AN EXPLORATION OF THE MEANING OF FOOD-RELATED OCCUPATIONS FOR INDIVIDUALS WITH LIVED EXPERIENCE OF ANOREXIA

ESTHER DARK

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Abstract

Background: The occupations associated with food and eating are meaningful parts of our everyday lives and used therapeutically within the domain of occupational therapy in the field of eating disorders. Despite the importance of this, the meaning of food-related occupations has received little empirical attention.

It is argued misconceptions around anorexia hinder effective treatment and form barriers to therapeutic relationships, underlining the call for eating disorder research to further integrate lived experience. Exploring the meaning of food-related occupations phenomenologically can offer much needed insight into the everyday experience of being anorexic.

Aim: The aim of this doctoral research is to generate new knowledge within an area relatively unexplored, considering how individuals with lived experience of anorexia experience and make meaning from food-related occupations.

Objectives:

Explore the meaning of food and eating across time and analyse the wider factors which contribute to these meanings for individuals with anorexia prior to and during treatment, including their current daily experiences.

Critically consider how findings can be applied within occupational therapy practice and inform conceptual understandings around meaning within occupational therapy.

These were achieved through addressing the following research questions:

What are the experiences and meanings of food and eating for those with lived experience of anorexia before and during treatment?

How do individuals with lived experience of anorexia experience and give meaning to food and eating in their day-to-day life?

Methodology and methods:

This research utilised Interpretative Phenomenological Analysis (IPA), rooted in its three philosophical tenets: phenomenology, hermeneutics and idiography. Data was gathered from in-depth interviews with nine individuals with lived experience of anorexia, exploring their experiences of food-related occupations during their illness, in treatment and in recovery. Findings were analysed using the analytical steps of IPA laid out by Smith, Flowers, and Larkin (2022).

Findings:

The research found five interrelated meaning constructs:

1) meaningful doing,
2) meaningful being,
3) meaning belonging,
4) meaningful resisting and
5) meaningful becoming.

Conclusion:

Food-related meanings in anorexia are not haphazard, static, or one-dimensional, rather they serve a purpose; are complex, embodied, dynamic, and culturally situated. Findings support the theoretical concept the dark side of occupation, which contests long-standing notions that occupations are only positive and health-promoting. The findings call attention to the complex and diverse nature of occupational meaning and the importance of including occupational therapists, who have a holistic, and experiential focus, in the treatment of eating disorders.

COVID-19 impact statement

The Doctoral College advises postgraduate research students whose research has been disrupted due to the COVID-19 pandemic and related closures to adjust their project as far as is practicable to mitigate the effects of the disruption. However, despite these efforts, it is recognised that research submitted for examination may still have been affected and that candidates may wish to inform their examiners as to the nature of the disruption and subsequent actions to mitigate that disruption. In such cases, a COVID-19 impact statement may be supplied along with the thesis when first submitted.

> I submitted my application to study at Brighton in 2019, prior to the pandemic and envisaged visiting campus regularly throughout the year. However, following the pandemic and the move to remote working and supervision, this did not materialise. The impact of this placed restrictions on my research engagement with the postdoctoral community including and attending research-related events. Although I have engaged remotely with training, learning and supervision and have accessed library resources via postal delivery, this has not matched face-to-face interactions. As such, I have found the research process at times isolating.
>
> Furthermore, the COVID-19 regulations meant all face-to-face data collection was paused, meaning I had to revise my research from face-to-face to remote interviews. Although interviews were conducted remotely, I feel I was able to collect rich data for my study. Nevertheless, this may have impacted the researcher-participant relationship, embodied observations and what was disclosed by participants. Lastly, there was also issues with connectivity during some of my interviews, which may have led to missing visual cues. These aspects of the research are elaborated on further in the methods chapter of this thesis.

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List of Acronyms

IPA research seeks small homogenous samples. Therefore, participants were recruited by their shared experience of identifying with the term anorexia. However, this does not assume homogeneous meanings within participants' lived experiences. Whilst this thesis used the generalising term 'anorexia', I acknowledge this as a limitation of language, as it is believed no nuanced, or detailed explanation will ever capture the full narrative of living or have lived through anorexia. This research takes inspiration from Lelwica's (1999) comment, who writes anorexia "has become part of this culture's vocabulary… I use the terms because I want to communicate, not because I accept their traditional meanings" (p.16).

Aside from when used in a direct quote, or part of a title, acronyms commonly used in this thesis include:

- Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V)
- Occupational Therapy (OT)
- Eating Disorder (ED)
- Eating Disorders (EDs)
- Atypical Anorexia Nervosa (AAN)
- United Kingdom (UK)
- National Health Service (NHS)
- Evidence Based Treatment (EBT)
- Nasogastric Feeding (NGF)
- Family Based Therapy (FBT)
- Cognitive Behavioural Therapy (CBT)
- Mental Health Act (MHA)
- Interpretative Phenomenological Analysis (IPA)
- Personal Experiential Statements (PETS)
- Group Experiential Statements (GETS)

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I would lastly wish to express my appreciation towards my family, who have kept me grounded, and who have generously offered me unwavering encouragement to continue in my studies. I especially wish to extend my gratitude to my son, who was just weeks old when I naively commenced this PhD and who has waited patiently for his mummy to be fully present again.

Author's declaration

I declare that the research contained in this thesis, unless otherwise formally indicated within the text, is the original work of the author. The thesis has not been previously submitted to this or any other university for a degree and does not incorporate any material already submitted for a degree.

Signed

Esther Dark

Dated

September 2023

1.Chapter One: Introduction

The purpose of this chapter is to contextualise the research, explaining its significance and justification; clarify my relationship towards the research phenomenon and briefly describe anorexia and current treatments, focusing specifically on the profession of occupational therapy (OT). The chapter will also provide a critical review of fundamental historical understandings of eating disorders (EDs) and finally, an overview of the role of food and eating in treatment.

1.1 Significance and Justification for the Research

Anorexia, considered "a spectacle of thinness" (Warin, 2004, p. 97), has been well-researched and documented, conceptualised from multiple perspectives, all holding distinct hypotheses and assumptions (Dell'Osso *et al.*, 2016). Within these diverse considerations, it is considered third-person medical interpretations are privileged over first-person narratives (Gooldin, 2008; Conti, Rhodes and Adams, 2016). Arguably diagnostic definitions of anorexia, focusing on physical symptoms, promote reductive notions of anorexia (Rich, 2006; Eli and Lavis, 2021), where medicalised discourse obscures the complexity of personal meanings. As a research methodology, IPA and its associated philosophies, concerning itself with the detailed examination of lived experience, is a powerful method of inquiry to illuminate meaning, and experience outside of predefined categories (Millman, 2017; Neubauer, Witkop and Varpio, 2019). This can offer a valuable counter viewpoint to that of dominant medical conceptualisations of anorexia, often situated upon positive and empirical epistemologies (Botha, 2015).

There are often implicit assumptions within established treatment models that weight-based recovery is a prerequisite for broader psychosocial and emotional recovery (Munro *et al.*, 2014a). Although cognitive function including flexibility, central coherence, decision making, attention and memory, are impacted by, and contribute to the continued presence of anorexia (Treasure and Schmidt, 2013), improvements following weight gain and treatment are inconclusive (Hemmingsen *et al.*, 2021). Studies show fear and anxieties around food and eating persist (Jenkins and Ogden, 2012) and individuals experience ongoing social, psychological and behavioural distress, creating barriers integrating back into community settings following intensive treatment and maintaining change (Cockell, Zaitsoff and Geller, 2004; Steinglass *et al.*, 2012), highlighting the challenge of an exclusive focus on food and weight in the treatment of anorexia (Rance, Moller and Clarke, 2017; McEntee, Philip and Phelan, 2023).

Although weight restoration via the provision of food in the treatment of anorexia is vital, prioritised to save life (NICE, 2017), eating is not merely a function of biology, it is associated with contextual and social factors (Lavis, 2018), which OT acknowledges (Beagan and Etowa, 2011; Absolom and Roberts, 2011). Therefore, whilst weight gain is undeniably fundamental and undisputed by this research with much literature correlating low weight with poorer treatment outcomes and prognosis (Frostad *et al.*, 2022), alone it is insufficient in achieving long-term meaningful recovery (Barko and Moorman, 2023).

Existing literature criticises the minimisation of subjective experience, overlooking individual voices (Conti, 2015), alternative meanings of food (Boughtwood and Halse, 2008; Lavis, 2018) and the multiple and variable ways individuals narrate their recovery (Conti, 2015). In recent years, recovery-orientated literature calls for greater understanding of the broader variables which contribute to recovery from anorexia (Kenny, Trottier and Lewis, 2022). Significant factors purported to enable recovery centre upon self-acceptance, re-building identity and connection with others (Dawson, Rhodes and Touyz, 2014a; Hannon, Eunson and Munro, 2017), falling outside the rubric of physicality (Conti, Rhodes and Adams, 2016). Although anorexia today is encouraged to embrace a biopsychosocial approach, some suggest the psychosocial equation is minimised, with imbalanced attention given to physical symptoms (Holmes *et al.*, 2017; Eli and Warin, 2018).

Exploring food-related occupations within occupational science is underpinned by the belief that what people do reflects and forms subjective meanings (Wright-St Clair *et al.*, 2005; Knight, 2022). Occupational therapists are one sector of the eating disorder (ED) workforce who may use food therapeutically (Mack, Stanton and Carney, 2023); considered particularly skilled in addressing food-related engagement (Lock *et al.*, 2012; Biddiscombe *et al.*, 2018). Despite this, no research to date has phenomenologically explored the meaning of food-related occupations in anorexia from an OT perspective. Significant, as individual's meaning-making is of central concern to OT practice (Doble and Santha, 2008; Ikiugu and Pollard, 2015). Focusing on meaning-making processes offers opportunity to build deeper relationships with individuals and unlock OT's potential in nurturing wellbeing and personal development (Reed, Hocking and Smythe, 2011; Mello *et al.*, 2021). Therefore, the overall aim of this research was to gain a deeper understanding of the meaning individuals with anorexia place upon their food-related engagement within the context of their life worlds.

It is envisaged findings will contribute to occupational science and OT literature concerning the role of food-related occupations in the field of eating disorders (EDs) and have relevance for practice and theory.

1.2 Situating the Researcher

Finlay writes “Phenomenological research starts with the researcher” (Finlay, 2012, p. 175); indeed, research questions are not created in a vacuum, but are formed subjectively from curiosity and passion. It is, therefore, essential phenomenologists consider their personal values, beliefs, motivations and context to give attention to the phenomena under investigation (Finlay, 2008). This also relates to axiology, pertaining to the researcher’s role and values in the research. As such, I assume the research is value laden and inevitability biased, therefore my pre-conceptions are openly presented.

Reflexivity, described as dialogical engagement in “thoughtful, conscious self-awareness” (Finlay, 2002b, p. 532), is a practical effort to tease out these influences, a tool where “the problem of subjectivity … can be turned into an opportunity” (Finlay, 1998, p. 453). I intentionally and continually applied reflexivity throughout this thesis using Finlay’s (2002a) maps of reflexivity, introspection, intersubjective reflection, mutual collaboration, social critique, and discursive deconstruction as a guide.

> **Introspection**, refers to reflection on one’s experiences, geared towards achieving a better understanding of the phenomenon (Finlay, 2009b). Research is often guided by personal experience, “a passionate concern that calls out to the researcher” (Moustakas, 1990, p. 27). My passionate concern arose from my own lived experience of anorexia, subsequent experiences of treatment and later, professional experience as an occupational therapist working in EDs. My reflexive account is discussed in detail in Appendix 1. Negotiating these positions was a continued “reductive-reflexive dance” (Finlay, 2012, p. 179) moving back and forth between close experience and open awareness (Finlay, 2003a) ensuring I was “seeing with fresh eyes” (Finlay, 2012, p. 175). I was continually aware my frame of reference could skew my situatedness and relationship with participants. However, as an ‘insider’, I equally felt I could understand and connect with participants in ways ‘outsiders’ may miss (Finlay, 2003a). Nevertheless, mindful attention was continually deployed to avoid personal

experience overshadowing participant voice and falling into excessive self-analysis. To ensure primary focus remained on participants, "returning to the self" was only "part of increasing awareness and insight" (Finlay, 2002b, p. 542). Further elaboration of this is found in Chapter Four, methods.

Intersubjective reflection focuses on the relational context of the research, of "self-in-relation-to-others" (Finlay, 2002a, p. 216). Practically, an "attitude of wonder and openness" (Finlay, 2009a, p. 5) is required to truly listen and be open to uncertainty, ambiguity and beliefs which do not correspond with my own. Wertz describes this as slowing down and meditating on the meaning of other's experiences (Wertz, 2005), whilst others describe this as 'mindful' awareness, where researchers acknowledge their shared being-in-the-world (Hesse-Biber and Levy, 2011; Nicholls, 2019).

Mutual collaboration acknowledges research is born from a "co-created, embodied, dialogical encounter" (Finlay, 2009, p.4). IPA seeks to get as close to experience as possible, whilst recognising findings are tentative, emergent and contextual (Finlay, 2009b). To allow space for this, I offered participants follow-up interviews, as well as member-checking manuscripts, ensuring autonomy in how they narrated their stories. As PhDs are solitary endeavours, co-author member checking was absent; however, emerging experiential themes were discussed during supervision, fostering collaboration. Supervision is a relational process supporting reflexivity (Sherwin and Brady, 2022), allowing new meanings to emerge from different perspectives. Not all my supervisors were occupational therapists, which allowed professional language, assumptions and fore-conceptions to be challenged (Montague *et al.*, 2020). A commitment to the IPA analytical process, focusing on idiographic case-by-case analysis before moving onto general themes also ensured "openness" (Gadamer, 1960/2004, p. 271) and avoided reaching understandings "too quickly, too carelessly, or slovenly" (Dahlberg, Dahlberg and Nystrom, 2008, p. 130).

Social critique and discursive deconstruction refer to the tensions and imbalances arising between the researcher and participant, whilst the latter calls attention towards the ambiguities of language (Finlay, 2002a). These positions helped challenge notions of objectivity, take note of the cultural dimensions of research and the multiple meanings implicit in language. Reading feminist critique inspired and encouraged self-reflexivity and interrogated my assumptions and medicalised training, relevant, given the dominant psychiatric and clinical discourse in EDs and power imbalances existing in EDs (LaMarre *et al.*, 2022b). At the same time, I was aware that taken too far that this type of reflection could remove focus away from participants.

1.3 Anorexia

'Eating disorders' are an umbrella term to describe a collection of genetic and socially influenced mental illnesses, impacting physical, social, and psychological functioning, and carrying substantial social, health and economic costs (BEAT, 2015; Feng *et al.*, 2023). The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (APA, 2013) has undergone several modifications, now presenting criteria for eight types of EDs[1]. Although collected and grouped together under one chapter – 'Feeding and Eating Disorders' – the meanings and origins of EDs are vast and unique (Halse and Honey, 2005), with "diseases … defined and redefined" (Brumberg, 1985, p. 98) by their context (Dell'Osso *et al.*, 2016).

Anorexia nervosa, commonly known as anorexia, is one manifestation of an ED, as typified by the diagnostic tools DSM-V (APA, 2013) and the International Classification of Diseases (ICD:11, 2022). Although anorexia was named and described in the 19th century (Gull, 1874), its core features have remained unchanged over the last 150 years (Walsh, Hagan and Lockwood, 2023) and despite increasing research there is much we do not understand about anorexia (Feng *et al.*, 2023). Anorexia is defined as a restriction of energy intake, leading to the maintenance of a low body weight, accompanied by distorted body image and a pathological fear of becoming fat (American Psychiatric Association, 2013; WHO, 2022).

The more recent edition of the DSM changed from what was considered pejorative language of "**refusal** to maintain body weight", and "**denial** of the seriousness of low body weight" (APA, 2000, p. 589) to more neutralised language of "persistent lack of recognition of the

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[1] DSM-V presents 8 eating disorders and feeding disorders: pica, rumination disorder (RD), avoidant/restrictive food intake disorder (ARFID), anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED), other specified feeding or eating disorder (OSFED), and unspecified feeding or eating disorder (UFED - previously recognised as 'EDNOS' prior to 2013, yet still used in literature and practice interchangeably with this term.[1]

seriousness of the current low body weight" (APA, 2013, p. 338). It also modified language of "intense fear of gaining weight or becoming fat" (APA, 2000, p.589) to "persistent behaviour that interferes with weight gain" (APA, 2013, p. 338), to reflect those who do not express weight-phobia as a motive, and hold applicability to young people, who may not have the language abilities to express these specific concerns (Kenny, Ward-Lichterman and Abdelmonem, 2014). It also removed absence of menstruation, to better encapsulate the experience of males, premenarchal females and post-menopausal individuals. Categories were broadened and specified to reduce the number of individuals meeting the previous category 'eating disorders not-otherwise specified' (EDNOS), previously accounting for the majority of clinically recorded EDs (Eddy *et al.*, 2008; Walsh, Hagan and Lockwood, 2023).

In the DSM-V (APA, 2013), individuals with anorexia are subdivided into those with restricting sub-type (AN-R), characterised by fasting; and those with binge-eating/purging sub-type (AN-BP), characterised by binge eating and/or purging symptoms, with severity classified using body mass index (BMI). However, use of BMI is controversial, as psychological and physical symptomology do not always correlate (Surgenor and Maguire, 2013). Furthermore, BMI-based severity ratings arguably fail to identify biological markers of medical concern (Dang *et al.*, 2023).

Under the category of other specified feeding and eating disorders (OFSED), the DSM-V includes the category atypical anorexia nervosa (AAN), which meets all the criteria for anorexia, except significant weight loss, where instead individuals are within, or above 'normal' weight ranges (Birgegård *et al.*, 2023). However, the term 'atypical' has been controversial, considered to be highly stigmatising and invalidating for some and trivialised by healthcare professionals (Birgegård *et al.*, 2023). Despite deemed a 'normal weight', individuals with AAN are at risk of medical instability and have higher levels of ED psychopathology compared to those with anorexia, including greater distress related to body image concerns (Sawyer *et al.*, 2016; Moskowitz and Weiselberg, 2017). Given clinicians have historically used low weight as a primary marker for identifying those with anorexia, individuals with AAN can experience weight stigma and are at risk of delayed treatment and support (Harrop *et al.*, 2023; Loeb, Bernstein and Dimitropoulos, 2023), highlighting the problematics of using weight as a catch-all in understanding anorexia.

1.4 Diagnostic Issues

With the acceptance of socially constructed categories of EDs, the scientific community can employ comparative studies, seeking commonalities and differences and create standardised measures and treatment (Turner *et al.*, 2014; Sysko *et al.*, 2015). However, diagnostics remain contested, with their dimensions and boundaries considered invalidating, binary and marginalising (Botha, 2015; Millman, 2017; Eiring, Hage and Lynn Reas, 2021). With diagnostic crossover and migration relatively common and shared comorbidities, doubt has been cast on their validity (Eddy *et al.*, 2002; Birgegård *et al.*, 2023). Another limitation lies in symptoms emerging only in the later stages of the illness, when the illness is consolidated; thus, hampering treatment (Treasure, Stein and Maguire, 2015). Furthermore, their narrow definitions arguably only reflect a fraction of those who experience EDs (often white, young, heterosexual women) (Halbeisen, Brandt and Paslakis, 2022), which can exacerbate stigma and shame (LaMarre *et al.*, 2022a), and fail to capture the heterogenous nature of lived experience (Strother *et al.*, 2012; Sinha and Warfa, 2013).

Another issue when using diagnostic criteria to define EDs is that they are rooted in the medical model of mental illness which clusters experiences as normal/abnormal, healthy/ill (Radden, 2018), and hinges upon a weight normative approach (Tylka *et al.*, 2014). However, diagnostics are not neutral but contextually and discursively placed (O'Connell, 2023), which may misinterpret and overlook individual difficulties (Hawkins-Elder and Ward, 2020). Critical writers consider EDs to be an extension of normal dieting patterns and feelings of body dissatisfaction experienced by many in Western cultures (Bordo, 2003; Eiring, Hage and Lynn Reas, 2021). Diagnostics are considered to be a social construction, emerging from patterns of perceived behaviours which have deviated from social norms, which are then “reduced to an acronym” (Gelo *et al.*, 2015, p. 109). Although progress has been made in understanding the genetic predisposition in anorexia (Steinglass, Dalack and Foerde, 2019), the purported biological causes of EDs have yet to be identified (Dalle Grave, 2023). Conceptualising EDs as diseases and only biological individualises the illness, reducing the opportunity to explore other functions and meanings and neglects the complex social context in which EDs arise (Malson and Burns, 2009; Dalle Grave, 2023). Lastly, ED diagnostics lack cultural diversity (Halbeisen, Brandt and Paslakis, 2022), with screening and diagnostic tools developed and validated mostly among white women (Franko, 2007). This has led to calls for reclassifying EDs afresh, outside of cultural attitudes and assumptions (Hay, 2023).

1.5 Shifting Meanings of Anorexia

Gadamer states “the horizon of the present cannot be formed without the past” (Gadamer, 2004, p.317). An overview of the historical trends relating to anorexia have been considered in accordance with a hermeneutic approach, which contextualises our understanding in dialogue with our being-in-the-world. Further understood as our embeddedness and inseparability with our historical and social context (Heidegger, 2001; Gadamer, 2004). Through engaging in dialogue with texts, new insights and an integrative understanding of different aspects of a phenomenon can be established (Boell and Cecz-Kecmanovic, 2014). This was not intended to be a deep historical analysis but offers reflexive attention to how context and culture play a role in how anorexia has been framed.

There has been ongoing debate whether anorexia is a distinctly modern phenomena, reaching epidemic proportions within Western industrialised societies or whether it pre-existed medical nosology (Parry-Jones and Parry-Jones, 1994; Habermas, 2005; Dell'Osso *et al.*, 2016). Some older seminal literature considers historical accounts of self-starvation can be retrospectively diagnosed by what we know as anorexia today (Halmi, 1983; Bell, 1985; Corrington, 1986). Whilst others consider secondary historical reports lack validity, leading to uncritical judgements where anorexia is reduced to self-starvation, primarily related to weight, discounting psychological motives (Habermas, 2005). Critical writers appraise retrospective diagnostics as privileging current medical and psychiatric discourses of anorexia as objective and ahistorical truths which discount the cultural milieu in which they are situated (Malson, 1998; Conti, 2015). Ultimately, diagnostics will always be reliant upon the subjectivity and partialities of the diagnoser (Habermas, 2005); therefore, potentially omitting the subjective meanings and experiences of individuals themselves. From a social constructionist perspective, varying perspectives reflect changes in socio-cultural values and beliefs, and the language we have available to us to describe and explain eating behaviours and attitudes at that particular time (Gelo *et al.,* 2015).

Historical cases of self-starvation can be dated as early as the 4th century, where meanings of fasting behaviours were related to ideas of purification through ascetism, contextualised within socio-politico-religious contexts (Bell, 1985; Bemporad, 1996; Jassogne *et al.*, 2023). The fasting female saints of the European Catholic church during the Middle Ages were described as ‘anorexia mirabilis’, deriving from the Latin word meaning ‘miraculously inspired loss of appetite’ (Bell, 1985; Bemporad, 1997). Bell’s (1985) well-cited work, chronicled these accounts as ‘Holy Anorexia’ and cases were characterised as wonders of nature (Lester, 1995). Meanings of self-starvation during this era have been interpreted as symbolic of women’s agency, independence and spirituality within patriarchal institutions and practices (Sukkar, Gagan and Kealy-Bateman, 2017); akin to enlightenment and viewed as heroic ascetism (Vandereycken and van Deth, 1994).

Self-starvation continued to be documented in vernacular folk literature from the 16th to the 19th century, with women described as ‘miraculous maids’ or ‘fasting girls’ (Brumberg, 1985), who utilised food refusal to demonstrate their religious devotion, attracting curiosity of doctors and scientists (Lester, 1995). As time progressed with culture and society becoming more secular, the meaning of fasting moved from the divine, to scientific investigation (Dell'Osso *et al.*, 2016) and accounts were treated with suspicion (Malson, 1998).

Richard Morton is often endorsed as the first physician to describe cases of anorexia in 1689 (Marks, 2019), who viewed voluntary self-starvation as primarily physical in nature, described as “nervous atrophy, or consumption” (Pearce, 2004, p. 192). Interestingly, Erasmus and Darwin considered the meaning of anorexia as a desire for weight loss (Dell'Osso *et al.*, 2016), a view which has continued today. Yet it was Sir William Gull, a London Physician and his French contemporary, Charles Laségue, a neuropsychiatrist, who are cited as coining ‘anorexia nervosa’ within the medical realm (Soh *et al.*, 2010). Whilst Gull described mostly physical and behavioural aspects of anorexia, Laségue put greater emphasis on psychological aspects (Habermas, 2015). Their accounts were generally of female cases, and effective treatment was through ‘moral control’ (Gull, 1873). Gull advocated the use of a “strict feeding programme which paid no heed to the desires of the patient” (Gull, 1874, p. 24). Both considered anorexia as neurosis and hysteria (Simonovic, Gross and Ernst, 2015). Jean-Martin Charcot and his student, Pierre Janet proposed the meaning of anorexia to be psychosomatic, associating anorexia with hysteria and irrationality, reflective of Victorian discourse around women at the time (Hepworth and Griffin, 1990) and considered treating anorexia with hypnotism. Feminists, consider these early medical constructions of anorexia contribute to gendered doctor-patient relations and patriarchal control over women (Hepworth and Griffin, 1990).

Sigmund Freud’s psychoanalytical lens, in the 20th century, drew metaphorical parallels between appetite, sexual drives and conflicts (Lester, 2019). However, his controversial views around sexual development were not widely adopted (Court and Kaplan, 2016). Professor William Osler was the first to recognise anorexia as a distinct disorder, treated best with “a rest and restorative regimen” (Osler, 1899, p. 206). However, anorexia still fell under the umbrella of hysteria. Departing from Freudian understanding, biological explanations became popularised in 1914, spearheaded by Morris Simmond’s research, where anorexia was considered a disorder of pituitary disturbances (Court and Kaplan, 2016). However, by the 1940s, such explanations were considered unsatisfactory and anorexia was considered to be a “physical disorder secondary to a psychological disturbance” (Simonvic, Gross and Ernst, 2015, p.35). Women made up the largest proportion of those diagnosed with anorexia at the time and given the continued lack of ambiguity around anorexia’s origin, were typically placed in asylums (Court and Kaplan, 2016).

Hilde Bruch, well-known for her contributions in psychiatry in EDs, identified anorexia as a self-disorder, relating to deficits in body image, bodily perception, interpersonal relationships, and individuation (Bruch, 1982). She was the first to identify anorexia as a mental disorder instead of abnormal eating behaviours in the 1960s (Treasure and Cardi, 2017). Her teachings challenged perspectives of anorexia at the time and advocated for a patient-centred focus, which has inspired current practice (Treasure and Cardi, 2017). Although recognising the initial importance of weight restoration, Bruch challenged behaviour modification techniques to achieve this (Marks, 2019).

Bruch considered early life experiences were central to the development of anorexia, with a cohesive self, contingent upon caregivers’ abilities to respond appropriately to a child’s early feelings and basic needs and viewed early relationships relevant to the aetiology of anorexia (Treasure and Cardi, 2017). Models during this era emphasised family dynamics lay at the core of anorexia, and the “anorexogenic family” was described (Palazzoli, 1974). Minuchin and colleagues’ (1978) psychosomatic family model attributed the manifestation of EDs to poor parenting styles and disrupted attachments, describing family structures of adolescents with anorexia as one of enmeshment, conflict avoidance, and rigid and overprotective parenting. These psychological and familial interpretations of anorexia have been critiqued as individualistic, failing to situate behaviours within social and cultural meanings (MacSween, 1993), or take note of individual temperaments (Hawkins-Elder and Ward, 2020). Furthermore, research suggests that Minuchin's explanation lacks evidential support (Eisler, 2005), and fails to account for behaviours continuing outside of the family system (Hawkins-Elder and Ward, 2020).

Anorexia nervosa only featured peripherally in the first two editions of the DSM, understood as a consequence of emotional distress and associated with other medical conditions (American Pyschiatric Association, 1952; American Psychiatric Association, 1968). It was not until 1980, that EDs appeared as a category in its own right (American Psychiatric Association, 1980). Indeed, prior to the 1970s, anorexia was considered relatively rare, described by Bruch as a new disease (Burch, 1978), distinctly modern and Western, where primary motivators related to body image ideals, and weight phobia (Habermas, 1996). Anorexia gained momentum in the social domain during this time, propagated by mass media, rise in diet industry and the publicity surrounding the death of celebrity singer Karen Carpenter to anorexia, and Princess Diana's experiences of bulimia (Saukko, 2006).

Bruch wrote at a time when idealisation and internalisation of the thin ideal, fuelled by Western society's beauty standards, changing body ideals and economic profit made from the beauty industry, were acknowledged in playing a role in body dissatisfaction (Striegel-Moore and Bulik, 2007). Several sociocultural studies reveal a causal relationship between media exposure and body dissatisfaction, disordered eating and emotional distress (Stice and Shaw, 2002; Izydorczyk *et al.*, 2020). However, it is argued privileging media as the sole driver for EDs is a superficial and simplistic interpretation (Malson, 1998), overlooking personal meanings of anorexia and complex sociocultural factors (Musolino, Warin and Gilchrist, 2020).

A plethora of research reveals EDs are not exclusively tied to those who are Western and white, with cases recorded in non-Western nations (Hoek, 2016), and among ethnic diverse groups (Pike and Borovoy, 2004). However, acculturation and Westernisation are the main arguments for cases of anorexia outside of Western nations (Lester, 2004). Over-inclusive and blanket concepts of Westernisation offer little effort in deconstructing the local or individual meanings for food refusal within these contexts (Katzman and Lee, 1997; Lester, 2004). On the contrary, the symptoms suggestive of anorexia in non-Western countries are not associated with any weight or appearance concerns but situate around control, gender roles and parental influences (Lee, Ho and Hsu, 1993; Lee *et al.*, 2001; Meuret, 2010).

Feminist theory situates anorexia in relation to wider social and political gender ideologies and inequalities within patriarchal cultures (Bordo, 2003; LaMarre *et al.*, 2022b), providing a counter-narrative to medical and psychological discourses of anorexia as an individual pathology (Holmes *et al.*, 2017). Feminist approaches towards EDs are diverse and varied but for simplicity can be comprised of both classical and critical forms (Malson and Burns, 2009) or considered elsewhere in "waves" (LaMarre *et al.*, 2022a). Classical feminism, emergent in the 1970s, includes the works of Chernin (1981), Lawrence (1984) and Orbach (1978), practising counsellors and therapists, who developed their theories after witnessing a considerable rise in EDs at the time. They linked the contradictions and pressures around femininity within society to disordered eating (LaMarre *et al.*, 2022a), focusing on mother-daughter relationships, and how anorexia was a rejection of female identity shaped by patriarchal structures (Orbach, 2018), and means to gain control and influence around social positioning (Lawrence, 1984). Others interpret anorexia as attempts to succeed in a male-dominated world, by eradicating their feminine shape (Knapp, 2003). However, these critiques tend to privilege Western, white, heterosexual women (LaMarre *et al.*, 2022b), criticised as assuming a collective experience for all women, that "reduce anorexia to dieting" (Brain, 2006, p.50), at "the exclusion of other aspects of anorexia and female subjectivity" (Malson, 1998, p.93).

Since the 1980s, several feminists (Probyn, 1991; Eckermann, 1994; Bray, 1996), critiqued classical feminism's overemphasis of image consumption as inadvertently serving mind-body dualistic frameworks (Lester, 1997), missing other meanings and experiences (Brain, 2002). The prominence of metaphorical expressions of anorexia, as a "crystallization of culture" (Bordo, 1993, p.139), implies the body as a text, rather than embodied subject (Brain, 2002). Critical feminist approaches, influenced by postmodern and post-structural theories, view EDs as "discursively constituted and regulated categories of subjectivity, experience and body-management practices" (Malson and Burns, 2009, p.2). Rather than passive and docile "political prisoner" (s) within patriarchal structures (Wolf, 1991, p. 208), where culture is rendered static and reduced to images (Burns, 2009), critical feminist theories, consider EDs as "part and parcel of the (culturally normative) order of things" (Malson and Burns, 2009, p.2) and turn attention to wider restricted agency (Holmes *et al.*, 2017).

Following the view that traditional forms of individual psychoanalytic/psychotherapy were ineffective (Marks, 2019), by the mid-1980s, cognitive behavioural theories and treatments became popularised, with anorexia considered to be “the over-evaluation of eating, weight and shape, and their control” (Fairburn, Cooper and Shafran, 2003, p. 522). Based on its transdiagnostic perspective, cognitive behavioural theories account for a larger collection of EDs and offer a unified account of cognitive and behaviour domains. However, it has been critiqued as too bold in its ambition, which “forfeits explanatory depth” (Hawkins-Elder and Ward, 2020, p.99). Furthermore, its focus on inner mental processes, and an individual’s need for control, does not account for wider meanings and assumes meanings pertain to body shape and weight.

The Maudsley Approach, later coined family-based treatment (FBT), for patients under 18 with anorexia of less than three years duration has become first-line treatment, garnering much research (Lock *et al.*, 2001). Despite this, FBT does not show high levels of efficacy for all cases and has no foundational conceptual theory to explain why. Furthermore, its pragmatic focus upon weight restoration as a goal in treatment arguably overlooks broader emotional and contextual drivers (Hawkins-Elder and Ward, 2020).

With greater research and the launch of several ED specific journals, evidence-based ED treatment and manualised therapies have been introduced. However, critics have challenged what we consider to be ‘evidence’ in the field of EDs, which typically favours objectivist views of science and evidence, which may limit the development of other alternative treatments and models (Holmes *et al.*, 2017). Whilst treatment manuals promote rigorous research, clear guidelines for clinicians, and a shared language, rigid adherence may miss the complexity of real-word contexts, and potentially bear deleterious outcomes (Robertson and Thornton, 2021). Farrell considers most approaches for anorexia focus on the behaviours of the individual, but miss the meaning given to the symptoms themselves (Farrell, 2005).

With the advent of medical technology and propagation of science, anorexia is found to have an undeniable high genetic influence (Rikani *et al.*, 2013), with a fourfold increase in susceptibility amongst families (Zipfel *et al.*, 2015). Genetic framing is considered helpful in countering against the stigma and trivialisation that individuals may experience, moving away from views of personal volition (Easter, 2012). In contrast, genetic attribution can reinforce a medicalised view and anorexia can be assumed a permanent genetic aspect of self, marking those with EDs different to others; criticised as reductionist and oversimplified (Easter, 2012). Although biomedical explanations create important knowledge and herald new insights, they also foster a view that anorexia is a natural disease, existing within the subject, discounting contextual factors (Conti, 2016).

The current view of the aetiology of EDs is multifactorial and biopsychosocial, including developmental factors, underlying personality and behavioural traits, genetic predisposition and sociocultural factors (Treasure *et al.*, 2020). However, what has arguably dominated understanding is a medicalised framework (Rich, 2006), with diagnostic practices "aligned with reality" (Lock and Strong, 2012, p. 3), focusing on individual and pathological malfunctions (Orsini, 2017).

From reviewing the proliferation of competing theories and approaches around anorexia, it is felt subjective meanings are concealed beneath stereotypes and assumptions (MacSween, 1993; Conti, 2015), providing a fragmented picture of lived experience (Patching and Lawler, 2009). Although there have been advancements in understanding anorexia, its meanings remain enigmatic. This disjuncture in the thesis reveals how anorexia holds varying meanings, shifting across contexts and history (Dell'Osso *et al.*, 2016), and to understand what is hidden and implicit requires honouring individual's own meanings.

1.6 Incidence, Prevalence, and Mortality

Although anorexia is the most well-known and researched ED, it is also the least common (Keski-Rahkonen and Mustelin, 2016). Anorexia is complex and severe (Hambleton *et al.*, 2022), holding the highest mortality rate of all psychiatric illnesses (Sachs *et al.*, 2016), due to effects on the cardiovascular system and suicide (Arcelus *et al.*, 2011). Alongside medical comorbidities, a recent rapid review detailed the myriad of psychiatric co-occurring difficulties, contributing to the maintenance of behaviours, comprising functioning, quality of life, and influencing outcomes (Hambleton *et al.*, 2022; Hamilton *et al.*, 2022). Anorexia, and other EDs, are also associated with economic burdens, given high rates of emergency department admissions, hospitalisation, and outpatient care (Hart *et al.*, 2011a; Hamilton *et al.*, 2022).

Anorexia is considered prevalent world-wide and deemed a global public health concern, with predicted upwards trends (Galmiche *et al.*, 2019). Some estimate 700,000 people in the UK have an ED (NICE, 2019a), whilst others consider the figure is around 1.25 million (Beat, 2021). In a survey, 16% of all adults screened positive for a possible ED (NHS Health Digital, 2020), representing a threefold increase since 2007 (Official National Statistics Survey, 2007). However, figures concerning how many people in the UK have anorexia, or EDs generally, are not fully known (van Eeden, van Hoeken and Hoek, 2021). Statistics are obscured by the significant proportion of individuals not accessing treatment (van Eeden, van Hoeken and Hoek, 2021), due to stigma (Brelet *et al.*, 2021), misconceptions, and lack of identification (Nicula *et al.*, 2022), normalisation of disordered eating in culture (Musolino *et al.*, 2015), as well as individual factors including fear, shame, denial and the functional aspects of the illness (Ali *et al.*, 2020).

Prevalence varies dramatically across studies, due to the diverse tools used to diagnose and classify EDs, along with the broadening of diagnostic criteria (Micali *et al.*, 2017). Nevertheless, incidence rates[2] for females with anorexia are between 4.2-12.6 per 100,000 person-years and for males, 1 per 100,000 person-years (NICE, 2019b), median lifetime prevalence[3] for anorexia is 1.4% for women, and 0.2% for men (Galmiche *et al.*, 2019). Although anorexia can affect anyone irrespective of age, gender, ethnicity or socioeconomic status, it is more frequently identified in young, white females (Galmiche *et al.*, 2019), with women representing 90% of those with EDs (NICE, 2019b). This may be because anorexia presents differently in non-Western contexts (Soh, Touyz and Surgenor, 2006), due to differences in genetics and eating behaviours (Galmiche *et al.*, 2019), and stigma experienced by those from minority ethnic backgrounds accessing mental health support (Sinha and Warfa, 2013). Furthermore, the gender bias in EDs is considered to be influenced by traditional archetypes of the illness, where anorexia is often considered a female mental disorder (Roberts, Ciao and Czopp, 2018). Given the ED workforce is predominantly compromised of white women (Jennings Mathis *et al.*, 2020), this may further exclude more diverse groups seeking support. Data shows men constitute around 25% of community-based samples who meet the full criteria for an ED (Strother *et al.*, 2012). However, these rates should be interpreted as grossly underestimated due to poor recognition and diagnosis in this area (Murray *et al.*, 2017),

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[2] Incidence rates refers to the rate of new cases occurring in a specific population over a particular time period.

[3] Lifetime prevalence refers to the proportion of eating disorders at any point in life.

and the social stigma men experience seeking support for an ED (van Eeden, van Hoeken and Hoek, 2021). Onset is typically believed to occur in adolescence, between 15-22 years of age (Micali *et al.*, 2013); however, studies highlight rising incidence in later life (Smink *et al.*, 2016), and in children under 12 (Petkova *et al.*, 2019). Despite elevated risks for developing EDs, data on identifying those who are transgender, and gender diverse populations is scant, contributed by structural barriers i.e., ED stereotypes (Bryant *et al.*, 2022b).

1.7 An Occupational Perspective

Anorexia does not just impact upon physical and emotional health but psychosocial function and engagement in daily activities, otherwise known as occupations (Singlehurst *et al.*, 2007; Elliot, 2012; Coelho *et al.*, 2020), defined as "everyday activities that people do as individuals, in families, and with communities to occupy time and bring meaning and purpose to life. Occupations include things people need to, want to and are expected to do" (World Federation of Occupational Therapy, 2023).

Authors highlight how common psychological factors associated with anorexia, including perfectionism, cognitive rigidity, low self-esteem, and shame, impact motivation to engage in occupation (Lock *et al.*, 2012; Clark and Nayar, 2012a; Lock and Pepin, 2019). Continued social anxiety can lead to social avoidance and interpersonal difficulties, further perpetuating estrangement from meaningful occupations (Lock and Pepin, 2019), exacerbated by the effects of starvation (Gardiner and Brown, 2010), and cognitive difficulties (Godfrey, 2013). All which impact upon emotional regulation (Lock and Pepin, 2019) and reduce occupational performance. Without meaningful activities, individuals can feel bereft of their identity, withdrawn and isolated, leading to further emotional distress (Mack *et al.*, 2023).

Authors highlight how the over-valuation and investment in ED behaviours and pre-occupation with food reduces an individual's physical, social and psychology capacity to engage in other meaningful activities (Clark and Nayar, 2012b; St-Pierre *et al.*, 2023), including hobbies (Orchard, 2003) and interpersonal relationships (Gardiner and Brown, 2010). Participation in the community, where food and eating may be present, may provoke anxiety (Koller and Berg, 2021), and it is evidenced that individuals experience lower vocational engagement, and isolation (Safi *et al.*, 2022). This can ultimately lead to occupational imbalance (Monthuy-

Blanc *et al.*, 2022), impacting upon life roles, and lead to occupational deprivation (Sørlie *et al.*, 2020); that is prevention from participating in occupations of necessity, obligation and choice.

Engagement in ED-related occupations, such as food restriction and use of compensatory behaviours, can lead to the development of an occupational identity rooted in the ED (Dark and Carter, 2019), enabling feelings of competence (St-Pierre *et al.*, 2023); with ED occupations meaningful and valued, further maintaining its presence (Dark *et al.*, 2022). Research identifies normative cultural values around food, bodies and identity transcend into individual's worlds, and influence occupations (Dark and Carter, 2019). Our lives are patterned by routines, and the ED can create new habits entrenched and motivated by the ED (Mack *et al.*, 2023). As occupations of the illness are often responses to an occupational need (Clark and Nayar, 2012a), offering pleasure, productivity and feelings of competence (Sørlie *et al.*, 2020), when treatment attempts to eliminate the occupational engagement of the ED, it can potentially result in an occupational void (St-Pierre *et al.*, 2023).

1.8 Recovery

Despite calls for a standardised definition of recovery to aid treatment planning (Bardone-Cone, Hunt and Watson, 2018), recovery from anorexia remains a highly contested term (Williams, Watts and Wade, 2012), meaning recovery rates range widely, depending on the definition used (Kenny, Trottier and Lewis, 2022).

Outcome studies suggest less than half of individuals with anorexia recover at follow-up (Harbottle, Birmingham and Sayani, 2008), with an estimated 20-30% experiencing a long-term trajectory (Steinhausen, 2002; Steinhausen, 2009; Eddy *et al.*, 2017). Despite more favourable recovery outcomes for adolescents compared to adults (Murray *et al.*, 2019), a high proportion still require hospitalisation more than once (Steinhausen *et al.*, 2009). For these reasons, recovery remains elusive (Richmond *et al.*, 2020). Some commentators view anorexia as chronic, with no recovery prospects (Johns *et al.*, 2019), and those unresponsive to conventional treatment are considered as having 'terminal anorexia nervosa' (Gaudiani, Bogetz and Yager, 2022). Individuals were first identified as having 'severe and enduring eating disorders' (SEED) in 2015 (Robinson *et al.*, 2015). Such labelling has come with criticism, due to its conceptual vagueness, stigmatisation, and neglect of contextual factors (Elwyn, 2023), such as lack of ongoing care, and research in the field to identify optimal levels of care (Downs, 2023). Furthermore, given SEED can be applied to individuals with an active illness of 5-10 years (Wildes *et al.*, 2017), this means most adults with anorexia fall within this category (Treasure, Stein and Maguire, 2015).

Recovery is impacted by duration of illness, with prolonged starvation increasing risk of relapse (Touyz *et al.*, 2003); therefore, early intervention is vital (Fogarty and Ramjan, 2016). Other factors associated with poor prognosis include coexisting psychiatric conditions such as depression, anxiety, and obsessive-compulsive disorder (Keski-Rahkonen *et al.*, 2014), poor social adjustment and substance use (Franko *et al.*, 2013).

Physical and behavioural markers of recovery have largely been used in practice (Richmond *et al.*, 2020), determined by researchers and clinicians (Kenny and Lewis, 2021), minimising other variables including quality of life and psychological wellbeing (Stockford *et al.*, 2918; de Vos *et al.*, 2017). Traditionally, this falls within the medical model, where good outcomes are equated with symptom abatement and cure (Dawson, Rhodes and Touyz, 2014a). However, qualitative literature has found very few individuals attribute recovery to the physical process of gaining weight, and find medical definitions constraining and simplistic (Garrett, 1996; Conti, 2018). Instead, individuals describe recovery as non-linear, and complex, occurring in broader culture, compromising of several elements, including rediscovery and redefinition of self, meaning and purpose (La Marre and Rice, 2015; Wetzler *et al.*, 2020; Kenny, Boyle and Lewis, 2020). From a critical health perspective, writers have also drawn attention to how recovery is made challenging by numerous and conflicting discourses in clinical settings and Western culture, and how recovery is often determined by privilege, politics, and socioeconomic status (Lester, 2019; LaMarre and Rice, 2021b). Furthermore, rather than viewing recovery from a person specific lens, it is arguably instead the theories and models of care which are available for those with EDs which are flawed.

Harm-minimisation practices, commonly practised in areas of addiction and self-harm (Cliffe *et al.*, 2021), are considered in the context of EDs, acknowledging the practical realities that recovery may not be possible for all, given wider contextual circumstances, and the embodied significance of the illness (Joyce *et al.*, 2019; Musolino, Warin and Gilchrist, 2020). It acknowledges recovery can be prolonged, and rather than wait for a ‘cure’, with treatment dominated by objectives of 'successful outcomes' such as weight gain, goals are flexible, collaborative (Russell *et al.*, 2019), and quality of life is centralised (Touyz and Hay, 2015).

1.9 Treatment Provision

In the United Kingdom (UK), individuals access ED treatment most often via primary care (Johns *et al.*, 2019). However, several barriers exist in accessing appropriate treatment, including lack of understanding and knowledge, stigma, and negative perceptions of those with EDs amongst medical professionals (BEAT, 2017; Royal College of Psychiatrists, 2022b). Given the predominant focus on the physicality of the illness, EDs are often dismissed unless visible, severe, and entrenched (Robinson, Mountford and Sperlinger, 2013; Johns *et al.*, 2019). Furthermore, the egosyntonic nature of the illness, that is the value individuals place on their illness, can prevent acknowledgment and efforts to seek support (Treasure and Schmidt, 2001).

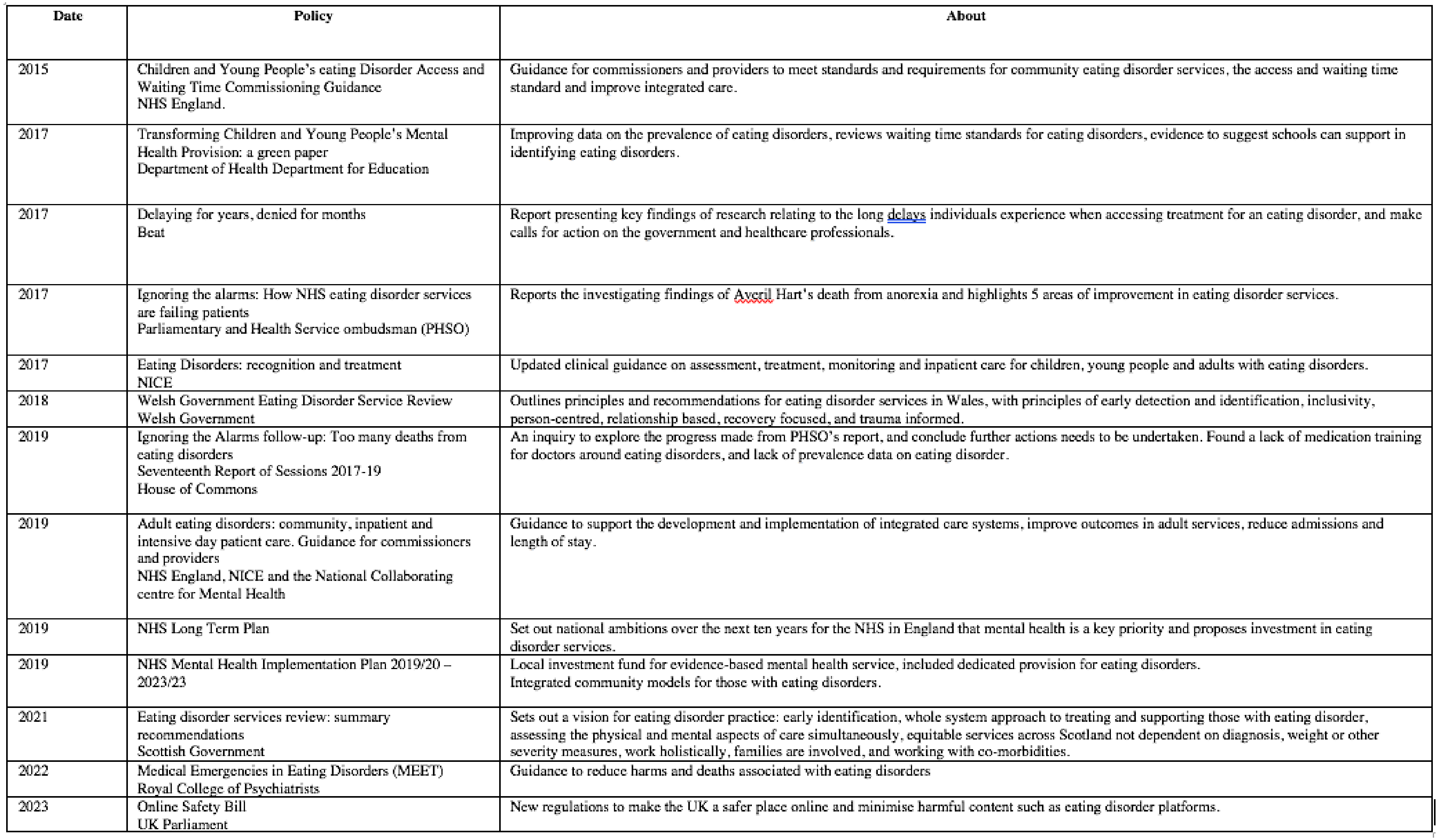
ED treatment is provided by the National Health Service (NHS) or private health care, delivered across a variety of settings including inpatient, day patient and community settings, within generic mental health services and specialist ED services (NICE, 2017). At present, regional disparities in service provision make accessing treatment a "postcode lottery" (BEAT, 2020, p. 4). The impact of treatment delays is significant as symptoms worsen over time and the likelihood of recovery decreases (Royal College of Pyschiatrists, 2019). The probability of recovering from anorexia is known to be highest after diagnosis, as the effects of starvation adversely affect brain structure and function (Treasure and Russell, 2011). It is estimated that only 19-36% of individuals with an ED receive treatment, with the mean duration of not receiving treatment three years (Schlegl *et al.*, 2019), and of those who do receive treatment (Hart *et al.*, 2011a), only 35-40% receive targeted treatment (Mond *et al.*, 2007).

EDs are considered best treated in the community, with inpatient treatment required for those with acute physical or psychiatric risks (National Collaborating Centre for Mental Health, 2019). However, studies assessing hospital trends have observed sharp increases in both new and repeat admissions (Holland *et al.*, 2016; Royal College of Psychiatrists, 2022a), whilst other mental health disorders are in decline (Degli Esposti *et al.*, 2021). Despite the aim to provide support for children and young people within one week for urgent cases and four weeks for routine (NHS England, 2015), the exponential rise in demand in the wake of COVID-19, has left services struggling to meet demand (Department of Health and Social Care, 2022). Due to lack of matched funding in adult services, adults are considered to wait up to 30% longer than children and young people (Royal College of Pyschiatrists, 2019). Given the long waiting lists for treatments, services have been reported to use rationing strategies such as BMI or severity to access care, leading to the increase in medical emergencies (Viljoen, 2022).

Although inpatient care improves physical health in the short-term, these gains are short-lived, with evidence suggesting psychosocial issues remain impaired (Goddard *et al.*, 2013; Fennig *et al.*, 2017), and lengthy hospitalisation contributes to social impairments (Treasure, Claudino and Zucker, 2010). Many individuals fail to make progress in inpatient settings, or even deteriorate (Munro *et al*, 2014), with relapse rates predicted to be between 20-50% (Hibbs et al., 2015). Overall, there is limited evidence on the efficacy of service models and questions remain when inpatient treatment is most effective (Friedman *et al.*, 2016). In recent years there has been an increased attention towards intensive home treatment teams and day patient services, supporting recovery within the context of the social environment (BEAT, 2019; Herpertz-Dahlmann *et al.*, 2021); however, provision is limited (BEAT, 2019).

Several service improvements and policies have been outlined in the UK (see Table 1 ‘Policies relating to ED services in the UK’). However, progress in the field is considered slow moving (The Hearts and Minds Genes Coalition for Eating Disorders, 2021b), with a review stating “the urgent need for improved treatment … cannot be overstated” (Murray, 2020, p. 21). ED services are considered overstretched and under-resourced (All-Parliamentary Group on Eating Disorders, 2021a), lacking capacity to meet commissioning standards, treat the entire spectrum of EDs, effectively manage transitions between services, connect with hard to reach populations and provide timely evidence-based treatment (EBT) (Viljoen, 2022).

Table 1 Policies relating to Eating Disorder Services in the UK



Date	Policy	About
2015	Children and Young People's eating Disorder Access and Waiting Time Commissioning Guidance NHS England.	Guidance for commissioners and providers to meet standards and requirements for community eating disorder services, the access and waiting time standard and improve integrated care.
2017	Transforming Children and Young People's Mental Health Provision: a green paper Department of Health Department for Education	Improving data on the prevalence of eating disorders, reviews waiting time standards for eating disorders, evidence to suggest schools can support in identifying eating disorders.
2017	Delaying for years, denied for months Beat	Report presenting key findings of research relating to the long delays individuals experience when accessing treatment for an eating disorder, and make calls for action on the government and healthcare professionals.
2017	Ignoring the alarms: How NHS eating disorder services are failing patients Parliamentary and Health Service ombudsman (PHSO)	Reports the investigating findings of Averil Hart's death from anorexia and highlights 5 areas of improvement in eating disorder services.
2017	Eating Disorders: recognition and treatment NICE	Updated clinical guidance on assessment, treatment, monitoring and inpatient care for children, young people and adults with eating disorders.
2018	Welsh Government Eating Disorder Service Review Welsh Government	Outlines principles and recommendations for eating disorder services in Wales, with principles of early detection and identification, inclusivity, person-centred, relationship based, recovery focused, and trauma informed.
2019	Ignoring the Alarms follow-up: Too many deaths from eating disorders Seventeenth Report of Sessions 2017-19 House of Commons	An inquiry to explore the progress made from PHSO's report, and conclude further actions needs to be undertaken. Found a lack of medication training for doctors around eating disorders, and lack of prevalence data on eating disorder.
2019	Adult eating disorders: community, inpatient and intensive day patient care. Guidance for commissioners and providers NHS England, NICE and the National Collaborating centre for Mental Health	Guidance to support the development and implementation of integrated care systems, improve outcomes in adult services, reduce admissions and length of stay.
2019	NHS Long Term Plan	Set out national ambitions over the next ten years for the NHS in England that mental health is a key priority and proposes investment in eating disorder services.
2019	NHS Mental Health Implementation Plan 2019/20 – 2023/23	Local investment fund for evidence-based mental health service, included dedicated provision for eating disorders. Integrated community models for those with eating disorders.
2021	Eating disorder services review: summary recommendations Scottish Government	Sets out a vision for eating disorder practice: early identification, whole system approach to treating and supporting those with eating disorder, assessing the physical and mental aspects of care simultaneously, equitable services across Scotland not dependent on diagnosis, weight or other severity measures, work holistically, families are involved, and working with co-morbidities.
2022	Medical Emergencies in Eating Disorders (MEET) Royal College of Psychiatrists	Guidance to reduce harms and deaths associated with eating disorders
2023	Online Safety Bill UK Parliament	New regulations to make the UK a safer place online and minimise harmful content such as eating disorder platforms.

Currently no pharmacological treatments for anorexia show reliable efficacy (Hawkins-Elder and Ward, 2020). In terms of psychological interventions, despite several established treatments, randomised controlled trials (RCTs) show that even with best current treatments only 50% of individuals show some improvement (Brockmeyer, Friederich and Schmidt, 2018; Murray *et al.*, 2019). The consensus reveals no clear contender for psychological therapy in anorexia, especially for adults (Jansingh *et al.*, 2020). First-line treatments for adults include Cognitive Behavioural Therapy for Anorexia (CBT-AN), Enhanced Cognitive Behavioural Therapy (CBT-E), Maudsley Anorexia Nervosa Treatment for Adults (MANTRA), and Specialist Supportive Clinical Management (SSCM) (NICE, 2017). Whilst for adolescents, much focus has centred on Family-Based Therapy for Anorexia (NICE, 2017). Standardised treatments vary in their applicability, but all address motivation, and focus on weight restoration (Zipfel *et al.*, 2014; Byrne *et al.*, 2017). Yet, their translation - which are typically tested in specialised and controlled environments - are considered inadequate to meet the demands and capacity of real-world settings (Anderson *et al.*, 2021), meaning adherence to EBT and models is lacking (Waller, 2009).

Despite the lack of definitively effective successful treatment (Hay *et al.*, 2015; Zipfel *et al.*, 2014), the current landscape of EDs, partly due to budgetary constraints, has shifted towards short-term efficiency, with little space to deviate from particular notions of what constitutes EBT (Lester, 2019). These treatments typically privilege a more objective view of science and reality (LaMarre *et al.*, 2022b), which aims for cure, defined by the absence of symptoms and a return to “normal” functioning (Dawson, Rhodes and Touyz, 2014b).

In light of poor responses to mainstream treatments, novel adjunct therapies are emerging (Carr *et al.*, 2020), with new approaches (Brockmeyer, Friederich and Schmidt, 2018), “fresh perspectives” (Botha, 2015, p. 328) and service models (Munro *et al.*, 2014a), along with the development of existing therapies (Murray, Loeb and Le Grange, 2018). Early intervention models (Brown *et al.*, 2018), staging models (Treasure, Stein and Maguire, 2015), and recovery models for anorexia are suggested, de-emphasising the role of weight gain in favour of addressing broader domains, and quality of life (Touyz and Hay, 2015), as well as advances in neuromodulation (Treasure *et al.*, 2021). Despite this, current treatment providers continue to preference ‘evidence-based interventions’, meaning alternative approaches which do not meet the ‘gold standard methods’ of RCTs are thwarted (Holmes *et al.*, 2017). Individuals express a desire for personalised approaches in treatment and criticise interventions applied rigidly and prescriptively (Mitrofan *et al.*, 2019; Conti *et al.*, 2021); it is clear the current status quo is insufficient to truly understand, and therefore, treat EDs (Downs, 2022; Hawkins-Elder and Ward, 2020).

1.10 Occupational Therapy's Role in Eating Disorders

Given the occupation focus of this thesis, it is of pertinence to examine the role of OT in EDs. Assessing the wider impacts of EDs is recommended in clinical guidance acknowledging "the impact of the home, education, work and wider social environment…[and] Address[ing] their emotional, education, employment and social needs throughout treatment" (NICE, 2017, p. 1.1.8). Furthermore, there is growing acknowledgement outside the field of OT that individuals require strategies to find alternatives to the meaning anorexia offers (Karlsson *et al.*, 2021), and that engagement in meaningful activities improves quality of life (de la Rie *et al.*, 2007). Researchers often cite 'activities' as one such strategy, although most often referencing employment and Western notions of productivity (Fox and Leung, 2009; Robinson *et al.*, 2015; Stockford *et al.*, 2018b). Although important, OT acknowledges occupation is much broader than this, where finding meaning, identity, and purpose in life through occupation is essential to ED recovery (Mack, 2019; Dark *et al.*, 2022).

Although OT has contributed to the ED workforce since the 1970s, Martin's 1998 publication, '*Eating Disorders, Food and Occupational Therapy'* was the first British publication for occupational therapists on the topic (Martin, 1998). Although praised for its contribution to the field, only a fifth was directly related to OT, limiting clinical and practical utility (Harries, 1999), critiqued as rigid in its application (Gadsby, 2001) and adherence to the medical model (Meredith, 2001). OT has since developed, for instance, several occupational therapists specialising in EDs meet quarterly through clinical forums in the UK (RCOT, 2023a) and more recently, occupational therapists have been involved at a more strategic level (Pepin, 2021). Despite this, there is a lack of published research on the effectiveness of OT interventions in EDs (Biddiscombe *et al.*, 2018).

As anorexia is complex and severe, a multidisciplinary approach to treatment is recommended, involving OT interventions (NICE, 2017). Nevertheless, occupation as a therapeutic medium, often takes lower precedence in the field of EDs over first-line psychological therapies, leaving occupational therapists pressured into adopting non-occupation-focused approaches (Devery, Scanlan and Ross, 2018). Whilst at the same time, required to evidence their practice and deliver occupation-focused interventions, resulting in competing demands (Devery, Scanlan and Ross, 2018). Furthermore, they many tend to work as generalist mental health practitioners (All About Occupation, 2023), potentially diluting their occupation-focused lens (Devery, Scanlan and Ross, 2018).

Occupational therapists are considered unique and distinct to their multi-disciplinary counterparts, who focus on the here and now, assessing function (Devery, Scanlan and Ross, 2018; Mack *et al.*, 2023) and utilising practical modalities, rather than talking therapies (Biddiscombe *et al.*, 2018). OT is also considered less directive than other therapies, and are positively perceived by service users (Klockzo and Ikiugu, 2005), given focus is not so much on food, weight and eating, but on broader life domains (Devery, Scanlan and Ross, 2018).

Occupational therapists can provide psychological treatments or integrate tenets of EBT into practice (Pepin, 2021b), but their overarching goal is engagement in meaningful occupations (Mack *et al.*, 2023), understanding what is valuable to the individual to facilitate long-term meaningful recovery (Biddiscombe *et al.*, 2018). Standing in contrast to dominant medical treatment models, occupational therapists work in collaboration with individuals, through an activity-orientated approach, and from a perspective that is rooted in understanding the relationship between occupation, health and wellbeing (Sørlie *et al.*, 2020), and the contextual impacts of recovery (Dark *et al.*, 2022; Mack *et al.*, 2023). They facilitate the development of functional life skills (Mack, 2019); essential, given the vulnerability of relapse following discharge from intensive ED treatments (Mack *et al.,* 2023).

OT appears to align more closely with the recovery model (Mack *et al.*, 2023) which seeks to understand individuals' own experience and meanings, encourages autonomy, and promotes hope (Clark and Nayar, 2012; Mack *et al.*, 2023). This position acknowledges that recovery is fragile, complex, and dynamic (Dark and Carter, 2019), with the aim to enable individuals to discover who they can be and what their life can be like beyond an ED (Lock and Pepin, 2011; Dark and Carter, 2019).

In terms of approaches and frame of references used within EDs, older literature discusses wide variability (Henderson, 1999), determined by the dominant model or a particular setting (Martin, 1985). Today, occupational therapists are considered to use a combination of approaches due to the complexity of EDs (Carr *et al.*, 2020). Whilst a range of approaches may be beneficial, this can result in the delivery of non-occupation based approaches due to differing perspectives of recovery (Pepin, 2021a). However, some occupational therapists explicitly use occupation-based approaches and models, which serve to justify their unique role and skills (Gardiner and Brown, 2010; Sørlie and Cowan, 2015; Sørlie *et al.*, 2020). For example, the Model of Human Occupation (MOHO) is often applied within EDs (Lock *et al.*, 2012), offering insight into how occupation is motivated, patterned, and performed (Horner, 2006). Due to the lack of available assessment and outcome measures regarding meal preparation, Lock et al. (2012) created the Eating and Meal Preparation Skills Assessment (EMPSA), based upon MOHO theory, to assess ability and motivation in meal-preparation activities. The Canadian Model of Occupational Performance and Engagement (CMOP-E), is also often cited in the literature (Polatajko, Townsend and Craik, 2007), a theoretical framework which considers the interdependence between the person, environment, and occupation (Gardiner and Brown, 2010; Coelho *et al.*, 2020; Duzyk, 2022). Sensory-based approaches, addressing bottom-up processing, that is change at the neurological level, have also been applied in EDs (Gardiner and Brown, 2010; Matson, 2022), and more recently recovery based models (Mack *et al.*, 2023). Koller and Berg (2021) provided a conceptual model for practice for occupational therapists working with individuals with anorexia, informed by the Person-Environment-Occupation-Performance (PEOP) model. Although enunciating a role for OT in assessment and intervention, the model has not been applied to clinical settings, thus clinical utility is unknown.

Despite these merits, the goal of OT input in the literature has traditionally emphasised re-engagement in occupations within a Western lens of what is considered healthy and balanced (Costa, 2009; Crouch and Alers, 2014). There is an undercurrent of individualistic neoliberal values of recovery in literature emphasising encouragement to pursue vocational roles (Gardiner and Brown, 2010) and independence in activities to promote “optimal occupational performance” (Gardiner and Brown, 2010, p. 141) and “maximize … function” (Henderson, 1999, p.44). Whilst reengagement in work may be important for those with EDs, Roberts and Skipsey’s (2021) phenomenological research found it was what individuals did not do which contributed to their recovery, such as stopping work to prioritise their health. This reconceptualises the tendency in practice to prescribe doing for health, challenging the traditional conceptualisation of occupation.

1.11 Meaning and Motivation

Given emphasis on meaning in this thesis, it is important to consider how meaning is considered in OT literature in relation to EDs. Although there are early mentions of exploring the meaning of EDs in OT literature, and how OT can increase awareness and insight for individuals (Meyers, 1989), there appears to be a shift in perspective from the 2000s from individualised prescription of doings and activities to a focus on valuing therapeutic use of self (Klockzo and Ikiugu, 2005). Several writers encourage the use of motivational interviewing to promote relationship building and support an individual's own identification and motivation for change (Orchard, 2003; Sørlie *et al.*, 2020). Lock and Pepin (2019) discuss interventions enabling spiritual participation which provide meaning, and Gogarty and Brangan's phenomenological research, called for occupational therapists to understand the individualised and contextualised "personal meaning" of functional difficulties (Gogarty and Brangan, 2004, p. 17). More recently, Mack and colleagues advocate clinicians to understand individual perspectives to support good clinical practice (Mack *et al.*, 2023). However, studies looking at engagement and perspectives, have often studied this quantifiably through time-use data (Singlehurst *et al.*, 2007; St-Pierre *et al.*, 2023), or via brief feedback reporting (Mack *et al.*, 2023) limiting subjective exploration around meaning-making.

Elliot (2012) explored the meaning of occupations associated with EDs through a figured world perspective. Although using older literature to support her claims, and based upon a figurative case study, she introduced the concepts of 'illness-infused meaning' and 'illness-directed meaning', capturing the complexity of how individuals' occupational lives can be affected by EDs. Elliot described how some occupations emerge from the ED, whilst pre-existing occupations, can be infused with meaning through the integration of ED behaviours. Occupations of the ED are situated within cultural meanings, and occupations were not either healthy or unhealthy but understood as having complementarily poles. Viewing occupational engagement in this way, brings a deeper understanding to view EDs, and how recovery requires occupational therapists to explore meaning in collaboration with individuals. Other articles have also drawn attention to how ED behaviours can be valued (Orchard, 2003), pursued and practised in place of wider activities outside of the ED (Singlehurst *et al.*, 2007). Writers emphasise that merely pointing out unhealthy behaviours is not enough and may add to shame and deception; rather, understanding the motivation behind behaviours is the first step in facilitating lifestyle changes through a therapeutic alliance (Costa, 2009), using people's own images or words which are meaningful to them (Sørlie *et al.*, 2020). Dark and Carter's (2019) narrative research into identity changes with women in recovery from an ED found although the same occupations were still engaged with, such as exercise or eating, it was the meaning of these which changed. Dark and Carter (2019) conclude that focusing solely upon occupational performance only yields partial understanding of an individual's doings and encourage critical examination of the sociocultural factors surrounding ED recovery.

1.12 Food in Treatment

Food is considered the first important step in recovery from anorexia (Garber *et al.*, 2016) and remains integral in the treatment pathway (Royal College of Psychiatrists, 2022b). It is not the intention to detail every possible way food is used in the treatment of EDs but provide overview of the most salient.

1.12.1 Refeeding

Refeeding refers to nutritional rehabilitation through reversing the effects of malnutrition, considered necessary and lifesaving to prevent 'refeeding syndrome' (Royal College of Psychiatrists, 2022b) – that is detrimental electrolyte and clinical changes when transitioning from a malnourished to a fed state (Khan *et al.*, 2011). Much research relating to refeeding is quantitative in design, such as retrospective study designs (Hindley, Fenton and McIntosh, 2021), often omitting psychological variables (Kezelman *et al.*, 2016) with qualitative accounts sparse (Halse *et al.*, 2005). This is salient as concerns have been raised around the psychological impacts of refeeding (Fox and Diab, 2015b). Weight restoration and refeeding are often considered prerequisites for engagement in psychological therapy due to starvation-related cognitive deficits (Munro *et al.*, 2014b). However, relegating therapeutic work towards the end of treatment can both obscure and heighten emotional distress (Wufong, Rhodes and Conti, 2019; Conti *et al.*, 2021).

Guidelines concerning the calorific rate to commence refeeding vary (Garber *et al.*, 2016). Historically, approaches followed low-calorific diets upon admission with slow progression to avoid refeeding syndrome (Hofer *et al.*, 2014). The approach has been raised as too conservative, and unsuitable for patients who are not medically compromised (Royal College of Psychiatrists, 2012a; Garber *et al.*, 2013), leading to slower progression, extended hospital admissions, and adverse psychosocial consequences (Katzman, 2012). Furthermore, cautious refeeding can result in underfeeding and avoidable deaths (Royal College of Psychiatrists, 2012, 2014, 2022). Since 2013, emerging evidence supports higher calorific diets, with earlier advancement, resulting in faster weight gain and shorter admissions without negative effects (Garber *et al.*, 2013; Garber *et al.*, 2016; Pettersson *et al.*, 2016; Peebles *et al.*, 2017; Garber *et al.*, 2021). However, rapid weight gain programmes have also been critiqued as prioritising practical pressures and cost savings over individual considerations (Birkbeck, 2018), with staff experiencing systemic pressure for patients to "move people on quickly" (Breeze and Repper, 1998, p. 1303).

Although disparity exists between providers and countries regarding refeeding protocols (Hart *et al.*, 2011b; Hart *et al.*, 2013; Rocks, Pelly and Wilkinson, 2014), food is typically offered first, and if not tolerated, equivalent calories in the form of portion-controlled liquid nutritional supplements, and lastly, consideration of enteral or parenteral nutrition[4] (Falcoski *et al.*, 2021; Hart *et al.*, 2013). Nasogastric feeding (NGF) is a type of enteral feeding, referring to the intake of food through a narrow plastic tube via the gastrointestinal tract, commonly referred to as 'tube feeding', and used in cases of medical instability and/or failure to meet oral intake[5] (Royal College of Psychiatrists, 2021). Whilst NGF enables clinicians to take control of treatment in life-threatening circumstances (Draper, 2000), and support rapid decision-making, this medicalised view may obscure wider risks such as psychological impacts, the breakdown of trust between patients and staff and jeopardise multi-disciplinary consensus (Fuller, Tan and Nicholls, 2023). In isolation, NGF is believed to have a "limited role in the treatment of anorexia" (Royal College of Psychiatrists, 2004, p.18), and cannot be assumed as cure (Mental Welfare Commission for Scotland, 2019). Although a number of guidelines exists (Fuller, Philpot and Group, 2020), and ethical and legal implications (Fuller *et al.*, 2022), there is a lack of research around when to initiate NGF. This is a much-needed area of research in order to understand the complexities of NGF in real-world settings.

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[4] Parenteral feeding provides nutrition in a solution form (containing amino acids, lipids, and dextrose), delivered via a peripheral or central vein.

[5] NGF can be delivered though different methods such as continuously, multiple single meals (bolus feeds), or overnight to supplement daytime oral intake.

Some consider NGF does little to support improving an individual's relationship towards food or help them to learn about normal eating (Halse *et al.*, 2005; Hart *et al.*, 2008). From a patient perspective, there are contradictory and multiple meanings attached to the experience of NGF (Mac Donald *et al.*, 2023), whilst a proportion find the experience necessary and helpful, medicalising and neutralising the experience, others perceive it as punishment, and reflective of their own "non-compliance or failure" (Halse *et al.*, 2005b, p. 269), inducing feelings of guilt (Street and Fuller, 2016; Kezelman *et al.*, 2016). Individuals also highlight feelings of distress of observing fellow patients restrained and fed against their will (Colton and Pistrang, 2004). The physical tube itself can contribute to personal and social labelling (Halse *et al.*, 2005), offering a sense of being a "perfect anorexic" (Zuercher *et al.*, 2003, p. 275). This response can incite competition, or an unhealthy bond with other patients, and compound the risk of over-dependence on NGF (Neiderman *et al.*, 2001); all of which contribute to feelings of ambivalence towards normal eating within treatment (Stockford *et al.*, 2018b).

It is recommended consent should be initiated prior to enteral feeding (Armer, White and McNair, 2019); however, in Neiderman et al.'s *(*2001) study only 29% consented to NGF (Neiderman *et al.*, 2001). Experiences around NGF are not just troubling for patients, but also for staff, who experience guilt, distress and conflict (Street and Fuller, 2016; Fuller, Tan and Nicholls, 2023). Kodua, Mackenzie and Smyth (2020) phenomenological study, exploring eight nursing assistants' experiences of feeding under restraint in an adolescent ED unit, describe the practice as traumatising. To manage the emotional and physical toll of restraints, staff detached themselves to become "immune to the screams, the noises, the fighting" (Kodua, Mackenzie and Smyth, 2020, p.1186). Literature elsewhere also highlights how staff can become numb, and desensitised (Ramjan and Gill, 2012), and move through routine and scripted care (Hage, Rø and Moen, 2015).

Research identifies that although distressing at the time, individuals reflect they were pleased they had been fed against their will, removing responsibility of eating themselves and the loyalty towards anorexia (Tan *et al.*, 2003; Tan *et al.*, 2010; Rienecke *et al.*, 2023). Whilst healing from the passage of time was not reflected in Neiderman and colleagues' questionnaire feedback, where 44% reported: "I hated it then and I hate it now" (Neiderman *et al.,* 2001, p.445). Some evidence highlights how measures, when unexplained, can augment suffering (Halse *et al.*, 2005) and hold a lasting traumatic imprint (Mac Donald *et al.*, 2023). However, when restrictive practices are communicated sensitively, within the context of trusting relationships, they can be experienced as care (Tan *et al.*, 2010), and through collaboration, individuals feel empowered in taking responsibility (Offord, Turner and Cooper, 2006). Therefore, it is not enforced refeeding, which is detrimental per se, but how it is experienced that matters (Elzakkers *et al.*, 2014), and the circumstances, relationships, and context in which it occurs (Tan *et al.*, 2006). These points highlight the clinical importance of exploring the meanings and experiences of NGF (Halse *et al.*, 2005), clear communication (Rienecke *et al.*, 2023), focusing on de-escalation (Fuller, Tan and Nicholls, 2023), and offering psychological input in tandem (Offord, Turner and Cooper, 2006), to strengthen the therapeutic alliance for engaging in such procedures.

1.12.2 Meal Support

Historically those with EDs were treated passively with bed rest and NGF, but since the introduction of therapeutic meal support, there has been a reduction in such methods (Leichner, Standish and Leichner, 2005; Courtier and Mahmood, 2009), and those who receive consistent meal support, have shorter hospital admissions (Kells *et al.*, 2017). Therapeutic meal support is now recognised as a cornerstone of inpatient and day patient settings (Leichner, Standish and Leichner, 2005; Hart *et al.*, 2008). Mealtimes are therapeutic in themselves, with individuals encouraged to view meals as “an experiment” (Garner *et al.*, 2017, p. 2) offering exposure to feared foods and supporting emotional regulation in the presence of anxiety (Stewart and Williamson, 2004). Despite, the lack of evidence that exists for the use of time limits (Watt and Dicken, 2018), individuals are expected to eat the entirety of their meal within strict fixed time limits, under certain expectations and etiquette (Long *et al.*, 2012a; Ramjan and Gill, 2012). Feminist work has criticised rigid rules such as timing in ED settings; considered to contribute to hostile rather than therapeutic relations (Gremillion, 2003b).

Inpatient or day treatment settings involves close supervision from staff, with the aim to replicate family members (Kells *et al.*, 2012), role model, normalise eating behaviours, offer emotional support, and support in decreasing disordered eating behaviours (van Ommen *et al.*, 2009). The level of meal supervision given is typically dependent on weight gain and programme compliance (Ramjan and Gill, 2012), with gradual progression towards independent eating once nearing discharge (van Ommen *et al.*, 2009). Evidence suggests close supervision is valued at the beginning stages of treatment, particularly managing with the emotional impact of meals (Offord *et al*, 2006; Bakker e*t al*, 2011). Although the initial lack of autonomy around mealtimes can provoke aversion, conversely some report directional actions from staff, their continual presence, and the structured routines of meals helpful in learning how to eat normally (van Ommen *et al.*, 2009).

A consistent and structured approach (Leichner, Standish and Leichner, 2005a; Monaghan and Doyle, 2023), emotional availability of staff (van Ommen *et al.*, 2009), staff training (Hage, Rø and Moen, 2017) and teamwork (Gardner and Trueman, 2021), have all been raised as important in mealtime delivery (Long *et al,* 2012b). However, in the absence of mealtime guidelines, support is highly varied, dependent upon staff experience, leading to inconsistencies (Long *et al.*, 2012b; Monaghan and Doyle, 2023), as such, mealtimes have been described as chaotic and disorganised (Gardner and Trueman, 2021). Diverse approaches can lead to friction between staff and patients, heightening distress and confusion (Long *et al.*, 2012a; Monaghan and Doyle, 2023), and staff can become easily frustrated, and fall into confrontational patterns (Ramjan and Gill, 2012).

Although variation exists, most ED units have a clear structure around meals with embedded internal scripts, allowing staff to perform several tasks simultaneously and collectively, without verbal interactions with one another (Hage, Rø and Moen, 2015). These internal know-hows can ease difficulties, offering clear expectations and routines, leading to fewer negative feelings from staff and patients (Hage, Rø and Moen, 2015). However, collective processes risk staff becoming mindless and routines performed automatically, leaving little space for flexibility or individualisation. Lack of personalised care, in combination with ritualised meal structures can add to feelings of detachment and passivity (Long *et al,* 2012a). Furthermore, when staff deviate from the script, this can cause tensions, highlighting the importance of staff collaboration (Hage, Rø and Moen, 2017).

