May 2015.

For confidentiality purposes, all the participants’ names were changed and were randomly assigned as: Natalie, Rosie, Olivia, Ben, Lucy and Emily. All prospective
participants received information about this study via email (Appendix 2) and, after clarifying any emerging questions and participants confirming their interest in taking part in this study, the researcher and participants agreed on a mutually convenient place, date and time for the interview meeting. Before the recording started and during the interview meeting, the researcher explained, again, the nature and purpose of the study and encouraged participants to ask questions. After clarifying these questions, consent forms for the research were obtained (Appendix 3, Appendix 4).

The study used a one-to-one life-story interview as a method for data-gathering (Murray, 2008a). This type of interview aimed to allow participants to express themselves freely and openly and, by doing so, provide the researcher with extensive accounts of individuals’ lives and rich data for future analysis. This way of data-gathering enabled the researcher to conduct an in-depth exploration and analysis of the way participants perceived themselves at different times of their experience of bulimia and the way they narrated their identity. In order to encourage individual voices to come to the forefront, the researcher aimed to retain a neutral stance throughout the interviews (Murray, 2008a).

Each interview took approximately 60 minutes and was started by the researcher asking the participant an open-ended question: ‘Could you please tell me about yourself?’ This was followed by more specific questions related to the participant’s narrative (for the research interview schedule, please see Appendix 5).

Upon completion of the interviews, the researcher collected and stored all the unedited data securely. The only other person that had access to the full data gathered was the research supervisor. All the data was placed on a password-protected laptop. Any data used in the research report was edited for confidentiality.

To minimise the risk of any adverse effects of this research on participants, before starting interviews the researcher asked the participants if there were any distressing memories that might be triggered by the interview. This was because conducting such in-depth interviews carries the risk of bringing back memories or thoughts which participants may not have extensively thought of before. All participants stated that
they felt OK to proceed with the interview. The researcher also informed participants of the possibility to decline answering a question or withdraw from the study at any time, if it felt uncomfortable, without there being any negative consequences.

Credibility of the Study
Conducting an in-depth one-to-one life-story interview (Murray, 2008a) and analysing the collected data requires an active involvement from the researcher at all stages of the research project. In this process, the participant and researcher co-create meanings and are both affected by the process of the interview (Murray, 2008a). Therefore, it is vital for the researcher to reflect on her own contribution to the research project and the impact that her presence and assumptions might have had on the data gathered and subsequent findings. Reflections on these were captured in the additional reflective paper (Appendix 6).

The researcher followed Yardley’s (2000) framework to ensure the high standard and credibility of this qualitative study. Firstly, the researcher expressed sensitivity to the context of the proposed study by acknowledging the existing literature and research on the topic under investigation. The researcher also reflected on and considered the socio-cultural context of this research and its active role at all stages of the research process, as described above. Furthermore, the researcher expressed commitment and rigour during the process of data analysis by adhering to Murray’s (2008a) guidelines of analysing the narrative data and detailed planning of the study. Transparency and coherence (Yardley, 2000) were also demonstrated in the detailed description of all stages of the research process. More so, all research findings have been grounded in the actual interview data. In this way the researcher aimed to enable the reader to track the interpretations back to their source and, by doing so, ensure that the logic behind interpretations were made explicit. In this respect, the researcher also ensured that the outcomes of this study were the subject of ‘comfirmability’ (Mertens, 2010, p. 19) and, once published, could also become a subject of wider outside scrutiny (for details of the chosen journal, please see Appendix 7). The impact and importance of these research findings is demonstrated in the context of existing literature. Moreover, its
contribution to counselling psychology is acknowledged throughout this report (Yardley, 2000).

Data Analysis

The interview method used was life-story interviews which allowed the researcher to collect extensive accounts of individual life stories (Murray, 2008a). Participants were informed about the topic of the study. They all, in different ways, talked about themselves in relation to their bulimia and its role/presence in their lives. This created a large quantity of rich and in-depth data. The collected data was analysed using Murray’s (2008a) guidelines on conducting narrative analysis.

Three of the recorded interviews were transcribed by the researcher and the remaining three by a professional transcriber. The process of data analysis was divided into two stages: descriptive and interpretative. Firstly, the researcher engaged in the descriptive phase. This phase comprised of the researcher familiarising herself with the data collected by reading and re-reading the transcribed interviews (for an interview example please see Appendix 8). At this point the researcher highlighted parts of the interview which were of relevance to the researched topic. The researcher prepared summaries/synopses (Murray, 2008a) of each interview. These outlined the aspects of each narrative which related to the topic of this study.

