An exploration of self-disgust in females with eating disorders

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ABSTRACT

Background and Aims: Research suggests that the emotion of disgust plays a role in psychological distress associated with eating, body shape and weight related concerns, though evidence is inconsistent. Recent theoretical and empirical literature have highlighted the potential relevance of the emotion of disgust towards the self (i.e. self-disgust) in various presentations of psychological distress. However, research in this area remains in its infancy. This study aimed to build on emerging research by employing a qualitative approach to gain more of an understanding of the perspectives of women who experience psychological distress associated with eating, body shape and weight.

Method: Eight semi-structured interviews were conducted with women with an eating disorder diagnosis. The interviews were analysed using thematic analysis.

Results: Four main themes were developed: the interpersonal and sociocultural context of self-disgust, self-disgust as both transient and enduring, self-disgust as a complex emotional experience, and the ongoing struggle to protect the self. The findings highlight how self-disgust appears to be understood as emerging in the context of being harshly judged and treated in relation to one's body weight and shape, and not fitting in societal expectations regarding body size. Self-disgust also appeared to be understood as having trait and state-like components as well as cognitive-affective aspects congruent with an emotion schema, and be experienced in conjunction with other emotions. Participants appeared to employ a number of strategies to manage feelings of self-disgust, including calming breathing, distraction and avoidance.

Conclusions: This study emphasises the potential usefulness of an increased clinical awareness of self-disgust to support individuals experiencing psychological distress associated with eating problems. The theoretical, clinical and research implications are discussed, and possible limitations of this study are considered. It is hoped that the present findings will contribute to better outcomes for those experiencing psychological distress associated with eating problems.

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1. INTRODUCTION

Over recent years there has been a growing interest in the role of the emotion of disgust within a number of different presentations of psychological distress. Research has emerged exploring the role of the disgust emotion in various presentations of psychological distress, including those related to sadness and eating, body shape and weight related concerns and difficulties (e.g. Fox & Harrison, 2008; Troop, Treasure, & Serpell, 2002). Whilst evidence is inconsistent it seems that disgust, and specifically self-disgust, may be a common feature of such presentations (e.g. Fox & Power, 2009; Power & Dalgleish, 2008). The current study seeks to build on these emerging findings by employing a qualitative methodology to gain more of an understanding of self-disgust by exploring the perspectives of women who experience psychological distress associated with eating, body shape and weight.

1.1. Overview

This chapter begins by outlining the terminology used throughout the study to help orientate the reader to the language being used. Following this the context for this research will be delineated by considering the epidemiology, outcomes and costs with regards to psychological distress associated with eating, body weight and shape concerns and difficulties and those who are affected. Then, the conceptualisations of the emotion of disgust and self-disgust will be considered in the context of this research. This will be followed by a discussion of current theoretical understanding of emotions within psychological distress. A review of the relevant literature on self-disgust within different presentations of psychological distress will then follow, with the aim to critically consider existing knowledge and highlight important issues within the literature. The chapter will conclude with the study rationale, aims and research questions.

1.2. Terminology

Psychological distress regarding one's body shape, weight and eating related concerns and difficulties has been described in the literature throughout history, entering the psychological and psychiatric realm in the 19th century when it started to be treated as a psychological condition (Cromby, Harper, & Reavey, 2013). From within the psychiatric framework, psychological distress related to eating, body shape and weight related concerns and difficulties is defined as eating disorders (EDs), and described as a persistent disturbance in eating-related behaviours that leads to altered consumption of food and significant impairment in physical health or psychosocial functioning (American Psychiatric Association [APA], 2013). The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) classifies EDs into eight diagnostic categories: anorexia nervosa (AN), bulimia nervosa (BN), pica, rumination disorder, avoidant/restrictive food intake disorder (ARFID), binge-eating disorder (BED), other specified feeding or eating disorder (OSFED), and unspecified feeding or eating disorder (UFED) (APA, 2013). Applying discreet diagnostic categories to psychological distress associated with eating related problems and weight and body shape concerns implies the existence of distinct categories of illness or disorder. However, there is evidence showing that there are core common features between eating related difficulties and many overlapping psychological dimensions across diagnostic categories, specifically the over-evaluation of eating, shape and weight and their control (Fairburn & Bohn, 2005; Fairburn, Cooper, & Shafran, 2003; Waller, 1993). This emphasis on the similarities between the different presentations is referred to as a transdiagnostic framework which encourages moving away from discreet diagnostic categories.

According to the transdiagnostic perspective, individuals experiencing eating related problems share the same clinical features including dietary restriction, binge eating, compensatory behaviours, body checking and avoidance, and preoccupation with shape, weight and eating (Castellini, Trisolini, & Ricca, 2014; Fairburn et al., 2003). Moreover, it has been proposed that in some individuals the core common features of over-evaluation of eating, shape and weight and

their control interact with additional maintaining processes including perfectionism, low self-esteem, emotional dysregulation, and interpersonal difficulties (Fairburn et al., 2003; Murphy, Straebler, Cooper, & Fairburn, 2010; Shafran, Cooper, & Fairburn, 2002).

In this study, it is acknowledged that there are dilemmas and limitations with regards to using psychiatric definitions and diagnostic classifications such as the overlap between categories and reductionist view of individuals' experiences (Boyle, 2007; Harper, 2013; Moncrieff, 2010). Psychological distress related to eating, body shape and weight is understood to be variable and heterogenous experiences influenced by a variety of psychosocial and biological factors, cultural norms and values. The term EDs and other psychiatric classifications and diagnostic categories such as depression are only used when employed by researchers whose work I will be drawing upon in this study. The term eating problems is also used to collectively describe experiences of psychological distress in relation to eating, body shape and weight concerns and difficulties.

1.3. Epidemiology, Outcomes and Costs

Studies of the prevalence rate of psychological distress related to eating, body shape and weight, as with other studies exploring this experience of psychological distress, have mostly used psychiatric diagnostic categories of EDs. The prevalence rate has been estimated to range from 608,849 to 724,845 in the United Kingdom (PricewaterhouseCoopers [PwC], 2015). Incidence rates are significantly higher in females than in males, and are higher among those under the age of 20 years old (Fairburn & Harrison, 2003; Micali, Hagberg, Petersen, & Treasure, 2013; Smink, van Hoeken, & Hoek, 2012). The prevalence rates of OSFED have been found to be lower than previous rates of EDNOS (Quick, Berg, Bucchianeri, & Byrd-Bredbenner, 2014). This may be related to the decreased thresholds for the diagnoses of AN, BN and BED in the DSM-V.

Psychological distress related to eating, body shape and weight at the clinical level is associated with great physical, social and psychological consequences

and costs. Experiences of weight and body shape concern and eating problems have long been associated with low recovery rates (Pritts & Susman, 2003; van Hoeken, Seidell, & Hoek, 2003), high relapse rates and high mortality (Arcelus, Mitchell, Wales, & Nielsen, 2011; Herzog et al., 2000; Keel, Dorer, Franko, Jackson, & Herzog, 2005; Steinhausen, 2009). This may be due to a number of factors, including the physical complications associated with these presentations of psychological distress (e.g. Mitchell & Crow, 2006) and increased risk for suicide (e.g. Franko & Keel, 2006; Preti, Rocchi, Sisti, Camboni, & Miotto, 2011). It may also be related to delays in seeking support, waiting times for treatment, type of support available or duration of treatment (PwC, 2015). Psychological distress related to eating, body shape and weight has significant long-term implications on the well-being and quality of life of individuals who are affected and their families, as well as significant financial costs to individuals, their carers and the NHS (PwC, 2015).

1.4. The Emotions of Disgust and Self-Disgust

Over the years, there has been a growing interest in the role of emotions in the development of psychological distress within clinical research (e.g. Gross, 2015), and disturbances in emotion have been associated with a wide range of psychological difficulties (e.g. Aldao, Nolen-Hoeksema, & Schweizer, 2010). A considerable body of research has implicated the emotion of disgust in many different presentations of psychological distress (e.g. Davey, Buckland, Tantow, & Dallos, 1998; Fox & Harrison, 2008; Olatunji & McKay, 2007), and it has been argued more recently that disgust towards the self may be of particular relevance in a number of psychological difficulties (Power & Dalgleish, 2008). The conceptualisations of disgust and self-disgust are considered next.

1.4.1. Conceptualisations of Disgust

Disgust is considered to be one of the six basic universal emotions (i.e. fear, anger, sadness, disgust, surprise, and happiness) which is recognisable across many cultures (Ekman, 1992; Izard, 2007) and characterised by distinctive

characteristics, including distinctive facial expressions (e.g. nose wrinkle), visceral physiological reactions (e.g. nausea), cognitive responses (e.g. fear of contamination) and behavioural responses (e.g. avoidance or rejection of some object, situation or event) (Rozin, Haidt, & McCauley, 1999, 2008; Rozin, Lowery, & Ebert, 1994).

Over the years, the conceptualisation of disgust has evolved to acknowledge a range of disgust domains and functions. Rozin and colleagues (1994, 1999, 2008) have identified four types of disgust domains: core disgust, animal-nature disgust, interpersonal disgust and moral disgust. The core function of these four domains is thought to be protective in nature, including protection of the body from infection or disease, protection of oneself from reminders of one's mortality, and protection of the social order (Olatunji & Sawchuk, 2005; Rozin et al., 2008). Disgust also has a function of communicating cultural values and norms, such as judgements about culturally accepted body shapes (Markham & Davey, 2010). This communicative function appears to be influenced by individuals' sensitivity to the other disgust domains, which are themselves influenced by individuals' sociocultural context. For instance, in cultures where thinness is valued core disgust may be elicited by high-caloric food or overeating, and interpersonal disgust may be elicited by being overweight or being in contact with people who are considered to be overweight.

It is argued that the expression of disgust responses is observable from birth, and that disgust functions as an effective adaptive mechanism to reject potential harmful substances and avoid disease (Rozin & Fallon, 1987). It is also believed that the range and intensity of disgust responses change over individuals' life span via sociocultural learning (Power & Dalgleish, 2008; Rozin et al., 2008). These findings are particularly pertinent to psychological distress related to eating, body shape and weight as research suggests individuals with eating problems hold very high socio-moral norms (Nemeroff & Cavanaugh, 1999). Thus, sociocultural ideals of thinness may provide a context in which overeating and being overweight is associated with disgust. Indeed, it has been found that a community sample rated individuals who ate unhealthy and high-caloric foods as

less likable and attractive (Stein & Nemeroff, 1995). Individuals may therefore experience elevated disgust when societal and personal socio-moral expectations regarding eating behaviour, body shape, appearance and weight are violated.

1.4.2. Self-Disgust Conceptualisations

Self-disgust has been to date used inconsistently within the literature. Self-disgust is often described in terms of the emotion of shame (Power & Dalgleish, 2008) including body shame (i.e. negative experiences related to the appearance of own body) (Gilbert & Miles, 2002), and used as a synonym for self-hatred (Green, Moll, Deakin, Hulleman, & Zahn, 2013). Self-disgust has also been defined as a negative personality trait (Olatunji, David, & Ciesielski, 2012), as the basic emotional experience of disgust directed towards the self (Power & Dalgleish, 2008), a discrete self-conscious emotion (Roberts & Goldenberg, 2007), and as an emotion schema (Izard, 2007, 2009; Powell, Simpson, & Overton, 2015a). Additionally, self-disgust has been conceptualised as a form of self-to-self relating based on self-criticism and internal negative evaluations of the self as unattractive or object of disgust within particular social contexts (Gilbert, 2015; Gilbert, Clarke, Hempel, Miles, & Irons, 2004).

Whilst the above conceptualisations may capture some aspects of the concept of self-disgust, they present a great challenge to understanding the emotion of self-disgust as researchers tend to draw on different conceptualisations in the literature without any clarification. In this study, self-disgust is viewed as a common feature of various presentations of psychological distress. Echoing Roberts and Goldenberg (2007), it is argued that self-disgust is a distinct emotion that may be better understood as a cognitive-affective construct or emotion schema (Powell et al., 2015a) involving disgust-based appraisals and emotional responses towards the self. It has been suggested that while feelings of self-disgust may be adaptive and functional such as in conforming to social norms and facilitating disease avoidance (e.g. feeling self-disgust when eating spoiled food), they may become maladaptive and have negative effects on individuals' psychological wellbeing (Powell et al., 2015a).

1.4.3. The Emergence of Self-Disgust

The emergence of self-disgust is thought to be influenced by a number of factors including individuals' personal characteristics, certain psychological traits, internalisation of negative experiences (namely childhood trauma), personal learning experiences and sociocultural factors (Fox, Grange, Power, 2015; Powell et al., 2015a). Some scholars have suggested that self-disgust is more likely to emerge during the childhood and adolescence period through parental modelling and social learning experiences (Power & Dalgleish; 2008). However, it has also been suggested that self-disgust can develop at any age (Powell et al., 2015a).

One key contributing factor for the emergence of self-disgust seems to be related to the individual's sociocultural context and learned repertoire of disgust elicitors. In particular, it has been argued that self-disgust may arise in response to violations of sociocultural expectations of the self (Powell et al., 2015a). When aspects of the self (e.g. body shape) feature, or are perceived to feature in the sociocultural repertoire of disgust elicitors, or the individuals' repertoire expands through personal experiences (e.g. childhood abuse, trauma, weight gain) and social learning (e.g. idealisation of thin bodies) to include them, self-disgust is thought to emerge as a response. In the case of eating related problems, research has documented greater body dissatisfaction among women in the Western society where there is a drive for a thinner body shape (e.g. Tiggemann & Slater, 2004). Additionally, literature concerning self-objectification has implicated self-disgust in psychological distress related to eating, body shape and weight. The self-objectification theory posits that women are socialised to view themselves as an object or from an observer's perspective so that they evaluate themselves based on their appearance (Fredrickson & Roberts, 1997). Research has shown that self-objectification is associated with increased disgust directed at the body, body shame and disordered eating patterns in women (e.g. Calogero, Davis, & Thompson, 2005; Moradi, Dirks, & Matteson, 2005; Noll & Fredrickson, 1998).

In sum, the emotion of disgust has evolved from its role as a pathogen avoidance mechanism to incorporate a socio-moral and communicative role. The range of stimuli that elicits disgust is believed to be acquired through sociocultural learning experiences, and it is argued that it can incorporate the self or particular features of the self. Self-disgust is a relatively new concept in research which remains elusive and poorly understood. The stance taken in this thesis is that self-disgust can be understood as a distinct emotion involving disgust-based appraisals and emotional responses towards the self, and that it may be a characteristic feature of a number of different presentations of psychological distress.

1.5. Current Theoretical Understanding of Emotions

Whilst it is acknowledged that there are different models that consider the role of emotions within psychological distress, the model addressed here is the Schematic Propositional Analogical Associative Representation System model of emotion which considers both the emotion of disgust and self-disgust within psychological distress (SPAARS; Power & Dalgleish, 2008). The SPAARS model proposes that emotion-related stimuli are initially processed at the analogical level via different sensory modalities such as visual, olfactory and tactile, and that emotions are generated via two routes: an appraisal route and an associative route (Fox & Power, 2009). In the appraisal route emotions are triggered through the processing of internal or external stimuli within a schematic framework, whereas in the associative route individuals' emotional responses are considered to be outside their conscious awareness (Fox & Power, 2009). Within the schematic framework, the model sets out three beliefs about the self, others and the world (e.g. self as being bad or worthless, others as important and the world as being unsafe) (Fox & Power, 2009). According to the model, psychological distress occurs when the processing system becomes 'locked' such as when certain components of the system start to activate others. For instance, when a schematic representation of the self has been activated which indicates that the self is bad this may then lead to the activation of a propositional representation such as 'I am a bad person'. In turn this could then lead to the activation of an associative link to feelings of low mood through a feedback loop.

Moreover, the model proposes that emotions can become coupled (i.e. experienced simultaneously) where one emotion is used to facilitate or inhibit another emotion. In particular, it is argued that anger may come to be perceived as dangerous and unacceptable due to beliefs of low self-efficacy and invalidating childhood, and subsequently become ego-dystonic and detached from the individual's sense of self (Fox & Power, 2009). Disgust may then become a dominant emotion through the associative route to inhibit or redirect feelings of anger (Fox & Power, 2009).

The SPAARS model has been applied to eating related problems (i.e. SPAARS-ED). According to the model, eating related problems function as a way of avoiding painful emotions by engaging in behaviours such as restraining eating, but as these negative emotions are not completely avoided they become directed to the body and self as self-disgust (Fox, Federici, & Power, 2012; Fox & Power, 2009). The coupling of emotions proposed by the model may account for the comorbidity within eating related problems and low mood (Fox & Froom, 2009). The SPAARS-ED model provides an integrated cognitive model of emotion within which both the emotions of disgust and self-disgust can be understood in relation to psychological distress related to eating, body shape and weight.

1.6. Why Focus on Women in Relation to Eating Difficulties and Disgust?

Although there are disparities in the theories regarding the development of eating related problems in men and women, existing research suggests eating problems are more common in women than in men (Fairburn & Harrison, 2003; Micali et al., 2013) and that their onset occurs earlier in women (e.g. Sharp, Clark, Dunan, Blackwood, & Shapiro, 1994). In addition, it has been documented that women present with increased body checking and avoidance compared to men (Anderson & Bulik, 2004; Lewinsohn, Seeley, Moerk, & Striegel-Moore, 2002; Striegel-Moore et al., 2009). Moreover, research on disgust suggests women are generally more sensitive to disgust than men (Haidt, McCauley, & Rozin, 1994; Olatunji, et al., 2007). Disgust has also been shown to partially mediate the relationship between women's concerns about physical appearance and dislike of

overweight people (O'Brien et al., 2013). Exploring the emotion of disgust towards the self in women with eating related problems was therefore deemed appropriate as the results may be applicable to a larger proportion of individuals experiencing self-disgust and psychological distress related to eating, body shape and weight.

1.7. Literature Review

Despite growing interest in the relevance of self-disgust to psychological distress, there remain relatively few studies exploring the emotion of self-disgust. The current review sought to explore existing literature on the emotion of self-disgust across different presentations of psychological distress.

1.7.1. Literature Search Strategy

The literature search strategy adopted for this study involved systematic searches across Academic Search Complete, CINAHL-Plus, PsychArticles, PsycINFO, PubMed and Scopus databases. Key references of retrieved publications were searched, and both Google and Google Scholar were used to identify grey literature and any additional relevant publications that may have otherwise been missed. The search terms used to access literature pertaining to this study's topic were disgust, self-disgust, disgust towards the self, psychological distress, mental health plus a range of related terms such as mental health difficulties/problems and mental health disorder as these terms are often used within the literature.

1.7.2. Inclusion and Exclusion Criteria

The search was limited to work written in English. Priority was given to qualitative studies and research conducted within the UK, however given that these were limited in number quantitative studies were also included as well as research from across other countries was included. No restrictions were applied to the date of publications.

1.7.3. Summary of Search Results

The literature search resulted in a total number of 185 publications. After removing duplicates and articles not relevant to the topic of the current research, 59 records remained which were then reviewed. This review yielded 22 relevant publications. On the whole, the identified literature has predominantly adopted a quantitative approach and employed a number of different self-report measures to explore the emotion of self-disgust across different presentations of psychological distress. The identified studies employed diagnostic categories and used both clinical and nonclinical samples and varied in their design, use of measures and sample size. Only four studies employed a qualitative approach to explore the perception, experience and management of emotions, including self-disgust within psychological distress. These will be presented first in order to explore how self-disgust has been talked about and experienced across different presentations, and delineate what its shared characteristic features may be from the perspective of those that experience it.

As previously stated, diagnostic categories will be used when discussing existing literature as these have been employed by the researchers whose work I will be drawing upon. However, an effort has been made to focus on the emotion of self-disgust in relation to the experience of different presentations of psychological distress rather than on diagnostic classifications.