Mealtimes can be highly stressful experiences, stirring up emotions such as guilt and increasing ED cognitions, particularly those concerning weight gain (Monaghan and Doyle, 2023), especially when regulations are enforced (Bakker *et al.*, 2011). Long et al. (2012a) observed close supervision can be supportive to some but uncomfortable for others, as if “all eyes are on you” (Long *et al.,* 2012a, p.424), and mealtimes became either battlegrounds for control or resulted in disengagement and ambivalence; a consequence highlighted in other studies (Boughtwood and Halse, 2008; O'Connell, 2023). Mealtimes can also foster comparison, leading to rivalry and the imitation of ED behaviours (Monaghan and Doyle, 2023). Conversely, the effect of peers can be positive, increasing a sense of commonality and shared understanding (Monaghan and Doyle, 2023).

To mitigate mealtime anxiety and monitor ED behaviours, many settings offer activities around mealtimes (Long *et al.*, 2012b), which bear positive effects on reducing anxieties and diverting attention away from the meal itself (Bibb, Castle and Newton, 2016; Griffiths *et al.*, 2016). Long et al. (2012b) report 13.6% of services in the UK offer a pre-meal activity whilst almost half of services offer post-meal activities including community meetings, support groups or reflections. This is important, given individuals report intensifying emotions and thoughts following mealtimes, increasing ED behaviours (Levinson *et al.*, 2018; Monaghan and Doyle, 2023). Despite distraction techniques being commonplace, staff in Long et al. (2012a) question the efficacy of distraction, and the use of distraction and avoidance during mealtimes is found to conversely maintain and perpetuate EDs in the long-term (Vanzhula *et al.*, 2020).

Individuals report a lack of opportunities to engage with the practical aspects of food-related activities (Duzyk, 2022), offered only in the later stages of recovery (van Ommen *et al,* 2009; Bakker *et al,* 2011), creating difficulties in managing a return to normal eating (Offord, Turner and Cooper, 2006; Arnaiz, 2009; Stockford *et al.*, 2018b). A way of managing increased responsibility is discussed by Sandy et al. (2007), through utilising a cafeteria-style mode of delivery, where individuals help themselves from serving containers and eat with “real” cutlery and utensils, rather than pre-packaged meals served on trays. The authors found the “home like” appearance of meals gave a sense of normality which felt less “like you are in the hospital” (Sandy *et al.,* 2007, p.378).

Literature often cites nurses as predominantly responsible for managing mealtimes (van Ommen *et al.*, 2009; Bakker *et al.*, 2011), yet their presence is often portrayed as authoritative, non-negotiable, and disciplinary (Gremillion, 2003a; Ryan *et al.*, 2006; Zugai, Stein-Parbury and Roche, 2019), perceived metaphorically as ‘jailers’, ‘baddies’, ‘police officers’, or ‘sergeant majors’ (King and Turner, 2000; Ramjan, 2004; Ramjan and Gill, 2012). Beukers et al. (2015) research found staff considered an uncompromising focus on mealtime rules and “well-dosed pressure” (Beukers et al., 2015, p.524) was needed to restore eating patterns. Staff in Beukers et al. (2015) study continuously monitored eating habits in a didactic manner, directing individuals on the minutiae of how to sit on their chairs, use their knife and fork, how much to eat and at what pace, whilst directly commenting on habits and behaviours.

Although a rules-based approach has been recommended in mealtime management (Lacalaprice *et al.*, 2023), enforcement can result in a lack of individualisation and cultural sensitivity (Reyes-Rodríguez *et al.*, 2016), or real-life application (Arnaiz, 2009) with expectations to eat “unappetising, repetitious and bland food” (Boughtwood and Halse, 2008, p. 275). It has been highlighted an uncompromising focus on the rules of food and eating at mealtimes reinforces ED behaviours (Beukers *et al.*, 2015), diminishes the therapeutic relationship (Birkbeck, 2018) and bears little impact upon restoring the wider aspects of food-related activities beyond that of weight gain (Arnaiz, 2009). Nurses themselves experience exhaustion and frustration when individuals resist treatment (Ryan *et al.*, 2006), becoming demoralised and conflicted (Zugai, Stein-Parbury and Roche, 2019), by the “idealized and actual world of nursing practice”(King and Turner, 2000, p. 144), as their core values are challenged and replaced with controlling practices and perceptions that patients are “untrustworthy” (Holmes, Malson and Semlyen, 2021). However, studies report clinicians feel they lack opportunity to influence front-line decisions (Long *et al.,* 2012a), due to pervasive systemic depersonalisation within the very culture of ED treatment (Malson and Ryan, 2008; Birkbeck, 2018). For change to occur, it has been argued that change needs multi-disciplinary investment - difficult to achieve in already short-staffed and over-stretched services (Gardner and Trueman, 2021).

1.12.3 Dietetic and Nutritional Approaches

Dietitians play a crucial role in multi-disciplinary treatment for anorexia (Heafala *et al.*, 2021; Patterson *et al.*, 2022). According to dietitians, weight gain is a narrow marker of recovery (Heruc *et al.*, 2020; McMaster *et al.*, 2020), instead their focus addresses underlying eating behaviours and cognitions, support meal preparation and exposure to fear foods and provide nutritional education and nutritional counselling (McMaster *et al.*, 2020; Elran-Barak, Lewis and Schifter, 2021). Dietitians advocate for a holistic approach to care, beyond that of weight restoration, but fostering healthy relationships towards food (Trammell, Reed and Boylan, 2016). Conversely, nutrition is believed to be neglected in treatment, in favour of medical stabilisation, with the prevailing belief that abnormal eating behaviours correct themselves spontaneously once refeeding has occurred (Hart, Russell and Abraham, 2011). However, difficulties in eating behaviours have been found to persist after weight restoration (Schebendach *et al.*, 2012). Furthermore, favouring weight gain over nutritional rehabilitation risks missing life-threatening complications for individuals who are not underweight (Shane and Heruc, 2020).

Although of importance, within the field of EDs, dietetic interventions are not well defined (Hart *et al.*, 2008; Hart, Russell and Abraham, 2011), increasing the risk of inconsistent interventions, and barriers accessing dietetic support (Heafala *et al.*, 2021). For dietitians, this can contribute to difficulties in articulating their role to service users, and professional uncertainty around boundaries (Heafala *et al.*, 2021). Conversely, variability in practice, may reflect a client-centred and individualise approach to care.

A key intervention for dietitians in EDs is meal planning, which aims to establish consistent, organised nutritional intake and energy requirements, and desensitise individuals from feared, binged, or purged foods (Mittnacht and Bulik, 2015). However, to date, no effective or superior meal plan, or materials have been established (Hart *et al.*, 2008). Dietitians have been criticised for drawing upon general population healthy eating guidelines to develop meal plans, despite these typically designed for overweight populations to reduce diet-related conditions (Stiles, 2014), resulting in harm (Hart *et al.*, 2018). More recently, Hart and colleagues (2018) developed the 'REAL Food Guide' (**R**ecovery from **EA**ting disorders for **L**ife), a pictorial-tool illustrating components of a healthy relationship to food specifically designed for those with EDs. Individuals with lived experience of an ED evaluating its use report the guide offers reassuring messages that "All foods are okay" (Hart *et al.*, 2018, p. 6), and reduced guilt through the inclusion of "fun foods". Although the REAL Food Guide offers promising tailored nutritional support for those with EDs rather than generic information, its application and utility is yet to be demonstrated in practice due its infancy. Nevertheless, given nutritional advice sometimes falls to non-specialist clinicians, where knowledge is poor and lack expertise (Cordery and Waller, 2006), and manualised ED treatments contain unsubtantiated nutritional information (McMaster *et al.*, 2021b), a simple and standardised resource means non-specialist clinicians can access evidence-based nutritional care in the absence of dietetic support (Hart and McMaster, 2024).

Often meal plans are influenced by the Western sociocultural milieu of what is considered "normal" (Boughtwood and Halse, 2008); however, normal eating is not well defined among dietitians (Hart, Russell and Abraham, 2011). Perceived "perfect little eating plans" (Malson, Clarke and Finn, 2007, p. 420) provided by treatment can create tensions and conflicts within prominent cultural contexts of dieting and "correct management of body weight" (Malson, Clarke and Finn, 2007, p. 420). LaMarre and Rice's (2015) research, highlight the challenging concept of "normal eating" for those in recovery, illuminating how dominant societal norms which instruct individuals how to be healthy and eat normally are juxtaposed against biomedical constructions of ED recovery. They argue whilst meal plans provide a protective factor for combating dominant discourses around weight and food, meal plans paradoxically contributes to body surveillance, compliance, and rigidity. Indeed, many individuals report following meal plans, long after treatment, as they offer a level of security and safety (Cockell, Zaitsoff and Geller, 2004; Garner *et al.*, 2017), and express fears of deviating away, where meal plans are positioned as a "regime of truth" (Boughtwood, 2006, p. 133). Derived from their observations of a four-year research project, Padrão, Barbosa and Coimbra (2012) consider the deleterious effects of following meal plans, who describe prescribed meal plans are "a way of maintaining anorexia, instead of suppressing it" (Padrão, Barbosa and Coimbra, 2012, p. 112). Individuals in their study followed them rigidly, inhibiting spontaneity and pleasure, paradoxically becoming another method of control, where anything eaten outside of the plan felt criminal. It appears normalised eating is a fluid concept, changing with time, and across culture (Stiles, 2014), therefore something difficult to be prescribed or taught, and needs to be individualised and explored with individuals. Understanding the meaning of food-engagement is essential, as qualitative research has found some individuals seek out nutritional intervention not for recovery, but as means to control their food intake (Petry, Vasconcelos and Costa, 2017).

1.12.4 Food in Family Therapy

Structural family therapists, Minuchin, Rosman and Baker (1978), emphasise the use of a family lunch session as a key component of their psychosomatic family model, enabling therapists to observe family structures and dynamics (Wallis, Godfrey and Robertson, 2016). The lunch session was specifically to "develop a crisis around eating" and "induce a confrontation…immediately and dramatically related to the presenting symptoms" (Jaffa *et al.*, 2002, pp. 200-201). The rationale is preserved in the manualised treatment, Maudsley Family-Based Treatment (Lock *et al.*, 2001), otherwise known as Family Based Therapy (FBT) titled 'the family meal' (Lock and Le Grange, 2013). These meals are designed to be less confrontational than Minchin's earlier approach; observing how families interact during mealtimes, and through a collaborative stance, coach parents in taking charge of their child's eating (Godfrey *et al.*, 2015). Despite its seeming merits, there continues to be a lack of literature regarding the family meal, and no controlled trials to assess its efficacy (Cook-Darzens, 2016). Various studies consider it unhelpful and highly confrontational, with short-term gains rapidly reversed once control is relaxed (Eisler, 2005), with good outcomes observed in other family-based interventions, without the presence of the family meal (Herscovici, Kovalskys and Orellana, 2017).

The family meal involves families bringing a meal which they feel their child "needs to eat in order to recover from anorexia" (Cook-Darzens, 2016, p. 387). Parents are fully in control and given the task of supporting their child to "eat one more mouthful" than they are willing to through repetitive and insistent behavioural approaches to demonstrate their authority (Godfrey *et al.*, 2015, p. 77). The goal is to help families consider how "anorexia is irrational and negotiation is counterproductive" (British Dietetic Asssociation, 2019, p. 43). When this occurs, it represents a symbolic victory for the family over the ED, giving parents a "taste of success" (Rienecke, 2017, p. 70) to continue with the task of refeeding their child (Lock and Le Grange, 2001). The focus here is not to empower the child but parents, as such, FBT has been criticised as missing the young person's voice (Williams, Wood and Plath, 2020). Furthermore, qualitative research has revealed the family meal can feel a false occasion (Whitney *et al.*, 2012), with application outside of the therapeutic environment inconclusive, without the guiding presence of a therapist (White *et al.*, 2015b).

Family therapists draw upon supportive strategies, including affirmations, encouragement, and empathy (Godfrey *et al.*, 2015), yet experience anxieties when faced with conflict (Couturier *et al.*, 2017). Only a small number or therapists report using the family meal regularly due to its sense of intimidation and anxiety, and its lack of applicability to meals in real-world contexts (Couturier *et al.*, 2013). Nevertheless, 'therapist drift', referring to the lack of adherence to EBT is common within the context of EDs (Wallace and von Ranson, 2012). Divergence from such manuals to guide treatment may arguably reflect clinical judgements based on a broader grasp of FBT, and the integration of other therapeutic strategies (Kosmerly, Waller and Robinson, 2015). Although the manual provides some brief interventions when the meal is not proceeding as planned, family meals are a "varied occasion" (Godfrey *et al.*, 2015, p. 78), bringing into question whether a manualised approach can attend to the unique contextual elements of family life and eating. It is suggested therapists would benefit from discussing the meal of choice with the individual to improve engagement, and ensure meals are adequately challenging (Godfrey *et al.*, 2015).

Several researchers and clinicians criticise overemphasis on eating and weight gain as the only successful outcomes within FBT (Gardner and Wilkinson, 2011; Lindstedt *et al.*, 2015). This may result in individuals improving eating habits to appease those around them, creating a pseudo-recovery, but experience persisting cognitive and affective symptoms when treatment ends (Conti *et al.*, 2021). Herscovici and colleagues (2017) deviate from the manualised version in favour of clinical judgement, advocating the success of the family meal is based on individualisation and repetition. Their approach emphasises patient empowerment including encouraging individuals to select meaningful symbolic foods, which conjure up a sense of pleasure and instil agency and hope; with whatever eaten at the end of the meal, considered a success. Although their vignettes are anecdotal in nature, their findings reveal the importance of tailoring support, retaining a flexible stance and exploring meaning.

Parents are positioned as experts for devising a nutritional plan for their child in FBT, whilst therapists remain neutral, in a consultative position (Lock and Le Grange, 2013). However, concerns have been raised around the responsibility of care given to parents in FBT, which has felt beyond their capacity (Hay, Touyz and Sud, 2012; Wufong, Rhodes and Conti, 2019). Wufong et al. (2019) study, interviewing parents utilising FBT, felt the narrow focus on eating behaviours neglected broader issues, and expressed feelings of guilt attributed to refeeding. FBT is based upon a non-blaming approach of parents; however, findings paradoxically reveal FBT had an opposite effect; significant, as parental empowerment has been found to be the most salient factor of FBT (Dimitropoulos *et al.*, 2016). Although treatments have been called to move beyond behaviours and incorporate more flexibility (Williams, Wood and Plath, 2020), Aradas et al. (2019) narratives of nine clinicians utilising FBT found dominant medical discourses centred around the use of ‘evidence-based practice’ overshadowed any flexibility, undermining clinician judgement and patient preference.

1.12.5 Cognitive Behavioural-Based Approaches

Cognitive Behavioural Therapy (CBT) in the context of ED treatment, offers a structured approach towards behavioural and cognitive changes around food intake and eating patterns; housing several techniques including food diaries, meal planning, behavioural experiments, and exposure therapy (Waller *et al.*, 2007). It is underpinned by the notions that over-valuation of weight and shape drives ED behaviours (Fairburn, Cooper and Shafran, 2003), leading to avoidance and safety behaviours (Butler and Heimberg, 2020). Exposure therapies, originally developed for anxiety-based disorders, is commonly used, or integrated into existing treatment (Steinglass *et al.*, 2012), such as practical food groups (Biddiscombe *et al.*, 2018), food shopping, or eating in restaurants (Stewart and Williamson, 2004b), to confront eating and food fears, disprove ED related fears, and create new associations towards food and eating (Butler and Heimberg, 2020).

Fear of food following acute weight restoration is considered one of the most challenging obstacles in recovery (Cardi *et al.*, 2019). As a response, Steinglass and colleagues developed Exposure and Response Prevention for Anorexia Nervosa (AN-EXRP), a manualised treatment specifically for anorexia, addressing eating-related anxiety in a hierarchal gradual manner; producing preliminary results in reducing anxiety (Steinglass *et al.*, 2012; Steinglass *et al.*, 2014). However, as individuals may value their ED, exposure therapy may be limited, as individuals may pursue behaviours to sustain their illness. Another limitation includes the time-limited nature of CBT, which may foster feelings of failure if 'recovery' is not achieved in this time (Treasure *et al.*, 2011). It is therefore recommended that exposure-based therapies are adapted to an individual's level of motivation (Schaumberg *et al.*, 2021). Glasofer et al. (2016) singular case study, provides qualitative insight into how AN-EXRP can be flexibly modified, and effective in establishing a therapeutic alliance, building self-efficacy, and fostering confidence. The therapist, who authored the piece, reflectively reported the intervention was primarily collaborative (Glasofer *et al.*, 2016). In contrast to disempowering meal descriptions in inpatient settings, which removes all control (Boughtwood and Halse, 2008), this study reveals the treatment's potential in encouraging responsibility, choice, and ownership.

Mirroring principles of CBT, Biddiscombe and colleagues' (2018) describe an Australian OT food group within an ED day programme. Groups included cafe and restaurant visits and preparing and cooking meals under the guidance of an occupational therapist and dietitian to challenge negative food behaviours and thoughts. Non-standardised questionnaires found overall food exposures increased participants' social confidence, reduced anxiety and provoked more positive thoughts around facing future challenges. However, some individuals discuss difficulties replicating the changes outside of the programme due to a lack of community support and challenges of engaging with recovery within a weight-conscious society. This highlights the critique of CBT, locating EDs within the thought processes of individuals, and neglects wider factors and influences (Gremillion, 2009). Contrasting to Biddiscombe et al. study which recruited less acutely ill individuals to participate, Mack et al. (2023) describes the benefits of experiential learning and exposure to feared foods in an OT led inpatient meal preparation group. The group supported the normalisation of meals and highlights the importance of earlier involvement of OT in meal preparation interventions to effectively support individuals transition to lower levels of care. However, the qualitative aspect of their mixed-methods study was limited to brief statements as opposed to in-depth exploration, giving justification of this thesis.

Literature cites practical food groups promote choice, social inclusion and improve functioning and lasting recovery following hospital discharge (Lock *et al.*, 2012; Wheatley *et al.*, 2014). Significant, as it is noted that individuals in recovery seek active roles in eating activities (Long *et al.,* 2012b; Mack *et al*, 2023) and petition for real-word experiences (Offord, Turner and Cooper, 2006). Occupational therapists provide such opportunities through peer-led support, and engagement in every-day contexts, linking life to living in the outside community (Godfrey, 2016).

1.12.6 Community Meal Support

Community meal support has been recognised as an important aspect of recovery (Watt and Dickens, 2018) aiming to restore eating behaviours, promote weight gain, prevent admission to inpatient units, and for children and young people, empower parents to support their child to eat at home (Kells *et al.*, 2013). Like that of inpatient nutritional management, community care has also been criticised for lacking clear protocols and guidance (Bezance and Holliday, 2014), and its use in the community, poorly evidenced (Long *et al.*, 2012a). However, despite calls for standardisation (Watt and Dickens, 2018), this would appear contradictory to the petition of personalisation lacking in other studies (Long *et al*, 2012a). For young people, community meal support’s effectiveness depends largely upon parent input and dedication (Bezance and Holliday, 2014), inadvertently resulting in increased pressure upon parents, with some families reporting the presence of staff during mealtimes act as an intrusion, reducing any sense of normality (Bezance and Holliday, 2014).

Watt and Dickens’ (2018) study exploring the perceived use of community mealtimes from the perspective of six mental health clinicians found as weight gain was the primary goal, mealtimes were reduced to a medium to “just get the calories into them” (Watt and Dickens, 2018, p.34). Although no protocol existed for how the intervention is delivered, it typically followed nurses providing support within young people’s homes, with families preparing a meal according to a meal plan devised by a dietitian. Time limits were introduced as well as vigilant direction and close observations of “manipulation techniques” (Watt and Dickens, 2018, p. 32). The rationale for mealtime management is typically administered to assist individuals to learn new skills and provide a normative experience in relation to eating a “typical meal” (Bakker *et al.*, 2011). In contrast, the results from this study reveal clinicians focused firmly on temporary weight gain, and not therapeutically, resulting in a “wrestling of power” (Watt and Dickens, 2018, p. 35).

An alternative intensive community model for severe and enduring anorexia has been proposed (Munro *et al.*, 2014b; Hannon, Eunson and Munro, 2017). The programme provides long-term continuity of care through forming positive therapeutic relationships and treatment is flexibly applied, aimed at addressing all aspects of the person, where nutrition is just one component. Phenomenological accounts found patients found of a sense of safety in practicing changes in real world contexts, offering a sense of normality (Hannon, Eunson and Munro, 2017). Nutritional changes were gradual, made at the patient’s own pace and choice. Recovery was only made possible by exploring the meaning and function of the illness, which developed self-insight. The authors conclude pushing patients to change is ineffective, when they are not ready to do so, and negatively reinforces experiences of failure. This approach stands in sharp contrast to experiences of treatment where weight gain is the priority, and through commitment to long-term care, it diverges from time limited input (Bezance and Holliday, 2014), leading to a sense of abandonment through fast outputs of care (Matthews *et al.*, 2019).

1.13 Conclusion to Chapter One and Overview of the Thesis

Chapter One introduces the reader to the context of the thesis, and provides a reflexive account which underpins this thesis, and a rationale for why this research was needed. It offers an overview of anorexia and ED treatment, OT's role in EDs, and literature pertaining to the role of food and eating in treatment. It also provides a critical overview of the varying understandings of EDs, to highlight how EDs including anorexia are socially constructed and culturally influenced, whilst importantly real and serious. In conclusion to this chapter, despite the importance of food in treatment, few studies explore the meaning of food-related occupations from individuals own perspectives, giving weight to the proposed research.

The subsequent chapter, the Literature Review, will further explore the meaning of anorexia to present justification for the proposed research. Following this, Chapter Three will present the research methodology, considering the philosophical underpinnings of the research, and rationale for Interpretative Phenomenological Analysis. Chapter Four will present the methods, including recruitment, tools for data collection, analysis, and ethical considerations. Chapter Five presents the findings of the research, presenting five emergent themes, with their own sub-themes. Chapter Six details the discussion, linking the findings with existing literature and theories, as well as implications for the research, and the unique contribution of this research.

2.Chapter Two: The Literature Review

Chapter Two presents a hermeneutic literature review, which draws upon qualitative literature to explore how behaviours and symptoms of anorexia are meaningful. The chapter concludes by critically and uniquely considering the literature review findings in light of OT theory, in order to consider how the practices of anorexia can be conceptualised as meaningful occupations.

2.1 Literature Review Aim

Numerous studies examine illness experiences and perceptions using quantitative measures (Holliday *et al.*, 2005) and assessments have been developed to elicit the function of anorexia, and its beneficial and detrimental aspects (Cockell, Geller and Lindern, 2002; Serpell *et al.*, 2004; Marzola *et al.*, 2016). Although helpful, these standardised measures may omit existential and embodied meanings (Naess and Kolnes, 2022). Individual's views of their illness are considered to play a significant role in determining health outcomes (Petrie and Weinman, 2012). Pertinent, considering insight into the function of anorexia is assumed to produce lasting and meaningful changes (Geller, 2006). Yet, many theories concerning the meaning of anorexia are postulated from theoretical and clinical inferences, rather than empirical accounts and individuals own language (Nordbø *et al.*, 2006; Nordbø *et al.*, 2012). Furthermore, the lack of attention to individuals' own meaning-making inhibits therapeutic relationships, contributing to poor outcomes (Voswinkel *et al.*, 2021). Despite the cited benefits of focusing on individual insights, due to clinical, practical and theoretical reasons, "'meaning focused' therapies [have] faded from the field" (Troupp, 2019, p. 19), superseded by attention towards physical restoration and standardised treatment pathways.

As the focus of this study is upon individual subjective accounts, this review sought to explore:

- What are the meanings attributed to the behaviours and symptoms of anorexia expressed by individuals themselves? and,
- To consider from an occupational perspective, in what ways anorexia is a meaningful occupation.

2.2 Literature Review Approach

Considerable debate has been given to the use of literature reviews within phenomenological research, considered by some as potentially limiting access to the lifeworld of others due to the phenomenological concept of bracketing (Fry, Scammell and Barker, 2017). However, rather than bracketing preconceptions and assumptions - as later elaborated in the methodology section - IPA works from a hermeneutic perspective, where understanding emerges from interpretation (Heidegger, 2001; Gadamer, 2004).

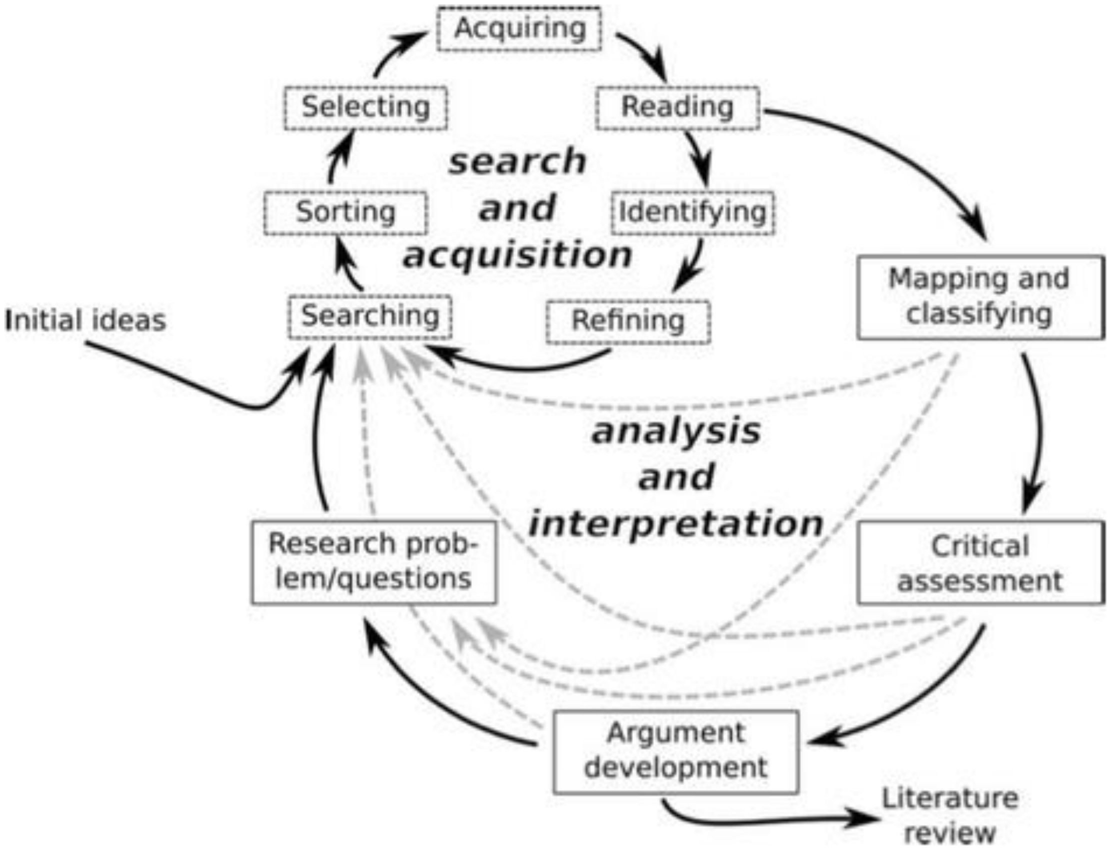
The review did not intend to answer a pre-defined, closed research question, where emphasis is placed upon objectivity and technicality. Therefore, a hermeneutic approach to the literature was adopted, which allowed for flexibility in the research question, changing as understanding deepened and developed; an iterative, interpretative, rather than linear approach (Boell and Cecez-Kecmanovic, 2010).

A hermeneutic framework provides a way of being attuned during the research process, which is open and in dialogue with texts to offer a unique interpretation (Smythe and Spence, 2012). This approach reflects the philosophical roots of the study, mainly of Heidegger and Gadamer; later discussed in methodology. According to Heidegger, the meaning of phenomenon "lies hidden…covered up…[and] in disguise" (Heidegger, 1962/2001, p. 59) within the familiarity of experiences but is revealed through reflection and questioning. Gadamer considers understanding is "the art of listening" (Gadamer, 1995, p. 274) and understanding always involves interpretation.

Existing ED research is argued to contribute to taken-for-granted assumptions, and medicalised constructions of anorexia (Rich, 2006), contributing to "pervasive cultural systems of representation" (Warin, 2004, p. 95), whilst lived experience remains latent (Warin, 2004; Musić *et al.*, 2022). Hermeneutics does not seek to solve answers or make categorisations, but is open to multiple interpretations and possibilities - a fitting approach for anorexia, which too is marked with ambiguity and complexity (Williams *et al.*, 2018). Indeed, anorexia is considered a "largely uncharted land that is far from "certainties" (Conti, 2015, p. 178). The hermeneutic lens for this study sought to reveal what is hidden in taken-for-granted notions through critical questioning and reflection.

Hermeneutic reviews do not seek to simply present knowledge that someone else has written but acknowledge inherent preunderstandings, with no final understanding or claims made (Bartley and Brooks, 2021). The end result is considered a re-interpretation to "provoke thinking" (Smythe and Spence, 2012, p. 12). Although iterative and creative, hermeneutic literature reviews are systematic in nature. Boell and Cecez-Kecmanovic (2012) describe two mutually intertwined hermeneutic circles, 'the search and acquisition circle' and 'the wider analysis and interpretation circle' (Figure 1). Within this, searching and acquiring is systematic yet iterative, and as sources accumulate, interpretation and clarification are needed through progressive focusing.

Figure 1 The hermeneutic circle as a framework for literature Reviews [6]



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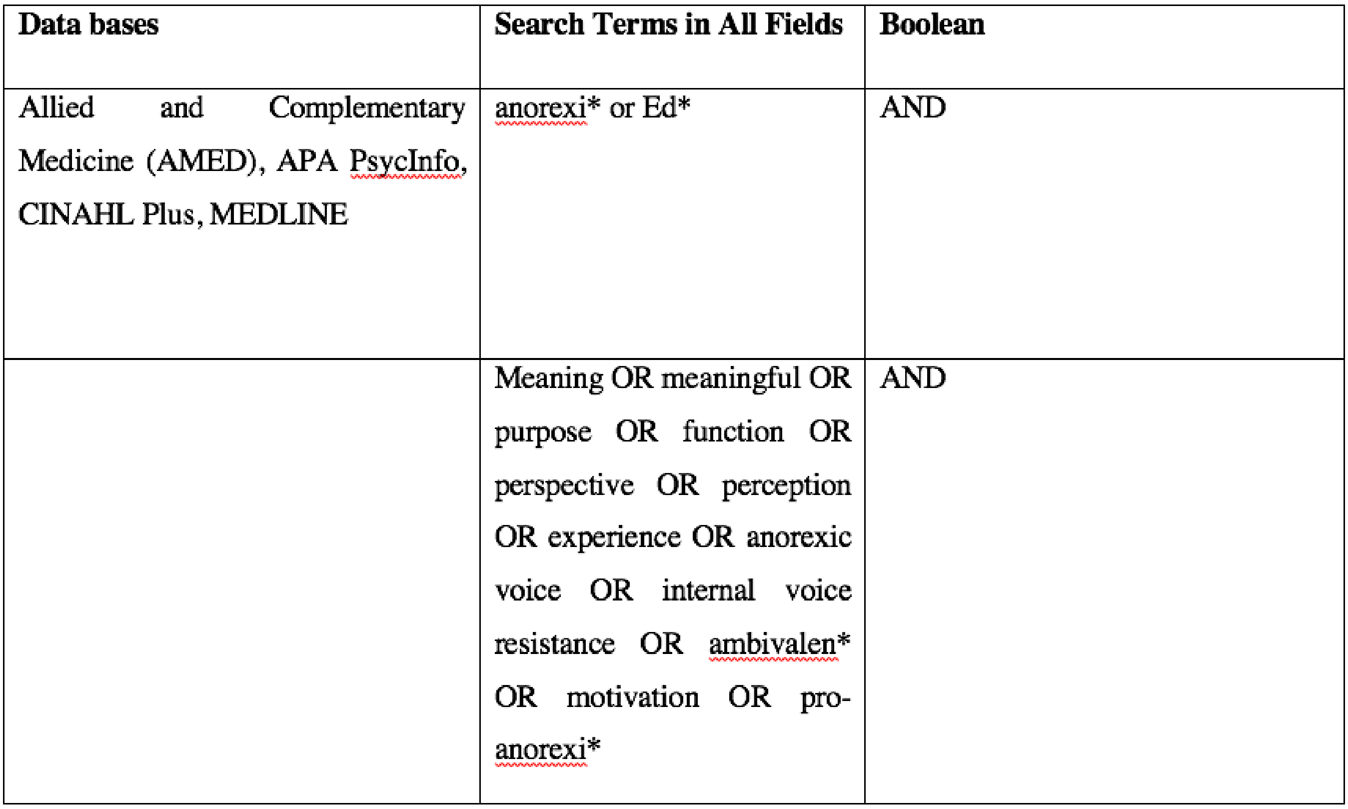
[6] Image used with permission from Sebastian Boell.

2.3 Search and Acquisition Circle

Initial engagement with the literature emerged from a concern to understand the role of food and eating in the treatment of anorexia, therefore policies and grey literature were read widely, leading to tracking evidence cited. These findings have been summarised, condensed, and integrated into the context chapter of this thesis, helping to map the range, extent and nature of existing research, bringing attention to how research is typically conducted in the field and identifying knowledge gaps. Yet a description of food activities in anorexia and treatment seemed vague, as I questioned what defines a food 'activity'? Through a process of analytical reading, deeper understanding led to further questioning, thus the research question shifted from activities, to an *'exploration of the meaning of food and eating in anorexia'.* The focus becoming less on the doing and activity, but rather on the experiential nature of the meanings associated with food-related engagement in anorexia. Based on my initial readings, I concluded a more focused search was required.

Searching for literature is considered itself to be a hermeneutic circle, part of wider analysis and interpretation (Boell and Cecz-Kecmanovic, 2014). A combination of terms via EBSCO Host were searched, to find relevant publications (Table 1 Search Terms)

Table 1 Search Terms



Data bases	Search Terms in All Fields	Boolean
Allied and Complementary Medicine (AMED), APA PsycInfo, CINAHL Plus, MEDLINE	anorexi* or Ed*	AND
	Meaning OR meaningful OR purpose OR function OR perspective OR perception OR experience OR anorexic voice OR internal voice resistance OR ambivalen* OR motivation OR pro-anorexi*	AND

Due to the volume of findings (6,447), and as hermeneutic reviews prioritise a limited number of highly relevant publications (Boell and Cecz-Kecmanovic, 2014), the following criteria was applied:

Inclusion criteria:

- Reference to/or direct focus on meaning of anorexia/illness, and/or meaning of behaviours/symptoms for individuals living/lived with anorexia,
- Individuals recovering/recovered from anorexia either self-diagnosed or medically[7], or part of a mixed sample of individuals,
- No time restrictions on publication to ensure maximum coverage,

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[7] Although aware that underlying mechanisms around food and eating are considered similar across different ED presentations from a transdiagnostic model, the focus of this research was upon individuals with a label of anorexia, therefore other presentations were omitted. Samples which included eating disorders, yet did not specify which eating disorder, were judged on their own merit and how well it addressed the research phenomenon. This is because the term anorexia may not be used by all authors due to epistemological, methodological or personal positions.

- Published empirical primary research,
- Published in English language due to time and financial constraints for translation and
- Adult and adolescent populations.

Exclusion criteria:

- Where focus is solely on meaning of recovery, meaning of treatment and not on meaning of the illness itself,
- Quantitative literature as the focus was on meaning which lends itself to a qualitative framework rather than a focus on physical symptoms and behavioural patterns,
- Where anorexia is not the primary focus (e.g., co-morbidity and cancer),
- Secondary reviews (although reference lists were searched if the review topic was applicable) as the aim was to get as close to first person perspectives rather than third order interpretations,
- Where perspective was solely caregivers and/or healthcare professionals, as the focus was on lived experience. However, if the sample included a mixed sample of professionals, patients and families these were included.

Following filtering of peer-reviewed journals in English language, 3,582 articles were located. Articles were screened for their relevance to the phenomenon by reviewing titles, followed by abstracts. In the case of findings produced by the same author of the same study, but presented in multiple journals, only one journal was used (although both may be referenced below).

Following this, reference tracking helped to identify further pertinent literature. A second literature search specifically focusing on the meaning of food and eating was conducted. Therefore, additional terms such as “food”, “eating”, “meal” and “cooking” were also included, reflecting the iterative nature of the review.

2.4 Analysis and Interpretation Circle

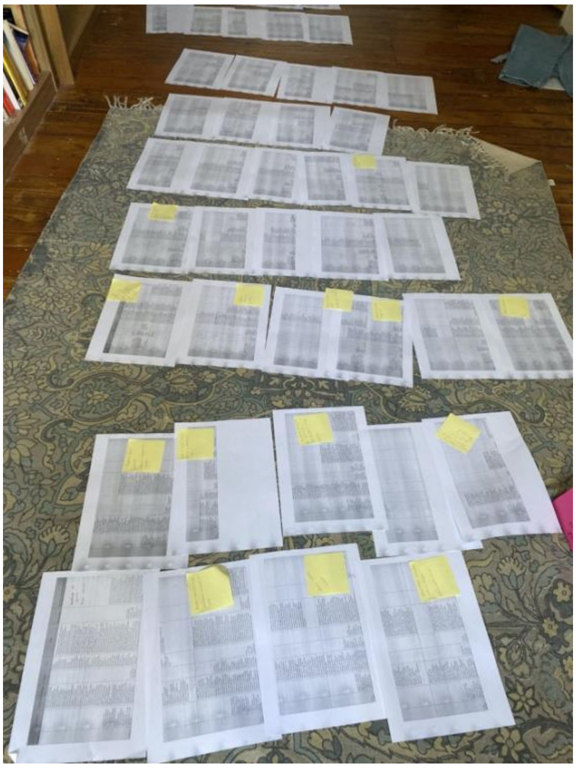
Hermeneutics is concerned with the process of interpretative understanding, which never occurs in isolation but is interpreted in context of other papers. In other words, “how the understanding of parts relates to the understanding of a larger whole” (Boell and Cecez-Kecmanovic, 2010, p. 132). Reading, is therefore a core component (Boell and Cecz-Kecmanovic, 2014), as Finlay states, “the more you dwell, the more you will feel yourself engaging with the phenomenon" (Finlay, 2012, p. 186). As new insights emerged, additional terms were searched, and integrated into the search strategy. It was not considered certain search terms would enable access to all knowledge, rather these were gateways in language to further understanding. Nevertheless, as meaning is highly idiosyncratic, the linguistic parameters put in place may have obscured all forms of meaning.

I followed the hermeneutic notion of 'inclining' (Heidegger, 1976): a concept which encourages the researcher to follow lines of enquiry in texts which offer inspiration and understanding. This encompassed reading grey literature in the form of theories and texts from feminism, anthropology and social sciences. I also attended conferences to deepen my understanding, a valuable source of knowledge and supported by hermeneutic reviews which highlight that published journals and texts are not the only way to gain understanding of a topic.

The process was open-ended and circular in nature, moving continually between the two circles as described by Boell and Cecez-Kecmanovic (2010). Reading challenged common and taken-for-granted assumptions, as well as reflexive self-awareness considering biases, prejudices and pre-understandings as my "fusion of horizons" expanded. A notion referring to the possible interpretations which emerge from an individual's worldview, which are inextricably linked with being-in-the-world (Gadamer, 2004).

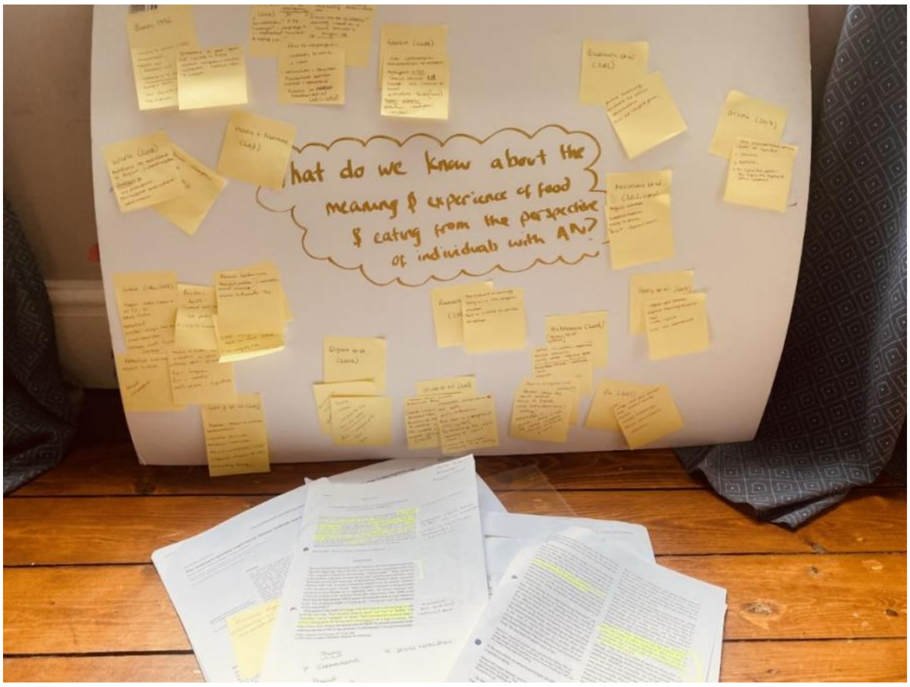
Assessing articles based on tools, such as the Critical Appraisal Skills Programme (CASP, 2018), were considered unsuitable given the range of epistemological/methodological frameworks presented. Rather critical assessment involved mapping and classifying articles based on the disciplinary/theoretical lens, methods for data collection, sample of participants and a summary of main themes to explore how the phenomenon has been typically viewed. This helped consider connections/disconnections and identify gaps in the literature. I engaged with this in a physical and embodied way by printing the stored table of literature findings, laying them out on the floor and taking time to build an understanding of how individual publications, are connected with the whole (Figure 2 mapping and classifying).

Figure 2 Mapping and Classifying



To attempt a more radical critique, Boell and Cecez-Kecmanovic (2014) recommends a reflexive attitude towards the literature, where previous assumptions are scurtinised and reconsidered (Alvesson and Skoldberg, 2009). Therefore, I reflexively considered the meaning of food and eating in anorexia in practical ways including brainstorming and journalling (Figure 3 Practical Reflection).

Figure 3 Practical Reflection



Knowing when to cease a literature review remains undetermined. However, within hermeneutic studies, knowledge is dynamic and contextually situated to time and place (Williams *et al.*, 2018). Therefore, ceasing the literature review occurred when knowledge saturation was subjectively reached, and I could justify the research whilst remaining curiously open to possibilities.

2.5 Critical Assessment of the Whole Body of Findings

From the database searching, 21 qualitative articles were selected and included. Most articles reflect a psychological/psychiatric disciplinary lens (11). The remaining include post structuralist/feminist (2), anthropology (2), clinical/nursing (2), physiotherapist/psychological (1), and three undisclosed, however from the author's professional leaning appear to be psychologically orientated. This makes sense, as concepts such as meaning, and experience are psychological-related terms, and therefore findings may reflect the language we have available to us to describe the phenomena.

The methodology/framework range from grounded/constructivist grounded theory (3); critical discursive analysis (2); variations of phenomenological analysis (9); thematic analysis (3); coding (1); Polkinghorne's life history/classification of analysis (2) and one unclear concerning the analysis procedures undertaken. Data collection methods include interviews (14); written methods (3); online methods, such as forums, online messages, online focus groups and e-messages (4). For participant recruitment, most studies use participants purposefully selected by their treatment team, rather than recruited from the wider community or self-selected. A limitation of this method potentially excludes a more diverse sample population and poses ethical dilemmas, including author or clinician bias and feelings of obligation to participate. All studies represent females, except two, which had a mixed sample; in these, females significantly outnumbered males. This may reflect the greater proportion of females compared to males diagnosed with anorexia and seeking treatment (Räisänen and Hunt, 2014). Research emanated mostly from Western countries, such as USA, UK, Canada, Europe, and Australia except one which recruited a diverse range of international participants online. The lack of non-Western contexts is pertinent as it is identified that meanings attributed to anorexia in non-Western countries are different to that of Western accounts (Lee *et al.*, 2001; Soh, Touyz and Surgenor, 2006).

From hand searching, a further 17 articles were located. The disciplinary and theoretical lens are mostly psychologically orientated (5), followed by anthropological (3); embodiment theory (1); nursing (1); feminism (2); bioethical (1); sociological/social sciences (2); narrative approach (1) and two were unclear The analysis include phenomenology (3); grounded theory/constructivist grounded theory (3); thematic analysis (4); constant comparative analysis (1); feminist post structuralist analysis (1); ethnography (1); autoethnography (1) and three unclear. Data collection methods included interviews (10) within these, one used photo voice and another used digital storytelling; ethnographic methods (2); online forums (1); written materials (2); focus groups (1) and autoethnographic material (1). Although letter writing could assume a more creative approach, these were constrained by word count (Tierney and Fox, 2011). However, more creative and collaborative approaches were also described (La Marre and Rice, 2015; Broomfield, Rhodes and Touyz, 2021). Like the database search, most participants were recruited from treatment centres with a clinical diagnosis of anorexia and were female, aside from five studies, which included a mixed sample of males. This may reflect difficulties in accessing participants, thus justifying the use of gatekeepers. However, this approach tends to privilege medical diagnosis of anorexia over lived experience (LaMarre *et* *al.*, 2023). All but two originated from Western countries. Four studies include adolescent perspectives, and the remaining reflect adult populations. Only one study describes the sexual orientation of participants (La Marre and Rice, 2015), a gap in knowledge, as research indicates lesbian, gay, bisexual and transgender (LGBT) individuals experience higher prevalence of EDs (Parker and Harriger, 2020).

From the second literature search which explored the meaning of food and eating in anorexia, a further 15 articles were located. Despite a central concern of food in ED treatment, qualitative studies exploring how individuals with anorexia perceive food and eating are limited. This literature review found experiences of food and eating spanned different stages and contexts, with participants actively unwell (McNamara, Chur-Hansen and Hay, 2008); in treatment (Long *et al.*, 2012a), as well as those in recovery (Ulian *et al.*, 2013). It is noted stages of recovery impact the experience of food and eating (McNamara, Chur-Hansen and Hay, 2008), therefore not all meanings of food and eating presented in this review are homogenous. Studies suggest experiences of food and eating do not wholly normalise once in recovery and meanings were similar whether considered ill or in recovery (Savuskoski, Uusiautti and Määttä, 2016; Petry, Vasconcelos and Costa, 2017). The theoretical framework varied including anthropology (6), phenomenology/cultural phenomenology (5), psychology (2), and a Foucauldian lens (2). These studies used broader methods of data collection aside from interviews, including diary writing and drawings and mixed methods, including ethnographic fieldwork and psychological evaluation, narratives, and photo elicitation methods alongside interviews. This may reflect the idea that understanding the meaning of food and eating requires a more creative and varied methodological approach to elicit relevant data. These studies also include a more diverse sample of participants, four studies were from non-Western countries (Brazil and Israel), including male representation, with most relying upon self-diagnosis, rather than diagnostic clarification for participation. This may be reflective of the predominance of a social science lens, as opposed to a psychological lens found in the initial search.

It is important to highlight that no studies were located from the field of OT on the meaning of anorexia, overshadowed by psychological and clinical perspectives. Although helpful, this may only look at the meanings located within the mind of the individual, rather than broader occupational and social meanings. Most of the literature understood the meaning of behaviours as a drive for weight loss, perfectionism and achievement. The exceptions were from the field of anthropology, feminism and social sciences, where meanings were contextualised within individuals' everyday lives. Overall, most studies reflect female perspectives, a criticism, as the experience of males is often overlooked in the field (Robinson, Mountford and Sperlinger, 2013) and highlights a need for more diverse experiences of ED. Although OT was not mentioned, many authors discuss how "spending time involved in occupational activities such as work, school or hobby (Fox, Larkin and Leung, 2011, p. 122), contributes to recovery (Broomfield, Rhodes and Touyz, 2021).

Whilst there has been some tentative exploration of the meaning of anorexia in OT (Godfrey, 2013), these have been constrained by small study research (Duzyk, 2022), such as case studies (Sørlie *et al.*, 2020) or engaged at a theoretical and conceptual level (Elliot, 2012). No research to date has phenomenologically explored the meanings of food-related occupations from an occupational perspective.

Based on a hermeneutic literature approach, the findings are thematically presented below.

2.6 Anorexia and Conflicting Meanings

Serpell and colleagues' (1999) grounded theory study was among the first to empirically explore the psychological meanings anorexia holds. 18 female patients were instructed to pen a letter to anorexia, addressing it both as friend and enemy. Based on these letters and recurring themes, the authors developed a coding scheme of the 'pros and cons' of anorexia. Reported benefits of the illness include feeling protected and safe, gaining a sense of control, feeling special and different, increased confidence and avoiding unpleasant emotions. Despite expressed benefits, individuals were aware of the deleterious effects of anorexia, impacting their bodies, relationships and what they wanted to do. This highly cited and pioneering work reveals the diverse ways in which anorexia is experienced and led to further empirical investigations, based upon Serpell et al.'s (1999) original coding scheme (Freedman *et al.*, 2006; Marzola *et al.*, 2015). Although insightful, these studies present a polarised view of the qualities of anorexia, and arguably reduces meaning to a singular code, whilst other research reflects the multi-layered and contradictory meanings, which are not exclusively positive or negative but simultaneous and co-existent (Petry, Vasconcelos and Costa, 2017; Moola and Norman, 2017; Stockford *et al.*, 2018b).

Nordbø and colleagues' (2006) study, unlike the aforementioned studies (Serpell *et al.*, 1999; Freedman *et al.*, 2006) did not request individuals to discuss beneficial or deliterious aspects of anorexia but invited individuals to discuss meaning on their own terms. Meanings were not static, but changed, becoming more or less prominent during the course of the illness. Their findings reveal eight functional themes anorexia offers: a sense of security; avoidance of negative emotions and experiences; an inner sense of mastery and strength; self-confidence; a way to craft an identity; eliciting care from others; a form of communication and a wish to starve oneself to death. Regarding the latter, some consider that death is not a willingness to die borne out of depressive symptoms but rather that anorexia is more valued and powerful than life itself (Tan *et al.*, 2006).

Other research references the shifting and temporal nature of meaning, revealing positive attributes of the illness appear more strongly during the early stages of the ED, adapting negatively as the illness develops (Tierney and Fox, 2010; Ison and Kent, 2010; Tierney and Fox, 2011). These interpretations assume a linear journey from positive to negative affect or vice versa, presenting a dichotomy of meanings, whilst other studies reveal the co-occuring and paradoxical presence of both positive and negative aspects (Conti, 2015; Kolnes, 2016), which continue long after critical phases, or treatment (Cheney, Sullivan and Grubbs, 2018). Eli's (2018b) phenomenological study concludes the nature of the illness is full of co-existent contradictions, which are both "desirable and destructive" (Eli, 2018b, p. 15). This brings attention to conceptual debates whereby the medical model positions anorexic subjectvity under a singular pathologised identity and meaning structure. Yet more critical readings, consider anorexia as plural, representing multiple identity positions and meanings (Gooldin, 2008; Conti, 2015). Conti (2015) considers that "no one meaning accounted for the entirety of… lived experience" (p.170), and rather individuals in her study lived with simultaneously negotiated multiple meanings.

Looking past binary description of positive versus negative meanings, a range of metaphors describe the meanings of anorexia. Some of these affirmative, such as a constant reliable friend (Warin, 2006; Williams and Reid, 2010); a saint (Mulveen and Hepworth, 2006); guardian (Freedman *et al.*, 2006) and rock (Colton and Pistrang, 2004). These contrast to more undesirable connotations, such as an enemy, alien (Voswinkel *et al.*, 2021) monster, leech and demon (Williams and Reid, 2012). From these studies, it can be considered that anorexia takes on an entity, persona and relationship of itself. Tierney and Fox (2011), who used creative methods to elucidate meanings including written descriptions, poems and artwork, parallel the relationship with anorexia to relations involving domestic violence, both of which revolve around appeasing an abuser, diminishing self-esteem, and contributing to ambiavelent feelings leaving such relationships. Although findings highlight the ensnarement of anorexia, their methodology which placed restrictions on word count and time taken to return materials may have limited exploration of meanings. Williams and Reid (2012) also discuss the meaning of anorexia as a relationship, where participants metaphorically describe anorexia as a "love-hate relationship' … between 'an abused woman' – and her 'abuser'" (p. 805).

Anorexia is described as a solution to past traumas (Dignon *et al.*, 2006; Broomfield, Rhodes and Touyz, 2021), a sanctuary, a piece of life which can be owned (Fox, Ward and O'Rourke, 2005a), and a "bubble of your own making" (Williams, King and Fox, 2016, p. 220), providing a means to cope with life's challenges (Gulliksen *et al.*, 2017) and resolve underlying psychological difficulties (Higbed and Fox, 2010; Fox, Larkin and Leung, 2011; Stockford *et al.*, 2018b). Anorexia is considerd to enter life at a time of vulnerability, stressful situations and unhappiness, which brings order, safety and a welcome distraction from existing concerns (Tierney and Fox, 2010; Williams and Reid, 2010; Stockford *et al.*, 2018b; Kolnes, 2016). Many accounts also discuss how anorexia occurrs during a developmental window (Tan, Hope and Stewart, 2003b; Dignon *et al.*, 2006; Williams and Reid, 2010; Broomfield, Rhodes and Touyz, 2021), reflective of theoretical and clinical literature where anorexia establishes during identity development (Weinreich, Doherty and Harris, 1985; Orbach, 2018). Fox, Larkin and Leung (2011) consider this relates to the sense of 'specialness' anorexia offers, which coalesces with stage of development, resulting in an exaggerated egocentricity - a tendency to think of self as unique or special. Whilst, O'Connor and Esterik (2008) consider anorexia develops during adolesence, as it is a time of transition, where individuals need to find and express their identity. Discussions of development may be due to the majority of study participants, in the body of literature being adolecents or young adults.

Anorexia is not only a response to past traumas (Broomfield, Rhodes and Touyz, 2021), or end-goal, but a way of being, and surviving the here and now (Williams and Reid, 2012). The term 'functional' is frequently used in the literature (Williams and Reid, 2010; Higbed and Fox, 2010; Fox, Larkin and Leung, 2011), described elsewhere as a "logical solution" (Musolino, Warin and Gilchrist, 2020, p. 5), and "the glue" (Musolino, Warin and Gilchrist, 2020, p. 7) holding life together. Anorexia is pursued as means of survival (Musolino, Warin and Gilchrist, 2020; Lavis, 2018), becoming the “lesser of two evils” (Rance, Clarke and Moller, 2016, p. 132). Considering the poweful meaning anorexia offers here, and the consequences of leaving a controlling force (Tierney and Fox, 2011), brings understanding as to why individuals pursue anorexia inspite of severe medical and social implications (Lavis, 2018). Gooldin (2008), in her anthropological investigation of ‘Being Anorexic’, considers anorexia is not just a response to cultural meanings or ways of “shaping the body”, but “meaningful ways of being in the world” (p.291), where everyday ED behaviours and feelings of hunger are transformed into self-efficacy, power, and achievement. This shows how subjective experiences and meanings can be vastly different to that of medical and clinical opinon.

Although appearing to be the solution to distress and offering control, anorexia is acknowledged as paradoxical, contradictory, and ambiguous, becoming, and transforming into something which is controlling and critical (Williams and Reid, 2010; Robinson, Mountford and Sperlinger, 2013). The literature discusses how anorexia results in a loss of agency (Lavis, 2018), likened to a prison-like sentence (Tierney and Fox, 2011), contributing to missed life opportunities (Stockford *et al.*, 2018b). Addiction-like discource is often used, with anorexia likened to a “drug” (Eli, 2018b, p. 8) or a ‘crutch’, something individuals need to survive (Williams and Reid, 2012; Conti, 2018). Therefore, the positive aspects of anorexia are fragile and fleeting (Kolnes, 2016), this tension is described as a “double bind”, a “CATCH-22” (Rance, Clarke and Moller, 2016, pp. 129, 132), and self-perpetuating (Stockford *et al.*, 2018a). Fuelling further avoidance and fear (Dignon *et al.*, 2006), preventing access to a wide range of life domains (Fox and Leung, 2009; Mulkerrin, Bamford and Serpell, 2016), creating imbalance (Button and Warren, 2001), and negatively impacting upon identities (Stockford *et al.*, 2018b).

2.7 Ambivalence Towards Recovery

Given the perceived benefits, anorexia has been correlated with high levels of ambivalence around change, which contributes to treatment avoidance and withdrawal (Nordbø *et al.*, 2012). In the wider literature, there have been attempts to measure ambivalence (Hoetzel *et al.*, 2013); however assessment tools may limit in-depth exploration around meaning, or take into account the clinical environment where individuals may struggle with verbalising their emotions

(Nordbø *et al.*, 2012), or are hidden, or misunderstood within treatment contexts perceived as harmful.

Whilst some literature positions ambivalence simplistically as a fear of weight gain (Gale *et al.*, 2016), others more broadly draw attention to the paradoxical meanings of anorexia, where anorexia is considered valued, familiar and safe, but also tormenting, distressing and dangerous (Mulkerrin, Bamford and Serpell, 2016; Broomfield, Rhodes and Touyz, 2021). Furthermore, beliefs and behaviours are not always within an individual's control (Higbed and Fox, 2010), with individuals describing feeling powerless and trapped (Mulkerrin, Bamford and Serpell, 2016) and the qualities of the illness too strong to depart from (Tierney and Fox, 2011; Kolnes, 2016). Ambivalence appears to arise from conflicts of pursuing anorexia, which ultimately leads to death, but living in coherence with one's values, or to abandon one's values altogether, leading to moral and existential dilemmas (Orsini, 2017). However, to fully understand ambivalence, a broader perspective beyond the individual, including their social context, and treatment factors need to be considered.

Ambivalence is sometimes used interchangeably with denial in the literature. However, denial should not be conflated with a lack of insight or incompetence (Vandereycken, 2006). The literature reveals that despite being very low in weight, individuals can speak with clarity and hold insight into the nature and consequences of their anorexia (Tan, Hope and Stewart, 2003b; Stockford *et al.*, 2018b). Offering an alternative position to the medical position of denial as a pathology, Conti (2015) in her critical discursive analysis, identifies how women were not in denial but did not identify with medical constructions of anorexia within their lived experience. Similarly, in Cheney, Sullivan, and Grubbs (2018) study, biomedical framings of anorexia were rejected in place of one's own definitions, and instead referred to as a "troubled relationship with food" (p.443), to support presenting their self-image. Denial of anorexia can also relate to sociocultural norms and the language we have available to us to describe 'anorexia'/ 'recovery'. For example, Morris and Szabo's (2013) study in South Africa, found individuals denied anorexia and instead connotated it to a "white woman's disorder" (p.339).

Several qualitative studies identify ambivalence towards treatment itself, where individuals express uncertainty whether they want to recover (Colton and Pistrang, 2004; Reid *et al.*, 2008; Williams and Reid, 2010). Recovery for some felt an impossible and distant construct, which increases despair (Nordbø *et al.*, 2012). Whilst some describe wanting to maintain parts of anorexia, such as confidence and positive body image but relinquish more negative parts (Mulkerrin, Bamford and Serpell, 2016; Kolnes, 2016), and ambivalence ascends from not being able to imagine or anticipate life without anorexia (Kolnes, 2016). This echoes wider discussions in the literature where medical conceptions of recovery assume divorcing self from anorexia (Conti, 2018; Kenny and Lewis, 2021), and Western conceptualisations of time in recovery, force individuals into describing recovery in a linear way (LaMarre and Rice, 2021b). This was not the case for the majority of individuals in the literature, who describe recovery as an ongoing process (Conti, 2018; Broomfield, Rhodes and Touyz, 2021). Literature discusses the iatrogenic harm caused by treatment, referring to harm inadvertently caused by the process of treatment (Elwyn, 2023). Due to a predominant focus on food and weight gain, the literature describes feelings of neglect, trauma and judgement, contributing to ambivalence and strengthening the influence of the ED (Tierney and Fox, 2011; Stockford *et al.*, 2018b; Broomfield, Rhodes and Touyz, 2021; O'Connell, 2023).

Ambivalence is most often framed negatively contributing to shame and stigma; whilst more recent opinion contends that ambivalence can be understood as self-protective (Elwyn, 2023). This was reflected in the literature where ambivalence was a strategy for navigating ED treatment (Eli, 2015a). It has been suggested recovery could be promoted by treatments which find balance between the conflicts underpinning ambivalence, recognising the control that anorexia offers and the threat treatment poses (Reid *et al.*, 2008). Research conducted by Nordbø and colleagues found willingness to recover is fundamental for readiness to change (Nordbø *et al.*, 2006; Nordbø *et al.*, 2008; Nordbø *et al.*, 2012) and advocates exploring individual values and attitudes to define motivation to change (Mulkerrin, Bamford and Serpell, 2016). Similarly, Patching and Lawler (2009) found recovery occurs when it is determined by the individual, enhancing self-determination.

2.8 Embodied Meanings

Emotions towards eating and food range from being “complex and tortured” (Moola and Norman, 2017, p. 270), but also pleasurable, comforting, offering security and warmth, and embodied release (Moola and Norman, 2017; Eli, 2015a). Narrative research by Savuskoski, Uusiautti and Määttä (2016) interprets women’s relationship with food and eating as their “voice, a way of expressing the malaise” (Savuskoski, Uusiautti and Määttä, 2016, p. 81).

McNamara, Chur-Hansen and Hay's (2008) study explored the emotions of adults with an ED after watching a series of 16 images depicting food items. The study, involving one-to-one interviews, found images of food elicited a diverse range of emotions, including disgust, shame, embarassment and guilt as well as feelings of enjoyment and positive control. As food images were presented via two-dimensional representations rather than in-vivo, the findings may have potentially missed emotional reactions that could have been elicited by the multi-sensory aspects of real food. Nevertheless, findings strongly highlight the range of emotions food incites, and encourages practitioners to explore what food means to individuals. Eli's (2015b) research on the meaning of binge eating found participants' binge eating episodes were related to complex emotions and existential experiences. Blackburn, Thompson and May (2012) interviews with four women with anorexia using IPA methodology to understand how individuals perceive hunger, found food was often associated with having an immediate and unwanted effect on the body. They found hunger representing self-control, was a welcomed sensation; a finding echoed in other studies (Gooldin, 2008). Together, these studies highlight how eating represents more than a physiolgical encounter but is laden and grounded in embodied sensations.

Qualitative accounts describe how anorexia avoids and detracts from distressing and overwhelming emotions (Dignon *et al.*, 2006; Fox, Larkin and Leung, 2011; Musolino, Warin and Gilchrist, 2020) and close relationships which may incite emotional vulnerability (Williams, King and Fox, 2016). Unwanted and distressing feelings become manageable when transferred onto something objective such as food (Savuskoski, Uusiautti and Määttä, 2016; Moola and Norman, 2017). Espeset and colleagues' (2012) qualitative study exploring emotions with 14 individuals with anorexia, found anorexia, and the associated behaviours act as a coping mechanism to suppress unwanted and uncomfortable emotions. These findings echo theoretical views concerning impaired emotional processing in anorexia which underlie, or are a consequence of restrictive eating behaviours (Bruch, 1969; Cockell, Geller and Lindern, 2002; Oldershaw *et al.*, 2012). However, this analysis assumes a temporary and linear transition from negative to positive states (Eli, 2015b), discounting the possibility that behaviours are capable of holding paradoxical and simulatenous meanings.

From a more critical perspective, the safety found in anorexia is situated within complex sociocultural contexts and meanings (Musolino, Warin and Gilchrist, 2020), where practices of anorexia connect with being-in-the-world, keeping individuals safe from distress, produced by interpersonal relationships and structural pressures (Eli, 2018b). It is considered anorexia's numbing qualities "anaesthetised" individuals from painful emotions and the world (Lavis, 2018, p.460), and "starved down"… everyday life circumstances" (Musolino, Warin and Gilchrist, 2020, p. 7).

Feminist writers consider how food is positioned as "dangerous, dirty, and disgusting" (Malson, 1998), drawing on Christian language where food is "tainting of the flesh" (Bordo, 1988, p. 95). However, these Foucauldian analytical findings, position food as part of discourse, neglective of the embodied and individual meanings of food (Warin, 2003; Gooldin, 2008). Scholars discuss the embodied materiality of food and eating, where food is much more than an objective or static substance but something which "spills into every aspect of life" (Probyn, 1999, p.217). Personified as "mean and sneaky" (Lavis, 2016, p. 60), as a "villain" (Petry, Vasconcelos and Costa, 2017, p. 5), which "lurks" insidiously" (Moola and Norman, 2017, p. 269); and its human-like qualities, crossing spatial and bodily bounds (Warin, 2003). Warin's (2003, 2010) ethnographic study contests popular understandings that anorexia is a fear of weight gain or a desire to lose weight but emanates from fear of contamination. She draws attention to the specific materiality of food, such as fats and calories - invisible and ambiguous in nature - and therefore food-engagement creates a threatening liaison, due to fears of being out of control where food has the potential to invade bodies and the self. Lavis' (2016, 2018) ethnographic research and theoretical insights using materialist theory, discusses how engagement with food can be simultaneously agential but also fearfully accidental. Although disgust and fear are considered factors in food avoidance (McNamara *et al.*, 2008), Moola and Norman (2017), from a phenomenological perspective, consider how disgust responses and intense emotional meanings around food, should not be approached as individual psychological dispositions, but complex relational encounters, which produce boundaries between self and others.

2.9 Disconnection from Self and Others

Over time disordered and ritualistic eating becomes "routine" (Eli, 2015, p. 369), and practices taken-for-granted (Musolino, Warin and Gilchrist, 2020), with individuals becoming disconnected from internal bodily states (Blackburn, Thompson and May, 2012; Ulian *et al.*, 2013), and their internal voice (Tierney and Fox, 2011). Distanced not just from emotions, but also removed the social and relational world (Kolnes, 2016), contributing to feelings of isolation and loneliness (Rance, Clarke and Moller, 2016).

Eating is a highly relational act; therefore, it is not surprising that the literature reveals the interpersonal impacts of anorexia (Petry, Vasconcelos and Costa, 2017; Stockford *et al.*, 2018b). Kolnes (2016) describes how everyday social relations produce ambivalence. Whilst spending time with others provides distraction, emotional commitments also hold the potential to increase negative feelings, therefore, leading to further ED behaviours. Eli (2018) discusses how ED practices "altered the ways in which participants perceived, sensed and related to others" (p.10), and creates a 'liminal' existence in the world, both 'in and removed'. Through the lens of 'liminality' – a concept referring to in-between states of indefinite temporality and spatiality – Eli, highlights how practices are not individualistic coping mechanisms, but are contextualised in individual's life stories, where practices afford disconnection from broader themes of social exclusion, marginalisation, and oppression. Warin's (2006) anthropological and ethnographic research, also moves past an individualistic reading of anorexia, revealing the diverse ways commensality and relatedness are negotiated. For example, in her study women negated the biological grounding of their bodies – such as menstruation and childbirth - as a way of rejecting potential relationships which could connect them in terms of social obligations. Moola and Norman (2017) also discuss the complex ways in which family relations are entangled in their distress, and suppressing eating, provided distance from intergenerational patterns of disordered eating. Cheney, Sullivan, and Grubbs (2018) examine how denial of food is a way of showing care and enacting a maternal role towards others. These studies, which epistemologies lean more so to a socially constructed worldview, encompass a wider discussion of how anorexia relates to self, the others, and the world.

Whilst anorexia can distance individuals away from others, it can also draw individuals together, through commonalities and sense of belonging in treatment, support groups, or through online spaces (Warin, 2004; Rich, 2006). Coming into contact with others who have experienced anorexia can foster a shared understanding of the symbolic power of anorexia, of its allegiance, distinction, unique set of language and practices (Warin, 2006), and of a "shared destiny" (Eli, 2015a, p. 5). Although narrating accounts retrospectively, Eli's (2015a) ethnographic research of adults hospitalised on inpatient units found individuals connected with another through "a shared way of being-in-the-world" (Eli, 2015a, p. 5) through collective embodied practices and experiences. However, connections are not always positive as they can fuel comparison (Colton and Pistrang, 2004; Rance, Clarke and Moller, 2016) and competitiveness (Stockford *et al.*, 2018b). Some descriptions liken anorexia to a competitive sport, with “the best [at being anorexic] is dead – that’s when you win” (Warin, 2004, p. 101) or a “successful anorexic” (Musolino *et al.*, 2015, p. 21). Eli (2015a) considers treatment ambivalence is a negotiation of being “a part of, and apart from” the ED community, wanting and belonging, but also distinguishing self away (Eli, 2015a, p. 8). Similarly, Warin (2006) describes patient dynamics are in continual flux, where individuals both feel allegiance and affection, but also attempt to disconnect when they want to seek recovery. These reflects the complexity of dynamics, with connections experienced as frustrating and untrustworthy (Rance, Clarke and Moller, 2016).

Whilst disordered eating can give distance from the self, Lavis’ (2018) ethnographic research show how food practices gives connection to oneself, grounding individuals in the present. An individual in Musolino, Warin and Gilchrist’s (2020) study discuss how eating practices are “the only time that I feel okay about myself…[and] makes me feel better being in my own skin” (p.6). Hunger, in Gooldin’s study became a way to “feel herself” (Gooldin, 2008, p. 282) but also a way to disconnect and be outside of the body. A sense of relatedness is formed through a relationship with anorexia, where anorexia replaces other intimate contacts (Warin, 2006), and belonging to the normative practices of the illness connects individuals to the world around them (Musolino, Warin and Gilchrist, 2020). Lester (1997), in her discussion of the (dis)embodied self in anorexia, deconstructs the presumption of medical and feminist cultural models of anorexia, where anorexia arises from a split between self and body. Lester (1997) instead argues anorexia “springs from the all-too-painful realisation that I am my body” (p.485). A body which defines who one is and sends messages to how others respond. Thus, denial of the body is an acknowledgement of the body (Gooldin, 2008). The evidence in the literature strongly supports Lester’s (1997) argument that to analyse anorexia is to incorporate a theory of embodiment, which considers an individual’s psychological experience, and the historical and cultural context in which bodies are situated.

2.10 Anorexia as Identity

In the literature, terms of identity and self are used interchangeably (Tan, Hope and Stewart, 2003b), leading to a lack of conceptual clarity. Nevertheless, the literature reveals anorexia is integral to one’s identity, interpretated as detracting from underlying identity conflicts

(Robinson, Mountford and Sperlinger, 2013) and protection from a fragile sense of self (Williams, King and Fox, 2016) or diminished sense of self (Stockford *et al.*, 2018b). Anorexia can offer an appealing substitute for existing feelings of low self-worth and self-efficacy (Williams and Reid, 2010; Williams, King and Fox, 2016), offering self-control, discipline and virtue (Mulkerrin, Bamford and Serpell, 2016), a sense of power, and feeling special (Espíndola and Blay, 2009).

Anorexia can embody personal values such as achievement and perfectionism (Tan *et al.*, 2006; Williams and Reid, 2012; O'Connor and Van Esterick, 2008), related to themes of morality (Gooldin, 2008), being "good, pure, light" (Banks, 1996), and "holy" (Rance, Clarke and Moller, 2016, p. 132). Mulkerrin, Bamford and Serpell's (2016) phenomenological study provides insight into how anorexia acts in congruence with personal values, becoming symbolic of self-control, discipline, and achievement. Similarly, Williams and Reid's (2012) phenomenological study of meanings of anorexia on pro-recovery websites, found perfectionism – an esteemed value – became actualised in anorexia, perfecting their identity. In a life with a lack of valued roles, such as careers and meaningful relationships, anorexia, becomes a way to fill a meaningful value gap in lives (Stockford *et al.*, 2018b). Anorexia is therefore "not merely accepted as consistent with the 'real self', but valued as accomplishments of the 'best self'" (Vitousek and Gray, 2007, p. 181). Whilst themes of asceticism have been cited in theoretical literature, these tend to be more psychologically-orientated (Palazzoli, 1974; Bruch, 1978). In contrast, Bank's (1996) anthropological case study of an American woman with a long-standing history of anorexia and conservative religious beliefs, gave meaning to her illness within themes of morality, and the spiritual realm. Although dated, Banks' research is significant in understanding the meaning of anorexia on identity formation, as the woman in the case study did not identify as being sick, rather through such beliefs, she formed a positive sense of self.

Identity experiences are not always described positively, individuals discuss losing themselves to anorexia, which is incongruent with their values, and leaves little space for their former self or valued parts of life which form their identity (Tierney and Fox, 2011; Voswinkel *et al.*, 2021). Conti (2015) describes how recovery from anorexia involves a reconstruction of meaning based on individual's values and Broomfield, Rhodes and Touyz (2021) describe recovery as a redefinition of one's values and goals.

Identities are reinforced by others and engagement with the world (Kolnes, 2016). Under the "coveted title" of anorexia which produces a sense of pride, and in the context of diagnostic hierarchies (Ison and Kent, 2010), anorexia is seen as a productive and empowering state of distinction, creating a boundary between who is inside and outside of anorexia (Warin, 2006). Social identity can affect how individuals perceive themselves and engage with treatment; if individuals view anorexia positively, encouraged by social norms, this may contribute to resistance or ambivalence, whilst if they experience a negative social identity, this can enhance motivation to change (Rich, 2006; Ison and Kent, 2010). Identities are also formed by our sense of belonging to family, cemented by rituals and traditions. Much theoretical literature focuses on first degree relatives, especially mother-daughter relationships in the role of anorexia. Whilst Ramalho et al's (2021) study of the role of food in adolescents with anorexia and bulimia, found food is a source of generational conflicts and calls attention to future research to explore the role of food and eating across different cultural contexts beyond the nuclear family.

For some, anorexia becomes integral and enmeshed into their sense of self (Williams, King and Fox, 2016), whilst for others, anorexia is a separate and distinct entity (Williams and Reid, 2012); ego-dystonic, external, and alien to self (Voswinkel *et al.*, 2021). Some studies highlight this spectrum in identification and disconnection (Broomfield, Rhodes and Touyz, 2021; Voswinkel *et al.*, 2021). Disssonance and conflict between self and anorexia creates divisions in the self, "like there are two people in my head" (Williams and Reid, 2012, p. 798), and feelings of leading a "double life" (Rance, Clarke and Moller, 2016, p. 132), where dual qualities represent aunthentic or inauthentic parts of self exist (Voswinkel *et al.*, 2021).

One of the ways anorexia is expresssed in relation to self is through an internal anorexic voice (Fox, Larkin and Leung, 2011; Williams and Reid, 2012; Graham *et al.*, 2019). The characteristics of the voice changes during the course of anorexia, initially giving praise (Tierney and Fox, 2010), a voice that can be depended upon (Williams, King and Fox, 2016), but as time progresses, transforms into a dominant, bullying and critical voice (Tierney and Fox, 2010; Williams and Reid, 2012). Individuals express helplessness in the face of its demands, forced to obey, or feel guilt and disgust, resulting in a loss of self and their own voice (Higbed and Fox, 2010). This toxic relationship with the voice is described as abusive and controlling in nature (Williams, King and Fox, 2016). Tierney and Fox (2011) drew upon literature from women's perspectives of being in abusive partnerships as well as written accounts of indivdiuals' experiencing this inner voice, outlining similiraties of the persuasive and toxic ensnarment of these relationships, where escaping is not a simple process, but creates internal pain, fear and helplessness. Fox, Larkin and Leung (2011) in their IPA study of the personal meaning of symptoms, discuss how the anorexic voice is something which individuals want to get rid of, but also desire to keep, helping them achieve diteary retraint and forming an important part of their experience. Williams and Reid (2012) theorise the anorexic voice as not consistently experinced as a separate entity, and draw upon dialogical theory to conceptualise how the mind can contain multiple positions, which dialogue with one another.

Given the centrality of this voice, a number of EBTs externalise the voice from self to promote compassion and distance (Vitousek, 2005). Qualitative experiences of externalisation reveal mixed experiences, with some feeling dismissed as a person (Voswinkel *et al.*, 2021). LaMarre and Rice (2015) reject clinical ideas that "recovery entails … overcoming and divorcing self from eating disorder" (p.137), and Tierney and Fox (2011) caution such an approach may risk ignoring individual's concerns or thoughts. Indeed, individuals refute labelling of their lived experience as disordered (Conti, 2015) fostering ambivalence around the proposition that they could be separate from themselves, or their social worlds (Hardin, 2003; Musolino, Warin and Gilchrist, 2020). Vitousek argues dualistically separating the self into the 'real self' who is morally elevated above the demonised 'anorexic self' obscures the positive aspects and traits of anorexia, as well as diminishes the individual (Vitousek, 2005).

2.11 Imposed Meanings

Button and Warren (2001) describe how individuals view anorexia as an "outward sign of what's going on inside" (p. 81). The diagnosis of anorexia itself offers recognition and authenticity (Conti, 2015), becoming a sought-after 'title' (Eli, 2015a; Rich, 2006), desired, and positioned as empowering (Warin, 2004; O'Connell, 2023). However, anorexia, which is often characterised by physical definition (O'Connell, 2023), can make these identities "slippery" (Eli, 2015a, p. 4), dependent on the continuous justification to retain and maintain a body which is perceived as 'anorexic' (Rich, 2006; Eli and Lavis, 2021). An identity based on weight loss can contribute to delayed help seeking with individuals not acknowledging difficulties, unless severely underweight (O'Connell, 2023). When individuals begin to recover physically, they are often left questioning their identity and sense of self (O'Connell, 2023). Warin (2006) describes the tensions of psychiatric and medical diagnostics, which can both place and identify yet displace and redientify, with individuals not feeling like ‘real anorexics’ if they do not fit dominant assumptions.

Assumptions based upon dominant medical and clinical narratives of anorexia can contribute to misaligned assumptions of individuals as “just another anorexic” (Colton and Pistrang, 2004, p. 310), or a “typical anorexic” (Boughtwood and Halse, 2008, p.274), obscuring individual narratives, and other meanings (Rance, Clarke and Moller, 2016). Rich’s (2006) ethnographic study highlights the tension of medical pathologising stereotypes of anorexia, which are interpreted through the body, contributing to feelings of alienation and disconnection. In her study, peers, families, and friends, focused on weight and food, making individuals feel under scrutiny and different. Similar findings highlighted by Ison and Kent (2010) noted that when individuals disclosed ED difficulties, they received dismissive and unhelpful responses from others, impacting feelings of self-worth and increasing their isolation.