After preparing all synopses, the researcher read the transcripts and synopses again, in order to ensure that the prepared synopses captured all relevant information. Next, in order to organise this large quantity of data and prepare it for further analysis, the researcher decided to arrange each synopsis chronologically and divide it into three parts: beginning, middle and end. The researcher looked for patterns, subplots and links that connected different parts within each narrative. The researcher also looked for the main themes, images and metaphors underlying the values and beliefs, and the way participants in each narrative oriented their stories to the listener (Murray, 2008a).
Next, the researcher read several times across different synopses and identified the main issues, themes and patterns present across all the different narratives and, by doing so, developed a ‘coding frame’ (Murray, 2008a). This coding frame took the form of a chronological life story which captured the main issues raised across different narratives and also highlighted specific issues present within each narrative. A coding frame developed in this way can be then applied to different narratives as it captures general and more specific issues (Murray, 2008a).

Secondly, the researcher embarked on an interpretative stage of analysis and began developing in-depth interpretations of the way participants narrated their present selves and relayed their stories; the way they talked about themselves through their stories and how they subsequently oriented themselves towards their bulimia.

The researcher analysed the narrative structure using Gergen and Gergen’s (1986) classification. This classification divides the way stories are told into three categories of: ‘progressive’ - where the individual described progression towards achievement with a sense of improvement; ‘regressive’ - where they described difficulties in achieving and the existence of obstacles; and ‘stable’ - where there was no change. The tone of narratives was further identified according to their structure into progressive positive or regressive negative (Murray, 2008a). The researcher decided to use Gergen and Gergen’s (1986) classification as it has been regarded as a useful analytic tool (Murray, 2008a). It was also previously indicated in the literature that some individuals who recovered from bulimia nervosa described their recovery process using metaphoric language. They described their recovery from bulimia nervosa as a transformation, achievement and victory over the disorder, coupled with a contradictory view of their bulimia as a chronic disorder. Their findings were discussed in reference to the object relations theory and the splitting mechanism (Elran-Barak et al., 2012).

Concluding from these studies, the researcher thought that Gergen and Gergen’s (1986) typology would be the most suitable in analysing ways in which individuals who recovered from bulimia nervosa narrated their present selves.
The way the researcher chose to organise and present collected data aimed to focus on narrative accounts and reflect the nature and character of the life stories collected. This way of approaching and organising data reflected what Murray (2008a) described as a flexible use of theoretical assumptions by letting the data shape the subsequent findings rather than imposing the framework or simply describing the narrative accounts.

Findings
This section presents findings by, firstly, highlighting patterns, themes, metaphors and underlying values and beliefs which participants expressed in their narratives. In this respect, to capture these co-occurring patterns present in all narratives, rather than choosing one paradigmatic case out of six (Murray, 2008a), the researcher decided to present the findings by using the coding frame developed based on all six cases. In this way, rather than prioritising one personal story or one person’s meaning over others, the researcher enabled all the voices to be heard as equally valued and important. This was in line with the social constructivism paradigm (Burr, 2003) employed in this study, which advocates that no opinion, experience or idea is more ‘true’ or ‘valuable’ or more ‘representative’ than others, but they all bring valuable insights and perspectives to the studied phenomenon. Furthermore, the researcher decided to present findings in this way as it appeared impossible to understand the ways in which individuals narrated their present selves without the coherent background of their life stories.

Narrative Structure and Content
There were commonalities in the structure of the participants’ narratives - the participants’ tones and the shifts present across the narratives. In response to the scheduled question, participants talked about themselves and their bulimia in the context of their family and culture. Individuals described various difficulties during their experience of bulimia. However, this all led to victory and a sense of achievement. In this respect, their narratives had a progressive structure (Gergen & Gergen, 1986) and a positive tone (Murray, 2008a). Participants established a timeline
from being moulded by parental and wider social contexts, pressures and influences, to then beginning to question these and embark on redefinition and renegotiation of an identity that was felt confused or ambivalent in the past. The narratives expressed the way participants thought of their identities as being shaped throughout their interactions with the world before and after their experience of bulimia nervosa. More so, all the participants’ narratives described important turning points as key experiences that had impacted on them, and these marked shifts in the tone of their narratives.

All the participants’ narratives showed different timelines which the researcher organised chronologically into beginning, middle and end, and highlighted the common patterns across all data, which can be seen as a core storyline: 1) The Family Context: a Formative Ground; 2) Developing a Mask; and 3) Redefining the Self. This storyline was formed by further patterns which reflected different timelines in individual narratives. More so, after establishing timelines for each narrative, the researcher found that these narratives had no clear ‘end’. Rather, narratives were left open to further construction and reconstruction in the light of growing understanding, different social interactions and multiple possibilities of reinventing one’s identity through narrative.