1.8. Qualitative Explorations of the Perception and Experience of Emotions including Self-Disgust

To date, two qualitative studies have explored how individuals experiencing psychological distress related to eating problems, defined by the researchers as anorexia nervosa (AN), perceive and manage negative emotions. The first study employed grounded analysis to explore the perception and management of emotions amongst a clinical sample of eleven participants, five were inpatients and the remaining six were attending a day service (Fox, 2009). The study revealed that participants related their AN to the emotion of anger which was described as being toxic, dangerous and threatening, and to a lesser degree to

sadness, which was referred to as being a sign of weakness. The emotion of disgust appeared to be salient, in particular towards the body, and the emotion of fear emerged as a secondary emotion, e.g. fear of being disgusted about the self, the body and food (Fox, 2009). It also seemed that for some participants, the emotion of anger was coupled with the emotion of disgust towards the body. These findings are in line with contemporary accounts within the literature, specifically the SPAARS model idea of ego-dystonic emotion and coupling of emotions within psychological distress (Power & Dalgleish, 2008). A strength of the study was the use of researcher reflexivity and having participants who were at different stages of their eating related difficulties associated with a diagnosis of AN as it may have allowed for a fuller exploration of emotions. However, recruiting from only one site and only those presenting with psychological distress associated with the diagnosis of AN may have limited the generalisability of the findings and the amount one can extrapolate from them. Using multiple sites and individuals experiencing psychological distress associated with other eating related diagnoses may have provided a more comprehensive data sample and theoretical transferability.

The second study explored how women with AN manage the basic negative emotions of sadness, anger, fear and disgust and link these with their eating problems using grounded theory methodology (Espeset, Gulliksen, Nordbø, Skårderud, & Holte, 2012). Given with the focus of this literature review and study aims, the discussion of the above study will be centred around the emotion of disgust. The researchers reported that women talked about experiencing disgust towards themselves and their body and described it as a being strong, intense and invading emotion associated with feelings of nausea or sickness (Espeset et al., 2012). Most women linked the emotion of disgust to body dissatisfaction, food intake and the feeling of being full (Espeset et al., 2012). In this study, disgust was described as an emotional response triggered in situations when participants were reminded of or became aware of their body appearance such as when taking a shower, or in social situations when they felt judged or when others made negative comments. In such situations participants reported feeling ‘disgusting’ and ‘fat’. These findings seem to suggest that disgust towards the self

may be a relatively automatic response. This is consistent with the idea proposed by the SPAARS-ED model (Fox & Power, 2009), which suggests self-disgust may become a learned and automatic emotion within psychological distress associated with eating, body shape and weight concerns and difficulties.

Moreover, the researchers reported that participants engaged in avoidance strategies linked to their eating related problems in order to manage the emotion of disgust, such as avoiding food and body awareness, physical closeness and sexuality (Espeset et al., 2012). In addition, disgust was found to be linked to the emotions of fear and sadness. Feelings of sadness led participants to feel dissatisfied with themselves and experience their body as disgusting, whereas fear led participants to imagine that their bodies were expanding or that they were fat which made them feel disgusting (Espeset et al., 2012). Again, this is in keeping with the idea of emotion coupling proposed by the SPAARS model. A strength of this study was the use of rigorous coding procedures (open, axial, confirmatory and selective coding) to develop concepts grounded in the data. However, the researchers did not explain the rationale for using a descriptive version of grounded theory instead of the original theory building version raising questions with regards to the suitability and appropriateness of chosen method of analysis in relation to the study's aim of exploring how women with a diagnosis of AN manage negative emotions.

More recently, Powell, Overton, & Simpson (2014) explored the phenomenological experience of self-disgust in women who scored clinically relevant symptoms of sadness as measured by the depression subscale of the Depression, Anxiety and Stress Scale (DASS-DEP; Lovibond & Lovibond, 1993), and high levels of self-disgust as measured by the Self-Disgust Scale (SDS) developed by Overton and colleagues (2008) based on the Self-Description Questionnaire III (SDQ-III; Marsh & O'Neill, 1984), a measure of the thoughts and feelings people have toward themselves. The SDS measures disgust towards physical aspects of the self and behaviour (Overton et al., 2008). Using Interpretative Phenomenological Analysis (IPA), the researchers found that self-disgust was perceived as a consuming, visceral experience with trait and state

components, and that it was associated with particular antecedent factors such as disgust-based criticism from others and negative comparisons with others (Powell et al., 2014). The researchers reported that participants described self-disgust as having negative consequences such as dissociation, self-persecution and avoiding looking at the self. In addition, self-disgust was described as being experienced alongside other emotions including shame, anger and sadness.

A number of limitations should be considered when interpreting these findings particularly the selection and recruitment of participants based on the use of self-report measures instead of using a self-selected sample. Although the SDS (Overton et al., 2008) has demonstrated a high level of internal consistency, test-retest reliability and concurrent validity with the Disgust Sensitivity Scale (DSS; Haidt et al., 1994), its construct validity has yet to be firmly established particularly using clinical samples where self-disgust may be most relevant. Self-disgust as measured by the SDS seems to share as much commonalities with other self-directed constructs, such as self-criticism and self-hatred as with external-related disgust. Moreover, it is arguable whether participants account of self-disgust actually referred to feelings of disgust towards the self. It has been proposed that in lay language disgust is often used to describe feelings of anger, irritation or annoyance (Nabi, 2002). Indeed, self-disgust was described to be associated with the emotion of anger in this study suggesting that they may be closely related emotions and may even overlap when directed to the self. However, as remarked by the researchers, the visceral sensations of disgust described by participants such as the sensation of nausea, the behavioural response of avoidance and feelings of repulsiveness appears to indicate that participants were indeed describing feelings of disgust.

Benson, Boden and Vitali (2015) conducted secondary qualitative analyses of data from two studies to explore experiences of self-disgust in self-harm. The researchers drawn upon a mixed-methods study that explored experiences of self-harm (Horne & Csipke, 2009) and two case studies from an ongoing study exploring the experiences of individuals who have attempted suicide, their significant others, and those bereaved by suicide. The researchers purposely

used secondary thematic analysis to search for implicit and explicit experiences of self-disgust. Benson and colleagues (2015) reported that explicit accounts of self-disgust were relatively unusual. A fraction of participants (25 out of 827) talked about experiences of feeling disgusting about themselves or their actions either before (n= 2) or after self harming (n=23) in the first online survey phase of Horne and Csipke's (2009) study. In the second phase 37 e-mail interviews were conducted with only five participants explicitly identifying feelings of self-disgust (Benson et al., 2015). Participants reported that self-disgust was experienced before self-harming, and for one of the participants feelings of self-disgust also occurred in response to self-harming. Benson and colleagues argued that the use of the term self-disgust was consistent with the idea of 'basic self-disgust' which implies a set of behavioural and physiological rejection responses (Rozin & Fallon, 1987; Rozin et al., 2008) and 'moral self-disgust' elicited in response to moral disapproval or violations (Rozin et al., 2008). This conceptualisation of self-disgust is akin to the assertion that the basic emotion of disgust, anchored around a shared function of avoidance and/or rejection and of communicating cultural values and norms, can include features of the self and lead to both functional and maladaptive self-directed disgust (Power & Dalgleish, 2008).

Beson and colleagues (2015) hypothesised that rather than being part of the emotional state preceding self-harm, self-disgust may contribute to it in a causal way, and that the relative absence of self-disgust prior to self-harming may be explained to a certain degree by the experience of depersonalisation (i.e. a feeling of unreality, detachment or unfamiliarity with one's sense of self or aspects of the self). They proposed that depersonalisation is likely to have become an engrained emotion regulation strategy amongst those individuals who self-harm preventing explicit representation of intense and overwhelming emotions including that of self-disgust. Furthermore, the researchers proposed that although the emotional state experienced prior to and directly contributing to self-harm was not disgust in a basic emotional sense, it was similar to a disgusting object that cannot be easily separated from the self (Benson et al., 2015). The researchers termed it 'integral' self-disgust, i.e. a feeling that the emotional part of the self is disgusted which evokes a response of rejection. This

type of self-disgust experience was described as an overwhelming, intense and unassimilable feeling about the self, being out of control over one's emotions and related thoughts and a threat to the integrity of the self (Beson et al., 2015). In these cases, participants described using self-harm to gain order, mastery and a feeling of integrity. After self-harming, the participants' emotional state was characterised by a vulnerability to moral self-disgust and other related self-conscious emotions including shame, embarrassment guilt, hatred and self-directed anger (Horne & Csipke, 2009). This finding is in line with Roberts and Goldenberg's (2007) conceptualisation of self-disgust as a distinct self-conscious emotion that may co-exist with other self-conscious emotions such as shame and embarrassment, and the idea of emotion coupling proposed by the SPAARS model of emotion (Fox & Power, 2009).

Furthermore, there was evidence in the online survey (Horne & Csipke, 2009) that others' response of disgust, either imagined or perceived, towards one's self-harming behaviour may be internalised as moral disgust resulting the self to be viewed as morally disgusting. These feelings of moral self-disgust are believed to contribute to the overwhelming emotional state that leads to feelings of 'integral' self-disgust contributing in turn to self-harming as an attempt to manage these feelings (Beson et al., 2015). These findings highlight the need for psychological interventions to focus on developing tolerance and acceptance of difficult, overwhelming feelings in the context of self-harm.

Overall, the emotion of self-disgust has been to date described as being a strong, intense and consuming emotion associated with visceral sensations of nausea or sickness and experienced alongside other emotions particularly sadness, anger and shame. Self-disgust also appears to be an automatic response to triggering situations such as when one becomes aware of own body and physical appearance and others negative feedback or judgment. Furthermore, the experience of self-disgust appears to evoke avoidance strategies such as avoiding looking at the self, and contribute, in a causal way, to the emotional state preceding self-harm behaviour. Moreover, the expression of self-disgust in the context of self-harm provides support for the conceptualisation of self-disgust

as a distinctive emotion which may be experienced alongside other emotions such as shame. Although these findings offer rich descriptions and useful insights about the emotion of self-disgust and are in keeping with contemporary theoretical understandings of self-disgust as a distinct emotion (Roberts & Goldenberg, 2007) that may be experienced in conjunction with other emotions (i.e. SPAARS model, Fox & Power, 2009), it should be noted that only one of the above studies focused explicitly on the emotion of self-disgust. It is argued that it is pertinent to conduct further qualitative research to gain a richer and informed understanding of individuals perspectives upon self-disgust. Moreover, the conclusions drawn from the above findings need to be interpreted with caution due to a number of methodological limitations. In particular, the theoretical significance and transferability of the findings may have been limited due to recruitment of participants from single sites (Fox, 2009; Powell et al., 2014), and the use of the SDS (Overton et al., 2008) self-report measure to select and recruit participants (Powell et al., 2014) as its construct validity has yet to be firmly established, particularly using clinical samples where self-disgust may be most relevant.

1.9. Quantitative Investigations of Self-Disgust Associated with Psychological Distress

In light of the recent growing interest in the emotion of self-disgust, researchers have directly explored the link between self-disgust and a number of different presentations of self-disgust. Ille and colleagues (2014) investigated self-disgust in people with eating problems (n= 40), ‘major depression’ (n= 21), ‘schizophrenia’ (n= 15), ‘spider phobia’ (n= 19), and ‘borderline personality disorder’ (BPD, n= 17). In this study self-disgust was measured by the Questionnaire for the Assessment of Self-Disgust (QASD; Schienle, Ille, Sommer, & Arendasy as cited in Ille et al., 2014), a German version of the SDS (Overton et al., 2008) developed via exploratory factor analysis. The QASD mirrors the SDS, comprising of two sub-scales assessing “personal disgust” (concerned with one’s own physical appearance and personality) and “behavioural disgust”. The researchers found that compared to healthy controls,

self-disgust was significantly elevated across the different presentations of psychological distress with the exception of 'spider phobia', indicating that self-disgust may be of particular relevance to psychological distress. Researchers also reported that the "personal disgust" domain was more pronounced than the domain of "behavioural disgust" in the clinical samples, and women scored higher on both subscales compared to men (Ille et al., 2014). Participants with a diagnosis of BPD and eating problems reported the highest scores on both domains. They also showed the most elevated personal disgust scores (i.e. disgust towards own physical appearance and personality) compared to the other presentations (Ille et al., 2014). The researchers identified 'psychoticism' (the idea that something is wrong with your mind') and hostility best predicted personal disgust within the clinical sample while interpersonal sensitivity, and anxiety were the best predictors for behavioural disgust (Ille et al., 2014). Methodological limitations include poor description of the study sample, a lack of reporting regarding screening for possible comorbid psychological distress, and small sample size meaning group comparisons are likely to be underpowered. Moreover, although the QASD has been found to be reliable, it seems to tap more into self-negativity rather than self-disgust itself (e.g. "I regret my behaviour"). This raises questions as to whether the measure captures self-disgust as a discrete emotion.

More recently, Zahn and colleagues (2015) explored self-disgust in the context of self-blaming moral emotions (e.g. guilt, shame, disgust/contempt towards oneself) in relation to psychological distress associated with feelings of sadness. Using a retrospective cross-sectional design and a sample comprised of individuals with remitted depression (n= 132), the researchers assessed self-blaming emotions by employing a phenomenological psychopathology-based interview (AMDP; Faenhdrich & Stieglitz as cited in Zahn et al., 2015) translated from German and with added new items to assess moral emotions including self-disgust. Questions included "Do you sometimes feel disgust, contempt, hate or loathing?" and "Is this mostly towards yourself, others or both?". During a depressive episode, self-blaming emotions were found to be quite common (82%), with self-disgust/contempt being the most common (46%) followed by guilt

(39%) and shame (20%). Moreover, self-disgust/contempt was most strongly associated with the core depressive symptoms of hopelessness and feelings of inadequacy (Zahn et al., 2015). These findings suggest that feelings of self-disgust/contempt may be more highly associated with the depression rather than feelings of guilt or worthlessness as specified in the diagnostic criteria of depression. However, such interpretation must be considered with caution due to the study's methodological limitations. The retrospective assessment of self-blaming emotions may have biased participants to under report certain emotions. In addition, the items included in the AMDP to assess self-disgust were combined with the constructs of contempt and loathing which are arguably theoretically distinct constructs, and therefore may not represent a valid and comprehensive assessment of the emotion of self-disgust.

Self-disgust has also been explored in relation to deliberate harming of the self in a physical way (e.g. cutting, scratching, punching the self) without the intent of committing suicide using a quantitative approach across different presentations of psychological distress. This is often referred to as either self-harm, self-injury or deliberate self-harm, and it has been assigned a distinct diagnostic classification termed non-suicidal self-injury (NSSI; APA, 2013) which has been employed by some the researchers whose studies will be discussed next.

1.9.1. Self-Harming Urges and Behaviour

Abdul-Hamid, Denman and Dudas (2014) investigated whether self-disgust may be an emotional trigger for self-harm urges in people experiencing psychological distress associated with the diagnostic categories of BPD (n= 17) and major unipolar depression (MDD; n= 27). In this study, a self-relevant task (SRT), which asked participants to reflect on the negative aspects of their person in general and then their body, was administered in a quasi-experimental design followed by the administration of visual analogue scales (VAS) to measure levels of disgust and change in level of self-harm urges. The researchers found that changes in VAS rating of self-disgust (after the SRT focusing on negative aspects of the person in general) were associated with increased self-harm urges in the group of participants who had a diagnosis of BPD compared to the healthy control

group (n= 25), but not different from those who had a diagnosis of MDD (Abdul-Hamid et al., 2014). This finding appears to suggest that self-disgust may be more salient in certain presentations of psychological distress. However, it should be noted that in the free narrative on the thoughts and emotions evoked by the SRT, self-disgust was significantly associated with an increase in self-harm urges among the whole sample. Post SRT self-disgust levels or changes in disgust were only associated with changes in self-harm urges among those who had a diagnosis of MDD in the task focused on the negative aspects of the person in general (Abdul-Hamid et al., 2014). This may have been due to the greater sample size in the group of participants who had a diagnosis of MDD. Overall, sample sizes across the clinical groups were relatively small meaning that some of the statistical tests may have failed to find a statistically significant difference or association due to lack of power. Thus, findings should be considered preliminary. There was also no control condition and therefore the specificity of self-directed emotions in the changes observed during and after the SRT could not be checked. However, arguably the two tasks may be regarded as each other's controls. It is also noteworthy that inter-rater reliability checks were not conducted on the written narratives which may have led to over-reporting of disgust related labels.

A recent study investigated the role of self-disgust (as measured by the SDS) as both a mediator and maintaining factor in the context of self-harming behaviour (Smith, Steele, Weitzman, Trueba, & Meuret, 2015) amongst a non-clinical sample (n= 549). The researchers found that self-disgust fully mediated the relationship between depressive symptoms and NSSI, and partially mediated the relationship between sexual abuse and NSSI (Smith et al., 2015). These findings suggest that self-disgust may serve as an emotional trigger for NSSI, and that sexual abuse may represent a risk factor for NSSI via the development of self-relevant disgust. Researchers also found that those individuals who had engaged in recent NSSI behaviours reported the highest levels of self-disgust and depressive symptoms compared to past or non-self-harmers. This finding highlights the potential role of self-disgust as a maintaining factor in self-harming behaviour. Although, a number of important variables were controlled for in this

study (e.g. anxiety sensitivity), the cross-sectional design of the study meant that the temporal associations between the study constructs could not be examined. Nevertheless, taken together the above findings provide preliminary support for the role of self-disgust in self-harm behaviours.

Bachtelle and Pepper (2015) investigated the association between self-disgust (as measured by the SDS) and the psychological meaning made of NSSI scars. In this study a community sample of undergraduate students (n= 49) who endorsed current self-injurious behaviour and had scars from previous self-harming behaviour completed questionnaires about the meaning of their scars and emotions associated with their scars. The researchers found that levels of scar-related shame, measured by the use of the differential emotions scale (DES-IV-A; Izard, Libero, Putnam, & Haynes,1993) were positively associated with self-disgust while levels of scar-related growth were negatively associated with self-disgust (Bachtelle & Pepper, 2015). These findings add to the literature discussed above by suggesting that feelings of self-disgust may not only trigger self-harm, but may perhaps be a consequent emotional response to scars caused by self-harm. This hypothesis is supported by Beson and colleagues (2015) secondary thematic analyses which suggested that self-disgust may not only occur prior to self-harming but may also be experienced in response to self-harming.

A recent study investigated whether self-disgust may act as a mechanism linking trauma related symptoms with suicide risk (Brake, Rojas, Badour, Dutton, & Feldner, 2017). The researchers found significant positive associations between trauma related symptoms severity and self-disgust (as measure by the SDS) and suicide risk beyond the effects of depression. Interestingly, after controlling for trauma related symptoms and depressive symptoms, only the disgusting self feature of self-disgust showed a significant association with suicide risk (Brake et al., 2017). These findings suggest that suicide risk among people with psychological distress related to trauma may be explained, at least partly, by feelings of disgust towards the self or aspects of oneself as opposed to disgust directed towards one’s behaviour. The researchers hypothesised that disgust

towards one's sense of self subsequent to trauma experiences may be perceived as less escapable than disgust towards one's behaviour. As a result, self-disgust post traumatic experiences may increase one's vulnerability to engage in suicidal behaviour by increasing feelings of inadequacy and hopelessness. While Brake and colleagues' (2017) study suggests that self-disgust may play a significant role in the relation between trauma related symptoms and suicide risk, only tentative inferences are possible given the early stage of research in this area. The cross-sectional and correlational nature of the study preclude temporal and causal inferences.

Overall, research suggests that self-disgust may be of particular relevance to psychological distress and that it may serve as a mediating and maintaining role in deliberate self-harming, and potentially be both an emotional trigger and a consequent emotional response to self-harming. The reported elevated levels of self-disgust across different presentations of psychological distress suggests that it may be a characteristic emotional experience of various presentations. Moreover, the above findings also suggest that self-disgust may be a contributing factor in suicidality among individuals with psychological distress, in particular in the context of eating problems and trauma. In light of the above findings, self-disgust may represent an important target for prevention and therapeutic interventions. However, there are a number of methodological limitations that need to be taken into considered when interpreting the above findings. The lack of data regarding possible comorbid psychological distress means their potential impact on the reported findings cannot be accounted for, and the use of the QASD and the AMDP measures to assess self-disgust is questionable due to overlap with other constructs such as contempt. This raises concerns about the validity of these measures in capturing the emotion of self-disgust, and consequently the validity of the findings presented above. The use of a more specific self-disgust measure (e.g. SDS-R; Powell et al., 2015b) may have enabled to make inferences more confidently. Moreover, the relative small sample sizes mean group comparisons are likely to be underpowered, and the cross-sectional and correlational nature of the studies preclude temporal and

causal inferences. The above findings therefore need to be considered preliminary.