Based upon historical medical notions of anorexia, established in associations of hysteria and irrationality (Hepworth and Griffin, 1990), research shows that those with anorexia can be labelled “manipulative” (Lester, 2019, p. 290) “irrational, seeking attention or ‘abnormal’” (Rich, 2006, p. 298), “mad” “psycho”, or “crazy” (Conti, 2015), and “untrustworthy” (Voswinkel *et al.*, 2021, p. 9). In contrast to discursive readings of anorexia, Rance, Clarke and Moller (2016) offer insight into the experience anorexia phenomenologically, resulting from a sense of otherness and perceived lack of understanding, leading to experiences of shame.

Medical assumptions do not always fit with individuals’ lived experiences (Cheney, Sullivan and Grubbs, 2018), and create a dualistic repertoire between disordered/normal (Conti, 2015), as well as fracturing trusting relationships, essential for effective treatment engagement (Nordbø *et al.*, 2006; Holmes, Malson and Semlyen, 2021). Therefore, although diagnostics offer legitimacy, they also overlook complex social and emotional difficulties (Rich, 2006). Other imposed meanings of anorexia emerge from cultural interpretations of anorexia (Gooldin, 2008). Some meanings in the literature discuss the influence of certain body ideals (Broomfield, Rhodes and Touyz, 2021), which create pressure to conform (Morris and Szabo, 2013), reinforcing anorexic behaviours. However, other studies reveal bodily readings contribute to feelings of frustrations and belittlement by this one-dimensional perspective, reducing the complexities of anorexia to a desire to be thinner (Tan, Hope and Stewart, 2003b; Dignon *et al.*, 2006; Ison and Kent, 2010; Hilton, 2018).

Some literature poses recovery is possible when individuals base their identity outside the concern of anorexia (Williams, King and Fox, 2016). This is problematic when individuals do not relate to medical metaphors and the anorexic identity is integrated within the self and letting go results in loss and grief (Tan, Hope and Stewart, 2003b; Conti, 2018; Broomfield, Rhodes and Touyz, 2021). Alternative meanings are described of "victory, strength, authenticity, will, and power" (Gooldin, 2008, p. 281), where anorexia is self-inflicted (Conti, 2015), and an autonomous selfhood, contrasting against medical imposed meanings of anorexia where those with anorexia are ill and out of control. Warin (2004) considers this is a "reconfiguration of power" (p.101), and Rich (2006) describes this as 'discursive resistance'.

When individuals do not relate to popular medical and psychiatric discourses around anorexia, they may seek alternative presentations of themselves. This has been studied in relation to "pro-anorexia", or "pro-ana" online forums and connections (Rich, 2006; Lavis, 2018; Gale *et al.*, 2016; Hilton, 2018). Online spaces offer connections for individuals to gain support, acceptance and understanding of their beliefs (Mulveen and Hepworth, 2006) and construct and maintain their identity (Rich, 2006; Williams and Reid, 2010). These online forums have been theorised as challenging biomedical notions, opposing the view that anorexia is an illness to be cured (Fox, Ward and O'Rourke, 2005b), rather presenting anorexia as a lifestyle (Mulveen and Hepworth, 2006; Musolino, Warin and Gilchrist, 2020), and religion (Hilton, 2018) where individuals are 'enlightened' and members of an elite (Day and Keys, 2008). Individuals value the sanctuary online communities offer, absent from the stigma of pathologised or medicalised viewpoints of anorexia (Rich, 2006). Contrastingly, Hilton's (2018) study, involving individuals from a pro-ana website, considered respondents who viewed anorexia as a mental illness rather than a lifestyle choice may have held this view as a deliberate way to circumvent accusatory messages associated with illness and instead invoke sympathy and empathy. However, as data was gathered from naturally occurring online sources following up or clarifying responses with participants was not possible. Whilst Mulveen and Hepworth (2006) IPA research on pro-anorexia internet websites found polarised views, with users distinguishing between anorexia or 'ana' as a lifestyle, representing freewill, control and choice, and 'anorexia nervosa' as a mental illness, where participants used websites to gain understanding and support, and users who existed on a spectrum between the two.

Meanings are more than a desire to be thin but a way to connect, and relate through broader themes such as lack of control, and a way to escape from emotions (Hilton, 2018). Through concealing and secretive practices, individuals can reassert their sense of autonomy and self (Rance, Clarke and Moller, 2016), and in the context of negative treatment experiences, pro-ED websites act as protection (Gale *et al.*, 2016). However, these meanings and associations are not absolute, as individuals experience connection and disconnection within these communities (Eli, 2014), and perspectives can change during recovery (Gale *et al.*, 2016), reflecting the fluid and contradictory meanings of anorexia (Rich, 2006).

2.12 Anorexia within Contextual Meanings

Anorexia is described as a "quest for thinness, purity and virtue" (Day and Keys, 2008, pp. 8-9), and individuals express meanings within control narratives (Conti, 2016). These meanings are embedded within cultural meanings, where food choices are dictated by what is deemed 'healthy' (Ulian *et al.*, 2013; Savuskoski, Uusiautti and Määttä, 2016), and control over the body is positively perceived (Banks, 1996; Musolino, Warin and Gilchrist, 2020). These meanings are influenced by themes of aestheticism and purity (Banks, 1996; O'Connor and Van Esterick, 2008), women's social positioning (Day and Keys, 2008), Western notions of productivity, and citizenship (Musolino, Warin and Gilchrist, 2020) and religious and moral frameworks (Cheney, Sullivan and Grubbs, 2018). Therefore, cultural acceptance and belonging to social norms are motivating and maintaining factors (Mulveen and Hepworth, 2006). Moral concepts influenced by Judeo-Christian theology and traditions (Banks, 1996; Cheney, Sullivan and Grubbs, 2018) are considered influential in the meanings attributed to anorexia, where control and denial over hunger, pleasure and bodily needs are embodied; and anorexia achieves a "moral conversion" (Orsini, 2017) and "salvation" (Rance, Clarke and Moller, 2016). Meanings have also been described as political, where experiences are situated in "social suffering" (Eli, 2018b).

Meanings relating to food engagement are influenced by cultural traditions, informed by local, cultural codes and symbols (Gooldin, 2008; Cheney, Sullivan and Grubbs, 2018). For example in Zulu culture, purging is viewed as a form of cleansing to promote wellbeing and remedy physical and emotional maladies, and vomiting before eating is commonplace, as well as overeating during mealtimes (Morris and Szabo, 2013). In Gooldin's (2008) Israeli study, anorexia negotiates local discourses of normative femininity in terms of fertility and the reproductive body. Cheney, Sullivan, and Grubbs' (2018) ethnographic research in Southern Italy shows how women with disordered eating are influenced by cultural images of women as self-sacrificial. These findings suggest eating difficulties represent a range of diverse subjective meanings, which do not include Western ideals of body image concerns. However, seeming to challenge these findings Savuskoski, Uusiautti and Määttä's (2016) article reinforces the viewpoint that anorexia is a response to body image concerns, interpreting anorexia as an "infinite desire to lose weight, and a huge fear of weight gain" (Savuskoski, Uusiautti and Määttä, 2016, p. 80). It is worth highlighting that Savuskoski, Uusiautti and Määttä's article was in Finnish, thus meaning may be lost in translation. Furthermore, the authors were selective about the data they used to illuminate their findings, describing some of the narratives used for analysis as "repetitious" (p.77), whilst rejecting some written narratives by participants.

Musolino and colleagues (2015; 2020) through a lens of embodiment, describe the taken-for-granted, highly gendered, normative practices of health embedded within society. In their papers, individuals concealed and rationalised disordered eating practices through cultural norms such as exercise practices, popularised diets, and food intolerances. This is also evidenced by Lavis' (2011) research where the pursuit of health enacts forms of self-care; as "good anorexics are healthy anorexics" (Lavis, 2011b, p. 243). Similarly, in Conti's (2015) study, one participant describes themselves as a "safe anorexic who was in control" (p.172); inferring a paradoxical embodiment. Kolnes and Rodriguez (2016) discuss how participants would minimise and redefine the extremes of their overexercising, as being 'sporty', and their engagement represents care for the body. Navigating recovery in sociocultural contexts which privileges certain bodies and food related behaviours is problematic (La Marre and Rice, 2015), as cultural norms encourages self-surveillance over food, weight and bodies (Hardin, 2003).

2.13 Conclusion to the Literature Review Findings

Before commencing this literature review, the background and context chapter found much literature was quantitative in nature, analysing and measuring food behaviours and attitudes (Alvarenga *et al.*, 2014; Foerde *et al.*, 2018), but rarely exploring subjective meanings of food and eating. The parameters placed on the review, including a focus on meaning, therefore offers a distinct perspective, contrasting to the prevalent ways food and eating are often portrayed.

A range of disciplines recognise the meaningful aspects of anorexia are central to the maintenance and entrenchment of ED behaviours (Espíndola and Blay, 2009). However, these are mostly from a clinical or psychological lens, focusing on individual psychopathological cognitions (Tchanturia, Lloyd and Lang, 2013). Studies also tend to position meaning in a dualism between positive and negative attributes of the illness (Serpell *et al.*, 1999; Marzola *et al.*, 2015). However, the findings of this review offer a more nuanced understanding of these aspects, viewing them as diverse, temporal and fluid, and situated in context.

Although literature has shifted away from a sole focus on the meaningfulness of body image, with the broader aspects of anorexia discussed in the fields of anthropology and feminism (Mulveen and Hepworth, 2006; Eli, 2015a), the wider emphasis still remains on individual emotional factors or cognitive distortions, insinuating individuals are emotionally unbalanced, with internal character flaws which need fixing (Rich, 2006). This means characterisations of anorexia in clinical theory and literature are often individualistic, whose beliefs are 'pathological' (Saukko, 2008), and their 'egosyntonic' symptoms reinforce the illness, preventing a willingness to engage (Nordbø *et al.*, 2012; Lester, 2019). Such perspectives root themselves in long-standing, medical archetypes of anorexia, where anorexia is pathologised and othered (Botha, 2015).

Treatments based on the meanings of anorexia support individuals to consider the advantages and disadvantages of the illness, with the therapist's task to work with person-specific defence mechanisms preventing therapy (Abbate-Daga *et al.*, 2013). The focus here is individualistic, discounting wider cultural and gendered meanings of health, food, and the body which influences subjectivities (Malson, 1998; Musolino *et al.*, 2015). Such readings downplay the social, economic, political, and environmental factors which contribute and maintain anorexia (Rich, 2006; Joyce *et al.*, 2019). Indeed, Musolino and colleagues wrote to "divorce oneself from anorexia nervosa would be to … step outside of culture" (Musolino, Warin and Gilchrist, 2020, p. 8).

Notwithstanding these limitations, the literature review revealed that outside of OT, there is a greater acceptance of the nuances and complexity of anorexia including positive associations. Understanding anorexia and its associated occupations as meaningful may be an uncomfortable consideration for the OT profession, due to OT's inherent assumptions around concepts such as meaning and occupation, positioned as positive, productive and health-promoting (Twinley, 2013; McKay, 2021; Kiepek *et al.*, 2022b). In calls for greater critical perspectives of occupation (Hammell, 2009a; Phelan, 2011), considering anorexia and the associated occupations as meaningful will provide a unique opportunity to understand anorexia more richly and bring occupational concepts into a more critical light.

2.14 Occupational Meaning

Occupational science concerns itself with the study of occupation, describing what people do (Hocking, 2009), with a related interest in understanding the meaning of these doings (Elerin, 2015). It has been suggested that understanding the meaning of an occupation is essential in clarifying its true nature (Ikiugu and Pollard, 2015), and making and expressing meaning through occupation is the "ultimate therapeutic intervention" (Crabtree, 1998, p.507). Meaning in occupation is the means through which individuals interpret their lives and find value in their existence. Despite this, occupation within professional discourse has historically been obscured by arbitrary categorisation, discounting meaning (Wilcock, 1998d; Hammell, 2009a). However, research shows meaning of occupations rarely fit into neat categories; meaning is not static, but dynamically changing (Hammell, 2004; Twinley, 2021b), dependent on affect, goals, social-environmental factors, the presence of others, time and place (Hammell, 2009b). Furthermore, occupations can hold multiple and conflicting meanings (Hocking, 2009), varying across culture and time (Hammell, 2009a).

Writers suggest occupation should be experientially viewed (Wilcock, 1998c; Hammell, 2004), emerging first and foremost from personal experience (Hammell, 2009b; Reed, Hocking and Smythe, 2011), through a synthesis of doing, being, becoming, and belonging (Hitch and Pepin, 2021). Others contend 'outcomes' (Doble and Santha, 2008), and 'occupation-as-ends' should be removed from OT terminology altogether, rather focus should be on the phenomenological process of "doing with meaning" (Royeen, 2002, p. 116).

Outside simplistic categorisation of occupation (self-care, productivity and leisure), several scholars call attention to occupations which people choose to do and find meaning in but are unhealthy, antisocial and risky (Hitch, Pepin and Stagnitti, 2014b; Twinley, 2017; Rule and Twinley, 2021). Twinley (2013) coined the concept the dark side of occupation to challenge taken-for-granted pervasive assumptions within the profession around the connection between occupation, health, and wellbeing. This concept acknowledges neglected meanings amidst "theories of occupation [which] are culturally specific, class-bound, ableist, and lacking in supportive evidence" (Hammell, 2009b, p. 107).

Therefore, methods for categorising occupations have received a wealth of critique (Doble and Santha, 2008; Jonsson, 2008b; Hammell, 2009b), neglecting the complexities and idiosyncrasies of meaning (Roberts and Bannigan, 2018). These have been considered to be reflective of Western sociocultural ideologies (Hammell, 2009b), privileging individualistic, goal-directed, purposeful activities for economic benefit (Hammell, 2004; Hammell, 2009b). Such categorisation arguably offers little insight into how occupation is experienced and given meaning to by individuals (Jonsson, 2008a). Furthermore, it lacks attention to diverse cultural meanings (Reed, Hocking and Smythe, 2011) and reduces meaningful occupations to include only those which are positive for health and wellbeing (Twinley and Addidle, 2012; Kiepek *et al.*, 2022b). Gaining further understanding of the experiences of human doing, requires “a new direction for theory that fully encompasses the concept of meaning” (Hammell, 2004, p. 301); one that captures the complexity and different aspects of meaning (Reed, Hocking and Smythe, 2010; McKay, 2021).

The personal meaning of particular occupations have been empirically explored from walking (Wensley and Slade, 2012), cycling (Feighan and Roberts, 2017) to cake decorating (Scheerer *et al.*, 2004) and dancing (Borges de Costa and Cox, 2016). However, consideration of who defines meaning, the dimensions of meaning, and the link between occupation, meaning and health, remains unclear despite OT’s value of meaning (Doble and Santha, 2008; Reed, Hocking and Smythe, 2011). Furthermore, there has been a lack of concordance in conceptualisations of meaning across studies (Eakman *et al.,* 2018). Doble and Caron Santha (2008) assert OT have failed “to understand how meaning is generated and call for research to find steps to “enhance meaning”” (2008, p.189). Without clearer understanding of meaning, studies jeopardise being “incomplete, over-reaching, or misplaced” (Elerin, 2015, p. 404).

Whilst bearing in mind the limitations of OT’s positive bias around meaning, based upon the common attributes and characteristics described in OT literature relating to meaning/meaningful occupations, the following section will address the second objective of the literature review, exploring how anorexia and the associated practices can be considered meaningful occupations. It will avoid being repetitive and duplicate the literature review findings above, therefore, what is presented below makes brief parallels between the literature review findings and studies and theories of occupational meaning.

2.15 Anorexia as a meaningful occupation

2.15.1 Subjectivity

In occupational science and OT literature, the personal and subjective aspects of occupations (Scheerer *et al.*, 2004; Roberts and Farrugia, 2013) defines what is considered meaningful (Polatajko *et al.*, 2004; Black *et al.*, 2019). Hammell (2004) suggests occupations should be understood through reference to the meanings attributed to occupations, where meaning is described as a feeling or experience which meets intrinsic needs.

Pierce (2001) contends that as occupations are personally constructed; objective interpretations of meaning are “necessarily inexact” (p.139). Therefore, what is perceived as meaningful is not something concrete but abstract, unique, and idiosyncratic (Hasselkus, 2011) and assumptions to classify, define and understand occupation by outward appearance overlook its essence (Twinley, Jacobs and Clarke, 2021). The findings of this review reveal anorexia is subjectively and personal meaningful for individuals (Eli, 2015b; Cheney, Sullivan and Grubbs, 2018), and although attempts have been made to code such meanings into universal themes (Serpell *et al.*, 1999), these meanings are multiple, diverse and shifting (Conti, 2015). For example, some of the literature highlights how anorexia is perceived as a mental illness (Hilton, 2018), whilst others view this as an uneasy concept, considering anorexia as part of their identity (Higbed and Fox, 2010; Conti, 2015). The meanings of food and eating are also highly variable; inciting fear and anxiety (Savuskoski, Uusiautti and Määttä, 2016; Blackburn, Thompson and May, 2012), a form of distraction (Lavis, 2018), as an object to exert control over (Moola and Norman, 2017), but also a form of pleasure (Ulian *et al.*, 2013), comfort (Williams and Reid, 2012), and desire (Warin, 2003). Whilst in treatment, food can be perceived as both relief and discomfort (O’Connell, 2023). These variable meanings highlight inherent in the notion of meaning is recognising its subjective and unique elements (Eakman *et al.*, 2018).

Individuals in the literature express difficulties in locating meanings within socially constructed and/or objective medical assumptions of anorexia (Rich, 2006; Conti, 2015). They can experience frustrations when the meanings of their doings are imposed by pre-suppositions (Dias, 2003; Warin, 2006), such as a desire for bodily thinness, visually defining and legitimatising what it means to be anorexic (O'Connell, 2023).

Therefore highlighting the need to honour individuals own subjective meaning-making and how they interpret their own experiences. As Weinblatt and Avrech-Bar assert “It is impossible to give an individual’s occupation any meaning other than the subjective meaning that they, themselves, choose to give it” (Weinblatt and Avrech-Bar, 2001, p. 169).

2.15.2 Agency and Control

Given the emphasis of personal subjectivity, it appears occupations which are autonomously chosen, allowing individuals to exercise their agency, are those most meaningful (Eklund, Erlandsson and Persson, 2003; Ikiugu, 2005; Black *et al.*, 2019). In the literature, anorexia is meaningful as it offers a sense of control (Button and Warren, 2001; Williams and Reid, 2010), fostering feelings of power and mastery (Conti, 2015; Nordbø *et al.*, 2006). These meanings are embedded within an individual’s context, where gaining control over food represents a search for autonomy and independence from family members (Ramalho *et al.*, 2021), or within Western contexts, where the thin body carries connotations of a controlled life (Musolino *et al.*, 2015). Furthermore, amidst lives with a lack of perceived control, restricting food may be viewed as the only aspect which can be controlled (Williams and Reid, 2012). For example, in environments where there is a lack of autonomy, such as ED treatment, individuals in the literature found even greater meaning in their ED practices (Warin, 2010; Broomfield, Rhodes and Touyz, 2021). However, the control anorexia offers is equally positioned as an illusion (Dias, 2003), becoming controlling in nature (Williams and Reid, 2010), representing “slippages and losses of agency” (Lavis, 2016, p.57).

2.15.3 Purposefulness and Goals

In the literature, anorexia is frequently referenced as ‘purposeful’ in nature (Higbed and Fox, 2010; Tierney and Fox, 2011; Broomfield, Rhodes and Touyz, 2021). In all eight thematic constructs on the meaning of ED symptoms, Nordbø and colleagues (2006) found all behaviours served a purpose and were functional in nature. In OT literature, purpose and meaning have been inextricably linked, with meaning giving purpose to occupations whilst purpose can be derived from meaning (Aguilar *et al.*, 2012). However, although occupations are often labelled ‘meaningful’, these are criticised as focusing on purposeful, and goal-directed doings framed within Western contexts (Hammell, 2004).

Hasselkus (2006) proposes meaning is more closely associated with how it is perceived and engaged, rather than its outcome or purpose.

Meaning is also fostered by achieving goals which direct and motivate occupational engagement (Bejerholm and Eklund, 2006). The literature reveals anorexia serves as a goal that individuals feel safe and comfortable with, increasing self-confidence (Fox, Larkin and Leung, 2011). The diagnosis of anorexia itself is perceived as a desirable position and an ambition which individuals strive towards (Warin, 2006; Lavis, 2011a). The visual dimensions of anorexia, including bodily thinness, often defines what it means to be anorexic within medical and cultural spheres (Rich, 2006; O'Connell, 2023); thereby acting as a form of communication to show others the legitimacy of their suffering. However, anorexia is not connected to any particular common reason, such as striving for an ideal physique, but situated in various areas of life and meanings (Savuskoski, Uusiautti and Määttä, 2016). Contrary to views that anorexia is motivated by the end-goal of becoming thin, the literature review describes the purposes of anorexia are meaningful and purposeful through embodied everyday practices and a way of being (Gooldin, 2008; Eli, 2018b). Furthermore, some individuals in the literature do not relate to cultural stereotypes such as a desire to be thin (Morris and Szabo, 2013) and draw upon local contexts and meanings which justify and shape ED practices (Gooldin, 2008; Cheney, Sullivan and Grubbs, 2018). Other studies show how the physical effects of anorexia are undesirable (Fox, Larkin and Leung, 2011). This therefore highlights Lavis' statement that although "anorexia is enacted with the body … [it is] never simply about the body" (2018, p 464).

2.15.4 Values

When occupations hold value and importance, they contribute to a sense of meaningfulness (Reed *et al.,* 2011). Value is thought to be a prerequisite of meaning; where value is that which is concrete and visible, personally or culturally symbolic or holding self-reward (Perrson *et al.*, 2001). Anorexia in the literature reflects personal and cultural values (Tan *et al.*, 2006; Williams and Reid, 2012; O'Connor and Van Esterick, 2008). Literature describes how the physical and behavioural doings of anorexia become symbolic and representative of one's morality and values, such as self-control, discipline, and hard work (Mulkerrin, Bamford and Serpell, 2016; Cheney, Sullivan and Grubbs, 2018), with the thinner the anorexic body, the higher the coherence between values and self (Orsini, 2017). In clinical literature and theory, characteristics such as perfectionism and a need to achieve are often tied to individual personality traits or a consequence of starvation (Vitousek and Stumpf, 2005; Schmidt and Treasure, 2006). The focus here is on individual factors and not on wider consideration, including sociocultural Western ideals which shapes values (Musolino *et al.*, 2015). Indeed, the need to be perfect can be a response to parental expectations or way to conform to societal expectations around gender roles and body shape (Williams and Reid, 2012).

Values are not always positively framed, occupations can be valued when they relate to obligation, determined by what concerns us (Reed, Hocking and Smythe, 2010), and those which are undesirable (Avrech Bar, Forwell and Backman, 2016). This contrasts to the often positive framing of value in OT literature, including those which are joyful and offer a sense of flow (Kiepek *et al.*, 2022b). In the literature review, the practices of anorexia are not always within an individual's control, considered a compulsion, addictive (Nordbø *et al.*, 2012), and something which is controlling and dictating (Tierney and Fox, 2010). The values relating to anorexia compromise and create tensions with other life domains and values (Mulkerrin, Bamford and Serpell, 2016). Vitousek and colleagues suggest highlighting this dissonance in values may enhance motivation for treatment and change (Vitousek, Watson and Wilson, 1998). The literature reveals a re-evaluation of one's values supports motivation and a reconstruction of meaning (Conti, 2015; Mulkerrin, Bamford and Serpell, 2016). However, acknowledging this incongruence may equally lead to feelings of guilt, loss and shame, with individuals unable to reconcile the values of anorexia and their personal values (Mulkerrin, Bamford and Serpell, 2016).

2.15.5 Performance

Meaning is often associated with the quality of occupational performance and 'doing' (Hammell, 2014), contributing to self-esteem and feelings of success (Pöllänen, 2013). Although occupation is intended to be an inclusive term "replete with meaning" (Nelson, 1997, p. 22), it has been traditionally attributed to self-directed, and action-orientated doings (Hammell, 2014). A continued problem among the profession is the expression and understanding of occupation, and its synchronicity with activity (Pierce, 2001). Polatajko et al. (2004) describes an activity becomes an occupation if the activity is personally meaningful and specific, a view shared by others, where occupations are subjectively lived and contextualised (Pierce, 2001; McKay, 2021).

Doing involves embodied and active engagement, relating to bodily sensations and evoking sensory infused memories and feelings (Hannam, 1997; Beagan and D'Sylva, 2011; Roberts and Bannigan, 2018). Similarly, the findings emerging from the literature reveal anorexia is made up of meaningful embodied practices (Lavis, 2016; Blackburn, Thompson and May, 2012); conjuring up sensory qualities (Warin, 2003), which defines identity (Mulveen and Hepworth, 2006). Whilst anorexia nervosa literally means loss of appetite, this was not reflected in the findings, where individuals are active in their suppression of hunger (Petry, Vasconcelos and Costa, 2017), rather than its loss (Orsini, 2017). Hunger is something which is lived through, rather than only a physiological response (Gooldin, 2008; Eli, 2015b), and anorexia and its practices offers a way of being-in-world which responds to and navigates distress (Williams and Reid, 2012).

Anorexia is made up of a performance, of what is expected, informed by diagnostic categories (O'Connell, 2023). Lavis (2011) discusses how bodily thinness visually defines what it means to be anorexic and is central to its performance. Treatment replicates the practices that it assumes to be central to the illness, and through this projection, "many learn how to 'do' and 'be' the clinic's anorexia" (Lavis, 2011, p.279). However anorexia requires 'continual work' to maintain its presence (Lavis, 2016), and committing to recovery can lead to tumultuous emotions, with an identity and body no longer defined as anorexic (O'Connell, 2023).

Meaning and performance is not considered as only positive; women in Tierney and Fox's (2010, 2011) study did not relate to anorexia as an empowering state, instead they discuss how anorexia is constraining, creating despair and despondency. Indeed, much of the literature highlights the negative effects of anorexia, impeding role formation and its social and relational impacts (Kolnes and Rodriguez-Morales, 2016; Broomfield, Rhodes and Touyz, 2021), as well as bearing physical and psychological consequences (Blackburn, Thompson and May, 2012). Meanings are multiple and fluid, transitioning and changing depending on context (Broomfield, Rhodes and Touyz, 2021), where practices and anorexia are both wanted but also painful and out of control (Williams and Reid, 2012; Lavis, 2018). Similarly, OT literature highlights how meaning is contextually dependent, varying across the life span (Ikiugu and Pollard, 2015).

Meaning is also associated with self-efficacy and competence in occupations (Leufstadius *et al.*, 2008; Ikiugu *et al.*, 2015). In order for individuals to experience competence, the just-right-challenge of engagement must be present (Argentzell, Håkansson and Eklund, 2012). In the literature review, the practices of anorexia can be empowering and foster feelings of being a 'good' anorexic (O'Connell, 2021). However, they also reveal although those with anorexia appear skilled and competent in food-related engagement (for example preparing food for others), the meaning of this could be located firmly in anorexia rather than in recovery (Gooldin, 2008; Lavis, 2018). Therefore, assuming meaning based on competence or doing, can miss the underpinning motivation behind the action.

Meaning closely relates to the motivation to continue engagement. In a study of cake-decorating, Sheerer et al. (2004) found meaning and motivation are mutually influencing, meaning supports initial engagement and influences motivation, whilst motivation sustains engagement, and in turn influences meaning. Motivation can be influenced when meaning is for others, for example when receiving praise from others (Pöllänen, 2013). In the literature, the anorexic voice is considered motivating (Tierney and Fox, 2010), reinforced by the social environment (Musolino *et al.*, 2015), with the functions of the illness driving further engagement (Serpell *et al.*, 1999), impacting motivation to recover (Nordbø *et al.*, 2012).

Meaningful doing also relates to how we spend our time, offering structure, and contributing to feelings of self-worth (Hammell, 2004). The related practices of anorexia also offer routine and structure (Serpell *et al.*, 1999; Musolino, Warin and Gilchrist, 2020), provides a meaningful role (O'Connell, 2023) and creates value amidst a lack of other meaningful life roles (Stockford *et al.*, 2018b) and social networks (Broomfield, Rhodes and Touyz, 2021). Continued engagement with the illness; however, creates distance from other occupations and life roles and produces the conditions which perpetuate the desire of anorexia, and “to do anorexia well (instead of normal life)” (O'Connell, 2023, p. 273).

Nevertheless performance of the practices of anorexia can prevent further harms in life (Lavis, 2018), mitigating distress and responsibilities (Lavis, 2018; Godfrey, 2013), whilst offering adaptive qualities, such as increased confidence and productivity (Nordbø *et al.*, 2012; Musolino *et al.*, 2015). This corresponds with Kiepek et al.'s (2022) consideration of substance misuse as a meaningful occupation, of which engagement can indirectly affect other occupational pursuits, making these more pleasurable. As well as Trombly's (1995) view of meaning, where meaning is motivated by not only the estimated reward but also the threat or fear of detrimental consequences from non-participation. It has been considered that other occupational pursuits cannot be matched with the pleasure and meaning gained from the ED. As Sørlie et al. (2020) identifies as an occupational therapist working in EDs, engaging in "“unhealthy behaviours” were the only activities … engaged in during the day that did not carry the pressure of meeting the needs of others" (p.155).

2.15.6 Wellbeing

Meaning gained from occupation relates to a sense of wellbeing (Hammell, 2014). Research shows engaging in meaningful occupations helps relieve feelings of sickness and pain, and maintain a sense of wellbeing during stressful life experiences (Pöllänen, 2013). Whilst a lack of meaningful occupations can have a negative effect on health (Whiteford 2000). Much OT literature emphasises positive aspects of meanings related to health and wellbeing when engaging in occupation, such as producing calming and relaxing effects, (Roberts and Farrugia, 2013), offering a sense of flow (Križaj *et al.*, 2019), allowing individuals to de-stress (Wensley and Slade, 2012) and view things from a new perspective (Pöllänen, 2013). Likewise, anorexia is shown to have psychological benefits (O'Connell, 2023; Nordbø *et al.*, 2006) as well as physical benefits such as greater body confidence and absence of menstrual periods (Serpell *et al.*, 1999).

Although there has been a focus upon the health-promoting effects of meaningful occupations, meaning and health are not binary constructs but are nuanced and complex. Eidevell and Leufstadius (2014) discuss that painful, as well as positive emotions can arise from engaging in meaningful occupations. Similarly, Feighan and Roberts (2017) found in their study of cycling, that cyclists experienced joy and visceral pleasures and a way of expressing undesired pent-up feelings. Kiepek and colleagues' (2022a) study on substance use, found substances, although bearing negative effects also elicit positive emotions, including winding down, a way to manage with stress and feel good (Kiepek *et al.*, 2022a). Kiepek and Magalhães (2011) challenge dichotomising occupation being healthy or unhealthy, or good or bad, rather occupation can hold multiple meanings. Ikiugu et al. (2019) also criticise a narrow focus on socially sanctioned occupations constrains critical scholarship relating to social change. In taking up a non-medicalised perspective of health and wellbeing, as encouraged by theorists in the profession (Whalley Hammell and Iwama, 2012; Hammell, 2017), the review found anorexia can relate to this broader description of wellbeing, offering positive emotions, and a sense of belonging (Warin, 2006; O'Connell, 2020), despite also eliciting pain, suffering and shame (Rance, Clarke and Moller, 2016; Lavis, 2018). Musolino et al. (2015, 2020) argue that ED practices such as ‘detoxification’, fasting, and following common health and nutrition practices, can be ways of performing care. Lavis (2016; 2018) also found that not eating is a form of self-care, protecting from painful interpersonal relationships and traumatic life events. Physiological explanations of anorexia identify food restriction increases opioids in the brain, and lifts mood, and thus creates a sense of wellbeing (Gorwood *et al.*, 2016). The qualitative literature from this review elucidates this, describing how anorexia offers a ‘high’ (Warin, 2006; Nordbø *et al.*, 2012), and ‘buzz’ (Musolino, Warin and Gilchrist, 2020).

OT studies and theorists often draw from Csikszentmihalyi’s writings when discussing meaning (Persson *et al.*, 2001b; Ikiugu *et al.*, 2019), a positive psychologist, who put forward that optimal experiences in everyday life contribute to quality of life and meaning. ‘Flow’ is a construct defined by Csikszentmihalyi which describes subjective psychological states, occurring when there is complete engagement in an activity (Csikszentmihalyi, 1997). Roberts and Bannigan’s (2018) meta synthesis, identify that occupations are meaningful when they offer complete absorption, adding a sense of restoration, joyful and spiritual emotions, echoing the fundamental characteristics of a sense of flow. The results of the literature review found anorexia can hold characteristics of flow, being immersive and offering rest (Lavis, 2018), fostering feelings of excitement (Musolino *et al.*, 2016), and a way of feeling good (Button and Warren, 2001).

Ikiugu and colleagues suggest meaningful occupations do not always trigger positive affect (Ikiugu *et al.*, 2015) and their work has since attempted to differentiate meaningful occupations from psychologically rewarding occupations (Ikiugu *et al.*, 2016; Ikiugu, 2018).

They determine that occupations associated with flow are psychologically rewarding; however, not all meaningful occupations are immediately psychologically rewarding but can in the long-term, produce a sense of health and wellbeing (Ikiugu and Pollard, 2015). Meaningful occupations can in fact be mundane or involve pain and suffering (Ikiugu *et al.*, 2015). Although both concepts share some similarities: both offering a sense of control and self-transcendence, meaningful occupations are unique in that they relate to identity, connection to other people and a larger reality, competence and self-expression. These findings challenge presuppositions that meaningful occupations are only those that offer positive effects.

Wellness, illness, and recovery are not binary constructs in the literature. LaMarre and Rice's (2015) study discuss how 'full recovery' is an overwhelming rather than helpful goal, and this definition only intensifies the battle between self and the anorexic voice (Williams and Reid, 2012). Wellness is not simply the absence of anorexic symptoms, recovery instead is a non-linear process, and reticence to claim full recovery does not imply individuals give up or settle for 'less than' (La Marre and Rice, 2015). Whilst medical conceptualisations of recovery focus on the absence of symptoms, with emphasis on the body, the literature review suggests recovery is psychosocial (Stockford *et al.*, 2018), with some individuals focusing more so on quality of life irrespective of symptoms. Furthermore, rather than seeking to obliterate anorexia wholly from their lives, the review indicates that individuals learn to live with anorexia (Conti, 2018). Higbed and Fox (2010) emphasise therapy should support individuals to "maintain life with anorexia" (p. 321), and others discuss rehabilitative models, which do not focus solely on symptom reduction, but allow individuals to function with their illness (Hannon, Eunson and Munro, 2017; Stockford *et al.*, 2018b).

2.15.7 Identity

In the literature, some occupations are considered to be "always part of my life" (Boerma, Russell and Aguilar, 2010, p. 80) whilst other research reveals engagement in occupations can form identities (Unruh and Elvin, 2004) away from labels, illness, or disability (Eldevall and Leufstadius, 2014). Anorexia in the literature is powerful in shaping identity (Warin, 2006; Williams and Reid, 2012), providing a distinct and empowering identity amidst feelings of low self-worth (O’Connell, 2023), emerging in the backdrop of one’s life narrative (Kolnes and Rodriguez-Morales, 2016). In the context of stigmatising labels (Rich, 2006), anorexia may be rejected as a mental illness or diagnostic label, instead related to as an “empowering state of being… and way of life” (Warin, 2010, p.7). Through engagement with the doings of anorexia, further identification with the illness is established (O’Connell, 2023). The earlier suggestion from Christiansen (1999) that engagement in occupation builds multiple identities, is reflected in the literature review where individuals relate and shift between the anorexic identity and their personal identity (Williams and Reid, 2012).

When individuals are no longer able to engage in meaningful occupations that reflect their identity, as can happen during illness, life-transitions or life disruptions, they can experience a loss of self-definition, which can be detrimental to their self-image (Blank, Harries and Reynolds, 2015). Hammell (2004) describes how biographical life disruptions can offer the creation of new meanings, and that occupations can change the meaning of life disruptions. In the literature, anorexia is experienced as a consequence of, and also a solution to “biographical disruption” (Lavis, 2018, p. 4). It emerges at a time of stressful situations, and life transitions (Williams and Reid, 2010), and over time, becomes relied upon as a constant and dependable entity; thus, envisaging life without anorexia creates pessimism and fear (Higbed and Fox, 2010). The literature also identifies how loss of the anorexic identity creates existential questioning (Williams, King and Fox, 2016).

Identities are associated with certain social or cultural groups and what is valued within these settings (Feighan and Roberts, 2017). Engaging in occupation can reflect one’s cultural and social identity. Engagement in occupations, also connects individuals to past relations, fulfilling family obligations and rituals (Beagan and D'Sylva, 2011) and preserving one’s cultural identity, whilst maintaining and shaping future identities (Hannam, 1997; Wright-St Clair *et al.*, 2004). Anorexia is seen to emerge in the context of family stress and financial problems (Morris and Szabo, 2013), family enmeshment (Banks, 1996) or disconnected family relations (Broomfield, Rhodes and Touyz, 2021). Food in the literature also contains intergenerational meanings (Moola and Norman, 2017), and within the context of family, identity and belonging; acceptance of food was viewed as akin to care (Ramalho *et al.*, 2021; Orsini, 2017).

Conti, using narrative theory, encourages an approach which seeks to understand individual’s own metaphors, which allow alternative identities to be reclaimed (Conti, 2015; Conti, Rhodes and Adams, 2016).

Vitousek and colleagues' urge therapists to acknowledge the meaning of the illness and the difficulties within change to "*experiment* with new ways of being" (Vitousek, Watson and Wilson, 1998, p. 414).

2.15.8 Life Story

Empirical evidence suggests occupation is meaningful when it contributes to an individual's meaning in life, bringing coherence and continuity (Reed, Hocking and Smythe, 2010; Perrson *et al.*, 2001). People are meaning-makers, who use occupation to express themselves and know their authentic selves (Eidevell and Leufstadius, 2014). 'Being', a dimension of occupation, is often referred to as capturing this aspect of reflection, contemplation and discovering oneself (Wilcock, 2006). Experiences of meaning are bound to identity, integrating the past, present and future (Christiansen, 1999), within this integration, people envision a future self, a dimension of 'becoming', pertaining to what one wants to become and do in future life. Anorexia is considered to be always part of one's life and one's identity (Lavis, 2016); a constant reliable friend and 'rock' (Williams and Reid, 2012). Therefore, imagining a future or self without anorexia felt impossible (Tan, Hope and Stewart, 2003b). Life narratives provide cohesion and meaning across the life span (Eidevell and Leufstadius, 2014). To understand the meaning of anorexia, it has been suggested to consider an individual's life course and history, and through this context, we may see how anorexia develops (O'Connor and Van Esterick, 2008).

2.15.9 Social Meanings

Clark and colleagues define occupations as "chunks of culturally and personally meaningful activity in which humans engage that can be named in the lexicon of the culture" (Clark *et al.*, 1991, p. 30). In this seminal description, meaningfulness closely relates to context, including the sociocultural, historical, and political dimensions of occupation (Eakman *et al.,* 2018). Perrson and colleagues point out "the micro-perspective components of an occupation lack purpose, value and meaning if addressed without reference to the meso and macro perspectives, i.e., the entire context" (Persson *et al.*, 2001a, p. 14), and Beagan and D'Sylva state "meanings … cannot be easily divorced from broader social contexts" (Beagan and D'Sylva, 2011, p. 211). In other words, actions detached from the person's context are meaningless, rather it is the influence of socio-cultural contexts which inform and influence the meanings ascribed to occupations (Phelan and Kinsella, 2009; Križaj *et al*., 2019). A number of studies highlight how occupations hold shared social meanings and are situated within specific sociocultural contexts (Wright-St Clair *et al.*, 2004; Wright-St Clair *et al.*, 2005), which include connection with family generations, culture, tradition and rituals (Beagan and Etowa, 2011; Roberts and Farrugia, 2013). In the literature review, studies highlight how EDs are deeply relational (Warin, 2006; Eli, 2018), and meanings are shaped by context including treatment and the perspectives of others (O'Connell, 2023).

Meaning is also influenced by the belief that one is doing the right thing (Christiansen, 1999), what is judged to be right or wrong personally or societally (Taylor, 2015); within these descriptions, there is moral significance to the meaning of occupation (Kiepek *et al.*, 2022a). Research from this literature review highlights how anorexic bodily practices become moralised (O'Connor and Van Esterick, 2008; Cheney, Sullivan and Grubbs, 2018), influenced by cultural notions of self-control, hard work, asceticism, cleanliness and the suppression of denial and bodily needs (Banks, 1996; Warin, 2003; Eli, 2018a). Aspects of the ED, such as self-control, perfectionism and autonomy may be a way to conform to social norms, gendered roles and moral standards, valuing productivity and economic participation (Musolino *et al.*, 2015; Orsini, 2017). Identifying as a 'successful' anorexic affords a certain status and sense of empowerment (Rich, 2006). These interpretations challenge medical individualistic framing of anorexia, which divides mind from body, and individual from society (O'Connor and Van Esterick, 2008).

Alongside historical, social, political, and cultural contexts, the physical places and the environments in which people live and engage in occupations also generates meaning (Rowles, 2008). Place holds particular meaning in the experience of being anorexic, where individuals use the private spaces of their homes to engage in eating and exercise routines (Musolino, Warin and Gilchrist, 2020), and eating in private is a way to "cleanse" the self (Warin, 2003, p. 89). Eating in the context of treatment can also create meanings, such as disconnection from the 'real world' (O'Connell, 2023), becoming a "haven … and a little lab.. that you could be inside" (Eli and Lavis, 2022, p. 351).

2.15.10 Belonging and Interconnectedness

A sense of belonging and relationships are strongly associated with meaning (Hvalsøe and Josephsson, 2003; Hammell, 2004; Roberts and Farrugia, 2013), defined as an experience of being connected to or supported by others through occupation (Eakman *et al*., 2018). Doing with others can offer a sense of connection, and "through that connection the occupation comes to have meaning" (Reed, Hocking and Smythe, 2010, p. 145). In the literature, ED practices offer belonging on an individual and collective level: belonging with others with anorexia, through treatment and in online spaces (Day and Keys, 2008), belonging to the diagnosis itself (O'Connell, 2023), and belonging within culturally normative practices (Musolino, Warin and Gilchrist, 2020). In light of relationship difficulties, literature describes how individuals with EDs use food restriction as a way of disconnecting from the world and form of protection (Eli, 2018), offering a separate "world" and "safe space" away from others (Lavis, 2016, p. 57).

Leufstadius (2007) found feeling accepted and recognised by others is an important dimension of meaning, and Eakman and colleagues' (2018) qualitative synthesis of meaning, found belonging was the most commonly identified form of personal meaning. Given anorexia can hold a negative social identity (McNamara and Parsons, 2016), individuals may be attracted to ED communities who share commonalities which reduces shame (Warin, 2006; Gale *et al.*, 2016; Hilton, 2018). However, ED communities can also encourage a sharing of 'anorexic tricks' (Warin, 2004; Rich, 2006), where anorexia is normalised and strengthened. In inpatient treatment, group dynamics can produce both anger and competition (Long *et al.*, 2012a), but also alter one's self-concept, and bring about greater self-awareness (Eli, 2015a). Connection to ED services and treatment also creates a form of protection from the outside world (Eli, 2015a), yet detachment from 'normal life' (O'Connell, 2023). To sever connections and leave these aspects of belonging is considered threatening (Warin, 2006) and lead to a sense of loss (Tierney and Fox, 2010).

2.15.11 Spirituality

Spirituality and its connection with occupation is complex given the conflation of spirituality and religiosity. Unruh et al. (2003) stated “Spirituality may give life meaning but meaning can be found in many other ways that may have nothing to do with spirituality” (2003, p. 150). Hammell (2001) instead suggests the term ‘intrinsicality’ is a better description for spirituality as not all individuals experience a pervading life-force, and associate meaning with personal dimensions, philosophies, and personal life choices. Although the term spirituality and its role in practice has been contested, it is understood to be central to investing occupations with meaning (Townsend, 1997), and empirical studies show that finding meaning has spiritual qualities (Leitao *et al.*, 2023). Meaning in occupation takes on a broader view of spirituality, which expands beyond religious affiliation, but transcendence beyond oneself, and spiritual connection and wellbeing (Beagan and Etowa, 2011; Feighan and Roberts, 2017). In the literature, anorexia offers transcendence from reality and the self (Gooldin, 2008), and the suffering of anorexia becomes representative of personal, social and moral transformation (Conti, Rhodes and Adams, 2016; Orsini, 2017). Individuals describe anorexia as a way of living, and “more like a religion” (Hilton, 2018, p. 872). Older seminal literature considers recovering from anorexia is spiritual, associated with reconnecting with self, others, and connection with nature (Garrett, 1997).

2.16 Summary of Findings

From this literature review and making parallels with OT literature associated with meaning/occupational meaning, it can be concluded that anorexia and its related practices are meaningful occupations. Corresponding with critical OT scholarship that meaning is not fixed, always positive, or health promoting (Ikiugu *et al.*, 2015; Kiepek *et al.*, 2022b), the literature review interpreted meanings, in the context of anorexia, as paradoxical, contextual, and shifting. It is considered exploring alternative sources of meaning in an individual’s life is an important factor of therapeutic work in the field of EDs (Fox, Larkin and Leung, 2011; Cowan and Sørlie, 2021).

Consistent with critical writers, this thesis advocates for a rethinking of occupation, turning attention to meaning and experience (Whalley Hammell, 2018), and broadening interpretations beyond assumed positive meanings (Dingus, 2022). OT is argued as most relevant and powerful when it addresses meaning outside of narrow categories (Hammell, 2004; Roberts and Farrugia, 2013; Twinley, 2021b). With occupational science defined as "the systematic study of the form, function, and *meaning of occupation*" (Jackson *et al.*, 1998, p. 327 italics are my own emphasis), without deeper and more critical comprehension of meaning, arguably the core of our practice is threatened (Elerin, 2015).

Contrasting to Ellerin's (2015) call for meaning to achieve "standardized [and] recognised definition" … to be "reproducibly and reliably called upon in the design of future occupational studies" (p.418), this research does not feel meaning can ever be consistent as meaning is subjective and finding a unifying concept would undermine the very nature of meaning. Whilst this research does not deny the detrimental impacts of anorexia, instead it seeks to uncover and explore meanings outside of individualistic and dominant and binary constructions of positive versus negative, and analyse individual meanings situated in cultural and social contexts.

This research, along with others, contends that a lack of coherence around meaning may align more closely with our profession, which embraces complexity and subjectivity (Rudman *et al.*, 2008; Eakman *et al.*, 2018). As Kiepek stated, "it is not the role of occupational therapy to 'uncover' or 'ascribe' universal meanings … rather, occupational therapy can contribute insights to the ways in which contextually situated meanings shape people's occupational choices" (Kiepek *et al.*, 2022a, p. 19). Therefore, this research does not intend to provide a universal understanding of occupational meaning but to broaden understanding on the diverse meanings of occupational engagement.

2.17 Research Question

Following the literature review, reflexive attention to the precise research question was considered, see Figure 4, 'Reflexive Journal Entry: Research Question'.

Figure 4 Reflexive Journal Entry: Research Question

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Eating behaviours according to diagnostic criteria - are characterised and inferred as holding intense fears of gaining weight or becoming fat. But I question what is eating in anorexia? Biologically is it an internal disturbance of brain circuitry, or genetic predisposition? Psychologically, is it symbolic of emotions, or managing interpersonal relationships? Cognitively, is it related to cognitive mechanisms around weight and dieting concerns, or habitually conditioned behaviours? Culturally, is it influenced by gendered constructions of bodies and food in society? Medically, is it related to starved cognitive deficits, which miraculously resolve once weight restoration has been achieved? Treatment is fundamentally based upon using food to save life, with the aim to restore weight – which I do not argue - but are there other meanings? Why are treatment outcomes so poor? Why do so many individuals with anorexia struggle with food and eating after treatment and weight gain? These are all questions I ponder.

Based on these considerations, the following research question was formulated:

How individuals with lived experience of anorexia experience and make meaning from food-related occupations.

The research question is formulated and grounded in my epistemological position which assumes the experiential data gathered from this research can inform me of participants' subjective involvement and orientation towards the world, and how they make sense of their experiences. Research questions in IPA tend to be open, exploratory, and centre on meaning and experience (Smith, Flowers and Larkin, 2022). Given IPA is concerned with detailed examination of experience, research questions are not grand in scale, but focus on specific phenomenon or experiences.

2.18 Conclusion to Chapter Two

Chapter Two provides an interpretative and critical review of the literature relating to the meaning of anorexia. Succeeding an appraisal of the findings, and making connections with OT literature relating to meaning/occupational meaning, identified gaps in the literature were identified, including a lack of phenomenological research, and studies from an OT perspective. Based on these insights, a novel research question was formulated. The following chapter will discuss the research methodology, outlining my philosophy, providing justification for the methods used.

3.Chapter Three: Methodology

3.1 Introduction to Chapter Three

Although used interchangeably, methodology is distinct from methods: methodology encompasses philosophical and theoretical commitments, which demarcates the types of methods to be used for a study (Willig, 2008). Therefore, Chapter Three will clearly explicate the philosophical underpinnings of this research encompassing my ontological and epistemological views, as well as the theoretical underpinnings of IPA, before introducing the methods used in Chapter Four.

Well-designed research studies claiming to be phenomenological, should draw upon its associated philosophical principles (Smith, Flowers and Larkin, 2022), reflecting how these relevant theoretical foundations combine to establish IPA. Therefore, Figure 5 provides a visual overview of my methodological research choices.

Although there have been some controversies around IPA's grounding in phenomenological philosophy (Giorgi, 2010; van Manen, 2017; Zahavi, 2019), Smith (2019) contends IPA subscribes to a broad and holistic phenomenology and challenges prescriptive views of what phenomenology is, and is not.

Figure 5 Overview of my Methodological Research Choices

Interpretivist paradigm
Assumptions:

- multiple interpretations can exist.
- experiences and meaning are situated and influenced by the social context.
- interaction between the researcher and participants.

Assumptions:

- there is a real world out there.
- person-centred view, focusing on subjective meanings ascribed to experiences,
- contextualised perspective of being, we are influenced from our being-in-the-world.
- dynamic and influx.
- human existence is enmeshed in meaningful contexts.
- through engagement, meaning and reality is constructed.

Contextual constructionism:
Assumptions:

- truth can never be grasped, it is relative and dynamic.
- knowledge is influenced from being-in-the-world.
- open to uncertainty.

Assumptions:

- research is value laden and the researcher is integral to the research process
- OT values
- person-centred
- recovery principles
- valuing lived experience

Naturalist methods

- semi-structured interviews
- Photo elicitation

Interpretive Phenomenological Analysis

Assumptions:

- phenomenology: exploring experience in its own terms.
- idiography: focus on the detail and what is of particular significance for people.
- hermeneutics: role of interpretation
- our experiences are embodied and relational.

Analysis - IPA

1.reading and re-reading
2. initial noting
3. developing experiential statements
4. searching for connections across experiential statements
5. consolidating the personal experiential statements into themes and a table
6. continuing individual analysis of other cases
7. developing group experiential themes across cases.

3.2 Paradigmatic Concerns

A research paradigm refers to the belief system and worldview held by the researcher, containing ontological, epistemological and methodological questions (Guba and Lincoln, 1994). The epistemological and ontological position of IPA is only vaguely defined in the first and second editions of IPA (Smith, Flowers and Larkin, 2009; Smith, Flowers and Larkin, 2022). This can reflect the often overlapping epistemological underpinnings of qualitative approaches (Smith, 2004). However, a lack of clear articulation can add to criticism that IPA lacks a theoretical basis (Sousa, 2008; Giorgio, 2010). Personally, for me this led to ongoing and deep grappling with the philosophical underpinnings of the research and reflexive attention to my own worldview.

After much contemplation, it was considered this research sits within an interpretivist paradigm of inquiry (Laverty, 2003), encompassing a range of nuanced epistemological positions (Larkin, 2022). The research is influenced by the hermeneutic orientation, concerned with how people make sense of and attribute meaning to their everyday experiences, which takes into consideration the world in which meanings and experiences are located (Crotty, 2005). This view acknowledges that reality is subjective multiple and socially constructed, and acknowledges the role of interpretation of both myself and participants (Kelly, Dowling and Miller, 2018).

3.3 Ontological Position

When thinking ontologically, researchers reflect upon the nature of reality and what exists (Creswell, 2014). Heidegger radically challenged Western traditional philosophies of his time, focusing on positivist sciences through empirical and rational approaches. Heidegger placed ontology ahead of knowledge (epistemology), focusing upon what it means to be human and how the world is made intelligible to us (concerned with sense making) (Neubauer, Witkop and Varpio, 2019). Through prioritising being – denoted by the term Dasein – the meaning of being becomes our "primary object of interrogation" (Heidegger, 2001, p. 36). Therefore, interpretative phenomenology leaves the question of reality open and one to be explored by participants only.

IPA considers individuals to be sense-making agents, who are inherently self-reflective (Smith, 2018d). This person-centred view and conceptual focus on being also embodies the philosophy of OT and occupational science (Wilcock, 1998b), which holds humanistic values. Occupational therapists seek to uncover the subjective meanings ascribed to experience, acknowledging individuals as self-adaptative (Schultz, 2014; Walder and Molineux, 2017). According to OT, meaning does not exist outside the perception of the person (Hammell, 2009b); meanings are 'real' because they hold personal significance, as they are experienced by the individual (Hasselkus, 2011). This position challenges current discussions based on reductionist positivist ontological frameworks (Burkitt and Sanz, 2001), that "privilege a third-person perspective … at the expense of first-person accounts" (Osler, 2021, p. 3) and which arguably oversimplify the complexity and multidimensional nature of EDs.

To Heidegger, individuals' realities are invariably influenced by the world in which they live (Lopez and Willis, 2004) and consciousness is a product of the historical and cultural context from which it arises. Therefore, we are never able to remove ourselves from the world, in order to find out how things 'really are' (Larkin, Watts and Clifton, 2006). This research therefore does not subscribe to naive realism and positivist paradigms, where universal and definable truths can be 'discovered' and where reality is 'out there' and independent of the researcher (Denzin and Lincoln, 2000). Phenomenologists criticise empiricism and intellectualism's view of reality as naïve, as they accept the primal reality of lived experience which serve their foundations (Husserl, 1970), as Merleau-Ponty writes "objective thought ignores the subject of perception" (Merleau-Ponty, 1945, p.230).

Although Heidegger considered truth to be relative to Dasein's being, this does not mean truth is "left to the subject's discretion" (Heidegger, 1962/2001, p. 228) or follows a radical relativist ontology, rather what is meaningful is through what we encounter, within the context of our lives (Larkin, Watts and Clifton, 2006). Indeed, hermeneutic phenomenology does not deny there are natural entities (Larkin, Watts and Clifton, 2006), but the nature and meaning of them depend on our encounter with them within the context of our lives (Dreyfus, 1991). Perception and experience are composed and united in a field of "social practices, objects and discourses" (Merleau-Ponty, 1968, p.331) and what we perceive as reality is what exists in relation between our embodied selves in the world (Larkin, Watts and Clifton, 2006). Instead of ascribing to either a realist or relativist position, considered a "false divide" (Ussher, 2002, p. 7), and dualistic (Yanchar, 2015), this study views lived experience as reality, according to individual interpretation, which occurs "in-between persons and the world" (Burkitt and Sanz, 2001, p. 39). This ontological position therefore sought to grasp the lived experiential meaning and contextually-bound lifeworld of individuals, understanding reality is not fixed, but multi-dimensional and dynamic in agreement with Lester's statement "Ontologically speaking, the thing termed "eating disorder" unfolds as an interpersonal process" (Lester, 2018, p. 524).

Situated freedom is an existential phenomenological concept, referring to how individuals are free to make choices, but freedom is not absolute, it is circumscribed by the conditions of everyday life (Merleau-Ponty, 1962/2005; Sartre, 1972; Lopez and Willis, 2004; Neubauer, Witkop and Varpio, 2019). Similarly, OT recognises individuals can choose their occupations (Doble and Santha, 2008), influenced by volition (Kielhofner, 2008), and are autonomous agents (Townsend, 2012). However, also recognising our being is influenced by what is made possible to us, bound by external forces, which may constrain, influence, or open up possibilities (Laliberte Rudman, 2015; Whalley Hammell, 2020).

Ontologically, the research considers that no objective truth can be obtained, rather different researchers could facilitate disclosure of something different about a phenomenon, and truth is always unfinished (Yanchar, 2015). This reflects the double hermeneutic within IPA studies, and that we do not have direct access to reality, rather that which we seek to understand is always in flux (Smythe *et al.*, 2008), and we can only aim to get as close to the experience as possible (Smith, Flowers and Larkin, 2022). Furthermore, humans are always self-defining, as Sartre stated "existence precedes essence"(Sartre, 1946/2001, p. 292), therefore existence and reality is not static, but dynamic. This too mirrors the philosophy of OT, where human beings are in a process of becoming and adapting (Wilcock, 1998c; Hitch and Pepin, 2022).

Hermeneutic phenomenological views of a person hold several assumptions, which will be discussed below.

3.3.1 Persons in Context

Heidegger's ontology and concept of Being through the notion of Dasein – ("Da" meaning 'there' and "sein" meaning 'being') – rejects the view that subjects are spectators of objects, rather Dasein and world are inseparable (Heidegger, 1962/2001). Beings are thrown into the world, influenced, and shaped by *das Man*, "they". Here, Heidegger presents an interpersonal entity of person-in-context, "absorbed in the world" (Heidegger, 1962/2001, p. 80), where reality is understood relationally, through "intersubjective and common meanings" (Plager, 1994, p. 71). This holds relevance for this study, as the cultural dimensions of anorexia have often been considered reduced to contributory or facilitatory (Malson, 1998), and current therapeutic formulations isolate individuals from the social contexts in which EDs arise (Riley *et al.*, 2008). A phenomenological perspective understands perceptual experience embedded in a particular culture, which holds particular meanings.

The world is described as "beforehand" (Heidegger, 1962/2001, p. 42) therefore, world is a priori, given to us in our historical, cultural, and linguistic practices. Being-in-the-world is not used to describe a spatial "dwelling" (Heidegger, 1962/2001, p. 89), but an "involvement"

(Heidegger, 1962/2001, p. 115) and familiarity. Heidegger uses the term "totality of involvements" (Heidegger, 1962/2001, p. 116) to describe the relational nature of our world-hood.[8] Heidegger's view that it is only against a backdrop of meaningful activity, that possible to gain access to what is relevant and true (Heidegger, 1962/2001). This reflects the influence of my own professional experience as an occupational therapist, which holds the belief that meaning is created through engagement in purposeful occupation within the environment (World Federation of Occupational Therapists, 2023). Applying this ontology to the research phenomenon, it is considered everyday engagement with food and eating is believed to be influenced within a "world of objects, relationships and language" (Smith, Flowers and Larkin, 2022, p. 13), and this relatedness to the world is fundamental to our being (Larkin, Watts and Clifton, 2006). These everyday practices, "adds up to an understanding of what counts as real for us" (Dreyfus, 1984, p. 73). It is considered that ED recovery takes place in normal environments and activities (Jepsen Trangsrud *et al.*, 2020). However, aspects of our engagement are covered up with familiarity; thus, the concern for hermeneutic phenomenologists is to consider the practical engaged activities of our everyday lives, and what might be covered up in the process of being-in-the-world.

Heidegger also acknowledges the temporal existence of Being, and criticised time as linear (Wheeler, 2011). Heidegger considered our past is constitutive to who we are, and Heidegger uses the term 'thrownness' to describe how Dasein's existence is always projected forwards. In other words, we are always becoming and in a process of change. Occupational therapists too consider we are informed by our past, present and future (Wilcock, 1998b; Hasselkus, 2011) and life story (Christiansen, 1999); in a process of constant change and becoming (Hitch and Pepin, 2021). This ontological view, therefore, challenges dominant positivist conceptualisations of anorexia, which through tools such as the DSM-5, present static and individualistic views of reality and truths of anorexia (MacSween, 1993; O'Connell, 2023). Whilst a phenomenological view considers individuals cannot be detached from context and time, and individuals are in a constant state of flux.

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[8] Heidegger famously uses the example of a hammer, where there is "involvement" used to make something "fast… protection against bad weather" Heidegger, M. (1962/2001) *Being and Time.* Oxford: Blackwell Publishing Ltd. – in this example, the hammer has significance in the context of the craftsman's life.

3.3.2 Persons Embodied

Although Merleau-Ponty is often associated to the “bodily turn” of phenomenology (Crossley, 2001), Husserl too considered bodily perception in his transcendental phenomenology, emphasising we are conscious of this world through our sensory perception (Husserl, 1983). Husserl emphasises that through a subject’s perception – their spatial orientation and body kinesthesis – their “every worldly experience is mediated and made possible by … embodiment” (Zahavi, 1994, p. 66).

Husserl highlighted we do not just have a physical body (body-as-object), *Körper,* which has a spatial and temporal location in the world, but we are also our lived body (body-as-subject), *Leib*. These aspects are intertwined and fluid and can come into conflict with one another. For example, the lived body becomes an objective body when we become aware of it through illness or injury (Fuchs, 2022). A third dimension of embodiment is the lived-body-for-others, a concept proposed by Sartre, referring to how one apprehends their body when it is looked at by another. The lived body is no longer a direct experiential experience, but an entity viewed externally (Sartre, 1993). From a phenomenological perspective, those with anorexia are considered to view their bodies as an object looked at by another, rather than from first-person lived perspectives (Mancini and Espostio, 2021).

Merleau-Ponty places the body at the centre of ontology - “I am my body” (Merleau-Ponty, 1962/2005, p. 231), and emphasises our embodied connection to the world. This view holds several ontological and epistemological implications for this research, as if we are our body, it must be considered “the body as a psychological, cultural and historical phenomenon as well as a biological and material one” (Duesund, 2017, p. 80). This presents a holistic view of being, for which occupational therapists too share (Finlay, 2004; Kielhofner, 2008). Merleau-Ponty’s writings attempt to identify an alternative to intellectualism and empiricism, by critiquing their common presupposition of a ready-made world, which fail to consider the historical and embodied nature of experience (Merleau-Ponty, 1963; Merleau-Ponty, 2005). Merleau-Ponty highlights the things of the world are “within me” (Merleau-Ponty, 2005, p. 515), and although the body is lived subject, perceptions exist in-between people and are in “communion” (Merleau-Ponty, 2005, p.82) with the world. All knowledge takes place within the horizons opened by perception, and perception is learned in embodied, and contextual environments, for “only in the world does he know himself” (Merleau-Ponty, 2005, p.xii). Merleau-Ponty writes how the world contains a “system of meanings” (2005, p.149), it is this “familiarity and communication” (p.151) which allows us to understand our world, which the body actively groups sensuous experiences to produce patterns of meaning. This Gestalt view and writings on embodiment expunge Cartesian-dualism thoughts of the body, instead the body is fundamental to perception (Grosz, 1994). Merleau-Ponty also highlights the intentional and personal meaning of our embodied experience therefore although empathy can be shared, we can never share in another’s experience, as their experience belongs to their embodied position in the world (Smith, Flowers and Larkin, 2022). Therefore, this position requires an open phenomenological attitude, which focuses on the phenomenon with curiosity, whilst recognising understandings will always be partial and incomplete (Finlay, 2008).

Ontological views of embodiment are helpful in considering anorexia. Existing literature is considered to objectify and individualise the experience of anorexia, discounting embodied and subjective experiences, situated within social and cultural worlds (Englebert, Follet and Valentiny, 2018). From a phenomenological point of view, we can see culture lived through the body (Burkitt and Sanz, 2001), and the body is not an object to be studied, but a subject of culture (Csordas, 1990). Medical views, defined by the DSM, describe anorexia as a “disturbance in the way one’s body weight or shape is experienced” (DSM, 2013), implicit in this is an overly cognitive representation, and that those with anorexia have faulty perceptions. Whilst embodiment views, do not locate anorexia only inside the mind of the individual, but view lived experience, and the “self as culturally constituted” (Csordas, 1990, p. 5). On the other hand, anorexia has also been framed as an “empty vessel ready to absorb and display cultural discourses” (Lavis and Eli, 2022, p. 345) within social and cultural theories. This position removes the autonomy of individuals (Bray, 1996), where bodies are static (Probyn 2009), and overshadows the experiences of dynamic, lived and feeling bodies (Bray, 1996; Moola and Norman, 2016).

3.4 Epistemological Position

Epistemology explores the nature of knowledge, and the relationship between the inquirer and inquired (Cuthbertson, Robb and Blair, 2020). This research is heavily influenced by the writings of Heidegger, Gadamer, and Merleau-Ponty, which call for a contextualised way of interpreting experience. Although sharing in Husserl’s commitment to the lived experience, their writings recognise knowledge is generated from being-in-the-world (Smith, Flowers and

Larkin, 2009), complementing the epistemological position for this research, considered to fit within contextual constructionism. Larkin et al. (2006) also considers IPA fits with contextual constructionism, focusing on persons-in-context.

Contextual constructionism, described by Jaeger and Rosnow (1998) and later Madill et al. (2000), is philosophically associated with critical realism, recognising the role of subjectivity in the production of knowledge, and that “true” knowledge cannot be fully grasped but is relative and dynamic (Cuthbertson, Robb and Blair, 2020). Likewise philosophers rooted in hermeneutics, and the methodology of IPA asserts our understanding of the world is finite, and we are never capable of producing complete interpretation (Gadamer, 2004; Smith and Osbourne, 2003). As such, the knowledge put forth from this research is “local, provisional and situation dependent” (Madill *et al,* 2000, p.9), emerging from subjective and personal experiences.

Heidegger’s philosophy, considers how history and forms of tradition are imprinted in our being; “Dasein’s Being finds its meaning in temporality” (Heidegger, 1962/2001, p. 41), however, this history is not always known, therefore the task is “explicating Dasein… in its temporarily and historicity” (Heidegger, 1962/2001, p. 21). Similarly, Merleau-Ponty’s philosophy considers how culture is lived through the body, and draws attention to the temporality of perception, “in every focusing moment my body unites present, past and future, it secretes time” (Merleau-Ponty, 2005, p. 278), and Gadamer (1960/2004) who calls attention to how history impacts our horizons of understanding. These positions therefore acknowledge the data collected will be influenced by several factors: the participants’ interpretations, my own interpretations, and the research context.

Contextualism accepts indeterminacy, regarding absolute truth or knowledge as an ideal, that cannot be realised, and embraces the complexity and open-ended nature of ongoing active events. Merleau-Ponty’s writings also consider the fluid nature of experience and the “ambiguity of being-in-the-world” (Merleau-Ponty, 2005, p. 98). Hermeneutics requires a tolerance of uncertainty, both in topic and interpretation. This position is apt for researching anorexia, the uncertainty and inconsistences within the illness, and the ambiguous and paradoxical meanings involved (Williams *et al.*, 2018).

3.5 Axiological Position

Axiology refers to a researcher's understanding of their role in the research, examining their values, beliefs and ethical positions which guides their practice and interpretations (Guba and Lincoln, 1994; Ayton and Tsindos, 2023). From outlining my ontological and epistemological positioning, my axiological assumptions can be inferred, which recognises the research is value-laden and the inseparability of my role within the research process and therefore, what emerges is partial and contextual. Axiology also takes into account ethical considerations of the research, which are later elaborated on in chapter four.

Researcher's questions, methodology and interpretation of findings always arise from their unique historical and traditional perspectives. However, my conclusion from reviewing the literature was that often these pre-conceptions were not made explicit in published work. This omission treats anorexia as an object for investigation and denies the value of context, which includes the pre-understandings of researchers. Phenomenological research, including the interpretivist paradigm, makes clear researcher subjectivity, where the researcher's values and lived experience cannot be divorced from the research process (Finlay, 2009b; Smith, Flowers and Larkin, 2022). Given the hermeneutic leanings of this research, I view my role in the research as imperative to "shine forth" the phenomenon (Smith, Flowers, and Larkin, 2009, p.35), which requires investigative work on behalf of myself to make sense of experience. Therefore, my axiological positioning permeates this research project, and I have explicitly threaded reflexivity throughout this research.

The philosophy of this research, which is phenomenologically orientated, is underpinned by person-centred values. IPA is argued to offer a person-centred approach, developing deep insights into the meanings individuals attach to their experiences in the context of their social worlds. This view is consistent with my client-centred philosophy as an occupational therapist, which upholds the uniqueness of individual experiences and meanings, but at the same time, views individuals embedded within their socio-cultural contexts. As such, meanings cannot be considered in isolation from their environment (Eakman *et al.*, 2018). Client-centred values are characterised by being egalitarian, striving to reduce power inequalities, listening to individuals, and are non-authoritarian and judgemental (Hammell, 2013; Drolet, 2014). These values infiltrated my choices for the qualitative methods I undertook, participant recruitment, my relationship with participants, my stance in the interviews and how the data of this research is viewed as emerging from co-created encounters.

Closely aligned to this, is the value I place on recovery orientated paradigms and the importance of lived experience in the field of EDs, which respects the subjective, rather than what is measurable and objective. This positioning is thought to offer nuanced and detailed descriptions of individual experiences (Holmes, 2023). Typically, the experiences of those with EDs in the literature has been researched from objectivist perspectives, using standardised assessments and statistical analysis, which may overlook the diversity of lived experience and broader contextual factors (Hower *et al.*, 2022). The voices of those with EDs is often considered to be "outside of the true" (Saukko, 2008, p.61). Therefore, my value of lived experience, means honouring individual's subjective accounts, using phenomenological methodology to get as "close" to participants' embodied experiences, utilising small sample sizes to allow for in-depth engagement of experience, and viewing knowledge produced as collaborative and mutual (Finlay, 2005).

3.6 Qualitative Approach

While equally helpful in advancing understanding, quantitative methods can "bury the 'voice' of research subjects beneath piles of anonymous standardised data" (Roberts, 2014, p. 3). Given the exploratory nature of this research, a qualitative approach was more fitting, offering rich insight into experience, which can attend to nuance and ambiguity. A qualitative approach was also appropriate as it is not reliant upon medical assumptions, or pre-defined categories (Reed, Hocking and Smythe, 2011), but offers "meaningful information … about experiences of emotional distress" (Cosgrove, 2000, p. 247), allowing for the emergence of unanticipated findings.

Qualitative research can illustrate everyday occupations such as food and eating (Reed, Hocking and Smythe, 2011), the quality of meaning (Marzola *et al.*, 2015), especially topics sensitive in nature (Liamputtong, 2006). Furthermore, the conceptual perspective of the dark side of occupation, understands occupation and subjective meanings of engagement are complex and multifaceted (Twinley, 2021). Given anorexia is a complex phenomenon, qualitative paradigms are sensitive to exploring these dimensions (Williams *et al.*, 2018).

3.7 Theoretical Foundations of IPA

Researchers ascribing to IPA anchor their studies within these philosophical underpinnings to produce “sophisticated and nuanced analyses” (Smith, Flowers and Larkin, 2009, p. 4). As such, this research will now discuss the three main pillars of IPA: phenomenology, hermeneutics and idiography.

3.7.1 Phenomenology

Phenomenology is a broad and diverse construct, considered a movement, philosophy, and method of inquiry (Finlay and Ballinger, 2006). In sum, phenomenology seeks to return to concrete, lived human experience (Smith, 2018b; Neubauer, Witkop and Varpio, 2019), bringing forth what is concealed or hidden by our everyday unconscious engagement with the world, or preconceptions and biases from science and tradition (Smith, 2018b; Eatough and Smith, 2017).

Phenomenological philosophy, often accredited to Husserl in the early 20th century, is a radical way to approach philosophy (Moran, 2000). Husserl viewed science secondary to personal experience, and instead rallied for careful attention to human experience[9] (Husserl, 1927). For Husserl, consciousness was the foundation to all experience, which is easily obscured, and not easy to isolate due to pre-existing categorisation (Eatough and Smith, 2017). Our consciousness relates to intentionality, a term describing how consciousness is always directed towards something, in other words, our perceptions and orientations hold meaning (Davidsen, 2013). Contrasting to positivism and empiricism methods of the time, which assume the nature of the world can be revealed objectively through observations of external reality, Husserl considered that phenomena, perceived by the individual’s consciousness, should be the object of inquiry (Smith, 2018b). This has relevance for the research; given much ED literature has been governed by such paradigms, positioning anorexia as an “object of medical science” (Hepworth, 1999, p. 6), which undermine the sociocultural dimensions (Malson, 1998), and medicalise lived experience (Rich, 2006).

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[9] Phenomenology appeared in earlier works in the 18th century, from Immanuel Kant, Georg Wilhelm Freidrich Hegel and Ernst Mach, viewed as a “new way of doing philosophy” (Moran, 2000, p.1).

Husserl formed descriptive phenomenological tradition, otherwise known as transcendental or descriptive phenomenology, aiming to “go back to the things themselves” (Smith, Flowers and Larkin, 2009, p. 12), transcending the contextual and personal. Husserl’s phenomenology involves stepping outside our everyday habitual unconscious engagement with the world, that is our ‘natural attitude’, to grasp the lifeworld and the content of consciousness (Husserl, 1927 para. 2). The lifeworld is what individuals experience pre-reflexively without resorting to interpretations. This requires a conscious shift from the natural attitude to the ‘phenomenological attitude’, through a series of reductions and ‘bracketing’, to access “pure consciousness” (Moran, 2000, p. 60) detached from preunderstandings and biases which are acquired throughout life (Eatough and Smith, 2017). This is fundamental to the eidetic reduction (Smith, Flowers and Larkin, 2009, p. 14) or *epoché* to focus on the content of consciousness to gain access to a deeper level of the essence of things, and describe the essential features of experience (Zahvi, 2003). Husserl’s philosophies have been a helpful grounding for this study, bringing attention to the prioritisation of subjective experiences, and elucidating the nature of a phenomenon, free from second-order terminology.

Heidegger was a German philosopher, and contemporary to Husserl, indebting his intellect to Husserl in his seminal work, *Being and Time* (1962/2001). However, Heidegger diverged from Husserl’s transcendental perspective, arguing it was predominantly descriptive, to a hermeneutical and existential emphasis of phenomenology (Moran, 2000). Heidegger advocated phenomenology is one of interpretation, and through the concept, Dasein, focuses on the ontological question of experience itself, and the practical activities, context, and relationships Dasein is engaged in (Smith, Flowers and Larkin, 2022; Horrigan-Kelly, Millar and Dowling, 2016). Heidegger adopts a worldly view of person-in-context and emphasises the shared interactive nature of our engagement with the world. Thus, for this research, I positioned individuals’ accounts in relation to the wider social and cultural contexts they are embedded in and viewed their being-in-the-world perspectival, temporal, and in relation to something.

3.7.2 Hermeneutics

Heidegger opposed Husserl’s theory of bracketing, asserting it is impossible to separate previous knowledge or experience, as every interpretation “has its fore-having, its fore-sight, and its fore-conception" (Heidegger, 1962/2001, p. 275). IPA re-evaluates the role of bracketing and adopts "a more enlivened form of bracketing as both a cyclical process as something that can only be partially achieved" (Smith, Flowers and Larkin, 2009, p. 25).

I too questioned the ability to suspend my attitudes and beliefs and recognised my situated role within the research process, and the value this could offer, potentially giving rise to useful and creative interpretations (Dahlberg, 2006). This position came into focus after studying and reading more broadly into hermeneutics, that is the theory of interpretation, and the works of Heidegger who considered we cannot step outside of our lifeworld without reference to the context in which it is embedded (Laverty, 2003; Neubauer, Witkop and Varpio, 2019). Although recognising there are other philosophers and contributors to the hermeneutic movement (Smith, Flowers and Larkin, 2022), this research will draw upon Heidegger and Gadamer, as these were most influential to this research process. Both Heidegger and Gadamer emphasised how interpretation is a foundation mode of being and "to live a life is to interpret" (Eatough and Smith, 2017).

Heidegger focuses on "bringing forth" a phenomenon into "appearance" which always necessitates interpretation (Heidegger, 1962/2001, p. 53). Appearance has a dual quality, that which is visible, and that which is concealed or "hidden… or "gets *covered up* again, or which shows itself only '*in disguise*'" (Heidegger, 1962/2001, p. 59). Heidegger's phenomenology is concerned with examining that which is "latent, or disguised, as it emerges into the light" (Smith, Flowers and Larkin, 2009, p. 24). This has relevance to the dark side of occupation, where meanings of occupational engagement can be concealed, and has a concern for bringing occupations out of the shadows (Twinley, 2013). Our understanding does not occur spontaneously, rather analytical and interpretation is required to bring phenomenon into appearing (Heidegger, 2001).

Hermeneutic phenomenology goes beyond describing a phenomenon, and a self-contained individual subjects, but understands our lifeworld is always influenced by our background and context (Neubauer, Witkop and Varpio, 2019). Moreover, given the temporality of Dasein, understanding is necessarily determined by a particular history context and cultural heritage of our time (Heidegger, 1988). Due to this historical embeddedness, we always have a 'primordial' understanding of the world, which helps us to make sense of world objects (Watts, 2011).

Hermeneutic phenomenology accepts that we will never have direct access to experience, as interpretation is always a second order account, which aims to provide a critical and conceptual commentary of the participant's sense-making activities (Willig, 2012). This draws attention to the double hermeneutic, that is participants attempting "to make sense of their world" whilst "the researcher is trying to make sense of the participants trying to make sense of their world" (Smith and Osbourne, 2003, p. 51). It also relates to the hermeneutic circle, that is the dynamic and non-linear role of interpretation, which concedes to understand the part, you look at the whole, and vice-versa (Willig, 2012). For myself, this involved a stepping back in my data, reflecting on the socio-cultural context which may have influenced participant accounts and continually reflecting upon my own relationship to the data. Hermeneutics also embraces the use of theories and context to help focus and understand an object of study (Neubauer, Witkop and Varpio, 2019)..

Gadamer also aligns with Heidegger's thoughts and rejects the notion of phenomenological bracketing, rather claiming all understanding arises in and through our pre-understandings (Moran, 2000). Gadamer emphasises the centrality of hermeneutics within the interpretative process and asserts that our fore-conceptions are always present, which are sometimes known, but at other times emerge during the process of interpretation. Either way, the inquirers task is to "remain open to the meaning of other person" (Gadamer, 2004, p. 271). These theoretical positions had implications for the research, including becoming aware of my own individual perceptions, thoughts, and opinions. It also meant recognising that I did not approach the research neutrally but required a reflexive stance from the outset of the research, to provoke and identify hidden prejudices and fore-meanings. Indeed, the depth of understanding in which one arrives is dependent on the depth of self-reflection for which pre-understandings are identified (Maxwell *et al.*, 2020). It secondly meant being aware of how I approached the literature, including my lens as an occupational therapist, to ensure pertinent texts were not excluded, so "that the text can present itself in all its otherness" (Gadamer, 2004, pp. 271-272). Gadamer suggests our pre-understandings are not static but are continually modified as part of a sense-making process. This thirdly, necessitated a continued movement between understanding and interpretation, and remaining open to possibilities. Therefore, I used a range of reflexive methods including voice notes, as Gadamer states dialogue is an essential step in the process of gaining understanding (Gadamer, 2004), as well as reflexive journaling, and speaking with others which broadened my "horizons" of experience (Gadamer, 2004, p. 302).