In their narratives, participants emphasised the sense of triumph and victory over bulimia and emphasised the sense of growth as a person based on their experiences. However, they all did it in a slightly different way. Rosie talked about ‘being a different person now’, whereas Olivia and Ben emphasised ‘returning back to the person they were before bulimia started’. Furthermore, Emily, Lucy and Natalie talked about ‘bulimia being a part of them’. These three main orientations identified in the individuals’ narratives represent possible ways in which they made sense of themselves and their experiences and narrated their present selves. These different stances are presented by the picture below (please see Picture 2 for details).
The family context as a formative ground
- The beginning: bubbly and happy persona
  - Having to grow up quickly
  - Emotions are weakness
- Being what others want me to be, just to be loved
- Comparison with others and experience of rejection
  - Experience of rejection

Putting on a Mask
- The middle: bulimia as an outlet for imperfections
  - Shame and guilt
  - Feeling deceived

Redefining Self
- The end: dealing with social pressure

‘Returning back to the person they were before bulimia started’

‘Being a different person now’  ‘Bulimia being a part of identity’

*Picture 2: The way individuals with past experiences of bulimia nervosa narrated their present selves*

This picture presents the core storyline and the different ways in which individuals narrated their present selves in the context of their bulimia. Bulimia was described as an integral part of them which was intertwined in all their experiences in everyday life. In this respect, all participants narrated their present selves by closely linking it with their past, and either placing their current self in contrast to or in line with their past.
1) The Family Context: a Formative Ground

This first pattern reflects the beginning of most narratives. All participants indicated the family as the initial environment where their first dialectical interactions with the world took place. Not surprisingly, participants felt their family to have a strong influence on them and explained how the family shaped their first thoughts, ideas and values and how their identities emanated from these interactions. In this respect, participants talked about parents and family history as a formative ground. While talking about their parents, five out of six participants described them as ‘perfectionists’, ‘high achievers’, ‘working long hours’, ‘never being there’, ‘having high ambitions’, ‘constantly climbing’, ‘trying to be better than what s/he started as’, ‘being very successful, driven’. How these descriptors played a role in the participants’ identities is described below.

The beginning: bubbly and happy persona

In their narratives, participants situated the beginning of their identity development in their childhood. At that time, through interactions with others, they started developing an idea of themselves. They used words like ‘happy’ and ‘bubbly’ and ‘seen by others as excitable’ when referring to their childhood. They talked about being seen as ‘jokers’ and ‘the heart and soul of the party’ by people around them. Olivia expressed how easy it was for her to meet new people and strike up friendships:

“As a child I would do anything, I would go anywhere. My mum and dad always joked (...) They said I didn’t know anyone at all and I was just like, ‘Go, I’m fine,’ and that was me. I would talk to anyone; I would make friends with anyone. I always made friends easily.” (Olivia)

Participants’ narratives implied that these comments were expressing positive qualities valued by the people around them.
Having to grow up quickly

Although participants described themselves as bubbly and happy, they also noted that they had to ‘grow up quickly’. They thought that the atmosphere at home and their responsibilities demanded that they adopt a more ‘grown up’ identity. They took various roles within their family and learned from their parental figures the importance and value of hard work. They talked about expectations others had of them and feeling obliged to fulfil them, wanting to ‘be better’, ‘stronger’ so that the family could rely on them and be proud of them. Olivia recounted this:

“I grew up in a family, my dad was a very hard worker; he wasn’t there very often. My parents had a business so, even as a child, I had to be quite grown up, because the business was run from the house. We had rules for answering the phone, so it was quite strict. Even as kids, we had quite a lot of pressure on us.” (Olivia)

Natalie talked about her experience of responsibility for others:

“(…) when my parents divorced, at that point my mum was in bits, so I took over quite a lot; I grew up quite quickly. I kept things together because I had to and I knew that I couldn’t do what she was doing, I think, because we couldn’t have two of us like that (...)” (Natalie)

Also Ben described how he had to act more maturely than he thought other children his age acted:

“I had to take the responsibility for granddad and grandma because there wasn’t anyone to look after them. So it was all on me.” (Ben)

In his narrative it was linked with feeling grateful to them for looking after him and wanting to be a perfect son to them.

Emotions are weakness

Furthermore, and in some cases as part of this reaction to their perceptions of having to grow up quickly and take on various responsibilities, participants described how
they began controlling their emotions in order to cope with outside demands. Participants, in these early stages of their lives, came to see ‘emotions as weaknesses’ and as ‘a negative feature of their personality’. They talked about having a conviction of it being good to always be in control of emotions. Rosie’s words captured what other participants also described in their narratives:

“(…) I think my family and my culture around me, you didn’t cry. From such a young age, I was kind of the person, even from really young, I’d fall over and get back up. My parents would be like, ‘She doesn’t cry, it doesn’t bother her, she just gets up and gets on with it. So I think I also had that kind of thing around me.” (Rosie)

And later Rosie also added:

“(…) You don’t let things affect you. Even if things affect you, you shouldn’t show it. It was schooling as well, being that better person. You don’t want to be that person in class who is the cry baby and, ‘Oh, she’ll cry over anything.’ So it was trying to be that good enough, if that makes sense (…).” (Rosie)

**Being what others want me to be just to be loved**

From these experiences of being moulded by the societal context and interactions, participants’ narratives reflected their belief and desire to become what the parents and others wanted them to be in the hope of being praised, attracting love and attention. Reacting like this was described as a ‘modus operandi’ in these first years. Natalie talked about wanting to be like her dad and please him to get closer to him:

“(…) So, I’ve always thought that my interests (…) were because my dad liked them and I always wanted to be close to my dad”. (Natalie)

And later she also adds:

“So I always try to put myself into what he expected. I pushed myself at uni, not for me but for him. When I got my degree that’s the first time I can remember him
saying, ‘I am proud of you.’ (...) I’ve always wanted to fit directly into his little mould that he made (...)’” (Natalie)

Also Olivia talked about her belief that if she was perfect then her dad would not be so absent from her life:

“If I’m perfect, maybe he won’t go.” (Olivia)

Others, however, talked about feelings of ‘not being good enough’, and ‘never meeting others’ expectations’. Rosie’s narrative captured this:

“(…) Even from school reports coming back when I was a lot younger. I used to get quite high grades like As, and I remember having one C and, when I gave my mum the report, the first thing she pointed out was the C. (...) So I think it’s little things like that, that are kept in my head and fuelled it a bit (...)” (Rosie)

**Comparison with others**

In this primary social context, whilst their ideas, values and beliefs about themselves were formed, they also described comparing themselves with others (siblings, friends, others) which further served them as a source of who, how and what they should be like. In the face of this search for identity, participants also talked about a constant search for reassurance and acceptance from their parental figures, friends, and teachers. Rosie described this in her narrative:

“(…) I think it was a contribution of people wanting me to be a certain way (...) it’s like you almost have to be that perfect person. I think, when I didn’t reach that or, somehow, was seen as not perfect, it just really upset me, but then I couldn’t be upset about it. So it was like a circle (...)” “(…) I think I was a person that did seek reassurance quite a lot but didn’t get it. Even at school, it’s hard when you’ve got 30 people in the class and you’re trying, and, I don’t know, I just needed extra reassurance constantly (...)” (Rosie)
Emily talked about the comparison with her brother, who did well at school, and her having high expectations because of his success. On the other hand, Lucy’s narrative described a specific culture which she experienced at her school - an all girls’ school attended by high achieving girls from influential backgrounds. She talked of it being a highly competitive culture with eating disorders being something that everybody did and knew about. She said that, in order to ‘fit in’, she dieted and, subsequently, developed bulimia. She described how it made her believe that ‘it was normal to throw up food after each meal’ or ‘not eat at all’.

**Experience of rejection**

These early experiences of being moulded by the societal context and interactions also had a distressing dimension. Some of the individuals’ narratives emphasised the experience of being bullied, of social exclusion and of ‘not feeling like fitting in’. They talked of how this influenced their perception of themselves and further moulded them to ensure they were not rejected again. Natalie captures this experience:

“I never felt worth enough or important enough to matter, because I was bullied throughout school, pretty much, and I had lots of friend trouble. I never felt like I belonged anywhere, so it’s really important to me that the people I did like stayed (...)” (Natalie)
2) Putting on a Mask
The second pattern, which was the part of the narratives describing the development of bulimia, was closely related to the first one and captured the further development of personal identity, which felt confused and ambivalent. Participants expanded on how, through interactions with the wider world, they were becoming more and more socially aware of what was accepted and expected of them in various contexts. Natalie talked about how she adapted herself to people around her to meet their expectations:

“I try to be a bit like a social chameleon (...). It’s how I make sure that I don’t end up rejected, that’s all, is how I make sure I fit into that group.” (Natalie)

And further she describes her ‘perfect self’ which she presents to the world as:

“Confident, put together, organised, able to tackle anything, clear goals, driven, secure, settled, without any emotional problems at all (...)” (Natalie)

This ‘mask’ aimed to cover up something that they thought of as their ‘faulty’ self. Rosie expressed how she used a bubbly and happy identity to mask her real feelings:

“For me, I just wanted to mask how I actually felt (...) I wanted people to have the impression that I was OK. So I just carried that in my head, ‘OK, I need to seem OK, so I need to act in this way. Because, from a very young age, everyone said, ‘Oh, you’ve got such a bubbly personality.’” (Rosie)

The way this mask played a role in the participants’ identities and their understanding of themselves in this context is described below.

The middle: bulimia as an outlet for imperfections
In this process of masking their feelings, participants’ narratives expressed feelings of ‘becoming so false’ that they felt as if they were losing touch with themselves and reality. Rosie talked about ‘putting on a performance every day’, because she was so scared that, if people saw how she really felt, they would hate her and reject her. The
participants described bulimia as being a part of them, helping them to cope. It was also expressed as ‘my secret life’. Olivia talked about it as her:

“(…) secret weapon against everything that is going on (…)” (Olivia)

Furthermore, participants characterised bulimia as a ‘balance off’ which outweighed the pressures of others’ expectations. It was also defined as the only moment when they did not feel perfect; bulimia was their ‘secret imperfect self’ over which they felt they had ‘perfect control’. Within time, participants described losing this control and becoming more aware and ashamed of it. Bulimia started representing their ‘weaknesses’; the part of them which was ‘faulty and emotion-driven’ and which they could not stop: ‘It was me at my ugliest’. Participants talked of feeling ‘exhausted all the time’ and ‘tired of pretending’ to be someone else. This made them gradually withdraw more and more from interactions with people.