1.9.2. Self-Disgust and Distressed Bodies

Emerging research suggest that self-disgust may be a characteristic feature in presentations of psychological distress associated with eating and weight concerns, and negative evaluation or scrutiny of the perceived flawed physical self in relation to an idealised self. Recent research has found that high levels of self-disgust were associated with eating problems in a clinical sample of females who have attracted a diagnosis of AN (n= 16), bulimia nervosa (BN; n= 35) and other specified feeding or eating disorder (OSFED; n= 17) compared to a healthy control group (n= 68), and a clinical control group (consisting primarily of depression, n= 64; and social phobia, n= 54) (Moncrieff-Boyd, Byrne, Allen, & Nunn, 2016). In this study, self-disgust was measured using the revised SDS for EDs (SDS-ED; Moncrieff-Boyd et al., 2014). In this revised measure, several items have been rephrased to be more synonymous with self-disgust rather than with self-dislike (e.g. “It bothers me to look at myself” was changed to “It sickens me to look at myself”), and added new items to assess body disgust that may be relevant to psychological distress associated with eating problems (e.g. “Parts of my body are foul”). The researchers found no significant differences between the three ED diagnostic groups (Moncrieff-Boyd et al., 2016). This finding may be explained by the overlapping psychological dimensions across the ED diagnostic categories, specifically the over-evaluation of eating, shape and weight and their control (Fairburn & Bohn, 2005; Fairburn et al., 2003). The relationship between self-disgust and ED symptomology remained significant when self-esteem was controlled for in the analysis (Moncrieff-Boyd et al., 2016). This provides support for the distinctiveness of the construct of self-disgust. When examining specific items on the SDS-ED, the ED clinical group showed higher scores on items assessing disgust at the body than the control clinical group, suggesting that disgust towards the body is of particular significance in psychological distress related to eating, body shape and weight concerns and difficulties. This finding provides empirical support for the abovementioned qualitative investigations suggesting self-disgust is a relevant emotion in psychological distress associated

with eating problems (Espeset et al., 2012; Fox, 2009). Although psychometric testing using a sample of undergraduates revealed that SDS-ED has good test-retest reliability and internal validity, further testing is required to confirm its construct validity (Moncrieff-Boyd, Allen, Byrne, Nunn, 2014).

More recently, the relationship between self-disgust and sensory processing has been investigated among a large female sample (n= 304) with a self-diagnosis of either AN (n= 270) or BN (n= 104), while controlling for possible confounding variables such as disgust sensitivity, anxiety, depression and anger (Bell, Coulthard, & Wildbur, 2017). The researchers revealed that both AN and BN groups showed higher levels of self-disgust (as measured by the SDS) compared to those with no history of eating problems. With regards to sensory processing (characterised by four processes: sensory sensitivity, sensation avoiding, low registration and sensation seeking), the researchers revealed that low sensation seeking and high anxiety were significantly associated with elevated self-disgust across all three groups (Bell et al., 2017). This seems to indicate a possible association between those who may both feel anxious and be less likely to actively seek sensation in a given sensory environment, and feelings of self-disgust within psychological distress associated with eating problems. Furthermore, the researchers found that in the BN group self-disgust was most strongly associated with increased sensation avoidance and decreased sensation seeking when controlling for confounding variables such as anxiety and disgust sensitivity (Bell et al., 2017). Whereas in the AN group, self-disgust was most strongly associated with greater registration and lower sensation seeking after controlling for confounding variables. This finding suggests that individuals with AN may not notice sensory stimuli as much as others, and may engage in passive coping strategies within a given sensory environment. The researchers hypothesised that low sensation seeking may contribute to self-disgust beyond disgust sensitivity (Bell et al., 2017). Although this study offers novel insights about self-disgust and its relationship with sensory processing within psychological distress associated with eating problems, is not without some limitations. The use of the SDS (Overton et al., 2008) to assess self-disgust meant that mainly the cognitive component (i.e. thoughts and evaluations) of self-

disgust was assessed. The physiological component (i.e. visceral bodily sensations) and behavioural consequences associated with self-disgust (e.g. avoiding looking at the self) reported in previous literature (e.g. Powell et al., 2014) were not covered. This raises concerns as to the validity of the findings. Also, the fact that some items seem to share many similarities with other self-conscious emotions such as shame and self-hatred may limit the understanding of the multidimensional and complex nature of self-disgust.

1.9.3. Self-Disgust and 'Disordered Personalities'

Three studies explored self-disgust in relation to psychological distress experienced by people who have attracted a diagnosis of BPD. These studies used cross-sectional group comparison designs, two of which adopted a neuroimaging methodology.

Schienle, Haas-Krammer, Schöggl, Kapfhammer and Ille (2013) investigated whether self-disgust plays a role in psychological distress experienced by women who have a diagnosis of BPD amongst a female clinical sample (n= 30). In this study self-disgust was measured using the QASD (Schienle, Ille, Sommer, & Arendasy as cited in Ille et al., 2014). The researchers found elevated self-disgust scores in the clinical sample compared to control sample (n= 25). Self-disgust was positively correlated with severity of BPD symptoms as measured by the Borderline Symptom List (BSL-23; Bohus et al., 2009), and there was a stronger correlation between both the "personal disgust" (concerned with one's own physical appearance and personality) and the "behavioural disgust" subscales of the QASD for the BPD group compared to the control group (Schienle et al., 2013). These findings were replicated by Schienle, Leutgeb and Wabnegger, (2015) who found that self-disgust as assessed by the QASD was associated with BPD symptom severity, specifically with auto-aggressive behaviour in a clinical sample (n= 25) in relation to the healthy control sample (n= 25). Using neuroimaging methodology, the researchers reported that self-disgust was associated with increased insula volume and correlated negatively with the volume of the secondary somatosensory cortex (Schienle et al., 2015). The researchers argued that increased insular volume may be a risk factor for

experiencing self-disgust or that perhaps enduring and intense feelings of self-disgust may lead to increased insular volume. Using the same participant sample, Schienle, Wabnegger, Schongassner and Leutgeb (2015) conducted an fMRI study to investigate the effects of personal space intrusion in women who had a diagnosis of BPD. In this study, the clinical sample showed greater amygdala activation to disgust faces, and the degree of self-disgust was able to predict amygdala activation in response to disgust faces (Schienle et al., 2015). The researchers concluded that individuals with a diagnosis of BPD may be particularly sensitive to social contexts involving the emotion of disgust which may be associated with trait levels of self-disgust.

Overall, the above studies suggest that self-disgust may be a characteristic feature in a number of different presentations of psychological distress, including those related to eating, body shape and weight concerns, feelings of sadness and 'disordered personalities' (e.g. Ille et al., 2014; Schienle et al., 2013; Zahn et al., 2015). The relationship between self-disgust and psychological distress related to eating problems appears to remain significant when controlling for other variables such as self-esteem (Moncrieff-Boyd et al., 2016), disgust sensitivity, anxiety, depression and anger (Bell et al., 2017). The above reviewed studies also suggest that self-disgust may act as a mediator and maintaining factor in deliberate self-harming (e.g. Smith et al., 2015), and serve as both an emotional trigger (e.g. Abdul-Hamid et al., 2014) and a consequent emotional response to self-harming (Bachtelle & Pepper, 2015). Emerging neuroimaging studies have offered further support for the assertion that self-disgust is relevant within psychological distress. Existing evidence suggests that self-disgust is associated with increased insula volume (Schienle et al., 2015a) and greater amygdala activation (Schienle et al., 2015b) among individuals who have attracted a diagnosis of BPD. Despite the useful insights provided by the above studies, a number of methodological limitations must be considered when interpreting the reported findings. The relative small sample sizes across the studies mean group comparisons are likely to be underpowered. In addition, the reliance on self-report measures and use of different measures to assess self-disgust (e.g. SDS, QASD, AMDP) may have biased and influenced the results

and hindered exploration of self-disgust. Although these measures have been shown to be reliable, their validity has not been firmly established. They include terms such as hate and dislike (e.g. in the SDS) as well as contempt and loathing (e.g. in the AMDP) raising questions regarding their validity to assess the emotion of self-disgust. Recent attempts have been made to improve the validity of self-disgust instruments (Moncrieff-Boyd et al., 2014), and a refined self-report measure was used by Moncrieff-Boyd and colleagues (2016) to assess self-disgust within psychological distress associated with eating problems. However, further testing is required to confirm its construct validity. Moreover, the retrospective assessment of emotions in Zahn and colleagues' (2015) study may have biased participants to under report certain emotions, while the lack of a control condition in Abdul-Hamid and colleagues' (2014) study meant the specificity of self-directed emotions in the changes observed could not be checked. Consequently, the reported findings need to be interpreted with caution.

1.10. Self-Disgust as a Mediator

Some researchers have explored the role of self-disgust as a possible within psychological distress. Amongst the identified studies, two studies utilised a cross-sectional design to examine whether self-disgust (measured by the use of the SDS) mediated the relationship between what they termed 'dysfunctional thoughts' (as measured by the Dysfunctional Attitudes Scale (DAS; Weissman, 1980) and depressive symptoms as measured by the Beck Depression Inventory (BDI; Beck, Ward, Mendelssohn, Mock, & Erbaugh,1961), and the Depression, Anxiety and Stress Scale (Lovibond & Lovibond, 1993). Using an opportunistic non-clinical sample (n= 111), Overton, Markland, Taggart, Bagshaw and Simpson (2008) found that self-disgust was significantly correlated with the measures of depression and partially mediated the relationship between dysfunctional cognitions and depression. This finding led the researchers to propose that self-disgust may have a functional role in the development of depression. The relationship between dysfunctional cognitions and depression was still significant when controlling for self-disgust suggesting that other mediator variables are likely to be involved. These findings were extended by Simpson, Hillman,

Crawford and Overton (2010) who examined whether self-disgust (measured by the SDS) and self-esteem, as measured by the Rosenberg self-esteem scale (RES; Rosenberg 1965) mediated the relationship between dysfunctional cognitions and depressive symptoms among a nonclinical sample (n= 120). The researchers found that self-disgust and self-esteem were conceptually distinct constructs, and both were found to partially mediate the relationship between dysfunctional cognitions and depression (Simpson et al., 2010). In both of the above studies, the sample sizes were sufficient to confer statistical power however the use of a non-clinical sample may have limited the generalisability of the findings. Moreover, it has been suggested that only longitudinal data can be used to test mediation hypotheses (Maxwell & Cole, 2007). Therefore, the conclusions drawn from their data need to be interpreted with caution.

Powell, Simpson and Overton (2013) employed a prospective longitudinal approach to investigate the temporal validity of the abovementioned hypothesised mediation model, i.e. self-disgust as mediating the path from dysfunctional cognitions to depression. The researchers collected self-report data on self-disgust, dysfunctional cognitions and depressive symptoms online from a non-clinical sample. Longitudinal follow-ups were conducted at 6 months (n= 152) and 12 months (n= 110). Researchers found that self-disgust significantly predicted depressive symptoms over time, but not the reverse. This finding supports the hypothesis that self-disgust may be considered as an antecedent to depression (Overton et al., 2008), and suggests a degree of stability in self-disgust which in turns is suggestive of an emotional schema (Izard, 2007, 2009; Powell et al., 2015a). An emotion schema is thought to result from the dynamic interaction between emotion and cognition that develop from learned associations, and the emotional component is believed to continual at some level of awareness (Izard, 2007, 2009). The researchers also found that the initial hypothesised mediation model was too simplistic and that rather than dysfunctional cognitions leading to self-disgust resulting in depression, dysfunctional cognitions and self-disgust are likely to interact over time, and that physical self-disgust was a stronger predictor of depressive symptoms than behavioural self-disgust over 6 months (Powell et al., 2013). However, this was

not sustained over the 12-month period. Overall, the above results lend support to assertion that self-disgust may be involved in the genesis of depression. However, there was a notable degree of sample attrition over the study period which may have biased the data, and the relationship between dysfunctional cognitions, self-disgust and depression may have been confounded by variables that may not have been controlled for, such as seasonal effects or environmental stressors that may have predicted depression over time.

More recently, Olatunji, Cox and Kim (2015) investigated the role of self-disgust (measured by the SDS) as a mediator of the relationship between shame and symptoms of BN, 'obsessive-compulsive disorder' (OCD) and general anxiety. Self-disgust was found to predict symptoms of BN, and partially mediate the relationship between shame, BN and OCD amongst a large nonclinical sample (n= 403, 67% female) but not generalised anxiety (Olatunji et al., 2015). The observed mediating effect of self-disgust in BN and OCD is likely to be interactive in that each one influences the experience of the other, and may be explained by the shared aspects of EDs and OCD such as obsessions and compulsions, and similar neurocognitive deficits (Steinglass & Walsh, 2006). The researchers suggested that a negative appraisal of the self in response to shame may lead to self-disgust which then increases risk for experiencing BN and OCD (Olatunji et al., 2015). However, the cross-sectional nature of the data means that it is difficult to make definitive inferences about the direction of the observed relationships between the study constructs. Longitudinal research is needed to determine whether shame precedes self-disgust and whether self-disgust precedes eating problems. Moreover, the generalisability of the reported findings may have been limited by the use of a nonclinical sample.

Moreover, Chu, Bodell, Ribeiro and Joiner (2015) have suggested that self-disgust plays a mediator role in the evidenced link between eating related problems and suicidality. Using a subscale of the Disgust with Life Scale (DWLS; Ribeiro, Bodell, & Joiner as cited in Chu et al., 2015) which assesses disgust with the self, others and the world, the researchers found that the risk for suicidal ideation (as measured by the Beck Scale for Suicide Ideation (Beck, Kovacs &

Weissmann, 1979)) was elevated when disgust was directed to the self amongst a large nonclinical sample (n= 341). Consistent with previous research, positive relationships were found between self-disgust and levels of ED symptomatology. In addition, eating related problems were associated with higher risk of suicide among individuals with higher levels of self-disgust beyond the risk factors of anxiety and depression (Chu et al., 2015). The results also indicated that body dissatisfaction and drive for thinness were associated with increased disgust with the self, others and the world and disgust propensity (Chu et al., 2015). Taken together these findings suggest that self-disgust may be one of mechanism that contributes and/or maintains the rates of suicidality among individuals with psychological distress, in particular in the context of eating problems. However, the results should be interpreted with caution as the study used a non-clinical sample where only 2.4% of the sample endorsed symptoms of suicidal ideation which was the main outcome variable of the study. Future replication with a clinical sample who present increased levels of suicidal ideation would be useful in understanding the role of self-disgust in the context of suicidality risk within psychological distress.

In sum, self-disgust appears to have a functional role in the genesis of depression by acting as a mediator between dysfunctional thoughts and depressive symptoms. While Overton et al. (2008) and Simpson et al. (2010) studies appear to suggest a rather linear mediating path where dysfunctional thought lead to increased feelings of self-disgust culminating in feelings of sadness, more recent findings suggest a potential bidirectional relationship between self-disgust and ‘dysfunctional cognitions’ (Powell et al., 2013). Although the generalisability of these findings may have been limited by the use of non-clinical samples and the observed attrition in Powell and colleagues’ (2013) study may have biased the data, the above findings demonstrate the potential role of the emotion of self-disgust as a mediator within psychological distress. In addition, the observed stability of self-disgust over time suggest that self-disgust may be best conceptualised as an emotion schema comprised of both cognitive and affective disgust-based components. Moreover, self-disgust has been found to mediate the association between shame and psychological distress associated

with presentations marked by compensatory behaviours like purging and compulsions (Kim et al., 2015). However, the cross-sectional nature of the research precludes temporal and causal inferences. It has also been suggested that self-disgust may contribute and/or maintain the rates of suicidality among individuals with psychological distress associated with eating problems (Chu et al., 2015). Although this finding offers useful insights about the potential role of self-disgust in the context suicidality risk, future replication with a clinical sample who present increased levels of suicidal ideation is needed.

1.11. Managing Self-Disgust

Very little research has explored ways to manage or attenuate feelings of self-disgust in spite of its increasing implication in psychological distress. Only two studies were identified in this review which looked at therapeutic strategies to attenuate the effects of self-disgust. Powell, Simpson and Overton (2015c) explored whether self-affirmation of kindness could attenuate self-disgust among a nonclinical sample. Researchers conducted two studies: one in a controlled laboratory environment (n= 56; 37 women and 19 men) and the other in an ecologically valid context (n= 116; 83 women and 33 men). In this study, self-disgust was measured using the SDS (Overton et al., 2008) and the SDS-R (Powell et al., 2015b) which was revised following the qualitative work discussed above exploring self-disgust in relation to depression (Powell et al., 2014). The revised measure aimed to increase its face validity, reduce overlap with other self-directed constructs such as self-dislike, and incorporate visceral features of disgust at the self and body (e.g. “I found the way I look nauseating”). The researchers showed that self-affirming the behavioural trait of kindness led to less reported disgust (and anger and sadness) toward one’s physical appearance under the laboratory conditions across a nonclinical sample. Beyond the laboratory, the effects were confined to disgust, with those who scored higher in the self-disgust measure showing the greatest benefits (Powell et al., 2015c). Given the cross-sectional design of the study, it is not possible to assert whether self-affirming may alleviate self-disgust over the long-term. Nevertheless, these findings suggest self-affirming kindness may be useful as a preventative strategy

for self-disgust and psychological distress associated with body appearance concerns.

Palmeira, Pinto-Gouveia and Cunha (2017) explored the relationship between self-disgust and eating, body shape and weight related concerns and whether self-compassion may mediate this relationship. The sample comprised of 203 individuals (50.2% males and 49.8% females) with overweight and obesity (as measured by the body mass index; BMI) seeking nutritional treatment for weight loss, and self-disgust was measured by the Multidimensional Self-Disgust Scale (MSDS; Carreiras, 2014). The MSDS assesses self-disgust concerning different aspects of disgust towards the self: physical (defensive subscale, e.g. “I have the feeling my body contracts”), behavioural (avoidance subscale, e.g. “I disguise/dissimulate those aspects of me that I disgust”), behaviours used to exclude and eliminate what is perceived as self-disgusting (exclusion subscale, e.g. “I feel like cutting, burning or excluding that part of me”), and emotional and cognitive aspects (cognitive-emotional subscale, e.g. “I hate/despise that part of me”). This measure has showed good internal consistency, good convergent and divergent validities (Carreiras, 2014). Only the cognitive-emotional subscale was used in this study.

The researchers found that self-disgust was positively and moderately associated with eating problems (measured by the Eating Disorder Examination Questionnaire; Fairburn & Beglin, 1994). This finding suggests that individuals who experience more self-disgust based thoughts and emotions may be more vulnerable to experience eating related problems. This is consistent with previous literature abovementioned in this review showing that self-disgust is related to psychological distress associated with eating, body shape and weight concerns (Moncrieff-Boyd et al., 2016), as well as restrictive eating, purging, body dissatisfaction and urge to lose weight (Espeset et al., 2012). Furthermore, the researchers found that the ability to have a warm and caring relationship with oneself was negatively associated with feelings of self-disgust and symptoms of eating related problems, particularly among women (Palmeira et al., 2017). This finding is in keeping with literature that suggests that women are more self-critical

and have less self-compassion skills than men (Neff, 2003; Yarnell et al., 2015), and it suggests that the effect of self-disgust in eating problems is, at least in part, mediated by one's inability to be self-compassionate. Thus, developing a more accepting and compassionate relationship with one's negative emotions may be particularly helpful in managing feelings of self-disgust and psychological distress associated with eating related concerns and problems. Although this study offers useful insights, the cross-sectional design precludes conclusions regarding causality. Longitudinal research is needed to determine the directionality of the associations found and future studies should account for possible confounding variables such as participants' history or experience of EDs, and emotional regulation processes (e.g. decentering, experiential avoidance) which may bias findings.

Taken together, the above two studies suggest that therapeutic interventions focused on developing self-affirming kindness and more compassionate attitude towards the self may be useful in managing or alleviating the negative effect of self-disgust within psychological distress. The cross-sectional design of the studies precludes making temporal and causal inferences about the studies' variables. Future work is needed to expand research efforts in this area.