3.7.3 Idiography

Contrasting to nomothetic approaches which make generalisations at a population level, idiography is concerned with the particular and detail of experience (Smith, Flowers and Larkin, 2022). IPA has an idiographic sensibility, offering detailed and nuanced insight into lived experience (Smith, Flowers and Larkin, 2022), IPA therefore gives 'voice' to certain people groups, and matters of lived experience (Larkin, 2020). This can offer a lens to view things differently and challenging conventional practice (Neubauer, Witkop and Varpio, 2019). Within the field of EDs, there is strong advocacy and need for the presence of lived experience (Music *et al.*, 2022). Yet historically the field has been dominated by quantitative studies, analysing changes in weight, behaviours, and thoughts (Kenny and Lewis, 2021), from third-person perspectives. IPA findings offer a highly nuanced and fine-grained understanding of a phenomenon, which can be used to contextualise existing quantitative research to inform understanding of novel or under-researched topics.

3.8 Interpretative Phenomenological Analysis

Many scholarly writings and approaches derive from phenomenology including transcendental, hermeneutic and existential phenomenology, and more contemporary approaches such as lifeworld research and post-intentional phenomenology (Neubauer, Witkop and Varpio, 2019). Few approaches, however, provide clear methodological guidelines (Groenewald, 2004). IPA, on the other hand, has specific guidance on analytical procedures, increasing rigour and transparency, thus defending my choice to use IPA over other types of phenomenological methods. IPA was chosen over descriptive/transcendental phenomenology as I do not consider that human experience can be examined by setting aside all prior knowledge. Hermeneutic research assumes researchers, including their prior knowledge, play an active role in the co-production of meaning (Bartley and Brooks, 2021).

IPA is a qualitative methodology emerging in the 1990s (Smith, 1994; Smith, 1996; Smith, 2004), originally popularised within the field of health psychology. Since then it has developed substantially and has a wide reach across diverse fields (Smith, 2018c). IPA was chosen as it aligns with the aims of the research, concerned with subjective meanings and "exploring experience in its own terms" … without fitting experience into "predefined or overtly abstract categories" (Smith, Flowers and Larkin, 2009, p. 1). Traditionally ED research has been overshadowed by medical assumptions, collected, and grouped together in diagnostic frameworks; or cultural analyses, both of which detract from the underlying and personal meanings (Lester, 1997; O'Connor and Van Esterick, 2008). As phenomenology aims to explore "things in their appearing" (Langdridge, 2007, p.11) this strongly supported the aims of the research, which sought to explore the meaning and experiences of individuals, removed from medical or cultural explanations and taken-for-granted meanings. IPA therefore supports contemporary healthcare approaches and demands in ED practice, which seek person-centred care (NHS England, 2019).

Furthermore, IPA studies typically explores individuals' experiences during events which create 'hot cognition' (Smith, 2011a), referring to circumstances which tap into matters of a person's life which are "burning, emotive and dilemmatic" (Eatough and Smith, 2017, p. 28). Sartre (1951) suggests when a person becomes unwell, their position shifts from a pre-reflective perception of sensations to reflective awareness of illness. Given treatment, the experience of EDs and food-engagement in EDs can elicit strong emotional experiences, existential questioning, and reflection (Pettersen, Wallin and Björk, 2016; Smith *et al.*, 2016; O'Connell, 2023), this methodology was also considered fitting.

IPA acknowledges the researcher as a sense-making individual, who "is trying to make sense of the participants trying to make sense of their world" (Smith and Osbourne, 2003, p. 51). This further drew my attention to IPA, as it takes notice of my own subjectivities and interpretative efforts, through engagement in the double hermeneutic. This methodology allies with my epistemological position, which considers knowledge as a co-constructed effort, and the inevitability of biases, preconceptions, and assumptions in knowing. Giorgi (1994) commented "nothing can be accomplished without subjectivity, so its elimination is not the solution. Rather how the subject is present is what matters" (p.205). Therefore, presuppositions were engaged with fruitfully for the purpose of understanding and increasing insight (Finlay, 2003a; Neubauer, Witkop and Varpio, 2019).

In this co-constructed view, IPA was also advantageous, as it takes note of both of phenomenology (the individual's experience) and the social context (where the experience takes place). As Smith et al. (2009) succinctly captured on the dual phenomenological and hermeneutic framing in IPA "Without the phenomenology there would be nothing to interpret; without the hermeneutics, the phenomenon would not be seen" (Smith, Flowers and Larkin, 2009, p. 37). Through this research, I have fully acknowledged the socio-cultural influences upon anorexia, and meanings of food-related engagement (Hardin, 2003; La Marre and Rice, 2015; Grynick, 2016). Phenomenology and social constructionism are both inductive, and committed to seeking the lived experience of individuals, understanding meaning and experience are inextricably linked with being-in-the-world (Smith, Flowers and Larkin, 2022). Cosgrove (2000) identifies social construction and phenomenology can be combined to reveal rich and complex understandings of anorexia. However, IPA takes a 'lighter stance' of social constructionism, with the aim of understanding the person and their experience (Smith and Eatough, 2006), whilst pure social constructionist approaches focus on the discursive features of interaction (Smith, Flowers and Larkin, 2022).

IPA has been utilised as a methodology in much of the identified research relating to meaning, experiences and EDs (Offord, Turner and Cooper, 2006; Nunn, 2009; Fox, Larkin and Leung, 2011; Smith *et al.*, 2016; Roberts and Skipsey, 2021), particularly relevant to the subjects proposed, whose voices and experiences are often silenced (Polit and Beck, 2012). IPA's ability to illuminate hidden meanings also fits with my interest in illuminating the dark side of occupation (Twinley, 2013; 2021) in terms of those occupations related to EDs that have gone unseen of overlooked from an occupational perspective. Understanding gained from phenomenological research can have clinical and theoretical implications, challenging dominant ways of thinking and provoking thinking (Colton and Pistrang, 2004; Neubauer, Witkop and Varpio, 2019). Indeed, interpretation in IPA seeks to find the elusive "gem" (Smith, 2011c) in the data corpus, which when uncovered, can provide invaluable insight into how individuals' make sense and grasp their inner worlds. Understanding subjective expressions is what Conti, Rhodes and Adams (2016) describes as "listening in the darkness" (p.5), and necessary, if we are to contribute to new paradigms for EDs (Touyz and Hay, 2015). A phenomenological-informed approach keeps the narratives of individuals at the centre, creating "true dialogue" (Puuronen, 1999, p. 229).

3.9 Consideration of Other Methodologies

As with all research, including IPA, consideration should be given to alternative approaches, to justify their approach (Smith, Flowers and Larkin, 2009). Although many kinds of qualitative methodologies exist which focus on experience and meaning, IPA's mission to examine detailed and nuanced aspects of lived experience, whilst acknowledging the intertwined relationship between the individual, their world, and the researcher (Smith, Flowers and Larkin, 2022), mirrored my research aims and the interpretivist paradigm of the thesis.

3.9.1 Grounded Theory

Grounded Theory, specifically that of the constructivist kind, was considered as it shares similarities with IPA in its interpretative and inductive foundations, contextual view of the world, and reference to symbolic interactions which shape meaning (Smith, Flowers and Larkin, 2009). There have been a number of fruitful studies in the field of EDs using grounded theory to explore experiences (Drinkwater *et al.*, 2022), and existential views of self (Williams, King and Fox, 2016). However, grounded theory draws on themes within a larger sample to support wider theoretical explanations, whilst IPA is more psychologically grounded, concerned with giving detail to individual experiences from smaller samples (Willig, 2013). Furthermore, grounded theory does not engage with existing theoretical constructs, whilst hermeneutic research interprets findings based upon pre-understandings which may encapsulate theories and wider literature (Bartley and Brooks, 2021).

This research did not intend to produce explanatory theory, where findings can be generalised and applied to others, as it does not subscribe to a perspective that knowledge is relative to all. Instead, the research aim was on meaning and experience, and focused on individual experiences. This is at odds with grounded theory which seeks a "unified theoretical explanation" (Corbin and Strauss, 2007, p. 107). Lastly, grounded theory adopts notions such as 'data saturation', which IPA does not align with, as new or different meanings and insights can emerge with each participant added to the study (Brocki and Wearden, 2006)

3.9.2 Narrative Analysis

The research question could have been explored through narrative analysis, allowing participants to express experiences and meaning through life history stories, or autobiographies

(Reissman, 2008). This has previously been engaged with to explore ED experiences and meanings (Patching and Lawler, 2009; Joyce *et al.*, 2019), and a methodology used in my Masters research project, giving further familiarity with the methodology (Dark and Carter, 2019). Interpretation is integral within narrative inquiry, viewing the researcher as a co-creator of meaning (Reissman, 2008), and therefore, well aligned with the interpretative paradigm (Bruner, 1987). Both narrative methodologies and IPA are person-centred, have a focus on meaning-making, and understand context influences the telling of accounts (Griffin and May, 2012). However, IPA is clearly rooted in the associated phenomenological philosophies, whilst narrative analysis is broad, and has a range of influences (Smith, Flowers and Larkin, 2022), including those which focus more so on the structure of stories (Gergen and Gergen, 1988), whilst I had a vested interest in the content of participants' accounts.

3.9.3 Discourse Analysis

Aware of the dominant discourses which create and maintain anorexia (Hepworth, 1999) as well as the strong symbolism food and eating holds (Churruca, Ussher and Perz, 2017), methodologies rich in a social constructionist perspective, such as that of discourse analysis were considered. Although incredibly insightful for critically interrogating discursive ways participants speak of anorexia, and their food-related practices, it was felt the heavy focus on linguistics and performance, may omit the agency, voice, and embodied experiences which this research sought. As Boughtwood and Halse (2004) cautioned the reader of their discourse analysis study involving individuals with anorexia: "this should not be interpreted as giving voice" to participants (Boughtwood and Halse, 2008, p. 277). It has been suggested these methodologies "look *through* rather than *at* the anorexic as a whole person" (O'Conner and Esterik, 2008, p.6). This research instead is experientially orientated, looking directly at the meanings and experiences of anorexia, and food and eating, representing an individual level of analysis, rather than the nature of anorexia. Thus whilst discourse analysis looks at the structure of context, IPA is considered with persons in context (Smith, Flowers and Larkin, 2022).

This research does not deny that language and discourse contribute to our experiences. Phenomenology understands language is a part of culture, which "brings to the surface all the deep-rooted relations of the lived experience wherein it takes form" (Merleau-Ponty, 1968, p.

126). Yet it does not consider experience is encapsulated by language and discourse; for language is limited in expressing our meanings and experience (Smith and Osbourne, 2003).

Phenomenology, especially that of the interpretative kind, is suggested as bridging the divide between distant and discursive explanations with close understandings (Alvesson and Skoldberg, 2009) exploring both individual meaning, whilst conscious and sensitive to wider meanings. Therefore, making findings applicable to real-world settings, which pure constructionist approaches, such as discourse analysis may fall short on (Reid, Flowers and Larkin, 2005).

3.10 Conclusion to Chapter Three

My ontological and epistemological orientation and research question lends itself to a form of inquiry which focuses on meaning and experience. The philosophies discussed in this chapter fits within a methodology which roots itself in phenomenology and hermeneutics and that is IPA. This methodology follows my view of knowledge generation which is co-constructed, lived, practical, relational and embodied (Heidegger, 2001; Merleau-Ponty, 2005). However, this knowledge is always partial, and incomplete, accepting it is never possible to capture a given experience in its entirety. The philosophical writings of Husserl, Heidegger, Gadamer and Merleau-Ponty have influenced my decisions when considering my methods for data collection and how I engaged with the research process.

4.Chapter Four: Methods

4.1 Introduction to Chapter Four

Following the discussion of my methodology, Chapter Four will outline the methods I undertook to conduct my study. It will also describe the practical and ethical considerations of my research including recruitment, data management, and process of analysis. These details provide clarity, and satisfy quality criteria in relation to transparency, rigour and enhance trustworthiness of the study.

4.2 Participant Recruitment

From the literature review, it was established most studies purposefully recruited participants from health-care settings, possibly preventing more diverse experiences from being heard. Therefore, to avoid privileging biomedical labelling over lived experience, there was no requirement for formal "proof" of diagnosis for participation; rather eligibility was based on individual discernment of living/lived with anorexia. This follows recovery-orientated principles, valuing lived experience and personal accounts over clinical perspectives (Dawson, Rhodes and Touyz, 2014b; LaMarre and Rice, 2021a). Receiving a formal diagnosis for anorexia is problematic and lengthy (BEAT, 2015), coupled with systemic constraints such as stigma, systemic barriers and misunderstandings (Griffiths *et al.*, 2015; Ali *et al.*, 2020); therefore, selection criteria ensured participants were not excluded on the basis of not (yet) having a diagnosis. This is a position adopted by other researchers in the field (Fox, Larkin and Leung, 2011; La Marre and Rice, 2015; Rance, Moller and Clarke, 2017). This recruitment choice was with the intention of using methods to enhance sensitivity, inclusivity and embrace lived experience (Halse and Honey, 2005). This 'label' therefore can be self-imposed and acknowledges a person's own subjectivity and truth of anorexia, aligning with the ontological and epistemological position of the research.

IPA seeks small samples who can grant access to a particular perspective on a phenomenon, which in this study relates to participants perspectives concerning their experiences of food-related occupations and the necessity of engaging in ED treatment. It is important to clarify that, although homogeneous relating to the object of the inquiry, the research does not assume homogeneous meanings or considered participants alike. Rather, by making the group as uniform as possible, it is possible to explore detail and variability within the group, including convergence and divergence (Smith, Flowers and Larkin, 2022). The inclusion and exclusion criteria for participation was:

Inclusion criteria:

- being 18 years-old and over,
- have or had received a label of anorexia,
- received treatment for anorexia, for which engagement with food-related activities is*/was part of their treatment and,
- UK-based.

Whilst exclusion criteria:

- have a hearing or speech impairment which would compromise two-way communication via Microsoft Teams,
- unable to understand and communicate in English,
- unable to provide informed consent, and
- in receipt of inpatient care at the time of the research to avoid interference with the intensity of their treatment plans and allow opportunity away from the inpatient setting, which could prove to be traumatic.

There are no set guidelines on how many participants should be recruited for IPA studies; however, Smith and Nizza (2021) recommend for doctoral studies, 10-12 is sufficient. I aimed to recruit up to 10 participants (the lower end of this recommendation), to ensure attention to detail was captured, and in-depth analysis made, rather than risk producing surface-level analysis. Individuals were recruited via ED charity gatekeepers. The names of which have been omitted for confidentiality purposes. Posters advertising the research were sent via the gatekeeper's media channels and those subscribed to their marketing channels. To increase the reach of recruitment, participants were also recruited via ‘word of mouth’, made possible through a variety of social media posts, published via a private Twitter account (created specifically for this research) to promote the research.[10]

4.3 Participants

Although aiming for ten participants, this study recruited a sample of nine female participants who met criteria for participation. Demographic information requested from participants include years of identifying with anorexia, the types of treatment they received for their ED, ethnic origin, gender, relationship status, and age range. Specific age of participants was discouraged by the ethics panel, which might contribute to increased risk of participants becoming identifiable.

All participants were Caucasian and female, and most (66%) were in the 25-34 age range. This was not the intention of the research and considered a limitation, and I am conscious this can contribute to stereotypes of anorexia (young, white and female) (Gordon, Perez and Joiner, 2002). Nevertheless, it arguably reflects the predominance of females with anorexia and seeking treatment (Thapliyal, Hay and Conti, 2018), as well as my own influence in the study as a female researcher.

Participants had a range of treatment experiences including both child and adolescent mental health service and adult services, as well as generic mental health and specialist treatment, and statutory and private care. Mean time of years since diagnosis was 9.6 years. However, this should be interpreted cautiously, as many participants discuss in their interview experiencing disordered eating, and emotional difficulties prior to diagnosis/treatment.

I understand that the term ‘recovery’ may not resonate with all individuals (Conti, 2018), thus preventing some individuals to opt out of such studies (Kenny and Lewis, 2023). As such, this information was not requested; however, all participants disclosed during their interviews they felt they were in a stage of recovery.

All participants for this research offered a perspective of living with anorexia and experiences of treatment for which food-related activities were part, providing a sufficiently homogeneous

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[10] https://twitter.com/Meaning_of_Food

sample required for the purposes of an IPA study. Table 2 shows the demographic data gathered from the sample.

Table 2 Demographic Data

Pseudonym	**Age category**	**Years since having a label of anorexia**	**Type of treatment received (narrative from patient)**	**Ethnic origin**	**Gender**	**Relationship status**
Harriet	35-44	23	1 general CAMHS inpatient stay, 3 admissions to a private eating disorder unit, 1 admission to a paediatric ward for refeeding.	White British	Female	Married
Kelly	25-34	6 years	4 eating disorder inpatient admissions Outpatient CBT-E	White British	Female	Married
Fiona	25-34	12 years	4 eating disorder inpatient admissions 1 general hospital admission 7 years under outpatient team	White British	Female	Single
Sarah	25-34	16 years	CAMHS inpatient, CAMHS outpatient service, 5 adult eating disorder inpatient treatment, general hospital admissions, outpatient treatment and supported living.	White British	Female	Single
Maria	25-34	11 years	MANTRA therapy and person-centred counselling outpatient	White British	Female	Relationship

Jennifer	25-34	5 years	Community eating disorder treatment, inpatient eating disorder treatment	White British	Female	Single
Katie	18-24	2 years	Outpatient CBT and dietitian appointments	White Irish	Female	Relationship
Barbara	18-24	9 years	1 CAMHS eating disorder inpatient admission, outpatient CAMHS, outpatient private treatment.	White British	Female	Married
Danielle	25-34	3 years	Community outpatient treatment	White British	Female	Engaged

4.4 Piloting the Interview Schedule

Preparing the interview schedule was an iterative process, made up of multiple reviews to ensure meaning and experience was captured. To ascertain interview questions posed were sensitive and did not cause unintentional harm, I piloted the interview on practising ED therapists, recruited via Twitter to gain their feedback and perspectives. Following this, small adaptations to the interview schedule took place.

The questions on the interview schedule (Appendix 2), were designed to elicit open and expansive responses from participants. Aware that topics such as meaning and experience are abstract, I used an eclectic mix of questions, some narrative and descriptive, to encourage a description of food activities; some evaluative, to encourage consideration of how participants felt during these activities; some exploratory, to encourage reflection; and some experiential, to delve into rich descriptions of experience (Smith, Flowers and Larkin, 2022).

4.5 Methods of Generating Data

Semi-structured interviews are favourable in IPA, where researcher and participant enter into a dialogue, giving space for flexibility to allow for novel and unexpected topics to emerge (Smith *et al*., 2009). A key part of being reflexive was to consider power relations between participants and myself. Therefore, I considered interviews joint endeavours (Anyan, 2013), and a method through which each person can bring something to the encounter

(Eatough and Shaw, 2019). Therefore, I built in capacity for participant validation, and clarification of meaning.

I intended to conduct interviews face-to-face in my original research plan; however due to the COVID-19 pandemic, the university temporarily placed restrictions on this. Therefore, all interviews were conducted online using the secure digital platform, Microsoft Teams, aside from one participant who had a telephone interview. Conducting interviews remotely is considered as a strength in the field of ED research, giving flexibility (Roberts and Skipsey, 2021), and allowing participants to talk freely about their experience without the interviewer's presence (Shabir, 2017). However, I aware of the limitations of this, where observing embodied gestures, expressions and so forth, may have thwarted the ability to empathetically grasp the subjective nature of participants' experiences (Finlay, 2006b).

Interviews explored experiences and meanings of food-related engagement prior to, during treatment, and how food and eating are given meaning to in the here and now. Although 'food-related engagement' is difficult to define due to their expansive personal meanings, it was necessary to provide focus to the interviewing questions to ensure relevant data was captured. Therefore food-related engagement was based on the literature and evidence base (Lock *et al.*, 2012; Long *et al.*, 2012b; Biddiscombe *et al.*, 2018; Duzyk, 2022), although not limited to, included:

- food shopping,
- meal preparation for self and others,
- social or group eating,
- visiting cafes and restaurants, and
- meal planning

An interview guide and structured set of questions was initially appealing as a novice researcher, offering standardisation, and avoiding anticipated moments of silence. However, phenomenological interviews embraces the unexpected directions emerging from collaborative dialogue (Eatough and Smith, 2017). This skill was fostered through practising the research interviews with friends and family members. In practice, it meant being continually aware of my unconscious need to control the narrative of interviews, especially in moments which I did not consider to be relevant and instead as Thomas (2021) states tolerating the sometimes "circuitous narrative" (Thomas, 2021, p. 488). I felt my insider status strengthened my interviewing skills as I was conscious of what questions to ask, and what could be potentially distressing (Berger, 2013), such as topics directly related to shape and weight.

Participants were offered a follow-up interview or follow-up e-mail if they felt one interview was insufficient, or too emotionally exhausting to communicate their experiences. Only one participant provided a follow-up email response, which was analysed alongside their interview transcript. I recorded interviews using Microsoft Teams (including that of the telephone interview) to obtain a transcript of the data. Acquiring transcripts without video recording was not a possible feature on Microsoft Teams. However, videos were deleted immediately afterwards. I also used a hand-held recording device and voice memo app for copies of the audio recording in case technical errors arose. Once interviews were completed, audio recordings were saved securely to my personal OneDrive account and only accessed by myself via a secure password.

4.6 Photo Elicitation

Conscious that food and anorexia can be a loaded and emotive subjects, and interviews can be researcher-led as opposed to participant-led, alternative approaches to give 'voice' to participants were considered (Larkin, Watts and Clifton, 2006). Developing creative and collaborative methodologies in ED research is advocated in the field to further understanding of experiences such as digital storytelling (La Marre and Rice, 2015) and photo voice (Saunders and Asia, 2018). Creative methods such as visual stimuli can help guide interviews and have been used in IPA interviews (Kings, Knight and Moulding, 2020; Burton *et al.*, 2022). Photo elicitation, is a term coined in anthropological research, to engage participants in the research process, and intended to stimulate latent memories and emotional expression (Collier, 1957). I decided to use photo elicitation to enable participants to both "show as well as tell" (Bartoli, 2019, p.10) their experiences. There are some challenges within this approach, including placing undue pressure on participants, and adding a layer of interpretation within the analysis process (Burton, Hughes and Dempsey, 2017). To overcome these factors, it was emphasised bringing photos to interviews was not mandatory and only optional. Furthermore, photos were not part of the interpretation process, as these were not intended to be an object of analysis, rather their purpose was to guide dialogue.

Participants in this study were invited to bring photo/s (no more than three) of their choice to elaborate on meanings attributed to their food and eating. To protect anonymity, these photos were instructed to be of objects, foods, or places (with non-identifiable people or places). Unfortunately, none of the participants brought photos to the interview, with only one bringing a personal drawing. This may have been impacted by the optional element of the request, or lack of clarity in promotional materials of the research. Some commented they did not understand the request, and others felt taking photos of food would be a sign of disordered eating and a triggering experience. For others, they described difficulties locating a picture to represent the complexity of their experiences, as one participant reported "*I'm not even sure if there would be a photo to describe it*" (Fiona).

4.7 Reflexive Interviewing

Navigating between different layers of interpretation is required in IPA, to encourage the phenomenon of interest to "shine forth" (Smith, Flowers and Larkin, 2009, p. 35). This emerges from a complex intersubjective process of experience and reflection, by both participant and researcher (Finlay, 2006a). Ricoeur (1974) discusses a dual layer of interpretative engagement including the hermeneutics of empathy or affirmation and hermeneutics of suspicion. IPA encourages a both, and approach; on one hand striving for empathy and re-imaging participants' experiences, whilst also being iteratively and critical of what appears, through probing and considering undisclosed or inferred meanings (Eatough and Smith, 2017).

My research is based on an epistemology which considers knowledge is to be interpreted and co-constructed through embodied subjective and intersubjective engagement (Husserl, 1983; Merleau-Ponty, 2005), and therefore, had implications for how I engaged with the research process. I took inspiration from Finlay's (2005) practice of reflexive embodied empathy, which offers a conceptual and practical orientation towards the research. Finlay describes three layers of embodied reflexivity: the first, paying attention to embodied reactions during and after interviews to connect with participants, secondly, using imagination to re-enact participants' experiences, and thirdly, a process of merging self-understanding with participants' understanding to transform thinking (Finlay, 2009c). A reflection of this approach is described in Appendix 3 'Reflexive Embodied Empathy'. Underscoring my approach was an openness and unknowing approach to participants and their experiences, a probing into my own embodied responses, and recognition that interviews were an intersubjective relational space (Finlay, 2006b).

4.8 Ethical Considerations

IPA acknowledges the co-constructed nature of knowledge, and actively positions participants as collaborators. This stance can contribute to demarginalization, and lead to feelings of empowerment and allyship (Musić *et al.*, 2022). Nevertheless, there are many complexities involved in safe and ethical inclusion of individuals with lived experience of EDs in research including the potential detriment to their wellbeing by partaking (Musić *et al.*, 2022). Although no ethical issues arose, there were ethical considerations, which needed to be considered.

Procedural ethics alone is not sufficient for ensuring ethical practice, given the potential unexpected or more subtle ways ethical issues can emerge (Guillemin and Gillam, 2004). Therefore, an ethics-as-process framework (Ramcharan and Cutliffe, 2002) was adopted which describes ongoing ethical engagement to attend to these nuances.

As a registered HCPC Occupational Therapist, I am bound by the professional standards and ethical expectations laid out by the Royal College of Occupational Therapists (RCOT, 2021) and the standards of conduct, performance and conduct framework by the Health and Care Professionals Council (HCPC, 2016). As a student of University of Brighton, I followed relevant postgraduate research policies, including research integrity (The University of Brighton, 2020), research ethics (The University of Brighton, 2022) and data management (The University of Brighton, 2023). After a process of review, this research was approved by the Cross-School Research Ethics Committee A at University of Brighton (Appendix 4.A Ethics Letter of Approval). An amendment to the project was also submitted requesting follow-up interviews to be included (Appendix 4.B Ethics Letter of Amendment).

4.8.1 Informed Consent

All participants had capacity to give consent to participate (Appendix 5) and they were fully and truthfully informed about all aspects of the research through the Participant Information

Sheet (Appendix 6). It was important participants were aware of their consent to participate not only in the interviews, but also consenting to use their data for analysis, and verbatim extracts for publication. Participants were encouraged to thoughtfully consider their participation via the Participant Information Sheet or e-mail. Conscious that participants may still have questions about the nature of the research, or sought clarification, I offered opportunity of a pre-interview meeting; however, no participants took up this opportunity. Participants were asked to digitally sign the content forms before proceeding with their interviews. It is considered general good practice in qualitative research when researching sensitive topics to revisit informed consent within the interview itself (Liamputtong, 2006; Klykken, 2021); as such, this was clarified during interviews.

4.8.2 Sensitivity

To support ethical and sensitive research, I engaged with ED literature and developments in the field, demonstrating sensitivity to context – a marker for assessing quality and validity in qualitative research (Yardley, 2000). Training and continuing professional development courses in the field of EDs, alongside professional experience fostered a strong skill set for collecting personal information sensitively and ethically. My personal experience also provided me with a more nuanced and sensitive understanding of my participants and their responses, including what was hidden or unsaid, allowing me to probe more efficiently (Berger, 2013).

Aware that revisiting or reflecting upon sensitive topics related to food and ED treatment can be potentially upsetting (O'Connell, 2023), I ensured participants were fully aware of the sensitive nature of taking part in the research via the participant information sheet. During interviews, participants were encouraged to engage with continued self-monitoring of their wellbeing, such as taking a break, withdrawing, and the opportunity to not respond questions they did not comfortable answering.

Participants were offered the choice to turn their camera off if they felt this was more comfortable. Unlike other qualitative methods, IPA is mainly interested in the contents of the interview, therefore a transcription of what was said, as opposed to what is seen is considered sufficient (Smith and Nizza, 2021). For those who chose to have their cameras off, or a telephone interview, raised some prior ethical considerations, such as difficulties identifying indications of distress or upset (Sweet, 2002). This meant being attentive to tone of voice, and continually checking in with participants during the interview if they comfortable to continue. Nevertheless, there is little evidence suggestion the quality or data interpretation is compromised in telephone interviews (Novick, 2008).

During the interview, measures were taken to minimise the risks of personal discomfort when discussing sensitive issues and a distress protocol was developed (Appendix 7 Distress Protocol). There can be a greater likelihood of role confusion when researchers have familiarity with the subject matter and have insider status, risking overstepping professional boundaries (Dwyer and Buckle, 2009). To mitigate this, I emphasised to participants my role as a researcher, and the boundaries of interviews which were not a substitute for treatment. However, in recognising my ethical obligation to respond to potential requests of support, I resolved if any arose, instead of providing any direct advice in the interviews, I would instead be empathetic, caring and understanding. I conducted sensitive verbal debriefs, and signposted individuals to relevant sources via a debrief sheet (Appendix 8 Debrief Information Sheet).

Participants were made aware if they disclosed information which would warrant a safeguarding matter such as serious concern for their own safety or of others, I would follow local safeguarding policies or contact statutory services. However, no matters arose during the process and no participants experienced distress or upset which were made known during the research process.

Participants were offered the opportunity for a follow-up interview or e-mail interview to respect their lived experience and the time and emotional strain it may take to recount this. To honour participants' involvement and offer a gesture of goodwill, I sent a £5 high street gift card digitally via the e-mail address provided. However, only six out of the nine accepted, with one asking me to donate it to an ED charity.

4.8.3 Anonymity

To anonymise data, I used aggregations to describe participant characteristics such as age ranges and did not include specific information such as location. In this research, I ensured anonymity by removing information which could identify participants including referencing names, and hospital locations, in replacement for pseudonyms. Whilst presenting the analysis, I was conscious that combining details such as treatment type, relationship status, would not inadvertently lead to identification.

4.8.4 Confidentiality

Participants were encouraged to join Microsoft Team interviews in a private location to discuss sensitive topics freely and without interruption. I conducted interviews from within my own property, in a private room and at a time I knew I would not be overheard or seen. I discussed with participants about an ‘exit plan’ in the event of interruption which included ending the interview and waiting until the interruption was resolved or rescheduling completely.

Participants were made aware their involvement in any charities (if they discovered the research from this source) would not affect their support they may be receiving, or any other opportunities, and were assured gatekeeper charities would not be aware of their involvement.

For the telephone interview, I called the participant on a withheld number, managing their data in accordance with the rest of the participants.

4.8.5 Managing Risk to Self

Engaging with reflexive research can be confronting and raise several conflicting emotional responses (Finlay, 2003b; Goldspink and Engward, 2019; Thomas, 2021). I began the research many years after ED treatment and in a place of recovery. However, phenomenological reflexive research requires revisiting past and current experiences and brings attention to one’s unconscious; therefore, conducting self-study can be an emotionally draining process, placing demands on one’s wellbeing (Pearce, 2010). Although not as revealing as autoethnographic studies, Dashpher (2015) encourages researchers to consider the aftermath of their writings, which can lead to feelings of vulnerability. I was therefore mindfully aware about documenting my own experiences in this thesis, and the implications this would have on my career and clinical practice. Speaking about my lived experience is not novel, I have previously spoken openly and transparently about my lived experience, for example in national publications

(Dark, 2019), and other opportunities within my profession. I concluded the perceived benefits of this study outweighed any potential personal or professional risks.

However, there was several safeguards I put in place including choosing not to disclose my personal lived experience or explicitly discussing my own professional work as an Occupational therapist with participants. This was to ensure to the focus remained on the participants and to avoid upsetting or triggering participants. I also continued to discuss my engagement with my supervisors and the Doctoral College Lead, reached out to other postgraduate researchers, and familiarised myself with postgraduate student support services. I was continuously aware of the impact of the research on my well-being and took ownership of this, taking breaks from study and the data, when it became emotionally draining. Conducting a series of in-depth interviews in quick succession led to compassion fatigue therefore I quickly adapted and spaced-out future interviews. Emotions are not to be avoided withing a phenomenological approach, but rather the intersubjective relationship between researcher and participants, and acknowledgement of emotions is critical to the development of new insights (Boden *et al.*, 2016).

4.8.6 Data Protection

Alongside following The University of Brighton's data protection management policy, I also followed requirements for managing and sharing personal data (GDPR, 2016; Data Protection Act 2018).

Consent forms, recorded audios, demographic information and transcripts were uploaded to my password encrypted University Microsoft OneDrive account and accessed only by myself. Information collated was only that which was relevant to the purposes of the research. Data transcripts were coded, with all identifiable information replaced with pseudonyms such as places, names, and hospitals. Consent forms, recorded audios, and demographic information are stored until the end of the research process and then destroyed. Whilst anonymised data transcripts, any photos shared, and relevant field notes, will be stored securely and safely on the University of Brighton's data repository, which can be up to 10 years for publication purposes.

In line with GDPR (Data Protection Act, 2018), participants were free to withdraw from the research process at any point. However, after cross-case analysis had taken place (4 weeks after their interview), their anonymised comments would still be included. Participants were made of aware of this via the participant information sheet, consent forms, and during the interview. This is in line with General Data Protection Regulations for as long as all personal data is anonymised and does not identify participants, this data can be included as part of the research.

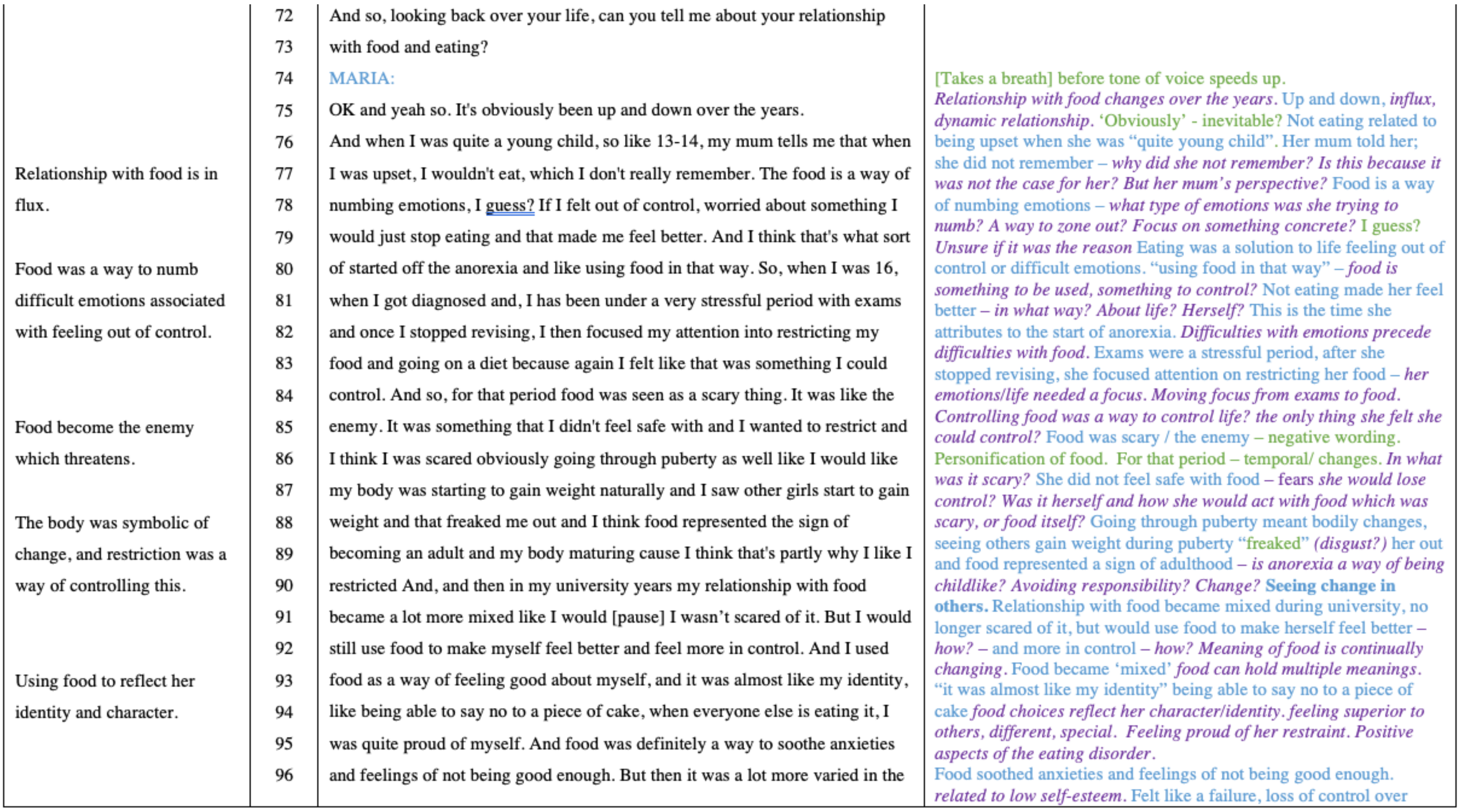
4.9 Data Analysis

Data was analysed using the framework laid out in Smith and Nizza's (2021) and second edition of IPA (Smith, Flowers, and Larkin, 2021), using the revised IPA terminology. The process is based on the hermeneutic circle, an iterative and inductive process, moving from the idiographic to the shared, and back to the idiographic (Smith, Flowers and Larkin, 2022). Although the steps laid out below assumes linearity, this is not the case, the hermeneutic phenomenological underpinnings of this research require reapproaching the analysis as "dynamic, interactional, multi-faceted, complex, long, and often very frustration" (Engward and Goldspink, 2020, p. 44). Although Smith, Flowers and Larkin provide a systemic approach for analysis, increasing methodological rigour, analysis still requires playfulness, imagination, and reflexive critical and conceptual thinking (Smith, Flowers and Larkin, 2009).

Step one involved checking the verbatim transcripts for accuracy against the recording of interviews, as well as repeatedly listening to recordings to immerse myself in participant's narratives. Once transcripts were checked for accuracy, they were then copied into a table (using the template laid out by Smith and Nizza, 2020), with the transcript in the middle, exploratory notes on the right-hand column and experiential statements on the left-hand column.

Step two involved a close line-by-line analysis, to understand the experience and meaning of each participant, with the purpose being to create a dialogue with the transcript. In the right-hand column, I colour coded descriptive, linguistic, and conceptual comments. Descriptive comments focused on a summary and face value descriptions of what participants said (these are in blue). Linguistic comments looked at language features of how participants discussed their experiences, taking note of tone, repetition, fluency, and use of metaphor (these are in green). Finally, the conceptual comments involved an interrogative and interpretative reading of the material, these comments took on the form of questions and reflections (these are in purple). This was an iterative process, often meaning returning to these comments after listening to the transcript again and again; with the more intimately engaged I became, the greater the depth of comments and questions I made. As this was a highly changeable process, this was completed via a word processor as opposed to handwritten, examples of which can be seen in Figure 6 of snapshot of 'Maria's Transcript'.

Figure 6 Maria's Transcript



Relationship with food is in flux. Food was a way to numb difficult emotions associated with feeling out of control. Food become the enemy which threatens. The body was symbolic of change, and restriction was a way of controlling this. Using food to reflect her identity and character.	And so, looking back over your life, can you tell me about your relationship with food and eating? MARIA: OK and yeah so. It's obviously been up and down over the years. And when I was quite a young child, so like 13-14, my mum tells me that when I was upset, I wouldn't eat, which I don't really remember. The food is a way of numbing emotions, I guess? If I felt out of control, worried about something I would just stop eating and that made me feel better. And I think that's what sort of started off the anorexia and like using food in that way. So, when I was 16, when I got diagnosed and, I has been under a very stressful period with exams and once I stopped revising, I then focused my attention into restricting my food and going on a diet because again I felt like that was something I could control. And so, for that period food was seen as a scary thing. It was like the enemy. It was something that I didn't feel safe with and I wanted to restrict and I think I was scared obviously going through puberty as well like I would like my body was starting to gain weight naturally and I saw other girls start to gain weight and that freaked me out and I think food represented the sign of becoming an adult and my body maturing cause I think that's partly why I like I restricted And, and then in my university years my relationship with food became a lot more mixed like I would [pause] I wasn't scared of it. But I would still use food to make myself feel better and feel more in control. And I used food as a way of feeling good about myself, and it was almost like my identity, like being able to say no to a piece of cake, when everyone else is eating it, I was quite proud of myself. And food was definitely a way to soothe anxieties and feelings of not being good enough. But then it was a lot more varied in the	[Takes a breath] before tone of voice speeds up. *Relationship with food changes over the years*. Up and down, *influx, dynamic relationship*. 'Obviously' - inevitable? Not eating related to being upset when she was "quite young child". Her mum told her; she did not remember – *why did she not remember? Is this because it was not the case for her? But her mum's perspective?* Food is a way of numbing emotions – *what type of emotions was she trying to numb? A way to zone out? Focus on something concrete?* I guess? *Unsure if it was the reason* Eating was a solution to life feeling out of control or difficult emotions. "using food in that way" – *food is something to be used, something to control?* Not eating made her feel better – *in what way? About life? Herself?* This is the time she attributes to the start of anorexia. *Difficulties with emotions precede difficulties with food*. Exams were a stressful period, after she stopped revising, she focused attention on restricting her food – *her emotions/life needed a focus. Moving focus from exams to food. Controlling food was a way to control life? the only thing she felt she could control?* Food was scary / the enemy – negative wording. Personification of food. For that period – temporal/ changes. *In what was it scary?* She did not feel safe with food – fears *she would lose control? Was it herself and how she would act with food which was scary, or food itself?* Going through puberty meant bodily changes, seeing others gain weight during puberty "freaked" *(disgust?)* her out and food represented a sign of adulthood – *is anorexia a way of being childlike? Avoiding responsibility? Change?* **Seeing change in others.** Relationship with food became mixed during university, no longer scared of it, but would use food to make herself feel better – *how?* – and more in control – *how? Meaning of food is continually changing*. Food became 'mixed' *food can hold multiple meanings*. "it was almost like my identity" being able to say no to a piece of cake *food choices reflect her character/identity. feeling superior to others, different, special. Feeling proud of her restraint. Positive aspects of the eating disorder*. Food soothed anxieties and feelings of not being good enough. *related to low self-esteem*. Felt like a failure, loss of control over

To ensure comments were not too descriptive yet avoided being too abstract and far from participants' original meaning, reflexive practice, supervision and sharing preliminary interpretations within the IPA community ensured interpretations were rooted in the data. Inevitably interpretations are influenced by the researcher being-in-the-world (Annells, 1996), however these influences were used to heighten understanding and make sense of the participant's meaning-making.

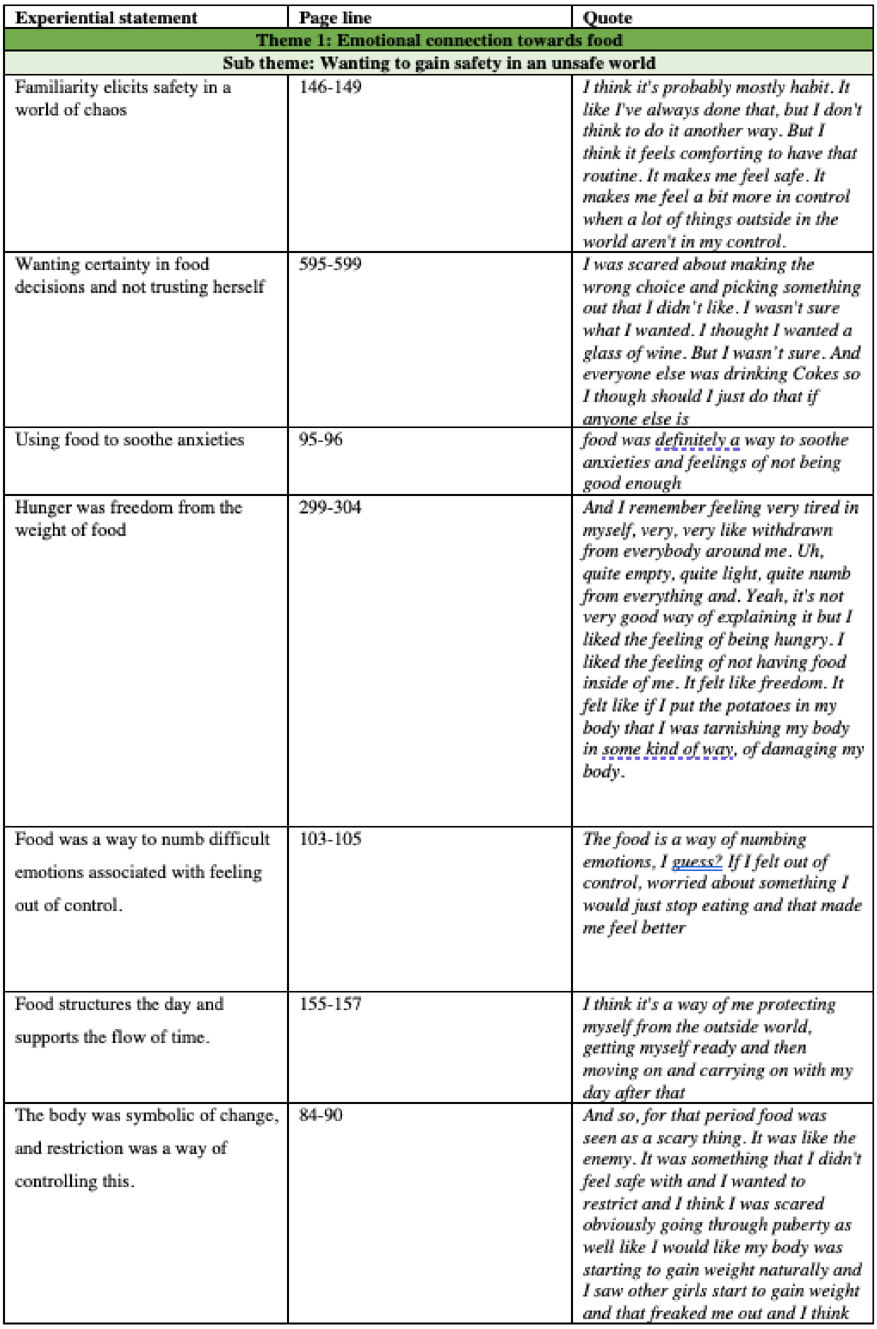
Step three involved formulating personal experiential statements (ES); these are succinct statements about the meaning of experience which sit between the concrete (what was said by the participant), and the psychological (what was interpreted). Some statements were connected to a particular text, whereas other statements referred to segments in the whole transcript. This requires both a focus on the individual level, whilst also holding in mind the whole narrative; reflecting the hermeneutic circle where the part is related to the whole and vice versa (Smith, Flowers and Larkin, 2022). Smith (2011) suggests paying attention to discrete passages in the data corpus which may intrigue, mystify, or have significance (Smith, 2011c).

Step four involved clustering the ES by copying and pasting all the ES into a word document, printing and cutting these out, and then spreading them out on the floor. This offers a bird's eye view of all the ES, to consider "what should go with what" (Smith and Nizza, 2021, p. 43). Some ES were very similar to one another, in that they expressed similar experiential meaning, and these were grouped together. When ES felt interlinked, and connected to one another, these were placed next to each other in clusters. This process involves not only seeking similarities, but also differences in the data. Some clusters revealed conflicting meanings and experiences regarding anorexia, food, eating and treatment, and these were brought together to highlight the complexity of experience. Figure 7 example of 'Clustering Experiential Statements'.

Figure 7 Clustering Experiential Statements

Step five involved developing personal experiential theme (PET) and sub-themes from the clustering of ES. Sometimes if PETs were similar, these were removed or converged into one statement. A distilling process was required to finalise a small number of PETs (between three to five is recommended), to ensure quality as opposed to quantity (Smith, Flowers and Larkin, 2022). After this, sorting the PETs into some chronology allowed an illustration of a passage of time, and this usually followed, experience of food and eating prior to, during, and after treatment, see example of Figure 8 'PETS table for Maria'.

Figure 8 PETS table for Maria



Experiential statement	Page line	Quote
Theme 1: Emotional connection towards food		
Sub theme: Wanting to gain safety in an unsafe world		
Familiarity elicits safety in a world of chaos	146-149	*I think it's probably mostly habit. It like I've always done that, but I don't think to do it another way. But I think it feels comforting to have that routine. It makes me feel safe. It makes me feel a bit more in control when a lot of things outside in the world aren't in my control.*
Wanting certainty in food decisions and not trusting herself	595-599	*I was scared about making the wrong choice and picking something out that I didn't like. I wasn't sure what I wanted. I thought I wanted a glass of wine. But I wasn't sure. And everyone else was drinking Cokes so I though should I just do that if anyone else is*
Using food to soothe anxieties	95-96	*food was definitely a way to soothe anxieties and feelings of not being good enough*
Hunger was freedom from the weight of food	299-304	*And I remember feeling very tired in myself, very, very like withdrawn from everybody around me. Uh, quite empty, quite light, quite numb from everything and. Yeah, it's not very good way of explaining it but I liked the feeling of being hungry. I liked the feeling of not having food inside of me. It felt like freedom. It felt like if I put the potatoes in my body that I was tarnishing my body in some kind of way, of damaging my body.*
Food was a way to numb difficult emotions associated with feeling out of control.	103-105	*The food is a way of numbing emotions, I guess? If I felt out of control, worried about something I would just stop eating and that made me feel better*
Food structures the day and supports the flow of time.	155-157	*I think it's a way of me protecting myself from the outside world, getting myself ready and then moving on and carrying on with my day after that*
The body was symbolic of change, and restriction was a way of controlling this.	84-90	*And so, for that period food was seen as a scary thing. It was like the enemy. It was something that I didn't feel safe with and I wanted to restrict and I think I was scared obviously going through puberty as well like I would like my body was starting to gain weight naturally and I saw other girls start to gain weight and that freaked me out and I think*

Step 6 involves repeating steps 1 to 5 for all other interview transcripts, treating each case on its own terms to reflect the idiographic commitment of IPA. Inevitably researchers are influenced by what has already been found. As Heidegger stated "every interpretation which is to contribute some understanding must already have understand what is to be interpretated"

(Heidegger, 2001, p. 194). However the systematic rigour of the analytic process ensures new insights emerge with each case (Smith, Flowers and Larkin, 2022).

Step 7 involved a dynamic process of developing group experiential themes (GETS). This required a rigorous screening between PETs, whilst reflective and analytic engagement considering similarities and differences. Practically this meant looking across the PET tables and taking note of similarities in terminology at a broad level. Following this, PETS were printed out and placed on to the floor (similar to the clustering process), whilst considering and making note of what connections there are across each case and thinking about how each participant lived through their experiences (Figure 9 'Developing GETS').

Figure 9 Developing GETS

Once GETs were synthesised, they were placed into a table, with subordinate themes and superordinate themes. IPA does not seek generalisations of experience, and contrasts with nomothetic approaches, but rather dual attention is needed to commonality, producing patterns of connections of experience, whilst highlighting differences (Eatough and Smith, 2017).

Established themes were those evident in more than half of the participant's transcripts (Appendix 9 GETS table). Below in Figure 10 is a visual demonstration of how many participants related to each theme.

Figure 10 Visual demonstration of how many participants relate to a theme

How many participants related to each theme

GET 1	Meaning doing: relationship with food-related occupations as a coping strategy	
Sub theme 1	Controlling food and eating amidst lives perceived as uncontrollable	All 9 participants
Sub theme 2	Seeking safety and certainty through eating.	All 9 participants
Sub theme 3	Food and eating are a threat.	7 participants: Maria, Fiona, Barbara, Katie, Sarah, Kelly, Danielle
Sub theme 4	The push and pull of the doings of anorexia.	8 participants: Maria, Danielle, Harriet, Barbara, Katie, Sarah, Kelly, Jennifer
GET 2	Meaning being: Food-related occupations are an expression of identity	
Sub theme 1	Relationship with food reflects personal identity.	6 participants: Katie, Jennifer, Maria, Danielle, Sarah, Barbara,
Sub theme 2	Not feeling good enough to be anorexic	7 participants: Barbara, Maria, Harriet, Katie, Kelly, Jennifer, Danielle.
Sub theme 3	Food and eating are a form of communication.	Katie, Jennifer, Barbara, Danielle

GET 3	**Meaningful belonging: contextual influences upon the meaning of food-related occupations**	
Sub theme 1	Positive interpersonal influences upon food and eating.	8 participants: Sarah, Maria, Katie, Barbara, Jennifer, Harriet, Danielle, Kelly
Sub theme 2	Negative interpersonal influences upon food and eating.	All participants
Sub theme 3	Environmental influences upon food and eating.	6 participants: Danielle, Jennifer, Harriet, Fiona, Sarah, Barbara
Sub theme 4	Cultural influences upon food and eating.	7 participants: Sarah, Katie, Jennifer, Kelly, Barbara, Danielle, Maria
GET 4	**Meaningful resisting: the influence of treatment upon relationship with food and eating**	
Sub theme 1	Disempowerment and empowerment.	8 participants: Fiona, Danielle, Harriet, Kelly, Sarah, Maria, Barbara, Jennifer
Sub theme 2	Medicalisation of food conflicts with food normality.	All participants
Sub theme 3	Playing the treatment game.	7 participants: Kelly, Fiona, Katie, Jennifer, Harriet, Barbara, Sarah
GET 5	**Meaningful becoming: repairing self, with the world and with others**	
Sub theme 1	Food enables access to life.	7 participants; Kelly, Fiona, Sarah, Maria, Danielle, Barbara, Katie
Sub theme 2	Food is reconnection with others.	All participants
Sub theme3	Balance with food and self.	6 participants: Katie, Maria, Harriet, Danielle, Barbara, Jennifer

Empathetic dwelling refers to staying and dwelling with participants' descriptions so that "one becomes ever more open what is being communicated" (Churchill *et al.*, 1998, p. 65). Themes were placed visually on my wall, to encourage being-there (Heidegger, 2001) with participants and the complexity of their felt-experiences (Boden *et al.*, 2016), see Figure 11.

Figure 11 Embodied Reflection.

These were continually reflected upon, moved around, and shifted, as new insights emerged. Engward and Goldspink (2020) suggest 'living with the data', which requires time and commitment. However, caution was also exercised, aware that spending too much time can allow taken-for-granted thinking to creep in. Thus, it was important for my own wellbeing and management of the research process that I placed a timeline on this process.

4.10 Post analysis reflection

Reflexivity through critical self-awareness, drew upon my own personal experiences and pre-understandings, allowing new and novel insights to emerge. Goldspink and Engward, (2019) discuss the concept of attending to "echoes" in the analysis process, whereby researchers are aware of their own historicity, and temporality. My analysis too elicited what Goldspink and Engward define as "booms, clangs, and whispers" (Goldspink and Engward, 2019, p. 303) where participant's comments triggered memories, recognising my experiences mirrored in theirs, which were noted, reflected and scrutinised. Engaging with the data was a more emotional and embodied experience than I anticipated, and their narratives gave me insight into meanings and experiences that literature and textbooks so often trivialise.

Although being aware is important, of equal importance is questioning and filtering their relevance as Finlay (2002) notes reflexivity can result in falling into excessive self-analysis at the expense of understanding. This is where journaling was essential to attend to the unknown and taken-for-granted, to ensure my experiences are not presented, but enriched understanding. For example, a participant discussed recalling eating soup, triggering memories of her mum making her soup as a child. This comment took me back to my own childhood memories of being cared for and loved when I was unwell, and my own relationship with my mum. This reflection led to a practical outcome, where I returned to the transcript and raw data, seeing more clearly how food connects participants to relationships and meanings can transport through time. This shows the double hermeneutic process where the relational intimacy between the interpreter and interpreted is constantly exercised.

I also felt a deep sadness at the cessation of the interview period, and analysis of the transcripts. Often when I would make exploratory comments, I questioned what happened next? Hanna (2019) discussing researcher emotion, found researchers may feel a lack of closure, and concern for the outcome of participants. A feeling described by other IPA researchers when entering into a research-participant relationship where no firm conclusions can be made (Carruthers *et al.*, 2023).

The process of grouping PETs was a complex process. Some PETS were overtly similar and easier to group together. At other times, it was much more difficult to find a ‘label’ for the entire group experience, leading to guilt and confusion. I often felt overcome by the conflicting meanings and wide array of experiences. Holding onto the unique lens of experience and each participant, whilst also trying to look across experiences felt an impossible feat, and at times, overwhelming. I sometimes felt tempted to overlook experiences if they did not fit into a commonality of experience, or emerging theme. Whilst also worried that by looking across themes, I would lose the essence of the individual and not give justice to their experience. This entire process required time and patience and was a dynamic activity of zooming in (reading the PETs and table transcript for each participant) and zooming out (looking across cases). It was messy and uncomfortable, where I often sat surrounded by pieces of paper, where the experience felt de-contextualised from the whole. PETs and sub-themes were re-named, and pieces of paper continually moved around, therefore keeping an audit trail through note taking, audio recording my own thoughts, and taking pictures helped to keep track of changes I made.

4.11 Trustworthiness of the Study

I recognise knowledge and experience of the world is not objective but profoundly shaped by subjective and cultural interpretations (Heidegger, 2001; Cuthbertson, Robb and Blair, 2020). Therefore, concepts such as ‘truth’, ‘knowledge’ and ‘reality’ are created by the shared construction and negotiation of meaning. Unlike quantitative research, there is no fixed and universal criteria for establishing truth and knowledge in qualitative research (Leung, 2015), and debates exist whether placing quality and validity measures reduces complexity to simple checklists (Lester and O'Reilly, 2021). Aligning with my philosophy of the research, I do not feel there is one ‘true’ interpretation waiting to be discovered; rather I bring my experiences, values, and preconceptions into interpretations to co-construct meaning with participants. Therefore, unlike a quantitative researcher’s goal of validity, the pursuit of trustworthiness is deemed more relevant, which poses the question ‘can the findings be trusted?’ Therefore, based on the strategies I have engaged with below, it is hoped readers gain a sense of confidence in the findings reported (Braun and Clarke, 2013; Korstjens and Moser, 2018).

As IPA is a highly “creative process” and does not follow a “rule book” (Smith *et al*., 2009. p.184), it is of paramount that researchers seek to demonstrate the trustworthiness of their findings. IPA studies often apply Yardley’s (2000; 2008) broad evaluative criteria for ensuring the trustworthiness of findings, considering sensitivity to context, commitment and rigour, transparency and coherence and impact and importance (Smith, Flowers and Larkin, 2009). These aspects are discussed, whilst also considering Lincoln and Guba’s (1986) seminal facets such as credibility, confirmability, dependability, and transferability (Lincoln and Guba, 1986; Korstjens and Moser, 2018). Furthermore, given IPA’s emphasis on interpretation, reflexivity is an important dimension of establishing trust in the findings, and therefore this has been made explicit throughout the thesis. In addition to these dimensions, to ensure the specific methodological approach IPA was appropriately and coherently applied, I have also considered Nizza, Farr and Smith's (2021) four markers of high-quality IPA research.

4.11.1 Yardley's Evaluative Criteria

Sensitivity to context has been demonstrated through formulating a research question which has relevance to the existing theoretical and research literature, and the observation that food-related meanings in OT literature is sparse. Sensitivity also requires understanding the perspectives and sociocultural context of participants. This has been displayed through building a rapport with participants, so they felt comfortable and heard, as well as being thoughtfully aware to the power dynamics which have traditionally occurred in EDs, instead participants were viewed as co-collaborators (Thomas, 2021). Sensitivity to participants' perspectives is demonstrated through piloting the interview schedule and making subsequent revisions, using open-ended questions, utilising verbatim extracts, employing critical reflexivity, and embracing an embodied, relational and emotional attitude (Burkitt, 2012), all facets considered to improve the rigour and credibility of studies (Boden *et al.*, 2016).

Commitment and rigour are considered to be fulfilled through displaying expertise in the methods employed, undertaking a systematic and in-depth analysis (Yardley, 2000), and maintaining reflexive engagement (Boden *et al.*, 2016). These strategies, alongside the use of member checking findings, can instil confidence in the findings, therefore establishing credibility (Morse, 2015; Forero *et al.*, 2018). Furthermore, frequent supervision throughout the project and training in IPA's methodology developed strong methodological skills to meet this criterion. Yardley (2000) states commitment and rigour can be demonstrated by "prolonged contemplative and empathic exploration of the topic" (p.222); I have fulfilled this through in-depth engagement with the research phenomena and numerous personal sacrifices throughout the project duration.

Transparency and coherence are achieved when readers understand how findings are established, and concerns itself with the process of analysis (Smith, Flowers and Larkin, 2009; Smith, 2011a). These elements have been demonstrated through a personal research audit trail involving all steps taking (from initial field notes, the annotated transcripts, the clustering of PETS, the PETS table, the GETS clustering and the GETS table, as well as supervision meeting notes and reflexive note taking). Key features of dependability include transparency and trust in the data collection procedures (Bloomberg and Volpe, 2012). As such, alongside the audit trail, several appendices and figures are included in this thesis as well as reflexive attention to my influence throughout the research process. Coherence is addressed by documenting a clear relationship between one's philosophical perspective, method of investigation and research question and analysis (Yardley, 2000); a thread explicated in the methodology and methods of this research. These practices ensure the confirmability of the study, that is the confidence that findings can be confirmed or corroborated by other researchers (Morse, 2015). This has been achieved by implementing reflexivity throughout, showcasing how interpretations emerged through a process of analysis, as well as considering how findings are situated within the wider literature (Stahl and King, 2020).

Impact and importance are evidenced when research can provide interesting, important, and useful findings (Yardley, 2000). This research responds to calls for greater research in the field of EDs from an OT lens, as well as qualitative consideration of food-related occupations (Biddiscombe *et al.*, 2018; Mack *et al.*, 2023). In addition, this thesis provides novel insights and practical and theoretical implications to consider.

4.11.2 Consideration of Transferability

Given the strong idiographic commitment, the utility of small samples, and how IPA is highly creative, context-dependent, and interpretative, questions concerning IPA's clinical utility and generalisability may be raised (Pringle *et al.*, 2011). However, IPA makes fairly modest claims in relation to generalisation and dependability, which aims to provide detailed exploration of experience, from individual perspectives (Smith and Osbourne, 2003). Dating back to 1982, Stephens distinguishes between horizontal generalisability and vertical generalisability. Horizontal generalisability, is how findings can be applicable across settings; whilst the latter, is concerned with building interpretative theory (Stephens, 1982). The findings relate to vertical generalisability; meaning it is the interpretative concepts which can be broadly generalised rather than specific contexts or populations (Smith, 2018a). Therefore, it is hoped readers interrogate the findings to explore whether there is resonance with their own experiences and provoke re-evaluation about what is understood about the phenomenon.

Given the hermeneutic nature of the research, which implicates my own analytic reading of participants account to uncover meanings which are "hidden by the entity's mode of appearing" (Moran, 2000, p. 229), requires a level of interpretation. These interpretations are inevitably influenced by my own experiences, values, and pre-understandings. Nevertheless, to support illuminating subjective meanings, reflexive attention was paid when identifying themes to ensure interpretations were grounded in participant's data, as well as maintaining a curious and open stance, and vigilant self-monitoring of the impact of my biases and personal beliefs upon the research process.

4.11.3 Quality Indicators of IPA Studies

In terms of judging the quality of methodology used, I draw upon recent guidelines to strive for excellence in IPA (Nizza, Farr and Smith, 2021). In the new edition of IPA, Smith, Flowers, and Larkin (2022) encourage quality and validity measures to be applied flexibly given the creative and explorative nature of IPA.

Following methodological developments in IPA, Nizza, Farr and Smith (2021) expand on Smith's (2011a 2011b) benchmark guidelines for IPA studies, and produce four quality indicators, which are discussed below:

4.11.4 Attending to Convergence and Divergence. It is considered excellent IPA studies are those which strike a balance between commonality and individuality (Nizza, Farr and Smith, 2021). Within this study, sufficient attention has been given to similarities between cases, without losing sight of idiosyncratic differences. This has been demonstrated by continually returning to participants' individual narratives, and how these converge or diverge from other accounts. Individual PETS were not dismissed if they did not 'fit' claims of the whole data set, but held on to, and reflected upon, exploring if other participants expressed this theme in another way. In this way, the analysis illuminated diverse manifestations of meaning.

4.11.5 Close Analytic Reading of Participants' Words. Commitment to a close analytic reading was maintained to ensure richness of interpretation, encouraging a shift beyond surface level descriptions. This has been demonstrated through active person-driven data analysis as opposed to using digital software to make exploratory comments which pulled on words and phrases, tones, repetitions, and metaphors. Surpassing first order analysis, interpretations, and conceptualisations were brought to the fore by continually questioning the data; asking what the meaning is here. Larkin, Watts, and Clifton (2006) encourage engagement with phenomenological theory and supervision to move beyond descriptive accounts. As such, belonging to various IPA study groups, attending IPA workshops, and training and reading the philosophical works associated with IPA, supported a more interpretative analytical process.

4.11.6 Developing a Vigorous Experiential and/or Existential Account. IPA studies draw on what is important to individuals, and circumstances, which engage reflection and meaning making. To illustrate the idiographic commitment, the sample size of this study was relatively small, and concentrated on specific individuals, who experienced specific situations and events in their lives (Larkin, Watts, and Clifton, 2006). Gaining experiential data often depends on the quality of the interview. As such, the interview schedule was piloted on experts in the field to gain feedback, with subsequent adaptations made, as well as this, I practiced my interview technique, to ensure high-quality data. The questions posed in the interview were purposefully selected to gain rich experiential data, considered to reflect something of the participants' selves and how they relate to their world. The interview was flexible to probe participants into discussing more in-depth about their experiences. Nevertheless, IPA acknowledges that "'experience' is both partial and complex" (Larkins, Watts, and Clifton, 2006, p.104), and interpretation – influenced by the double hermeneutic – means we can never have direct access to first person accounts. This means quality and trustworthiness is achieved through reflexivity and reflection (Vicary, Young and Hicks, 2017). From start to finish, I have maintained a reflexive journal and have presented written extracts from this in this thesis.

4.11.7 Constructing a Compelling Unfolding Narrative. I have met this standard by purposefully selecting participant quotes, alongside insightful and interpretative commentary, and connecting these with other cases, to produce a story which is rich, cohesive and has momentum. Skilful writing was not achieved by first attempt, and prolonged time was taken to write a compelling narrative to give my analytic work justice.

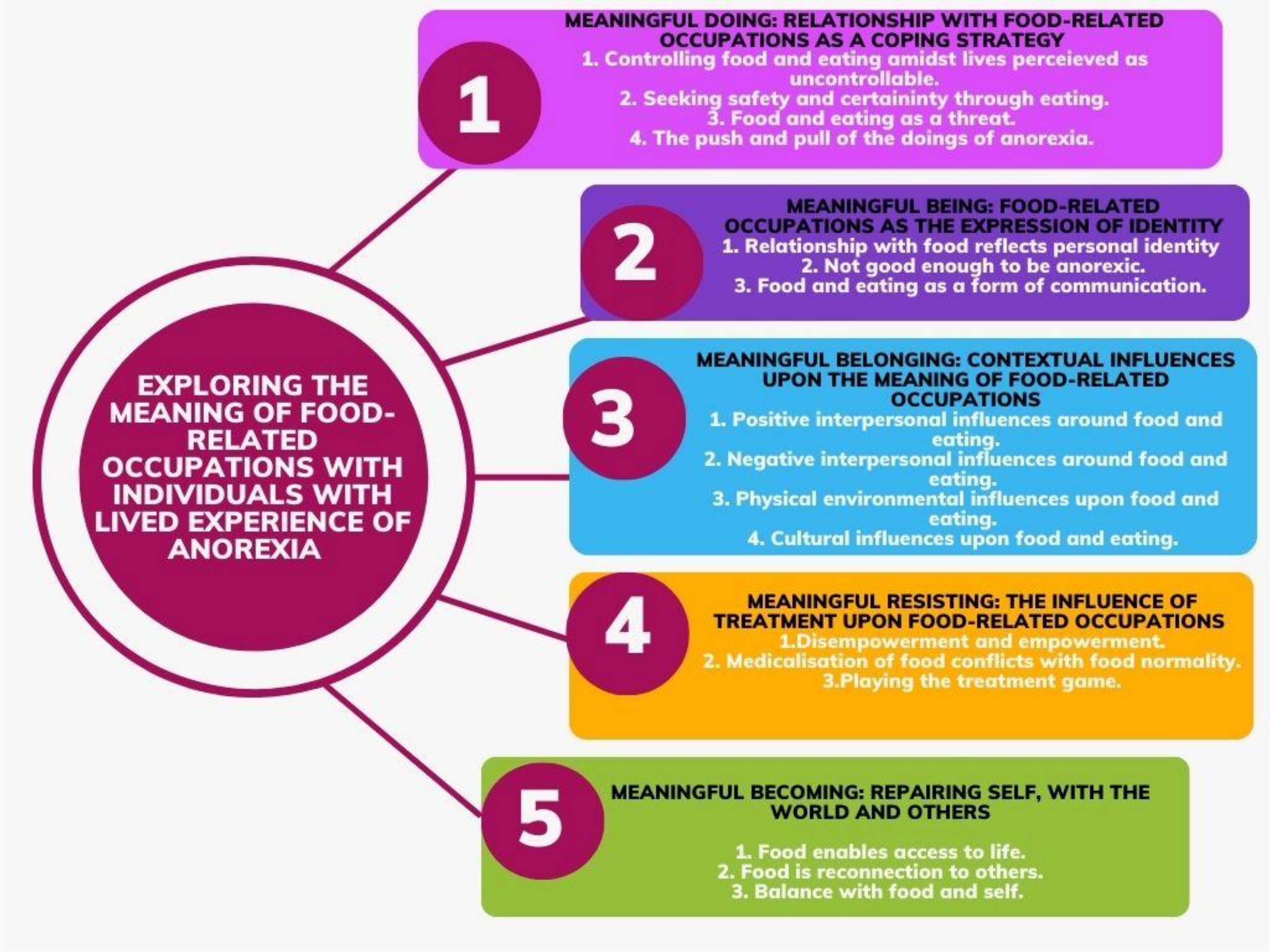
4.14 Conclusion to Chapter Four

Chapter Four provides a description of the methodological choices I made and justify these within phenomenological philosophy and theory including recruitment, and methods for data collection. I follow this with consideration of ethical implications and reflexive interviewing. I then provide a vivid description of the dynamic and interpretative analytical processes which led to the findings of this research. I conclude by outlining measures I put in place to achieve trustworthiness and quality in the study.

5.Chapter Five: Findings

This chapter presents the findings from the analysis of the interview data from nine individuals with lived experience of anorexia, and their experiences of food-related occupations during their illness, whilst in treatment and during recovery. A visual overview of the identified master themes and related sub-themes is presented in Figure 12.

Figure 12 Overview of Identified Master Themes and Related Sub-Themes



The identified themes reflect my own interpretation of participants' experiences through a process of inductive analysis. As such, the findings are one possible reading of food-related meanings, and themes may not encapsulate all experiences. The identified themes seek to reflect participants shared and collective experiences; however, variation and divergence is discussed within themes. Themes have been presented in a way which reflects a story, from illness (doing, being) to treatment (belonging, resisting) and in recovery (belonging); however, these are not linear and overlap. Interpretations are grounded in direct quotations from interviews, supporting trustworthiness. Quotations were selected according to their relevance to the research phenomenon, with minor changes made to verbatim extracts to improve readability, such as hesitations and utterances removed, and replaced with dotted lines (…) and when something is referred to, this has been included in square brackets […]. All identifying information has been removed, including names and hospitals to maintain participant anonymity.

5.1 Master Theme One

Meaningful Doing: Relationship with Food-Related Occupations as a Coping Strategy

This theme and related sub-themes capture how food-related occupations - framed in the meanings and motivations of anorexia – are meaningful doings, to gain mastery, autonomy, and fulfilment. It contextualises meanings within participants' being-in-the-world, where food-related occupations adopt meaning amidst a backdrop of uncertain life events. In sub-theme two and three, participants personify food, characterising it as threatening and dangerous and control exerted over food-related occupations creates feelings of safety. Sub-theme four, finally discusses how meanings are not binary, but contradictory and multi-layered, containing both positive and negative attributes, contributing to a push and pull in the doings of anorexia.

5.1.1 Sub-Theme One: Controlling Food and Eating amidst Lives Perceived as Uncontrollable

This sub-theme focuses on the dichotomy between the outside (food) and the inside (person), and how eating can be a liminal and obscure space where potential change, threat and transformation can occur. Restriction and control over food provides a way for participants to exert control over their external worlds. Katie admits to "*feel*[ing] *out of control in life*" during a time of several social and environmental stressors, including her friend's mental breakdown, and feelings of loneliness. The meaning of food restriction transformed a sense of powerlessness into empowerment, of "*taking responsibility for* [her] *life*". Similarly, Kelly describes the personal meaning of licking crisps but not digesting them, "*I think it was a lot about ... controlling what I put inside my body when I couldn't control a lot of things around me"*. Kelly associates this behaviour with a time in her life when her body felt out of control due to the epilepsy medication she was taking, which she believed made her gain weight. Although her inner bodily drives were "*hungry all of the time"*, her yearning "*to control something... "* creates conflict between mind and body. Fiona explains how re-engaging with disordered food-related engagement, after lengthy hospital admissions, enabled her to "*manage the stress of uni"*. Fiona's disordered eating was inferred as a familiar and comforting practice, helping navigate the stressors of life outside of hospital.

Resonating with Katie and Kelly's need to restrict food, similarly Jennifer's negative view of her appetite resulted in food restriction. Developed in the context of family influences, she explains:

> *... a healthy appetite or a bigger appetite was seen as something that was greedy not just that a person needs more food at that time... it was you're just greedy, your eyes are bigger than your belly kind of thing.*

Jennifer's belief that appetite equates with greed implies bodily needs are misplaced and distrusted, rather than legitimate responses to normal bodily functions. Barbara's account depicts a battle of control between mind and body, "*top-down* [mind] *control overriding the bottom-up* [body] *control*". Mind and body appear to be in a state of constant threat and negotiation for power, as Jennifer illustrates "*I have always felt at war with my body*". These findings interpret the body as carnal, unbounded and in need of discipline; whilst food-restriction offers superiority and difference, as Maria describes:

> *I used food as a way of feeling good about myself... it was almost like my identity...being able to say no to a piece of cake, when everyone else is eating it, I was quite proud of myself.*

Like other participants, Maria explains how anorexia is integral to self; she later describes how engagement and disengagement with food became a sedating coping mechanism, "*numbing* *emotions… If I felt out of control, worried about something I would just stop eating and that made me feel better".* It appears anorexia is a way to create space from the outside world and escape unpleasant feelings - "*to fade away*" (Jennifer). However, as anorexia is relied upon and integrated into how participants engage with the world, they describe drawing inwards, being "*cut off from emotions*" … "*resentful and put off from the rest of the world*" (Katie) and *"emotionless*" (Fiona). It appears persistent ED-related doings, increase alienation not only from the subjective body and its felt experience, but from the world and others. Nevertheless, participants' accounts evidence that they were not emotionless shells – on the contrary, some experience emotions too "*strongly*" (Harriet). It appears difficulties do not result from a lack of insight but emerge from struggles expressing emotions to others. For example, Kelly describes long-standing guilt over engaging in ED behaviours during her marriage proposal - "*I kind of had ruined a memory that I'm going to have for the rest of my life*". However, instead of articulating her needs to her fiancé, she explains, "*I just couldn't tell him how I was feeling*". Unexplored meanings may also relate to the unmentionable nature of EDs amongst families and friends, where difficulties became the "*elephant in the room*" (Jennifer).

The need to control food emerges from fears of unpredictability, evidenced by Maria, who expresses fears, when describing feelings associated with puberty "*my body was starting to gain weight naturally ... that freaked me out ... food represented the sign of becoming an adult and my body maturing".* Her account suggests a state of alarm and recoil from the natural transition from child to adult and implies a challenge to Maria's sense of self. It can be construed that her difficulties with food became embodied and an expression of existential concerns during a particular transitional moment. Other participants discuss how food restriction enables them to avoid development and remain child-like, as Kelly describes: "*my eating disorder is, very much is a way of me like reverting to childhood*" and fulfils a desire "*to be looked after*". These comments indicate how anorexia, and associated practices enable Kelly to re-enter a phase of her life where she feels protected, with anorexia personified as a guardian-like figure. Katie similarly likens anorexia to a "*teacher*" and "*authority figure*", inferring an entity providing direction and guidance during crucial life moments. She describes how following the rules and demands of anorexia meant "*at least I would be achieving something*" alluding to low self-efficacy, where anorexia offers feelings of success. However, control is an elusive, fleeting concept for many. Jennifer describes her relationships with food becoming "*strained .... The be all and end all ... the constant fixation in the day*" whilst Fiona explains initial feelings of control over food quickly spiralling into a relationship that was "*very* *tense… not comfortable at all*", and Harriet describes food as "*a scary thing … the enemy*" implying food as threatening and destabilising, necessitating protective behaviours.

Danielle explains that instead of following her intuition by responding to bodily cues, she places trust and security in fitness trackers and calorie-counting. Similarly, Fiona describes life as a "*number's game"* and Sarah too explains how she "*managed life by numbers with numbers".* These explanations suggest diminishing food to calorific values simplifies the process of eating by scaffolding and controlling food choices, providing concrete safety limits. Over time, these actions become habituated patterns of behaviour, where food loses all sense of pleasure, reduced to "*something that needs to go down*" (Barbara). Participants were not blind to this, but aware of the consequences of anorexia, as Fiona describes:

> *no part of whenever I got poorly, or when I was really unwell, that I have thought yeah, I'm controlling my weight like this feels good cause you don't feel good cause you're not really in control.*

As eating practices become engrained into daily life, and hold purposeful functions, they also prevent envisioning a life beyond anorexia. As Harriet describes challenging set food and eating practices felt "*incomprehensible"* creating a *"fear of stepping outside*" the bubble and safety in anorexia. For Maria, anything out of the ordinary and "*unplanned"* evokes distress. Kelly finds less choice around food *"comfortable"* avoiding *"having to shift between too much*", here, familiar habits and routines evade the volatility of life. However, paradoxically, striving to be in control led participants further away from making autonomous decisions based on their own values, as Sarah comments "*I lost all sense of who I was and what I wanted",* revealing how becoming embroiled in the occupations of anorexia leads to disconnection with self. Which resonates with Barbara, describing how persistent food restriction led to confusion and distrust in her internal signals "*I've overridden hunger cues for so long, that I don't know if the hunger cues are missing or if I don't recognise them".* Therefore, being estranged from the body, creates alienation from one's true and inner self. Maria describes feeling "*frightened*" and discomfort after eating a "*ridiculous amount of pizza*" whilst Barbara discusses how eating a bite of an apple led to a disproportionate emotional reaction - "*I had one bite of an apple… and I just broke down in tears and felt awful … I felt like I had lost all sense of control".* These examples illustrate not only participants overgeneralising and selective attention, but wariness in their own judgements concerning food choices; where any deviation from the familiar becomes destabilising, causing distress.