**Shame and guilt**

This mask aimed to cover up the ‘faulty self’, which was perceived as shameful and epitomised all the imperfections which they wanted to hide from everyone. This shame, often being seen as ‘faulty’, prevented them from telling anyone about their struggles. Rosie talked about this experience:

“I just became more and more unwell. I became really unwell because I couldn’t cope with the fact that my secret was out and I thought that people thought those things (...) that people would think I was disgusting for doing it (...)” “(...) I was like, ‘Everyone’s going to think I’m disgusting; everyone’s going to be like, ‘Why does she do that? How strange? How abnormal?’” (Rosie)

Also, Olivia described how telling her partner about her bulimia made her feel ‘like her shame doubled’. She experienced being watched by him and started lying to him, which made her feel more ashamed and guilty and pushed her even more into bulimia.
Feeling deceived

As participants described struggling with their identity and trying to balance outside pressures, responsibilities and the demands of being seen as perfect, together with increasing struggles with bulimia, they also began realising the costs of maintaining their mask and ‘putting up a performance’. Participants talked of gradually realising that this perfection which they strived for was an impossible standard. In the face of becoming disillusioned with what they believed in, participants began a process of re-evaluating their thoughts, beliefs and actions. Emily described not realising that purging did not get rid of all calories and that ‘once she realised, it opened her eyes to how pointless what she was doing was’. Also, Rosie thought that glossy magazines, which were promoting people who lost a lot of weight in a short space of time, made her believe that it was OK to diet and lose a lot of weight. Ben talked about regretting all the money he had spent on diet pills and stuff that was promising a lot but never worked.
3) Redefining Self
The third pattern reflects the ultimate part of the interviews in which participants drew on the changes within their identity in the face of their recovery. For participants, who previously put every effort into being seen as perfect, to be ‘discovered’ as ‘imperfect’ was devastating and initially prompted strategies to maintain this desired identity at all costs. However, as being ‘imperfect’ did not meet the ‘ultimate rejection and condemnation’ which they had anticipated, it, instead, initiated the process of re-evaluating their identity in the light of changing dynamics and changing social interactions. Participants described taking new roles, negotiating new identities and responses within their social interactions. This process was described as dynamic, lengthy and gradual, which led to revaluation - finding new values, beliefs and identities. Some of the aspects of this process are described below.

The end: dealing with social pressure
This process of redefining the self seems to have begun when their bulimia became open and they were ‘discovered’ as ‘imperfect’. This initiated a process of rebelling against pressures from outside. Rosie and Olivia expressed their desire to go against the mainstream. Emily’s words captured this attitude:

“I did not have to be this happy-go-lucky person anymore, there was no pressure (...) Nothing was expected of me, like f*** off everyone.” (Emily)

From their experiences and through the process of recovery and redefining the self, dealing with social pressures, learning anew and finding new values, individuals took different stances towards the way in which they thought of themselves. As it was mentioned in the initial part of this section, some participants felt that after recovery they were a completely different person; others thought that their experience of bulimia was an integral part of their identity; and some participants thought that they had returned to who they were before bulimia started.

Individuals narrated their present selves in three ways and these are discussed in more detail below:
Being a completely different person now

Subsequently, Rosie thought that recovering from bulimia allowed her to get to know herself and discover new things around herself:

“(…) The thought that, so many times, walking down shops, looking at calories or making myself sick, when, now, spending the day with my nieces or nephews, it’s like the best thing in the world. I think I value a lot more things now. Through recovering and getting my relationships back, I think that’s been the most important thing. I’ve kind of learnt what I like and what I dislike. For the two years I was really unwell, you don’t have any other activities; you don’t have any other interests apart from food, apart from watching cooking shows and reading about food (…).” (Rosie)

She felt that throughout her life she had pretended to be someone different, always masking her feelings. Recovering allowed her to get to know and accept different parts of herself. She emphasised experiencing new, improved relationships with people and embracing the joy of interacting with other people without needing to pretend to be someone different. She felt that she was a different person now; that all her life and everything that led up towards bulimia was behind her and that she had discovered a completely new self and had a completely new life. She talked about holding different identities depending on social contexts and interactions, and using them flexibly without experiencing obsessive feelings from the past.

‘Returning back to the person they were before bulimia started’.