1.12. Summary and Study Rationale

Over recent years the importance of emotions within psychological distress has become increasingly recognised, and the reviewed research showed that there is evidence implicating the emotion of self-disgust in a number of different presentations of psychological distress. This review highlighted that self-disgust may indeed be a characteristic feature across conditions potentially contributing to their development, course and maintenance. Only four qualitative studies (Benson et al., 2015; Espeset et al., 2012; Fox, 2009; Powell et al., 2014) were identified in the literature review and only one of these focused explicitly on participants' experiences of self-disgust. In these studies, self-disgust was described as being a strong, intense and consuming emotion associated with visceral sensations, disgust driven behavioural responses of avoidance and

rejection, and negative disgust related thoughts. Thus, suggesting that self-disgust may be best conceptualised as emotion schema with self-directed disgust related cognitive-affective components. Self-disgust appears to be an automatic response to triggering situations such as when one becomes aware of own physical appearance, and evoke a desire or urge to avoid or reject aspects of the self experienced as disgusting is such as avoiding looking at oneself. This may also take the form of the purging behaviour commonly observed among individuals suffering from BN or the excessive washing that is often exhibited in OCD presentations (Olatunji et al., 2015). Furthermore, the qualitative findings suggest that self-disgust can be experienced alongside other emotions particularly sadness, anger and shame. This is consistent with the theoretical framework of emotions proposed by the SPAARS model (Fox & Power, 2009). The view of self-disgust as an emotion schema which can be experienced both as an enduring emotional state and as a more reactionary feeling (Espeset et al., 2012; Powell et al., 2014) is consistent with longitudinal data discussed in the current review, which highlighted the stability of self-disgust over time in predicting psychological distress associated with intense feelings of sadness (Powell et al., 2013). Moreover, the idea of self-disgust as a distinct emotion received support from two studies which demonstrated that self-disgust was distinct from the construct of self-esteem (Moncrieff-Boyd et al., 2016; Simpson et al., 2010).

This review also highlighted that self-disgust may have a functional role in the genesis of psychological distress associated with feelings of sadness by acting as a mediator between ‘dysfunctional thoughts’ and depressive symptoms (Overton et al., 2008; Simpson et al. (2010). This relationship between self-disgust and ‘dysfunctional cognitions’ appears to be bidirectional (Powell et al., 2013). Self-disgust also appears to mediate the association between shame and psychological distress associated with psychological distress marked by behaviours like purging, obsessions and compulsions (Kim et al., 2015), and trigger self-harming urges and behaviours and suicidality across different presentations (Abdul-Hamid et al., 2014; Bachtelle & Pepper, 2015; Brake et al., 2017; Chu et al., 2015; Smith et al., 2015). Given the evidenced negative effect of

self-disgust, it seems pertinent to find ways of managing self-disgust within psychological distress. The reviewed literature suggests that a therapeutic awareness of self-disgust as a potential characteristic phenomenon within psychological distress may prove beneficial in developing interventions focused on reducing feelings of self-disgust, particularly as it may be associated with self-harming behaviour and suicidality. Although research in this area remains quite scarce, the reviewed studies suggest that interventions focused on decreasing levels of shame and experiential avoidance, promoting psychological flexibility and acceptance, and developing self-affirming strategies and self-compassionate skills may be helpful (Palmeira et al., 2017; Powell et al., 2015c).

In the current review the vast majority of the studies relied on self-report measures which may not reflect accurately individuals' perspectives upon their understanding and experience of self-disgust. Besides, a number of different self-report instruments were used to assess self-disgust some of which appear to tap into related self-directed constructs such as self-hatred and self-negativity instead of self-disgust itself (e.g. SDS). The variety of measures used raises concerns as to the validity of the measures in capturing the construct of self-disgust and accordingly to the findings presented in this review. These are likely to be serving to add to confusion and ambiguity surrounding the construct of self-disgust. Given the early stages of research exploring self-disgust, current evidence is limited by the largely cross-sectional designs employed. These limit causal and temporal inferences about the association between self-disgust and different presentations of psychological distress. Moreover, the relative small sample sizes mean that comparisons among the different variables are likely to be underpowered, and the use of nonclinical samples may have limited the strength of the associations between self-disgust and various presentations of psychological distress. Further research is needed to validated findings and explore how self-disgust may manifest within psychological distress overtime. Given that self-disgust is a relatively new area in empirical investigations and is not clearly delineated, it seems pertinent to conduct qualitative research to gain a better understanding of how it may manifest across various presentations and accordingly, contribute to the development of a more integrated understanding

and theoretical framework. This seems particularly important given the limitations regarding the construct validity of current self-report measures, and the apparent lack of clarity regarding the theoretical framework that underpins them. To date, only one qualitative study explicitly explored the emotion of self-disgust. Further qualitative research is warranted to gain more of an understanding of individuals' perspectives upon their experience of self-disgust. The increasing incidence, high relapse rates and low recovery rates associated with psychological distress related to eating problems highlight the need to further develop our understanding of eating related difficulties and conduct research that could lead to more effective treatments. The reviewed research showed that self-disgust appears to be implicated in eating problems and may contribute to the evidenced link with suicidality risk. It is therefore proposed that exploring the perspectives of women who experience psychological distress in relation to eating, body shape and weight concerns and problems could help to inform our theoretical understanding and inform approaches to psychological interventions.

1.13. Research Aims and Questions

This study aims to gain more of an understanding of self-disgust by exploring the perspectives of women who experience psychological distress associated with eating, body shape and weight concerns. It is hoped that this study will contribute to the development of a better understanding of self-disgust, and ultimately to the development of more effective interventions and better outcomes for services users and their families.

The present study aims to address the following questions:

- How do women with eating, body shape and weight concerns understand self-disgust?
- How do women with eating, body shape and weight concerns experience and manage self-disgust?

2. METHODOLOGY

This chapter begins by outlining the epistemological position and rationale for the methodology and method adopted in the present study. This is followed by information regarding recruitment and participants, procedural aspects of the study related to data collection, ethical considerations, data analysis and reflexivity.

2.1. Epistemological Position

Epistemology is concerned with the theory of knowledge describing what is possible to know and how knowledge is attained (Barker, Pistrang & Elliott, 2002; Willig, 2013). Accordingly, epistemology influences the assumptions held about the relationship between the data gathered and the world, and the choice of methodology and method of analysis. This study was approached from a critical realist epistemological position which sits between realism, where a direct relationship between reality and what is observed is assumed; and social constructionism, where multiple realities are assumed mediated by individuals' own perspective and wider sociocultural, political and historical context (Harper, 2012). In taking a critical realist position in this study, the 'reality' of eating, body shape and weight related concerns as psychological difficulties and self-disgust as a psychological concept and emotional response are not rejected. Instead, these are recognised as being mediated by contextual factors such as the participants' own perspectives and experiences, available discourses and sociocultural constructions regarding emotional experiences and psychological difficulties. In addition, it is acknowledged that participants may not have been fully aware of all the factors influencing their views and experience (e.g. family beliefs, cultural expectations), and that multiple realities or interpretations of the research data may exist depending on the participants' and the researcher's own realities (i.e. perspectives and experiences). This epistemological position fits with the researcher's own world view that phenomena such as psychological distressed associated with eating, body shape and weight related concerns, and self-disgust exist and are 'real' experiences, but how each individual experience

and talks about such phenomena can differ and be shaped by contextual factors leading to different multiple realities.

2.2. Methodology

2.2.1. Rationale for Using a Qualitative Approach

The choice of research methods is delineated by the research aims and the type of research questions being asked (Braun & Clarke, 2012; Silverman, 2013). This study aims to explore the perspectives of women who experience psychological distress associated with eating, body shape and weight concerns in order to gain more of an understanding of how self-disgust may be understood, experienced and managed. The research questions are broad and exploratory in nature. A qualitative approach enables to open up such route of enquiry by answering questions regarding how individuals understand and experience certain phenomena (Green & Throgood, 2010; Willig, 2013). A qualitative approach also allows for an in-depth exploration of individuals' experiences, detailed descriptions and greater understanding of phenomena that is not directly observable or easily quantifiable and under-researched as in this study (Willig, 2013).

The importance of qualitative research in the field of psychological distress associated with eating, body shape and weight concerns has been noted in the literature with authors arguing that the lack of such research weakens the development of theory and clinical practice (Hepworth, 1994, 1999; Nevonen & Broberg, 2000; Serpell & Treasure, 2002). Due to the lack of extensive knowledge about how women who experience eating, body shape and weight concerns and difficulties understand self-disgust, a qualitative approach was therefore deemed more suited to gain a richer understanding of this under-researched topic and generate new insights. A quantitative approach would require specific research questions to test clearly defined hypothesis which could constrain investigation into the field and risk oversimplification of phenomena (Barker et al., 2002). Using a qualitative approach lends itself well to exploring sensitive issues, and empowers individuals to have a voice by allowing participants' experiences to be heard (Barker et al., 2002). This is of

importance for the current study as, to date, there is no exploration into the views and perspectives of women who experience psychological distress associated with eating, body shape and weight concerns in relation to the emotion of self-disgust. Taking the above into consideration, a qualitative approach was therefore chosen as most appropriate to gain a richer understanding of participants' perspectives upon self-disgust.

2.3. Method

2.3.1. Method of Data Collection

Individual interviews were considered to be the most appropriate method of data collection for the present study. Individual interviews enable participants to speak openly about their experiences, with a level of confidentiality that is not possible when using other methods such as focus groups. This was particularly important in this study given the sensitive and personal nature of the research questions. It was also felt that it would give participants the opportunity to discuss any issues arising from taking part in the study. However, interviews are resource intensive and time consuming both in terms of data collection and analysis, and involve the researcher as part of the research instrument (Kvale, 1996). This requires researchers to be quite skilled in order to avoid bias or privileging their own agendas. Skills gained through the clinical work and training were useful to apply to the process of setting up and conducting the interviews in a sensitive and skilful manner.

A semi-structured interview format was adopted in this study. An interview schedule (Appendix 1) was created to guide questioning that would allow exploration of the research questions whilst providing flexibility to probe and ask follow-up questions to elicit greater detail from participants (Hays & Singh, 2012). This allowed the researcher to gather a richer understanding of the topic while also allowing for unanticipated and new insights to emerge. A semi-structured interview format privileges participants' knowledge, giving them a significant role in deciding what it is that they want to share. By combining formal interview features such as an interview schedule with features of an

informal conversation such as open-ended questions, a semi-structured format facilitates the process of establishing rapport (Willig, 2013).

2.3.2. Method of Data Analysis

A number of approaches were considered when selecting the method of data analysis for this study, particularly Interpretative Phenomenological Analysis (IPA) and Thematic Analysis (TA). Whist there are similarities between these two approaches in that they both aim to identify and analyse patterns of meaning and are compatible with the epistemological stance taken in this study, they have distinct features which set them apart. IPA is phenomenological in that it is focused on providing in-depth exploration of participants' subjective lived experiences and the meanings they attach to them (Smith, 1996; Smith & Osborn, 2008). Moreover, IPA takes an idiographic approach which involves a detailed analysis of how each individual participant experiences particular events or phenomenon before exploring the patterns across the data set. On the other hand, TA involves systematically identifying, analysing and reporting salient patterns of meaning (themes) across the data set, making sense of shared understandings and perspectives upon particular phenomenon (Braun & Clarke, 2006, 2012, 2013; Braun, Clarke, & Terry, 2015). TA is not linked to or grounded in a particular theoretical framework, and is considered to be suited for examining a given group's views and understanding of the phenomenon under study (Joffe, 2012). TA has been described as being one of the most systematic and transparent method of analysis as it regards the prevalence of themes to be important without sacrificing the depth of analysis (Joffe, 2012). TA is also often viewed as a foundational method of analysis as it can generate useful information for conducting further research (Braun & Clarke, 2006). This is particularly pertinent to the present study given the scarcity of research exploring self-disgust within psychological distress, particularly within presentations related to eating, body shape and weight concerns.

TA was therefore chosen as the most appropriate method of analysis as it complemented the research aims allowing a comprehensive, broad exploratory analysis of participants' perspectives upon self-disgust focusing on meaning across the entire data set, rather than trying to explore participants' lived

experience of self-disgust focusing on making sense of each participant's experience per se. TA also complemented the researcher's epistemological stance by acknowledging both the way in which individuals understand self-disgust and the broader social context imposed on their understanding and perspectives, while recognising the limits of 'reality' (Braun & Clarke, 2006). Moreover, TA was deemed more fitting with the study's relative heterogenous sample (in relation to age, ethnicity and eating problems). IPA is geared towards a reasonably homogeneous group (Smith, Flowers & Larkin, 2009).

2.4. Recruitment and Participants

2.4.1. Recruitment Strategy

The researcher aimed to recruit from two NHS EDs specialist services. Recruitment was conducted from October 2016 to April 2017. Team meetings were attended to provide information about the study and encourage recruitment. Team members introduced the research to potential participants using an invitation letter (Appendix 2) and participant information sheet (PIS; Appendix 3). They gained verbal consent for the researcher to contact participants either via e-mail or telephone to further explain the study and answer questions. Participants also had the option of contacting the researcher directly. If they were interested an interview date was scheduled.

Due to difficulties with recruitment, the researcher applied to recruit from Beat (the leading UK charity for people with eating difficulties) in December 2016. However, given Beat limited resources to support recruitment within the project deadline, recruitment did not go ahead. The study was also advertised on Student Minds (UK's student mental health charity) website in January 2017. However, no participants were recruited via Student Minds. Recruitment was only possible at one of the NHS sites.

2.4.2. Inclusion and Exclusion Criteria

Participants were required to be women aged 18 years old or over with an active eating related problem (i.e. AN, BN, pica, ARFID, BED, OSFED, and UFED), be able to speak English to a level that did not require an interpreter, and self-

identify as having felt disgust towards themselves either currently or in the past. As discussed in the previous chapter, only women were recruited due to the reported higher incidence of eating related problems and higher sensitivity to disgust in women compared to men. In addition, the sample was limited to women to keep the sample homogenous in this respect. This study adopted a transdiagnostic view of psychological distress associated with eating problems and therefore no restrictions were made with regards to diagnosis. Only those able to understand and speak English fluently were invited to participate as there was no funding available for interpreting services. It was not anticipated that this would neglect a particular participant group as the majority of individuals attending the services could speak English. Allowing participants to self-identity with having experienced self-disgust was in keeping with the researcher belief in the importance of respecting and valuing first person accounts. Clinicians used their clinical judgment to establish whether potential participants were able to participate in terms of emotional stability and communication skills. Anyone with special communication needs or experiencing thought disorder or acute psychosis was excluded.

2.4.3. Sample Size

Qualitative research is concerned with the richness of information rather than with quantity, and hence involves fewer research participants compared to quantitative research (Mason, 2010; O'Reilly & Parker, 2012). The focus is on sample adequacy rather than on sample size. Adequacy of sampling is related to data saturation, that is, the point at which the collection of more data does not contribute to more emergent patterns in the data (O'Reilly & Parker, 2012). Data saturation is generally reached between six and twelve interviews (Guest, Bunce, & Johnson, 2006). The researcher intended to conduct between eight and twelve interviews as in line with research on data saturation and related literature (Fox, 2009; Powell et al., 2014).

2.4.4. Participant Sample

It is not known how many participants were approached by clinicians or how many declined for their details to be passed to the researcher. Contact details for twenty potential participants were provided. Two participants were excluded

as they were male, four could not participate due to work/study commitments, and six declined to take part (two participants initially agreed to take part, but then cancelled on the day of the interview). Participants were not pressed to provide a reason. In total eight participants took part in the study. This was considered to be an appropriate sample size to conduct a meaningful analysis and address the research questions. Participants had different eating related presentations, identified with a range of ethnicities and sexual orientations, and had an age range of 21 to 59 years. Participant characteristics are presented in Table 1. Pseudonymous have been used to ensure anonymity of participants.

Table 1: Demographic details of participants

Pseudonym	Age	Ethnicity	Sexual Orientation	Diagnosis	Length of diagnosis
Charlotte	35	Black British	Bi-curious	BED	2 years
Maria	59	White Caucasian	Heterosexual	BED	1 week
Nadia	33	Bangladeshi	Heterosexual	BED	7 months
Joanne	25	Black Caribbean	Heterosexual	EDNOS	2 years
Lucy	21	White British	Bisexual	AN-R	2 months
Kiran	22	Asian	Straight	BN	Over 1 year
Lucinda	31	Spanish	Straight	BN	15 years
Amy	27	Berber	Heterosexual	EDNOS	1 year

2.5. Procedure

2.5.1. Data Collection

An interview schedule was developed (Appendix 1) based on existing research exploring self-disgust (Powell et al., 2014) and discussions with the research supervisor. The interview schedule was reviewed and discussed with the research supervisor prior to recruitment to ensure the questions were appropriate to address the research questions, and were not leading participants in a particular direction. The schedule contained prompt questions

to allow a thorough exploration of participants' perspectives and understanding of self-disgust, and it was used flexibly to allow for discussion of unanticipated findings.

2.5.2. Pilot Interview

A pilot interview was completed with a consenting participant to establish whether the interview questions were clear and appropriate, and whether there were areas of enquiry pertinent to the aim of the study that had not been covered. The questions were deemed to be appropriate and useful as a tool for generating responses relevant to the study's topic. Therefore, no changes were made to the interview schedule.

2.5.3. Interview Procedure

Interviews took place in a private and quiet room within the NHS recruitment site. This ensured that individuals could access their clinical team should they wish to discuss any issues that might have been raised during the interview. Interviews lasted between 30 minutes and 90 minutes, with an average duration of 50 minutes. The interviews were recorded using a digital recording device and then transcribed verbatim with all identifying information removed. Participants were informed that the interviews would be audio recorded and consent was sought prior to starting the interview.

2.6. Ethical Considerations

Ethical considerations were guided by professional codes of ethics (British Psychological Society, 2009) and guidance on research (British Psychological Society, 2010).

2.6.1. Ethics Approval

Ethical approval was sought and granted from one NHS Research Ethics Committee following request for further information (Appendix 4). Relevant local NHS research and development approvals were also obtained (Appendix 5). The project also received ethical approval from the University of East London (Appendix 6).

2.6.2. Informed Consent

Participants were provided with both an electronic and hard copy of the PIS (Appendix 2), outlining the aim and purpose of the research and what participation would involve prior to the interview. This was to support participants deciding whether to participate in the study. Participants were given the opportunity to ask questions prior the interview, and were informed that they could withdraw from the study at any stage without having to give a reason, and without affecting any support they received from the service where recruitment took place. Participants conveyed consent to participate using the consent form (Appendix 7).

2.6.3. Confidentiality and Anonymity

The limits of confidentiality were made clear before each interview. In particular, it was explained that if participants said anything that raised concern about their or anyone else's safety, then I would be obliged to share that information with their care team. Participants were aware that interviews would be audio recorded and then transcribed verbatim. All data was anonymised, and pseudonyms were given to participants. Participants were informed that transcripts might be read by supervisors and examiners, and that anonymised extracts would be included within the final write-up of the research and future publications.

Identifying data such as consent forms were kept securely and separately from all other material related to this study in accordance with the Data Protection Act (1998). All electronic data was held on a password-protected computer within password-protected files. Participants were informed that following examination and award of the doctorate, the audio-recordings would be destroyed and that anonymised transcripts would be held securely for five years post submission.

2.6.4. Managing Potential Distress

I was mindful of potential distress for participants due to discussing their personal experiences of self-disgust, and therefore I used my clinical skills to conduct interviews in a sensitive and respectful manner. In addition, interviews were carefully set up so that participants felt as safe as possible to discuss their

experiences. In particular, the interview process and distress management were discussed before the interview (e.g. offering breaks or the opportunity to reschedule), and at the end participants were given the opportunity to discuss any issues arising from the interview and were provided the contact details of sources of information and support (Appendix 8). In addition, the interviews took place at time and place when a member of their clinical team was available should support be needed.

2.7. Data Analysis

2.7.1. Transcription

Transcription is considered to be the first stage in data analysis as it enables the researcher to start becoming familiar with the data (Braun & Clarke, 2013). The audio recordings of the interviews were transcribed verbatim, with attention placed on what was said rather than the way in which it was said (e.g. tone). The transcription convention used was based upon Braun and Clarke's (2013) notation system (Appendix 9). All personal details of the participants were removed and anonymised. The transcripts were checked for accuracy through listening to each interview alongside the respective full transcript. Transcripts were edited and punctuated to improve readability when presenting extracts. For example, words were at times omitted (e.g. repetitions or false starts) and "(…)" was inserted to represent this, with any added comments placed in brackets.