However, descriptions of losing of control did not always lead to negative affect, as Maria describes binging represents a "*release of pressure… letting go*" from the holds and control of anorexia and "*a way to numb and zone out of everything*". She describes experiencing "*excitement and euphoria and a rush of almost like … a child, you know you've done something wrong"*. Through binge eating, Maria was able to break free from the ED's ongoing subjugation, acting as embodied release, and powerful way to express herself.

5.1.2 Sub-theme Two: Seeking Safety and Certainty through Eating

This sub-theme discusses how participants means of controlling food and eating is functional in gaining control over their lives, which they perceive as uncontrollable, in turn fostering a sense of safety and protection.

Danielle discusses some of the *"rules"* relating to her eating practices, highlighting not only the importance of her food choices, but the significance of her food preparation - "*they'd always have to be cut up into four"*, a routine marking the sacredness of her eating rituals. Maria's narrative reveals it was not just food that needed to be perfect but also the objects and environment associated with eating; where eating breakfast sitting on the floor with a "*specific cushion*" was important to her morning ritual, an order helping her to "*face the day properly"*. The familiarity creates consolation and security, echoing findings in sub-theme one, allowing her to feel in control:

> *I've always done that… I don't think to do it another way… it feels comforting to have that routine. It makes me feel safe. It makes me feel a bit more in control when a lot of things outside in the world aren't in my control.*

In the context of working as a doctor, and the unpredictable demands of her role, Maria identifies familiar food routines as being supportive in "*transitioning into work*" and "*integrating*" into life. The implication is that controlling eating acts as a counterbalance to stress; allowing Maria to move through life.

Jennifer also emphasises "*having to do things in like a certain order…"* and eating with a "*certain spoon or a certain bowl*", creates feelings of safety amidst anxiety. Her repetition of certain implies how specific utensils and timings infer a sense of assurance in life and predictability. Barbara explains "*I have to eat things incredibly slow… in a certain order*", possibly drawing out the process of eating. Fiona explains she "*had to eat things in a certain order*", adding *"which is another common thing"*, implying knowledge of a behaviour shared with others with anorexia. This internal know-how provides her with reassurance and validates the act of her disordered eating practices, reducing the possible stigma she may experience. Others also justify the doings of anorexia, and place their rituals and routines as common place, framed within the diagnosis of anorexia – "*it's kind of the same old for most of us that have an eating disorder"* (Jennifer), and Kelly "*I think that's common in eating disorders".* The attention to detail regarding the specifics of food is echoed in Katie's responses; describing her relationship with eating as a "*big deal"* and food had to be "*right*", leading her to efforts for it to be *"perfect*". To have the space she needs to prepare and eat foods in a particular way, Katie eats very late at night, ensuring she can be alone, allowing her to "*be very secretive ... and …do whatever it was I wanted to do*". Katie's desire to keep her engagement with food and eating distant from others, is reflected in her unyielding mindset where "*anybody who disagreed with me ... was wrong and ... they were going to be some sort of comeuppance*" suggesting her concern for food is more valued than her relationships with others. She states the meaning behind this was an overinvestment in food-related occupations, "*I couldn't stop thinking about food ... it was ... very interesting to me… I always wanted to be doing food related things*", this value in turn altered her occupations, such as spending more time cooking, "*walking around shops… aimlessly*" and engaging in movement, even though "*never* [being] *very athletic or into sports*", revealing how new meanings emerge through embodied doing.

Most participants refer to "*safe*" foods (Maria, Barbara), which they "*had to eat*" (Harriet), and when followed, dictated their enjoyment in life, as Barbara describes her orange juice bursting over her packed lunch, "*it was sticky it had ... ruined the rest of the trip*", reflecting an all or nothing attitude. Harriet describes her safe foods include "c*ertain bread, ... Quorn slices ... one certain type*". Harriet felt so compelled to follow her rules she ate out-of-date food; explaining "*I couldn't think about having anything else"* … regardless of how "*far"* it took her. These behaviours intensified prior to Harriet's hospital admission, where she felt bound to "*do a certain amount of star jumps before eating*". In the context of her belief of not "*liv*[ing] *up to that title [anorexia]",* Harriet embodies the practices and doings of anorexia to legitimate her admission. It appears in the background of feeling out of control with her looming hospital admission, reducing her food choices and compensatory exercise seems to offer Harriet a sense security and being in control.

5.1.3 Sub-theme Three: Food and Eating as a Threat

This sub-theme, reveals how some foods appear threatening, holding the potential to "*pollute… or contaminate …"* (Sarah). Maria personifies food, attributing it with the ability to move, feeling herself "*pulled away by*" its presence. The threat posed by food caused participants to avoid places, relationships (Kelly) and everyday food-engagement to avoid being "*dirty*" "*icky*", and "*messy*" (Barbara) to prevent the ambiguous qualities of food being "*absorbed*" (Fiona). These examples reveal the interconnection between participants' doings with food, and the threat it poses on their sense of belonging and connection with others and place. Fiona viewed food as not only unsafe to eat but also to be in proximity with "*I wouldn't go into the kitchen because I would feel ... the steam from cooking the pasta was going to be absorbed ... through my skin and ... I would gain weight".*

Similarly, Kelly explains "[I] *didn't even like holding things like butter*". As a result, she purposefully distances herself from food, "*avoiding food places*", impacting her engagement with the world. Barbara describes food's potential to actively traverse bodily bounds from the outside to the inside "*there's ...a subconscious fear of things ... going in through my skin, like touching and handling food will contaminate me or something".* This is interpreted as food needing to be kept outside of bodily boundaries, representing something which can transform and defile. Barbara describes eating as "*some kind of dirty task, that I have to get it done quickly so I don't have to dwell on it".* Her words convey eating as prohibited, with food akin to an illegal-like substance that could corrupt and pollute her body. The use of "*don't have to dwell*", expresses not only her reluctance to even think about food, but her aversion to inhabit the same space as food. Contrasting to periods where she intentionally eats slowly, reflecting changeable behaviours but both seeking the end result of gaining safety in life.

As Barbara considers her childhood and the contributing factors towards her relationship with food, she describes how her mum avoided waste by making stews. However, this method of cooking "*bothered* [her] *because it wasn't like neat like this is the recipe, and this is* *what's in it…"*. Mixing foods was something which creates discomfort, inferred as things being out of place and orderly. Other participants discuss avoiding mixing foods, with Sarah commenting how she prefers "*simple pasta…*" and having "*simple tastes*" rather than eating "*something ... like a lasagne*", considered a multi-layered, messy form. Danielle, like Barbara also discusses separating her foods out:

> *…I had those plastic plates with different sections, and it wasn't until I met my girlfriend ... and she came to my house and was horrified ... I ate off these sterile plastic divided plates. ... foods touching became a thing.*

It seems neatly sectioned and separated compartments counteract the potential of food to create disorder and chaos. For Danielle, the environment and context were implicit in maintaining her behaviours, reporting she was unaware of how normalised these became until her girlfriend drew attention to it. Danielle and Barbara's comment highlight a desire for life to be pure and clean, where food is the antithesis of this, messy and uncontrollable. Barbara admits that despite her attempts to control food, she acknowledges "*life will always be messy*".

In contrast to eating, restriction and hunger embodies a sense of freedom, purity, and lightness - free from the burden of food and the threat of its effects on the body. Maria describes how she would try to hide potatoes at mealtimes during Sunday dinners with her family:

> *I liked the feeling of being hungry… of not having food inside of me. It felt like freedom. It felt like if I put the potatoes in my body that I was tarnishing my body in some kind of way, of damaging my body. I didn't like the feeling of having something inside me that I didn't want there.*

The self and food here appear to be entwined. The potatoes are interpreted as anthropomorphist, actively damaging, and weighing down the body. Similarly, Kelly metaphorically discusses being weighed down by food, feeling a sense of being held captive by food:

> *I ... see it like a heavy thing in my in my mind …carbohydrate foods kind of almost like forming like a big ball inside of my stomach. That won't kind of come out ... And that*

> *then ... making me put weight on and making me heavy ...like it was trapped in my body.*

Kelly likens the heaviness not just in her body, but within her "*mind*", showing how her perception of food influenced her whole being. The self appears to be trapped within the sensual desires of the body, interlinking with the previous discussion about the suppression of desire. She later reports of the permanency of food, damaging, engulfing: "*I ... had that association that once it was in me, I couldn't get it out*". Jennifer echoes the feeling of being physically ensnared by food, *"when you're eating that food, it's hard to then separate yourself from it".* A feeling shared by Fiona, who describes the sensation of her brain entwined with a bowl of spaghetti she was eating: "*basically my brain was just in that bowl or trying to get out of that bowl".*

Barbara discusses the sensuous nature of food, with its odorous properties, creates an internal terror "*... it just freaks me out because I could smell food, like fridges scare me cause, I can smell food".* Sarah discusses how pre-packaged manufactured foods felt safer, as there was some degree of certainty and "*guarantee*" in how they would be prepared. On the other hand, homemade and food prepared in treatment gave space for the unknown. She describes the effect of this during ward mealtimes:

> *My anxiety around mealtimes got worse because I didn't know how the food was going to come up, how big it was going to be. If the serving size is going to be the same as someone else's, or whether it's going to be the same as last week cause it wasn't that guarantee, and it depended on who serves food.*

Likewise, Fiona felt safe eating pre-packaged foods when she knew "*what the calories are* and *what's in them*". The importance of knowing the composition of food from manufactures is also illustrated by Barbara who describes punishing herself by compulsively exercising, after misreading a label on a drink, presuming it was sugar free. Feeling tricked by food, created "*trust issues"* around having drinks prepared for her in the future. These findings interlink with the previous discussion of participants' objectification of food to a "*number's game*". Sarah, Fiona and Barbara's preference for pre-packaged foods appear to be safer choices and easier to control as they are reliable, and dependable as opposed to homemade food prepared by others.

5.1.4 Sub-theme Four: The Push and Pull of the Doing of Anorexia

This sub-theme reflects the ambiguity and often shifting meanings around food and eating. Food-related engagement was rarely experienced in clear-cut terms such as good/bad and healthy/unhealthy, rather, meanings were multiple and varied across contexts and environments. This theme also reflects the conflicts of food-related engagement in recovery, and how participants felt continually pulled towards the doings of anorexia, whilst also pushing away and resisting ED-related doings.

Maria's description of her feelings when binge eating, illustrate both positive and negative emotions occurring simultaneously "*excited because you know you're going to get in trouble… the adrenaline is going… soon afterwards I felt sick, lethargic and disgusted ... guilty"*. Barbara explains she felt proud of herself for eating, but also experiences "*anorexia screaming at your that you failed"*. When participants committed to recovery, the meanings of food shifted, most often in positive terms: experiencing "*freedom*" (Maria, Fiona) and feeling "*free*" (Sarah). Katie explains "*I love food now… it plays the role ... it would have been when I was a child",* insinuating a sense of carefree relationship to food. These connotate a sense that anorexia was imprisonment of one's occupational engagement and potential, whilst recovery is emancipation. It was often in embodied doing that a change in meaning was realised, for Barbara writing daily helps her to uncover her motives in doing. Whilst Danielle describes baking made her more aware of what parts of her life were driven by the ED:

> *I would make the most beautiful looking things…but it wasn't until I did the baking in groups that I realised that I didn't enjoy it at all. And that… was probably part of my eating disorder, and I don't enjoy it now, so I guess it was helpful in realising that it's ... part of my eating disorder and not a part of me*.

The meaning of the same occupation changed dependent upon time, place, and context. However, meanings were not wholly positive, and recovery was not a linear progression from positive to negative. Barbara describes her healthy self and anorexia were in opposition, leading to a "*battle*" with anorexia:

> *…there is still always going to be that… voice going "you shouldn't have done that. You could have got away with that. You didn't need that" ... But also, a reasonable part of me just felt happy that I'd managed to do the right thing and that I knew my husband was proud of me.*

This dichotomy between anorexia and self is also articulated by Kelly, who feels she is "*two people ... I've got my eating disorder separate person to me"*. She describes conflict in her mind between these two entities during treatment, where she wants to be free from treatment, without the consequences of gaining weight "*The eating disorder was saying "just eat your way out" ... But ... how can you still do that without putting on too much weight?*" Kelly describes a relentless aim for weight loss, trapped her in a battle anorexia but also wanting to be free of the deleterious aspects, impeding recovery. An experience resonating Katie's account, who in treatment tried to "*micromanage the entire experience… even though I knew I needed to gain weight"*. She believed that "*eventually* [she] *would get to a point where I'd be able to ... eat all this food I wanted to eat. But obviously this had been going on for… a few years… so that was never going to happen*". The deceitful nature of anorexia is evident here, convincing Katie she could turn things around on her own if she wanted to, but ultimately recognising and aware this was not possible.

Participants discuss current, ongoing eating difficulties in their interviews despite professing recovery. Barbara describes eating as a "*fight"*, and Sarah states there were "*certain foods… I'm still scared of"* continuing to weigh and control food in social situations. Kelly claims "*now, post treatment, I still struggle quite a lot ... I go through stages where things aren't good and things are better"*. Kelly's comments highlight that difficulties with food fluctuate and are fragile, changing with life context. However, participants also appear to be in control of when to invoke anorexia's presence in their lives, for example Barbara explains how she placed "*anorexia ... on the back burner*" when other difficulties presented themselves, whilst at other times, anorexia was a way to "*survive"* life's challenging moments.

Fiona highlights how she was "*still having panic attacks going into a supermarket*" despite being discharged. Other participants also discuss how quick treatment throughputs which get "*people to a safe weight as soon as possible*" (Jennifer) impact upon sustaining the recovery-orientated doings. Focus solely on physical health as a marker of recovery in treatment, appears to come at the expense of social and occupational functioning.

Harriet became a vegetarian during an inpatient admission, which many years later, continues to be a behaviour she has *"hung onto".* Whether or not this was motivated by restriction, or dietary preference, or a way to hold onto a fraction of the ED, remains unclear in the interview. This uncertainty about motive and meaning was also pondered by Harriet herself in the interview, who reflects what she would do if a client she was working with in her own therapeutic work wanted to make a meat dish. She resolves "*for the sake of them, I would eat it"*, highlighting how context and belonging changes motivation and meaning of food-engagement.

Similarly, Kelly explains how context can influence relationships with eating. During her nursing placement experiences, she assured herself she could lose weight and avoid eating through being busy but caveated this with "*I've not resorted to like really bad behaviours".* This highlights the lack of clarity between disordered eating and anorexia – her comments concerning what she would consider "*really bad*" behaviours are ambiguous. A tension she is aware of, knowing that placements are only a short-term solution: *"I've kind of ... realised now that when I qualify, I'm not going to ever be able to say it's OK when I'm not on placement ... cause I'm always going to be working*". Therefore, recognising that repairing a relationship with food is beyond isolated life circumstances.

Most participants describe recovery as a continual, process of learning, and not a definitive end point. Harriet explains how recovery means she is continually evolving: "*ten years ago I would have said I was recovered. Well, I'm a completely different version of recovered the year after that. The year after that and now*". Katie describes recovery as a daily choice: *"recovery, isn't just for a period of your life ... it's for the rest of your life".* Barbara explains meticulously planning eating into her day-to-day life otherwise "*things start to crumble again*", underscoring the fragility of recovery. Committing to recovery, and discovering their own motivation, is a journey which participants wanted to do in their own time. To commit with intention requires facing the underlying roots of anorexia, as Barbara describes "*I think there's a big thing about recovery when you're ready for it and that forced recovery, while absolutely can be lifesaving, it's not always going to treat the root cause",* highlighting self-determination in recovery.

5.1.5 Summary of Master Theme One

Master Theme One reveals the meaningful functions of performing and doing anorexia and associated food-related occupations, purposefully supporting the avoidance of unpleasant emotions and being able to cope in participants' everyday worlds. The descriptions provided by participants show how anorexia relates to an embodied self-experience. Eating is a conflicting experience, related to bodily desires, and in opposition to the control anorexia offers. However, the doing of anorexia creates alienation from the self and the body. The final sub-theme reflects how recovery is a gradual, non-linear process, where participants are continually evolving and becoming.

5.2 Master Theme Two

Meaningful Being: Food-Related Occupations as the Expression of Identity

Master Theme Two encapsulates the essence of how in the context of fragile selves, focusing on food and eating offers participants a personal and social identity, which centres on themes of morality: to be perfect, achieve and morally superior. This identity is a form of communication to others and draws upon cultural notions of morality, and what it means to 'be' anorexic.

5.2.1 Sub-theme One: Relationship with Food reflects Personal Identity

Most participants considered their personal identity in relation to anorexia, and how the doings of anorexia become embodied expressions of self. Barbara explains how food restriction enables her "*to be small and dainty and to disappear".* This was in the context of Barbara's narrative of grief following losing a child, therefore, embodying a certain form offers her to "*escape from everything*" and withdraw from life. She contrasts this with being *"fat",* representing being "*arrogant and taking up more space than I should"*. Not only do different bodily states symbolise character, but these comments reflect Barbara's sense of worth, with her physical body encapsulating the *"space*" she feels justified to inhabit. Maria also discusses how emptiness and lightness in her physicality creates a numbness to everything; to be "*empty, quite light, quite numb from everything*".

Katie explains how anorexia was "*a big part of my identity"* therefore, eating became a threat to this identity so *"food was a big source of conflict at that time".* Lack of engagement and isolation impacted identities, as Fiona describes resigning herself to living with anorexia as she could not envisage herself without the illness "*I thought this is just going to be in my life right now. I just didn't care to be honest; I really didn't care".* The more participants engaged with the doings of the illness, the more they expressed not knowing who they were - "*it changes your personality*" (Barbara). A lack of other meaningful occupations intensified the fusion between illness and identity, as expressed by Danielle "*I was really isolated. At the time, the eating disorder was the only thing I had".* Sarah also explains how anorexia was all-encompassing, becoming the lens through which, she placed her value and worth "*If someone identifies as someone with an eating disorder ... they don't see nothing else, and they don't feel they have any worth or any value"*. These extracts reveal the inter-related connection between what participants do, the impact of this on the roles, and their sense of identity. However, there was some divergence as Kelly describes "*Even though difficulties are still there, I am still here",* highlighting how difficulties can co-exist in life, and identity is not engulfed by the ED.

Identities were caught up in wider themes of cultural morality as Maria discusses her ability to restrict was something which set her apart from others and means "*of feeling good about myself... of feeling good enough"*. Anorexia fostered feelings of increased self-worth; inspiration to be "*perfect*" (Danielle) and a "*better person*" (Katie). Danielle's eating patterns contributed to her sense of self, explaining eating the same foods, gave her connection to herself "*it sounds strange, but I have a sense of identity with a peanut butter sandwich ... it feels ...that is something concrete about me".* The word "*concrete"* suggests stability, possibly at a time when other areas of her life felt out of control. Her peanut butter choice is a defining attribute which makes her identity known to others "*it's certain and clear and other people know it"*. Here, food acts a symbolic symbol of self to communicate to others. Similarly, Maria discusses how food functions to communicate her self-control to others: "*it was almost like my identity, like being able to say no to a piece of cake, when everyone else is eating it, I was quite proud of myself".*

Participants report ~~e~~xistential crises when their known and valued eating patterns are disrupted in treatment *"...when your whole like daily life and identity is revolving around food and exercise like once that's taken away from you... it's like you have to rebuild everything"* (Jennifer). Sarah describes how treatment represents "*stripping someone's power away*" creating vulnerability and exposure, questioning "*I didn't know who I was without anorexia".*

Power is a potent descriptor to describe the meaning and agency anorexia offers Sarah in her life, underscoring the ambivalence of separating self from anorexia, leading to feelings of loss. Conversely treatment's central medicalised focus upon food for Sarah neglects what lies at the heart of anorexia "*life and identity and that's the problem*". Danielle alternatively explains that treatment was valued when *"it gave ... identity outside of my eating disorder".* Consequently, recovery encompasses "*finding out who we are… find*[ing] *ourselves again"* (Harriet), and assessing one's values, as Katie states recovery is a "*180 on your whole… belief system*". Rebuilding identity requires commitment in doing, as Harriet explains "*Recovery is a full-time job. It takes everything. You have to change everything you do, and who you are".*

5.2.3 Sub-theme Two: Not Good Enough to Be Anorexic

This sub-theme, resonating with seven participants, underscores findings where participants experience themselves negatively, undermining their efforts to eat. Participants used pejorative terminology to describe themselves "*I didn't like myself, and I was self-conscious*" (Danielle). Themes of guilt and self-hatred were common in participants' narratives as they blamed themselves for ruined Christmases' (Jennifer) and spoiled engagements (Kelly).

Harriet discusses "*not feeling* [she] *deserved to be cared for"*, resulting in "*depriving* [herself] *of nice things*", and "*neglecting* [herself]"; these descriptions illuminate how food is positioned as something to be earned, as Harriet describes how movement before eating was "*me justifying to myself that I deserve that food"*. Other participants also discuss the importance of productivity, movement or doing for "*justification for eating*" (Jennifer) and food is positioned as a "*reward"* (Harriet). Barbara explains:

> *if I have got no energy, I don't need to eat…If I have not done 10,000 steps, I'm not doing 15,000 steps. I'm not climbing around the place… Like barely mov*[ing] *on the sofa, I don't need to eat then.*

It appears that Barbara does not have the self-motivation and self-value to eat of her own accord. This stands in contrasts to external pressures which motivate her to eat such as eating in treatment or eating to appease others; knowing her husband and best friend are "*really proud of me when they see me eat"*.

Restriction counteracted negative feelings of self, as "*a way to soothe anxieties and feelings of not being good enough*" (Maria), salient in the context of "*beliefs… that were very tied to … feelings of low self-worth*" (Katie). Negative experiences of self, relate to tendencies to be perfect, which ultimately leave participants feeling "*a failure*" (Maria), unable to live up to their standards. Such negative views of self, result in avoidance and disconnection from the world and food, in order to "*numb*" (Maria) oneself from unwanted thoughts, emotions and situations.

Several participants associate anorexia with a certain way of being, that is underweight, an outward recognisable marker of the illness. Conflicts arose when participants did not fit this criterion either prior to treatment or during recovery. Experiencing a lack of physical authenticity worsened eating behaviours, as Harriet describes: "*I felt that I didn't really live up to that title and that I didn't look ill enough to be like that, so I … cut back even more so that I justified that diagnosis".*

This belief created self-doubt and uncertainty of who is deserving of treatment, which in turn worsened eating behaviours to gain validation and acknowledgement from medical authorities. Barbara explains, despite restricting for a long time and experiencing bruising on her hips and knees, she "*wasn't … that massively skeletally skinny that everybody thinks of*", implying there is collective understanding of what it means to be anorexic. Indeed, she later describes "*there's a societal expectation of acceptance and unacceptable*", of what it means to have anorexia. As she was not significantly underweight, she did not "*raise massive alarm bells" or "qualify for any support"*. Barbara therefore considers herself a "*high functioning anorexic*", someone who can engage with multiple roles, and study but continue to maintain her ED practices; a contradictory embodiment of being both "*high functioning*" and anorexic. In the context of a lack of early intervention, she reports a flurry of medical attention around her:

> *when things got bad, they got bad, really acutely…I hadn't gotten to unbelievably skeletally skinny when it was at the point where I was told that I either was admitted, or accept the tube now, or they will section me within like … three to four hours.*

Finally appearing to get the help she needs, Barbara reports doing "*all the refeeding*", but after reaching "*my hospital healthy weight*", inferring a weight not claimed or owned by her, but decided by medical professionals, she "*got dumped*" and discharged from services, resulting in a series of relapses. Similar to Barbara, Maria states that as she had "*not been that low*" (in weight), allowing her to "*fit into society and no one would look at me and know I had a problem…I could just exist and carry on as normal*". These findings give insight into the self and the body, funnelled through the lens of common misconceptions of what anorexia should look like and for participants in this study their definition focuses on thinness. These beliefs are internalised as Fiona reports after gaining weight, people would assume she would not have an eating disorder - "*I don't think you would look at me and think oh she's … had an eating disorder now".*

Physical and psychological wellbeing were not attained simultaneously, with physical bodies recovering more quickly than mindsets. Jennifer voiced this by explaining "*I've reached a healthier weight ...people assume that you struggle less, but I don't think that's the case because your brain takes a long time to catch up with things"*. Yet psychological difficulties persisted in weight-restored bodies, *"all I had was… my thoughts, this horrible body that I've been forced to get into*" (Fiona). Barbara recognises the need for ongoing support to help *"transition into normality*" as "*it's not going to be fixed when you're out of the hospital".*

Danielle shared a powerful drawing in her interview (Figure thirteen), which she drew during her outpatient treatment to depict her difficulties and the "*noise in my head*". She explains the image represents a time when she was *"struggling with still being very unwell mentally, but physically I was fine. So, I felt like every time I faced a meal that I was a fraud and that I shouldn't be eating."*

Figure 13 Danielle's Drawing

Danielle depicts the dichotomy of her struggle between the "mental" and the "physical". Her expressions of guilt for not "*just naturally going to my eating disorder thoughts… I think mostly it was about … being a fraud*", infers her ED thoughts were more "natural" and intrinsic than her recovered self and how eating made her feel an imposter in a weight-restored body, no longer defined physically by the illness.

Although participants report identifying with anorexia, this sense of belonging was shifting, wanting the distinction anorexia offers but not willing to relinquish who they are within this. They were critical of being totalised by an illness, for being *"different*" (Jennifer), and others not "*treating* [them] *as individuals rather than just an eating disorder*" and "*tarred with the same brush*" (Fiona).

5.2.3 Sub-theme Three: Food and Eating as a Form of Communication

This sub-theme reflects how the embodied doings of food-related engagement offers participants a voice and a way to communicate their needs to others.

Danielle describes how limiting her food choices as a child, was a way to *"exercise boundaries"*, and challenge her parents, asserting *"no matter what the situation is, you will not* *get me to eat this food*". Communicating through denial was also expressed by Maria, who recalls the "*conflict around meals and the tension around the table and how no one would be able to relax because they were all watching me and watching everything that was on my plate*"; however, in response to their "*fuss",* she further protests and anorexia becomes stronger: *"The more they shouted, the more I refused".*

It appears engagement (or avoidance) with food becomes a powerful form of communication within relationships, a way to assert agency and voice. Danielle discusses the sense of shame she felt from being eligible for free school meals, which made her feel socially isolated from her peers. She discusses the "*stigma"* of having "*a bright yellow card to exchange for food".* In response to this "*ordeal"*, Danielle evaded lunch in the canteen to avoid feelings of social alienation.

Whilst it was common for individuals to conceal the effects of low weight, for some being underweight also brought a source of recognition and care from others, as Katie discusses:

> *I did not look well and… all of my friends were always kind of pulling me saying like look, we're really worried about you and I kind of loved it cause I was like well like ... finally I am getting validation for this.*

Possibly finding difficulty in verbally communicating her needs, Katie communicates her needs through her body, gaining social recognition, albeit transient. The praise she receives reinforces her restrictive practices, creating a tension, knowing if she gained weight, it could alter other's perspective of her, and she would *"lose the respect of* [her] *peers… feel ... unlovable and* [her] *family wouldn't love* [her]". Similarly, Jennifer discusses how she was known for being "*the healthy one*", therefore, to maintain care and acknowledgement from others, participants allude they must continue to be defined by a thin body. Participants express certain expectations placed upon themselves, around their social roles and their bodies. For example, Kelly describes the societal expectations of being a dancer, meaning her body needs to be "*small"* and persistently needs to "*stay on top of that*".

The body was a vessel for communication and projection of emotions, as Barbara explains "*not eating is a physical manifestation of ... grief*". When Barbara losses her baby, she explains there was an expectation from others about what grief should embody "*it's expected that a* *grieving mother is going to lose a lot of weight, like that's just accepted…And…if I wasn't looking fragile and ill, I didn't love my baby enough"*. Barbara explains not eating was "*the norm*" and restriction was unquestioned until it became prolonged and severe. Barbara states her mental health team reassured her "*it's OK. It's understandable. We understand you're not going to have an appetite*". It is possible that these condolences could have given permission for Barbara to continue to restrict to embody her distress.

5.2.4 Summary of Master Theme Two

Master Theme Two reveals how anorexia became entwined with identities, a form of self-definition, and way of communicating and embodying difficulties. It also discusses how participants drew upon dominant cultural understanding of the self, and how biomedical framings around anorexia shape identities, and carry expectations, which can limit self-expression.

5.3 Master Theme Three

Meaningful Belonging: Contextual influences upon the Meaning of Food-Related Occupations

Master Theme Three captures how interpersonal influences and contextual factors including culture and environment shape food-related engagement including belonging to and with others in treatment, and its impact on identity. These findings highlight how meanings of food-related occupations are not individualistic or exist in a vacuum but are contextualised by individual's being-in-the-world.

5.3.1 Positive Interpersonal Influences around Food and Eating.

This sub-theme illuminates how relationships with others, including family, friends, and/or healthcare professionals positively shaped the meanings of participants' food-related occupations.

Some participants describe positive recollections of childhood where eating was marked by a sense of abandonment and freedom, as Maria discusses on her experiences of eating at school:

> *I remember such excitement… we would just sit there in class and the bell would go just before half 10, and ... we'd all literally sprint from the classroom* [laughs] *... And it was almost like a challenge as well to see who could get the waffles or the chocolate croissant… it was a very social experience.*

There is a powerful mutuality expressed by Maria in her experiences of eating during break-time, where eating was a socially shared experience, and food was not the focus, but the importance was being with others – "*the food was great, but it was more the excitement of getting".* Eating was highly nostalgic, often a portal to the past, rekindling childhood memories, Katie recalls her experience of eating soup on a recent outing during her interview "*It tasted delicious, really good ... and reminded me of being a kid like when my mum would take me out for a bowl of soup, and it was really lovely".* Here food is symbolic, with Katie associating the warmth of the soup, with maternal care.

Childhood is often positioned as an idyllic period in participants' lives, where their eating patterns were not tainted by the concerns of anorexia. During treatment, Harriet discusses the importance of preparing childhood foods in treatment which were meaningful and gave her a sense of relating to home:

> *It was fish fingers, pasta, and beans ... it was something my dad cooked for me ... it was lovely being able to kind of choose that…. to remember where I ate that and that was at home and ... make something that was personalised to me and not have somebody cooking all of these things for me that the dietitian said. And it wasn't anything driven by my eating disorder. It was just a really good memory for me.*

Food in Harriet's account is associated with comfort, of being loved and cared for, contrasting to the "*punishing aspects of eating*" she describes in treatment; thus, preparing food carried her into the past. Katie also expresses a desire to return to the carefree experience of eating during childhood in treatment:

> *just eating the food that would have been nice when you were a kid. Like eating like tea cakes or you know whatever kind of pre-packaged shite ... from the shop because ... that's the joy of food.*

It appears that for these participants childhood represented an untainted and joyful relationship with food and eating, possibly in contrast to the challenges of adolescence and adulthood, which carries responsibility and ramifications over one's choices. However, Jennifer identifies her relationship with food and eating during childhood, prior to the illness, could be skewed by an idealised perception - "*because you look back at that period with kind of rose-tinted glasses from before the illness".*

The contradictory and conflicting gendered meanings and assumptions around food and bodies were touched upon in narratives, of "*teenage girls diet talks*" (Maria) and how "*women have different standards on them ... in how they eat*" (Fiona). Danielle explains her male friends hold "*a different relationship with food typically*", and their spontaneous freedom around meals reflected in her own relationship with food, which "*made it* [eating] *easier*". Danielle highlights that eating with her male friends was more concerned with sharing an experience rather than a focus on food, lessening her own anxieties.

Harriet also describes the positive influence of peers. When she was with her friends, she found herself more spontaneous, such as going to parties, something she "*never done before*". Following hospital treatment, the meaning of eating shifted due to the influence of her peers "*From that point, I had stop overs with friends ... I could eat a lot more easily with them and something I'd look forward to".* However, she acknowledges this change was also motivated by the comparison of not "*being left behind*". Harriet considers anorexia arrested her life and development and the pressures she experienced to keep pace with her peers leading her to self-discharge before her 21st birthday.

Maria recounts how sharing food with her Bulgarian partner and his family changed the meaning of food and eating for her. Although the food was "very *different from what I'm used to"* and expressing anxieties around the novelty of the food, she was able to engage in the meal, motivated by wanting to show respect and care, and not wanting to "*create a fuss".* This was an epiphany for Maria, *"a real transition point because I realised that I cared more about his mum's feelings then I cared about food".* In the context of social eating, the meaning of food and eating changed from a pre-occupation and fear to something which empowered Maria. However, in this extract it also appears Maria dismisses her difficulties and communicating her anxieties as creating a "*fuss*" to appease others.

Kelly describes the influence of different friendship groups upon not only the experience of eating but on her sense of self, interlinking with the previous theme on identity. She describes the positive impact of moving away from her hometown, from friends who "*see me as* [Kelly] *with anorexia",* to a new friendship group, who *"see me as like* [Kelly]*"*. Thus, although Kelly identifies with anorexia, she also sought to be seen by others as a unique person. Describing her current friendship group, she stated food is not a "*big deal*", and "*if I only have a bit of pizza... they're not going ... to think too much into it... it's a relaxed social thing*". This extract suggests that anorexia can carry feelings of self-monitoring and surveillance around food-related engagement, something which is expected to be performed by others. Whilst her new friends are free from negative expectations of her, enabling her to carve out a new self and identity. Sarah also describes how finding friends from her church community supportive of her eating and "*find a new identity outside an eating disorder*". She describes how her faith changes her perspective and motivation for recovery, commenting "*everything* [I do is] *is for the glory of God... I'm not doing this for me. I'm actually doing it for God".* Sarah's motivation towards recovery appears rooted in a shift of identity - an identity no longer in anorexia, but instead shaped by her faith, and in belonging with a church community.

Participants describe seeking "*normal eating*", as such, their eating patterns were often modelled on what others ate, rather than trust in their intuition. As Harriet describes: "*I used to sort of model what I ate on my best friend…. and would make myself like the same things as her and not really think about what I liked to eat".* Sometimes observing and imitating others are positive – for Harriet, her husband, who is a *"real lover of food*" helps change her relationship to food, because of his carefree attitude "*just because of the way he eats*". Similarly, Kelly describes going out for a coffee with an occupational therapist during treatment. Initially she reports feeling overwhelmed by the coffee shop environment, with an internal monologue reflecting panic: *"Oh my God, there's the board up there with all the drinks. What am I even allowed to have?".* She questions "*what am I even allowed to have?",* which could be in relation to permissible choices on her hospital meal plan or her own internal rules relating to the ED, as she later states, "*that goes against all of my set of rules*". It appears Kelly seeks permission to eat by observing others. She explains by choosing the same drink as the occupational therapist "*made it more ... helpful"*. However, in contrast to Katie's account, observing others eating was not always positive. Katie felt a sense of difference when watching her friends who had a "*positive relationship with food"*, which became a "*jarring kind of* *experience*", bringing to light the intensity of her difficulties. She reports "*It really became obvious to me how isolated, I felt from that… I felt so far away from that ability to be in the moment while eating".*

Nevertheless, when food feels threatening, being with "*safe people*" (Sarah) provides an emotional safety that changes the meaning of food. Jennifer also illustrates this, when she describes sitting with others in an inpatient setting who were eating "*full portions"* gave her permission to eat and freedom to "*... challenge myself".* Similarly, Harriet explains "*it was super helpful to sit with others of like minds*". Participants were mindful about these connections, purposefully seeking relationships with those who had healthy relationships with food.

Harriet explains her role as a mother changed her perspective of food and eating because she felt responsible for creating "*a positive attitude around food".* Similarly, Barbara also discusses how being a mother influences her behaviours with food "*I have a 5-year-old son and I don't want him to pick up on those behaviours. I want him to stay happy with his body".* These extracts reveal how embodying roles support changed relationships with food; however, whether participants relationships with food were internally motivated or relate to pressures and expectations tied to their roles is unclear. As Barbara equates regular and normal eating, with being a "*good mum… good wife*" highlighting the implicit societal expectations and messages upon such roles.

5.3.2 Sub-theme Two: Negative Interpersonal Influences around Food and Eating

This sub-theme captures the enduring effects of early life experiences, and the negative influence upon food-related engagement, including both overt and covert expressions from healthcare professionals, family, and friends.

Despite the positive aspects of belonging, familial relationships were in some cases considered to negatively impact upon food-engagement. In contrast to her reflections of family mealtimes, marked by expectations, "*conflicts… and tension*", Maria found eating in isolation during her ED a "*comforting ... and safe*" space where she found independence and autonomy. Katie also discusses how eating alone offers protection from the scrutiny of others, thus impacting her relatedness to others.

Whilst Fiona reports feeling "*comfortable eat*[ing] *on* [her] *own*" offering the opportunity to freely engage in her "*rituals*" and eating in a "*certain order*", possibly without the watchful gaze of others.

A theme running through several accounts was mother-daughter relationships, revealing the significant role mothers have in shaping early beliefs around food and eating. Kelly describes "*my mum was always like on a diet, so I ... always just had a bad association with food"*. These influences were not always verbally expressed, but observed, through bodily scrutiny. Jennifer explains her family's implicit weight management practices led to herself becoming self-critical "*Family members are diet focused and I think that's been a big thing in my upbringing ... I was kind of surrounded by my mum who is constantly on a diet"*. Jennifer experiences her body here through the objectification and the gaze of others; describing how significant peoples' judgements shape her perception of her body and self-worth - "*My mum and siblings criticise their own body and criticising what they're eating ... then you apply that to yourself*".

Harriet also discusses how early-life experiences around food and eating are deeply connected to family relations "*I've got various memories of my step mum ... feeding me the fat off the skin of the chicken and her seeming to enjoy that and me liking that attention that was getting me"*. Harriet assumed she had never been accepted by her step-mum; in Harriet's interview she reflects how these early childhood experiences impact her current relationship with food:

> *It was something my mum didn't have at her house. But my dad always did...I ended up always feeling very mixed up when I moved between the two places...maybe there's a connection with ... those sugary high fat foods being at my dad's house, and I never really felt accepted by my step mum, and that's why I liked them.*

It appears Harriet used food to feel placed as she moved between homes and the fat off the chicken offered by her step-mum became what she describes as "*entrenched*" and "*tangled up in my relationship with food because it was her that was feeding me*". This reflects earlier discussions on how food is a form of communication and a medium to manage feelings within the context of family relations.

Danielle describes how her mum normalised her selective eating, to compensate in ways she was unable to fulfil as a mother, giving Danielle permission to continue with her food-restriction to appease her mum: "*I think my mum was OK with it. She was like, well, "this is all she eats. So, this is what I'll give her", and I think it gave her a sense of being a good parent because she could give me what I wanted ... Whereas in other parts of motherhood she couldn't meet my needs".* Kelly also describes how difficulties such as making herself sick and struggles with exercise went unnoticed if she continued to eat socially:

> *I did struggle with exercise and making myself sick as a way of kind of trying to hide that I had something, that I wasn't eating basically, cause if I was having something to eat and everybody was saying "oh, but you you've lost so much weight" I could say, well I'm still eating.*

Kelly describes the subterfuge she felt necessary to protect the ED. Whilst other participants describe avoiding social eating, Kelly ate socially to avoid having her weight loss being linked to the illness. She describes:

> *If I like went out with my friends, I would make sure that I picked something on the menu that I would then be able to… bring all of it up…. if I chose like soup or like something, or a salad or risotto ... It's a lot easier to bring it back up and make myself sick, so then I knew that I could get rid of almost all of it*

This is a powerful statement as she alludes to the opposing pressures of the shame she feels in not eating and the societal value of weight loss.

Despite participants' desire for others to take notice of their distress manifested in anorexia, shame and secrecy were common themes shared by participants around food. Kelly discusses how she concealed her eating from her partner, pretending her hospital admission was for irritable bowel syndrome rather than anorexia. Others discuss how they would go to lengths to hide their behaviours from others and present a persona that was socially acceptable to others, to avoid *"raising suspicion"* (Kelly). This shame led to being "*withdrawn"* (Maria) and tension between family members, as Jennifer describes Christmases with her family were "*dreaded*", tainted by feelings of "guilt", describing:

> *you're trying your best, and you've got like the voice that it's in your head saying "No, you shouldn't eat that. You shouldn't eat that" ...But then you're aware of your*

> *family ... looking at you and thinking... you know, I know... they know ... but still ... you wish you were doing better just so things were easier for them*

Here food becomes an unspoken wedge between Jennifer and her relationships, and a taboo "*you know ... they know"*. Mealtimes at home were charged with high emotions and conflict, as Katie illuminates, disrupting family traditions and routines:

> *there was a lot of conflict around food and eating because I wanted to continue to do those ... rituals... my family wanted to do kind of normal things with food and ... eat when they were hungry and eat for pleasure and eat for like community... my parents were very worried about me, but I didn't really want to hear it.*

Participants spoke of fear and lack of understanding from family members. Kelly's mum asked her to "*swear on granny's life that you won't make yourself sick*" on a family holiday. A promise carrying unrealistic expectations, leading to guilt and shame when she purged, making her feel "*awful*" and powerfulness against the ED, realising "*no matter what I'm still going to make myself sick…or not eat or just do anything just to prevent putting weight on".* Kelly's account highlights the compulsion around her eating practices; however, pressures placed on her from her mum to "*swear on granny's life*" only adds to personal culpability, rather than considering this may have been too difficult for Kelly to manage at the time. A lack of understanding from parents and healthcare professionals was noted by Barbara, who felt her difficulties were trivialised through comments to *"just eat*" and from healthcare professionals, *"you don't look like you've got an eating disorder"* or *"you're not really underweight".* Healthcare professionals' attitudes and communication was important for participants; Danielle felt their lack of genuine care was patronising "*She'd* [the dietitian] *always say things like keep going lovely, which I actually hate ... also in my opinion, it wasn't coming across as genuine empathy".*

Participants' experiences of eating with others in treatment was mostly unconstructive. The atmosphere described as "*tense"* (Jennifer), "*toxic"* (Sarah), an environment which fosters comparison and competition to be "*the best anorexic*" (Barbara), which Harriet states creates a "*domino effect"* affecting everyone. Jennifer explains, that being in a setting where you are *"surrounded by other people that are very anxious*" compounded her own anxieties, bringing into question her own food choices during the dining room. Others' difficulties with food were internalised, as Jennifer describes "*I'd be eating something and then someone else would be finishing less than what I was having. And I was like, oh, I shouldn't be eating this but still feeling hungry". Through comparison, participants began to learn negative patterns of behaviour from others, and participants discussed needing to guard and "*protect*" (Jennifer) against the negative influence of others.

5.3.3 Sub-theme Three: Physical Environmental Influences upon Food and Eating

This sub-theme reflects how the material environment form and influence food-related engagement, with different contexts changing participant's relationship and meaning of food and eating.

Barbara articulates this when discussing the effects of her primary school's polices to "*clear your plate even if it made you sick"* which became problematic when she moved schools where *"diet culture was very much alive and well*". These conflicting expectations tied to place create confusion, influencing her connections with others: "*I'd been ... trained... from school that you had to finish what was on your plate… I found that difficult… then kind of bullying because I would eat what was on my plate because that's how I've been brought up and that's what you had to do*".

Danielle also discusses how experiences of food were mapped on to certain environments, for example when eating at college:

> *one of the lecturers came over to me and was like, "oh, what have you got?" It was just a conversation, but that was it, I just put my food down and I could… never eat in that place again, I don't really know why because it wasn't a judgment. It was just some awareness had been made …* [to my] *eating.*

The attention drawn to her eating practices and being singled out created fear of the college environment - tapping into her inner self-consciousness - fuelling further avoidance of social eating in trepidation this would happen again.

Belonging to ED treatment held an ambiguous place, Jennifer describes "*I didn't feel I belonged*", describing shock when encountering other ED patients, and were exposed to *"some quite scary things*" (Fiona). This shared sense of misplacement is vividly captured by Harriet: *"it was just horrible. I was stuck in this tiny room… I remember feeling really embarrassed… it didn't feel the right place for me".* Although describing initial feelings of wanting access to treatment and to belong to the diagnosis of anorexia, belonging in a community with other patients was conversely not something they wanted to identify with. Living among individuals who were *"revolving door patients*" (Jennifer), and on a "*ward with people who were 50,60. They're both dead now*" (Fiona), brought into light own existence, and what they wanted in life, spurring motivation and change. It could be inferred that participants realised from evidence of other patients' experiences that recovery is not possible, dashing their visions of what treatment could offer.

Place shaped occupational engagement. Harriet describes how her experiences of food at university, influenced by the social context, enabled a markedly different experience compared to her time in hospital. She explains "*being with people, my own age and somehow being away from home helped me to eat more normally again".* The normative influence of others her own age enabled motivation to eat, more so than the eclectic mix of people in the hospital environment, whose focus at the time was on EDs. Sarah also discusses her changed experience of eating when outside of a medical context *"I quite enjoyed it, because it meant that I got out of eating lunch on the ward so that was quite nice, and I could just eat my food in my own space and not worry about what anyone else is doing".* Sarah alludes to the freedom which comes from eating by herself outside the inpatient setting. Her use of "*space*" includes both physical space but also emotional space from the negative influence of other patients and the impact that they had on her own mental state. Place and environments held powerful sensory with its *"feelings and smells*" (Kelly) eliciting strong emotional reactions and lasting memories in relation to food. Fiona discusses avoiding certain places due to their sensuous properties: "*I remember having an absolute meltdown in Marks and Spencer's Food Hall…That smell in Marks and Spencer…I still remember it"*, and Barbara explains how she can still "*feel*" the NGF tube in her throat today.

Certain environments cause greater difficulties with food and eating, as Fiona describes "*I lived in the middle of nowhere with my family. I …* [have] *got all these poor associations in that house with things that I used to do, foods I used to eat, behaviours"*. Being aware of the "*poor* *associations*" embedded within her family home, Fiona requests for discharge to a different environment following treatment. Kelly and Sarah also describe carving out a new identity when they moved away from their hometowns, where people did not view them as someone with anorexia.

Kelly describes a particular coffee chain represents "*bad stigma*", symbolic of *"everything around my eating disorder*", where she would go to purge after she ate and hide away when she was signed off work. However, during an inpatient stay she was encouraged to return to the coffee shop chain with the occupational therapist. Although the coffee shop was not the same one as in her hometown, the same décor and menu evoked strong feelings of avoidance and fears. Through a positive experience with the occupational therapist, she was able to create a new memory. Upon reflection she explained how the meaning changed, and she now feels "*completely different, even though the menu is the same*". She has confidence now to return to this coffee shop "*because* [she] *had a positive experience*", highlighting how fears concerning food are mapped onto and connected to environment but can shift and change depending on belonging and connectedness with others.

5.3.4 Sub-theme Four: Cultural Influences upon Food and Eating

This sub-theme reflects on the wider influences of culture and society which shape participants' eating practices and relationship with food. These were mostly viewed as detrimental to anorexia recovery; however, there were some anomalies in the data, where a desire to fit in, and eat "*normally"* were motivational. For example, Katie challenges her self-doubt around food, by asking "*If I wasn't meant to eat this food, then why would they be selling it in supermarkets ... if it was so bad for me, then why do most of the country eat it and like it"*; thus, considering wider social norms helps re-evaluate her own doings.

Nevertheless, many participants discuss the influence of diet propaganda and media messages in the development of their eating, shaping views of themselves and their characters. This led to a sense of self-doubt concerning their eating and an awareness of food which did not exist before, as Maria discusses:

> *I ... think some of it has come from media. The whole perception of diet culture ... if you eat a salad, you're being good, whereas if you eat chocolate, you're being bad. And that's very much given me that all or nothing mentality of one food being good and one food being bad and there is no in between.*

Katie felt disordered eating was a "*common experience*" of the general population, a normalised practice, which masks her own difficulties. She identifies the pressure of not only explicit diet fads, but also subtle healthy eating guidelines. She specifically describes an annual national health-eating initiative focusing on "*bettering ourselves through weight loss*" which becomes a community endeavour "*the shops get into it and all the primary schools and clubs*". Losing weight appears to be a collective effort, and thus not joining in for Katie would represent "*letting the side down*" indicating pressure to conform to the status quo.

Jennifer also draws attention to how popular discourses such as clean eating, are "*touted as wellness" suggesting "that if you eat certain foods, then it's really damaging for your health and its morally kind of wrong".* Although considering this "*unrealistic*", the message nevertheless became "*damaging"* for her recovery and she acknowledged that it "*set me back*". Barbara's account resonates with Jennifer's observation, stating that not eating is "*seen as a good thing…the ability to ... have the willpower to not eat is seen as societally as a good thing".* These views were commonplace, meaning the line between anorexia and disordered eating observed in society was blurred. Kelly states, "*I thought ... healthy was to not eat a lot"* and Barbara explains "*it's normal to skip meals"*, and instead of breakfast "I *grab a coffee in the morning cause that's acceptable".* Katie discusses hiding her ED behind "*healthy eating practices*" such as "*adding lots and lots of salad to my meals to try and bulk them out".* Engaging with socially acceptable doings appears to disguise the illness to others and themselves, these doings were not just related to food and eating but to productivity and movement. Barbara reports feelings of productivity and activity positively reinforces the ED "*feeling good... I'm doing loads of stuff, there's the excuse of I'm too busy to eat".* Similarly, Maria explains within the culture of healthcare, where she works, "*people don't take breaks…I see some of the others doctors just working through and not eating".* Not eating here means a good work ethic; therefore, taking a break and nourishing herself goes beyond the restrictions of the ED but bound up in her work role.

Participants' sense of self appears to be shaped by Western cultural beliefs, where food is form of self-transformation, reflecting character and morality. As Jennifer explains "*if you seem to be eating the right amounts of food and your body looks in a certain way, then you're a better person"*. Physical bodies carry moral connotations which are internalised and become a barometer for how participants judge themselves and others, as Katie states:

> *I attached a lot of morality to fatness and thinness… thinner people were more virtuous, and that other people had more respect for them … they were doing their best and they were good people.*

Unlike the distant influences from media and magazines these beliefs also emanate from localised social interactions: schools, workplaces, and friendship groups, as Barbara and Maria's extracts below illuminate:

> *Diet culture was very much alive and well in primary school.... It was a lot like you'd be expected to be like wearing makeup and straightening your hair every morning in when you're like age like 9* (Barbara).

> *… other things that have influenced it is my job, I work in healthcare. We're told that certain foods are bad, and that labelling is very endemic in my training which really has not helped* (Maria)

These comments not just shape perceptions around what to eat, but how to behave around food, Maria reports:

> *… adults when I was a teenager would say … "oh, are you not watching your figure?" or "women are always on a diet". I think that made me believe that women were supposed to watch their figure and women were supposed to not eat chocolate and that those foods were bad* (Maria).

Maria alludes to the gendered constructions around food and eating where women should be able to demonstrate restraint over their bodies. These messages are widespread; Maria's female colleagues "*nurses…were always … talking about the latest diet"*. Jennifer also expresses motivation to diet to fit into a "*little bikini"* bought by her auntie along with "*little products*".

These findings highlight cultural beliefs around how women's bodies and eating were felt to be, where bodies were "little", and women should "diet". Fiona describes of being aware of popularised diets such as "*keto diets*" or eating "*vegan food… it's a fashion thing… protein bars and stuff like that*". However, instead of following these trends, Fiona reports of voicing her concerns to others during social eating, through vulnerability and honesty - "*I'd let them know that I was not impressed… or that I didn't find it… helpful"* - she explains this came from a steadfastness to seek recovery, and was able to separate herself from the dominant diet culture of culture, reporting "*what bothered me what I was having".*

5.3.5 Summary of Master Theme Three

This theme reveals food-related meanings are not individualistic but are shaped by relationships, structural influences, and cultural belonging, which can both encourage and constrain motivation. It also illustrates how for participants food is morally laden and intersects with dominant cultural categorisations of food as good/bad, which fuel avoidance and fear.

5.4 Master Theme Four:

Meaningful Resisting*:* The influence of Treatment upon Food-Related Occupations

Master Theme Four encompasses the multi-dimensional meanings ascribed to treatment. All nine participants discuss negative aspects of food and eating in treatment, where they felt a lack of autonomy and personalisation of care. Harriet describes treatment in prison-like terms, being "*locked in*", with "*bars on it".* However, many also discuss positive aspects, where the same, or subsequent treatments were personalised, and gave a sense of empowerment. Participants discuss how the medicalised nature of food and eating in treatment conflicted with ideas of normal eating, with a ritualised approach towards food mirroring the ED. This medicalisation reinforced disordered eating practices, and control was subverted by participants.

5.4.1 Sub-theme One: Disempowerment and Empowerment

All participants discuss damaging aspects of treatment around food and eating, mainly that of disempowerment and depersonalisation, which were not only harmful, but worsened relationships towards food. However, this sub-theme also highlights treatment encounters which empowered participants, with professionals who shared care, and curiosity – "*eaking out that process of eating*" (Jennifer), was valued.

Sarah describes treatment as "*brutal*", focused solely upon the physical effects of the ED, without acknowledgment of the wider aspects of care. She considers treatment metaphorically as "*a feeding farm",* inferring a dehumanising experience, and expressing incredulity at their vision: "*we've found the cure for anorexia. We just feed them".* This comment contrasts to the promise of what she assumed treatment to be "*a specialist eating disorder unit... first of its type*". Yet despite its professed specialism, Sarah felt the exclusive focus on food neglected other aspects of her being. Sarah's first inpatient admission set the tone and expectation of future treatments, impacting her engagement, feeling "*traumatised by every experience*", where "[she] *only saw* [food] *as punishment or as something to be scared of...".* Fiona echoes this in her description of her re-admission to the adult unit, "*I think it was the same really, if not worse, because I knew what was coming".* Here, Fiona alludes that all treatments had a similar effect, leaving her hopeless.

Many participants describe treatments which involve coercive measures around feeding practices, which were punishing and controlling in nature. Fiona describes feeling "*tricked"* and "*blackmailed"*, whilst Harriet details "*punishing aspects of eating and around mealtimes"* and for Barbara, treatment was "*horrific".* In their experiences, inpatient treatments operated on a rule-based culture, which left little or no control in supporting decision making. Sarah describes "*I had no control and no autonomy, and if we went out for meals and stuff, they basically told you that you had to eat a certain calorie count".* Paradoxically within treatment, Sarah was told she had to eat within a "*certain calorie count"* despite calorie counting being a feature of her ED. Thus treatment's focus on "*numbers and weighing*" felt in harmony with the controlling nature of anorexia.

Harriet used the word "*suffocated"* because of the lack of autonomy and choice she felt, compounded by the *"rituals around food*" within inpatient treatment and Barbara reported staff always had "*close eyes on*". Harriet felt patronised and belittled by the treatment she received, "*they would try and cook me ... food as if we were little children. We were little teddy bears. It was just horrible ... it ... felt like something that was being done to me".* Likening herself to a teddy bear, evokes an image of a powerless passive doll, to be controlled. Other participants describe passivity whilst in treatment, something which was

was done to them, rather than an active engagement. This lack of choice led participants further into the ED as their only means of exerting control, as Kelly describes: "*I would then get angry. I'd be like well why would I want to then eat because I have a choice in it. I didn't feel like I had any control*". Not only was inpatient treatment detrimental, but so was community care, which acted as a bubble from the outside world. Katie describes a sense of looking upon life from the outside, "*because I ... had lost any sense of what normal eating looked like*".

Many participants describe how staff labelled them within an illness framework, as people with EDs and not as unique individuals. Fiona explains this created an internalised view of self, impacting her motivation, and fostering a desolate outlook on recovery:

> *I think at that point they thought I'd be what they call ... a functioning anorexic for life. And they used that term with me, and they ... said you're just going to be a functioning... revolving door patient.*

Kelly also expresses a desire for personalisation where she is treated as an individual but instead, she was "*standardised*".

> *I found my first inpatient admission with food actually very difficult because ... everybody was on the same meal plan. So, everybody had to have this amount .... it's ... standardised like she* [the dietitian] *believed that everybody had to have the same amount of food.*

Although preferring routine and sameness can be characterised as part of the illness, Sarah describes this stems from her neurodiverse needs:

> *because I've got ADHD and I think I might be autistic my eating disorder is so different, so like when they were asking me to make food with the amounts of foods that they were suggesting I was like, yeah, but this isn't the same as what we eat on the ward... I think that's just messed with my head because I couldn't get my head around the differences.*

Despite her individual needs, Sarah's difficulties with change were dismissed and considered part of the ED. Fiona also describes the lack of understanding, in her experiences of unanticipated and uncontrollable vomiting at the dining table secondary to anxiety. However, staff labelled her behaviour as disordered and ignored her petitions for accommodation. She vividly describes this on one occasion:

> *traumatic times… where everything was locked… I'd run back from the … dining room… and they wouldn't open up a bathroom for me and there was patients and their visitors… and I was literally… throwing up in my hands in front of these other people.*

There appears to be a lack of trust from healthcare professionals in the legitimacy of participants' relationships with food, some describe having to convince staff they were vegetarian (Barbara), of their allergies (Fiona), or food preferences (Kelly). Barbara explains this distrust was extended to family members, who were "*briefed on these are the behaviours that you need to look out for"* during family meals and dictated on the "*rules*" of eating. Jennifer describes how being closely monitored whilst she ate was uncomfortable and anxiety-provoking, preferring if staff at the same food as her. Danielle explains during the cooking group, its helpfulness was overshadowed by micromanagement:

> *the unhelpful side of it for me was that we still had to follow these rules related to the dietetic side, so like if we were making something with chips, we would have to, every single person would have to have exactly 16 chips each, and we had to count these chips.*

Danielle considers herself a talented baker and cook, but instead of staff understanding this aspect of her identity, they assumed she struggled with food based on assumptions of the ED, showing suspicion and cynicism. Vocalising her frustration when asked to count chips on her plate, she comments, "*just because I have anorexia doesn't mean I think that eating four chips is appropriate*".

Contrasting to negative treatment experiences, several participants discuss positive aspects of care (within the same, or subsequent treatments), as well as a need for greater collaboration and personalisation of care. Indeed, some view treatment as lifesaving: Katie felt she "*would not be here… if not for treatment*". These comments often relate to the medical aspects of saving life where weight gain "*saved my life physically"* (Danielle). Interestingly, Kelly welcomed the direction of others as it gave her permission to eat "*I was also actually relieved* *to be in hospital because I was so hungry, and I haven't let myself eat and eat and kept it inside of me for such a long time*".

Despite treatment helping Harriet to overcome the physical "*fear of putting food to* [her] *mouth"* the wider aspects of her difficulties – psychological and social – were unresolved. Kelly also highlights this point "*hospital got me up to a healthy weight. It got me to the point that ... I wasn't at risk of dying again…. Physically I was OK, but that's only one part of it"*. These narratives emphasise how treatment did not consider participants holistically but focused on the physical aspects of their being. Participants often pointed these failures towards systemic factors, around "*capacity*" (Kelly), "*budget and provision*" (Barbara), time-limited care, giving participants only a fraction of "*getting used to life*" outside of an ED but then "*discharged"* (Danielle).

In terms of more positive experiences, Fiona explains a "*big turning point*" in her treatment was when the team adapted her meal plan, to replace items on the menu which made her unintentionally vomit. Fiona expresses disbelief from being included in her treatment, "*it was kind of weird to come to an agreement"*. This small gesture made a big impact, as Fiona felt heard, and sparked engagement in treatment. Similarly, working in partnership with services was valued, Kelly describes how a particular treatment team "*saved*" her and "*turned my life around*", by "*giving me like choices and didn't inflict things on me"*. This pivotal intervention occurred when she needed to gain medical clearance to study on a paediatric nursing course. Keen to obtain this, they "*worked as a team to make sure that* [she] *could do* [her] *nursing*". It appears having a goal and purpose increased motivation and engagement, whilst revealing how food connects with life, beyond the moment of treatment. Kelly also explains, feeling relaxed during treatment when the focus moved away from the present moment and anxieties to the future and her "*goals*". She valued conversations which "*didn't just relate around food*".

Sarah's past treatment experiences of refusing food, which often resulted in forced nutritional supplements or NGF, left her in surprise when one team explained in response to her refusal of food *"we're not going to do anything. It's your life"*. This was a significant moment as it was from a place of non-authoritative care that Sarah felt empowered to eat, responding with "*let's do this and then I ate it*". It appears when treatment is not enforced, individuals feel seen, encouraged and empowered – "*I chose to have the food I chose to have an active part in my recovery*" (Kelly).

Maria explains treatment is idealistic, as it does not consider the realities of her "*busy job"*, where eating regularly is not always possible. Participants explain food-related occupations should match their typical routines and "*unique lifestyles*" (Harriet) to be "*sustainable"* (Fiona). In preparation for university living, Fiona explains she wanted to practice eating in places which were "*accessible ... like Subway, not going to go to a Michelin star restaurant… I remember going out and buying a McFlurry once for a snack cause ...that's a normal thing to do and it's within my budget*". Harriet also describes "*eating takeaways*" so that she "*can fit in with everybody else and cook quick and easy meals*" and Sarah comments "*not everyone can afford to eat out in restaurants every day either or get takeaways. It needs to meet with that person's life, their routines"*. It appears participants desired for everyday food activities to be incorporated into their treatment such as ordering a coffee and planning and preparing meals.

Sarah describes how the meaning of food changed outside of hospital and treatment programmes:

> when *you're out in real life and ... not many other people around you have eating disorders, or if they do, it's not in your face all the time and you have different focuses in life. You are also able to just choose the food that you want to eat.*

Here the importance of not being around other people with EDs, having other focuses and goals and choice are important ingredients for a positive relationship towards food.

Relationships with staff were significant for participants in supporting them in their recovery. It was clinicians who showed curiosity, and "*pull*[ed] *on ... the meaning of food… and what my long-term goals are*" (Jennifer) which were valued. It was in everyday conversations, considering one's values and ambitions, and "*not anything ... psychologically involved*" (Kelly) which enhanced engagement. It was appreciated when treatment was individualised, and participants were seen for their unique selves rather than an EDs. Even in the most restrictive settings, Harriet valued the compassion and warmth she received from staff:

> *continually telling me all of the reasons why eating was the right thing to do sometimes even telling me I had no choice about it, seemed to help in the early days but they said this in such calm and compassionate voice.*

During meal-related activities, staff who focused conversation on everyday things (Kelly) and sat with individuals though raw emotional moments (Fiona) was valued. Although speaking of the "*panic"* (Harriet) and fear around food in treatment, participants paradoxically also desired a degree of "*experimentation*" and uncertainty, to *"learn and challenge yourself"*.

Although not directly asked about OT, many participants discuss the benefits of receiving OT treatment. Kelly explains eating lunch at work was highly stressful, where treatment enforced "*rules"* that specified sandwiches for lunch, despite her aversion to them. However, the occupational therapist explored what she liked, and where she prepared her meals, and from here, supported her to make real-world changes. In this way, lunch at work changed from something feared into something "*acceptable in my head"* and "*feasible doing it*[eating] *at work*". Another positive example was when Danielle explained avoiding serving food in treatment, related to her poor sense of self-worth and drawing attention to herself. However, the occupational therapist in the group noticed this, and encouraged her in this. Engaging with food in this way, Danielle reports "*helped my life in other ways"* and "*taught me a lot more personally rather than about food"* by improving her confidence.

5.4.2 Sub-theme Two: Medicalisation of Food Conflicts with Normality

This sub-theme reflects how all participants' experiences of food in treatment was positioned as medical and conflicted with ideas of food normality and the spontaneity of everyday life.

Fiona recounts her recoil at being served a portion size which she did not feel was typical, "*to this day, I have not seen a pasta size portion like that before, and I don't think I ever will to be honest"*. Sarah also describes the impact of having to eat *"sickening*" quantities of food in treatment. In both accounts there is an underlying sense of unfairness and bewilderment. Sarah recounts:

> *imagine all the worst food you could imagine having for someone with an eating disorder and you have to eat it, all day every day. It's like 3000 calories to 4000 calories*

> *worth of chocolate bars, cakes, sugary cereal, butter, whole milk, cream, ... It was so sickening because I feel like even people without eating disorders wouldn't want to eat all of that like for snacks and heavy meals and stuff.*

Participants felt eating in treatment conflicts with how "normal" people eat and the dietary expectations upon them did not feel sustainable. As Fiona exemplifies, "*normal people don't eat chips every day…firstly they're not going to cook chips every day. And secondly, it's not very healthy diet"*. Similarly, Danielle took concern with the micromanagement of food: "*no one without an eating disorder, typically eats, plans their meals for the whole week and their snacks and calculates what's in it and checks whether it's enough of XYZ"*.

This micro-management of food worsened participants relationship with food, mirroring the controlling nature of the ED. Sarah describes how treatment "*essentially… taught me that, I don't count calories now, but …obviously for 15 years I was then ruled by calories because that was the unit of measure that I've got obsessed with"*. Eating specific fractions of food during refeeding felt strange to Kelly:

> *so like alien ... like I'm to eat a quarter of a sandwich? And then at dinner time to have like a quarter of a main meal? And I was like this is so strange than it like increases. I just had no concept with any of that.*

It appears the reasons behind food and eating were not communicated, giving individuals more opportunity to engage. Sarah echoes this notion, expressing a desire for food to be presented as more than calories or energy, but explore the why behind the doing "*I think there needs to be more emphasis on why you need food, what food is for, the nourishment, like what's going on in your body"*. Fiona wanted staff to be "*transparent… fairer and treating people as individuals rather than just an eating disorder*". Dietary education was considered unsatisfactory and when it was offered, came across as patronising. Rather what is desired is practical support, as Fiona explains, "*The problem isn't me knowing that I need to have a balanced diet. The problem is me having one*".

Meal plans, although helpful for initially providing structure, were a particular area of contention, as their focus on food logging and tracking created new rules for the ED to thrive.

As Katie describes they "*present other kind of challenges…Because I started to suddenly kind of do calculations that I wasn't even doing previously.*

Fiona explains the community treatment team set her "*calorie targets. They were very set… if they said, "…go for like 200 calories for a snack". There's no way I was going over 200. So even if it's 201 and I'd always probably go under it anyway… I would never ever go over it"*. Similarly, Katie describes not wishing to step beyond the meal plan's bounds:

> *if it said like for your piece of fruit, have half a banana. I'll be like, Oh well, I'm definitely not going to eat a full banana then because the ... dietitians told me to have half a banana, then I'm a total pig like you know.*

Following meal plans formed barriers in the long-term to step outside their detailed "*prescribed*" (Katie) boundaries. Jennifer expresses a longing for life outside the confines of her meal plan:

> *I just want to be present. I want a normal relationship with food ... to be able to ... go shopping in Lidl and go to the bakery, and get tempted by something in the bakery, and just buy it and eat it without it being in my meal plan*

Barbara discusses meticulously following a meal plan, otherwise her life would *"crumble*". Conversely, regular eating made her feel dependent on food, "*if I have to eat like X number of times a day. I feel like I'm addicted to food and then I feel like I'm going to be fat and it all spirals",* implying a relationship with food which is a contradiction. Sometimes meal plans served the control of anorexia, Katie explains how she revelled in food logging, serving the ED's pre-occupation around food - "[I] *loved… talking about and thinking about food*" – and plans became an acceptable medicalised excuse to not engage with social eating, which was more spontaneous.

Often participants describe manipulating their meal plan as their only way to "*prove a point*" (Fiona), or "*picking a point"* (Kelly) with healthcare professionals, with food acting as a currency for power and communication. Kelly describes subverting the specifics of the meal plan against staff when eating out during treatment "*If doesn't equate to what my meal plan* *should be… I can't have it…That's the kind of like manipulative behaviour that I would have done to prevent eating out".*

Although critical of how food was reduced to biometrics, some also drew upon biomedical language to justify their need for food, possibly resolving guilt and choice, and giving logical sense to eating.

> *I had low blood sugar, like hypoglycaemia, and I was told I couldn't drive for quite a while, which obviously really scared me… I started to see food as sort of medicine and more of a fuel and a way of having energy* (Maria)

Most participants desire both psychological and medical aspects of care to be prioritised in tandem to support recovery, with progressive support towards social and fun aspects of eating. Katie recognises that being told what to do in the earlier stages of treatment is helpful whilst recognising the need to move beyond this as recovery progresses:

> *... it's very soothing in the earlier stages of treatment to hear… drink this milk. It will be good for your bones, but at a certain point. It's like just drink a beer cause you're on a night out ... I think acknowledging that not everything has to be good for you ... is really helpful.*

Participants looked towards friends and family to provide a counter narrative to that of healthcare's position of food and eating, helping them "*move away from ... rigidity and planning*" (Katie). Danielle contrasts her experiences of food in treatment and at home:

> *I live at home with my girlfriend who doesn't have any disordered eating and she is very flexible around food, so I had that model to me and knew how much of things we needed. I didn't need to be told that I needed to weigh my breakfast to make sure I was having enough sort of thing. To me, that was, and encouraging a disordered approach.*

Conversely, for some rigidity in their eating created a structure, creating safety within recovery and providing a useful "*fall back*" (Katie) or "*safety blanket*" (Jennifer). Kelly describes how her husband, who mountain bikes and eats an "*excessive amount*", often instructs her to eat more, but through her trusted meal plan she confidently responds with the exact amounts she needs. She explains: *"I feel safe now that this is an amount that a normal person should eat or like as a normal amount that I should eat for my meal plan*". Kelly explains that *"75 grams of rice is what a normal person should eat*", and this is a "*normal amount*", repetition of the word normal emphasises that by following the meal plan she is attaining some normality in her life through eating. Her meal plan is something, she feels safe with and can remain in control of her weight. However, safety and control, are the exact features of what she also describes regarding her relationship to food and eating during her ED - "*I was trying to control my life*".

5.4.3 Sub-theme Three: Playing the Treatment Game

This sub-theme describes how participants actively resist the medicalisation of food and eating – designed to make them gain weight – and performed secretive behaviours around food associated with anorexia. Resisting treatment allowed participants to remain intact with their sense of being and provide a sense of autonomy in environments where they "*had no control"* (Kelly), "*and no autonomy*" (Sarah).

Participants felt "*standardised*" (Kelly) with everybody complying with the same meal plan and required to "*eat a certain calorie count*" (Sarah). Food focused on reaching particular body weights, rather than what is meaningful, situated within participants' everyday routines and lives. Participants therefore relied upon "*real world*" experiences, and support from friends and families to "*model*" (Danielle) eating and find out what "*normal*" eating is. Paradoxically, treatment presents the antithesis to normalised eating, whilst everyday environments counteracted this, offering opportunities to learn how to be with food again. Kelly describes needing to "*break all of the rules at hospital put in place"* during recovery, and how "*back out into the real world… I had to overcome real food obstacles".* There was unanimity across participants around wanting food-related occupations to match their "real" worlds, incorporating elements of "*flexibility in … eating*" (Maria) to allow for "*real life*" (Sarah), situations, in "*normal … environments"* (Fiona), such as "*social aspects*" (Maria) of food. Many discuss becoming institutionalised from treatment, reliant upon others to dictate their eating patterns, creating long-term anxieties around food. The participants desire for "real" life experiences infers that the meaning of food and eating in treatment is artificial and illusory and a temporary solution to a complex situation.

Talking in third person, and taking up a biomedical view, Kelly, describes how the "*anorexic's brain*" is marked by rigidity and rules, and treatment's hyper-focus on rules and regulations emulates. She collectively explains:

> *we're perfectionists ... we have to do something in a certain way. ... you're then given more rules it's almost like that's what you're used to working with, like that's how you like to play the game in a way. It's almost like another set of rules that you ... use those rules to kind of be like wow, it doesn't fit this criteria and that's your criteria. And you say that I have to have X amount so I'm not going to have it because you're the one who made those rules and it doesn't fit sort of thing.*

Kelly describes how she destabilised the rules of treatment during social eating scenarios by refusing when food in the community did not fit the treatment's specific criteria. Similarly, Danielle reveals treatment provoked a "*rebellious teenage state*". Participants used the rules to the ED's advantage such as picking "s*afer*" (Jennifer) food options on the menu to avoid challenge. However, in doing so, Jennifer explains the deeper issues connected with food are unchallenged "*you could probably go your whole time in there, kind of avoiding it and picking the safer options".*

Barbara explains that selecting foods which are "*portioned*" gives a greater sense of certainty as opposed to the subjectivity of others serving her meals. Similarly, this was also the case for Sarah, who preferred manufactured dependable foods, rather than the uncertainty of liquid-based foods, which can be intuitively served, as this offers space for errors and imperfections. Fiona describes selecting meals as a tick box activity, where her goal was to select what she perceived to be the lowest calorie option. When questioned in the interview, if staff explored this, she explained there was a mutual knowingness between herself and staff of what she was doing, but regardless of the meaning, if she appeared to be eating and gaining weight it did not matter. Any exploration of her motive was dismissed as *"On paper, I was doing what I needed to do, and I don't think they really cared enough to be honest".*

Participants were aware these practices were not "normal", going as far to describe the approach as "*disordered*" (Danielle), leaving them conflicted regarding food-related occupations in treatment. Danielle expressed an abnormality and lack of normality when food shopping as a group in treatment, where difficulties are paraded as a public spectacle.

> *when we were out in public as a group of just really just a noticeable group of people standing in a shopping aisle having a conversation about… why you should have a normal yoghurt and not a light yogurt. To me it was just this hyperawareness with this isn't normal either.*

There were mixed feelings regarding supervision of staff, Harriet describes the close watch of staff encouraged her to tamper with her NG as a means of taking some form of control. Jennifer reports the awkwardness and unease of staff surveillance during mealtimes, who by not eating themselves created an abnormal environment. Seemingly, in opposition to the normality of the mealtimes they were intended to be.

Aware of the consequences of refusing food (i.e., NGF, supplements or prevention to occupations), meant they begrudgingly and resentfully engaged, describing themselves shifting between "*mechanical* ... [and] *robotic*" (Harriet) eating and going "*through the process of doing*" (Jennifer), to eating out of "*sheer panic*" (Harriet). Four of the participants reported passively eating and engaging to re-engage with anorexia in which they found purpose and value. Barbara reports "*I ate to get out of ... to get discharged",* and Kelly acknowledges:

> *for my first admission I literally decided that I was going to eat my way out, if that makes sense? ... I was going to do everything that they said come and then I was going to get out of hospital and go back to what I was doing*

These narratives indicate submission to the treatment but only as a means to be free from the control of others. Fiona's intention of eating in treatment was to *"prove a point and then lose the weight*". Far from being therapeutic, food became a contest in how much could be avoided, Barbara likens it to an "*exercise in how… much can I get away with".*

5.4.5 Summary of Master Theme Four

Master Theme 4 reflects participants meanings of food-related engagement whilst in treatment; it discusses aspects which were felt to be empowering and supportive and what was consider disempowering and negative. Participants discuss a need for individualised and collaborative approaches in their care. It outlines how treatment's narrow focus on the body, in relation to food-related engagement, conflicts against their perspectives and desire for food normality. Given the meaningful aspects of anorexia and in the context of adversarial framework and restrictive practices, participants discuss of actively resisting treatment to protect their sense of self.

5.5 Master Theme Five

Meaningful Becoming: Repairing Self, with the World, and Others

The final Master Theme describes how food-related occupations in recovery were restorative and repairing, and when re-framed through the lens of recovery, connected participants to themselves, others and to life. Through shifting the meaning of food and eating as a means to do, participate in the world and belong, food no longer was something to be feared or avoided but a necessity to access life.

5.5.1 Sub-theme One: Food Enables Access to Life

This sub-theme reflects participants' current experiences and meanings of food-related engagement in their interviews. Participants position food as a resource for accessing life, to engage in life roles, what they valued, or work towards a particular goal or greater ambition.

All participants discuss the importance of meaningful occupations beyond the ED to support motivation and recovery: from studying (Kelly) to travelling (Fiona), or engagement in day-to-day activities such as swimming (Sarah) or being outdoors (Danielle). As participants re-evaluated what they valued in lives, food and eating consequently became a "*by-product of my life and something that's in the background rather than forefront of my mind*" (Maria). Although recovery is a non-linear process – as illustrated in Master Theme One – some describe recovery in positive terms, an awakening to life, as described by Sarah "*I am tasting life that I never ever thought I'd ever experienced…it's just so exhilarating"* and express the spontaneity experienced in their food-related engagement, sharply contrasting to their negative descriptions during the ED.

For participants, their meaning of food changed in recovery, no longer seeing it as a threat, something to be avoided and minimised, but the thread connecting activities and people together. As Sarah states: *"it's almost like access to life, isn't it? To be able to do climbing and be with people"* and Fiona recognises that without finding freedom in what she eats she would never have been able to fulfil her sense of becoming: "*I could never have gone traveling. I could never have done my course or got to where I have got to ... because it was just so disabling".* Danielle notes food is "*connected to everything that I'm doing because it's part of it"*. Awareness that food is embedded into everything participants want and need to do however creates tensions, as participants describe continued self-reflection, to be "*on guard*" (Barbara) of anorexia's lurking presence.

Kelly reports regularly taking time to consider her motives when going to the gym: "*I... take a step back and ... analyse it and think to myself like in the long term. What will that achieve me?"* Self-monitoring intentions during activities, meant meanings were not static but shifting, depending on context. Barbara discusses temptations to restrict through being busy, excusing herself with menial tasks such as housework, which means consciously reflecting upon her motives, to consider if she is "*making excuses".* She describes not always feeling in control of her intentions – "*somewhere the eating disorder has got on top.... it's sometimes hard to separate it and ... I'm thinking I made that plan... But I didn't hang on. I haven't done that".*

Particular meanings of engagement changed as participants progressed through recovery; for example, the meaning of going to the gym or exercise, framed in anorexia was punitive, whilst in recovery, feeding oneself and exercise was recognised as a strength. Maria describes: "*I see food as the fuel that would allow me to do that, and if I didn't eat before I wouldn't be able to do a workout. I think that changed as well massively".*

Barbara explains a "*turning point*" in her thinking, was when she realised, that the only way to increase her life, was by eating - "*making everything else bigger, which you can only do by having the food*", as opposed to trying to "*beat the eating disorder*" in her own individual efforts. From this perspective, the focus of recovery shifted away from individualistic efforts of defeating the ED, to more positively, the broader aspects of life, and things she valued and held meaning in, which in turn, lessened ED thoughts, beliefs, and behaviours around food.

Although participants were highly critical around medical discourse of food in treatment, they often drew on biomedical terms, such as food as *"fuel"* (Sarah), "*a task"* (Barbara), or "*medicine"* (Kelly) to describe their current day-to-day food engagement. However, unlike treatment where food's purpose was for weight gain, medicalising food as 'fuel' for participants was means to do their valued activities or life roles.