Olivia and Ben emphasised feeling that they had returned back to the person they were before bulimia started. They described being ‘their happy, bubbly and confident self again’. They talked about returning back to their previous selves, which were not overly worried about what other people thought. Ben described this experience:

“I can be happy again…just like I used to be, joking around and having a laugh…and I meet people without worrying about everything all the time…it’s like I am this kid again” (Ben)
In this respect, they felt that their experience of bulimia was like a break in their identity which they did not want to associate themselves with. Olivia referred to people’s comments, which she used to believe in, and her reaction to them now:

“(…) Everyone is obsessed with food. Everyone is obsessed with eating (…)” “(…) ‘I’m having a pizza tonight,’ and he was like, ‘Well, you’ve worked hard, you can have it.’ I don’t like that attitude. I always had that attitude – ‘Oh well, if I’ve done that, OK, I can have it,’ but you should have it anyway and you should stay healthy”. (Olivia)

She also became one of the few women who practise a dangerous, male-dominated sport. In this respect, she rebelled against the idea that she had to be a certain way.

**Bulimia being a part of them**

Emily, Lucy and Natalie talked about ‘bulimia being a part of them’ and thinking that, although they were not engaging in the binge-purge cycle, they were ‘still careful with food and watched what they ate’ and that ‘their experience of bulimia will always be a part of them’. Natalie thought of her bulimia:

“I don’t think it ever goes away…I don’t think you could ever get over it, because I am still careful with what I eat and I try to watch my calories…but I don’t throw up anymore…” (Natalie)

These three participants thought of bulimia as one of their many identities; they talked about still being conscious of what other people thought of them and the impressions they made on others. Natalie talked about focusing on being fit and healthy instead of destroying her body. In the process of re-evaluating their lives, participants talked about feeling more open to the world and experiences. On the other hand, Lucy described her struggle as being down to society making her think that she had to ‘belong to some category’. When she had bulimia, she was ‘a girl with bulimia’, ‘a skinny girl’. Emily felt that ‘bulimia was her identity’ and recovering from it opened her eyes to many things which she had not noticed before as she had been so pre-occupied with food. These participants talked about realising new values and
meanings which bulimia allowed them to experience. In Lucy’s case it was the realisation of the fragility of life:

“My dad has a terminal illness and I am going to kill myself over food! What a stupid way to die!” (Lucy)

Overall, the participants’ narratives marginalised the role and importance of food, almost treating it as a distraction from the actual problems they experienced in their environment. In their recovery they emphasised the value of relationships with people who did not judge them, withstood their moods and listened to them and their needs rather than imposing their own ideas. They described feeling valued for who they were, not for what they had achieved or the way they looked. This experience of acceptance helped them to accept and value themselves.

Whichever ways individuals oriented themselves towards their experiences of bulimia, all these orientations were fluid and in a constant process of change. This means that these ways of narrating have the potential of being further reinvented, reframed and re-narrated, depending on other experiences and future contexts.

After recovery, ‘the self with bulimia’ was an important point of reference to which they took different stances. Some reinvented their identity and contrasted it with who they were during their bulimia; others incorporated the experience of bulimia into their current identity or, in their understanding, they returned back to the person they were before their bulimia started. Their experiences of bulimia were thought of as a learning curve and a source of growth and personal development. In this respect, they conveyed their stories to the listener as stories of struggle and confusion which led to triumph and victory over their bulimia nervosa. In the final stages of their narratives, participants talked about the future and wanting to give back to society, and to help and share their experiences with others. Murray (2008a) described this phenomenon as a way of developing a community of support but also challenging regressive narratives present in society.
Discussion
The findings from this study support what the vast majority of research in the eating disorders field has already established, particularly feelings of shame and guilt which drive individuals to increased secrecy, alienation (Pettersen et al., 2008) and continuation of their bulimic behaviours (Turek & Brown, 2014a). Participants talked about being aware of the negative social perception of bulimia (Brooks et al., 1998) and also had thoughts about their identity as a person with bulimia. The findings from this research are also in line with findings from Pettersen et al.’s (2008) research, where individuals described leading a ‘double life’ to combat feelings of failure and preserve their dignity. It also confirmed the findings from Bedoya-Hernández and Marín-Cortés’ (2010) study which found that culture impacts the individual identity.

The present study did not confirm the findings which stated that the body and the ‘other’ are the two main horizons in the identity construction (Bedoya-Hernández & Marín-Cortés, 2010). In fact, women in their narratives barely spoke about their bodies and the physical aspect of bulimia. Their narratives centred on various social interactions and the way those impacted on them. The findings from this study also dispute the idea that, while recovering, the individuals reject their ‘false self’, which was created out of societal expectations, and that this is a true sign of their recovery (Morrell-Bellai, 1997).

In this study, during their recovery individuals started acknowledging their feelings and needs but did not reject the identity they had before. Rather, as they were recovering, they embarked on the process of renegotiating their identity in the light of new positive social interactions. Their new identity, therefore, was a mixture of different past and present identities which they had taken throughout their lives.