2.7.2. Approach to Thematic Analysis

TA can be approached in an inductive ('bottom up') way where themes are grounded in the data rather than informed by a pre-existing theoretical coding frame, or in a deductive ('top-down') way where themes are mapped into a theoretically informed coding frame derived from the relevant literature (Braun & Clarke, 2012, 2013; Clarke, Braun, & Hayfield, 2015). In addition, a combination of these two approaches can be used whereby certain preconceived concepts and ideas are initially used to organise the data, but novel themes derived from the data are also identified (Braun & Clarke, 2013; Joffe, 2012). This study adopted mainly an inductive approach whereby the themes identified were driven by the data rather than being prescribed by a theoretical framework.

However, it is acknowledged that the researcher's epistemological stance and familiarity with the literature pertinent to the study's topic inevitably influenced how the data was interpreted and analysed. Therefore, the TA carried out in this study was both data-driven and influenced by the researchers' own understanding, experiences and thoughts about the topic formed through the completion of the literature review. Data was analysed both at the manifest level (also known as semantic level) whereby themes were derived directly from what participants have said, and at the latent level (also known as interpretive level) where themes indicate an interpretation of underlying ideas, assumptions and conceptualisations (Braun & Clarke, 2012, 2013; Braun et al., 2015).

2.7.3. Analytic Process

The analytic process followed Braun and Clarke's (2006) six-phase approach. Although data analysis is described as a linear process, the process of analysing the data was iterative rather than linear. Additionally, while some participants expressed more ideas than others, all accounts were considered of equal importance, and therefore themes were developed on the basis that they captured important elements from across the data. The analytic process was completed using both pen and paper and NVivo 10 (to assist coding and review of codes and themes). The phases of data analysis were as follows:

Phase 1: Familiarisation with the data

This phase started with the transcription of the audio recordings of the interviews, and continued through active reading and re-reading of the transcripts, as well as making notes in the margins of the transcripts of any initial observations or points of interest.

Phase 2: Generating initial codes

The ideas generated from phase one were used together with the data to develop initial codes based on semantics and latent level readings of the data. NVivo was used as a tool to code the extracts manually and collate the data for each code. Three rounds of coding were done for the entire dataset using the research questions to determine potential relevance of codes. Some data excerpts were coded more than once, and as coding progressed similar codes

were merged together (e.g. the codes ‘Being overweight as a child’ and ‘Parents' critical comments’ were merged into the code ‘Origins in childhood’). An example of a coded transcript excerpt is included in Appendix 10, the list of identified initial codes is in Appendix 11, and examples of coded data are provided in Appendix 12.

Phase 3: Searching for themes

This phase involved reviewing codes to identify similar ideas and/or overlap and patterns across the data set, and then clustering the codes into potential initial themes (Appendix 13). The relationships between codes, subthemes and superordinate themes were explored during this phase. A thematic map was created to aid this process (Appendix 14).

Phase 4: Reviewing themes

Themes were reviewed by checking the coded data extracts and examining whether each theme was supported by coherent and relevant data. This process also involved discussing the initial themes and subthemes and relevant codes with the research supervisor in order to verify the representativeness of the codes in the themes. In addition, themes were reviewed in relation to the whole data set to identify any themes that may have been overlooked, ensure that the identified themes captured the meaning across the data, and that the identified themes were meaningful in relation to the research questions.

Phase 5: Defining and naming themes

Themes were defined by checking the relevant extracts and examining whether the essence of each theme had been captured. The themes and extracts were then discussed with the research supervisor and a clinical psychologist working in EDs field to assess the utility of the findings. Following this, the themes were organised in a final thematic map presented in the next chapter.

Phase 6: Writing the report

This last phase of analysis is detailed in the next chapter where the analysis and data extracts were weaved together to provide a coherent description of the

data. The relevance of the findings in relation to the research questions and existing literature is discussed in the discussion chapter.

2.8. Reflexivity

To ensure good quality and transparency in qualitative research, discussed further in chapter four, it is important to consider the researcher's role in the research process and acknowledge that is impossible to remain totally detached from the research (Green & Thorogood, 2010; Horsburgh, 2003; Yardley, 2000). Willig (2013) highlights the importance of two types of reflexivity: personal and epistemological reflexivity. Personal reflexivity involves reflection on the ways in which the researcher's own assumptions, values, beliefs, interests and experiences shape the process of conducting the research and the conclusions drawn from it. On the other hand, epistemological reflexivity involves reflection upon the assumptions made about knowledge in the course of the research and its implications for the research and its findings. Both types of reflexivity were attended to during the development of this study and during data collection and analysis. This was supported by keeping a reflective journal throughout the research project (see Appendix 15 for an example).

It is important to acknowledge aspects of my context and experiences that could influence my position in relation to the research, especially regarding data collection and analysis. I identify myself as a White-European woman in the early thirties. I am a Trainee Clinical Psychologist in the final year of Clinical Psychology training at the University of East London. My views of mental health difficulties have been influenced by social constructionist and critical psychology ideas. I believe mental health diagnoses, including EDs, are best understood within the individuals' wider context. I held the view that the way in which eating difficulties and self-disgust were conceptualised by one participant was not the only one and that others may see and identify with them differently. Similarly, I accept that there are multiple possible interpretations of one data set and that I offer one possible account of the experiences of the women I interviewed.

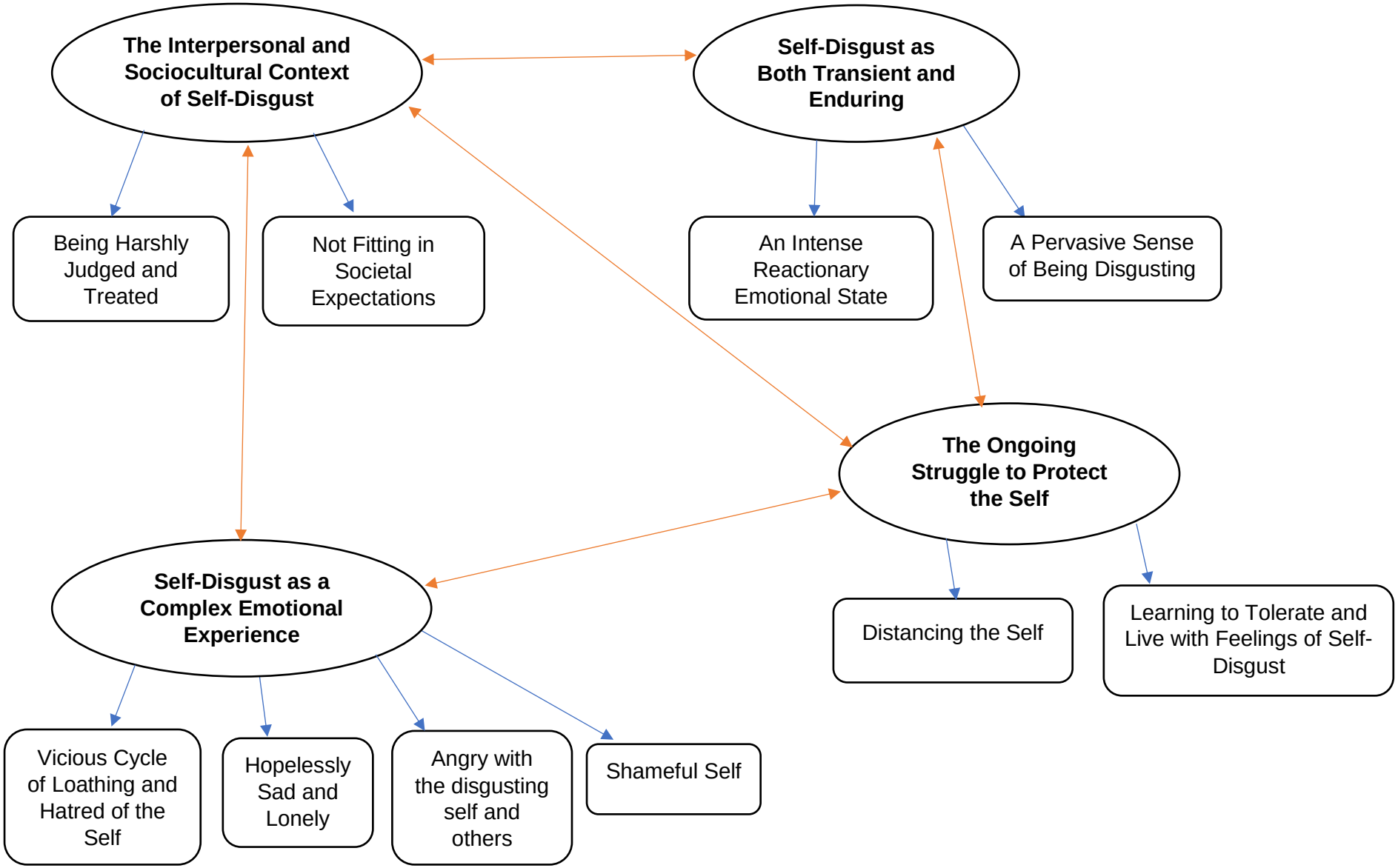
I have an interest in psychological distress associated with eating, body and weight concerns, and I am aware of the impact of difficulties related to eating problems, and the societal discourses that promote an idealised female body shape. I have lost two close friends due to health complications related to eating problems, and I have worked with women experiencing eating related difficulties. It was important for me to note that my personal and professional experiences may have influenced my interaction with participants during interviews. I made a conscious effort to remain curious during interviews and privilege participants' perspective and experiences. The use of a reflective journal helped me to reflect on my thoughts and feelings, and ensure that I did not respond in a way that could bias the data (e.g. the way I asked follow-up questions).

3. RESULTS

3.1. Overview

This chapter presents the results of the data analysis discussed in chapter two. Four main themes and ten subthemes were developed as illustrated in the thematic map in Figure 1. Each theme and its subthemes will be described and discussed with reference to excerpts from the interviews. Further discussion of the results in relation to existing literature is presented in the next chapter.

The pseudonyms used in chapter two are used here to protect participants' anonymity. To improve readability brief interjections, pauses and repetitions have been omitted from the excerpts presented. Words omitted to reduce length are indicated by (...). Descriptive terms such as all, most and some will be used to indicate level of participant response.


The Interpersonal and Sociocultural Context of Self-Disgust
Self-Disgust as Both Transient and Enduring
Being Harshly Judged and Treated
Not Fitting in Societal Expectations
An Intense Reactionary Emotional State
A Pervasive Sense of Being Disgusting
The Ongoing Struggle to Protect the Self
Self-Disgust as a Complex Emotional Experience
Distancing the Self
Learning to Tolerate and Live with Feelings of Self-Disgust
Vicious Cycle of Loathing and Hatred of the Self
Hopelessly Sad and Lonely
Angry with the disgusting self and others
Shameful Self

3.2. Theme One: The Interpersonal and Sociocultural Context of Self-Disgust

This first overarching theme captures the way in which participants talked about and understood their feelings of disgust towards the self as being rooted within their interpersonal and sociocultural context. Participants reported having experienced negative attitudes and behaviours from others with regards to their body weight and size, and appeared to relate these experiences to the genesis of their feelings of self-disgust. Participants also spoke about the influencing role of the societal expectations regarding one's body shape and weight in contributing to the emergence of feelings of disgust towards themselves.

3.2.1. Subtheme One: Being Harshly Judged and Treated

Participants spoke about how negative attitudes and behaviours of others with regards to their body weight and size had contributed to experience feeling disgusted towards themselves. These included both overt attitudes and behaviours, i.e. things that had actually been said or done to participants, and covert attitudes and behaviours, i.e. others' weight-related judgment (actual or perceived). What seemed to be most pertinent to how participants understood the genesis of their feelings of self-disgust was whether they perceived and experienced their physical self to be "fat" or overweight rather than their actual body weight.

Participants spoke about other people looking at them and described feeling judged based on their body size. Whilst it is possible that other people were not being derogatory, participants appeared to think that they were.

> *(…) As soon as I leave my house I'm like 'Yup that guy is looking at me because he thinks I am fat*.' *(…) I just feel like that the first judgement. I don't know I feel that is the first judgement people make as if you look fat*. (Amy)

> *How people judged me and how people said things to me has made me feel disgusted of myself so it's very hard to leave the house and feel*

> *comfortable on public transport, or going to places. (…) the judgement of the world (…) because I don't fit that's when you kind of you know get kind of it's like me. (…) I went into (name of the shop) and I felt that everybody was looking at me and I just exited the store straight away and I felt really uncomfortable that people like 'What is she doing in here? Nothing in here will fit you so why is she in here?'* (Charlotte)

Participants spoke explicitly about the negative associations or stereotypes that people made between their body weight and aspects of their personality and behaviour (e.g. being weak or lazy).

> *(…) you know when being seen as a person like weak for not doing anything about it.* (Maria)

> *The perception that you know that if you're fat you must be lazy, or you must be stupid.* (Nadia)

Participants also reported experiencing negative behaviours from others in relation to their body size. These experiences appeared to be significant in shaping participants' view of themselves as being disgusting. For example, Maria spoke about being bullied during childhood by her peers, family and strangers due to her size and also described being judged "*in a very narrow and superficial way*" in adulthood.

> *You said that you felt that other people felt disgusted by you <Yes>. Is that related to you feeling disgusted with yourself?* (Interviewer)

> *Yeah. Well the fact that I was bullied a lot since very early age when I started to put on a lot of weight, and you know it was in at school, at home, on the streets. People felt that they were entitled to say anything they felt like. It was really hard to take it and made me feel awful really. And you know people felt disgusted just by looking at me. (…) growing up and as an adult as well from other people like being judged in a very*

> *narrow and superficial way you know and who says what the right or wrong way to look?* (Maria)

Similarly, Charlotte described incidences where she was abused by adults and children in shops, public transport and on the street. The abuse was directed to her body weight and size and included derogatory remarks, physical bullying and aggression. These experiences seemed critical to the development of negative beliefs about the self as being disgusting (e.g. “I am quite disgusting”).

> *(...) Because I have had people chuck things as they drive past me. I have had people abuse me on the bus quite a few times. I have had people abusing me in the shops. (…) I got humiliated in a store by a bunch of kids. (…) I started getting teased and called fat. (…) So when you get that a lot personally you feel kind of like ‘Yeah I am quite disgusting.’ (…) I am always pre-empting an attack because I have been attacked before*. (Charlotte)

The incidents mentioned above were regularly experienced by Charlotte and were detrimental when she sought employment. Charlotte spoke about being discriminated against due to her body weight, and reflected on how this incidence had contributed to her feeling disgusted with herself.

> *I tried really hard to get employment but then my mum was just going ‘It’s your weight, it’s your weight. That’s why you are not getting employed.’ (…) mum was like ‘they probably don’t think you can do it because of your size’, and that made me like disgusted with myself.* (Charlotte)

For Kiran, being compared to her cousins during her youth and being criticised by her parents appeared to be directly related to the genesis of her feelings of self-disgust.

> *What makes me feel disgusted (…) when I was younger (…) people used to be like ‘Oh your cousins are so thin’ like um-hm I don’t know if people used to say ‘not like you’ or if I feel like I imagined it now I don’t even*

> *know. So when I was younger it was those kind of criticism and from my parents as well. Criticisms about like 'Why couldn't you be like so and so? Why can't you be like de de' and that kind of pulled on 'How do I fix myself?* (Kiran)

There was indication that the negative attitudes and behaviours of others were internalised by participants so that they came to view themselves as disgusting through learning or interpreting that they were disgusting to others. Nadia's account of her experiences of being judged by others including her work colleagues illustrates this process.

> *(…) I think inevitably that is internalised you know. You will take in people's negative feelings, thoughts and being treated differently*. (…) *I was once at work and one of the guys said 'I'm hungry' or something and I said 'Ah I've got some sweets, do you want some sweets?' but he went 'No, I'm going to end up being really fat if I have sweets' (…) I'm sure that thought towards me was 'Why are you eating?'* (Nadia)

3.2.2. Subtheme Two: Not Fitting in Societal Expectations

Participants spoke about the influence of their sociocultural context in becoming more aware of their physical self and in generating feelings of self-disgust. Inherent to the participants' sociocultural context was the idealisation of the thin female body type and perceived failure to meet societal expectations regarding body shape and weight. Participants appeared to understand self-disgust as having emerged in response to deviations from the sociocultural thin female body ideal.

Participants reported negative experiences of own body image in relation to the perceived sociocultural expectations to be thin, and appeared to link happiness with having a thin body type.

> *You live in a world that tells you that you have to look a certain way, you have to sound a certain way, (…) and when you don't achieve that it's sort of like you go into the self-loathing mode.* (…) *I find that it gives me*

> *self-loathing, self-disgust not fitting that mould, not making those achievements, not looking like the people that you're supposed to look like*. (…) *If I was you know a size 10, I don't think I would have any issues because nobody is judging me*. (…) *So happiness and to have everything you want, you have to lose weight*. (Charlotte)

> *(…) you're still overweight. (…) I suppose it's how again how I feel judged by society, culturally, and just generally I think society*. (Nadia)

> *(…) Why can't I be like this thin person? Why can't I be like I don't have anything and I just that's the only one that means a lot to me. I feel like it will make me so happy*. (Amy)

For Kiran, making comparisons with others was a significant trigger of self-disgust. Implicit in Kiran's account was the pursuit of an idealised body appearance that she yearned to achieve in order to be happy. Failure to meet her idealised body shape resulted in feelings of disgust towards the self.

> *Are there any particular aspects of yourself that makes you feel disgusted?* (Interviewer)

> *(…) I just feel like I see what people look like (…) and I crave how they look and so it's just like 'Oh if my stomach or my legs looked like that, if I was able to do this in the gym', or 'if I was to do this running wise then I would be happy'. That it is what happiness is and I wouldn't feel this way. (…) Physically I think the disgust has come from craving to be somebody else. I'm seeing, I'm always comparing myself to other people (…) if I don't look like that person then I'm disgusted with myself.* (Kiran)

Kiran also spoke about the influencing role of the media and the impact of comments about her body weight by members of her community. The excerpt below highlights how perceived violations of sociocultural norms and values in relation to body weight and size may trigger feelings of disgust towards aspects of the self that are integral to individuals' sense of self (i.e. physical appearance).

> *(…) I think entertainment and social media kind of have something to do with it. I was perceiving what I should look like (…) and I didn't feel like I was adhering to that. (…) when I was younger I was very much fed the whole blonde white kind of like that's what you should look like, that's what happiness is (…) and so I was disgusted with the way that I look*. *(…) in my culture it's quite normal for older people to be like 'You are getting big now. Look how chubby you are.' And that's normal but they don't understand how harming that is.* (Kiran)

Participants spoke of feeling "*different*" (Amy) in relation to other people or not having "*the ability to be normal* "(Charlotte). This sense of being different appeared to be intrinsically related to participants' perceived violation of the sociocultural thinness ideal. In addition, the sociocultural thinness ideal seemed to contribute to participants experiencing their body as undesirable and unattractive and feeling unworthy.

> *'Who would want somebody who looks like this?' That worthlessness that you know 'My God that's what, that's really what you look like' (…) and often you feel like if I wasn't fat, if I didn't have this problem, if I didn't eat the way I ate, I would then be worthy of a partner (…) the last relationship I was in (…) I felt like 'Why should he be left with me when he can have someone who is amazing, it's not fair because he's so great. He can have someone who is prefect' (Nadia)*

> *I feel like whenever a guy approaches, I feel like I don't deserve to be with that person because I look fat*. (Amy)

3.3. Theme Two: Self-Disgust as Both Transient and Enduring

Whilst there was an overall sense of self-disgust as being a "heightened" (Lucinda) and "overwhelming" (Amy) feeling that led participants to wanting to remove or change the disgusting features of the self, participants seemed to understand self-disgust as being both transient and enduring. Participants

described reactive feelings of self-disgust in response to particular elicitors or experiences, and also described self-disgust as an enduring emotional state which was ever-present in their lives. From participants' accounts, self-disgust was described as potentially having both state and trait like components.