Fiona used the phrase *"you don't ... live to eat, just eat to live"* to illustrate her current relationship with eating, indicating she eats food to function, rather than viewing food as pleasurable or for enjoyment. However, unlike the medicalisation of food as a means of weight gain, participants' meanings of 'food is fuel to do' are in the wider context of their lives, where food connects with their interests and values, as Fiona states: "*it's a means to do things that I do".* These functions support engagement with life roles, which offer new meanings, as Barbara describes:

> *I'm currently ... just trying to see it as fuel…or medicine, that… needs to be done regularly, and trying to work towards kind of normalising it. But the important thing is that something needs to go in three times a day and there needs to be enough. To fuel my body to let me do what I want to do, to let me do my degree, to let me be a good mum, to let me be a good wife*

It is interesting whether this positioning was a way for participants to shift emotion away from food to view it objectively as a *"function*" (Maria), and as a "*practical thing"* (Kelly). This may emanate from a desire to eliminate themselves from the process of eating, and stripping eating back to simplified engagement. Katie describes "[I] *just eat. And I'm like OK, grand like now I've eaten that meal let's get on and do the next thing".* Sarah considers her lack of enjoyment in food will always be different to others: "*I don't get the satisfaction of food that I'm assuming normal people do".* This infers a sense of defeatism, perceiving her relationship with food will never be a source of enjoyment; however, it may also suggest a sense of realism and acceptance. Perhaps "*mechanical eating*", is a way of showing oneself *"[I can] eat through tears and eat anyway*" (Jennifer), where food is part of, as opposed to defining life.

Participants appreciate the physiological and nutritional impacts of eating, where food is framed for 'health'. Harriet describes: "*I think about food in ... terms of what it can give me the vitamins that I need the calcium any because I did have quite severe osteoporosis".* Barbara reports how she needs food to repair and recover, contrasting to her previous considerations of food as something which needed to be earned: "*even if you're not doing as much, your body still hungry cause it's still repairing and growing from the day before"*. Similarly, Katie acknowledges the importance of eating despite her circumstances, recognising *"Not every day is easy… maybe you had a rough day… getting on with it and just eating again",* and Jennifer uses a metaphor of "*riding that storm*", of anxiety, and eating in spite of challenges and affect.

With greater understanding of self and the value of food value, food changed into a source of self-care, and nourishment. Maria explains changed associations towards her lunch breaks. She previously avoided lunch due to the busyness of her medical role; however, she now views *"the break as self-care ...I know we're busy. But I do have a right to a lunch break, and I will take it and I will eat in it because that's my way of keeping going".* This care for self in turn leads to care for others, as participants began to look outwards. Katie states:

> *I'm able to keep myself in a good place and it's a part of a system of just looking after yourself and taking care of myself so that I can be the best I can be to look after like others, look after the things that I care about.*

5.5.2 Sub-theme Two: Food is Reconnection to Others

This sub-theme reflects how as participants re-engaged with life; food also re-connected them relationally to others. Indeed, food is positioned as highly relational, bringing intimacy and connection to life, where "*the meaning is kind of bringing people closer* (Harriet). Whilst participants express anorexia as offering them a sense of individuality, Harriet also discusses how eating with others in recovery meant she was involved "*like everybody else"*. Here, there is both a desire to be inside, and outside of anorexia.

Participants often spoke of relationships with partners as changing their perspective over food, and themselves. In recovery, Katie developed a romantic relationship, one which would not have been possible during her illness, as "*firstly, I didn't like the way I looked and then secondly… I was obsessed with keeping it that way"*. Meanings of food changed, whilst sugar was previously perceived as shameful for Maria, "*a secretive thing that I did on my own"* yet within the context of her relationship, she "*started seeing these sugary foods as more of an* *enjoyable experience with somebody"*. Through eating with her partner, Maria experienced a change in herself, where she became "*spontaneous"*, transformed from shame, and allowed access to life "*trying new places*" this in turn, made "*food…a secondary thing… it wasn't a big deal what I ate, it more about the company and the conversation*".

Friendships and family relations also featured in participants' narratives, which involved being vulnerable and allowing others into their previous secretive engagement with food. Despite experiencing anxieties, Sarah explains she allowed her friends to serve her un-weighed amounts of food, a "*massive first"* affirming "*just how far I have come*". It was often in these collective moments of doing with others, that participants reflected on how far they had changed. It was not so much the eating, which was difficult per se, but the wider context of food, the preparing, the cooking, and allowing others to take control. Jennifer explains recovery means tolerating her levels of anxiety around food:

> *I feel like with me a lot of it is the anticipation of the event and the event itself is like not that bad ... but it's more the anticipation of the event and seeing it being prepared.*

Being with others who role modelled healthy eating patterns changed how participants viewed food and eating. Harriet recounts how being with her children and observing their eating patterns, influenced her own:

> *last week, for example, my eldest daughter had two friends, and I took them to this place ... which does waffles and cakes…And I sat there with them, and I was going to have a coffee. And I thought, no, I'm going to have a piece of cake with them.*

Through observing her daughter's freedom around food, Harriet impulsively decided to have a piece of cake "*with them*". This was similar for Sarah, when she went out for pizza with her friends, after watching her friends order a meal, she decides "*I just thought that you know what? I'm just going to go for it. It's my other two friends are getting it. And so, I literally then didn't look at anything else"*.

Returning to supportive communities is protective following intensive treatment. However, as Jennifer critically brings to light what happens if individuals do not have such belonging:

> *I think if you come home and you haven't got that solid support who will sit with you every night and make sure that you eat everything* on *your plate and actually know what you should be eating, then it's quite difficult to continue that maybe.*

Highlighting how recovery depends on social connection rather than individual efforts, as Sarah similarly comments "*if people are in families and they have support ... then there's no reason why someone can't do it [recovery] ... at home"*

5.5.3 Sub-theme Three: Balance with Food and Self

During anorexia, participants described their relationships with food, eating and self in the realm of extremes, situated around all-or-nothing thinking, with food categorised as good/bad unhealthy/healthy. This sub-theme reveals how during recovery, eating became contextualised into the bigger picture of their lives, rather than compartmentalised into specific moments in time, or related to emotional states. Participants sought balance not just in their relationship to food, but also in themselves, accepting who they were, realising that food and *"weight gain is not going to fundamentally change my life"* (Katie).

By allowing food back into her life, Katie describes food was no longer centralised in her thought processes, the "*be all and end all"*. She describes: *"when I allow it* [food] *to be part of my day and not try to exclude it from my day altogether, it doesn't end up being my entire day"*. Similarly, Danielle comments how food is "*part of the day, but not the whole day",* and Maria, how food sits in the "*background rather than the forefront of my mind"*, reprioritised "*to fit in with my life rather than the other way around"*. Accepting that food cannot be "*separate*", or "*compartmentalised*" from life, came acceptance, and from here, peace and freedom within oneself, as Maria states metaphorically: "*I am less at war with my body*".

This more compassionate stance to self, allows participants to accept the inevitable stressors around food and mealtimes, and when things went 'wrong'. Katie details an event, where her plans to eat in a supermarket were quickly changed due to a different layout of the supermarket. She describes *"everything is ruined... I might as well just not bother eating the food because clearly it was just a silly idea to think about eating... But today I was like "oh OK, that's a bit shit'".* Similarly, Maria discusses the panic she experienced from unassumingly picking up a full fat instead of low-fat yogurt at the supermarket on her way to work. Instead of throwing the yoghurts away, Maria was able to disprove the ED through eating them regardless and realising "*nothing scary happened... they're not a big deal, it's just yoghurt*". Similarly, Barbara explains challenging her all-or-nothing thinking in the face of disappointment - "*not just abandon things because plan A has gone wrong".* Although participants discuss the importance of the practicalities of doing recovery, Barbara notes "*You need to remember you are human being, not a human doing", and* Jennifer "*learning to be rather than do in recovery*". These comments illuminate the role of taking time to readjust in a new way of being in recovery.

Trusting the process of eating and stepping into the unknown was challenging and many discussed the importance of positive risk taking and experimentation. Doing inexorably means making mistakes; however, Danielle describes that through them she was able to learn and grow and accept her imperfections.

> *I'm able to try things so recently I'm doing classes ... to do figure skating and that is something ... I can't tell you how much I wouldn't have done that before, because I would have been too afraid to try something in case I wasn't perfect whereas now I love being imperfect and falling over because it means I'm learning... So, it's really just doing, doing things that matter to me, that's really helped.*

Here, food like life, are both made up of uncertainties and unknowns, something that might not be perfect, but only through doing – eating and life - can one move forward, grow, and become. Underpinned by becoming was a sense of hope that things can improve despite continued difficulties, of "*visualisations of what is would be like to eat normally*" (Harriet), and with self-compassion, holding onto "*tomorrow is a new day*" (Barbara).

5.5.4 Summary of Master Theme Five

Master Theme 5 outlines the ways participants positioned food in their current day-to-day lives, which was functional in nature, allowing them to 'do'. Food became a resource to live life incongruence with their values, and 'become' who they want to be and become.

5.6 Conclusion to Chapter Five

Findings of this chapter present five meaning constructs of food-related engagement discussed by nine individuals who consider/considered themselves anorexic. The analysis illuminates the multiple and conflicting meanings of food-related engagement, and how these are shaped by participants' being-in-the-world. Although there are commonalities in the meanings expressed, meanings were idiosyncratic, occurring in social, family, and cultural contexts, which enhance their meaning.

6. Chapter Six Discussion

Introduction to Chapter Six

This chapter will relate the research findings to existing literature and theory, consider implications of the research, propose suggestions for future research and discuss the limitations of the project. The chapter will conclude by outlining the study's unique contribution to knowledge, its significance and provide a final reflexive account of the research process.

The aim of this study was to gain a deeper understanding of how individuals with lived experience of anorexia experience and make meaning from their food-related occupations. The phenomenological interviews drew upon experiences which traverse meanings across time (before and during anorexia, and in recovery), and the contextual factors which contribute to these meanings. The findings identified five master themes (meaningful doing, meaningful being, meaningful belonging, meaningful resisting and meaningful becoming), and related sub-themes.

These findings add to the body of qualitative research which illuminate the personal meanings that anorexia holds (Serpell *et al.*, 1999; Nordbø *et al.*, 2006; Williams and Reid, 2010), and its relationship to identity and belonging (Higbed and Fox, 2010; Williams and Reid, 2012). The functional meanings may further illuminate why resistance and ambivalence towards treatment and recovery are often tied up in the conceptualisation of anorexia (Vitousek, Watson and Wilson, 1998; Gregertsen, Mandy and Serpell, 2017). Whilst some studies have explored food behaviours and cognitions in anorexia, no research to date has explored food-related meanings from an occupational perspective. Unique to this study, is that findings reveal how food-related occupations are central to this meaning-making framework, and how the performance of occupations within the illness shape participants' beings, their sense of belonging, and who they wish to become. The findings reveal the individuality and uniqueness of individual's own meanings with food engagement, and therefore meanings cannot be inferred by another.

Informed by phenomenological philosophy and the theory of the dark side of occupation, food-related occupations are more complex than an individual alliance to anorexia, they are nuanced, multifactorial and contextual. The study reveals engagement and doing is shaped by broader variables, such as the normalisation of disordered eating within participants' life worlds, the influence of the human and non-human environment, as well as systemic constraints, including barriers to early intervention, lack of understanding of doings and absence of ongoing practical food-related support. The findings highlight the importance of viewing food more than means to gain weight in the treatment of EDs, but can be a way to reconnect with self, and others, and the thread connecting all parts of an individual's occupational life.

6.1 Using Wilcock's Framework for Interpretation

Within hermeneutic phenomenological studies, pre-understandings, which can include cultural perspectives, and theories support understanding of a phenomenon (Neubauer, Witkop and Varpio, 2019) and are utilised for deeper evaluation (Smith, Flowers and Larkin, 2022). Hermeneutic research emphasises that understanding comes from the role of the interpreter, as much as it does from participants themselves, and pre-understandings are a key component of understanding. Indeed, whilst interpretations in IPA emerge from a systematic and detailed analysis of the data itself, they also arise from dialogue with existing theories (Allan and Eatough, 2016). Based on these points, the themes of this research are discussed in relation to Wilcock's dimensions of occupation: doing, being, becoming and belonging (Wilcock, 2006).

Heidegger, Gadamer and Merleau-Ponty consider the impossibility of stepping aside from our pre-understandings and phenomenologists emphasise the importance of explicating our subjective horizons of experience (Landridge, 2007; Finlay, 2009b). Given the role of subjectivity in this thesis, it is of importance to make clear how I came to consider Wilcock's dimensions to support my interpretation. As such, I have included personal extracts from my reflexive journal in Figure 14.1 and 14.2.

Figure 14.1 Reflexive Journal Extract

January 6th 2023

Now the analysis is complete, what now? What do the findings mean? A lightbulb moment occurs to me, as I realise how my findings, which up until now have been messy, interrelated, complex and difficult to tease apart into discrete themes, resonate with Wilcock's framework. Wilock also considers the interconnected aspects of the dimensions. I am conscious that perhaps these concepts came to the fore given my position as an occupational therapist, where such concepts are common and taken-for-granted, thereby holding greater relevance, and colouring my view of participants' experiences. So here I am, returning to the raw data, my analytical notes, and the broad generic themes that I have named so far – *identity, function, relationships, recovery* – which suddenly are becoming more and more distilled and mirroring Wilcock's framework. It's post-Christmas, and I have taken some dedicated time away following my second APR to take a step back from my analysis to ensure I am seeing afresh. With no computer, or textbook on hand to influence me, but only my findings, my reflexive journal, voice notes and participants' words printed in front of me, I cannot but help highlight and note in the margins 'DOING', 'BEING', 'BECOMING', 'BELONGING', sometimes these relate to whole parts and at other times, just sentences.

Figure 14.2 Reflexive Journal Extract

January 8th 2023

Wilcock's view that occupation should be valued for its meaning and how individuals feel when engaging in occupations was the thread which pulls everything together – this is the message I want to share - to advocate a view of meaning and experience in eating disorders.

As I consider Wilcock's dimensions in light of my findings, it affirms by perspective that my participants' engagement in food-related occupations cannot be arbitrarily categorised as 'maladaptive', but their doings must be considered integrated into the context of their occupational lives. Taking into account who they are (their identities, and sense of being), the impact of their relationships and contexts on their meanings (belonging), and their perspectives of recovery, and meanings of food, which are in flux and in a process of change (becoming).

Further justification for drawing upon Wilcock's framework is that it provides a multi-dimensional, dynamic, and situated way to conceptualise meaning (Martin, Hocking and Sandham, 2020; Berger *et al.*, 2022; Huglstad *et al.*, 2022). In addition, it is prevalently applied within OT and occupational science discourse to aid understanding of occupation (Hitch, Pepin and Stagnitti, 2014a; Hitch, Pepin and Stagnitti, 2014b) and compatible when researching occupations considered hidden or under researched (Hitch, Pepin and Stagnitti, 2014a).

Wilcock proposes occupation is more than goal directed doing, rather she argues that to understand occupation it should be valued for its meaning and how individuals feel when they are engaged (Wilcock, 1998a; Wilcock, 2006). A notion which echoed by others (Doble and Santha, 2008; Hammell, 2009b). Twinley, describing the concept of the dark side of occupation, advocates a shift from simple categorisation of occupation, to a focus on the "form, function, and meaning" (Twinley, 2021a, p. 9) of occupations to gain a richer understanding of people's expereinces.

It is this focus on the experiential aspects of Wilcock's framework which illuminate my findings and drew me to these core concepts. Hitch and colleagues assert that the dynamic of these dimensions are contingent upon personal meaning, environmental factors and occupational characteristics (Hitch, 2017; Hitch, Pepin and Stagnitti, 2018), which influence the health and wellbeing of individuals dependent upon their integration with one another (Hitch, Pepin and Stagnitti, 2018; Hitch and Pepin, 2022). This contextual and interconnected view of meaning reflects the perspective that meanings are multiple, and occupations are inherently social and culturally embedded (Eakman *et al.,* 2018).

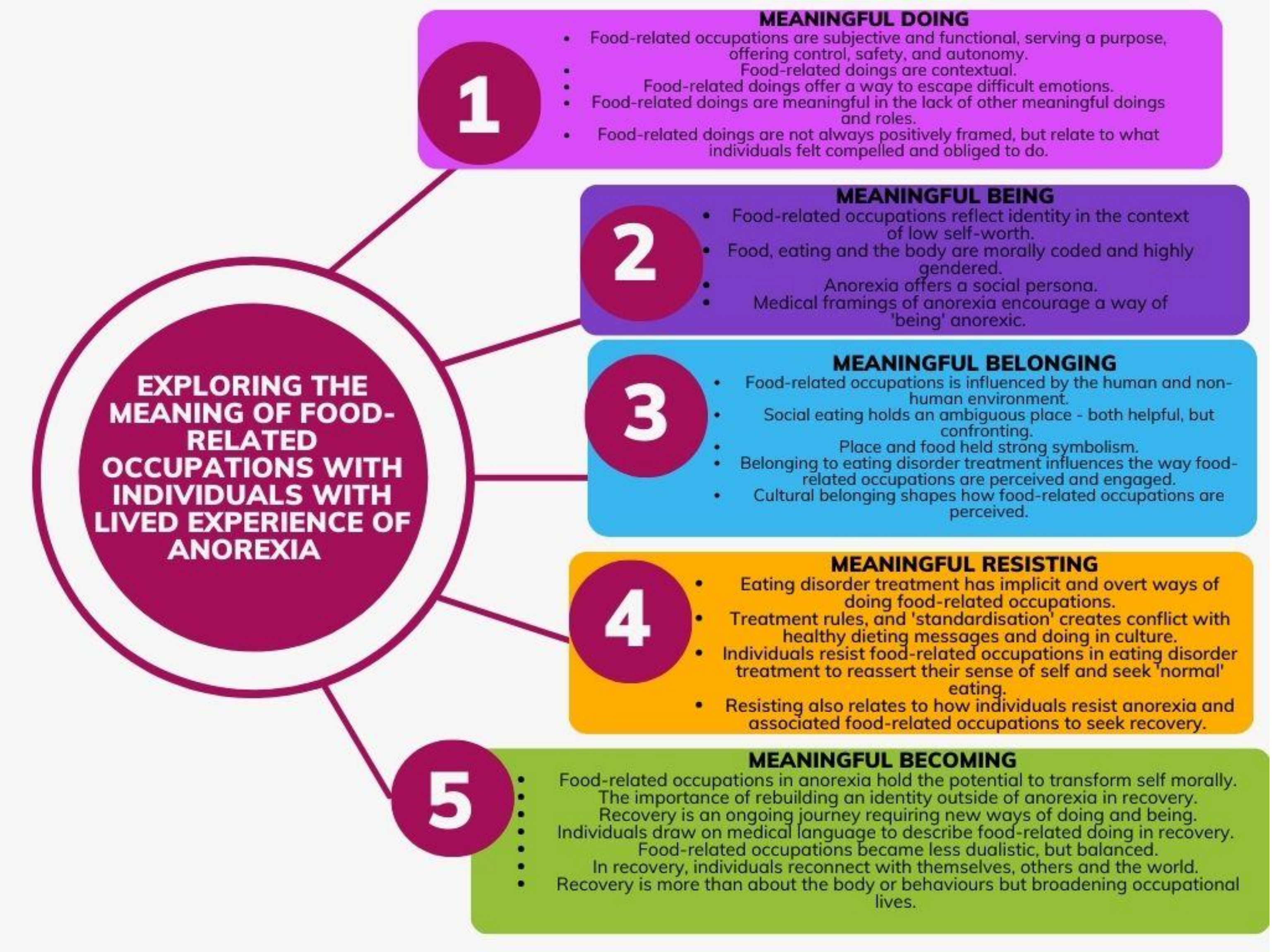
Although Wilcock's concepts are considered to continuously interweave and interact within a person's life and in their occupations (Hitch, 2017), research rarely discusses their interdependent nature (Hitch, Pepin and Stagnitti, 2014b). Although discussed separately below to support the structure and flow of the chapter, the telling and subsequent interpretation, was not as neat or linear. A quality indicator of IPA is constructing a compelling, unfolding narrative (Nizza, Farr and Smith, 2021), as such, the way in which these dimensions are presented aim to guide the reader through a story of participants' experiences.

Considering which parts of the data relate to each concept was a creative, iterative, and cyclical process. Smith, Flowers, and Larkin acknowledge there is no explicit distinction between analysis and the write up of an IPA study, stating "as one begins to write, some themes loom large, others fade, and so this changes the report" (Smith, Flowers and Larkin, 2009, p110). Gadamer (2004) considers the interpretation of meaning is a fusion of both participant and researcher's understandings. During the final write up, the interpretative process became extensive and unravelled once more, moving between participants' experiential accounts, my interpretation of these and the extant literature, reflecting the hermeneutic circle and fusion of horizons.

Participants' stories reveal how the adapted dimensions of Wilcock's framework: doing, being, belonging, resisting, and becoming, reflect a journey i.e., engagement in anorexia (doing), its association with identity (being), the impact of being-in-the-world, and influence of treatment (belonging), and how relationships with food changed in recovery (becoming). A fifth dimension, resisting, was identified. It is a discrete theme, referring to participants' resistance to food-related occupations in the context of treatment, encompassing aspects of doing, being, belonging and becoming, as well as their resistance to ED occupations in recovery. It was felt this dimension could not be compressed or dispersed into the existing framework without diluting its meaning.

It has been critiqued that Wilcock's theoretical framework is too theoretical and limited in its application to practice (Kielhofner, 2005; Hitch, Pepin and Stagnitti, 2014a). Furthermore, calls have been made to relate theory to empirical research on the personal meaning of occupation (Hocking, 2009). Therefore, this discussion will contribute to this gap, and clearly explicate the link between these dimensions with practical implications, discussed later in this chapter. The main discussion points of this chapter are summarised and presented visually in Figure 15.

Figure 15 Visual Image of Discussion



EXPLORING THE MEANING OF FOOD-RELATED OCCUPATIONS WITH INDIVIDUALS WITH LIVED EXPERIENCE OF ANOREXIA

1 MEANINGFUL DOING
- Food-related occupations are subjective and functional, serving a purpose, offering control, safety, and autonomy.
- Food-related doings are contextual.
- Food-related doings offer a way to escape difficult emotions.
- Food-related doings are meaningful in the lack of other meaningful doings and roles.
- Food-related doings are not always positively framed, but relate to what individuals felt compelled and obliged to do.

2 MEANINGFUL BEING
- Food-related occupations reflect identity in the context of low self-worth.
- Food, eating and the body are morally coded and highly gendered.
- Anorexia offers a social persona.
- Medical framings of anorexia encourage a way of 'being' anorexic.

3 MEANINGFUL BELONGING
- Food-related occupations is influenced by the human and non-human environment.
- Social eating holds an ambiguous place - both helpful, but confronting.
- Place and food held strong symbolism.
- Belonging to eating disorder treatment influences the way food-related occupations are perceived and engaged.
- Cultural belonging shapes how food-related occupations are perceived.

4 MEANINGFUL RESISTING
- Eating disorder treatment has implicit and overt ways of doing food-related occupations.
- Treatment rules, and 'standardisation' creates conflict with healthy dieting messages and doing in culture.
- Individuals resist food-related occupations in eating disorder treatment to reassert their sense of self and seek 'normal' eating.
- Resisting also relates to how individuals resist anorexia and associated food-related occupations to seek recovery.

5 MEANINGFUL BECOMING
- Food-related occupations in anorexia hold the potential to transform self morally.
- The importance of rebuilding an identity outside of anorexia in recovery.
- Recovery is an ongoing journey requiring new ways of doing and being.
- Individuals draw on medical language to describe food-related doing in recovery.
- Food-related occupations became less dualistic, but balanced.
- In recovery, individuals reconnect with themselves, others and the world.
- Recovery is more than about the body or behaviours but broadening occupational lives.

6.2 Meaningful Doing

1

MEANINGFUL DOING

- Food-related occupations are subjective and functional, serving a purpose, offering control, safety, and autonomy.
- Food-related doings are contextual.
- Food-related doings offer a way to escape difficult emotions.
- Food-related doings are meaningful in the lack of other meaningful doings and roles.
- Food-related doings are not always positively framed, but relate to what individuals felt compelled and obliged to do.

Doing refers to observable active engagement, participation and performance in occupations (Hitch, Pepin and Stagnitti, 2014a), whilst also representing hidden and latent dimensions of occupations (Martin, Hocking and Sandham, 2020). Doing is adaptable to personal circumstances (Hitch, 2017), dependent upon what is unique and meaningful to the individual (Reed and Hocking, 2013); therefore, given the subjective nature of doing, doing is not always positive or health-promoting (Hitch, Pepin and Stagnitti, 2014a; Boland, Marshall and Westover, 2021; Kiepek *et al.*, 2022b). Doing can also be impacted by external factors (Kay and Brewis, 2017), such as social norms (Berger *et al.*, 2022) and what is possible or constrained, bounded by socio-political practices, systems and structures (Laliberte Rudman, 2015; Murthi and Hammell, 2021).

Unlike dominant positionings, this study found food-related behaviours and attitudes are not merely effects of individual cognitive distortions, or maladaptive schemas – often described in quantitative literature (Legenbauer *et al.*, 2018; Simonazzi *et al.*, 2023) – rather the phenomenological insights consider food-related occupations are embodied, multifactorial, and contextual. Many participants shared experiences of objectification, trauma and low self-esteem when discussing the progression of anorexia in their lives. Within this context, anorexia and associated food-related occupations served a purpose, considered an important dimension of meaning (Petruseviciene *et al.*, 2018). These doings contribute to identities, communicate needs and are a way to adapt to life circumstances, offering power and control in lives perceived as unmanageable and uncertain. Research shows personal control and autonomy are dimensions of how meaning is formed (Hvalsøe and Josephsson, 2003; Hammell, 2009b). Although findings resonate with themes of control, meanings in this study are personally unique and contextually situated. The diverse descriptions of food-related occupations challenge the view that individuals with anorexia have a "homogeneity of disturbances in eating behaviour" (Walsh, 2013, p. 3) and draw attention to the varied subjectivities of individual doings.

The need for participants to exert control over food and eating is contextualised within their wider social and emotional circumstances. For example, becoming institutionalised during treatment and facing the prospect of a lack of meaningful doing following discharge, Kelly returned to anorexia as this was the only way she knew how to 'do'. Barbara, following the traumatic loss of her baby, considered food restriction to be a socially acceptable way of 'being', showing care and love for her lost child. Whilst control is often cited within the characterisation of anorexia (Froreich *et al.*, 2016), it is often framed as a negative quality, overlooking broader aspects of lived experience (Branley *et al.*, 2023). The dark side of occupation acknowledges human occupation is situated and always in context (Whiteford and Haddad, 2021).

Participants express frustrations when their doings around food-related occupations such as asking for a different brand of cereal at breakfast, having food allergies, or having a genuine preference for certain types of food in treatment was viewed through a medical narrative of control associated with anorexia. This draws attention to critically exploring the meaning underpinning the visible engagement of doing in EDs (Cowan and Sørlie, 2021; Dark *et al.*, 2022), and shifting focus from a control framework, which assumes anorexia as a choice or volitional (Holliday *et al.*, 2005; Bannatyne and Abel, 2015) to a contextualised view of doing and being-in-the-world. Instead of labelling engagement as a means of control, other researchers situate anorexia within individual's social and structural worlds (Eli, 2018), where anorexia is a form of coping (Williams and Reid, 2010; Branley *et al.*, 2023), and essential for survival (Lavis, 2018; Eli, 2018b). For all participants the functional aspects of doing fostered feelings of safety, certainty, and responses to fractured relationships, social expectations, or oppressive institutional constraints of ED treatment. This is echoed by other studies which use Heidegger prose to describe how anorexia is a meaningful way of "being-in-the-world" (Eli, 2015b, p. 367; Lavis, 2018, p. 456; Musolino, Warin and Gilchrist, 2020, p. 8), in the face of life stressors (Blackburn, Thompson and May, 2012; Savuskoski, Uusiautti and Määttä, 2016), tortuous emotions (Moola and Norman, 2017) or traumatic events (Lavis, 2018; Ramalho *et al.*, 2021).

Anorexia has been traditionally framed as the result of sociocultural pressures (Polivy and Herman, 1985; Wolf, 1991; Izydorczyk and Sitnik-Warchulska, 2018), with the meanings of anorexia conceptualised as passive responses to idealised thin femininity (Malson, 1999a). Participants in this study did discuss socially constructed social norms around bodies and diet; however, the meanings of food and eating provides other purposes beyond this, offering safety, identity and structure in their lives. They were critical of a privileged focus of the visual dimensions of the illness, contributing to misinterpretations and invalidation of social-emotional difficulties. These findings, like other critical writers (Bray, 1996; Lavis, 2018), challenge conceptualisations that those with anorexia are victims to media images (Bordo, 1988) and their doings are only meaningful-as-ends, attaining to a slender body. The findings of this study highlight how food-related occupations are meaningful-as-means, referring to a dynamic unfolding interaction between a person and their world (Royeen, 2002). This echoes other studies which show how the desire of anorexia is actively and autonomously engaged (Dias, 2003; Gremillion, 2003a; Lavis, 2018), and is meaningful in an individual's everyday world (Gooldin, 2008).

The doings of anorexia were found to be replete with complex emotions, providing a way to cope and escape from overwhelming and unmanageable affective states, corroborated by others (Serpell *et al.*, 1999; Nordbø *et al.*, 2006), the positive numbing qualities experienced for participants through restricting and control are similarly discussed elsewhere (Lavis, 2018). Alexithymia, the inability to identify or describe emotions, has been identified in the literature as often relating to anorexia (Gramaglia, Gambaro and Zeppegno, 2019). Research also cites a lack of cognitive insight into emotional reactions (Hasler *et al.*, 2004), and emotional avoidance relates to the physiological side-effect from malnutrition (Miller, Redlich and Steiner, 2003; Miller et al., 2009). The findings of this thesis challenge these generalisations, as participants were able to identify and clearly articulate their emotions rather their reflections showed difficulties in expressing themselves to those around them, leading to shame and secrecy, as well as from a lack of understanding in others. Other researchers identify that this may emanate from difficulties in tolerating emotions (Kolnes and Rodriguez-Morales, 2016), or the language we have available to us, which may limit self-expression (Conti, 2015), contributing to solitude (Rance, Clarke and Moller, 2016). This has implications for occupational therapists, where dominant terminology, language and concepts, as well as our own subjectivity and emotional experiences, can obscure the meanings for others (Twinley, 2021b).

The lived body and its corporeal senses such as hunger held an ambiguous place in this study. For Barbara and Jennifer hunger and appetite is something to be feared, distrusted and in need of control; however, for Maria, hunger is enjoyed, signifying her sense of control. Participants continually suppressed their desire for food and looked for other ways to satisfy their appetite through doings, such as licking but not digesting, watching others eat, or hoarding food. Narratives reveal hunger relates to internalised feelings of shame, intensified in scenarios when they felt they had lost control over their eating. These echo Turner's foundational view that "the anorexic avoids the shameful world of eating, whilst simultaneously achieving personal power and a sense of moral superiority through the emaciated body" (Turner, 1992, p. 221). There was a sense of bodily disconnection highlighted in the research between mind and body. In this study, anorexia is metaphorically described as the body symbolically fading away and disappearing, to avoid taking up too much space in the world, whilst food is described as "*tarnishing* [the] *body*" (Maria). Bates' (2015) study found the body is commonly described as an object and cage, becoming a barrier to one's true inner self (Bates, 2015). Similarly, this study found the body is something which is fought against, with participants feeling trapped within their bodies. From a feminist post-structuralist perspective, the disappearing body can be analysed as signifying child-like femininity (Malson, 1998), transcendence from the body (Malson, 1997), or produced by the post-modern condition as a signifier of female "identity put under erasure" (Malson, 1999a, p. 143). Distrust of bodily responses also resonates with Western discourses of Cartesian philosophy, assigning reason, intelligence, and selfhood to the mind, whilst the body is depicted as a threat, alien, and in need of control (Malson, 1998; Bordo, 2003).

From a phenomenological perspective of embodiment, research informs us that those with EDs can struggle to 'feel' their bodies in first person lived perspectives, contributing to an evanescent sense of identity, whereby they experience their bodies as objects (Stranghellini and Mancini, 2020). This is reflected in the findings and has implications that requires a shift from the overly dominant cognitive perspective existing in ED treatment, to recognising embodied dimensions of anorexia, acknowledging how individuals can feel alienated from their bodies and emotions (Cascino *et al.*, 2019). This requires a holistic approach in understanding doing, which involves body and mind (Dawson, Rhodes and Touyz, 2014b). Whilst mainstream treatments such as CBT challenge unhelpful thoughts concerning shape and weight concerns (Dalle Grave *et al.*, 2013), its concentration on ED symptoms and cultural focus is considered to lack attention to the complex emotional dynamics and embodied sensations involved in anorexia (Oldershaw, Startup and Lavender, 2019; Bryant *et al.*, 2022a).

Doing emerged in the context of a lack of other meaningful roles or perceived feelings of failure. Indeed, anorexia can offer feelings of mastery (Serpell *et al.,* 1999), and achieving mastery in occupation is a dimension of meaning in occupation (Roberts *et al*., 2018). However, this drew participants further into anorexia, as they felt unable to invest in other meaningful occupations leading to further allegiances with anorexia. As such, the doings of anorexia have a distinctive effect on role formation, as found in other research (Dahlborg Lyckhage *et al.*, 2015). Participants felt unsettled with inactivity and used productivity (exercise or general busyness in their place of work) to justify eating, revealing anorexia can lead to occupational imbalance - discrepancies in the balance of occupational engagement impacting wellbeing (Wilcock, 2006). Previous literature identifies occupational imbalance in anorexia as a need for productivity (Gardiner and Brown, 2010) and distorted body image (Clark and Nayar, 2012a). These references tend to place occupational imbalance within the control of the individual, discounting the language and practices shaping productivity embedded within Western culture, which overvalues achievement and self-improvement (Musolino *et al.*, 2015).

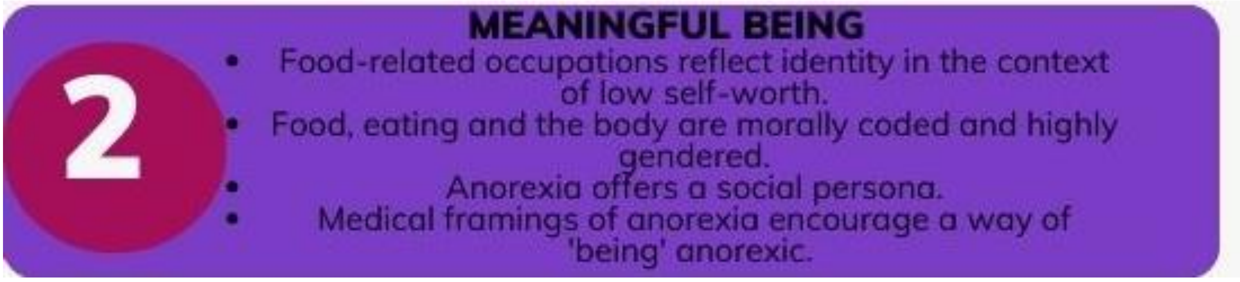
The personification and embodiment associated with food-related occupations reveals doings with food and eating are more than the physical and material negotiations but reflect the wider experience in which eating occurs, including the context, environment, and influence of others. Participants desire to set themselves apart from food, and be perfect could be viewed as acceptable within the sociocultural representations of food and eating in Western society, where food represents a threatening temptation, which must be kept outside of bodily boundaries (Malson, 1998; Warin, 2010; Lavis, 2011a; Lavis, 2013). Yet food is inescapable and unavoidable, it is embedded within everyday life, mapped on to places and environments, and part of belonging and relatedness (Warin, 2006). Participants describe feeling out of place and uncomfortable in the presence of food or even speaking and thinking about food. Kristeva's (1982) seminal psychoanalytical notion of abjection has been studied in relation to anorexia (Warin, 2003; Warin, 2010; Woolridge, 2021), a theoretical term used to account for the subjective horror when confronted by the breakdown between self and objects/other. Abject, describes what occurs outside of the symbolic order, what disturbs one's sense of order and identity. In this study, Barbara explains the horror of being confronted by food debris in the sink and food stored in the fridge.

Whilst Maria describes revulsion in her body after binge eating and Katie describes the disgust of her brittle appearance, yet also a sense of pride in her emaciation. There appears a continued oscillation between experiencing disgust, and pride in the body; reflective of Kristeva's (1982) understanding of abject encounters which incite both repulsion and fascination. These embodied reactions show meanings are far more than a desire to lose weight, but echo Merleau-Ponty's (2005) view that our bodies are vehicles for experiencing and being-in-the-world.

Doing relates not only to what individuals want to do, but what they feel obliged to do (Wilcock, 1998c). In this research, compulsions to act were so engrained, they were described as routine and normal, and change felt incomprehensible. Heidegger describes how our everyday engagement with the world is performed without reflection: so immersed are we in being-in-the-world, that we become unconscious to the ready-to-hand (Heidegger, 2001). Participants describe taken-for-granted doings, which were only brought into question when being with others, or a change in environment such as a hospital admission. This focuses attention on what may be considered ordinary and routine; revealed through doing. An approach resonating with the role of OT in Eds, which focuses on action-orientated doings to uncover difficulties (Devery, Scanlan and Ross, 2018). Unlike their MDT psychological-focused counterparts whose focus often concerns reflecting on difficulties., occupational therapists focus on action-orientated doings to uncover difficulties (Devery, Scanlan and Ross, 2018).

Yet, doing is not always positive; as expressed in previous studies (Colton and Pistrang, 2004; Reid *et al.*, 2008), participants' experiences of food-related engagement and anorexia were fraught with ambivalence. They consider anorexia provides safety and is functional, yet also acknowledge it is controlling in nature. The sub-theme in the findings - 'the push and pull of the doings of anorexia' - echoes the collective experience amongst participants around the conflict, battle, and multiplicity that anorexia offers, and their non-linear experiences of recovery. These findings are in line with previous research which discuss the simultaneous and shifting experiences related to food and eating for those with anorexia (Lavis, 2018), contributing to ambivalence (Warin, 2010; Williams and Reid, 2010) and how this affects hopes for recovery (Higbed and Fox, 2010).

6.3 Meaningful Being



2

MEANINGFUL BEING

- Food-related occupations reflect identity in the context of low self-worth.
- Food, eating and the body are morally coded and highly gendered.
- Anorexia offers a social persona.
- Medical framings of anorexia encourage a way of 'being' anorexic.

Our identities are considered closely tied to what we do (Christiansen, 1999), with our doing informing our sense of self and our being (Martin, Hocking and Sandham, 2020). Being is also associated with wellbeing, providing a sense of purpose and meaning (Hitch and Pepin, 2021). Although often commonly associated with agency and choice, being is also determined by our relationships and belonging with others (Lyons *et al.*, 2002; Hansson, Carlstedt and Morville, 2022).

As others illuminate, anorexic subjectivities in this research were closely entwined with identity and one's sense of self (Rich, 2006; Williams and Reid, 2010; Bryant *et al.*, 2022a), acting as a source of self-definition and functioning as a meaning-making framework guiding behaviours (Espíndola and Blay, 2009; Jenkins and Ogden, 2012). Food-related engagement became embodied and symbolic of being and doing anorexia, echoing literature, identifying food as central to identity (Ulian *et al.*, 2013); a way to embody one's values (Banks, 1992; Orsini, 2017) and eating is not just physiological, but metaphorical and meaningful (Eli, 2015b; Lester, 1997).

From a psychoanalytical and development perspective, Bruch (1973) seminally described anorexia as a "desperate struggle for a self-respecting identity" (p.250), emerging from a lack of self-definition in adolescence; which recent research corroborates (Stein and Corte, 2007; Biberdzic, Tang and Tan, 2021). Many participants recount the development of anorexia and difficulties with food during early life experiences, whereby anorexia became a source of identity, making food a source of conflict. Engagement in occupations, can become self-defining (Garci and Mandich, 2005) outside of other negative labelling (Eidevall and Leufstadius, 2014). However, anorexia became self-perpetuating, as the more entrenched participants became with the illness, the more they felt they felt out of sync with their being. It is well established that adolescence can represent a turbulent and challenging period, marked by a number of physical changes, giving rise to feelings of insecurity (Verschueren *et al.*, 2018). Bruch (1973) observed individuals with anorexia manifest difficulties in accurately perceiving and interpreting stimuli arising in their bodies, such as hunger. The findings of this research reveal how anorexia is utilised as means to control bodily signals and the development of the body, representing a sign of adulthood, which carries responsibility and change. From a CBT perspective, the anorexic identity relates to negative self-schema and poor self-esteem (Skårderud, 2007; Dahlborg Lyckhage *et al.*, 2015). Similarly, the findings in this research identified anorexia occurred against a backdrop of poor self-competence and low self-worth.

Feminist post-structuralist theory considers cultural pressures conflict with women's ability to develop an identity, necessitating dependence upon feminine ideals to cope with a lack of authentic self (Malson, 1998). Douglas' (1982) analysis of the body, considers the body symbolic of "social meanings" (Douglas, 1982, p. 1); thus, bodies cannot be understood outside of its social and historical context (Musolino *et al.*, 2020). Participants in this study describe internalising Western cultural meanings attached to slenderness, exercise, and restrained eating – desirable qualities, signifying self-discipline, morality, and health (Woolhouse *et al.*, 2012; Orsini, 2017). Participants' accounts also reveal how food and bodies were tied up in feminine constructions. Feminists have long situated EDs within gendered cultural practices around food and eating (Malson, 1998; Bordo, 2003) where overcoming hunger conforms to notions of femininity, and annihilation of bodily needs (Banks, 1996; Musolino *et al.*, 2015; Orsini, 2017).

Anorexia is considered to offer a social persona (Bryant *et al.*, 2022a) and functions as a social identity (McNamara and Parsons, 2016). The anorexic identity is embedded and reinforced within social interactions becoming validated through communicating and gaining belonging from others (Eli, 2015a; McNamara and Parsons, 2016). In this research, where language failed, actions through eating or not eating were sought to demonstrate to others the legitimacy of internal pain and suffering. The body here is morally symbolic, where becoming smaller, represents participants' values and sense of being, and offers a means of interacting and communicating. Yet this became problematic in recovery, as participants describe pressure to continue to conform and 'be' the anorexic identity, struggling to set themselves from being permanently marked as Othered, similarly described elsewhere (La Marre and Rice, 2015). This highlights how meaning relates to socio-cultural identity (Roberts *et al.*, 2018). Indeed, Hansson et al. (2022) identifies how occupational identity is influenced by social and cultural norms, and how not meeting perceived standards for being can bear negative implications.

Identities were further problematised by medical expectations about what anorexia should ‘be’ and look like. The biomedical framing and language of anorexia has implications concerning how individuals construct their identities (O'Connell, 2023; LaMarre and Rice, 2021b). Participants felt they did not qualify for support based on their physicality, which gave them a sense of permission to continue in their anorexic-related doings. This is summed up in Barbara’s comment, labelling herself a ‘high functioning anorexic’, which saliently touches on the paradoxical embodiments for many participants in this study who drew on socially sanctioned and collective ideas about productivity and being ‘high functioning’ whilst ‘being’ anorexic. This paradox is also reflected by Musolino and colleagues’ studies (2015, 2020) who use the term ‘healthy anorexia’, to refer to the idea how individuals can perceive themselves healthy whilst maintaining disordered eating.

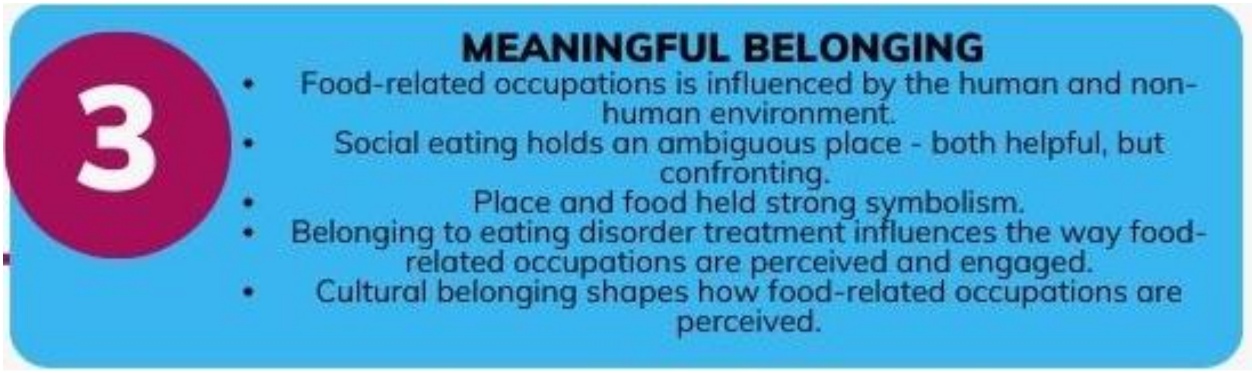
The diagnostic label of anorexia is considered to carry expectations of subjectivity which limit self-expression outside of its narrow boundaries (Malson *et al.*, 2011; Churruca *et al.*, 2020). Stereotypes of what it means to be anorexic influenced participants’ sense of self, contributing to a delay in help-seeking, as well as pessimism in their own recovery. Findings highlight anorexia is often associated with the physical attribute of being underweight and not necessarily other behaviours and occupations which co-exist alongside (Eiring, Hage and Lynn Reas, 2021). Participants felt undeserving of the esteemed title of anorexia, motivating them to lose more weight, to access support and gain validation. Some participants express the need for a diagnosis; to be “the best anorexic”, echoing other research which shows how anorexia can be desired (Lavis, 2011b; Eli, 2015a; O'Connell, 2023). However, this striving was fraught, as Lavis’ (2011) ethnographic analysis recognises, as central to being a ‘good anorexic’ is maintaining bodily thinness, which for participants in this study led to ontological anxiety, expressing feeling “fraudulent”, with weight gain undermining their identity. Diagnostic dynamics on identity, which carry certain clinical signifiers (Halse *et al.*, 2005) can lead to continued self-monitoring to do anorexia well (O'Connell, 2023). These findings echo wider conversations in the field of EDs to move away from a sole focus of weight and shape to understand underlying experiences and emotions (Rance, Moller and Clarke, 2017; Joyce *et al.*, 2019). Indeed, participants’ accounts reveal discord between body and mind, where the physical status of bodies did not always match their psychological wellbeing. The focus on surface physical features of anorexia have been discussed in the literature resulting in overlooking emotional and psychological distress (Rich, 2006; Bardone-Cone, Hunt and Watson, 2018). These findings support the importance of considering anorexia from a phenomenological view given the interconnectedness of body and mind situated in context (Merleau-Ponty, 2005), in contrast to medical views of anorexia, which reinforce objectification through a focus on the body (Burkitt and Sanz, 2001). It is argued that clinicians equipped with a phenomenological understanding of experience may be able to empathetically understand bodily experiences during illness and receiving healthcare treatment (Fernandez, 2020).

There appears to be a multi-layered experience in relating to anorexia, where participants describe shame, low self-worth, and the deleterious bearing of anorexia on other facets of their lives but also the sense of achievement and pride it offers. This led to confusion and dichotomy of both being inside and outside of anorexia (Eli, 2015a; Lavis, 2011b). Whilst participants positively relate to anorexia, they also problematise being totalised with the disempowering labelling and diagnosis of anorexia. Conti and colleagues' (2020) meta-synthesis found anorexia is experienced as both an identity investment and troubling entrapment (Conti *et al.*, 2020). Participants express frustrations when their being was imposed with common understandings and assumptions of anorexia. These findings, like others in the field (Lester, 2019; Holmes, Malson and Semlyen, 2021), call attention towards the negative terminology used to describe individuals with anorexia, including being devious, dishonest and manipulative (Rich, 2006; Dimitropoulous *et al.*, 2016; Lester, 2018). Such concepts negatively impact individuals with EDs and their families (Asaria, 2023). Findings resonate with recent controversies in the field of ED revolving around the term 'terminal anorexia nervosa' (Gaudiani, Bogetz and Yager, 2022). A criterion applied to those with anorexia, over 30, who have received high-quality care and have decision making capacity to refuse treatment, ultimately meaning accessing palliative care to die. Others contend such labelling is inherently dangerous, reduces hope (Asaria, 2023), and overlooks that EDs are treatable (Mack and Stanton, 2022). The findings from this doctoral research suggests that clinicians move away from negative and stigmatising labelling and instead ensure ethical reasoning is maintained when considering occupations of the illness, which despite being health-compromising may hold meaning for the individual (Greber, 2021).

When participants journeyed into recovery, they discussed the need to find themselves and understand their authentic voice. This aligns with previous work which considers recovery is possible when individuals relinquish the illness identity and form a new, but equally, meaningful recovery-orientated identity (Federici and Kaplan, 2008; Espíndola & Blay, 2009).

This identity re-development was diverse, some described that through doing they gained greater insight into their sense of self and who they wanted to become. For others it was being vulnerable and facing emotions, offering greater connection to themselves, and belonging with others. These findings highlight the inter-related connection between doing, being, becoming and belonging (Hitch and Pepin, 2021). However, this was not a straightforward process, as expressed in other studies (Fox and Diab, 2015b), individuals experienced the dilemma of giving up an identity rooted in anorexia, leading to an internal battle and existential questioning. Rankin et al's (2023) study identifies that as individuals negotiate a period of change in recovery, they move through a phase of liminality of being "betwixt and between" (Turner, 1974, p. 232); no longer identifying who they were dominated by the anorexic identity, and not yet who they are to become. Therefore, within this waiting, it is important that occupational therapists hold onto hope for individuals, demonstrating patience, and perseverance. Findings also indicate recovery requires a whole change in self, which means adopting a holistic perspective of being, which is in keeping with reports that only improving weight is insufficient in effecting emotional or long-term change (Haynos *et al.*, 2014).

6.4 Meaningful Belonging



3

MEANINGFUL BELONGING

- Food-related occupations is influenced by the human and non-human environment.
- Social eating holds an ambiguous place - both helpful, but confronting.
- Place and food held strong symbolism.
- Belonging to eating disorder treatment influences the way food-related occupations are perceived and engaged.
- Cultural belonging shapes how food-related occupations are perceived.

Wilcock (1999) defined belonging as acceptance and interpersonal connection. It refers to our sense of connectedness to communities, places, cultures, and the context which occupations occur (Hitch, Pepin and Stagnitti, 2014a). Belonging and connections with others can support understanding of who one is, related to our sense of being (Martin, Hocking and Sandham, 2020). Belonging can behold positive meanings, offering connection, contribution to others, and health-enhancing (Hammell, 2014; Roberts *et al*., 2018); however, belonging is mutable, and not always a positive experience (Blank, Flinlay and Prior, 2016).

In this research, food-related occupations are more than individual acts, they are relational, influenced by the human and non-human environment. These findings echo how food in OT literature and its meaning are contextually positioned (Hocking, Wright-St Clair and Bunrayong, 2002; Shordike and Pierce, 2005; Absolom and Roberts, 2011) deeply connected to emotions, symbolism, and roles (Howe, Hinojosa and Sheu, 2019), powerful in maintaining traditions, fostering relationships, and connections, and enhancing meaning in everyday life (Crepeau, 2015; Plastow, Atwal and Gilhooly, 2015). In the context of EDs, occupational therapists have a unique understanding of the contextual dimensions of food-related engagement, contrasting to how food is medically positioned in the literature (Arnaiz, 2009).

Research informs us that individuals with anorexia have smaller social networks (Doris *et al.*, 2014), and experience social and interpersonal functioning difficulties (Schmidt and Treasure, 2006). Through a focus on food-related engagement the findings resonate with this, where food-related occupations are preferred to be engaged alone, and how the monopolising focus on food-related engagement and all-encompassing nature of anorexia prevents the development of intimate connections. However, belonging, held multifactorial meanings of both yearning for social acceptance and connectedness, but also distancing and distinguishing self away. It is considered avoidance of social connectedness, may be driven by fear and discomfort of perceived loss of control (Cain *et al.*, 2010), and fears of abandonment (Gonçalves *et al.*, 2021). Participants report treatment further obstructed their social life, echoing previous qualitative reports (Kyriacou, Easter and Tchanturia, 2009; Patel, Tchanturia and Harrison, 2016). Recovery in this research was not individualised, but dependent upon social and professional support following intensive ED treatment and feeling connected to others; resonating with the notion that recovery takes place in the broader context of one's life, inevitably impacted by wider systemic factors (La Marre and Rice, 2015; Kenny and Lewis, 2023).

In clinical literature, the maintaining mechanisms of EDs are often situated at an individual level (McNamara and Parsons, 2016) where therapy supports the development of positive self-schemas in the individual (Stein *et al.*, 2013); neglecting the social context in promoting recovery (Malson *et al.*, 2011; Foran, O'Donnell and Muldoon, 2023). In this research, eating with others who positively influenced their relationship with food was essential, whether that be through healthcare professionals, romantic relationships, friendships, or family. It has been found positive role models play a crucial role in supporting recovery (Kästner *et al.*, 2021) and enhancing motivation (Venturo-Conerly *et al.*, 2020). This challenges how meal support is offered in ED settings, where meal planning and eating are structured occasions, and where all control is removed (Aradas *et al.*, 2019).This research, including that of other researchers consider that choice, flexibility and control can be offered even in restrictive settings (Long *et al.*, 2012a; Duzyk, 2022).

Social eating, that is co-occupations where individuals eat whilst participating in social situations (Duzyk, 2022), held mixed experiences in this study. Some discuss uncertainties and fears and observing others eating "normally" was an unsettling phenomenon, bringing to light the rigidity of their own eating patterns. Whilst others describe the pleasure of watching others eat, demonstrating their ability to withhold their desires and 'be' with anorexia. Nevertheless, in all accounts, there is a recognition and need for practical social eating experiences. Research indicates exposure to others' eating increases consumption and a willingness to accept unfamiliar foods (Mura Paroche *et al.*, 2017), and peer support can be helpful (McNamara and Parsons, 2016), counteracting the stigma attached to EDs (Linville *et al.*, 2012). Despite this, social eating is often omitted from ED treatment or relegated towards the end of treatment (van Ommen *et al,* 2009; Bakker *et al,* 2011), creating difficulties in managing a return to normal eating (Boughtwood and Halse, 2008). From the findings, it appears certain conditions are required to support comfortability around social eating and greater inclination to participate, including non-judgement, conversations which are absorbing and flow, and having choice. These findings therefore acknowledge the importance of what belonging means to individuals and adapting this to their stage of recovery.

Despite the motivational aspects of belonging, familial relationships were in some cases barriers to food-engagement; as reflected in research (Moola and Norman, 2017; Cheney, Sullivan and Grubbs, 2018). Indeed, from a theory of family systems, an individual cannot be understood without referring to their connections within the family context (Selvini Palazzoli, 1963/1974). Findings from the research, that even from an early age, family relationships became "tangled up" in their engagement with food echoes Lester's comments that EDs "do not exist *within* people, but emerge *between* people" (Lester, 2018, p. 523). Research indicates that even before infants are pre-verbal, they learn to associate food with emotions (Carper, Orlet Fisher and Bircher, 2000). For those with anorexia, food can offer a way to communicate needs (Serpell *et al.*, 2004), yet communicating through food in this study only led participants further away from connection with internal states. From a phenomenological perspective of embodiment, alienation from one's own body and emotions, can impact social interactions (Cascino *et al.*, 2019), affecting secure intimate interactions and increasing difficulties with social cognition (Monteleone *et al.*, 2017).

Several participants specifically discuss the harms of maternal self-criticism and observations of female family member's engagement with food. Although families do not cause EDs (Lock *et al.*, 2001), there is evidence to show how certain family dynamics and characteristics are potential risk factors in the development and maintenance of EDs (Schmidt, Humfress and Treasure, 1997; Patel *et al.*, 2002; Del Casale *et al.*, 2022), and maternal comments regarding body shape are associated with higher risk of eating pathology (Chow and Tan, 2018). Sarah, on the other hand, contests this assumption, denying any familial influence on her eating patterns, demonstrating the convergence and divergence that exists in family experiences.

Research indicates that individuals with EDs can feel alienated from families and friends (Rich, 2006; McNamara and Parsons, 2016). Participants discuss that others assume their difficulties with food were attention seeking or within their own control, which led to defensive and secretive behaviours, contributing to stress, conflict, and loneliness. However, eating in contexts where participants could craft an identity outside of the assumptions of the ED were freeing. This echoes the social coding of EDs as an object of fascination and confusion (Warin, 2004). Participants describe creating opportunities for new social belonging during recovery, such as moving area, belonging to church, or university. These new connections were supportive as no one identified them as a person with an ED history.

Relationships in recovery are often positively framed in the findings, helping shift the focus away from self and food to others and the world around them. This focus shift enabled participants to be in the moment, providing a context of acceptance and comfortability to challenge themselves. Research suggests supportive relationships (Wetzler *et al.*, 2020) and positive interpersonal experiences, such as strong relational ties (Dawson, Rhodes and Touyz, 2014a), are essential for recovery, and the need to promote social integration early in treatment is recognised (Nunez, 2019). Therefore, clinicians and occupational therapists may consider embedding recovery in supportive groups and networks to foster positive social connections.

The dynamics of belonging with other patients held mixed and complex experiences. Some outline the toxicity of belonging and eating with other patients at mealtimes, contributed to learning negative food behaviours; a finding reflected in other research (Colton and Pistrang, 2004). However, others found community and comradeship replaced the solitude of the ED with mutual understanding. Participants often discuss food-related behaviours in a collective-sense, assuming an insider knowledge of being and doing anorexia. Belonging to ED communities can offer a "shared way of being-in-the-world" (Eli, 2015a, p. 5) through embodied and shared practices (Rich, 2006). Some discuss the fear and horror of seeing anorexia in others, resulting in a need to protect, and set themselves apart. Belonging with others with EDs simultaneously fosters identification, and affirms anorexic identities, but participants also sought disconnection, seeking to distinguish self away from the dangers of belonging; as discussed by others (Rich, 2006). Participants' experience of themselves and their body shifted in treatment, through the gaze of others, where their lived body turned into the body as object. This draws attention to the phenomenological concept of the lived body-for-others, as explicated by Sartre (1969), describing apprehending our body from another vantage point. In some cases, viewing anorexia in others helped to externalise anorexia from self, contributing to compassion; however, in other cases it contributed to fear and disgust.

For many participants, food itself was not always anxiety provoking in inpatient treatment, but the wider context of group dynamics. This highlights that although food may appear be the source of distress, it is what is happening around the person in the environment, which needs to be addressed. Unlike other health professionals, occupational therapists have a particular focus on the environment (Baum, Christiansen and Bass, 2015), and meaning-making is considered to be contextualised, located in time and place, and influenced by human and physical environments (Mello *et al.*, 2021).

Cultural belonging also affects the way food-related occupations are experienced. Participants discuss disempowering and objectifying cultural forces contributing to the development of anorexia, including pervasive feminised body ideals promoted by mainstream media and diet-culture. Feminists writers highlight concerns about the scrutiny and sexualisation of the female body (Malson, 1998; Saukko, 2008). From this perspective, we can see how disordered eating arises from a background of objectification and body shaming. Malson and colleagues (2007) argue health policies characterise the values and concerns of EDs, and are re-articulated in terms of neo-liberal, individualised responsibility for health, equated with 'correct' body weight (Malson, Clarke and Finn, 2007). However, these influences in the study were not always obvious, tied to conventional dieting messages, but subtly normalised within everyday life, such as skipping meals, exercise, and diet. Therefore, this calls attention to the everyday activities, and how these may be culturally coded.

Musolino et al. (2015), borrowing Bourdieu's (1977) concept habitus - referring to the internalised social and cultural ideals of a particular group which contribute to their shared world-view - re-termed it as 'healthism habitus', to describe how those with EDs make choices around food to conform to the dominant habitus, which have social significance and value. The habitus described by Bourdieu reproduces itself and its subjects through socio-cultural conditions through which individuals relate to one another and becomes a self-perpetuating system (Bourdieu, 1977). Similarly other post structuralist thinkers, such as Foucault (1979) theorise operations of power in modern societies do not come from direct force but operate subtly on 'docile bodies', where individuals internalise moralising messages by engaging and conforming to what is considered normal, such as adopting normative behaviours around food, weight and health (Halse, 2009; Hepworth, 1999). In the context of a desire to belong, engrained notions of a good work ethic and productive doings in this study influenced participants' relationships to food and eating, such as valuing work and not having breaks, providing a legitimate reason for not eating. Participants also discuss of common cultural practices such as clean eating, a movement emphasising the consumption of "pure" and healthy foods, widely propagated through social and popular media, considered to increase the risk of EDs (Ambwani *et al.*, 2019), as well as following healthy eating to restrict food groups. These meanings turn attention to collective ideas of morality, citizenship and following healthy lifestyles (Crawford, 1980; Hepworth, 1999), which influence food-related engagement and what is considered "normal" eating.

Many participants describe pursuing recovery yet caveated these statements with aiming to eat "healthy, nourishing food". Writers note discourses of health legitimise oppressive practices that individuals engage with to achieve cultural standards of beauty and health (Bordo, 1988; Crawford, 2006). The paradox in the findings, is that although participants describe dieting as negative, they equally pursued what is considered healthy, and labelled foods as "good" and "bad". It appears "balanced" and "healthy" food-engagement are justifiable and common-place frameworks to view food, and a way to belong, which can be unchallenged by the dominance of their place in culture. This underscores the tension of participants belonging to the ED and society but also to recovery.

6.5 Meaningful Resisting

4

MEANINGFUL RESISTING

- Eating disorder treatment has implicit and overt ways of doing food-related occupations.
- Treatment rules, and 'standardisation' creates conflict with healthy dieting messages and doing in culture.
- Individuals resist food-related occupations in eating disorder treatment to reassert their sense of self and seek 'normal' eating.
- Resisting also relates to how individuals resist anorexia and associated food-related occupations to seek recovery.

Alongside doing, being, becoming and belonging, a fifth dimension of resisting is discussed, incorporating elements of doing, being, becoming and belonging. This dimension relates to how occupational engagement within treatment was in particular cases resisted and subverted to assert participants’ sense of self, and also how occupations related to the ED are resisted to pursue recovery.

Although ED services profess to normalise eating patterns, participants describe how treatment programmes intensified their ED through surveillance, and an overt and harmful focus on food, shape, and weight. Feminists have interpreted ED treatment through a Foucauldian perspective, which encourages body discipline and control and replicates broader societal idealisations of femininity and individuality (Gremillion, 2002; Gooldin, 2002; Holmes, Malson and Semlyen, 2021). Whilst some found relief and safety from their admissions, as well as medical legitimacy of their difficulties, as corroborated in other research (Rich, 2006; O'Connell, 2023), others found inflexible treatment regimens became a hurdle in the long-term, inadequately preparing them for life outside of hospital. These findings have been identified in other qualitative research, where treatment, although protecting individuals from outside stressors, acts as a bubble and abnormal space (Smith *et al.*, 2016), negatively impacting on relationships and occupations (Rienecke *et al.*, 2023), and exacerbating interpersonal difficulties (Fox and Diab, 2015a).

This brings attention to occupational injustice concepts including occupational alienation, defined as isolation, powerlessness and estrangement from society or self, resulting from engagement in occupations that do not satisfy inner needs (Wilcock, 2006). This is reflected in participants’ comments around tedious routines where they were “*couped up*”, and isolated, increasing pre-occupation with food and eating, and an ongoing need for the safe routines of the ED.

Passivity in treatment also highlights occupational imbalance, due to participants' occupational patterns being under-occupied, enforcing "idleness" (Hocking, 2017, p. 33). These findings have strong implications for occupational therapists, as petitioned by participants in this study, to have a greater opportunity to engage in meaningful food-related occupations in their own communities.

Participants express feeling demeaned by healthcare professionals who reduced their illness to strict adherence to diet regimes, prioritising normative body weights and physical markers over the complexity of their illness and their 'being'. Research suggests the body takes centre stage in ED treatment (Lester, 2019; Gustafsson et al., 2021), disqualifying and silencing the voice of individuals (Saukko, 2008; Holmes, Malson and Semlyen, 2021), at the expense of psychosocial factors (LaMarre and Rice, 2021b). Treatment's positioning of food creates conflicts outside of the treatment context, where food restriction is normalised through 'healthy' dieting messages and doings, as described by others (Malson, Clarke and Finn, 2007). Participants felt set apart from the rest of the world, contributing to feelings of not belonging, expected to eat 'sickening' amounts of calories, and obscene potion sizes. Aware of the consequences of refusing, resulted in resentment, describing themselves shifting between mechanical and robotic engagement, to eating out of sheer panic. Duzyk (2022) cautions a submissive position impedes long-term recovery by conditioning individuals to associate eating with fear of external consequences. This in turn made participants question and doubt the care surrounding food and eating from healthcare professionals, creating distrust and apprehension to fully engage. Participants sought "real world" experiences, and support from friends and families to model eating and find out what "normal" eating truly is. Paradoxically, treatment was the antithesis to normalised eating whilst everyday environments counteracted this, offering opportunities to learn how to be with food again. Pepin (2021) notes recovery happens in real-world everyday contexts, and it is in these environments that occupational therapists can best identify strengths, support skill development, and adjust environmental factors to promote participation. Therefore, highlighting the importance of the role of occupational therapy within community-based interventions (Clark and Nayar, 2012).

The sub-theme 'medicalisation of food conflicts with normality' identifies the overt or implicit expectations on the "correct" way of doing recovery and engaging with food, which for some did not match the spontaneity of life, or individual needs.

Researchers highlight there are narratives on how to be recovered in Western ED treatment, including dictates and performance standards on how to eat (Malson, Clarke and Finn, 2007; La Marre and Rice, 2015; LaMarre and Rice, 2021b). Often meal support and eating in treatment can lack cultural appropriateness (La Marre and Rice, 2015; Halbeisen, Brandt and Paslakis, 2022), or meet individual needs (Viljoen *et al.*, 2022; Field *et al.*, 2023). However, there is divergence in accounts, Fiona for example discusses how treatment normalised her approach to food and eating as during her childhood her mum was always on a diet; thus, she felt out of touch in knowing how to eat. It is also worth noting that meanings were multiple and shifting, with participants acknowledging the need for medical intervention to save life. Therefore, it is of importance to understand "There is no one way to do 'recovery'" (Kenny *et al.*, 2023, p.3).

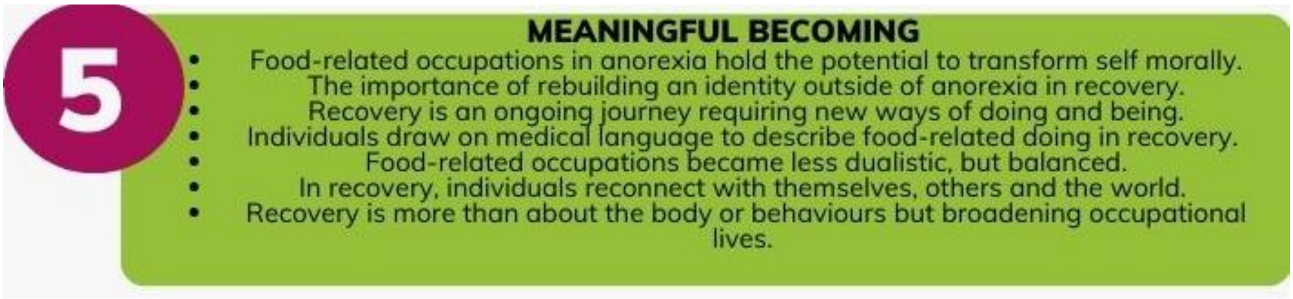
Participants felt treatment rationales were largely unexplained and de-individualised, often described as “punishment”, where they felt “tricked”, “blackmailed”, and “traumatised”. Therefore, resisting is not an individualistic doing, only related to the ED, but contextualised within therapeutic relationships and context (Abbate-Daga et al., 2013). As Foucault (1978) famously stated “where there is power, there is resistance” (Foucault, 1978, p. 95). Resisting treatment, through brief compliance, allowed participants to remain intact with their sense of being and provide a sense of autonomy in environments where they had little control or autonomy. Feminist scholarship challenge what is perceived as ‘resistance’, arguing treatment represents regimens of control and disciplinary environments (Gremillion, 2003a; Bell, 2006; Lester, 2019) and have criticised “assumptions that patients should submissively acquiesce to the authority and expertise of medicine” (Boughtwood and Halse, 2010, p.84). Hence, feminists view resistance as legitimate responses to disempowering and unethical practices (Lester, 2019). Research shows choice and autonomy in treatment is limited, with patients faced with the option to either comply or risk being pathologised as treatment resistant (Holmes, Malson and Semlyen, 2021). Several studies highlight when control is enforced, it can lead individuals further into the doings of the ED to maintain their sense of self and gain personal control (Warin, 2006; O'Connell, 2023). Although the merits of lenient approaches in ED treatment have been discussed 40 years ago (Touyz et al., 1984), there is little evidence to suggest these findings have been developed into current practice, and disciplinary approaches still dominate today (Holmes, Malson and Semlyen, 2021).

Negative terminology is often used in relation to EDs (Branley-Bell *et al.*, 2023). Where individuals are described as "manipulative… secretive, dishonest, sneaky… sly" (Lester, 2019, p. 290). The "perceived manipulative behaviour" of individuals is also held by occupational therapists (Klockzo and Ikiugu, 2005, p. 72). A key theme in the research was how participant's occupational engagement was reduced or attributed to the ED. This simplistic and reductionist view contributed to disengagement and distrust and highlights the importance of person-centred approaches in ED care, which acknowledges the heterogeneous nature of lived experience (Reay *et al.*, 2022).

Despite most recounting negative experiences, some discuss positive encounters, where change occurred within trusting therapeutic contexts where they were recognised as individuals and empowered by choice. Similarly, Joyce et al. (2019) found individuals with long-term experiences of EDs desired to work alongside services to optimise care for themselves. In this study, negative experiences of treatment were not relegated to individual practices but the whole system and culture of care. Therefore, if wider structural change does not occur within healthcare services, such as enhancing compassionate approaches, meaningful collaboration with service users is thwarted.

Alongside what is visible, doing includes mental and spiritual aspects (Wilcock, 2006). In the context of this study, doing in recovery reflects internal battles of resistance, as participants defied anorexic-related doings. Resisting anorexia included negotiating ED thoughts during mealtimes, making small everyday actions such as adopting healthy structures and routines, sharing meals with loved ones, and taking a critical step back to re-evaluate doings. This echoes Roberts and Skipsey's (2021) findings where recovery is not necessarily attributed to treatment protocols, but strategies and occupations embedded into one's everyday life. Doing recovery is an occupation, considered to be a "full time job", requiring space and time apart from the busyness of modern life. This challenges traditional OT interventions in ED practice, which priorities productive and Western notions of doing to support recovery, rather findings suggest clinicians should promote other dimensions of occupation such as play, leisure and rest (Gardiner and Brown, 2010). Furthermore, it echoes consideration of how withdrawal from life a beneficial choice for may be some when overwhelmed by personal circumstances, and not necessarily a sign of distress (Blank, Flinlay and Prior, 2016).

6.6 Meaningful Becoming



5

MEANINGFUL BECOMING

- Food-related occupations in anorexia hold the potential to transform self morally.
- The importance of rebuilding an identity outside of anorexia in recovery.
- Recovery is an ongoing journey requiring new ways of doing and being.
- Individuals draw on medical language to describe food-related doing in recovery.
- Food-related occupations became less dualistic, but balanced.
- In recovery, individuals reconnect with themselves, others and the world.
- Recovery is more than about the body or behaviours but broadening occupational lives.

The concept becoming relates to continual development and growth, as individuals change, develop and progress through life (Wilcock, 2006; Hitch, 2017). This growth is determined by goals and ambitions of the individual, which may adapt over time (Hitch, Pepin and Stagnitti, 2014a). Hammell (2004) describes becoming as an existential journey, referring to the notion that individuals envisage a future self, what they want to do and who they want to become.

In the context of anorexia, participants discuss how food, or the absence of food, held the potential for transformation which is morally and culturally defined. By not eating or avoiding certain foods, participants felt they could prevent change, helping them remain child-like, avoid development, and attain an idealised view of perfection. Anorexia has previously been described as a project of self-transformation, where the body, intermingled with cultural discourses of morality, embodies a symbol of change (Orsini, 2017), and theoretically, a way to prevent development (Oldershaw, Startup and Lavender, 2019). Participants viewed themselves critically prior to the development of anorexia, whilst food-related engagement in anorexia was attainment of perfection, becoming morally superior, and loveable. Christian theological concepts, where female bodies are considered sinful, and foods are dichotomised as good and bad (Banks, 1996; Malson, 1998), pervade contemporary secular culture and are considered to play a role in the meanings of anorexia. Within capitalist consumer culture, anorexia has been analysed as a project to be worked on, which is always in the process of becoming (Malson, 1999b). Thus becoming anorexic, situated within Western discourses, serves as a statement of success, autonomy and independence, and bettering oneself (Lester, 1995; Bates, 2015).

Although functional and meaningful, all participants express desires to live a life beyond anorexia; challenging mainstream clinical ideas that those with anorexia are reluctant to change and highlight the importance of hope (Downs, 2023). Participants' ideas of recovery involve a vision of becoming "normal" and they frequently referenced aspirations to eat "normally". This suggests how participants adopt dominant recovery discourses which encourage a return of normal eating (Bardone-Cone *et al.*, 2010). The concept normal; however, is ambiguous, creating tensions, as participants questioned what normal even is and found it hard to imagine themselves completely free from disordered food-related engagement. Other research highlights that concepts of a return to pre-morbid functioning can be perceived as constraining and contradictory (Conti, 2015; La Marre and Rice, 2015). Participants also cited fears of change, explaining how an absence of anorexia involved complex negotiations of their identity and of their doings. Thus their becoming self was more abstract in comparison to the concrete nature of their current experiences (Oyserman and Dawson, 2019), which may contribute to ambivalence. These findings relate to clinical writings on the egosyntonic nature of anorexia, and the paradoxical ways anorexia can be perceived (Rankin *et al.*, 2023).

Unlike dominant recovery criteria which positions recovery as a static end point – i.e. weight criterion (Kenny and Lewis, 2023), participants consider recovery to be an ongoing journey, and continued choice. A notion that resonates with other research (Federici and Kaplan, 2008; Matusek and Knudson, 2009) and also reflects OT's consideration of becoming as a process (Cutchin *et al.*, 2008). Participants' difficulties with food, body and self, were not eliminated all together; rather participants discuss setbacks, increasing their resilience, and a strength and pride in their lived experiences. Therefore, recovery may not be a divorcing self from experiences (La Marre and Rice, 2015; Conti, 2018), but holding a multi-faceted view of self (Saukko, 2008). Whilst treatment and healthcare professionals provide a singular identity for constructing anorexia, Malson (1998) argues anorexia is plural, "signifying a multiplicity of shifting and often contradictory subjectivities" (p.145).

Recovery is considered a re-evaluation of beliefs and values (Abbate-Daga *et al.*, 2013) and the deleterious consequences of the ED (Stockford *et al.*, 2018a). Participants considered what anorexia was costing them, compared to what they hoped their future self would become. Recognising the incompatibility of the two, supported them to adapt meanings or pursue recovery-focused occupations. The sub-theme 'food enables access to life' reflects how food in recovery is a medium to engage in meaningful careers, to travel, to have a family, and to do their day-to-day activities. Indeed, research exploring recovery emphasises the importance of quality of life including psychosocial factors and increasing social participation (Kenny, Boyle and Lewis, 2020; Bohrer, Foye and Jewell, 2020), and how recovery is a reclamation of self and identity outside of anorexia (Conti, 2018). Although increasing occupations was necessary, it was also ceasing certain occupations, or adapting the meaning of occupations which was of equal importance; reflected in other research (Dark and Carter, 2019). Indeed, occupations can be a contraindication to psychological improvement when it is used to avoid or detract from negative affect (Abeydeera, Willis and Forsyth, 2006), highlighting the importance of exploring the meaning of specific occupations.

Although participants were critical of reductionist frameworks of food in treatment, which stripped food of its meaning and emotion, they continued to use medicalised language to describe their food-related engagement. Food was referred to as "fuel", as a "practical thing", and "medicine" in recovery. However, the end goal of their food engagement in recovery related to their occupational lives, as opposed to the context of treatment where the end goal situated on weight-gain. Participants re-framed food as punishment but viewed food as a way of doing, and of self-care, connected with all aspects of their occupational lives: their doing, being and belonging, and therefore its importance cannot be eliminated. Rather than focusing on minimising the role of food and eating in lives, with the aim of excluding it altogether, or alternatively on the other extreme, focusing on only food in treatment as means to recovery - it was a focus on the broader dimensions of life, which in turn diminished an over-valuation of food and eating.

Motivation is widely researched in the field of EDs (Vitousek, Watson and Wilson, 1998), which a lack of, considered to contribute to poor outcomes (Clausen, Lübeck and Jones, 2013; Vall and Wade, 2015). Motivation is often defined as readiness, having a reason, need, intention or commitment to change (Miller and Rollnick, 1991; DiClemente, Schlundt and Gemmell, 2004); pertinent, as most participants describe the importance of choosing recovery in their own time, rather than it being externally imposed by others. However, findings show motivation to change was inhibited by the functional aspects of anorexia, corroborated in clinical and theoretical literature (Williams and Reid, 2010; Denison-Day *et al.*, 2018). Participants in this study distinguish between intrinsic and external motivators for change and becoming. They describe their choice to alter their food-related occupations related to responsibilities and roles such as being parents or spouses, or for their careers and external pressures, as opposed to more internally motivated reasons such as recognising their own emotional or bodily needs. This perhaps can lead clinicians and occupational therapists to use external motivators as the first step to inspire and ignite change. Indeed, discussing goals for the future which are incompatible with the ED can increase motivation (Venturo-Conerly *et al.*, 2020).

Findings also reflect how therapeutic relationships either diminish or contribute to motivation, for example non-judgemental and inquisitive approaches, and specialist rather than generic practitioners were considered helpful in this study. The impact of the therapeutic alliance upon motivation is substantiated by other findings (Pettersen and Rosenvinge, 2002; Venturo-Conerly *et al.*, 2020), where empathy, acknowledging the functions of the ED, and empowering individuals to make their own decisions to change is key (Vitousek, Watson and Wilson, 1998). However, reaching sustained levels of change requires enhancing intrinsic motivation by exploring and resolving ambivalence (Prochaska and Velicer, 1991). Participants discuss how shifts in values, and identity supports change, and therefore, occupational therapists should explore subjective experiences through open and honest dialogue, empathising with an individual's frame of reference and supporting autonomy (van der Kaap-Deeder *et al.*, 2014).