More so, this study brings a new dimension to the literature of eating disorders. In the field dominated by quantitative outcome studies, this research, in a unique way, encapsulates the individual and the social dimensions of human existence. It highlights the role of positions which individuals take in their social interactions, such as ‘being perfect’, ‘being the responsible one’, ‘being the one in control of emotions’. Employing these positions, not only brought benefits, but also the whole structure of
rights and obligations (Burr, 2003, p. 124). This left them feeling trapped with the emotional commitment of constantly being perfect. Bulimia, in this respect, was narrated as ‘their secret weapon’ and ‘secret escape’ which allowed them to have an ‘imperfect self’ over which they felt they had ‘perfect control’ and was purely ‘theirs’ as opposed to all other identities.

Current literature emphasises bulimia as a way of coping with emotions. However, this research brings further clarification to this understanding of bulimia by highlighting that bulimia, as a ‘secretive’ and an ‘imperfect’ part of identity, counterbalances the constant demands and pressures of social roles which are perceived by individuals as fixed - ‘they must be perfect all the time’. This also sheds some light onto widely described personal struggles to let go of bulimia. It seems understandable, in the light of this study, that bulimia constitutes an integral part of identity which is ‘allowed to be bad’ and brings relief in the face of constant high expectations.

**Limitations of this Study**

This study has a number of limitations. The individuals for this study were recruited through an advertisement and it is possible that they were more likely to share their experiences than people in the general population. More so, the advertisement asked for participants to be recovered and, therefore, participants may have withheld information about difficult experiences or experiences which could portray them in a negative way. Furthermore, two participants did not know the researcher and, therefore, the question, ‘Can you tell me about yourself?’ might be a difficult one for them to answer. Although the researcher explained the nature of the research, these two new participants appeared apprehensive and struggled to talk freely about themselves.

The interviews in this study were, on average, an hour long and limited to one interview. As the process of recovery is a long and complicated one, a one hour interview may not have been long enough to express the breadth and depth of experience and, perhaps, a follow-up interview may have added some further
information. This may have allowed for a better understanding of the perception of the self in the context of bulimia.

The relationship between researcher and participant was also considered (Yardley, 2000). In this research, this relationship was warm and friendly, particularly with those who had taken part in the previous study. This may have made them more comfortable and encouraged their openness, bringing more valuable information to the research. However, this may also have triggered a desire for participants to please the researcher. Additionally, as the researcher was a young female, this may have made the male participant feel more apprehensive about sharing details of his struggle with his identity.

The findings were not discussed with participants mainly due to time constraints. Being able to discuss these results may have brought some additional, useful thoughts and meanings to this research.

More so, regarding narrative analysis, it is often criticised for its lack of cohesive methods of data analysis, which may have affected the findings and the trustworthiness of the research (Rhodes, 2012).

**Implications for Clinical Practice**
These finding are very important and relevant to counselling psychology as they emphasise, not only the role of social interactions and the life context on the individual’s experience of bulimia, but, more so, they highlight social dynamics which might be present in the therapy room. In this way and enriched by this knowledge, therapists might develop more meaningful ways of supporting individuals who experience bulimia nervosa by promoting a different quality of relationship and, through doing so, encourage individuals to re-negotiate the various positions they have been holding in society. In this respect, it seems important to consider involving families in the treatment of the individual who experienced bulimia. This could direct treatment away from focusing purely on symptom reduction to a more holistic and non-judgemental understanding of an individual.
These findings are also important for counselling psychologists as eating disorders seem to be overseen and neglected by this profession. Therefore, it is highly valuable to deepen our understanding of distress experienced around food, as for many individuals it might reflect deeper relational difficulties.

**Future Research**

It seems that, although there has been extensive research carried out in the field of eating disorders, these are predominantly of a quantitative nature and aimed at measurements of effectiveness of therapy. Therefore, future research exploring experiences of bulimia amongst other individuals, such as ethnic minorities or stigmatised groups, might shed more light onto other aspects of identity. Understanding these could enable us to create a more multidimensional understanding of personal contextual experiences of bulimia nervosa. Also, it would be interesting to explore the identity of individuals who are in treatment and/or have dropped out of treatment, and identify ways in which they narrate their identity and make sense of these experiences.
References


Turek, A., & Brown, D. (2013). *Eating disorders: A review of the literature with the emphasis on an individual experience of bulimia nervosa and the help seeking process*. Literature review submitted on 14th July 2013, as a part of PsychD in Counselling and Psychotherapeutic Psychology award at the University of Surrey, Guildford.


Self-reflection

In the process of analysing personal narratives, the reader is an active co-creator of the story. In this instance, I reflected on the impressions evoked by the stories throughout the data collection and analysis process. These reflections informed my investigation and subsequent findings as the narrative analysis is not a passive process but involves an active engagement of the researcher (Murray, 2008).

Conducting my research last year and listening to accounts of the experience of individuals seeking help for bulimia helped me realise what a complex, multidimensional and relational experience it is. Listening to different experiences of seeking help for bulimia nervosa made me think, not only of the power of shame and guilt, but also the importance of the relational aspect of bulimia. It made me realise how relationships and others’ attitudes can have a powerful effect on individuals. Listening to these stories opened my eyes to the extent to which social interactions and information gathered through these interactions influences personal behaviour. While writing my research report last year, I felt that the changes within individuals happened predominantly through and within their interactions. These interactions were perceived as having different qualities and were described as full of understanding, support and acceptance.