3.3.1. Subtheme One: An Intense Reactionary Emotional State

As mentioned above, participants spoke about self-disgust as a reactive emotional state in response to various elicitors. These included weight gain, looking at the self or seeing own reflection, eating related behaviours and smell of food. Participants also spoke about elicitors in relation to perfectionism and feelings of failure.

From within participants' accounts self-disgust emerged as a response to gaining weight. This reactionary component of self-disgust is illustrated below in Joanne's account of her experience. Whilst she mentioned the overwhelming nature of self-disgust, she also conveyed the idea of self-disgust fluctuating in response to weight gain.

> *It can be quite overwhelming I think, but for me personally it's not there all the time. There's not like every minute of every day. Just kind of periods if that makes sense (…) it's normally if I have gained weight normally*. (Joanne)

Participants spoke about self-disgust being triggered in situations when they became aware of their own body appearance such as in seeing themselves in a mirror or seeing their own reflection. For Charlotte, there was an added element of feeling judged by others as well as judging herself due to her increased body weight. Participants also spoke about judging themselves due to their body weight and physical appearance, and being a "harsh critic" (Lucy) of themselves. Participants' self-judgments seemed to intensify their feelings of self-disgust.

> *It's just as I got bigger and the bigger I got, the more disgusted I felt with myself because the more people started to judge me um-hm but I judge myself the hardest because as I got bigger, I felt even more disgusted*

> *with myself*. (…) *The bigger I get the more disgusted with myself I get*. (Charlotte)

> *(…) that feeling when you catch yourself in the mirror without intending to or for example the TV (…) the reflection on the TV. Suddenly I could see myself and I felt (…) disgusted at myself of looking at that reflection. (…) you just get heavier and heavier and heavier and your feelings intensify*. (Nadia)

> *(…) if I look at myself in the mirror and I see myself like (…) sometimes I see my own reflection and I'll get like horrible, mean sort of thoughts about how I don't look nice (…) when my weight is higher (…) I get disgusted at just seeing myself*. (…) *I think it's hard because I'm more critical to myself than other people*. (Lucy)

Participants mentioned some corporeal aspects of their reactionary feelings of self-disgust in response to their own appearance and reflection as well as body weight, such as feeling "sick" and "shaky".

> *(…) I could see myself and in my stomach I feel sick looking and thinking about the reflection I feel sick. (…) I couldn't tolerate it, like I had to look away. Repulsion I think, yeah, repulsed by my own reflection*. (Nadia)

> *If I gain weight (…) it makes me feel actually sick and just shaky and horrible. (…) I would be really shaky and I would feel like really sick in my stomach*. (Lucy)

There was some indication that self-disgust may be triggered by external elicitors. In particular, Amy spoke of self-disgust as also being elicited by the smell of food. She spoke about how it made her feel "fat" and subsequently disgusted with herself, and described having an immediate urge to remove or cleanse the disgusting aspects of the self. From participants' perspectives, external elicitors may trigger or contribute to feelings of self-disgust when they are attributed

qualities (e.g. fattening qualities) that are related to one's repertoire of self-disgust elicitors (e.g. weight gain).

> *(…) The smell of the restaurant was making me fat so I couldn't wait to go home and just have a bath. (…) Because I feel so disgusted, I feel like I need to escape but I can't at that moment. I'm like literally rubbing myself, I'm trying to rub myself out*. (Amy)

Moreover, the above excerpt highlights how participants understood self-disgust as being elicited through a range of modalities including olfactory (e.g. smell of food) and visual (e.g. seeing own reflection) as captured by Nadia and Lucy's accounts described above.

Self-disgust was also understood to be elicited by eating related behaviours including binge eating or eating unhealthy food. Inherent to participants' accounts was a sense of lack of control which was perceived negatively by participants and created feelings of self-disgust. This was reflected in the terms participants used to describe themselves (e.g. "disgusting pig"). Again, self-criticism was very much implicit within participants' descriptions.

> *So I guess that I'm kind of lucky that I'm able to when I experience self-disgust to feeling it for short period of time. (…) Yeah well every time I binge basically. (…) when it happens, it happens every time I binge*. *(…) yes disgusting of eating irrationally like an animal, like gonna polish everything that is in front of you*. (Lucinda)

> *I felt kind of while I was eating it, I felt kind of really disgusted (…) I should have said was 'You have fish and chips. I will go and eat something healthier.' (…) I felt really disgusting with myself. (…) then just eat and feel 'Ah I'm a disgusting pig.*' (Charlotte)

For Kiran, feelings of self-disgust in response to binge eating was mediated by feelings of failure. It is likely that the traits of self-criticism and perfectionism characteristic of eating related problems may have played a role in how Kiran

perceived and experienced failure. This was captured in the excerpt below where she talks about not fulfilling the "*eating disorder*" based her own standards.

> *(…) if I don't complete the cycle of binge-purge then I feel disgusted with myself (…) because if feels like I have just failed. (…) It's like 'Another thing that you failed at, you can't even do an eating disorder properly'*. (Kiran)

Joanne spoke about reactionary feelings of self-disgust in relation to self-oriented perfectionism and self-criticism which she experienced from an early age whereby she would set herself high standards for achievement and evaluate herself negatively. She linked her experience of perfectionism to feeling disgusted with herself whenever she "got things wrong". In adulthood, the drive for perfectionism was directed to her eating behaviour. Not meeting her desired eating plan resulted in negative self-evaluations and triggered feelings of self-disgust.

> *I always plan what I'm going to eat each day, or like how many calories and if I stay within that I don't feel disgusted but if I go over I do*. *It's losing control and just feeling like you don't have any will power (...) when I was younger, like very young, I would always get yeah like more annoyed and disgusted if I got things wrong (…) I remember thinking like 'You're so stupid. You didn't mix it properly, you ruined it' and I felt like self-disgust as a four year old. (…) it's just like perfectionism but I feel it more than yeah. A lot of the time yeah then obviously now my idea of doing things perfectly is eating what I plan to eat*. (Joanne)

In addition to the above, participants spoke about feeling disgusted with themselves in response to feelings of failure and drive towards perfectionism. This included doing something that they perceived to be "wrong" (Lucy), not meeting own relationships standards, and failing to achieve one's own goals. These experiences appeared to be linked to an underlying tendency towards self-criticism. Participants described making negative evaluations of their own behaviour, seeking perfection and comparing themselves to others.

I get disgusted by (…) my behaviour if I do something that I think about in retrospect and I don't like then I get disgusted with that. Like if I feel like I didn't try harder enough to look after someone (…) or if I did anything wrong. (…) Just anything like if I break something (…) if I make a mistake. (…) *I think it's just kind of trying to be prefect all the time*. (Lucy)

Disgust in the way I'm with other people because I compare myself to other people and so I think that my relationships can be better so I'm disgusted at myself for not having what I would consider normal relationship with people. (Kiran)

(…) I would say number two [disgust factor] is not achieving my goals, so when I didn't achieve my goals that made me feel even more disgusted with myself. (Charlotte)

3.3.2. Subtheme Two: A Pervasive Sense of Being Disgusting

Captured within participants' accounts was also an enduring sense of feeling disgusted with themselves that was ever-present in their daily lives. This was reflected in how participants spoke of self-disgust as being "like a general feeling" (Joanne) that was "always present" (Charlotte) and come to "predominate" (Kiran) in their lives.

Participants spoke about living with self-disgust for most of their lives and becoming used to feeling disgusted towards themselves as it was always present. In some instances, participants seemed to understand self-disgust as having become an integral part of their concept of self.

(…) to me self-disgust is well yeah (…) I have lived in it for such a long time (…) It's always present (Charlotte)

(…) it starts to define you. It defines you a bit when you start to feel like that, like it sticks in your mind. *(…) Like you think about it all day like 'I'm*

> *a horrible person' and you start labelling yourself like 'I'm disgusting and fat or ugly'*. (Lucy)

> *I don't think there is an aspect of me that I don't have self-disgust towards so I think that is kind of circulates around my whole sense of being from social to physical to emotional. (Kiran)*

Joanne spoke of not always being aware of feeling disgusted with herself as she had become accustomed to experience it continually in her life.

> *I think I am just used to it. (…) I think I am just used to it like there is obviously some self-disgust there but it doesn't feel like I just mop around every day hating myself, because I think I am used to it so it's kind of just there*. (Joanne)

In addition, the enduring nature of participants' feelings of self-disgust appeared to result in a pervasive feeling of entrapment and learned helplessness. Participants expressed feeling that they could not "escape" the feeling of self-disgust and seemed to think it would always be part of their lives. This highlights how integral disgust seemed to have become to participants' sense of self in that they seemed unable to envisage a future without feeling disgusted with themselves.

> *(…) it kind of has developed and I just kind of just been predominate now, and I don't think that I have been able to escape the disgust. I think that whatever I do, I will always be disgusted at myself or waiting for that disgust to kind of set in, so it's always following me I guess. (…) I experience it on a daily basis it's just there*. (Kiran)

> *Yeah, I think it's because I have had it for so long. Like since I was very, very young and I that's all I have ever known really, so I feel like it will never go away. I don't think it will ever go away*. (Amy)

> *(…) it's just like 'Well that is it, this is what you're lumped with, and that's you and you've got no choice in the matter. So helpless*. (Nadia)

3.4. Theme Three: Self-Disgust as a Complex Emotional Experience

A recurring theme across the interviews was related to the complexity of the emotional experience of self-disgust. Participants expressed self-disgust as dislike and hatred of the self, and described a vicious cycle of self-hatred and self-disgust. Participants also spoke about feelings of self-disgust alongside feelings of sadness and loneliness in a bidirectional way, and feelings of anger both towards the disgusting self and others. From participants' accounts, self-disgust was also understood to be experienced alongside feelings of shame towards the disgusting self.

3.4.1. Subtheme One: Vicious Cycle of Loathing and Hatred of the Self

Participants expressed feelings of self-disgust related to self-hatred and a strong feeling of dislike and loathing of the self. These were directed to both physical aspects of the self (e.g. physical appearance) and psychological aspects (e.g. their behaviour and emotions). This is captured by Nadia's account below in which she explicitly expresses dislike and hatred at her physical self as well as her eating behaviour. Nadia seemed to associate these feelings to a lack of control and sense of failure that arose from her binge eating. She also described "entering a vicious circle" which seemed to perpetuate feelings of self-disgust and hatred for the self.

> *I suppose there's two different levels. One is the reflection and disgust with how I look. (…) I don't like my reflection, I don't like how I look. (…) but also the eating aspect. So if I do binge that feeling of self-hatred*. (…) *I think I end up entering like a vicious circle (…) and for me personally like a failure because (…) I haven't managed to achieve what I want to look like or you know I have not been able to control that aspect of my life (…) so that for me is when I would feel that sort of self-disgust, that hatred for that part of me.* (Nadia)

Similarly, Charlotte spoke about loathing herself and feeling trapped in a self-perpetuating circle in which feelings of self-disgust and self-hatred seemed to lead to further feelings of disgust towards the self. Alike to other participants' experiences, for Charlotte there was also a strong feeling of failure associated with her experience of disgust and hatred towards herself.

> *(…) loathing of who you are, what you are and what you have become* (…) *I hate my life, I hate me. You know why do I exist and you just feel like I will never going to climb up that ladder (…) you go into the self-loathing because you failed and it is just that circle of kind of like you never get off it, so everything you do seems like a failure*. (Charlotte)

Moreover, participants spoke about disliking everything about themselves including their physical self and how they felt, and at times seemed to understand the feeling of self-dislike as part of feeling self-disgusted.

> *(…) it's just obviously not liking what you see or what you feel within yourself.* (Joanne)

> *(…) not liking anything about yourself. That's disgust yeah that's how I would describe that type of feeling towards me*. (Lucinda)

3.4.2. Subtheme Two: Hopelessly Sad and Lonely

Participants spoke of feelings of self-disgust occurring alongside feelings of sadness and loneliness. From participants' accounts, there seemed to be "*a general feeling of unhappiness*" (Joanne), and feelings of sadness seemed to manifest itself as a heightened feeling that was close to experiencing "depression" (Charlotte) and was ever-present: "*I always feel really sad*" (Lucy). There was also indication that the emotion of sadness followed the feelings of self-disgust: "*upset because the disgust has happened*" (Kiran).

From participants' descriptions, feelings of sadness seemed to be understood as being associated with body dissatisfaction and experiencing aspects of the self as disgusting.

> *I will say that my feelings with self-disgust is sadness. I think it's sad yeah there is a lot of sadness. Always feeling that kind of sadness about it because you want to look in the mirror and be like you know what I actually like myself but I always feel kind of sad*. (Charlotte)

> *(…) just being very unhappy with yourself (…) so I guess that disgust in the way that I look, I think that disgust comes from being unhappy with the way I look*. (Kiran)

Apart from expressing feelings of sadness participants also described feeling lonely and hopeless. From participants' accounts isolation seemed to lead to increasing feelings of self-disgust. For Lucinda, sadness was intertwined with feelings of hopelessness and the combination of these with feelings of disappointment with herself resulted in feelings of self-disgust.

> *Yeah loneliness. I think it's really lonely. It's a very lonely world that I live in for like the bigger I have got, the more isolated I got and the more isolated I become the more disgusted I became of myself. It's very lonely*. (Charlotte)

> *I feel sad and I feel hopeless (…) when I'm eating and I realise that I'm binging all these emotions come in place like I feel sad, I feel hopeless, I feel careless and I feel well disappointed. So all of them came together and then I feel so disgusted with myself*. (Lucinda)

The recounted feelings of hopelessness appeared to be significant particularly when considering the reported intensity of feelings of sadness and 'depression'. This was reflected in how participants spoke about having "*thoughts about harm*" (Lucy) as well as having "*dark*" thoughts about ending their own life. For instance, Nadia spoke about thinking of ending her life when feeling depressed. For Nadia, the feelings of sadness/depression emerged as a result of feeling disgusted with herself.

> *For me in my depression what that translates to is I'm worthless. (…) I have never tried to kill myself or anything like that but they [the thoughts] sometimes became very dark. 'Life will just be very easier if I was dead' (…) if I've to write a sick note to say why I'm off work, it wouldn't be because I'm disgusted with myself but it would be the consequence of that. Of then feeling worthless um-hm then starting to feel depressed in starting to feel like 'Life is not worth living'.* (Nadia)

Similarly, Amy spoke about feeling suicidal as a result of experiencing intense feelings of disgust towards her physical appearance and body. She described feeling that she could not escape her body which she appraised and experienced as being fat and disgusting. This sense of feeling trapped within the self appeared to be associated with an underlying feeling of hopelessness which in association with feelings of self-disgust culminated in suicidal thinking.

> *Can you tell me a little bit more about how you understand the emotion of disgust towards the self?* (Interviewer)

> *For me it gets so bad and it makes me feel suicidal (…) it gets really, really bad like if it's when I look at myself in the mirror and I have those thoughts in my head and I'm looking in the mirror and I'm suicidal because I feel like I can't escape out of my body. I can't get out*. *(…) That is going through my head. Fat, fat and go on and on. You look really, really ugly. You look disgusting.* (Amy)

3.4.3. Subtheme Three: Angry with the Disgusting Self and Others

Participants also spoke about feelings of self-disgust alongside feelings of anger directed to the disgusting self. Participants appeared to understand self-disgust as preceding feelings of anger towards the self. Moreover, the feelings of anger appeared to be directly linked to a strong and intense feeling of self-directed blame. Participants explicitly recounted blaming themselves for their eating difficulties and experiencing feelings of self-disgust and subsequently feeling angry with themselves for "*not being strong*" (Nadia).

> *I feel angry about being self-disgusted. You feel angry with yourself that you did this to yourself you feel angry so there can be quite a lot of anger*. *(…) that sort of anger that you have towards being disgusted with yourself*. (Charlotte)

> *Angry at myself (…) because I'm disgusted. (…) I caused my own disgust, no one forced the disgust on me. (…) I did this, it's not like I can blame anyone for it. I think it's disgusting for me because I can't blame anyone and I do this to myself and I am just like 'You did this, so you can't be upset about it'.* (Kiran)

Whilst the feelings of anger were mostly directed at the disgusting self, participants also spoke of anger as being directed at others including their family and the wider society. For instance, for Nadia the anger was directed both at the self and others, including her family and the societal expectations and values regarding physical appearance and body weight which promoted a thin female body. Whist she emphasised self-directed anger as being more intense and predominant, there was a clear indication that anger towards others also played a significant role.

> *Angry at everything. Angry at myself, (…) but also angry at the outside world. Angry at my parents for letting me down, angry at people for just seeing fat you know rather than seeing who you are, what you've been through, why you are the way you are. (…) but mainly myself. Mainly the anger is towards me.* (Nadia)

In some instances, the anger towards others appeared to be outside participants' awareness. This was most evident in Charlotte's account below where she talks about only becoming aware of her feelings of anger towards her family during therapy. Elsewhere in her interview Charlotte discussed having "*a lot of negative input*" from her family and not feeling valued by her family.

> *(…) I probably was very angry at my family because when I first came here I remember reading erm seeing the scripts of what they said and I*

was kind of like 'I didn't think I was angry at my family' but what I said it was like yeah I am angry at my family. (Charlotte)

Interestingly, Amy seemed to express the emotion of self-disgust as anger towards others. During the interview, Amy recalled an incident where she had felt a heightened feeling of self-disgust that led her to feel quite angry towards a stranger. It is possible that for Amy the emotion of anger was less distressing or more tolerable than self-disgust, or perhaps feelings of anger towards others were just concurrent to her emotional experience of self-disgust.

(…) because at that moment I felt so disgusting, so ugly and so fat I kept beeping at him, getting his attention. I'm like 'Come here, come here, come here' in front of my parents, in front of my sister and I got into a massive argument. (Amy)

3.4.4. Subtheme Four: Shameful Self

Moreover, participants spoke of the emotion of shame as being associated with feelings of self-disgust. The self-conscious emotion of shame was expressed along with feelings of embarrassment, and was linked to both weight gain and eating related behaviours which participants had identified as elicitors of self-disgust elsewhere within their narratives. Inherent to participants' feelings of shame were negative self-evaluations about their body and behaviour as being disgusting and subsequently a source of shame to the self. The emotion of shame seemed to manifest at both internal and external level. For example, Joanne's narrative implied that she experienced internal shame whereby she saw herself as disgusting as a result of gaining weight.

You said that the moment you weigh yourself, you felt disgusted with yourself. <Yeah> Can you tell me a bit me about how you felt at that time? (Interviewer)

Yeah, obviously kind of embarrassment. I was quite ashamed, felt quite shocked even though I knew that I have gained weight because I could

see but I think seeing it the actual numbers almost like overwhelmed me and suffocating feeling. (Joanne)

On the other hand, Nadia seemed to experience external shame where she perceived or anticipated that others viewed her as disgusting or weak for the act of eating. In particular, she spoke about experiencing shame due to lacking control in relation to eating and described feeling the need to conceal her eating from her work colleagues. Nadia implied that the act of eating was viewed negatively by her colleagues as she was "overweight" which then acted as a source of shame to her. Interestingly from Nadia's descriptions the external shame (i.e. perceived negative judgments from others) seemed to be intertwined with internal personal shame (i.e. inner experience of the self as disgusting and lacking self-worth for not living up to the thin ideal).

(…) when I can't control my eating I'm ashamed (…) there is shame in saying 'Do you know what I'm stressed out, I'm going to eat chocolate'. For me that is an embarrassing thing (…) I will lock the door at work, make sure that nobody sees. (…) I will probably be eating to self-sooth (...) that's not seen as normal and that for me is something to be embarrassed about. (…) They will see you and know that you must eat in order to be overweight but to be seen eating is so shameful, and I suppose shame then leads to the feelings of lack of self-worth. (Nadia)

Moreover, Nadia's feelings of self-disgust appeared to be further facilitated by her religious upbringing and beliefs. Nadia explained that within her religious context both eating and having sex were seen as shameful as they both involved giving in to one's "desires" and subsequently led to feelings of self-disgust. Nadia's account implied a sense of being weak and internal shame about failure to control eating.