The findings convey the contrasting feelings participants discussed between the freedom and spontaneity of eating they experienced in recovery, opposed to their negative descriptions during the ED. They described an awakening, of "tasting life", as they progressed during their recovery. Recovery from an ED has been considered as a spiritual quest, with reconnection of body and mind, and connection with others (Garrett, 1996) and an awakening and of growth (Lewke-Bandara *et al.*, 2020). Spirituality in OT is defined as the way in which individuals construct meaning and purpose in their life (Unruh, Versnel and Kerr, 2002), considered a dimension of meaning-making (Beagan and Etowa, 2011). Whilst participants related to food in dualistic terms i.e., bad/good, unhealthy/healthy. In recovery, participants discussed adopting a balanced attitude to food, viewing things in perspective, as reflected in the sub-theme 'balance with food and self'. This relationship with food, in turn led to a more balanced view of self, where food was viewed less from a subjective moral lens, but a way of showing care and appreciation to self. Important, given the role of self-compassion in recovery (Geller *et al.*, 2022).

Although fear of eating is thought to impact treatment outcomes (Young *et al.*, 2020), current psychological treatments for anorexia do not tend to provide support for food-related anxiety and instead focus on body image dissatisfaction (Fairburn, Cooper and Shafran, 2003). Avoidance and safety behaviours were commonplace in the findings. These findings, like others show that learning to come alongside what is underpinning food-related engagement in anorexia, such as emotional uncertainty and anxiety, rather than avoidance, is an important step in reducing reliance on less adaptive ways of coping (Sternheim *et al.*, 2012; Drinkwater *et al.*, 2022).

Participants felt that the focus and goals of their treatment programmes did not reflect their broader conceptions of recovery, including gaining an identity beyond the ED and was not tailored to their unique occupational lives. An important point, as (re)authoring themselves on meaningful occupations such as careers, educational pursuits, and relationships, whilst improving function and skills in food-related engagement was what participants attributed their recovery to - the very doings of life. These broader psychosocial aspects of recovery do not necessarily fit into typical evidenced based treatments, protocols, or definitions of recovery. Underpinned by becoming was a sense of hope, that things can and will improve. Negative belief systems and cognitive biases, such as overgeneralising are typically present in anorexia, which can be strongly reinforced by negative labelling. Therefore, it is important that ED treatment instils hope (Asaria, 2023), and that life is worth living despite the potential continued engagement of occupations which are not considered healthy or adaptive.

6.7 Conclusion to Discussion

The discussion links the interpretative findings, grounded in participants' accounts, with theoretical and empirical research to reveal the inter-related connection between participants' doing, being, belonging, resisting, and becoming. The doing and being reveals the functional and meaningful aspects of food-related occupations in anorexia and how this relates to both personal and social identity. It further highlights the problematic ways food-related occupations are framed in ED treatment, and how dominant understandings obscure embodied and lived meanings. The belonging section describes how belonging is multi-factorial, where tensions exist of wanting to belong to culture and society but also belong to the ED. It also discusses how belonging to ED services can be both supportive and detrimental for long-term recovery. The unique element of these findings – resisting - reveals how resistance which is often tied to individual traits and the egosyntonic nature of EDs, was embedded and influenced by the context in which participants were situated. Resisting food-related engagement in treatment was a way to preserve their sense of being, assert their autonomy, and defend against oppression, thus resisting is a form of pursuing participant's own version of recovery.

Findings of this research highlight food-related occupations within the lived experience of anorexia should be viewed as complex, and dynamic, with multiple and shifting meanings, echoing the complex relations and meanings attached to anorexia in wider literature (Serpell *et al.*, 1999; Tierney and Fox, 2011; Williams and Reid, 2012). It is acknowledged environments can facilitate or constrain engagement in occupation (Brown, 2009), and context alters the meaning of occupation (Kiepek *et al.*, 2022b). These findings challenge the dominant medical discourse around EDs which position behaviours of food and eating statically, one-dimensionally, in the minds of individuals, obscuring broader influences (Malson, 1998), highlighting how individuals, place, and context can shape and mould meanings.

Whilst the literature review acknowledges engagement with anorexia is meaningful and makes implications to explore individual's personal meanings and values, it is often encouraged through verbalisation (Nordbø et al., 2006) with therapists tasked to explore these within the context of treatment (Fox, Larkin, and Leung, 2011; Nordbø et al., 2012). Whilst this has merit, for which this study would echo, the unique findings of this research suggest participants had insight and awareness into the meanings they ascribed to occupations, but often found it hard to express due to misaligned assumptions, the limitations, and constraints of language, or personal or social shame associated with their doings. Indeed, meanings can be difficult to articulate in words and do not lie independent from our embodied interaction with the world (Amos, 2016). As Johnson (2006) suggests "You *have* meaning, or are *caught up* in meaning, before you actually experience meaning reflectively" (Johnson, 2006, p. 21). Findings illuminate meaning is created and maintained in embodied ways, in doing or not doing, reflecting Merleau-Ponty's writings on our embodied relationship with the world. For example, Danielle realised what she valued in baking through doing, Harriet questioned the meanings and alliance she shared with anorexia when she ceased doings related to anorexia, and Sarah realised through eating with friends, and sharing in her vulnerabilities in recovery how the meanings of anorexia lessened. These findings highlight that meaning is not always uncovered in language but embodied in everyday engagement. Mostly, these did not occur within the structure of treatment or an individual basis, but in the world and in relationship with others, reflecting Heidegger's view of existence as world and in context rather than self-contained individual subjects.

6.8 Implications

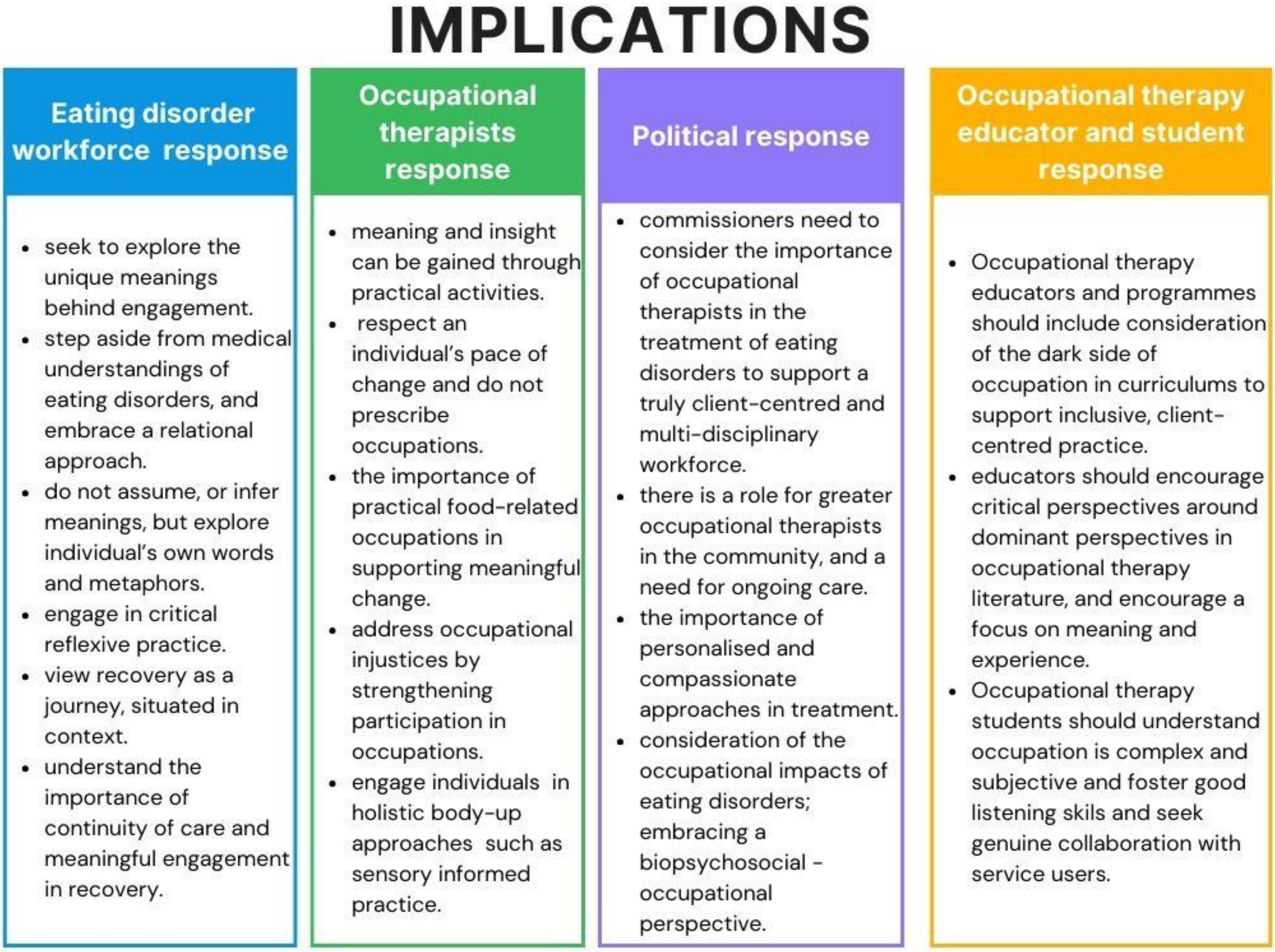
IPA focuses on interpreting how individuals attribute meaning to their experiences, which allows for the unearthing of phenomenon from lived experience perspectives and therefore, findings can be highly practical (Clarke, 2009). Pertinent, considering calls for the greater integration of lived experience perspectives in ED research and practice (Kenny, Trottier, and Lewis, 2022).

The findings of this thesis offer a nuanced and in-depth understanding into individuals' own meaning-making, which can contextualise existing quantitative understanding around food engagement in anorexia. Furthermore, IPA findings can be helpful for theory-building, informing understanding into a relatively under researched area of practice in OT, provoking reappraisal into how we conceptualise EDs, as well as OT concepts, such as meaning.

The implications of this study have been structured into three responses: practical and clinical responses for both the ED workforce as a whole, and more specifically for OTs; a political response and a theoretical response for both educators and students.

A visual image of how these relate to different audiences has been presented in Figure 16.

Figure 16 Visual Image of Implications



IMPLICATIONS

Eating disorder workforce response

- seek to explore the unique meanings behind engagement.
- step aside from medical understandings of eating disorders, and embrace a relational approach.
- do not assume, or infer meanings, but explore individual's own words and metaphors.
- engage in critical reflexive practice.
- view recovery as a journey, situated in context.
- understand the importance of continuity of care and meaningful engagement in recovery.

Occupational therapists response

- meaning and insight can be gained through practical activities.
- respect an individual's pace of change and do not prescribe occupations.
- the importance of practical food-related occupations in supporting meaningful change.
- address occupational injustices by strengthening participation in occupations.
- engage individuals in holistic body-up approaches such as sensory informed practice.

Political response

- commissioners need to consider the importance of occupational therapists in the treatment of eating disorders to support a truly client-centred and multi-disciplinary workforce.
- there is a role for greater occupational therapists in the community, and a need for ongoing care.
- the importance of personalised and compassionate approaches in treatment.
- consideration of the occupational impacts of eating disorders; embracing a biopsychosocial - occupational perspective.

Occupational therapy educator and student response

- Occupational therapy educators and programmes should include consideration of the dark side of occupation in curriculums to support inclusive, client-centred practice.
- educators should encourage critical perspectives around dominant perspectives in occupational therapy literature, and encourage a focus on meaning and experience.
- Occupational therapy students should understand occupation is complex and subjective and foster good listening skils and seek genuine collaboration with service users.

6.9 Practical and Clinical Response

The following implications will discuss practical ways ED clinicians, and occupational therapists specifically can consider and address food-related occupations.

For the Eating Disorder Workforce as a Whole

6.9.1 Drawing upon Individuals' Own Meaning-Making

The findings reveal food-related engagement is not haphazard, but serves a purpose, for which individuals gain meaning, create identities, habits, and routines. Therefore, a key recommendation is that clinicians should seek to understand the unique meanings individuals place upon their occupational engagement, rather than only assuming meaning based on observable and discrete behaviours.

Although treatment experiences were not wholly negative, participants describe feeling misunderstood when their experiences were trapped within existing frameworks and therefore misinterpreted their reality. This resonates with previous studies highlighting how individuals with anorexia often experience feeling disregarded and invalidated (Fogarty and Ramjan, 2016; Holmes, Malson and Semlyen, 2021; Venturo-Conerly *et al.*, 2020), and where dominant clinical discourse removes individual voice and agency, resulting in individuals being more reluctant to accept support (Lester, 2019).

The subjective nature of meaning-making in this study implies stepping aside from the master narrative of the medical model to a more relational approach to understand individuals' own metaphors, meanings, and stories. The need to develop person-centred approaches is advocated by others (Conti, Rhodes and Adams, 2016; LaMarre and Rice, 2021b) and tailoring treatment to an individual's preferred language and systems of meaning is considered a powerful cultural adaptation to therapy (Conti, 2015). This means clinicians need to challenge their elevated position of expert, and work alongside individuals collaboratively, emphasising their lived experience.

Individuals with EDs have typically been considered untrustworthy and inaccurate storytellers, a perspective which reduces their multifaceted, complex subjectivities into the 'eating disorder voice' (Saukko, 2008; Holmes, Malson and Semlyen, 2021). The findings of this research debunk such views, as participants in this study were highly insightful and able to articulate their meanings and experiences. Narrative techniques can encourage clinicians to make space for individuals to generate alternative meanings and re-write narratives (Gelo *et al.*, 2015; Conti, Rhodes, and Adams, 2016). Given the therapeutic alliance is key in determining outcomes (Werz, Voderholzer and Tuschen-Caffier, 2021), and individuals may avoid treatment due to anticipation of devaluation (Hay *et al.*, 2003), it is essential ED clinicians acknowledge dominant framings in EDs, seek out individual's own contextually-situated meaning-making, and offer opportunities for genuine collaboration. Other studies highlight the importance of therapeutic relationships based upon flexibility, compassion, and what is meaningful to individuals, rather than only referring to manualised care (Darcy *et al.*, 2010; Karlsson *et al.*, 2021).

A key recommendation for practice is to engage with the phenomenological concept ‘intentionality’, referring to understanding subjective and felt experiences (Bourget and Mendelovici, 2019). Hart (2021) considers that this is more than superficially seeing, but a way of stepping into the unknown, being inquisitive, curious, and critical of our own pre-conceived judgements. Reflexivity is a central tenet of phenomenological philosophy and practice (Finlay, 1998) and acknowledged as a resource in exploring under-addressed occupations (Agyemang, 2021). This research calls for explicit critical reflexivity in EDs, turning attention past the individual, to “the social conditions under which knowledge is produced” (Phelan, 2011, p. 165).

6.9.3 Situating Recovery in Context

Rather than alluding to a definitive endpoint of recovery, the findings discuss the ‘push and pull’ of the doings of anorexia, and how recovery is a non-linear ongoing journey. The term recovery may signify a socially constructed unattainable concept to many (Conti, 2015; LaMarre and Rice, 2021b). Therefore, it is important to honour individual’s own definitions of recovery, situating their experiences within their lifeworld. It is considered narrowly defining recovery may overlook important and broader aspects of recovery (Pettersen and Rosenvinge, 2002; Hower *et al.*, 2022). This therefore echoes Seed, Fox, and Berry’s (2015) implication for clinicians to move away from being ‘experts’, but to privilege individuals own subjectivities, embracing positive risk-taking and reducing coercive and medicalised approaches.

Participants in this study report of the detrimental impact to recovery when returning to environments and contexts with limited meaningful pursuits, such as careers, hobbies or interests and absence of social supports. For clinicians, this means moving past a reductionist and medicalised view of recovery, that is positioned as individual choice and effort, to understanding that for many, recovery is dependent upon privilege and circumstance (LaMarre and Rice, 2021b); deeply entwined with social inequities and possibilities (Morrow and Weisser, 2012). Therefore, clinicians need to consider the importance of continuity of care, the value of social support and meaningful engagement following ED treatment (Clark Bryan *et al.*, 2022).

For Occupational Therapists

6.9.3 Understanding Meaning through Practical Doing

Merleau-Ponty's (2005) writings on embodiment propose that our body schema is situational and experienced by our engagement in the world, similarly Heidegger (2001) considers meanings and experiences are rooted in activity. These philosophical ideas are reflected in my findings, which indicate emotional distress and meanings are not easily conveyed in words, but are embodied and performed, and insight can be gained through doing. Occupational therapists are uniquely skilled in identifying meanings which provoke participation in activity (Mack, Stanton and Carney, 2023). The findings encourage occupational therapists to utilise their skills in activity analysis, observing unspoken gestures, visceral responses, and body language to ascertain the meaning ascribed to occupation. The findings also suggest for occupational therapists to uphold their unique perspective and skill set in the field of EDs, by supporting individuals to participate in meaningful occupations. Engagement in activities, which individuals derive meaning from, supports identity formation and fosters hope that life is worth living (Mack, Stanton and Carney, 2023). Research has identified that recovery is not only cognitive, but practical and performative (Heywood, Conti and Hay, 2022). Rather than relying on language, meaning can be elicited through occupations such as letter writing, a method utilised in research (Marzola *et al.,* 2015), and practice (Heywood, Conti and Hay, 2022), which can foster the therapeutic alliance, or through other arts-based approaches which can privilege individual meanings (LaMarre *et al.*, 2023).

The findings suggest the need to respect the unique pace of change of individuals' journeys. Turning points in recovery can occur when individuals themselves gain insight into the function and meaning of anorexia in their lives rather than imposing or forcing change (Dawson, Rhodes and Touyz, 2014a). Therefore, this means not prescribing occupations, but adopting a theory of self-determination to journey alongside individuals to enable occupations which are truly meaningful, and promote choice. It is considered self-determination, including facets of autonomy, competence and relatedness are key in recovery (Bégin *et al.*, 2018). Through unjudgmental reflection, greater self-awareness into the function of occupations can be uncovered, providing a foundation to explore other occupations, and fill the gap left by the ED (Cowan and Sørlie, 2021). Conversely, my findings suggest if the functional nature of anorexia is removed through punitive, hasty, or one-size-fits-all approaches, before individuals become aware of anorexia's meaning in their lives, this may be negatively reinforcing.

Although no interview questions directly asked participants about their perceptions of OT, nor did promotional materials highlight OT, six participants discussed OT's benefits in treatment, particularly around food-related activities. This affirms the value occupational therapists hold in offering food-related activities in the treatment of EDs; echoed by others (Biddiscombe *et al.*, 2018; Duzyk, 2022). Despite occupational therapists' belief that their unique contribution and identity is being compromised within this field (Devery, Scanlan and Ross, 2018), it is evident from this study that occupational therapists are well placed to deliver food-related occupations in ED treatment. This is evidenced through their practical and activity orientated key skills, understanding the complex dynamic between person, occupation and environment, their use of grading and adaptation, and finding the just-right-challenge in activities (Biddiscombe *et al.*, 2008; Mack, Stanton and Carney, 2023).

6.9.4 Addressing Occupational Injustices

In a society where access to treatment is fraught with many difficulties outside of the control of the individual, including geographical remoteness, stigma in society and misconceptions, and where EDs remain marginalised within healthcare due to lack of funding and research (All Parliamentary Group on Eating Disorders, 2021a), occupational therapists have a clear role in addressing occupational justices in EDs and advocate for equitable opportunities for occupation (Hammell, 2017). They can explore what is available in an individual's environment beyond treatment and enhance wider support, educate the wider workforce on the occupational impacts of EDs, and advocate for a broader perspective around recovery.

Occupational therapists can promote occupational justice by utilising occupation-centred practice in restrictive inpatient care by strengthening participation in occupations (Whiteford *et al.*, 2019). From an occupational justice lens, food-related occupations can be viewed more broadly than individual doings but understand in relation to their social and contextual aspects, which shape meaning. Recently clinicians have adopted holistic biopsychosocial approaches, with care extending beyond symptom reduction, improving functioning (Touyz and Hay, 2015; Russell *et al.*, 2019), a view shared by occupational therapists, which supports individuals experience quality of life through participation in adaptive and meaningful activities (Lock and

Pepin, 2019). This means shifting from narrowly viewing food-related occupations as a tool for weight-gain but viewing food-related occupations as a way to belong, become, repair and re-connect with themselves, the world, and others. In calls for new ideas and paradigms in EDs (Touyz and Hay, 2015), occupational therapists can use their skill-set in collaboration, respect for autonomy and focus on practical doings to contribute to these developments, a view endorsed by recovery-orientated practice (Dawson, Rhodes and Touyz, 2014b).

The findings of the dehumanising and traumatising experiences of treatment, where food and eating were positioned negatively, underscores the importance of individualised and personalised care (Rance, Moller and Clarke, 2017; Joyce et al., 2019; O'Connell, 2023). It has been argued that occupational therapists can provide trauma-informed care in ED settings (Titus and Park, 2022). Through their values of respect for autonomy and positive risk-taking, occupational therapists can utilise interventions which are meaningful and personalised, which support reintegration back into community settings (Robinson, 2019).

6.9.5 Body-up Approaches

Findings highlight how the sensory qualities of food and eating generated emotional responses, including disgust and fear, leading to avoidance and safety behaviours. A body of work considers aversive learning processes, such as fear and disgust are driving forces behind food avoidance in anorexia (Hildebrandt *et al.*, 2012; Bektas *et al.*, 2022). Typically exposure therapies are offered to reduce disgust in anorexia (Plasencia *et al.*, 2019). However, the evidence-base for this is small, and conducted mostly in hospital settings; therefore, making it difficult to tease apart its efficacy from other contemporaneous treatments (Butler and Heimberg, 2020). Given participants in this study yearned for practical "real life" experiences, occurring in their own environments; offering exposure-based work to feared foods in context may be specific role for occupational therapists. Sensory integration, a framework often practised by occupational therapists, can enhance exposure therapy by understanding an individual's unique sensory profile within naturalistic settings (Scanlan and Novak, 2015; Camarata, Miller and Wallace, 2020).

More recently, interoceptive exposure has been suggested as a treatment in anorexia, which involves exposure to fear, worry and disgust around food, and practising skills to withstand distress generated by visceral sensations (Plasencia *et al.*, 2019). The interoceptive system refers to the perception and integration of internal bodily signals including pain, temperature, hunger, and thirst (Craig, 2002). Evidence suggests alongside impairments in the interoceptive system, individuals with anorexia have reduced ability to modulate sensory responses (Brand-Gothelf *et al.*, 2016). Not only this, but interoceptive signals afford us a mental representation of self within the body (Seth, 2013), impacting upon identity (Oldershaw, Startup and Lavender, 2019); therefore focusing on interoception, can support identity formation and self-regulation. Given compliance-based approaches can impair interoception, (Mahler, 2021) and findings reveal participants were out-of-sync with their felt bodily experiences, exasperated by treatment approaches rooted in Western philosophical dualism, privileging mind over bodies, body-based interventions may have promise in ED treatment (Rizzuto *et al.*, 2021; Trethewey *et al.*, 2023).

6.10 Political Response

This thesis has wider implications relating to policies, funding, and resources. Reflecting on wider contributing factors, participants often drew attention to the lack of resources and funding in treatment. ED treatment is under-funded, which is disproportionate compared to the seriousness of its presentation, prevalence rates and poor treatment outcomes (All-Parliamentary Group on Eating Disorders, 2021a). Not only this, but austerity measures create cultures where employees may not feel secure (Bhutani *et al.*, 2012), increasing the likelihood of uncompassionate responses (Joyce *et al.*, 2019; Parliamentary and Health Ombudsman, 2023).

Whilst some literature describes intensive psychological interventions for long-term EDs which adopt compassionate psychosocial principles (Touyz *et al.*, 2013; Dawson, Rhodes and Touyz, 2014b), most focus on medical stability and quick throughput (Kennedy *et al.*, 2017; Pehlivan *et al.*, 2022). In the treatment of those with anorexia, NICE (2017) guidance states "helping people to reach a healthy body weight or BMI for their age is a key goal" (NICE, 2017, p. 1.3.2) with weight gain acting as a foundation for other psychological and quality of life changes. Foregrounding care through weight reinforces the misconception that anorexia is only physical in nature, privileging visual and bodily changes, in turn neglecting individuals' own meaning making and needs (Eli and Lavis, 2021). By narrowly positioning nutrition as achievement for this goal, occludes wider occupational meanings around food-related occupations, possibly resulting in a form of care considered uncaring (Lester, 2018).

Occupational therapists look at the environment in which occupational engagement occurs (Law *et al.*, 1996), draw upon principles of occupational justice, defined as equity and fairness of individuals to engage in diverse, healthy and meaningful occupations (Hammell, 2015) and highlight the social conditions which restrict occupations (Hocking, 2017). Therefore, playing a key role in the current landscape of EDs and addressing occupational determinants. Occupational determinants including economy, policies and cultural values can affect health, and when not in balance and contribute to occupational injustice (Stadnyk, Townsend and Wilcock, 2010). One variant of occupational injustice is occupational deprivation referring to "externally imposed barriers to valued, meaningful occupations necessary for well-being" (Hocking, 2017, p. 33) has pertinence in this study. For those who experienced inpatient care, participants describe OT and other types of therapy were withheld until they were in a better nutritional place or had improved cognitive functioning. However, promise of this support either never materialised or was short-lived, as once participants were in a "safe weight", they were discharged. This is reflected in the OT literature, which suggests intervention begins once individuals are medically stable (Lim and Agnew, 1994; Mack *et al.*, 2023), and there is a lack of ongoing outpatient care (Gardiner and Brown, 2010). This was a gap in service recognised by participants, who desired for support to transition back home following intensive care, acknowledging this as a time of vulnerability. The findings from this research suggests OT should be offered throughout the treatment journey.

In the current political climate, there have been calls for improvement at a service-level, including challenging current practice, incorporating compassionate approaches, acknowledging the role services play in psychological distress, and adopting meaningful collaboration with service users (Joyce *et al.*, 2019). Although biopsychosocial approaches to EDs are growing, this thesis, in light of the wide occupational impacts of EDs, would suggest a biopsychosocial-occupational approach is required in order that clients truly receive integrated and client-centred care. Unlike other professions, occupational science does not view individuals through a disease or medicalised framework (Wilcock, 2001), in which treatment is used to cure, but views health and wellbeing more broadly (Greber, 2021). With OT's client-centred values, focusing on meaningful engagement, and holding a holistic and integrative approach to formulation, they have a clear role in contributing to service changes (Gardiner and Brown, 2010). The implications of this study echo RCOT's recommendations to expand OT input (RCOT, 2023b) and ensure ED teams meet commissioning requirements for a diverse workforce, which reflects the inclusion OT (National Collaborating Centre for Mental Health, 2019).

6.11 Occupational Therapy Theoretical Response

Lastly, this thesis has a number of theoretical implications for OT educators and students, regarding concepts such as meaning and the dark side of occupation.

Meanings in this study could not be placed into neat categories; on the contrary, participants discuss the ambiguity, mutable and contradictory nature of their meanings. The implication of this presents a challenge to dominant perspectives in OT theory where occupation has narrowly focused on positive attributes, obscuring critical attention to alternative experiences of occupation (Hammell, 2009b; Kiepek and Magalhães, 2011; Twinley, 2013). Others contend the complexity of occupation defies categorisation (Kiepek, 2021), and challenge binary and limiting conceptualisations, which limit real-world applicability (Twinley, 2021b). Similar to other theorists, the findings of this research call attention to viewing occupation in the context of meaning, away from a focus on goals, function, and activities, as meaning offers more authentic practice (Reed, Hocking and Smythe, 2010; Reed, Hocking and Smythe, 2011).

More recently the concept of occupation is broadening to encompass a wide range of lived experience (Kiepek, 2021); specifically, attention to the dark side of occupation is exploring the messy, unacknowledged and complex aspects of occupation (Twinley, 2021b). Scholarship illuminating occupations which individuals continue to engage in despite being harmful or health-compromising such as sex work (Rule and Twinley, 2021), smoking (Gätz, van Nes and Maersk, 2022), and substance misuse (Kiepek *et al.*, 2022a), facilitates a more inclusive view and discussion of occupation. Indeed, as Twinley (2017) states, we cannot claim to be client-centred and occupation-focused without acknowledging the broad range of occupations experienced and engaged by individuals. This research has added to this theoretical debate on such matters and calls for further research into the broad range of occupational engagement of EDs.

6.12 For Occupational Therapy Educators and Occupational Therapy Students

As advocated by others, occupational therapy educators should seek to include consideration of the dark side of occupation throughout the curriculum in order to explore the full range of subjective experiences of occupations, which can enhance understanding, and amplify voices of alienated and marginalised groups (Rule and Twinley, 2021; Natasi, 2021). Educators should also encourage students to be critical of socially constructed understandings of meaning and occupation and taken-for-granted concepts in OT literature. Critical approaches concern themselves with understanding individual subjectivity, and their structural, social, and political contexts, which can broaden understanding, and encourage critical reflexivity (Hammell, 2013). Beyond theoretical considerations, educators should seek to engage students in real-life case studies and offer diverse placement settings in order for students to be confronted with the complexity of human occupation.

Occupational therapy students should understand that occupation is highly complex due to the subjective nature behind participation (Pierce, 2001), and as such, be open to views which do not correspond with their own, fostering collaboration and client-centred practice (Agyemang, 2021). Students should seek to foster good listening skills, understand the importance of reflexivity and supervision, develop confidence to have bold conversations, and navigate ethical and moral dilemmas when tackling issues in relation to the dark side of occupation (Cunningham and Pace, 2021).

Through open dialogue, stigmatised occupations which carry shame, can be brought into the light, and support authentic therapeutic relationships (Cowan and Sørlie, 2021). In the context of this study, this is not to condone the harmful engagement of food-related occupations in EDs, but to step boldly into a place of understanding, being open and curious, and committing oneself to inclusive practice.

6.14 Recommendations for Future Research Endeavours

Studying anorexia from a phenomenological perspective supports understanding of the social, contextual, emotional and psychological dimensions of a phenomena, allowing for rich interpretation of experience (McNamara and Parsons, 2016; Boyce, 2021). Although the egosyntonic functions of anorexia are well-researched and considered to be central to the maintenance of maladaptive behaviours (Schmidt, Wade and Treasure, 2014), these aspects are often measured quantitively, limited to research-derived constructs, impacting interpretative exploration. Deriving a more nuanced understanding of experience, from individuals own lived experiences, is vital for the development of novel therapeutic techniques (Bryant *et al.*, 2022a).

Although this study focused on individuals with lived experience of anorexia, it would be beneficial to explore other ED experiences, such as those with bulimia or binge eating disorder, to reflect a transdiagnostic perspective. This is particularly pertinent, as many participants in this study discussed co-occurring symptomology including binge eating episodes and purging; highlighting how symptoms can sit on a continuum and are difficult to classify.

The methodology of this research, which collated data through interviews, presupposes that language provides participants with the necessary tools to capture their experiences; thus, relies upon the representational validity of language (Tuffour, 2017). To connect with participants in a more practical, embodied way it may be interesting to employ more creative methods such as diary writing or using multimedia storytelling. This would also enhance data triangulation to promote credibility (Stahl and King, 2020). Rice et al. (2018) discuss the use of digital storytelling to counteract the participant-researcher hierarchy and enhance collaboration, and when applied in EDs, such methods support collaborative efforts and garner new insights (LaMarre and Rice, 2016).

An area of IPA which has growing interest is multi-perspectival studies, supporting exploration of the complexity and relational nature of phenomenon especially where there are different perspectives (Larkin, Shaw and Flowers, 2019). Indeed, food and eating are not isolated acts but occur in-between people, with meanings co-created from being-in-the-world. It could be feasible to interview occupational therapists or family members on their perspectives and meanings of food-related occupations, this has been attempted elsewhere but not from an OT viewpoint (Ramalho *et al.*, 2021). This could help illuminate similarities and differences in experience and contextualise the phenomenon.

One way to address concerns regarding participants' accounts being retrospective and reflective, would be to conduct a longitudinal study, capturing experiences of food and eating over time. However, this carries multiple practical and ethical challenges including cost implications, participant retention, and lengthy commitments for both researcher and participant.

6.15 Limitations

Smith, Flowers, and Larkin (2022) discuss there are various levels of interpretation, with those new to IPA often producing cautious and descriptive interpretations. As a researcher new to conducting an IPA study, I was aware of the potential limitations which could incur. To overcome this, I attended additional trainings on IPA analysis with specialists in the field including those by Jonathon Smith, as well as advanced analytical training. I shared my developing analysis in supervision as well as with researchers and experts in the IPA community to gain feedback, and iteratively, and continually returned to the analysis to question my interpretations and seek deeper meanings.

The strengths of using IPA allowed for deep exploration of participants experiences, in which each interview was analysed following the steps laid out by Smith, Flowers and Larkin (2022) demonstrating rigour of the study. Although small sample sizes may be viewed as a weakness by some, for myself, and in the spirit of IPA, the small sample size was viewed as a strength, allowing time for in-depth analysis, ensuring the voices of participants were captured, thus meeting the idiographic commitment of IPA. Nevertheless, although homogeneous sampling is embraced in IPA, there was a lack of diversity in the study's sample including race, ethnicity, sexuality, gender, and socioeconomic background. However, participants did have a range of food-related experiences, and a wealth of different treatment experiences. They were also recruited from multiple different sources, and therefore not representative of one geographical area of the UK. In terms of trustworthiness, although one of the aims of the study was to understand experiences and meanings of food in treatment, a possible limitation inferred from this study is that all participants had engaged with treatment, which may have influenced their experiences and language they drew upon.

Although interviews included probing and exploratory questions and followed a collaborative, conversational approach to elicit hidden parts of phenomenon, participants may have concealed, or disconnected parts of their experiences. Therefore, this research does not claim to have accessed all aspects of participants lived experience, but used a method and process of analysis to get as close as possible (Smith, Flowers and Larkin, 2022).

Another limitation of the study was the communication of photograph elicitation. Only one participant brought photographs/drawings to support their recollections. This may reflect a lack of understanding on the use of images in the research study. Nevertheless, as the intention of the role of images was to support retelling of narratives rather than for them to be analysed, this did not impact the trustworthiness or credibility of findings.

It is acknowledged the interview schedule would have influenced the themes interpreted in the analysis. However, efforts were made to use additional follow-up questions in response to participants' answers and clarify meaning in interviews. Additionally, all participants were given the opportunity for a follow-up interview or e-interview, allowing for any unanticipated areas to be followed up. Only one took up this opportunity, possibly impacting upon the credibility of findings. However, this may have been impacted by other factors such as other personal commitments.

An improvement nevertheless would be to include individuals with lived experience to develop the interview schedule as opposed to only therapists. This could have enhanced the applicability of the questions and garnered new insights. On reflection, the interview question "Can you describe any habits or rituals around food and eating?" may have limited responses as the words 'habits' and 'rituals' may have been difficult to relate to. A final limitation was remote interviews, possibly omitting opportunities to attend to bodily responses (Finlay, 2006b), and embodied interpretations, as words may not encapsulate all experience (Amos, 2016).

6.16 Researcher Reflections

> Throughout the research process, I have been critically conscious of the multiple positions I carry; being an occupational therapist, a researcher, and someone with lived experience. I have engaged with critical reflexive practice throughout the process to ensure reflexivity was not a task to be done, but a process of being (Finlay, 2002b; Vagle, 2019; Engward and Goldspink, 2020). Self-analysis is required in IPA, as "without examining ourselves we run the risk of letting our unelucidated prejudices dominate our research" (Finlay, 2003b, p. 108).

I am aware now that my naïve use of the term of ‘anorexia’ for recruitment is likely to have excluded many other participants, whilst reproducing the established power relations bestowed upon researchers to speak on behalf of participants (Conti, 2015). Participants themselves discussed tensions relating to the diagnosis of anorexia, and the blurred lines in symptoms. Other research highlights the problematics of pathologising experiences of body weight (Hepworth, 1999), which are constituted within, rather than outside gendered normative values and ideals of Western culture (Malson and Burns, 2009). Although I did not choose to use a requirement of a medical or diagnostic label, I still used the language ‘anorexia’. This may have obscured other voices from being heard; indeed many individuals such as those of colour, different sexualities, men, and those in larger bodies, may fall outside the boundaries which eating disorders/anorexia are often interpreted and labelled (LaMarre and Rice, 2021b). Therefore, following this study, I am more mindful of the language I use to label experiences of health.

I am conscious that assumptions based on my gender, appearance, position as a doctoral student and occupational therapist may have influenced how participants responded and what they chose to disclose. Role duality, being both academic and clinician, necessitated continual reflection on which position I was adopting, as well as practical strategies including supervision, continually returning to the raw data and consulting with broader literature to situate findings (Probst, 2015). I am aware many participants were similar in age to myself, and three of them worked in healthcare, whilst another three were studying healthcare, this mutuality may have resulted in participants drawing comparisons or making assumptions and vice versa. Nevertheless, shared commonalities can be an advantage as I had a familiarity with participants’ contexts (i.e. working in healthcare) where knowledge may be built upon, thus increasing my credibility (Stahl and King, 2020) and increasing compassion, and understanding. Furthermore, research indicates participants may be less guarded to discuss sensitive topics when they feel researchers have a genuine understanding of their lived experience, resulting in more genuine data (Wilson, Janes and Williams, 2022).

Critically reflecting on the interviews, I am aware of my shortcomings as a novice researcher and how this may have impacted the quality of the interviews and interpretations made. Nevertheless, I immersed myself with the data of this research, demanding time, commitment, meticulous note taking, and at times, emotional self-analysis. It is through a process of 'living' with the data (Engward and Goldspink, 2020) that I was able to uncover unanticipated themes and findings beyond my initial horizons of understanding and embrace new and novel insights.

Alase (2016) considers a postscript self-reflection essential in IPA, not only increases the credibility and authenticity of research but accounts for the "mountains each study has climbed to get to their individual destinations" (Alase, 2015, p. 149). Upon reflection, engaging in a PhD has been an eye-opening, rewarding, and life-changing experience. It has deepened my understanding in an area that I truly care about, shaping me into a more compassionate, and knowledgeable occupational therapist. Equally, in reflection of Alase's comment of the mountains I have overcome, my doctoral studies have also come at great cost to my career development, my family and social life, and my wellbeing. I started the PhD during the pandemic, when my first child was only a few weeks old, and I have finished pregnant and exhausted with my second child. I have sacrificed many special occasions, and overlooked day-to-day life of being a mother, wife, daughter, and friend. I have engaged with my studies remotely and have often felt isolated and distant. Through this it has fostered a resilience I never knew I had, and a passionate belief to use the study findings to challenge medicalised and narrow views of food-related engagement in anorexia, to support a deeper understanding of the meaning of these.

I was naïve to the academic rigour, the continual battle with self-doubt and imposter syndrome, and personal discipline it would take to complete a PhD. I have found the comradeship gained from the IPA community deeply encouraging, and supervision a lifeline in reassuring and believing in me. Belief and conviction in OT's role in EDs and wanting to genuinely make a difference in practice through the findings of this research has spurred me on to continue. Engaging reflexively with the research and being confronted with my own being-in-the-world, has also led to greater self-acceptance, and compassion, as Finlay (200b) states through the intersubjective nature of the research, enables empathy, enabling understanding of self and others.

Through the framework of doing, being, becoming and belonging, Twinley (2018) wrote engaging with research methods which embraces subjectivity, such as this research, can increase understanding of the self, and develop a sense of connectedness.

> I too feel this process has led to personal development; I have become fluent and knowledgeable in a language I never knew existed, my beliefs have been challenged and broadened, and I have learned the value of persistence and strength. I feel more connected to the OT profession, and my own experiences. My hope is that the research findings will do the participants in this study justice of their lived experience and be of significance to the wider ED community.

6.17 Significance of the Study

In an arena with a lack of occupation-focused empirical research, this study provides a unique contribution in illuminating the phenomena of food-related meanings for those with anorexia. It is the first study, using IPA, in the field of OT to focus on this area of occupational meaning. It responds to calls for greater experiential research into meaning in the profession (Reed, Hocking and Smythe, 2011), and meanings which are nuanced and multifaceted (Kiepek *et al.*, 2022b), adding to theoretical conceptualisation of occupational meaning in anorexia. Using multiple theoretical orientations to interpret findings (phenomenological philosophy, Wilcock's Doing, Being, Becoming and Belonging and Twinley's Dark Side of Occupation) promotes credibility of the research (Stahl and King, 2020) whilst offering a unique perspective.

This thesis is an attempt to "strive to understand the dark side of occupation" (Twinley, 2013, p. 303), and encourage readers to consider what may have been "obscured, omitted and assumed" (Hammell, 2019, p. 13). It is a practical effort to take action on the profession's desire to understand under-addressed daily occupations, such as food-related occupations in EDs (Twinley, Jacobs and Clarke, 2021).

The findings from this study have real-world relevance to OT in EDs. Additionally, it has implications for other clinicians, and commissioners in EDs, highlighting the need for occupation-focused perspectives and more importantly a greater presence of OT in the field of EDs.

6.18 Conclusion

Although there is a growing literature base for studies exploring meaning and experience, most ED research is governed by quantitative studies, conducted from a positivist epistemology. These largely promote unquestioned medicalised understandings of EDs, which can side-line exploration of personal meanings and experiences.

In light of this knowledge gap, it was my intention to explore how individuals with lived experience of anorexia experience and make meaning from their food-related occupations through a phenomenological approach. The findings reveal food-related occupations are not static or one-dimensional engagements, rather their meanings are complex, embodied, dynamic and culturally situated. Through IPA inquiry, five inter-related meaning constructs were found: meaningful doing, meaningful being, meaningful belonging, meaningful resisting and meaningful becoming. Findings were analysed and interpreted through the conceptual model of Wilcock's framework of doing, being, becoming and belonging (Wilcock, 2006) and were considered using the dark side of occupation as a conceptual lens (Twinley, 2013). The findings suggest to holistically consider the meaning of food-related occupations is to broaden perspectives from mainstream medical perspectives of individualistic doings, but consider occupations as relational and contextual, which can emerge through embodied engagement with the world. Findings also imply privileging subjective accounts and encouraging a view that individuals are the expert of their recovery. Whilst alternative ED treatments have been identified which lean towards psychosocial and person-centred approaches (Bardone *et al.,* 2018), this research contends that an occupational perspective is required to substantially improve understanding into the complexity of anorexia.

Findings support the theoretical concept - the dark side of occupation - which contests long-standing notions that occupations are only positive and health-promoting, and turns attention to the multifaceted nature of occupation (Twinley, 2013). It also adds to recent literature, which challenges the profession's historic positive framing of occupational meaning, and instead calls to attention the complex and diverse nature of meaning (Kiepek *et al.*, 2022b; Huglstad *et al.*, 2022). In light of negative treatment experiences found in this research, which overemphasises weight with little acknowledgement of practical and meaningful engagement, findings support occupational justice calls, concerned with enabling and advocating for environments in which all individuals can participate in occupations which are meaningful (Hocking, 2017). Therefore, this research makes the claim that OT should be offered throughout the ED treatment journey and beyond in spite of illness 'severity'.

In conclusion, recovery from an ED is more than achieving physical and behavioural markers, but based on psychosocial factors, quality of life and improved relationships towards food and the body (Darcy *et al.*, 2010; Kenny, Boyle and Lewis, 2020; Bohrer, Foye and Jewell, 2020). Occupational therapists have a unique skill-set and paradigm which views those with EDs more than their physical being, but situates their interventions on what is meaningful (Dark *et al.*, 2022), and adopts a psychosocial recovery perspective (Clark and Nayar, 2012b).

This research advocates effective care entails exploring how recovery relates to an individual's own experience and meaning-making framework, in contrast to mainstream treatments which can presume all those with EDs require the same approach for recovery (LaMarre and Rice, 2021b). Occupational therapists view occupation as a unique and subjective experience, where meaning can only be perceived by the individual who engages with the occupation (Eakman *et al.*, 2018). OT also understands that recovery from an ED takes place in the context of an individual's life, and is shaped and impacted by external events and influences (Pepin, 2021a); thus aligning with contextualised and recovery-focused perspectives (Dawson, Rhodes and Touyz, 2014b; Kenny and Lewis, 2023). This research supports the belief that exploring meaning can foster trusting therapeutic relationships, considered an essential element in ED care (Holmes *et al.*, 2021).

IPA, and its theoretical underpinnings, provides rich understanding into meaning and through such an approach, this research has shed light on the complex, embodied and relational ways individuals with anorexia experience and create meaning from their food-related engagement. In the advent of manualised and digitalised approaches to treatment (Hart *et al.*, 2018; Fisher *et al.*, 2019; McMaster *et al.*, 2021a), attention to interpersonal and therapeutic processes emphasising empathy, trust and understanding are at risk of being overshadowed. It is hoped overall that the findings of this PhD will inspire a phenomenological perspective of anorexia and related occupations to support insight, and most of all compassion.

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Appendix 1

Reflexive Account of my Positionality

I commenced this PhD after completing a MSc empirical study which explored shifts occurring in occupational identity for those in recovery from an eating disorder. Occupational identity is referred to as "a composite sense of who one is and wishes to become as an occupational being" (Kielhofner, 2002, p. 119), which is believed to be disrupted or challenged following significant life events and transitions. My findings indicated, although discernible increases in occupational engagement arose during recovery, it was the changed meaning, form and purpose of occupations which transformed dramatically. For example, running for punishment changed to running for health and enjoyment, whilst eating in isolation changed to a joy and pleasure of eating with others. Changed meanings such as this contributed to an evolving, dynamic sense of self, transitioning from a self primarily defined by the illness, to a more elaborate sense of self, re-authored upon meaningful roles and occupations.

During this period of research, I came across Rebecca Twinley's concept, the dark side of occupation, providing a richer and broader understanding of occupation, which not only resonated with my research findings and what I witnessed in practice but also mirrored my own personal experience. As someone with lived experience of anorexia, I was attuned to the complexities and multiplicity of meanings towards treatment and anorexia itself. Anorexia is punishing and life destroying but also rewarding, comforting, shaping identity. Similarly, experiences of treatment, including my own, are often contradictory; lifesaving on one hand but traumatic on the other. This stirred my interest in the multiple and shifting meanings involved in anorexia and recovery, which can be hidden, latent or disguised (Heidegger, 1962). However, I felt meanings can often be overshadowed by dominant medical or cultural understandings of eating disorders. I became deeply curious as an occupational therapist around what makes an occupation 'meaningful' and does it always have to be positive and relate to health? I wondered in the field of eating disorders, how do occupational therapists support individuals transition from the meaning of their illness to recovery focused meanings, how do they address meaning aside from their own biases, assumptions, and cultural beliefs, or do they address meaning at all? With passion and enthusiasm, I submitted my application to study a PhD with a burning desire to make a difference and give voice to those with eating disorders.

Coming from my background as an occupational therapist, interested in subjective, felt experiences, I initially set out to only review articles qualitative in nature. However, it became clear that this narrow focus would not allow full comprehension of the phenomenon, as the literature surrounding this topic is often conducted quantitatively within bio-medical terms. In addition, such a narrow focus did not align to the hermeneutic tradition, which encourages researchers to be aware of their own biases that may colour understanding. Consequently, through reflexive attention, quantitative literature was reviewed and considered, which moves beyond viewing some research as more valuable than others, to seeing literature as consideration and appreciation of another's view.

The initial search strategy omitted terms such as 'enteral feeding, nasogastric feeding, or re-feeding', as these were methods I did not deem to be 'food-related activities' freely chosen by the individual, and a reflection of my values of choice and autonomy as an occupational therapist. However, as my knowledge increased it became clear that these were discursive medical terms used to describe nutritional care in eating disorders. Being continually aware of my own professional and personal biases throughout the literature review was key in preventing theories or fore-meanings to guide me. Noting my own thoughts and reflections throughout enabled me to "remain open to the meaning of the other person or text" leading to "enriching and broadening of horizons" (Boell and Cecz-Kecamnaovic, 2014, p.263). Individual experiences were generally absent from the majority of the literature I engaged with, where individuals were "generalised into notions of 'the anorexic'" (Boughtwood and Halse, 2010, p. 92). Critical literature such as feminist and post-structuralist writings inspired and excited me which scrutinised scientific claims, as up until my PhD, I had positioned medical knowledge as truth. From a period of reflection and gained insight, I committed my PhD to avoid contributing further to misaligned assumptions of those with anorexia, but to reflexively turn my attention back to the lifeworld of others, which Husserl claims provides experiential grounding for the scientific world (Husserl, 1936/1970).

Starting a PhD not long after graduating as an occupational therapist also came with its own challenges. I quickly became aware of the implicit dominant ideological assumptions of producing good quality research using scientific notions. This led to self-doubt, questioning whether I was producing "real research". I also became frustrated by the lack of neat boxes within the qualitative realm, and the experiences of eating disorders themselves, which felt messy and uncontained. Reflexively, I realised experiences of anorexia cannot be placed into "neat, categorical and homogenous times or spaces" (Warin, 2010, p. 19). This meant ceasing fitting experience into predefined categories, but remaining open, adopting a phenomenological stance to go "back to the things themselves" (Smith, Flowers and Larkin, 2022, p. 1). Throughout my PhD, I have struggled with imposter syndrome and a lack of self-confidence. I have challenged this by intentionally embracing opportunities to speak out about my research which has increased my confidence and ownership over my words.

When research mirrors personal experience, the process may be triggering, and stir up emotional responses. Measures were put in place to guard against personal distress or triggering emotions, such as debriefing and open dialogue with my supervisors, but also with friends and family. Although bracketing can appear to be a way to bury these emotions and protect researchers from emotionally charged material, reflexive engagement and consideration of my pre-understandings has transformed the research process and illuminated new insights. I believe my pre-understandings gave me access to the world of others, and as Gadamer acknowledges, we must look beyond them, but not away from them.

I acknowledge that my positionality and personal experience does not assume a position which speaks for all individuals with eating disorders, rather my interpretations and choice in language reflect my own understanding, situated within the context in which this thesis has been documented.

Appendix 2

Interview schedule:

<u>Opening statement:</u>

It is [date]. I am speaking to [Participant x].

The aim of this interview is to find out about your experiences and meaning of food and eating during your treatment and to the present day.

I plan to ask you a few questions, but I will mostly listen to your responses. This interview should last anywhere between 60-90 minutes; we can pause or stop at any point. Please ask me a question concerning anything you don't understand. If you do not feel comfortable answering a question, you don't have to respond, and we can move on.

I invited you to bring some photo(s) to this interview, which can be used to elaborate on any meanings and experiences you have towards food and eating, did you bring any?

If yes (continue below). If no (move to question 1).

- Could you tell me about the photo(s)?
- Prompt: What does the image in this photo signify? Or What prompted you to choose this photo?

Can you remind me of the treatment you have received for your eating disorder?

<u>Interview questions:</u>

The next few questions will ask about your relationship with food and eating before you received treatment for your eating disorder.

1. Looking back on your life, can you tell me about your relationship with food and eating?
   Prompt: Can you describe any habits or rituals around food and eating that you had at the time, and the meaning of these?

2. Can you describe any beliefs or thoughts you had towards food and eating?
   Prompt: Where you do you think your beliefs originated from?

3. Can you tell me about a memorable eating experience when you were unwell?
   Prompt: What was the meaning of this? Who was there? How did you feel afterwards?

The next few questions I will ask will be about your experiences of food and eating during treatment.

4. Can you describe your experiences of food and eating during your treatment?
   Prompt: Can you tell me a bit more about that?
   What was the best experience? What was the worst experience?
5. Can you provide a specific example of a food-related activity during treatment? By this I mean (supervised eating, meal shopping, cooking groups, meal planning etc.).
   Prompt: Can you tell me what you were thinking during the time? Can you tell me what you were feeling during the time? Who was there? Can you describe the positive and negatives of this experience? What did you do afterwards?

The next few questions I will ask will be about your experiences of food and eating in the here and now.

6. What effects has treatment had on your relationship with food and eating, and your meaning of food and eating?
   Prompt: How did it change? Who contributed to this?

7. What significance does food and eating have in your life now?
   Prompt: What contributes to this? What feelings or emotions does food and eating stir up?

8. Can you describe a recent memorable time when you ate in as much detail as possible?
   Prompt: Who was there? What did you do? What did you do afterwards? Can you tell me what you were thinking during the time? Can you tell me what you were feeling during the time?

Thank you for contributing to the interview.

End with an informal debrief.

(Provide debrief information sheet).

Appendix 3

Reflexive Embodied Empathy

1. Connecting with embodied responses

Prior to each interview, I made space to write reflexively about what I expected to discover, my expectations, and preconceptions, encouraging adoption of a phenomenological attitude.

In the interview themselves, often what participants share trigger an emotional, or cognitive response within me. Sometimes their words brought to surface memories, concealed, and hidden by the passage of time, or stir up raw emotional responses. Emotions however are considered helpful in interpretating research data (Hubbard, Backett-Milburn and Kemmer, 2001) enabling the production of more informed, contextualised and nuanced analyses (Boden *et al.*, 2016).

Prior to any annotations on the transcript, I reflexively consider my own biases, and preliminary responses. Following the interviews, to encourage embodied interpretation, I listen to the audio recording in full. I tune in empathetically to the words of participants, and through my bodily responses and intuition, I make space for noticing what I was thinking and feeling in my reflexive journal, including feelings such as guilt and relief, feelings of connection, of disconnection, and curiosity into what participants share or did not share. Below are illustrations of how practically engaged in this process, including extracts from my reflexive journal:

18th January 2022

Following my interview with X, she shared an experience which resounds with my own lived experience. She is talking about treatment, and I see myself in her, I feel angry, lost and alone. It hit a nerve, and I feel instant tension and cramping in my stomach. Suddenly flashes of the past flooded back. I feel uncomfortable and guilty, I didn't want her to notice this in me. I remember actively pinching myself and returning into the moment. I also feel guilty for lapsing into a more human response and wanting desperately to be objective and be 'the researcher'.

24th January 2022

In the interview, I find myself distracted by so many thoughts. I want to come across professional, define myself as a researcher, yet equally my instinct is to respond as a therapist. She starts talking and I intuitively want to offer guidance, signposting, and advice. I keep finding myself actively suppressing myself to speak, thinking more about the next question and my responses rather than this being a conversation.

By placing myself in the wider context of my lifeworld: as a novice researcher, a therapist and someone with lived experience, I was able to consider and situate participants within their context, drawing me closer to their lifeworld and creating greater insight, empathy and understanding.

Finlay (2003), who is also an occupational therapist, therapist and phenomenological research, recognises that she is unable to 'turn off' her responses as a therapist, as these have become a way of being (Finlay, 2003b). I too consider my own being and lifeworld implicated in the research process. Therefore, it is acknowledged that what is produced in this research is partly contingent upon the research-participant relationship.

These recorded felt experiences were conducted before any analysis of the research to ensure my own biases were attended to in the first instance.

2. Re-imagining the other's experiences

During analysis and the reading of transcripts, I strove to identify and enact the other's experience. This meant familiarisation with the voice of the participant, reading their transcripts over and over again to ensure their experience was the focus of my analysis. I often tried to reimagine and picture myself in the participants' lived experience, using their raw data to guide me. One participant discussed how she often experienced an unintended and uncontrollable need to be sick after meals on the inpatient ward. She discussed the deep shame she experienced from the toilets being locked and throwing up in her hands in front of visitors and other patients. I experientially imagined what it would have felt like for her, and a mix of anger, sadness, and understanding arose in me.

Although recognising my insider knowledge was greatly beneficial in knowing what issues to address, I was also aware that I could risk seeing participant's accounts through the lens of my own lifeworld, missing important aspects of their experiences (Daly, 1992a). I attempted to overcome this by checking the meaning of what participants expressed; but also holding onto appreciating their unique way of expressing themselves (Thomas, 2021). This also led me to scrutinise my annotations and later interpretations, to ensure any pitfalls of disproportionate self-analysis were avoided, so what emerged was not "echoes" of my subconsciousness (Goldspink, 2019).

3. Merging with the other's experience

Merleau-Ponty explained to experience a structure is "not to receive it into oneself passively: it is to live it, to take it up, assume it and discover its immanent significance" (Merleau-Ponty, 2005, p. 301). This means understanding arises from identifying with and enacting the other's experience. Many of the participants worked in healthcare or were studying healthcare roles, I reflected on my own lived experience of working in health care and related to their comments about the pressures and also rewards within this, as well as the tensions they experienced from having their own lived experiences whilst working in a helping role. I also reflected upon my own experiences of being in an inpatient ward, and my experiences with food.

Being open to the tensions of the familiar and unfamiliar is considered what makes phenomenological understanding possible (Kelly *et al.*, 2017). Although I shared a lot with participants' life worlds, a white, Western woman who had also experienced an eating disorder and treatment for this, this was not considered a limitation. Indeed, to recognise what is distinctive in the experience of others, there must be enough in common, otherwise there would "be wordless shock or even non-recognition" (Todres, 2007, p. 15)

Appendix 4 a

University of Brighton

Cross-School Research Ethics Committee A

424 Watts Building
Lewes Road
Brighton
BN1 4GJ

26/11/2021

Ref: 2021-8530-Dark More than calories? Exploring the meaning of food and eating for individuals with lived experience of anorexia

Dear Esther

Thank you for your submission to the Cross-School Research Ethics Committee A at the University of Brighton.

The committee are happy to offer a favourable ethical opinion for this study. There are only a few very minor comments to address:

- Consent form: Please change the statement "I am aware that the photos I share will not identify my identity". to "I will ensure that the photos I share will not identify my identity or that of others."
- Interview questions: Age: You should only ask for age groups, e.g. 20-25 years, rather than the precise age.
  Location: This should be general, e.g. 'Brighton' rather than postcode.

You don't need to re-submit anything, but please make the changes before contacting your participants.

Favourable ethical opinion is given on the basis of a project end date of 01/01/2025. If you need to request an extension, please complete a change request form. Please note that the decisions of the committee are made on the basis of the information provided in your application. The CREC must be informed of any changes to the research process after a favourable ethical opinion has been given. Research that is conducted without having been reviewed by the committee is not covered by the University research insurance cover. If you need to make changes to your proposal please complete and submit a change request form in order that the CREC can determine whether the changes will necessitate any further ethical review.

Once your research has been completed, please could you fill in a brief end of project report form. Finally please could I ask that you flag up any unexpected ethical issues, and report immediately any serious adverse events that arise during the conduct of this study.

We wish you all the best with your research and hope that your research study is successful. If the CREC can be of further assistance with your study please contact us again.

Best wishes

L Redhead

Lucy Redhead

Chair, Cross-School Research Ethics Committee A

Appendix 4 b

University of Brighton
Cross-School Research Ethics Committee A

424 Watts Building
Lewes Road
Brighton
BN1 4GJ

26/01/2022

Ref: 2022-8530-Dark More than calories? Exploring the meaning of food and eating for individuals with lived experience of anorexia

Dear Esther

Thank you for submitting your change request form to the Cross-School Research Ethics Committee A at the University of Brighton.

You have carefully considered the ethical implications and mitigation of risk associated with the addition of an email as an alternative to a follow up interview.

The Cross-School Research Ethics Committee A are happy to approve the proposed changes to your research protocol.

Best wishes

L Redhead

Lucy Redhead

Chair, Cross-School Research Ethics Committee A

Appendix 5

University of Brighton

Participant Consent Form

Exploring the meaning of food activities for individuals with lived experience of anorexia

Name of Researcher:
Esther Dark

Please complete this form, and please return it to e.dark@brighton.ac.uk

	Please initial or tick box
I have read and understood the information sheet for the above study and have had the opportunity to consider the information and ask questions.	☐
The researcher has clearly explained the purpose, principles and procedures of the study and any possible risks involved.	☐
I am aware that I will be required to take part in one interview. I also understand the interviewer will invite me to a follow-up interview or to send a follow-up e-mail if I have additional thoughts. What I say in the interview or interviews and e-mail correspondence will be used as data.	☐
I will ensure that the photos I share will not identify my identity or that of others.	☐
I understand my participation is voluntary and I am free to withdraw from the study at any point, without giving a reason and without incurring consequences from doing so. If I withdraw 2 weeks or later after my interview, my anonymised comments may still be included.	☐
I understand that although I have been asked to engage with a video interview, only audio data will be collected.	☐
I understand any confidential information I share will only be known by the researcher and not revealed to anyone else unless anything I say is a danger to myself or others.	☐
I understand that in the event of a safeguarding or crisis event, the researcher will follow local safeguarding procedures and may contact statutory services for my safety.	☐

……

Name of Participant Date Signature

……….

Name of Researcher Date Signature

Appendix 6

University of Brighton

Participation Information Sheet

Title of Study

More than calories?
Exploring the meaning of food and eating for individuals with lived experience of anorexia

Introduction and what is the purpose of the study/project?

My name is Esther, and I am a PhD student at The University of Brighton. I am currently researching the experiences of food-related activities in eating disorder treatment for those who have or have experienced anorexia.

I am also interested in finding out about individuals' wider engagement with food and its meaning in their everyday life.

Food-related activities refer to, but are not limited to meal preparation activities, social eating, preparing food, visiting cafes and restaurants, meal planning, dieting, food support groups, eating practices such as bingeing, and food shopping.

The purpose of this study is that through exploring the meaning and experiences of food and eating for people with anorexia it will give professionals' greater insight and understanding.

Invitation paragraph

Before you decide, it is important that you understand why the research is being done and what it will involve. I would encourage you to talk to others about the study and you are welcome to ask me anything that is not clear. You should give yourself time to think about whether you wish to take part before deciding.

You can participate in this research if:

- -18 years old and over,
- - Received a diagnosis of anorexia,
- - Received treatment for anorexia, for which engagement with food-related activities is/was part of their treatment and,
- - Be based in the UK.

This research does not require you to have "proof" of a formal diagnosis of an eating disorder, this is for you to determine.

Unfortunately, you will not be able to participate in this research if you do not speak English, and if you have a hearing/speech impairment due to inadequate funds for a translator and interpreter, as well as if you're currently receiving inpatient care. However, it is acknowledged recovery is a lengthy process, and therefore those receiving outpatient/day care (or other forms of outpatient treatment) will be included. You will also not be able to participate if you cannot provide consent.

Why have I been invited to participate?

There is a lot of research conducted by professionals in eating disorders around food activities in treatment. But there is a lack of research into the wider aspects around eating and food and the meaning of this beyond intake and quantitative variables. Which is why I want to find about your experiences of food-related activities in eating disorder treatment and your wider engagement with food in everyday life, so that professionals can better understand the experiences of those with eating disorders.

Do I have to take part?

It is completely voluntary to participate in this research and there is no pressure to take part. If you do decide to take part, you will be given this information sheet to keep and you will be asked to sign a consent form, this is called Informed Consent.

What will happen to me if I take part?

If you're interested in taking part, we can arrange a pre-interview meeting over the phone or online to discuss all aspects of the research as well as getting to know each other better. If you're happy to take part and after you've weighed up the pros and cons, I will ask you to send me back a signed electronic consent form, this will be stored securely. If you're not happy to take part, that is completely fine too. This consent form means you fully understand the research aims, processes, and ethical implications.

I will ask you to provide me with some demographic details such as your age range, gender, ethnic origin, relationship status, length of time since diagnosis, as well as the type of treatment you received.

As a participant, you will be invited to complete an interview (this can take place via telephone, virtually using Microsoft Teams) on a day and time which suits you best.

This interview will explore your engagement with food and eating on a day-to-day basis and reflect upon your experiences of food-related activities in treatment. This interview will last no more than 90 minutes. If you do not feel you're able to cover everything in one interview, we can arrange a follow-up interview, or you can send me information via e-mail.

I understand that talking about sensitive topics such as food and eating is challenging, therefore you are invited to bring photo or photos (no more than 3) along to the interview to represent your relationship to your food. To protect your privacy, these photos should not include people or identifiable places. If you consent, you can share these photos with me, which may be included in the publication of this research. Equally if you want to share photos in the interview, but don't want these to be published in the research, that is okay too.

These photos can include images of cutlery, food, spaces, or non-identifiable places.

Interviews will only be audio recorded. If you feel more comfortable, you can turn your camera off for the interview.

Will I be paid for taking part?

To thank you for your participation, you will be sent a digital £5 gift card. You can use this gift card to be spent on a variety of high street stores.

What are the potential disadvantages or risks of taking part?

Possible risks of the study have been kept to a minimum; however, any research study carries a possibility of risk. The nature of in-depth interviews, which entails speaking about your feelings and experiences in front of another person and retelling stories of the past may bring to surface emotions, not otherwise expressed in every-day life. Therefore, you should be aware that if you do decide to take part, you will be speaking in front of someone else about concepts of food, eating and your eating disorder, and you should be aware that this may be distressing or triggering. I encourage you to think about the risks of speaking about sensitive topics such as this before committing to this research.

If you feel fatigued or distressed at any point during the interview, we can stop, and resume at a time convenient for you, or stop the interview completely. If there are any questions asked during the interview that you do not feel comfortable answering, just say "pass" and we can move on. You do not have to answer any questions you do not feel comfortable with. We can also arrange a follow up interview if we run out of time in the first interview.

What are the potential benefits of taking part?

Benefits of taking part in this research include furthering understandings of food-related activities in eating disorder treatment.
Although small, to thank you for your time and contribution, you will also receive a £5 gift card.

Will my taking part in the study/project be kept confidential?

This research will abide by The General Data Protection Regulation and follow The University of Brighton's Research Data Management and Data Protection Policies[11]. Consent forms will be emailed in advance and uploaded to the researcher's password encrypted One Drive account, and if failing this, consent will be taken verbally and recorded prior to the interview taking

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[11] University of Brighton Research Data Management Policy
https://unibrightonac.sharepoint.com/sites/public/docs/Forms/AllItems.aspx?id=%2Fsites%2Fpublic%2Fdocs%2FRESP%2FGovernance%2FResearch%20Data%20Management%20Policy%2Epdf&parent=%2Fsites%2Fpublic%2Fdocs%2FRESP%2FGovernance&p=true&originalPath=aHR0cHM6Ly91bmlicmlnaHRvbmFjLnNoYXJlcG9pbnQuY29tLzpiOi9zL3B1YmxpYy9FVE1lbmhLeHVJZFBzQ0ZHbHlzUkFVSUJYdVlpYndhS0NpOGZEN1VqdmNMdDdBP3J0aW1lPUhRZ2ZzelZUMlVn

place. If interviews are conducted via telephone, verbal consent will be gained in lieu of written consent, and I will sign on your behalf.

Photos and demographic information sheets will also be sent via e-mail and then deleted and uploaded to my secure password encrypted One Drive account.

Everything you say in the interview, follow-up interviews, or follow-up email with the researcher will be used as data, unless you request otherwise.

If you do say anything in the interview which indicates serious harm to yourself or others, or puts you in danger, the researcher will inform you that they will follow local safeguarding policies.

Upon publication, a fictional name will be used to conceal your identity, and anything you do say will not be linked to who you are. Demographic details will be described in collective terms.

Findings, including photos that you give consent to be shared, will be disseminated with the university and the wider professional occupational therapy body to improve understanding and practice for those with eating disorders.

Anonymised data transcripts and photos will be stored securely and safely on the university's data repository, until an award has been conferred, but this can be up to 10 years for publication purposes.

What will happen if I don't want to carry on with the study?

If you change your mind about taking part at any point, you will be free to withdraw from the research process at any point without any repercussion or reason for doing so – please just let me know.

If you wish to withdraw from the research two weeks after your interview takes place, your anonymised comments may still be included as the analysis would have already taken place.

This is in line General Data Protection Regulation, for as long as all personal data is anonymised and does not identify individuals, this data will be included as part of the research. All personal data will be destroyed.

What will happen to the results of the project?

Your opinions and experiences will be used in a PhD thesis and moderated by The University of Brighton. Findings will potentially be shared with the university and wider professional body to influence knowledge and practice.

Who is organising and funding the research?

This research is not funded by any organisation.

What if I have a question or concern?

If you have any concerns, questions or want to find out more about the research, please do not hesitate to contact the researcher, Esther Dark on e.dark@brighton.ac.uk

If you have other concerns with the research, please contact the programme leader, Kay Aranda on k.aranda@brighton.ac.uk

Who has reviewed the study?

The University of Brighton have reviewed this study and provided ethical approval.

Appendix 7

The Distress Protocol

Steps taken prior to commencement of interview questions:

1) Participants will be informed in advance of the interview topics which will be addressed and the possible sensitive nature of such topics which will include subjects such as ‘food’ and ‘eating disorder treatment’.
2) Participants will be asked to provide their demographic details (first and last name, and general location) in advance, in order to facilitate contact with statutory services if necessary.
3) Appropriate helplines and website support in each participant’s area will be identified by the researcher in advance in order to be able to offer participants immediate further sources of support if distress arises in an interview.
4) The researcher will ensure their interview is conducted in a confidential location, only located by themselves, with minimal disruption, and has adequate internet connection.

Mild distress:

Signs to listen out for:
1) Sounds that indicate participant may be weeping; this can include sniffling, hesitation.
2) The participant’s voice becomes choked with emotion, the participant has difficulty speaking or has a tremulous voice.
3) Verbal signals such as “This is really hard for me to talk about”, or “I didn’t realise it would affect me so much to talk about it”.

Actions to take:
1) The researcher will ask the participant if they are okay to continue.
2) The researcher will offer the participant time to pause and compose themselves.
3) The researcher will remind the participant they can stop at any time they wish if they become too distressed.

Severe distress:

Signs to listen out for:

1) Uncontrolled crying, wailing, heavy sobs and an inability to talk coherently.
2) Expressions of strong feelings of personal guilt or responsibility for a negative event or harm to others.
3) Signs of high anxiety or panic attack, as heard by researcher and/or as reported by participant, for example heavy breathing.

Actions to take:

1) The researcher will intervene to terminate the interview.
2) The debrief will begin immediately.
3) Relaxation techniques will be suggested to regulate breathing and reduce agitation.
4) The researcher will acknowledge the participant's distress but suggest that s/he discusses their distress with external mental health professionals, reminding the participant that the research is not designed as a therapeutic intervention.
5) Offer signposting to counselling/therapeutic/helpline services available to the participant.

Extreme distress:

Signs to listen out for:

1) Severe agitation, lack of coherence, especially coupled with sudden termination of internet or telephone connection.
2) Verbal indications of suicidality especially coupled with sudden termination of internet or telephone connection.

Action to take:

1) If termination of internet connection occurs, the researcher will attempt to re-contact. If this is unsuccessful, and termination occurred in the context of a level of agitation or emotionality that caused the researcher concern for the participant's or others' safety, the researcher will inform emergency contact and/or local emergency services.
2) If the researcher has concerns for the participant's or others' safety and the participant is still present in the interview, the researcher will inform the participant that they have a duty to inform the emergency contact provided and/or local emergency services. The researcher

will suggest the participant presents themselves to the nearest Accident & Emergency department, or it may also be necessary for the researcher to contact the emergency contact.

3) If upon reflection, after the interview, the researcher has concerns around the participant's safety or safety of others, they will discuss making a safeguarding referral to the local authority. The researcher will discuss this with their supervisor in the first instance and also with the participant themselves. However, if urgency does not allow this, the researcher will act in the participant's best interests.

Appendix 8

Debrief Information Sheet

Exploring the meaning of food activities for individuals with lived experience of anorexia

Thank you very much for making this study possible.

Talking about your experiences may have left you feeling low or upset. This is quite normal and should pass within a few days. However, if these feelings persist there are local sources of support and comfort which may already be familiar to you.

The most immediate sources of comfort and help are likely to be your own family and friends. Alternatively, if you have support in place for your eating disorder at the moment, I encourage you to speak to them.

There are also several national organisations that can also offer support. These include:

- BEAT – the UK's leading eating disorder charity offering support through a helpline, training, and carer support.

  Email support help@beateatingdisorders.org.uk

  Telephone support 0808 801 0677

  One to One online support web chat

  You can also find support in your local area through their help finder

- Anorexia Bulimia Care – a charity supporting those affected by an eating disorder

  Email support support@anorexiabulimiacare.org.uk or familyandfriends@anorexiabulimiacare.org.uk

  Phone support and peer led support groups can be found on their website

- First Steps – a charity based in the Midlands providing support for individuals with eating disorders.

Contact them via telephone on 01332 367571

or e-mail them on info@firststepsed.co.uk

You can also make a self-referral online.

- Wednesday's Child – a social enterprise supporting those with eating disorders and their friends and families through befriending, training and coaching.

  You can e-mail them on hello@wednesdayschild.co.uk

- Samaritans – a charity which offers a listening telephone support

  Telephone 24 hours a day 116 123

  Email jo@samartians.org

If needed, you can also speak to your GP to find out about local support in your own area.

If you have other concerns with the research, please contact the programme leader, Kay

Aranda on k.aranda@brighton.ac.uk

You can also contact the Chair of the Cross School Research Ethics Committee (CREC) Dr Lucy Redhead on L.Redhead@brighton.ac.uk as the independent contact.