This influenced my idea for this research project - to explore how people narrate their fragile and sensitive identity after the secret of their bulimia is revealed. I realised that the majority of findings in the literature were explaining recovery as a process of change inside the person, but did not pay much attention to the social roles, structures, interactions with others and the wider interpersonal context. As the interviews I conducted last year inspired me to proceed with this research project, I decided to contact individuals who took part in my previous study. Meeting with them again and hearing how their life had changed over the past year made me feel pleased and inspired by their strength.

Therefore all these dynamics presented above influenced my attitude while conducting this study. Prior to my first interview, I thought about the role that shame and stigma play in bulimia and the assumption that it is very difficult for individuals
to overcome these feelings. I was curious as to how they may have done this. My first participant talked with pride and joy about how she had managed to survive and overcome her bulimia and how she has since been an active eating disorders’ campaigner. I experienced her narrative as an enthusiastic victory which was reflective and constructive, building on past experiences. I was impressed with her strength and resilience. A similar positive tone of victory and pride was present in the other narratives from my previous participants and I was amazed at how much they embraced their experiences and grew out of them.

These experiences made me re-evaluate my own assumptions that the stories would be full of shame, guilt and stigma, with the desire to completely separate from bulimia and reject past experiences. On the other hand the interviews with the two new participants made me step back again and reflect more deeply on the way personal familiarity, or the lack of it, may have impacted on the way the stories were conveyed to me. Although new participants expressed similar thoughts, they did so in a more settled and guarded way. This is understandable, taking into consideration the research question: “Can you tell me about yourself?” which, as indicated by Murray (2008), might leave participants feeling overwhelmed, wary and uncommunicative. Furthermore, it may take more than one meeting to gather enough in-depth information. However, this was not possible in this instance due to time limitations.

With these new participants, I feel that my therapeutic skills came to the fore. I used prompts throughout the interviews and on several occasions I reflected back and clarified the meaning by asking additional questions. This was not in line with Murray’s (2008) idea that, while collecting narrative accounts, the researcher should present a neutral stance with nods and encouraging remarks but refrain from commentary as it might disturb the personal narrative. This stance was more present with participants who knew the researcher as they appeared eager and willing to freely share their thoughts and did not need much encouragement.

This experience made me more alert to the different ways in which personal stories can be expressed and the fact that, although they all emphasised their sense of pride and victory, each had its own unique aspects. This became an important part of my findings as these impressions shaped my understanding of the researched topic. I
decided to use all narratives because in my perception they are all equally valuable and it was the unique combination of the social and personal dimensions of these different stories that I became so drawn to.

Therefore, the study I presented is a combination of the impressions these stories made on me and the way I made these impressions my own, in order to depict what the meaning different participants attempted to communicate to me. This process reflects the social aspect of knowledge as something that people create together in the process of constant social exchange.
Appendix 2

Research Interview

The interview has been edited for confidentiality: names and any significant details have been changed; I- Interviewer; P-Participant;

I: If you could tell me, to start with, something about yourself?

P: As myself, when I was unwell, I was very… A lot of people would describe me as outgoing, even though I probably didn’t feel it. I felt a lot out of control and I’d constantly almost need to put on a show for people. I don’t know if it was to hide all my insecurities, how I actually felt at the time about myself, because I think, if I focused on my personality and being really out there, people would concentrate on it so they’d be like, ‘That’s the girl that goes out a lot to parties, she’s really fun,’ instead of people commenting on my body. It was kind of like a mask for ages and it was so much energy, because I think, even at home that was the case. I’d wake up and almost step out of bed and breathe and be like, ‘OK, I’ve got to put this big show on now.’

I: Hmm, ok…well…what do you think you did it for?

P: I think it was just how many insecurities I had. I almost wanted to not let people know I had those insecurities, because I just thought, if everyone finds out that I actually struggle with my body image, they’d focus on it and then it would become about that. So I had to try and put on this big show all the time and it was extremely hard. I didn’t want anyone to find any fault in me… I think at that time I wanted to direct it away from the fact that I’d made myself sick. So, I had to make this big show, almost, have a performance every day…it was just the fact that people would think I was OK…that I am what they want…what they expect of me…and because everyone always thought, ‘That’s the girl who’s really happy, she’s really outgoing.’

I: can you tell me a bit more about this ‘girl’?

P: I think that was what I was like from such a young age. I was always quite out there and outgoing. Then, when I started to develop my eating disorder in myself, it was almost like someone took the ground from beneath me and everything. I felt, that was me just completely detached from me… I overemphasised what my personality was like, so I’d be too outgoing, so people just thought I was my normal self. When I first put on the mask of this outgoing person, people did just think I was myself, for me, I just wanted to mask how I actually felt.