Are there any other aspects of yourself or behaviours that have either now or in the past made you feel disgusted with yourself? (Interviewer)

> *(…) coming from a religious sort of background, I was brought up in a religious family where one chases the desires is shameful (…) whether that is in eating or by sex (…) there is shame in both of those.* (Nadia)
>
> *And does it make you feel self-disgusted?* (Interviewer)
>
> *Yeah because I suppose 'Why haven't I resisted that desire or urge?*' (Nadia)

Shame also appeared to manifest concurrently with self-disgust in relation to having a diagnosis of "*eating disorder*" or being seen by others to suffer from mental health problems. This was evident within Kiran's narratives. For Kiran, there seemed to be shame and disgust towards the self in being seen as belonging to a socially stigmatised group. She spoke about the social stigma within her culture (she defined herself as being Asian) against mental health including psychological distress associated with eating, body shape and weight concerns and difficulties. This resulted in a shame-based response (i.e. concealment of her eating problems) and feelings of disgust towards herself. Kiran also spoke of holding herself responsible which seemed critical in terms of generating feelings of shame and self-disgust.

> *(…) I guess disgusted in like the whole mental illness and like eating disorder thing. I'm very disgusted at that because there's social stigma in my culture. You don't talk about things like this. (…) it's self-disgusted because I have let my parents down (…) I have created this mental illness. I have created this eating disorder (…) it's disgusting to me that I have that so I don't. Like no one in my personal life knows that I've bulimia.* (Kiran)

3.5. Theme Four: The Ongoing Struggle to Protect the Self

This theme captures the way in which participants described how they sought to protect themselves from feelings of self-disgust by engaging in behaviours involving avoidance and distraction. These behaviours appeared to allow them to

lessen or better manage the effects of self-disgust. Participants also spoke about how they tried to live or learn to tolerate feelings of self-disgust by engaging in a range of strategies from calming breathing to self-talk and acceptance. These strategies appeared to enable participants to continue living their lives despite their feelings of self-disgust and moving beyond their experiences of self-disgust. Nonetheless, participants commented that the positive effects of these strategies did not last for a long period of time.

3.5.1. Subtheme One: Distancing the Self

Participants spoke about engaging in behaviours that involved distraction or avoidance in an attempt to distance themselves from the self or aspects of the self that were viewed and/or experienced as disgusting. These included avoiding looking at mirrors or one's own reflection, avoiding intimate relationships, isolating the self from the public sphere, avoiding thinking about their experiences of self-disgust and using distraction as a way of coping.

As a result of feeling disgusted towards their own body and psychical appearance, participants avoided looking at themselves in the mirror or seeing their reflection and also avoided taking pictures or seeing themselves in pictures. This acted as a way of distancing themselves from their physical self, as well as a way of protecting the self from experiencing reactionary self-disgust feelings.

> *I think self-disgust it gets that bad you just don't wanna see yourself like as soon as you like if you go past and like there is a mirror it just I just don't want to see myself*. (Amy)
> *I don't want to see myself in pictures next to my friends who are slim and beautiful (…) I don't want to see myself looking that way. (…) I avoid myself. I avoid myself and avoiding the painful sort of realisation when I do see myself*. (Nadia)

Participants also spoke about withdrawing themselves when they experienced feelings of self-disgust. For Lucy, withdrawing from social encounters appeared to be due to both feeling disgusted with herself and feeling low in mood.

I wouldn't go out if I was feeling disgusted because I would be feeling really low as well so I wouldn't like if I had plans to go out, I would probably cancel them. (Lucy)

Not really wanting to socialise. I think that is how it is for me anyway. When I feel it, I just want to stay on my own and yeah I don't want to mix. (Joanne)

If I feel really disgusted with myself, I won't meet up with friends. (…) It's because I don't like myself and it's a stronger feeling every day so I distance myself from everyone. I disappear from my friends, I can disappear for up to two weeks. (Amy)

Participants also spoke about actively avoiding physical closeness and intimate relationships in attempt to protect themselves from feelings of self-disgust and other negative experiences. Participants alluded to wanting to conceal own body from others as they felt disgusted towards their physical self and expressed fears of rejection.

What makes you feel disgusted with yourself? (Interviewer)

Well I just look at myself and (…) I don't think I look good. I don't like what I see basically. (…) Avoiding the intimacy because I don't look good. So I don't want to be intimate with anybody at the moment. (Maria)

What other ways have you found to manage those feelings [of self-disgust]? (Interviewer)

(…) I avoid intimate relationships. Fear um-hm it's fear, worry of rejection, worry of disappointing somebody else. (Nadia)

In addition, there was indication of avoiding situations in which participants had to either expose their body in front of other people (e.g. swimming) or come into close proximity with others (e.g. dancing). Although avoiding these activities

seemed to act as a way of preventing or protecting the self from experiencing self-disgust, it also appeared to be a consequence of feeling disgusted with the self. This is captured in Maria's excerpt below.

> *Can you tell me a bit more [about how would you describe your experience of self-disgust]?* (Interviewer)

> *Yeah for example, I love dancing* (…) *but now I feel much more self-conscious (…) and so my friends we usually go dancing but I said no many times you know this past year especially. (…) I like swimming very much (…) I used to go quite often but I haven't been there for ages and now even less (…) I am avoiding it at all costs at the moment.* (Maria)

A common coping strategy used by participants to create some distance from their feelings of self-disgust was to distract or keep themselves busy. Distraction appeared to be used in a conscious way to avoid or stop thinking about their experiences of self-disgust. They achieved this by engaging in a range of activities such as watching TV, listening to music, using social media, going for a walk or going out, and being with friends. Participants seemed to find distraction helpful in lessening the negative affect of their experiences of self-disgust even though its positive effect may have been short-lived.

> *I will do anything I can to distract myself because it's so painful (…) I just try to get myself away from the thoughts and distract myself. (…) I just change the subject really in my head, do something to distract myself*. (Nadia)

> *(…) I would just distract myself just with anything like I listen to music or I'll watch a film. I would go for a walk or just do something that I'm interested in because then you don't have all the negative thoughts really getting you down and it does help it to just go away*. (Lucy)

> *(…) I just turn the television on and I am watching hours of TV in the evening (…) yeah I think it's also by doing that I avoid thinking about it*

> *you know. Looking on Facebook, checking emails and watching TV, things that you know so that I am busy with something else.* (Maria)

The use of imagery seemed to be particularly helpful for Charlotte. She spoke about how imaging pleasant scenarios helped her lessen the distress caused by her experiences of self-disgust. However, it seemed to work only as a short-term strategy.

> *Are there any other things you do to try to manage feelings of self-disgust?* (Interviewer)

> *You know, I have a really good imagination so sometimes I imagine that I have a different life, and that is really good. And I imagine that I am somewhere else and doing stuff. (…) that's a really good way to handle it. To take myself out of my world and put myself somewhere else. Um-hm it worked but you always end up coming back to your own world*.
> (Charlotte)

Participants described food as being "a *friend*" and a source of distraction and comfort. Participants described how food and eating provided them an escape from themselves, their problems and feelings of self-disgust. However, the effects of food as a coping strategy seemed to be short-lived. Participants described food as an *"*enemy", and spoke about a "*cycle*" whereby they would turn to food when they felt disgusted with themselves in an attempt to help them to feel better, but then when they ate they felt "*even worse*" leading to further attempts at regulating or reducing feelings of self-disgust by using food. This is particularly evident within Nadia's and Lucinda's account.

> *I have no way out of the problem so the food helps me to sort of numb it and sort of blank it out of the situation but it is only in that period of time of eating where I am blanked out*. (…) *as I eat I am not thinking about me. I'm not thinking about the world. I'm not thinking about my problems*.
> (Charlotte)

> *(…) In the last teen-fifteen years that disgust, that looking at myself and then eating to comfort that and then feeling even worse in myself (...) because I've done that and I had that binge eating (…) food is my friend but my enemy at the time.* (Nadia)

> *It's just like a way of I don't know of keeping my mind away or thinking too much is like I continue eating*. (…) *I feel disgusted with myself, I try to comfort myself with eating more and then you know that feeling grows*. *(…) you feel worse than when you started and then it starts all over again because I'm trying to block all the self-disgust emotions that comes with it*. (Lucinda)

3.5.2. Subtheme Two: Learning to Tolerate and Live with Feelings of Self-Disgust

Participants spoke about using different strategies to help them to tolerate the feelings of disgust towards themselves and continue living their lives beyond their experiences of self-disgust. This involved using calming breathing and meditation to help them tolerate their feelings of self-disgust and get on with their lives.

> *I just take some deep breaths and compose myself*. (Lucy)

> *Well I try to take a deep breath and meditate a little bit.* (Lucinda)

However, the benefits did not seem to last long. Joanne spoke about how the thoughts about herself being disgusting would return soon after she had finished practicing meditation.

> *Colouring, mediating. I feel like I can zone out for like the ten minutes session or whatever it is and then as soon as I come back around I'm just thinking about it again so it's not really a long term. I need to find something longer lasting for sure*. (Joanne)

Participants explicitly described having learnt to accept and live with their feelings of self-disgust. It was unclear whether participants had learnt to tolerate their

feelings or whether they felt resigned to live with self-disgust due to its enduring and ever-present nature.

> *I think you just learn over the years to just live with it. You know, you learn to um-hm you learn to just um-hm to carry on. As they say 'keep calm and carry on'. It's kind of like that. (Charlotte)*

> *I've just accepted disgust and then it goes to acceptance. 'I accepted it and this is my life and now I can just move on, it's fine, it's there and I will just move on', I think that is it. (Kiran)*

Using self-talk and learning to be compassionate with oneself seemed to be a key mechanism for learning to tolerate and live beyond the feelings of self-disgust. Lucinda in particular spoke about these coping strategies to "*not go too hard on*" herself and to give herself "*more chances*" in life. Lucinda also spoke about the benefits of therapy in improving her eating problems and lessen the intensity of her feelings of disgust towards herself.

> *(…) so I try to as I said before like think about 'Well don't worry tomorrow is another day'. (…) I try to be more compassionate with myself, give myself more chances. (…) because I'm now in treatment I'm trying to get better, the situation has improved a little bit (…) my feelings of self-disgust are not as strong as they used to be and I have been more compassionate with myself as well.* (Lucinda)

Participants spoke about their attempts "*to get on with life*" (Nadia), and described making active efforts to feel better by looking after their physical appearance and focusing on aspects of their physical self that they liked.

> *I had showered, done my hair nicely, put my make up on because I didn't want to catch myself in the mirror without my make up on. Erm those are sort of my coping mechanisms because I'm like 'Fine okay you look okay now'*. (Nadia)

> *I look in the mirror and I say 'Oh my hair is not too bad (laughs) my face is not that bad' so you know and then my hands*. (Maria)

For Kiran getting a pet seemed to have made a significant difference in her life in terms of managing or dealing with her feelings of self-disgust.

> *(…) I think getting a pet really changed it (…) I really feel like it kind of helps with the disgust because it's like somebody needs me um-hm and I kind of need her. I feel this weird relationship like it kind of helps me get out of the moment*. (Kiran)

4. DISCUSSION

4.1. Overview

This research study aimed to gain a better understanding of the emotion of self-disgust by exploring the perspectives of women with eating, body shape and weight related concerns and problems. This chapter considers the findings in relation to the study's aims, research questions and existing literature. In line with a critical-realist epistemological position, the connections made to psychological theory are presented as possible ways of making sense of individuals' accounts rather than the one 'correct way' of understanding. This chapter also presents the study implications followed by a critical review, a reflective account and conclusions drawn from the study.

4.2. Summary of Findings

Four main themes and ten subthemes were developed from the analysis. The findings highlighted how self-disgust was understood to emerge within participants' lives in the context of being harshly judged and treated by others regarding their body weight and physical appearance, and the sociocultural idealisation of the thin female body type. From the way participants talked about their experience of self-disgust, it seemed that self-disgust was understood to incorporated both state and trait like components in that it was both described as being reactionary and enduring. Self-disgust also appeared to be understood as a complex emotional experience in that it was expressed as dislike and hatred of the self, experienced alongside feelings of sadness and anger towards the disgusting self and others, as well as feelings of shame with the disgusting (aspects of the) self. Lastly, the analysis highlighted participants' ongoing struggle to protect themselves from feelings of self-disgust, and live their lives beyond their feelings of disgust with themselves.

4.3. Findings in Relation to the Research Questions and Existing Literature

4.3.1. Research Question One: How Do Women with Eating, Body Shape and Weight Concerns Understand Self-Disgust?

Theme one - the interpersonal and sociocultural context of self-disgust relates to the first research question which sought to explore how women with psychological distress associated with eating, body shape and weight concerns understand self-disgust. Participants described how they understood their feelings of self-disgust as being rooted in their interpersonal and sociocultural context. In particular, they spoke about having experienced negative attitudes and behaviours from others with regards to their body weight and shape. Participants seemed to have come to perceive and experience their physical self to be “fat” and disgusting as a result of others’ weight-related judgments (actual or perceived). In this sense, feelings of self-disgust seemed to emerge as a result of participants’ appraisals of others’ evaluations of the self as “fat” and disgusting. Although it is possible that others’ weight-related judgments were not derogatory or negative, participants felt that they were. Participants described being harshly judged and treated by others including being bullied and a recipient of others’ aggression. These findings are in line with existing literature that suggest that self-disgust may arise from social learning experiences such as internalisation of others’ disgust reactions, whereby individuals learn what features of the self are considered socially disgusting (Fox et al., 2015; Powell et al., 2015a; Simpson et al., 2010). It also fits the idea of self-disgust as a schema emotion involving dynamic interactions between affective and cognitive components that are influenced by individuals learned experiences and sociocultural context (Izard, 2007, 2009; Powell et al., 2015a). Moreover, it is in keeping with theoretical accounts and empirical research that suggest that individuals experiencing psychological distress associated with eating problems tend to be hypersensitive about how others view them, assuming that others’ perceptions and appraisals towards them are negative (Fairburn, 2008; Ferreira, Pinto-Gouveia, & Duarte, 2013, 2014).

Participants also spoke about self-disgust as emerging in the context of not fitting in societal expectations regarding body shape and weight. They described

negative experiences of their own body image and feelings of disgust towards aspects of the self that were understood to be integral to their sense of self (e.g. physical appearance) in relation to perceived deviations from the sociocultural thinness ideal. From participants' accounts, self-disgust seemed to emerge through participants' negative self-appraisals of their physical self or negative body image in relation to the sociocultural thinness ideal. These findings may be understood within a number of theoretical perspectives, including the sociocultural perspective of eating problems (Stice, 1994) and disgust emotion (Power & Dalgleish, 2008), and the self-objectification theory (Fredrickson & Roberts, 1997) discussed in chapter one. Consistent with the present findings and the tenets of the above theoretical perspectives, previous literature has demonstrated that body image is an important aspect of women's self-concept (Ferreira et al., 2013; Gilbert, Price, & Allan, 1995), and that self-objectification can lead to increased disgust towards one's body and psychological distress associated with eating difficulties in women (e.g. Calogero et al, 2005; Noll & Fredrickson, 1998). It has also been shown that women often experience dissatisfaction in relation to their physical appearance, body size or shape (e.g. Rabak-Wagener, Eickhoff-Shemek, & Kelly-Vance,1998; Tiggemann & Slater, 2004). When women perceive appearance as an essential domain in self-evaluation, they may be more disposed to process information regarding physical appearance and sociocultural ideal standards. In this context, body dissatisfaction is likely to contribute to the genesis of feelings of self-disgust. Indeed, body dissatisfaction and drive for thinness have been found to be associated with increased disgust with the self (Chu et al., 2015). Body dissatisfaction has also been linked with disgust towards the body in a qualitative exploration of emotions in eating problems discussed in chapter one (Espeset et al., 2012).

Moreover, participants spoke of self-disgust in the context of both weight bias and internalised sociocultural appearance ideal. This was captured by their descriptions of weight-related stereotypes that portrayed overweight individuals as being "*lazy*" or "*weak*", and their tendency to associate happiness with having a thin body type. This is consistent with previous research that has showed the thin female body type has become a synonym of desirable features, such as

success and happiness (Strahan, Wilson, Cressman, & Buote, 2006), while deviations from the thin ideal have become stigmatised (Puhl & Heuer, 2009). Although it was not clear how participants come to perceive the negative stereotypes, it is possible that these were communicated at the societal level either directly or indirectly. Studies have showed that overweight body types are often ridiculed in media (Greenberg, Eastin, Hofschire, Lachlan, & Brownell, 2003), particularly overweight or obese female bodies (Fikkan & Rothblum, 2011), and that people often hold anti-fat attitudes (Watts & Cranney, 2009). Moreover, women with high scores on standardised ED measures have been found to experience elevated disgust of overweight body shapes (Griffiths & Troop, 2006; Harvey, Troop, Treasure, & Murphy, 2002). Considering previous research together with how participants seemed to understand self-disgust in this study, it seems plausible that internalisation of weight bias and the sociocultural thinness ideal may contribute and/or result in feelings of disgust towards one's own body and physical appearance within ED difficulties.

Overall, participants understanding of self-disgust is consistent with existing theoretical understandings and empirical evidence which have posited that the emergence of feelings of self-disgust is related to individuals' sociocultural context, including social learning and interpersonal experiences.

4.3.2. Research Question Two: How Do Women with Eating, Body Shape and Weight Concerns Experience and Manage Self-Disgust?

The second research question sought to explore how women with psychological distress associated with eating, body shape and weight concerns experience and manage self-disgust. Under theme two - self-disgust as both transient and enduring, participants described self-disgust as being both an intense reactive emotional state and an ever-present feeling of being disgusting, suggesting that self-disgust may incorporate both state and trait like components. This is congruent with previous qualitative research exploring self-disgust in females experiencing psychological distress associated with 'depression' (Powell et al., 2014), and the idea that self-disgust is an emotion schema (Izard, 2009). An emotion schema can be triggered or activated by particular elicitors, and it can also act as a trait of temperament/personality at some level of awareness. The

schematic view of self-disgust assumes a reciprocal interaction between state and trait components. It is believed that recurrent reactionary self-disgust responses facilitate a more lasting trait-like response, and that enduring or trait-like self-disgust facilitates the occurrence of more frequent reactionary or state-like feelings of self-disgust (Powell et al., 2015a). This may explain the presence of an enduring sense of being disgusting in conjunction with reactionary feelings of self-disgust as described and understood by participants.

In the current study, participants talked about reactionary feelings of self-disgust in relation to different aspects of the self, including physical attributes (i.e. body weight and physical appearance) and psychological aspects (e.g. behaviour). This finding is in keeping with the aforementioned phenomenological exploration of self-disgust in the context of psychological distress related to depression (Powell et al., 2014), suggesting that self-disgust may be experienced in a similar way across different presentations of psychological distress, particularly those related to eating problems and 'depression'. This may be related to the documented high comorbidity between eating problems and 'depression' (e.g. Blinder, Cumella, & Sanathara, 2006). However, it is also possible that the emotion of self-disgust may be a characteristic emotional experience of various presentations of psychological distress as suggested by the preliminary findings reported in chapter one. Interestingly, previous empirical evidence suggests that disgust towards one's physical appearance and body is more pronounced than behavioural disgust in eating problems (Ille et al., 2014; Moncrieff-Boyd et al., 2016). Likewise, participants in this study predominantly spoke about disgust towards the physical self. It is possible that disgust with one's behaviour may be understood or appraised as more changeable and therefore less integral to one's self-concept, or it may be that the nature of eating related difficulties makes individuals more susceptible to view or appraise their physical self as disgusting.

Furthermore, participants seemed to understand their reactionary feelings of self-disgust to arise in response to being or feeling judged as well as judging the self for weight gain. Inherent to participants' accounts was an underlying tendency to compare the self to others and being self-critical of own physical appearance. Linked to this was the perception of failing to meet the sociocultural expectations

regarding body shape, appearance and weight. Participants also described reactionary feelings of self-disgust in relation to perfectionism and self-criticism. It is possible that core maintaining processes of psychological distress associated with eating problems, such as self-criticism and perfectionism expressed in the form of striving to achieve the socially valued ideal body may result in, and possibly serve to maintain self-disgust among those with eating problems in response to (perceived) failure to meet the sociocultural appearance standards. This is congruent with previous literature that suggest that people with eating problems experience high levels of self-criticism, and that self-criticism is associated with self-disgust (Gilbert et al., 2004).