Thank you again for taking part

Appendix 9

Group Experiential Table Theme

Group experiential theme 1	Meaningful doing: Relationship with Food-related Occupations as a Coping Strategy
Sub-theme 1	**Controlling food and eating amidst lives perceived uncontrollable.**
Personal experiential statements to describe theme	**Quote & participant**
Gaining fulfilment and control in the guidance of anorexia (Katie)	*putting those systems of control in your life was a way of both imposing … a teacher or an authority figure to … tell me what to do, I kind of knew… if I was following those rules, at least I would achieving something.* (508-511)
Battle between mind and body (Jennifer)	*I have always felt at war with my body.* (102)
Fear of stepping away from the familiarity and safety of anorexia (Harriet)	*I couldn't think about having anything else, it just it was just incomprehensible really… I guess that the meaning behind that was … the fear of stepping outside. You know, being more flexible around what I was eating* (98-101).
The mind and body in a battle for control leaves her in a place of distrust (Barbara)	*trying to not trust my body when it says it's not hungry, but I know that I need to eat, but also trying to trust my body when I'm like now I've eaten what I need to eat today and my body is like 'no, I'm hungry'. And that's a bit of a mind bender that you … trust it when it says it's hungry, but don't trust it when it said it's not hungry … and the fact that I've overridden hunger cues for so long... I don't know if the hunger cues are missing or if I don't recognise them, and I don't think anyone really knows…. the kind of overarching top down control over riding the bottom up control.* (507-516)
Anorexia impacts values, and her sense of identity (Sarah)	*But I lost all sense of who I was and what I wanted.* (129-130)
Disappearing from the realities of life (Jennifer)	*It was a way to fade away.*(62)
Meticulous planning in advance gives feelings of safety (Maria)	*I remember being really terrified actually of just doing that spontaneously, it was unplanned, and I hadn't prepared myself for it.* (370-372).
Feeling out of control when responding to her bodily needs. (Barbara)	*I can remember on one occasion I had one bite of an apple as well, and I just broke down in tears and felt awful that I'd had a bite of an apple. I felt like I had lost all sense of control.* (174-176)
Attempting to be in control, resulted in loss of control (Maria)	*I remember that experience of food frightened me because it was the first time that I'd lost control, and I'd eaten more than I was comfortable with… It made me sick and scared* (273-275).
Bringing attention to food, meant wanting to seek control over it (Dannielle)	*I became really aware of food and for some reason I don't know what started it, but I decided that I should weigh my food. So, I stole the weighing scales out of the cupboard and had them in my bedroom and would weigh food …. And being quite strict with that.* (136-140).
Gaining control over food gave a sense of mastery (Maria)	*food used to be my coping mechanism and it was my way of feeling good about myself. It was my way of feeling good enough by controlling something and being good at something* (459-461).
Not eating to suppress unwanted emotions (Maria)	*The food is a way of numbing emotions, I guess? If I felt out of control, worried about something I would just stop eating and that made me feel better. And I think that's what sort of started off the anorexia and like using food in that way.* (77-80).
Anorexia is a manifestation of control but paradoxically means being out of control (Fiona)	*it was never really like a control thing and it kind of got to that. But I never started out thinking it was like a control thing like controlling what I was eating, and I think it then it just manifested in that way. But there was no part of whenever I got poorly or when I was really unwell that I have thought yeah, I'm controlling my weight like this feels good cause you don't feel good cause you're not really in control*. (165-171).
Being anorexic meant being cared for (Kelly)	*It made me feel like an adult as well, like my eating disorders, very much is a way of me like reverting to childhood…. I still feel like I'm a teenager or quite young…. I am like an adult and that's OK for us whereas before I*

	think like I wasn't in the place to feel that was OK… I wanted to be looked after.
Shame associated with bodily desire (Jennifer)	*In general, I think being seen as having a healthy appetite or a bigger appetite was seen as something that was greedy and not just that person needs more food at that time. It was kind of like, oh, you're just greedy, your eyes are bigger than your belly kind of thing* I *think there was a lot of shame affixed to eating and eating larger amounts or what you actually wanted.* (97-101).
Controlling food was a way of controlling what went into her body (Sarah)	*I counted minutes and I then I started counting calories. I counted every single little thing. In a way, I think it must have just been a way of controlling exactly what was going into my body.*(82-86)
Using food to control what felt out of control (being epileptic, weight gain). (Kelly)	*I was trying to control my life, I wanted to…* *I didn't feel like I had control over my weight because I was on medication that was making me gain weight cause that's epilepsy. My medication is like notorious for making you gain weight really fast.* (86-90)
Not eating to avoid the changes of a developing body (Maria)	*I think I was scared obviously going through puberty as well like I would like my body was starting to gain weight naturally and I saw other girls start to gain weight and that freaked me out and I think food represented the sign of becoming an adult and my body maturing cause I think that's partly why I like I restricted.* (86-90).
Food creates conflict between mind and body (Kelly)	*But I was, but it also makes you super hungry and I was having seizures as well so I was just so hungry all of the time. But I desperately wanted to lose the weight that I had put on, but also I just wanted to control something like at least I didn't.* (91-94)
Controlling the inside, controls the outside (Kelly)	*Yeah, I think it was a lot about kind of controlling what I put inside my body when I couldn't control a lot of things around me.* (102-103)
Sub-theme 2	**Seeking safety and certainty through eating**
Familiarity elicits safety in a world of chaos (Maria)	*It's like I've always done that, but I don't think to do it another way. But I think it feels comforting to have that routine. It makes me feel safe. It makes me feel a bit more in control when a lot of things outside in the world aren't in my control.* (141-149).
The sacredness and place of eating supports transitioning through the day (Maria)	*I think also for the breakfast thing it's a way of integrating, it's a way of starting my day, I'm not quite awake enough to sit at my table. It's like a halfway house between being in bed and then getting up and starting my day. It feels like a way of transitioning into work where I sit on the floor and have my breakfast and then I do a meditation and then once I've done that I'm ready to stand up and to actually put some clothes on and face the day properly. I think it's a way of me protecting myself from the outside world, getting myself ready and then moving on and carrying on with my day after that.* (150-158).
Wanting certainty in food decisions and not trusting herself (Maria)	*I was scared about making the wrong choice and picking something out that I didn't like. I wasn't sure what I wanted. I thought I wanted a glass of wine. But I wasn't sure. And everyone else was drinking Cokes so I though should I just do that if anyone else is. But then I did want wine and there was an element of like was that too much with the pizza? But I think. So uncertainty was in there.* (595-600).
Reduced choice in food can establish eating patterns due to the predictability (Kelly)	*I am very much like a creature of habit, so actually I would say that my most recent admission was probably the most beneficial for me with the smallest menu choice because I actually I was quite comfortable with not having to shift between too much.*(312-316).
Safety in numbers (Fiona)	*And it was just like a number's game, really.* (186-187).
Gaining certainty from using specific cutlery and doing things in a certain order in her life (Jennifer)	*having to do things in like a certain order, like having to do something before eating.* (59-60).
Not trusting her own self to eat, but placing trust in numbers (Danielle)	*calorie limits became a thing like I'll only X amount of calories today and tomorrow it will be this, those kinds of rules. I used things like my fitness pal and those another one that I actually paid for to track calories, things like that…cutting things up into so for example, if I ate strawberries, they'd always have to be cut up into four.* (218-223.
Separating food out gave an illusion of not eating a meal (Danielle)	*it just seems better if it's separate. And I guess it makes it loads of different foods rather than a whole meal in some way I don't know, I've never really thought about it.* (239-241).
Avoiding proper meals to stick with what is familiar (Danielle)	*but there was still really strict rules on things that I wouldn't eat and said I didn't like even if I'd never tried them and mostly those kinds of foods*

	were fruits and vegetables, and proper, like what I would say is proper food, like proper meals and things like that. I would tend to stick with things like peanut butter sandwiches or sweets rather than having like a broad variety of different food groups.(102-107).
Food rules created certainty (Sarah)	*I had to have my food in certain patterns or arrangements, and I couldn't have food touching each other. And, and I could only eat certain things, so it's quite it's quite odd [laughs] I think that's the word? It was a way to escape.* (70-73).
Eating was about feeling safe and in control (Harriet)	eating at certain times *You know it would be so you know that feeling safe within, you know, eating at certain times and often that would sort of create problems. Or we wanted to go out for a family. It would be about "Harriet's snack, Harriet's lunch, Harriet's afternoon snack" and.* *But I just couldn't see any, any other way around it really like.* *And it was just what felt safe to me to do and.* *I don't know if it's sort of. It's along the same lines, but so eating from the same plate using the same cutlery again, that was just all about feeling safe and in control, or something that I guess I felt so very out of control of really.* (108-116).
Eating needs to be savoured (Jennifer)	*I think equally like say a certain spoon or a certain bowl or something is if I feel like if you've been in restriction for a long period of time, then like food is something to be savoured so much that like say having a bigger spoon, a lot of I find that a lot of other people with eating disorders or so like… small spoons or a certain bowl that makes the appearance of having more food in the bowl*. (78-83)
Seeking perfection from the specifics of eating (Maria)	*something that I can remember are rules around times, so eating my lunch specifically at 12 or eating my breakfast specifically at like 9 or whatever, and if it got to sort of 2 or half one then I couldn't eat my lunch. It was too late then, I'd ruined it And rituals around making food the perfect temperature, for example having to put it in the microwave and then make sure it was hot enough.* (125-130).
Needing the perfect environment to eat (Katie)	*I would do a lot of just getting up and down from the table while I was eating so everything would have to be perfect so the door behind me would have to be closed. I knew that nobody was going to walk in and like for the moment while I was eating and the food would have to be the right temperature for even if I had to keep going back to the microwave again and again and I would cause it would take me a long time to eat I would and I just take things through like really tiny mouthfuls.* (115-122).
Food engagement is more valued than relationships with others (Katie)	*it kind of felt like this is definitely the right way, and that anybody who disagreed with me on that was wrong and like that they were, they were going to be some sort of comeuppance that we were all going to get… I was so rigid and my beliefs about food, and so I would kind of say like, well, look if they're not going to do it my way, then I'm going to do it and nobody else is going to do it. Nobody else is going to prepare the food because it's just not going to be right.* (108-114).
Counting food to elicit feelings of safety. (Barbara).	*I would have six like half-moon slices of cucumber and cucumber, celery so very thin, and it was counted out to feel safe.* (167-169)
Sub-theme 3	**Food and eating are a threat**
Food became the enemy which threatens safety (Maria)	*I has been under a very stressful period with exams and once I stopped revising, I then focused my attention into restricting my food and going on a diet because again I felt like that was something I could control. And so, for that period food was seen as a scary thing. It was like the enemy. It was something that I didn't feel safe with and I wanted to restrict* (81-85)
Food creating a lasting embodied reaction (Danielle).	*From then I didn't like the sugar on my teeth and the way it stuck* (270-271).
Tense and discomfort with touching or talking about food. (Fiona)	*There was things that if that if I knew that like something, I wouldn't eat it, touched some cutlery. I wouldn't use that cutlery even if it had been through the dishwasher. Yeah, I'd say my relationship with food was very… well, it was a relationship, but it was very tense, very just not comfortable at all, like even wouldn't even talk about food, even though obviously I was starving.* (70-77)
Eating fast means avoiding dwelling with food (Barbara)	*And conversely like eating is some kind of dirty task, that I have to get it done quickly so I don't have to dwell on it I suppose* (194-196)
Hunger was embodied lightness from the weight of food (Maria)	*but I liked the feeling of being hungry. I liked the feeling of not having food inside of me. It felt like freedom. It felt like if I put the potatoes in my*

	that I was tarnishing my body in some kind of way, of damaging my body (301-304)
Suspicions around the potentiality of being contaminated (Barbara)	*this last relapse, I've been restricting, well I was restricting fluids and I couldn't understand myself why. But I think part of it is that fear. That it's been contaminated, but it's got sugar in it cause I'd also had an issue where I was in a relapse, I had been drinking sugar free pop. And it was said on the front, sugar free. But it had sugar in. It must have been mislabelled. So instead of saying low sugar, it said sugar free when it did have a reasonable about sugar in and that freaked me out. And then I was having to like compulsively exercise.* *So that kind of trust thing* (290-297)
Physically separating food from life to avoid contamination (Barbara)	*But I do find things easier if things are like things are like tidy, I feel better about things and if there's food lying around, like if the if I don't like cooking smells I like. I couldn't cope with having a kitchen diner, not kitchen diner, kitchen living dining kind of thing. And things have to be separate.* (216-220)
Labelling foods at fat, would make her fat (Katie)	*I would have believed that it was like very gluttonous and unhealthy to eat, like fried foods like chips and stuff, and I believe that bread with bad for you and it was very fattening, and I had it like a lot of fat phobia. So just very afraid of being fat* (140-143).
Food is personified as active and can contaminate (Barbara)	*But I think there's like a subconscious fear of things like going in through my skin, like touching and handling food will like contaminate me or something. (*247-294)
Fat can get through the outside to the inside (Barbara)	*I've even had things like where I've had panic like putting moisturiser oil lip balm on because they're fat….like a fear that it's kind of if I'm rubbing fat on my skin, which is hard cause my skin gets so dry when I'm restricting.. (*223-227)
Food is polluting and contaminating (Sarah)	*I think I started to think about like I thought that food might pollute me or like contaminate me in some way (*121-122)
Choosing foods based on their certain properties deemed safer to eat (Sarah)	*So I tried to sort of limit my options as much as possible.* *In terms of like choosing certain foods that weren't fluid like you know Weetabix or like something else like if it was sliced, something that was already cut by the manufacturers you know, like things like that, yeah? (*355-359)
Food can transgress boundaries through seeing and touching (Fiona)	*So, like I remember, like my mum she ever cooked like pasta or something in the kitchen. I wouldn't go into the kitchen because I would feel like I'm like the steam from cooking the pasta was going to be absorbed from my [laughs] I'm laughing, it's just hilarious. And the steam would be absorbed through my skin and that I would gain weight that way.* (63-70)
Uncertainty of food can be contaminated (Fiona)	*There was things that if that if I knew that like something, I wouldn't eat it, touched some cutlery. I wouldn't use that cutlery even if it had been through the dishwasher.* (70-73)
Feeling trapped in her body by the burden and permanency of food (Kelly)	*I just almost see it as kind of like a heavy thing in my in my mind if that makes sense? I can't really explain it, but like I think yeah, part of it was almost just like seeing it kind of I don't know carbohydrate foods kind of almost like forming like a big ball inside of my stomach. That won't kind of come out if that makes sense? and that then, like ball, just turns into like making me put weight on and making me heavy and even just like… just I'll just being like it was trapped in my body. (*150-156)
Food connected to how her mum prepared food, which was chaotic and messy (Barbara)	*there is stuff around like my mum was always like very like avoiding waste and stuff and would make like stews over like whatever to stop everything going off and a very kind of like really sustainable way of like cooking and things. But that bothered me because it wasn't like neat and little like this is the recipe, and this is what's in it and mixing things together bothers me. Like, I like things to be organised and neat and I think that might have had some kind of impact.* (151-157)
Uncomfortable with what feels out of place (Barbara)	*it just freaks me out because I could smell food, like fridges scare me cause, I can smell food. And like cooking grease or, any kind of evidence of like, yeah, If I'm, like, washing up can be a really difficult thing, because if there's any like food debris, it just makes me feel icky* (241-246)
Sub theme 4	**The push and pull of the doings of anorexia**
Bingeing marked by conflicting emotions, excitement, and disgust (Maria)	*And, you're excited because you know you're going to get in trouble, and you've done something like you know the adrenaline going. I got that and*

	then. *And after I finished like quite soon afterwards. I felt really sick and lethargic and disgusted. Feeling guilty with myself* (293-296)
Feeling fraudulent for continuing to eat despite instincts to not eat. (Danielle)	*I was struggling with still being very unwell mentally, but physically I was fine. So I felt like every time I faced a meal that I was a fraud and that I shouldn't be eating.* *If I was OK, I shouldn't be OK. I shouldn't even be attempting to have breakfast, or I should just naturally go to my eating disorder thoughts. So, I think mostly it was about breakfast being about being a fraud.* (31-36)
Not giving herself permission after treatment (Harriet)	*actually when I came out of hospital, even the third time … the sorts of things that I that I would allow myself to eat was still so, so restricted.* (523-525)
Still control diet by being a vegetarian. (Harriet)	*And I wasn't a vegetarian before then, but because that option was available to me at the age of 13 I became vegetarian. That's the only thing I've hung onto. I'm still vegetarian* (73-75)
Meticulously planning eating prevents life collapsing (Barbara)	*So it's just a matter of everything is like trying to plan everything out meticulously. But if I'm not doing that things start to crumble again.* (213-215)
Eating regularly makes her feels she is dependent and addicted to food (Barbara)	*But then I feel like if I have to eat like X number of times a day. I feel like I'm addicted to food and then I feel like I'm going to be fat and it all spirals. It is about accepting life will always be messy.* (530-532)
Being honest rather than deceiving yourself (Katie)	*it's not always going to be easy, like. Not every day is easy, but I think the major thing is just being honest with yourself, acknowledging that you're afraid, acknowledging that maybe you had a rough day and you didn't eat much as maybe your body would have liked and then getting on with it and just eating again* (581-585)
Reminding who she is in spite of circumstances (Kelly)	*Even though difficulties are still there, I am still here, and keep going.* (820-821)
Convincing herself that one day her eating will spontaneously improve (Katie)	*and I kind of believed, I think that if I if I would keep losing weight then I eventually would get to a point where I'd be able to eat back up to a certain point and that I would be able to eventually eat all this food that I wanted to eat. But obviously this had been going on for quite a few years already, so like that we've never going to happen.* (70-75)
Recovery is not a moment but a process (Katie)	*the thing is like recovery, isn't just for a period of your life, like its for the rest of your life. It's like a medical treatment that you need to go through to get to the other side of being healthy*. (586-588)
Eating is a battle (Barbara)	*I can't fight this and I'm scared I'm going to lose my kidneys. And I'm scared that I thought all these suicidal thoughts. And now I'm just going to drop dead because I can't do this. I'm not drinking anything. I'm not eating anything and I can't fight it* (320-323)
Conflicting emotions around eating (Barbara)	*there is still always going to be that little like kind of voice, going, you shouldn't have done that. You could have got away with that. You didn't need that. But also a reasonable part of me just felt happy that I'd managed to do the right thing and that I knew my husband was proud of me for doing that.* (649-653)
There are still challenging food and behaviours around food which remain (Sarah)	*I still think there's certain foods that I'm scared of that I am still trying to challenge, but at some point, but generally, on the whole, I eat so that I can survive and do stuff and that's it if I am being totally honest.* (383-387)
Continuing to seek control (Sarah)	*I always eat the same breakfast. But that's just because I like it. I still weigh elements of it, so I still weigh that.* (480-482)
Conflicting priorities in treatment (Kelly)	*I think it just shows that like it's so multi-dimensional like often say how I'm, I'm almost like two people like I've got my eating disorder separate person to me, but really that it's kind of almost more than that. It was like the eating disorder was saying just eat your way out. But actually, how can you still do that without putting on too much weight? There's like even like and there's just like there were just so many layers of kind of like I didn't want to put weight on, but I wanted to not be in hospital.* (520-526)
Continually monitoring intentions. (Kelly)	*I kind of feel like I need to take a rest from the gym now because it's not about me getting strong or healthy. It's about me burning off what I've*

	eaten or even not burning off what I'd eaten, It was about like I had to do an hour on the treadmill for instance, and then like if I then did one day and I couldn't manage an hour so that wasn't good enough. It's all those kind of like repetitive things. I can now recognise I'm doing and take a step back and kind of like analyse it and think to myself like in the long term. What will that achieve me? Yeah, OK, it means I'll fixate on all of that, and I'll lose weight and that feel great. But actually then it just sets me back so much in my life. (827-837)
Understanding that recovery is up and down but finding other ways to manage food. (Kelly)	*And now, post treatment, I still struggle quite a lot and I go through stages where things aren't good, and things are better. But to say that I've managed to do a year and a half without making myself sick is like, shows that I can manage it enough to not have to go to the resorts of hiding the fact that I'm not eating anymore, making myself sick.* (846-850)
Reflecting on decisions, reveals underlying motives and meanings around food restrictions (Barbara)	*It's like you didn't forget. Did you know? Like when I did? And it's like, no, you can't forget to eat lunch somewhere the eating disorder has got on top but it kind of it's difficult because you don't, it's sometimes hard to separate it and it genuinely I'm thinking I made that plan and then it went to do this. I didn't hang on. I haven't done that. I haven't actually had lunch or haven't had breakfast. So logically, I presumably didn't actually forget, but it feels like I did* (204-210)
Recovery is a process you have to go through and eating in spite of emotions and circumstances. (Jennifer).	*I think as you going through the process of recovery, I think it's a necessary. I think there's going to be times where you do not want to eat a meal you like. You don't want to eat a certain food. It's like you can't even taste the food at that time because your anxiety is like so high and you're crying and you just you don't want it. But you know that used to like that and you've just got to get to that point of liking it again and feeling comfortable with it again. And I think it's just like riding that storm.* (456-462).
Group experiential theme 2	**Meaningful Being: Food-related occupations are an expression of identity**
Sub-theme 1	**Relationship with food reflects personal identity**
Her weight became her identity (Katie)	*I was trying to gain weight because it had definitely become a big part of my identity and food was a big source of conflict at that* time (265-267)
The self becomes entwined with food (Jennifer)	*when you're eating that food, it's hard to then separate yourself from it* (222-223)
A lack of engagement in the world increases alliance with anorexia (Danielle)	*I was really isolated. At the time, the eating disorder was the only thing I had.* (232-233)
A sense of superiority and difference (Maria)	*it was almost like my identity, like being able to say no to a piece of cake, when everyone else is eating it, I was quite proud of myself* (93-95)
Personalised view of food as a child created an emotional connection to food (Danielle)	*I don't know, really personalised food and made me, have a lot of feelings around food. I'm so I think a lot of my, I don't know a lot of the difficulties I feel and feelings I feel around food came from that.* (258-260)
Recovery is building an identity outside of the eating disorder (Sarah)	*And I think, I just think it's well, there's so much focus on food and not about life and identity and that's the problem. If someone identifies as someone with an eating disorder and they don't see nothing else, and they don't feel they have any worth or any value. I've never, I've never met an anorexic or someone with an eating disorder that's got a good identity, you know. So, like, I just think build people up and help them to find something, whether that's a course or a job, or a dream or anything. Just keep reminding people that life is bigger than their eating disorder.* (556-567)
Our doing reflects who we are (Harriet)	*Recovery is a full time job. It takes everything. You have to change everything you do, and who you are.* (449-450)
Being dainty relates to disappearing and not wanting to be seen (Barbara)	*it is kind of somehow like wanting to be small and dainty and to disappear and, which can be hard. I wanted to escape from everything* (271-273).
Her food choices gave her a concrete sense of identity (Danielle)	*I know that now, if somebody I don't know, it sounds strange, but I have a sense of identity with a peanut butter sandwich [laughs] like it feels like that is something concrete about me because I like this, and it's certain and clear and other people know it* (197-200)

Having choice over her food as a child was a way to exercise her sense of self (Danielle)	*I had a choice over and was able to exercise my boundaries of I, like, no matter what the situation is, you will not get me to eat this food, and it was, yeah, like a clear boundary.* (202-204)
Developing an identity outside of the eating disorder (Danielle)	*I think that the day patient probably saved my life physically, but it saved my life, because it gave me a life. It gave me an identity outside of my eating disorder* 458-461)
Building her life and self upon patterns of food and eating (Jennifer)	*For that to be stripped away from you, I feel like when your whole like daily life and your like identity is revolving around food and exercise like once that's taken away from you, what's left kind of thing and it's like you have to rebuild everything*. (588-592)
Questioning identity outside of anorexia (Sarah)	*I didn't know who I was without anorexia* (376)
Numbing self through hunger (Maria)	*quite empty, quite light, quite numb from everything* (300)
Sub-theme 2	**Not feeling good enough to be anorexic**
Not wanting to take up space in the world through the physical body (Barbara)	*I think is to do with not willing to take up enough space, not to take up too much space in the world, like in some ways to be fat is to be like arrogant and taking up more space than I should.* (269-271)
Using food to soothe anxieties (Maria)	*food was definitely a way to soothe anxieties and feelings of not being good enough*. (95-96)
Food is a form of care that she is not worthy of (Harriet)	*deprive myself of nice things*" (80cer3), and "*neglect myself*" (806), which was related "*not feeling I deserved to be cared for"* (807).
Food is a way to counteract negative feelings of self. (Danielle)	I didn't like myself and I was self-conscious. (144)
Thoughts around food are associated with low self-worth (Katie)	*I think that like a lot of my beliefs about that were very tied to like feelings of like low self-worth when I was a teenager* (167-169)
Food restriction is a way to justify the illness. (Harriet)	*I felt that I didn't really live up to that title and that I didn't look ill enough to be like that, so I almost sort of cut back even more so that I justified that diagnosis* (39-41)
Not feeling worthy to eat (Harriet)	*And I would do a certain amount of star jumps before eating … and I guess that was around sort of compensation. And me justifying to myself that I deserve that food* (105-107)
Internal shame and avoidance around being caught eating (Kelly)	*I refused to go into a coffee shop and drink a drink or eat something out of the fear that somebody would be watching me, go "ah you don't like you don't have a problem?"* (384-386)
Eating needs to be justified by moving (Jennifer)	*my eating disorder is very linked to movement.* *And I feel like often movement is a justification for eating so I feel like I have to do something before eating. It's kind of justify eating.* (71-73)
Not feeling worthy to eat based on physical changes (Danielle)	*Yes, I think at that point, uh, I was struggling with still being very unwell mentally, but physically I was fine. So I felt like every time I faced a meal that I was a fraud and that I shouldn't be eating* (31-33)
Not feeling deserving for intervention (Barbara)	*I hadn't gotten to unbelievably skeletally skinny when it was at the point where I was told that I either was admitted, or accept the tube now, or they will section me within like and they said like three to four hours they expected my stats would be low enough that they'd be sectioning me to get me to tube fed. But I wasn't like that, kind of. I mean, like, I'd be, like, bruising, like, lying down and things like that. I had bruising on my hips and knees. But I wasn't, like that massively skeletally skinny that everybody thinks of.* (56-63)
Movement and exercise are justification to not eat (Barbara)	*if I have got no energy, I don't need to eat, I don't need to eat. If I'm not. I have not done 10,000 steps. I'm not doing 15,000 steps. I'm not climbing around the place. I'm actually stuck. Like, can barely move on the sofa, I don't need to eat then.* (496-499)
Justifying eating sweet foods through everyday movement (Danielle)	*And then on the way home from school, I got given train fare and I'd walk home instead and use my train fare to buy sweets. And that was like, I don't know I suppose maybe like a reward because I've walked home and now* (126-129)
Did not feel unwell enough by her weight so communicated this by not eating. (Kelly)	*I was like, no, "I'm still not like a small as I want to be like, I'm not unwell enough to be in hospital yet" so I just refused to eat or drink cause I didn't want to undo any of the work and I just was so, I was just I just was shut off from everything up. It's almost like I kind of lost myself* (545-548)
Sub-theme 3	**Food and eating are a form of communication**

Gaining recognition from others through the body (Katie)	*If I ever lost a few pounds just by taking up football or whatever, like growing up, people would say "wow you look great" so then if I put it back on I'd be like well I better lose that weight again or people won't think I'm great* (176-179)
Labelled as the healthy one (Jennifer)	*As I said, like for me movement is a huge thing and they think that that one that's been in your identity for so long and like your identity's been linked to exercise or linked to being perceived as the "healthy one".* (567-569)
Being validated and cared for by others when underweight (Katie)	*You know, like I was cold I has no period. Like brittle, just awful like I did not look well and like all of my friends were always kind of pulling me saying like look, we're really worried about you and I kind of loved it. cause I was like well like now well finally I am getting validation for this.* (492-496)
Gaining weight meant losing respect from others (Katie)	*but I believed that if I were to gain weight, I'd lose the respect of my peers… feel like I'd be unlovable or my family wouldn't love me* (147-149)
Looking different but still struggling (Jennifer)	*As I've reached a healthier weight it's like, I think people assume that you struggle less, but I don't think that's the case because your brain takes a long time to catch up with things (*448-452
Not eating is a manifestation of distress (Barbara)	*if I wasn't looking fragile and ill, I didn't love my baby enough and. And I think that definitely linked with part of it and part of it (*267-269)
Feeling socially different to others was an ordeal (Danielle)	*because my mum was on certain benefits, I got given a food pass or something and you had to be in registration in the morning to get given the pass to then be able to use it to get your lunch and I was always late for school, so I never got my lunch pass, I could go and get it on my break time, but it was like an ordeal. So, and also, it was a stigma to have this like bright yellow card to exchange for food so it wasn't really something that I wanted to going get so often I didn't or I'd give it to a friend purely because I couldn't didn't like going into like the canteen environment.. (*116-124)
Being sick was a way to express emotions (Danielle)	*when I would make myself sick but it's not as a way to get rid of the food it was more I don't know of a way to express how I was feeling.* (141-142)
Having validation and recognition from others supports her to continue to eat (Barbara)	*I think and yeah, I know that my husband or my best friend, I know that they're really proud of me when they see me eat and they find it really reassuring to see me like eating and rather than just like struggling* (718-720)
Group experiential theme 3:	**Meaningful Belonging: Contextual Influences upon the Meaning of Food-related Occupations**
Sub-theme 1	**Positive interpersonal influences upon food and eating**
Eating in treatment is not real life (Sarah)	*But when you're out in real life and sort of like not many other people around you have eating disorders, or if they do, it's not in your face all the time and you have different focuses in life. You are also able to just choose the food that you want to eat.* (243-248)
Food is a way to show respect and appreciation to others (Maria)	*But because I really liked his mum and I wanted him mum to have a good time, and I didn't want to create a fuss, I would just eat whatever they gave me and that was a real transition point because I realised that I cared more about his mum's feelings then I cared about food.* (347-350)
Friends who have a positive relationship with food, which is carefree and spontaneous. (Katie)	*So, I had these two friends, and they were sisters and they would be people I would very much describe who had like a positive relationship with food. And I went over for dinner there and they were helping each other to make the meal. So they were making like these like burritos so they were like vegetarian burritos, like they went to the shop and they got all the ingredients like they laid them out on the counter and they were chatting and they were eating like nuts and stuff while they were making it and listening to music and then one of the girls is like oh, should we have desert? and she's like yeah like and she started making a dessert and I remember just being very blown away by the entire experience* (200-209)
Recovery is dependent upon social support	*But the difficulty is, I think if you come home and you haven't got that solid support who will sit with you every night and make sure that you eat everything on your plate and actually know what you should be eating, then it's quite difficult to continue that maybe.* *Uhm, luckily like I have received a lot of support from my dad since I have been back, he has been like very on the ball with it* (423-328).

Role as a mother influences her own behaviour with food (Barbara)	*And also I have a 5 year old son and I don't want him to pick up on those behaviours. I want him to stay happy with his body.* (663-665)
Eating with safe people was when she started to challenge herself (Jennifer)	*And I was eating with people that were like eating their full portions and stuff that I started challenging myself, and I felt safer to be challenging stuff myself.* (413-414)
Associating being fed with being cared for by step mum (Harriet)	*I've got various memories of my step mum sort of feeding me the fat off the skin off the chicken and her seeming to enjoy that and me liking that attention that was getting me but actually not liking the taste of it.* (30-32)
Food in treatment connected to early life experiences of being cared for. (Harriet)	*It was fish fingers, pasta and beans and it was something my dad cooked for me and it's really random, but that was the first thing I cooked and it was it was lovely being able to kind of choose that…. And to remember where I ate that and that was at home and kind of make something that was personalised to me and not have somebody cooking all of these things for me that the dietitian said. And it wasn't anything driven by my eating disorder. It was just a really good memory for me.* (205-212)
Eating socially helps to alleviate fears of food. (Harriet)	*From that point, I had stop overs with friends and I often found like I said, I could eat a lot more easily with them and I'd look forward to we'd buy some chocolate and some sweets and I'd look forward to being able to eat with them to begin with* (441-444)
Recovery is based on ideas of what normal eating is (Harriet)	*I started to sort of have visualisations of what it would be like to eat normally and used to visualise waking up in the morning.* (54-56)
Emotional safety increased confidence to challenge food behaviours (Sarah)	*So, I think it's one of those things, when I'm with people that I feel safe with and I'm actually probably pretty hungry. I think I'm going to just enjoy this if it's nice food, which I generally do with my friends* (511-515)
She became spontaneous around food because of others (Danielle)	*once I got to college, I think maybe, I remember I had a group of friends who are all male cause. I was, I think I was the only girl on the course. And for some reason that made it easier and so I would go and have lunch with them wherever that was in the college day and I don't remember that being an issue (*155-159)
Powerful mutuality in the experience of eating at breaktime where eating was a social experience (Maria)	*And I and remember such excitement like we would just sit there in class and the bell would go just before half 10, and we'd, we'd all literally sprint from the classroom [laughs] as fast as we could to get to the canteen and, and I remember every day it being like a race. And it was almost like a challenge as well to see who could get the waffles or the chocolate croissant. And, and if you managed to get there fast enough*, *you might share them with your friends (226-232) And the food was great, but it was more excitement of getting it. That was part of it* (236-237)
Mirroring eating behaviours based on other people. (Kelly)	*And then we sat down, and she was like "I might think I would like to have this" and I was like, "yeah, that sounds nice" And so I said I'll have the same as you because that made it more like helpful having the same thing as her. (*668-671)
Social eating normalises food and improves food choices (Sarah)	*And, and I just thought that you know what? I'm just going to go for it. It's my other two friends are getting it. And so, I literally then didn't look at anything else.* (530-533)
Sub theme 2	**Negative interpersonal influences on food and eating**
Feeling her difficulties with eating were overlooked by others (Fiona)	*I lived in a flat of 12 or 14 people, but I knew that people wouldn't challenge me about it because no one cares really, do they? It's like you know you know bat an eye lid If you think I am, not bothered about what they've had to eat each day, just like concentrate on what you're going to eat and then going to do whatever you want in your first year uni,* (276-283)
Learning what normal eating is through role modelling eating on others away from hospital (Harriet)	*obviously, exposure to community settings, even as an inpatient, I think is really important. You know, just starting to see all the people because I think for me it almost felt a shock to the system to see people talking and smiling while they're eating, not bent over the food and not knee jigging and not running away and being terrified of it. I think that was really, really important* (501-505)
Objectifying self through others self-criticism (Jennifer)	*My mum and siblings criticise their own body and criticising what they're eating and you're wanting the same thing. then you apply that to yourself.* (111-112).
Facing older people in treatment and learning behaviours from them (Fiona)	*I was on a ward with people who were 50, 60. They're both, they're all dead now. But uhm, yeah, so I'd never seen that, and I think that was quite damaging (*250-252)

Relationship with food is entangled in comparison against others (Harriet)	*She would say "oh your friends got lovely hair, but your hair is like rats tails" and things and I guess those little comments and things. Maybe just sort of tangled up my relationship with food* (172-175)
Influence of others in the group setting and comparison made eating harder (Harriet)	*But I actually found the group activities much harder than when I was doing it on my own because I felt like you always sort of looking at or what are they weighing out, what they're doing, and you know if somebody was struggling with a certain aspect of the task, I think that had a domino effect on kind of how everybody else sort coped and managed with it really. (*235-240)
Mother-daughter relationships shape engagement with food and eating (Kelly)	*I grew up my mum was always like on a diet, so I kind of like always just had a bad association with food* (29-31)
No grasp of normal eating (Kelly)	*I suppose my most recent kind of admissions have normalised food for me and normalised, actually that it is normal to have food during the day, which even before I had anorexia or I didn't think was normal cause my mum was always on a diet.* (794-798)
The influence of others in treatment can be toxic and influence the experience of eating and food (Sarah)	*Because you're on your own. Yeah, I think so. And you have different focuses, so like when you're in a unit, you are literally in a unit with all these other anorexics and it is quite toxic. But when you're out in real life and sort of like not many other people around you have eating disorders, or if they do, it's not in your face all the time and you have different focuses in life.* (240-247)
Her mum allowed her to continue with her eating habits to meet her needs and show care (Danielle)	*and I think my mum was OK with it. She was like, well, this is all she eats. So, this is what I'll give her, and I think it gave her a sense of being a good parent because she could give me what I wanted like that. Whereas in other parts of motherhood she couldn't meet my needs* (107-111)
Withdrawing from food, meant withdrawing from others (Maria)	*And I remember feeling very tired in myself, very, very like withdrawn from everybody around me.* (299-300)
Mealtimes were marked with tension and conflicts (Maria)	*I remember the conflicts around meals and the tension around the table and how no one would be able to relax because they were all watching me and watching everything that was on my plate.* (253-255)
Mother daughter relationship impacted upon beliefs around food and eating (Jennifer)	*Family members that a diet focused, and I think that's been a big thing in upbringing was that I was kind of surrounded by my mum who is constantly on a diet* (96-98)
Questioning herself when others find what they are eating difficult (Jennifer)	*And sometimes you could eat something that would be fine for you. But then another person would be crying over like half of what you're eating. And that was like really difficult at first and then I'd be eating something and then someone else would be finishing less than what I was having. And I was like, oh, I shouldn't be eating this but still feeling hungry so.* (385-392)
Protecting herself from the influence of others in inpatient (Jennifer)	*you know you got to protect yourself in there and people do make comments about food, and when you're eating that food, it's hard to then separate yourself from it. When you're challenging yourself kind of thing.* (221-224)
Learning negative habits from others (Jennifer)	*A lot of the people on the table weren't finishing food, so then I got into the habit of not doing that (*409-410)
Being guarded around food as a way to guard against others and reality (Katie)	*I was very guarded about food so I didn't want people to know that I had a problem or I wanted to convince myself and them I didn't know I had a problem and I also didn't want anybody interfering with what I was doing* (58-61)
Being influenced by mum and sister's relationship with food and eating (Katie)	*from like the things that my mum would say when she'd be dieting and also, like kind of my entire kind of time of being a teenager, like my sister would have been dieting, and I've later found out that she was having struggled with, she struggled with like disordered eating and she's recovered from that now.* (171-174)
There are rules on how to behave between patients (Danielle)	*when we'd finished that snack and went out, they were saying, like kind of giving me advice on things like how not to be triggering for other people. And like don't like we try not to look at other people's plates and just things like that. Which I don't know. I don't know whether it was helpful.* (320-325)

Reflecting about what she ate with others fostered comparison and doubt. (Danielle)	*And we did it as a group and it was difficult to hear everybody is kind of reflection on how they did the week before.* *Uhm, and it was difficult to hear when other people had so say, other people have just started, then they're allowed to have their porridge with water for example, because like you start slowly, I can see that now. But at the time, it just seemed unfair that I was having to have a big bowl of porridge and something else as well. So it was very that was a lot of comparison between other patients* (341-348)
Family expectations were overwhelming (Barbara)	*I just was so, so tearful and so upset and so like, kind of angry at people wanting me to eat and it just felt so frightening and being sat at the table and just in floods and floods of tears, like curled up in a ball cause I just couldn't eat it and I wanted everyone to leave me alone and stop trying to make me fat and trying to make me eat when I couldn't eat and I didn't want to eat. And I can remember my parents being frightened and confused and frustrated. And not knowing like what to do to help but also having no understanding of why you can't just eat, and I think that is hard to understand* (429-437)
Sub theme 3	**Environmental influences upon food and eating**
Notice turned to her eating practices felt threatening (Danielle)	*one of the lecturers came over to me and was like, "oh, what have you got?" It was just a conversation, but that was it, I just put my food down and I could… never eat in that place again, I don't really know why because it wasn't a judgment. It was just some awareness had been made that I was eating something and there was I don't know attention brought to me.* (174-179)
The palpable tension of the dining room environment. (Jennifer)	*I think when I first went like into the main dining room, the tension there was like it was horrible. You just felt like everyone was like either everyone was watching each other, or no one was making any eye contact at all. There was just no conversation like staff try certain staff tried to make conversation … bless them (*368-373)
A change in environment changed relationship with food. (Harriet)	*And being with people, my own age and somehow being away from home helped me to eat more normally again. (*58-59)
Experiences of food map onto environments and shape the experience of them (Fiona)	*I lived in the middle of nowhere with my family. I …got all these poor associations in that house with things that I used to do, foods I used to eat, behaviours (*315-317)
Freedom in university life, gave opportunity to control her food (Fiona)	*I went to uni and my relationship with food. It was just more like now I can. This part probably was control. It was like I can just do whatever, eat whatever. No one's going to like*. (273-276)
Certain environments feel safer to eat than others (Fiona)	*I feel more comfortable eating in a room on my own than with other people. I wouldn't not eat with other people, but if I had the choice, I would eat on my own.* (139-142)
Emotional reactions to different food environments (Fiona)	*I used to have like really bad panics when I went into supermarkets. I remember having an absolute meltdown in Marks and Spencer's Food Hall. It was true.* *That's smell in marks and spencer's now [laughs]. I still remember it. You know that's got that M& S smell? (*432-437)
Eating away from others in hospital improves the eating experience (Sarah)	*And I quite enjoyed it actually because it meant that I got out of eating lunch on the ward so that was quite nice, and I could just eat my food in my own space and not worry about what anyone else is doing which I found very actually quite nice.* (322-326)
Vivid memories of food being enforced at school (Barbara)	*I think I had issues where I the first school I went to from age 3 they had a policy where you had to clear your plate even if it made you sick. So I can vividly remember being sick at the table because I couldn't eat it. (*115-117)
Sub theme 4	**Cultural influences upon food and eating**
Societal and environmental factors change relationships towards food (Sarah)	*And then I think what didn't help was obviously magazines and stuff would always be like that's a bad food, so I was like that's a bad food, so I can't eat that one. And then and then, because I got heavily into athletics. I think then I started to get more involved with like healthy food.*

	(123-128)
Bodily states carry moral connotations (Katie)	*I attached a lot of morality to fatness and thinness, so I kind of believed that like thinner people were more virtuous and that other people had more respect for them and like that they were doing their best and they were good people* (143-146)
What I eat is connotated with morality (Jennifer)	*the insinuation that if you eat certain foods, then it's really damaging for your health and it's morally kind of wrong, and that there's all these morals around eating* (123-125)
If I eat this, I am a good person, and if I eat this, I am a bad person (Katie)	*A lot of those beliefs that like you were being bad or naughty, or you know you're letting the side down by eating just processed foods or eating things that were quote on quote unhealthy* (168-170)
Masking difficulties to others through eating (Kelly)	*but for me I did struggle exercise and making myself sick as a way of kind of trying to hide that I had something, that I wasn't eating basically, cause if I was having something to eat and everybody was saying "oh, but you you've lost so much weight" I could say, well I'm still eating* (216-220)
Having a coffee for breakfast is socially acceptable and not questioned as disordered (Barbara)	*So, I think from quite early on, I'd grab a coffee in the morning cause that's acceptable.* (165-166)
Diet culture at school made eating a conflicting experience (Barbara)	*And then when I moved to another school, diet culture was very much alive and well in primary school. And I'd been, like, trained from, like, the school that you had to finish what was on your plate. And that was very much not the done thing, it was like you had to throw away food that had to be part of it and it. But I think I found that difficult and also like UM. It was a lot like you'd be expected to be like wearing makeup and straightening your hair every morning in when you're like age like 9* (121-128)
Feeling she will draw attention to herself if she eats culturally bad foods (Danielle)	*other people would always comment on, how much sugar I eat so they say things like "I'm surprised that you've still got all your teeth". And this is something that went on, I remember it happening at university, people being like, "wow, how are you so thin when you eat so much sugar?" Which it didn't make me afraid of sugar, but it made me aware that people were aware of me and what I was eating* (276-282)
If everyone else has a problem with sugar, should I? (Daniele)	*But everybody would always say to me like your teeth will fall out because you're always eating sugar, always eating sweets. UM which I didn't see a problem with, but I guess eventually it with something that became it like came into my awareness of sugar is bad or it's bad that I am eating sweets and that everybody notices that I'm eating sweets.* (263-268)
There is a right and wrong way to eat (Danielle)	*"Why don't you eat vegetables? You should eat vegetables" so I don't know. I guess it just seemed like everybody else knew something that I didn't* (265-268)
Confused by what she was supposed to eat because of societal messages (Danielle)	This is always "Why don't you eat vegetables? You should eat vegetables" so I don't know. I guess it just seemed like everybody else knew something that I didn't. And then by the time my eating disorder developed, it was like I didn't know, what I was supposed to be eating? (290-293)
Beliefs around how women should behave around look contributed to beliefs around food (Maria)	*And I remember a few comments like that from adults when I was a teenager who would say, like, "oh, are you not watching your figure?" or "women are always on a diet". So I think that made me believe that women were supposed to watch their figure and women were supposed to not eat chocolate and that those foods were bad.* (187-191)
The influence of diet culture and the media shaped mentality around good foods and bad foods (Maria)	*and I also think some of it has come from media. The whole perception of diet culture, the whole idea that you know if you eat a salad, you're being good, whereas If you eat chocolate, you're being bad. And that's very much given me that all or nothing mentality of one food being good and one food being bad and there is no in between. I think that's what contributed to that.* *(*195-199)
Conversations around diets influenced beliefs around food (Maria)	*when I was working and I work in healthcare so a lot of nurses around me would always be talking about the latest diet they were on and the idea that if you eat some like chips, you're going to suddenly gain loads of weight* (169-172)

The normalisation of good foods and bad foods (Maria)	*I've definitely got these thoughts of fear around food, so the idea if you eat certain foods, then you will gain a lot of weight very quickly and, and I think that was from listening to friends when I was growing up at school. And there was a lot of talk around, you know cake is bad. This food is bad. You'll gain a lot of weight if you eat this food. There's a lot of sort of teenage girls diet talks that I definitely picked up* (164-169)
Feeling overlooked by appearing "normal" (Maria)	*And because my weight has always been, it's not been that low. It's been kind of BMI 18, BMI 17, so I'm able to fit in society and no one would look at me and know I had a problem. And I could just exist and carry on as normal.* (446-449)
Cultural dietary movements are touted as wellness which damage relationship with food and eating (Jennifer)	*you know when the clean eating phase came out I think that massively set me back and yeah, I think that that was a very damaging movement and it's still about, but it's just now touted as wellness and I think that that's been very damaging.* (115-118).
Societal influences shaped thoughts and beliefs around food and eating (Jennifer)	*You know, if you seem to be eating the right amounts of food and your body looks a certain way, then you're a better person kind of thing.* *And it's what people are told to aspire to, but it's just completely unrealistic*. (126-128)
Group experiential theme 4	**Meaningful resisting*:* The influence of treatment upon relationship with food and eating**
Sub theme 1	**Disempowerment and empowerment**
Humiliation felt from involuntarily vomiting not believed by staff to be genuine (Fiona)	*and I remember being on the ward, I'd run back from the like dining room cause I literally knew I going to throw up and they wouldn't open up a bathroom for me and there was like patients and their visitors like sitting on the ward and I was literally like throwing up in my hands in front of these other people and they would refuse to do it.* (387-396)
Lack of genuine empathy from staff (Danielle)	*She'd always say things like keep going lovely, which I actually hate it. I thought that was worse. And also in my opinion, it wasn't coming across as genuine empathy, but. (*331-333)
Trusting relationships comes from exploration of doings. (Jennifer)	*I think she really pulls on like the meaning of food to me on what my long-term goals are and what not.* *(*316-318)
Anticipated difficulties around food when readmitted (Fiona)	*because I then got readmitted into the same adult unit. I was there for seven months this time, I think it was the same really, if not worse, because I knew what was coming like I knew the staff would be like "oh I can't believe your back" I knew like the food the food there was horrendous.* , (285-290)
Being forced into a body which is not mine (Fiona)	*And that was really difficult because obviously I was it was in October so I couldn't go back to university because the year had just started again. So, I was kind of at a loss for a year. So, all I had was like my thoughts, this horrible body that I've been forced to get into, (*308-314)
Negative labelling from staff created internalised view of self (Fiona)	*I think at that point they thought I'd be what they call like a functioning anorexic for life. And they use that term with me, and they just said you're just going to be a functioning, you know revolving door patient (*301-306)
Eating out of sheer panic rather than choice (Harriet)	*And I guess that was around sheer panic, so I guess the meaning of food at that time was get me out of that situation, but not enjoying it. Not really thinking and trying to push all of the negative feelings aside.* (305-307)
NG felt something which was done to her and out of control (Harriet)	*And again, that about like something that was very much done to me, something that was out of my control. It was a one size fits all approach* (193-195)
Food choices had a collective impact increasing guilt (Harriet)	*I think it definitely shouldn't be around punishment like that. You know that that early experience of CAMHS having a knock on effect on what everybody else could do.* *I feel like that was quite damaging and I don't feel like that should be something that features* (467-470)

Feeling trapped and suffocated by the ritualistic practices around food (Harriet)	*I started to feel quite suffocated by everything at the unit and all the rituals around food started to drive me mad, that I felt I just didn't want to be around it anymore.* (766-768)
Refusing food was her only means of control (Kelly)	*Like I had a choice like I chose to have the food I chose to like have an active part in my recovery, whereas when I was in the priories it was just like I hadn't eaten or drinking in X amount of time, so it was "right we've spoken to the consultant or whoever, and we're going to give you an NG tube" and then it's like, "no, you're not". And they were like "we will" and then they would restrain you and give you an NG tube and it's just traumatic like it was it then, I would then get angry. I'd be like well why would I want to then eat because I have a choice in it. I didn't feel like I had any control.* (579-587)
Not treated as an individual, but standardised (Kelly)	*And I found my first inpatient admission with food actually very difficult because the dietitian there was completely like, She wasn't, it was literally everybody was on the same meal plan. So everybody had to have this amount, this amount. And that's the only inpatient admission I've ever had where it's been like a standardised like she believed that everybody had to have the same amount of food. Like once you've gone through refeeding like a normal human being, each depends off this amount.* *(*327-334)
Staff misinterpreted nutritional requirements as the eating disorder talking. (Kelly)	*I feel like that's frustrated me sometimes, because other people would have like more choices cereal, but I couldn't because I've got a nut allergy, so I would only be able to choose like 2 cereals. And then I'd get kind of like told offered using the same cereal every day. But it be like, well, I can only have that one cause I don't like that one (*369-374)
Being told what to do, creates tensions (Danielle)	*If I'm told to do something, and can be triggered into my rebellious teenage state. So, when I was told this, I was very vocal in saying that I think this is disordered* (380-382)
Eating in treatment was traumatising and affected subsequent engagement in treatment (Sarah)	*I literally can't remember; I think I was so traumatised by every experience and a lot of the time* (148-149)
Toxic experiences of treatment related to having no control or autonomy. (Sarah)	*So, like I had no, I had no control and no autonomy, and if we went out for meals and stuff, they basically told you that you had to eat a certain calorie count* (141-144)
No space for understanding in treatment (Sarah)	*because I've got ADHD and I think I might be autistic, my eating disorder is so different, so like when they was asking me to make food with the amounts of foods that they were suggesting I was like, yeah, but this isn't the same as what we eat on the ward. So, I think that's just messed with my head because I couldn't get my head around the differences* (156-161)
Weight gain is a surface variable of progress (Maria)	*I think the danger is that if you focus too much on and I get that it's important to focus on health and nutrition, but if you focus too much on it, I think people would gain some weight, feel better a bit better, but then slip back because they're not finding other ways of dealing with the emotional side.* (453-457)
Feeling she was not treated as an individual but as an anorexic and patronised (Danielle)	*Like, just because I have anorexia doesn't mean. I think that eating four chips is appropriate. I like I know what's OK and what's not. Uh, so those sides of things I found again, really brought in my awareness too aspects that hadn't even been made aware to me so before, I didn't know that was the correct portion of chips to be having, for example so I guess that's like the Dietetic informed aspect to the group rather than the group activity itself.* (383-391)
Treatment focuses on physical effects of recovery which does not support long term recovery (Sarah)	*It's all just around food and weight gain and hitting these markers and it's just like I just, you know it's just not going to work, it's not good. I mean it's never helped anyone in the long term.* (572-575)
Food was framed as punishing and fear of food was reinforced in treatment (Sarah)	*And I think because after that first experience and then ones later, I think my relationship with food, I only saw it as punishment or as something to be scared of. so, my fear of food got worse.* (345-348)

Voluntarily having the NG tube is a passive and traumatic experience (Barbara)	*So I did it voluntarily, but then I had guilt about that about. Or should I have waited? Should I have left? I could have lost more weight while waiting for it. And that caused quite a lot of guilt and like the fact that I've been voluntary and not had to be like physically restrained cause I know a lot of people that had had to have like 7 staff members to have an NG tube to put in, whereas I just sat there and let them do it cause it seemed like the only option I had.* (305-310)
Making agreements with staff and coming to common understanding (Fiona)	*Yeah, it was kind of weird come to an agreement cause yeah, we just knew that we were just going to go round in circles that I was better off me having a replacement than, throwing it all up to put it bluntly* (373-376)
A less forceful approach un treatment is empowering and less threatening (Sarah)	*And when I was in XXX so that was my last unit in xxx when I was adult, they didn't force anything. And actually, it was that approach that I found the most helpful and the most empowering because they didn't, they didn't threaten me with anything* (257-259)
Food represented feeling safe and comforted in hospital, and supported transitions (Harriet)	*I could actually recreate these recipes at home with my family and that brought a great deal of safety and comfort because these were people that I really do feel like they saved my life and actually.* (383-386)
Appreciating staff who explored behaviours (Barbara)	*And then I remember being caught by another staff member exercising and she was just like, right, come on that setting the bed. Let's talk about this kind of give you a hug. "What's going on?" And that difference can be really vital because nobody really responds well to being told off generally, for most things.* (449-454)
Food challenges need to match an individual's life (Jennifer)	*And doing like meal cookery I feel it would be beneficial but like being able to do that in your home environment and it to be yeah, or even going out for snack with OT but you know in your normal day to day life, not on an inpatient unit* (597-600)
Working with me not against me (Fiona)	*And so, they started working with me, which was just amazing (*363-364)
Given opportunities for independence with real life experience helps (Fiona)	*it got made that you are more independent with it and you could actually learn to live like, rather than like, because I was really institutionalised for a long time and I felt you know, I used to get really anxious just going out.* *Yeah, UM, and it kind of helped me be able to do things like socially with food. (*615-621)
Staff acting with calm and compassion supports eating (Harriet)	*continually telling me all of the reasons why eating was the right thing to do sometimes even telling me I had no choice about it, seemed to help in the early days, but they said this in such calm and compassionate voice (*744-746)
Establishing change in her own environment (Harriet)	*whereas for me and for many many other people, they're treated in counties where they don't normally live, and it's not their normal kind of eateries, hangouts or the normal routines.* (509-511)
The importance of understanding an individual and their lifestyle in supporting changes around food and eating (Harriet)	*I think it's I think very much it's finding out what, about the individual and their routine and what works for them. So obviously everybody has got unique lifestyles, haven't they?* (678-680)
Empowered by choice. (Kelly)	*They never made me do that like they kind of really gave me that they helped like empower me too, and I also didn't even know what the word, empowered, and all I ever write about now is empowerment now because I've nearly finished my degree, but before I went to the NHS ward, I didn't even know what the word empowerment meant, I thought that I thought my God, you're telling me that if I choose to eat and you don't NG feed me, that's empowering myself. You know, you all look crazy?* (571-578)
Realising that she did have a part to play in her recovery (Kelly)	*Like I had a choice like I chose to have the food I chose to like have an active part in my recovery* (579-580)

Valuing being involved in her treatment (Kelly)	*I think that the team have saved me and really turned my life around, were just much about giving me like choices and didn't inflict things on me* (624-626)
Food in treatment needs to meet with a person's life and their routines (Sarah)	*And not everyone can afford to eat out in restaurants every day either or get takeaways. It needs to meet with that person's life, their routines. That's it.* (585-587)
Adapting eating to fit in with the real world (Maria)	*because I have a really busy job and I am not always able to eat regularly at work so she was talking a lot about how, in an ideal world when you feel tired, you would have this, this and this, but in real life, you can't always do that, so how can you get around it, how can you adapt it to fit in with your real life?* (423-427)
Serving meals was a skill that she could reflect in others areas of her life (Danielle)	*So having to serve out the food and have somebody watch me and realising it was fine and that they weren't, they really didn't care and they weren't out to criticise me helped my life in other ways.* (406-408)
Appreciating a non-threatening approach (Sarah)	*"we're not going to do anything. It's your life".* (273)
Thinking about the future helped her to remain focused on the present. (Kelly)	*It was quite helpful because she was talking to me about something that was beneficial that doesn't just relate it around food was going, it's something that she was going to help me with to fill out later as well. And she also spoke about other things as well.* (698-701)
Through doing, she realised what was important and who she was (Danielle)	*I would make the most beautiful looking things, and they were nice. So, but it wasn't until I did the baking in groups that I realised that I didn't enjoy, enjoy it at all. And that that was probably part of my eating disorder, and I don't enjoy it now, so. I guess it was helpful in realizing that it's not, so that was a part of my eating disorder and not a part of me.* (422-427)
Food groups gave her insight into a sense of self (Danielle)	*I remember that being quite apparent in that group, because I knew how to you bake and I was good at it, but instead I would let other people do it all because they wanted to do it all, sort of thing. So, it taught me a lot more personally rather than about food.* (430-433)
Sub theme 2	**Medicalisation of food conflicts with food normality**
Meal plans do not fit into family life and spontaneous eating (Jennifer)	*I mean personally, for my family say if we went out for the day, they probably wouldn't have like 2 snacks, a meal at that time, like thinking they might have like meal at some random time, and that's where if you're on a meal plan, it can be very hard to do social stuff because it's like, well, hang on, I'm supposed to have my lunch now, or like I'm not supposed to have like brunch, where does brunch fit into my meal plan. If I had my breakfast and my lunch like, what does it even count as?* (532-538)
Food challenges need to match her life and routine (Fiona)	*it's not normal to eat, normal people don't eat chips every day. UM, firstly they're not going to cook chips every day. And secondly, it's not very healthy diet [laughs] likes to sustainable to be sustained on.* (963-967)
Eating on the inpatient unit did not feel normal (Jennifer)	*So it's like you make the meal, but then it's just you eating it and I feel like when you're in a super stress mode and you feel like someone just watching you eat, that's it's just not helpful. Whereas if you would eat some with the other person, they're eating the same food as you. Then it's like normal.* (248-252)
Not given opportunities to address personal challenges in inpatient (Jennifer)	*like you could only have erm a sandwich meal once a day, say.* *But if you had, if one of your fears was like having too much of one thing in a day, like too much bread items like having bread twice a day, like for me having things twice a day was always an issue, then surely you should be able to like challenge that that's identified as one of your issues.*

	(270-275)
Meal plans prescribed for weight gain (Katie)	*I started appointments with a dietitian and she prescribed me like a meal plan and explained I kind of why she's giving me that meal plan and explained like that the aim was to gain weight for the first phase of their treatment and up to a certain point,* (29-32)
Food diaries and meal plans created new rules for the eating disorder (Katie)	*I think that they can present other kind of challenges, you know. Because I started to suddenly kind of do calculations that I wasn't even doing previously.* (341-343)
Logging food changed its meaning, to something intended to help to a source of control (Katie)	*Like I, you know, when I was, always like logging stuff down, because I just loved having that record like it would be a great thing for control* (331-333)
Having friends supported moving away from the rigidity of the meal plan (Katie)	*And I think that I was very lucky in that I had friends around and it did start to kind of click with me like I kind of started to move away from that idea of rigidity and planning and just realised that it would be OK like whatever happened* (366-368)
Meal plans are a safety net (Katie)	*I think it's a really good fall back especially when you're living on your own and you're looking after yourself, I think you could fall back.* (356-358).
Portion sizes in hospital are not normal (Fiona)	*But to this day, I have not seen a pasta size portion like that before, and I don't think I ever will to be honest* (786-791)
Knowledge about food is not enough in treatment (Fiona)	*And I was like I don't need, I know this, I know there. The problem isn't me knowing that I need to have a balanced diet. The problem is me having one. But I would say what really helped me was like just doing those like normal things like being able to go and do it independently* (935-941)
Meal plans do not fit with normal life. (Kelly)	*Also one of the biggest things in my recovery as well because. I kind of had to accept that it was OK to eat in public and eat lunch, and that's normal, and that's OK. And it's OK to get something on a menu that may not fit into your criteria meal plans. So like at lunch, if you had to have this, this, this and this. Actually like that's great for when you're in hospital and when you're at home and when you have a meal plan.* (423-428)
The meal plan creates a new set of rules around eating. (Kelly)	*Well, that's not actually this this and this, so I can't have it cause nothing called the menu is exactly that, because if I have that, let's say if I said or if I have a toastie and a packet of crisps, that's over my meal plan, whereas if I don't have the packet of crisps, it's under my meal plan. So therefore, it's not. It doesn't equate to what my meal plan should be, so I can't have it. That's what I would do. That's the kind of like manipulative behaviour that I would have done to prevent eating out.* (438-445)
Recovery is breaking the rules the hospital put in place around eating. (Kelly)	*Like real life, in real life, you just kind of have to go with it a bit. Break all of the rules at hospital put in place.*(458-459)
Food in treatment is out of the ordinary (Sarah)	*But basically, that meant like, every single day it was like, imagine all the worst food you could imagine having for someone with an eating disorder and you have to eat it, all day every day. It's like 3000 calories to 4000 calories worth of chocolate bars, cakes, sugary cereal, butter, whole milk, cream, all of those things, but they were just. It was so sickening because I feel like even people without eating disorders wouldn't want to eat all of that like for snacks and heavy meals and stuff* (185-193)
Treatment was a feeding farm where feeding was the cure (Sarah)	*Basically, we've, we've found the cure for anorexia. We just feed them. [laughs] And it is basically like a feeding farm* (174-177)
Treatment created rules for the eating disorder to thrive (Sarah)	*So essentially, they taught me that, I don't count calories now, but I obviously for 15 years I was then ruled by calories because that was the unit of measure that I've got obsessed with.* (212-214)
Calorie counting is not a sustainable way to relate to food and eating (Maria)	*And I think she was talking more about sustainable ways of relating to food. And not being quite focused on certain amounts of calories or nutrition labels, that kind of thing.* (428-430)

Ritualised eating creates ritualised eating (Jennifer)	*Difficult because it's so ritualised and I feel like I don't know if that's a good thing or not. You know part of me thinks it's really not because when then it gets you into that habit of like more ritualised eating.* *But it's so hard cause you've got to have that structure at the same time* (211-214).
Rebelling against treatment to seek normality (Danielle)	*And at the time I was hung up on this isn't normal and all of the kind of aspects of the treatment that I've found unhelpful* *Whereas eventually I was able to flip it on. No, that isn't normal and I can see that isn't normal so I can do what I know is normal but that that took some time. (*416-420)
Treatment brought to an awareness and vigilance against food that was not there before (Danielle)	*I think the treatment team were extremely hyper focused about food there, they focused on numbers and weighing a lot more than I ever did (*467-469)
Micromanagement of food created perceptions of a right and wrong way to eat (Danielle)	*I think thought for example in the self-catering sessions that uhm, if that needed to be monitored, that could have been done without us being there in a way that wasn't quite so count this out because this is correct. Yeah so, I think it was just kind of the micromanagement of food that was really unhelpful* (471-476)
Treatment created conflicts within herself, knowing it was disordered (Danielle)	*I think because I was living in such conflict with my intellectual knowing self of being like "I'm fine" and also "this is, this is wrong on many levels. This is disordered*". (351-354)
Treatment mirrored the eating disorder (Danielle)	*no one without an eating disorder, typically eats, plans their meals for the whole week and their snacks and calculates what's in it and checks whether it's enough of XYZ and (* 349-351)
Contrast between her home life and treatment created conflict (Danielle)	*For me, because I live at home with my girlfriend who doesn't have any disordered eating and she is very, flexible around food, so I had that model to me and knew how much of things we needed. I didn't need to be told that I needed to weigh my breakfast to make sure I was having enough sort of thing. To me, that was, and encouraging a disordered approach. (*360-364)
Being told she had to weigh her breakfast encouraged eating disorder behaviours (Danielle)	*I didn't need to be told that I needed to weigh my breakfast to make sure I was having enough sort of thing. To me, that was, and encouraging a disordered approach.* (363-364)
Having normal food experiences helped in recovery (Fiona)	*Yeah, it was just more normal food, just more normal food, like not when you go out to a restaurant like cause that's what the other one was, it was like a restaurant and you know normal people don't eat one hot pudding and one cake a day they don't eat chips every day (*646-651)
Eating disorders are not fixed from refeeding (Barbara)	*because especially with an eating disorder, it's not going to be fixed when you out the hospital. That's not how they work. (*420-421)
Sub theme 3	**Playing the treatment game**
Replacing the rules of anorexia, with the rules of hospital (Kelly)	*but like for me and a lot of my friends who I've known we're such rigid and rule, we have to, and we're perfectionists that we have to do something in a certain way. So actually, when you're then given more rules* *it's almost like that's what you're used to working with, like that's how you like to play the game in a way. It's almost like another set of rules* (483-487)
Appearing to engage in treatment but having a different motive (Fiona)	*I went they were like "we need to admit you into hospital" and it was the same story that "I was like no, up my meal plan. I'll be able to do it blah blah blah" and I would be losing weight, losing weight* (199-203)
Eating more on the meal plan would be greedy (Katie)	*So like if it said like for your piece of fruit, have half a banana. I be like, Oh well, I'm definitely not going to eat a full banana then because the weight gain dietitians told me to half a banana, then I'm a total pig like you know* (343-346).
Desire to get back to herself and maintain anorexia. (Kelly)	*because I thought I had come out of hospital last time I'd eaten my way out of hospital and then it had been so hard to get back down to being so unwell again. And then I'd been put, I almost felt like I'd been put in hospital prematurely as well. I was like, no, "I'm still not like a small as I want to be like, I'm not unwell enough to be in hospital yet" so I just refused to eat or drink cause I didn't want to undo any of the work* (541-547)
Her actions are deceiving to herself and others (Katie)	*or I'd be like "yeah that's great" and then I would like give some of it to the dog so a lot of it was like trying to trick people and stuff and trying to trick myself into thinking that I was OK.* *(*305-308)

Encountering ambivalence in recovery (Katie)	*And I was still very much trying to micromanage the entire experience, so even though I knew I needed to gain weight, kind of trying to do it like tracking everything at the start of like trying to track everything on like a fitness tracker, and like trying not to gain weight whilst also telling everybody that I was trying to gain weight* (261-266).
Picking safer options in treatment and not being questioned by this (Jennifer)	*And you could probably go your whole time in there kind of avoiding it and picking the safer options* (242-243)
Eating to escape and feeling out of control. (Harriet)	*Just doing what I had to almost mechanical really, robotic, just doing it just to get me out of that situation.* (331-333)
Meal plans can be an excuse for not eating (Jennifer)	*I feel like it can be used in excuse as well. That's the other thing like I know that my dietitian if I went out for brunch. She wouldn't care as long as that I ate enough that day, she wouldn't mind that it diverted off the meal plan. But I feel like it's a convenient excuse to not challenge stuff as well. It's like, Oh no sorry you know, like where does that fit in? I'm just going to stick to my meal plan, because it feels safe.* *I feel like it's just like safety. yeah, safety blanket kind of thing.* (542-548)
Choosing meals was a tick box activity. (Fiona)	*Yeah, it was literally, I need to tick these boxes have the lowest calorie option or sometimes there wasn't a lower calorie option on the menu.* (527-529)
Acquiescing control to prove herself (Fiona)	*But no, it was just eating my way to get out. Prove a point and then lose the weight when I left.* (536-539)
Mutual understanding of playing the game between herself and staff (Fiona)	*They knew that I was pretty sick, but they couldn't. On paper, I was doing what I needed to do, and I don't think they really cared enough to be honest.* (544-548)
Playing the game in hospital. (Kelly)	*The way I'm saying it, but this is what happens when you've been in hospital for a long time. It's almost like you can then use those rules to kind of be like wow, it doesn't fit this criteria and that's your criteria. And you say that I have to have X amount so I'm not going to have it because you're the one who made those rules and it doesn't fit sort of thing* (488-493)
Eating her way out of hospital. (Kelly)	*But for my first admission I had literally decided that I was going to eat my way out, if that makes sense? So I was gonna do everything that they said come and then I was going to get out of hospital and go back to what I was doing. It was, it was just a way to get out of hospital cause I had to be in hospital like I didn't want to get better* (506-510)
Preparing breakfast became an activity to eat less (Barbara)	*like kind of things like making your own breakfast and stuff. But it just felt like an exercise in how, how, how much can I get away with? Like removing the butter from this and not putting enough butter on and like trying to like, knock a few like granola things off the granola when you're trying to put it in the bowl and things* (374-379)
Engaging in food-challenges with other motives (Sarah)	*we were going to do like our own lunch. I remember we walked to the Sainsbury's local. And I chose pitta, and I chose some prawns because it was the lowest calorie option* [laughs] (300-304)
Group experiential theme 5	**Meaningful becoming: Re-pairing with self, the world, and others**
Sub theme 1	**Food is access to life**
Recovery was motivated by wanting to be a nurse and life. (Kelly)	*to get better to make a meaningful recovery because I wanted to uh, be a nurse and I wanted to not live. I think I just really. I started to realise how much I was missing in life. And like all my friends are doing like wonderful things and I was spending like another Christmas in hospital kind of thing.* (531-534)
Food enables her to do meaningful activity (Fiona)	*I'd say it's a means of to do things that I do. obviously like studying and I work in A & E, and I work in a private hospital and like cycle a lot for both of those, it just gets me to do, to be able to function. I suppose it's a sociable thing like going out for meals. I really enjoy that and that with friends or my family. Yeah, so I say it like symbolises, freedom firstly because my relationship is so different with it now* (801-809)
Strength to do the things she wants to do (Fiona)	*And that I yeah, I just got a taste of a flavour If you like what life can be like and what I can do. I mean I could never have gone traveling. I could never have done my course or got to where I have got to If it was just so, you know, like cause it was just so disabling* *(*834-839)

Recovery is tasting life (Sarah)	*I think I've just I've got; I am tasting life that I never ever thought I'd ever experience. And it's just so exhilarating to have energy and to just sort of feel like free in myself think.* (454-458)
Viewing food as fuel which allows her to do the activities, she wants to pursue (Maria)	*So I see food as the fuel that would allow me to do that, and if I didn't eat before I wouldn't be able to do a workout. I think that changed as well massively.* (678-680)
The meaning of going to the gym changed how she viewed food and eating (Maria)	*I said more as fuel, but in the sense that activities and I think now you know it's if I have the snack, I will be more energised. I'm more active and I'm seeing food as a way of more doing that kind of thing, …* *in the past, I've never exercised because in my head. Why would I exercise when I could just not eat? That would be my way of doing that instead, and I know that you don't burn much energy from exercise, so I didn't like the treadmill for example so rather than doing the treadmill I would just miss a snack. Whereas now because my boyfriend and the treatment, I'm now at a point where I want to go to the gym for my mental health and I want to work out to build muscle and to feel good. So I'm now able to see food as a way of doing it, but I'll have an extra snack and go to the gym, and I won't restrict and I won't compensate and I won't see the gym as a way of burning calories, I see the gym as a way of feeling good about my body.* *(*664-677)
Being in the moment around food leads to a more spontaneous life (Maria)	*I think we will probably have a takeaway tonight or we will cook or something, but I don't know what we're having. And it doesn't worry me too much not knowing. And I am definitely more flexible, more spontaneous. I'm able to put my day ahead of the food.* (489-492)
Treatment made her realise what she valued (Danielle)	*So, it was, it was mostly treatment in that we did like an OT art day each day of the week, and it wasn't necessarily art, it was like you could, it could be gardening or whatever it was.* *And it made me really value those nice things and so now I deliberately, every single day do something for me entirely for me and I know more what I like, what I don't like* (528-533)
Understanding that she cannot do the things she loves without eating (Barbara)	*And trying to recognise that just kind of I like. I love to swim, and I can't swim if I haven't eaten and I can't walk my dog if I haven't eaten and I can't do my work properly if I haven't eaten…* (545-547)
The more she eats, the more she can do what she needs to do (Barbara)	*The more I eat what I need, so I can do what I need to do* (548-549)
When life becomes bigger, the eating disorder becomes smaller (Barbara)	*And I think that's been quite a turning point in the way of thinking about the eating disorder rather than like, all right, so the eating disorder, we've got to like do all this and try and beat eating disorder when actually it's kind of a matter of the way the eating disorder will go away is by keeping the food through, and making everything else bigger, which you can only do by having the food.* *(*604-609)
Food enables access to life and to do the things she wants to do (Sarah)	*Yeah, so it's almost like access to life, isn't it? To be able to do climbing and, and be with people.* *(*411-412)
Putting emotions aside when eating (Katie)	*But today I was like oh OK, that's a bit shit and I am getting a bit hungry now. So you know, like you know it's like. And then there's like OK, and I think it's actually really nice day. Why don't I go sit outside and there's like an Opera House theatre and they have kind of those step outside, so I was like OK I'll walk over there and I'll have my soup* *(*539-544)
Shifting the emotion of food to the functionality of food (Maria)	*I'm able to see food as more of a function rather than always using my emotions (*103-104)
Viewing food as energy for life (Maria)	*I'm able to see food is a way of giving myself energy to do the things I want to do in life and always I'm seeing it as more as fuel and looking after my body.* *(*104-106)
You don't eat to live, you eat to live (Fiona)	*I've got a taste of what life can be like.* *And then how it doesn't need to be ruled about times, food amounts, you know, and that you don't need to, I always get this to one where out you don't need to live to eat, just eat to live*

	(830-835)
Food is about survival to do life. (Kelly)	*I just have to look for you just at food is a very practical thing. Now just it, it allows me to do things to like do my job and to do social things with my friends and in the future. Like I want to have a family so I don't know if I will or not be able to but.* *I had to like just try and keep staying well to maximise the possibility that being a choice sort of thing. So yeah, it's just mostly about survival.* (902-907)
Food is just food (Sarah)	*but I don't get the satisfaction from food that I'm assuming normal people do* (383-384)
Changed viewpoint about purpose of eating (Katie)	*it's just I eat.* *And I'm like OK, grand like now I've eaten that meal let's get on and do the next things* (464-466)
Robotic eating is necessary when life is difficult (Barbara)	*And that I can cause even if I had that set meal plan that I was stable with and I could just keep robotically eating that until things calmed down.* (638-640)
Putting emotions aside, and viewing food as functional (Jennifer)	*It is necessary at some points in recovery to just mechanically eat*. (464)
Viewing food as a task and medicine, to enable to her to live well (Barbara)	*and it doesn't matter if on this day that is a task and that is your medicine not something that's oh yeah, I really fancy this, and it's just something that needs to go down* (532-535)
Some people live to eat, but she eats to live (Barbara)	*I think that's a big thing is, the kind of focus that food kind of maybe doesn't have like, you know, like, I know loads of people who feel like I live to eat. I love food. It's amazing. And it's accepting that it doesn't always have to be that* (483-487)
Viewing food as fuel to do the things she wants to do (Barbara)	*I'm currently kind of just trying to see it as fuel, fuel or medicine, that kind of, it needs to be done regularly, and trying to work towards kind of normalizing it. But the important thing is that something needs to go in three times a day and there needs to be enough. To fuel my body to let me do what I want to do, to let me do my degree, to let me be a good mum, to let me be a good wife.* (539-544)
Sub theme 2	**Food is re-connection with others**
Food allows intimacy and connection (Katie)	*it's a social thing so it's a lovely way like I've gotten so much closer with my friends and my family. And like I've gotten like a boyfriend like I never had a boyfriend before because if just wouldn't all, firstly I didn't like the way I looked and then secondly I did like the way I look but I was obsessed with keeping it that way so he never would have been just casual.* (47-475)
Caring for self to care for others (Katie)	*so that I can be the best I can be to look after others, to look after the things that I care about and.* (481-482)
Food is secondary to social interactions. (Maria)	*Food was just a secondary thing that was involved. It wasn't a big deal what I ate, it was more about the company and the conversation.* (474-477)
Feeling relaxed around food because others were relaxed (Harriet)	*I remember starting to feel more relaxed around food, you then you know I. I started to enjoy staff feeling more relaxed around me as well because they were enjoying what we were doing together* (776-780)
Giving self permission to join with others (Harriet)	*If they want to bake a cake, we bake cakes and mummy has some just like everybody else, and I think that's really encouraged me to adopt you know recovering I guess and be where I am.* (586-589)
Allowing others to take control and be vulnerable has a positive influence (Sarah)	*And I allowed them to serve me. Which was a massive first and I've also recently when I've had food at people's houses.* *I have just served myself and not weighed anything. And sometimes I have had seconds. So, I think it's one of those things, when I'm with people that I feel safe with and I'm actually probably pretty hungry. I think I'm going to just enjoy this if it's nice food, which I generally do with my friends. My friends are so good because they actually tell me what's in it. They are like "I mean like we just put this, this and this in it", or they will ask me, which has been great.* (508-518)
Being close through food (Harriet)	*we'll have a drink of wine and that would just be a social event. So the meaning is kind of bringing people closer* (626-627)

Changed meaning of food emerges from relationship (Maria)	*And I started seeing these sugary foods as more of an enjoyable experience with somebody rather than a secretive thing that I did on my own that I was ashamed of* (458-461)
Being open and honest about needing support is hard to articulate (Jennifer)	*He realised that this was important to me when I first came out when I said something about thanks for sitting with me tonight and he's like, oh, we're supposed to do that and I was like, well, you're not supposed to do anything but it helps.* *And then he asked me to an effort to sit with me every night.* (498-502)
Viewing food as a way to participate and join in with others (Maria)	*And I'm seeing it more as a social thing as well, like getting involved with my friends and my family and joining in with other people* (107-108)
Food gave a sense of togetherness (Danielle)	*It was kind of normalise that, it's like eating as a sociable thing, and cooking is like it can be a togetherness thing, so those aspects were helpful* (374-376)
Her husband having a deep understanding on how to help (Barbara)	*and my husband is fantastic. And has kind of an instinctive awareness of eating disorders and how to support me, which is amazing. (*406-408)
For the sake of others, she would eat. (Harriet)	*What would I do if she decided she decided she was going to make chicken soup or something meat that I would have to feel like I'd have to eat as well, and I thought to myself for the sake of them, I would eat it.* (545-547)
Her daughter's presence motivated her to eat cake with them. (Harriet)	*But like last week, for example, my eldest daughter had two friends, and I took them to this place called the Sugar Hut, and it's a new place which does waffles and cakes. And it's all sweet stuff and they thought it was amazing. And I sat there with them and I was going to have a coffee. And I thought, no, I'm going to have a piece of cake with them. (*595-599)
Allowing others to take control over food and eating (Fiona)	*And he wouldn't tell me where we're going, he just said we're going to go for sushi. So, I met him at this restaurant, and before that would have been totally off the cards I'd need to have known I'd needed to have looked at the menu.* (898-902)
Being connected to others through difficulties with food (Fiona)	*I felt like she was supportive. She just had her hand on my shoulder, but she didn't really know me, and I didn't really know her. I can't remember her name to be honest this today. (*747-750)
The experience of eating with her friend was relaxed. (Kelly)	*I really enjoyed the food. I really enjoyed the wine and then I really enjoyed afterwards just sitting and being able to like socialise with XXX and just talk to her about things in life (*936-938)
Being vulnerable with others in the day to day challenges of eating (Jennifer).	*I did enjoy it afterwards I feel like with me a lot of it is the anticipation of the event and the event itself is like not that bad thing, but it's more. The anticipation of the event and seeing it being prepared so.* *Often if it is a challenging food now, he will send me out the kitchen because he would just know it's not worth it. But I appreciate him being there.* (489-493).
Sub theme 3	**Balance with food and self**
Creating space to be rather than do (Jennifer)	*I think also it is about learning to be rather than do in recovery to come to terms with things (*451-452).
Acknowledging that not everything has to be good for you to be good for you (Katie)	*I know that it's very soothing to people in the earlier stages for treatment to hear that, like oh like drink this milk. It will be good for your bones, but at a certain point. It's like just drink a beer cause you're on a night out like you know. And so I think acknowledging that not everything has to be good for you to be good for you. I think that that really, really helpful.* (598-603)
Recognising her own internal needs and rest (Barbara)	*You need to remember you are a human being, not a human doing* (532-533)
Wanting balance around the types of in treatment (Katie)	*Like just eating the food that would have been nice when you were a kid. Like eating like tea cakes or you know whatever kind of pre-packaged shite like from the shop because like that's the joy of food and like when you're able to eat whatever, then you're able to engage and move on with your day* (593-596).
Seeing a food to care rather than punish (Maria)	*So, I started seeing food as a way of, as a more of a health thing, as a way of looking after myself rather than a way of punishing myself* (326-327)

Food is related to health and nourishment (Harriet)	*You start to think about your body differently and I want to nourish it, so we're kind of the meaning behind food now is about nourishing my body properly.* *(*621-622)
Viewing food as self care and looking after self (Maria)	*But now I see the break as self care and I see like I, I know we're busy. But I do have a right to a lunch break and I will take it and I will eat in it because that's my way of keeping going. That's definitely changed.* (575-578)
Food and eating reprioritised so that there is room for other things (Katie)	*And I think when I allow it to be part of my day and not try to exclude it from my day altogether, it doesn't end up being my entire day.* (467-469)
Trusting the process of eating (Katie)	*And you know when I'm going to see if I could drop a few pounds and like that's great but it's not just going to leave me back to being really unwell. Or do I continue to just kind of be in the moment and see what happens, And I think that's kind of how I managed to day like in the right place when it comes to food* (434-439)
Food is not the be all and end all, life is bigger than food (Katie)	*And yes, so its really just it's a part of my day and I think like that it's all like meant to be. I don't think he's meant to have this big moral kind of connotation, and I think that that's in a lot of people give to food.* (483-485)
Finding peace with a changing body (Katie)	*I don't like the way I look today. Oh, that's fine cause I might like the way I look tomorrow like I think it's about.* (448-449)
Understanding the consequences of not eating and that nothing bad will happen (Maria)	*So I did, I have them with my lunch and I text my boyfriend afterwards this is the thought that came in and this is the rational thought and I need to work on this. And nothing scary happened and I've still got the rest of them in my fridge for later, but they're not, they're not a big deal, it's just yoghurt.* (399-402)
Being flexible with food means adventure and flexibility in life (Maria)	It made me realise that no food is good, no food is bad, it's all about balance, and moderation. And so, it has made me feel less black and white around rules around food. And it's allowing me to be more flexible with food as well, and for it to fit in with my life rather than the other way around. I am less at war with my body. *(*476-481)
Food is in the background rather than foreground of life (Maria)	*But I think overall its changed from, it's definitely become less of a way of numbing my emotions and it's changed a way of controlling and dealing with things to now being a by-product of my life and something that's in the background rather than forefront of my mind all the time.* (111-115)
Gaining perspective over food and eating (Danielle)	*for example, today I made lunch and I didn't like the taste of it and rather than thinking "Oh my God, that was a waste of calories". I just thought "I really didn't like that". And I'm able to move on with my day, whereas before I don't think I would have been able to try something new, and to move on, it would have been kind of the end of the world to that this meal wasn't perfect, whereas now I think I can just accept that things are in perfect and, that classic, like food, is just food.* (487-494)
Food is connected to everything she is doing, because it is part of everything she does, but not the whole of everything (Danielle)	*And also connected to everything that I'm doing because it's a part of it, sure, but it isn't the whole thing* *(*505-506)
Food no longer is a defining factor, but part of the fabric of her life (Danielle)	*Uhm, mostly connection to, I don't know, like I so I live by the sea and for some reason, food is food is a big part of like being outdoors. If you go for a walk somewhere and there's an ice cream van, then I really appreciate that now, and, I don't know, I try to connect with that child part of me. That's like, Uhm "oh yay, ice cream" and sit there, with my girlfriend and just, it be a part of the day, but not the whole day. So, it's helped me be more, I guess be more spontaneous and free. And also connected to everything that I'm doing because it's a part of it, sure, but it isn't the whole thing.* (499-506)
Challenging all or nothing thinking when it comes to eating (Barbara)	*Or I'll put the milk in the fridge and have a cereal bar and a cup of tea. And then I'll have my cereal in about an hour. But making those steps to not just abandon things because plan A has gone wrong.* (642-644)

Learning to take risks and trusting the process (Harriet)	*Actually, you don't need to be this rigid. You can have some flexibility in and it's OK, it's learning, isn't it? To take that risk, I guess.* (447-449)
Relationship with food changes from rules to eating freely (Harriet)	*Whereas right now I don't need to think about what's on the back of the wrapper and you know, if I had for ages, I would have a thing where I would only eat a sandwich for lunch and then it be a warm meal in the evening and now if my husband's making soup for lunch and we have a warm meal that doesn't matter.* (525-529)
Holding onto hope (Barbara)	*and remember tomorrow is a new day* (680)
Making mistakes means she can grow (Danielle)	*And I'm able to try things so recently I'm doing classes to be, to do figure skating and that is something I would, I can't tell you how much I wouldn't have done that before, because I would have been too afraid to try something in case I wasn't perfect whereas now I love being imperfect and falling over because it means I'm learning, uh, yeah. So, it's really just doing, doing things that matter to me, that's really helped* (533-539)