Participants' descriptions of their reactionary feelings of self-disgust indicated that they understood that a range of modalities were involved in the processing of self-disgust elicitors, including olfactory (e.g. smell of food) and visual (e.g. seeing own reflection). These findings are consistent with the SPAARS model of emotions in eating related problems discussed in chapter one, which proposes that emotion-related stimuli are processed via different sensory modalities (Fox & Power, 2009). Moreover, in the present study self-disgust seemed to be understood as having disgust-driven cognitive-affective qualities. Specifically, participants' reactionary response of disgust towards the self was understood be accompanied by corporeal reactions such as feeling "*sick*", disgust-driven responses of avoidance towards aspects of the self appraised disgusting, and cognitions or beliefs related to disgust towards the self (e.g. "*I'm a disgusting pig*"). These findings are congruent with the schematic perspective of self-disgust which suggest that it is these disgust-based cognitive-affective aspects that distinguishes self-disgust from potentially overlapping constructs such as self-hatred (Powell et al., 2015a), and lends support to previous qualitative research (Espeset et al., 2012; Powell et al., 2014) reviewed in chapter one.

The reported embodied qualities of self-disgust can be understood in the context of existing theories of embodied cognition which propose that emotional processing involve an embodied experience of emotion (e.g. Niedenthal, Winkielman, Mondillon, & Vermeulen, 2009). The emotion of disgust is often described in the literature as being visceral (Olatunji & Sawchuk, 2005; Rozin et

al, 2008), and as an emotion schema, self-disgust is hypothesised to incorporate some aspects of the emotion of disgust (Powell et al., 2015a). Likewise, the reported desire to avoid the disgusting features of the self is consistent with existing literature which suggest that the emotion of disgust instigates avoidance or rejection (e.g. Espeset et al., 2012; Rozin et al., 2008).

Within theme three - self-disgust as a complex emotional experience, participants talked about self-disgust as being expressed and experienced alongside other emotions, namely self-hatred, sadness, anger and shame. This is in line with the SPAARS-ED model discussed in chapter one which proposes that disgust towards the self and body is experienced simultaneously with other emotions (Fox & Power, 2009). It is also in keeping with the aforementioned phenomenological exploration of self-disgust in depression (Powell et al., 2014), and the secondary qualitative exploration of self-disgust in the context of self-harm (Benson et al., 2015) which reported that participants associated their experience of self-disgust with other emotions. In the present study, the emotion of sadness appeared to be understood to follow feelings of self-disgust, and being linked to feelings of loneliness and hopelessness. The combination of these emotions appeared to be understood to result in further feelings of self-disgust. It is possible that the hopelessness expressed by participants may be related to the enduring nature of self-disgust as participants talked about feeling that they could not "*escape*" the ever-present feeling of self-disgust. The feelings of hopelessness appeared to be significant particularly given participants reported suicidal thinking. This finding is in keeping with recent research that suggest self-disgust is a contributing factor to suicidal ideation in psychological distress associated with eating problems (Chu et al., 2015), and highlights the importance of targeting feelings of self-disgust in psychological interventions. Moreover, the association between feelings of self-disgust and sadness may explain the high comorbidity between eating problems and 'depression'.

Contrary to previous research and theoretical accounts which suggest that feelings of anger precede disgust (e.g. Fox & Harrison, 2008; Fox et al., 2013) and that disgust may function to inhibit anger (Fox & Power, 2009), in the present study participants seemed to understand feelings of self-disgust as preceding

feelings of anger towards the disgusting self. It may be that self-disgust was viewed or experienced as more distressing than anger, or perhaps in some cases anger may be a consequence of feeling disgusted with the self. Participants spoke about feelings of self-directed anger being linked to self-directed blame for their eating difficulties and feelings of self-disgust. Sociocultural factors may partly account for this. As discussed in chapter one, the emotion of self-disgust may be understood as a self-conscious moral emotion in that violations of sociocultural norms and expectations appear to trigger feelings of self-disgust (Powell et al., 2015a; Simpson et al., 2010). In this sense, self-disgust is believed to share commonalities with sociomoral disgust which in turn has been associated with high levels of anger (and sadness) (Simpson, Carter, Anthony, & Overton, 2006). Moreover, it has been argued that women are particularly apt to reflect on their own (perceived or actual) failures (Roberts & Goldenberg, 2007). Accordingly, the internalisation of the thin-ideal and weight bias may make women more liable to attribute blame to the self for not achieving the socially valued thin-ideal, and experience both self-disgust and self-directed anger for perceived shortcomings and failure to live up to the thin-ideal.

Self-disgust has been associated with the emotion of shame, with some scholars proposing that they are both directed to the body within psychological distress related to eating problems (Fox & Power, 2009), whereas others have suggested that self-disgust plays a mediator role between shame and eating problems (Olatunji et al., 2015). Likewise, in this study participants understood shame to be associated with feelings of self-disgust. Again, this is consistent with the SPAARS-ED model discussed in chapter one which posits that self-disgust is experienced concurrently with other emotions (Fox & Power, 2009). From participants' accounts, feelings of self-disgust and shame were viewed to be related to having a diagnosis of ED. This is in line with a recent systematic review revealed that the most frequent barriers to help-seeking among those with eating related problems are shame and stigma (Ali et al., 2017). Self-disgust in conjunction with feelings of shame could potentially contribute to the perpetuation of eating difficulties as individuals may feel too ashamed to access treatment due to perceiving the self to possess socially undesirable features (e.g. excess of

weight) and belong to a socially stigmatised group (i.e. those with a diagnosis of EDs).

In theme four - the ongoing struggle to protect the self, participants described engaging in behaviours that involved both avoidance and distraction in an attempt to protect themselves from feelings of self-disgust. This is consistent with the disgust emotion as an instigator of avoidance responses (Rozin et al., 2008), and previous research which suggest that individuals with eating related problems often use distraction and avoidance strategies to manage negative emotions including the emotion of disgust (Coggins & Fox, 2009; Espeset et al., 2012). It has been argued that such avoidance behaviour may serve to maintain self-disgust through negative reinforcement (Powell et al., 2015a). Indeed, participants noted that the benefits of the employed strategies were short-lived. This may be related to the enduring nature of self-disgust described by participants, or the reported difficulty to unlearn disgust responses (Olatunji, Forsyth, & Cherian, 2007). Participants' attempts to distance themselves appeared to have negative consequences such as reduced social interactions. In some cases, participants feared to, and seemed to expect to be rejected by others. This is consistent with the phenomenological exploration of self-disgust in 'depression' where participants described experiences of rejection and social withdrawal as well as expectations to be rejected (Powell et al., 2014). These negative consequences have the potential to further reinforce and maintain self-disgust and associated negative emotions such as sadness and shame. Moreover, participants spoke about using food to comfort oneself from feelings of self-disgust, and how comfort eating led them to feel "*even worse*" leading to further attempts at regulating or reducing feelings of self-disgust by eating more or bingeing. In this sense, self-disgust may be understood to contribute to maintain eating problems symptomatology such as bingeing.

Participants also spoke about how they sought ways to live beyond their feelings of self-disgust by engaging in a range of strategies such as self-talk, self-compassion, acceptance, and attentional focus on aspects of their physical self that they liked. This finding resonates with the self-affirmation theory (e.g. Sherman & Cohen, 2006), and is in keeping with empirical evidence that

suggests self-disgust may be attenuated by self-affirmation (Powell et al., 2015c). Moreover, it is congruent with literature that suggests that self-compassion (i.e. being understanding and encouraging to oneself) and non-judgmental acceptance of one's own emotions can help fostering more positive body image and self-directed thoughts and feelings (Goss & Allan, 2009, 2014). It is also in line with a recent empirical evidence that suggest a more compassionate attitude towards the self may be useful in managing or alleviating feelings of self-disgust within psychological distress (Palmeira et al., 2017).

Overall, participants understanding of self-disgust is in line with the phenomenological exploration of self-disgust in the context of psychological distress associated with a diagnosis of depression. Both samples of participants talked about reactionary and enduring feelings of self-disgust and described, to some degree, visceral aspects such as nausea. Moreover, in both studies self-disgust appeared to be experienced alongside other emotions. This is suggestive that self-disgust may be a characteristic emotional feature across different presentations of psychological distress. However, further research is needed to validate this proposition. These findings are also in keeping with contemporary theoretical understanding of self-disgust as an emotion schema, and the SPAARS model of emotions which proposes self-disgust may become 'coupled' with other emotions. Participants' account of their ongoing struggle to protect themselves from feelings of self-disgust highlight the pervasive sense of being disgusted which they spoke of as well as the intense recurring reactionary feelings of self-disgust. As in previous research, participants spoke about trying to distance themselves from their feelings of self-disgust by engaging in avoidance and distraction. Participants' attempts to live beyond their feelings of self-disgust seemed to suggest that self-affirmation and self-compassion may help to tolerate and/or attenuate feelings of self-disgust.

4.4. Implications

The findings of the current study have a number of implications for theoretical understanding of self-disgust, clinical practice, wider societal context, and future research. These are discussed below.

4.4.1. Theoretical Implications

As discussed in the above exploration of findings in relation to the literature, the current findings provide support for the relevance of the emotion of self-disgust within psychological distress in particular in the context of eating, body shape and weight related concerns and difficulties, and emphasise the potential need to consider emotional experiences rather than looking at general emotional regulation alone. Although in lay language the construct of disgust appears to describe feelings of anger, irritation or annoyance, and thus embody a combination of the theoretical concepts of disgust and anger (Nabi, 2002), the present findings seem to suggest that participants' descriptions of self-disgust corresponded to 'real' feelings of disgust towards the self and were congruent with the theoretical meaning of the construct of self-disgust. In particular, participants' references to visceral sensations of disgust (e.g. nausea), the marked tendency of behavioural avoidance and rejection of the disgusting parts of the self appeared to encompass the theoretical meaning of self-disgust as a discrete emotion with cognitive-affective aspects akin of an emotion schema which may incorporate both state and trait-like components (Powell et al., 2015a). Nevertheless, it is likely that the emotions of anger and disgust are closely related and may overlap when applied to the self. Indeed, in the present study self-disgust was understood to be experienced alongside feelings of anger towards the disgusting self and others. Participants also seemed to understand self-disgust as occurring alongside feelings of sadness, self-hatred and shame. This is consistent with previous research that has found self-disgust to be highly related to other emotions both within psychological distress and in the context of self-harming (e.g. Benson et al., 2015; Powell et al., 2014). This lends support to the contemporary theoretical understanding of emotions, in particular the SPAARS-ED model (Fox & Power, 2009) which proposes that self-disgust can become coupled (i.e. experienced simultaneously) with other emotions such as anger and sadness. The coupled emotional experience of self-disgust and feelings of sadness appears particularly pertinent as it might explain the high comorbidity between presentations associated with eating problems and 'depression', as well as self-harming behaviour and suicidal ideation among clinical populations. Furthermore, participants understanding of self-disgust seemed to suggest that it may be related to and/or experienced in association

with other cognitive phenomena, namely perfectionism and self-criticism. Whilst it is possible to be perfectionist and critical of the self without experiencing feelings of self-disgust (Gilbert et al., 2004), striving for perfectionism and being self-critical may precede or accompany feelings of self-disgust. While self-disgust was understood to be associated with other emotional and cognitive phenomena, participants also appeared to understand self-disgust as having specific disgust-based cognitions (e.g. “I’m a disgusting pig”), disgust-based behavioural responses of avoidance of the disgusting (aspects of the) self, and congruent physical sensations of nausea as described in previous qualitative exploration of self-disgust in ‘depression’ (Powell et al., 2014). This is suggestive that self-disgust may a characteristic feature of different presentations of psychological distress.

4.4.2. Implications for Clinical Practice

Following on the present findings, it could be useful for practitioners to consider both trait and state-like components of self-disgust as both may impact negatively upon individuals’ psychological wellbeing, and potentially serve to maintain (and/or exacerbate) eating related difficulties via the use of bingeing, vomiting or food restriction to regulate feelings of self-disgust. In addition, it may be useful to consider how other emotions, such as anger and sadness, may influence how individuals perceive themselves and result in further feelings of self-disgust which in turn could impact on eating problems symptomatology. For instance, in formulating the clients’ eating difficulties it could be useful to explore how working with their body image dissatisfaction may potentially impact on feelings of self-directed anger and blame via the emotion of self-disgust, as well as impact on eating problems symptomatology (e.g. bingeing). Similarly, it may be valuable to assess and formulate feelings of self-disgust, in conjunction with feelings of sadness, in relation to suicidal ideation and/or an increased severity in depression. This is of particular relevance given the increase risk of suicide in psychological distress associated with eating, body shape and weight concerns (Preti et al., 2011), and the documented comorbidity between eating problems and ‘depression’ (Blinder et al., 2006).

Based on the present findings and previous literature, it could be useful for practitioners to consider the emotion of self-disgust not only at the propositional and schematic level (akin of negative automatic thoughts and core beliefs in cognitive behaviour therapy), but also at the automatic associative pathway to emotion generation as proposed by the SPAARS-ED model (Fox & Power, 2009). The associative route is believed to work at the unconscious level, and therefore be more resistant to change particularly if using only cognitive strategies. Experiential techniques such as the two-chair dialogue in which individuals are invited to engage in dialogue with the critical, disgusting self may be useful in working with feelings of self-disgust in psychological distress associated with eating, body shape and weight concerns (Fox et al., 2012). Moreover, exposure work and behavioural experiments may be useful in supporting individuals to learn, via the associative route, non-disgust responses towards the self (Power & Dalgleish, 2008). For instance, attentional training in body image distortion may enable individuals to learn to associate alternative emotions to their body, and thereby reduce feelings of self-disgust in psychological distress associated with eating, body shape and weight concerns (Fox & Power, 2009).

Some psychological treatment approaches to eating problems have started to consider the issue of emotional avoidance captured in the present study. For example, Dialectical Behaviour Therapy (Linehan & Chen, 2005) and Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 1999) argue that individuals need to accept their own emotions, whether positive or negative, without making judgments with the view of learning to manage negative effect more adaptively. This idea of non-judgemental acceptance fits with some of the participants' accounts that suggested they had learned to, or sought to, accept their feelings of self-disgust. Moreover, participants' descriptions of using calming breathing and meditation resonates with mindfulness-based techniques used in both DBT and ACT approaches. Hence, such approaches may be useful treatment options for working with self-disgust within psychological distress associated with eating, body shape and weight concerns. However, further research is necessary to explore their effectiveness for working specifically with self-disgust.

Additionally, approaches focused on decreasing shame and increasing self-compassion (e.g. Compassion Focused Therapy) may well be beneficial for individuals with eating, body shape and weight related concerns and difficulties experiencing self-disgust. As Gilbert and colleagues (2004) suggest, and as consistent with the present findings, the experience of self-disgust appears to be characterised by self-criticism and be associated with feelings of shame. Hence, interventions that support individuals to develop an emotional relationship with oneself based on validation and compassion may be helpful in addressing self-disgust. Indeed, there was indication that participants sought to be more self-compassionate to ameliorate feelings of self-disgust. Participants also spoke about focusing on aspects of the self that they liked. This suggests that using affirmation techniques, where alternative aspects of the self are self-affirmed, may be useful in managing the negative effects of self-disgust. Self-affirmation could potentially be used as a preventative tool for negative emotions in psychological distress associated with eating, body shape and weight concerns.

4.4.3. Implications for Wider Societal Context

Beyond the aforementioned individual interventions, preventative measures that deal with the negative interpersonal experiences in relation to one's body weight and size, and the sociocultural thinness ideal may potentially impede the emergence of self-disgust or perhaps help ameliorate its negative effect. For instance, negative weight stereotypes and unrealistic sociocultural body type standards could be counteracted by social movements and campaigns promoting a healthy body image and realistic body size. Indeed, there has been a rise over recent years of body positive movements and campaigns, such as the 'No Size Fits All' campaign launched in the UK ahead of London's fashion week (Women's Equality Party, 2016), and the 'Be Real' national movement founded in 2014. Such campaigns and movements can help to create greater awareness of diversity in body shapes and sizes and promote self-acceptance.

As discussed earlier, feelings of shame in conjunction with feelings of self-disgust were understood to be related to having a diagnosis of ED. A recent systematic review revealed that the most frequent barrier to help-seeking in psychological distress associated with eating, body shape and weight concerns are shame and

stigma (Ali et al., 2017). Self-disgust alongside shame may be potential significant deterrent factors on help-seeking. This is particularly significant given that delays in accessing treatment are associated with poorer outcomes for individuals with eating problems (Reas, Williamson, Marin, & Zucker, 2000). Although Beat, the leading UK charity for people with eating problems, has been prominent in promoting awareness of psychological distress associated with eating, body shape and weight concerns, and the 'Time to Change' campaign has helped reducing mental health stigma (Sampogna et al., 2017), further mass media campaigns could be useful in normalising help-seeking behaviours and promoting self-compassion among individuals experiencing eating difficulties.

4.4.4. Research Implications

Whilst the current study has provided more of an understanding of the emotion of self-disgust, more research needs to be carried out to provide a more comprehensive understanding. Based on the present findings it is hypothesised that internalised thinness ideal and negative attitudes and behaviours of others are likely to contribute to the development of self-disgust. Future research could investigate the validity of this link and identify other factors that may be potentially involved in the genesis of self-disgust in psychological distress associated with eating, body shape and weight concerns. Early experiences of abuse and trauma have been identified as risk factors for eating problems (Holman, 2012), and body shame has been identified as a key moderator between BN symptomatology and childhood abuse (Andrews, 1997). It is therefore plausible that experiences of trauma and abuse may contribute to the development of a self-disgust schema in presentations associated with eating, body shape and weight concerns. This may represent a useful avenue for further investigation.

Given the broad exploratory nature of this study, future research could focus on exploring particular aspects of women's experience of self-disgust. For example, a phenomenological approach could be taken to explore the enduring and reactionary feelings of self-disgust described by participants. Moreover, future research could explore the relationship between trait and state aspects of self-disgust. In this study participants talked about self-disgust in relation to both physical and psychological aspects of the self, and previous research suggest

that disgust towards one's own physical appearance and body is more pronounced than behavioural disgust in presentations associated with eating problems (Ille et al., 2014). Future research could explore whether disgust towards more stable aspects of the self, such as physical appearance and body image is more distressing or detrimental to eating difficulties than disgust towards less stable attributes such as one's behaviour. There is also scope for further exploration of the relationship between self-disgust and other emotions including self-hatred, sadness, anger and shame and how these may impact on eating problems symptomatology.

Moreover, it may be useful to explore self-disgust in relation to specific eating related behaviours such as bingeing and purging. In the present study, there was some indication that self-disgust could potentially act to maintain eating related behaviours such as bingeing as an emotional regulation strategy. However, further research is needed to elucidate the precise role of self-disgust in relation to specific eating problems symptomatology. It may also be useful to explore whether and how feelings of self-disgust may alter throughout psychological treatment. Some participants mentioned having had psychological treatment and alluded to its benefits in ameliorating the impact of self-disgust in their lives. However, the present study did not explore whether the experience of self-disgust was moderated by psychological treatment. Additionally, future research could explore potential gender differences in the experience of self-disgust. This could be useful when tailoring treatment interventions.

4.5. Critical Review

4.5.1. Quality in Qualitative Research

Yardley's (2000, 2011) principles for quality in qualitative research have been used to evaluate the quality of this research. These are discussed below.

4.5.1.1. *Sensitivity to context:* good qualitative research is contextualised in relation to existent relevant theoretical and empirical literature, and is sensitive to the perspective and context of participants (Yardley, 2011). These aspects were demonstrated by presenting a review of existing literature exploring the emotion

of self-disgust across different presentations of psychological distress in chapter one. Additionally, the findings were discussed in relation to relevant literature. During the data collection stage, I aimed to use open-ended questions to encourage participants to talk openly about their experiences. In the analysis stage, I supported my arguments with verbatim quotes.

4.5.1.2. Commitment and rigour: commitment was achieved through extended engagement with existing literature and data set to ensure a thorough analysis. I sought to develop competence and skills in TA by attending lectures and workshops, reading relevant resources and seeking advice from my supervisor. The analysis process was described in chapter two, and the initial codes and themes were discussed and reviewed together with my research supervisor. The analysis was also discussed with a psychologist working in the eating problems field.

4.5.1.3. *Transparency and coherence*: the approach to data collection and analysis was described in chapter two. Additionally, an example of coded transcript excerpt was presented in the appendices together with the list of initial codes and themes. The transparency of the analysis was achieved by grounding the analytical interpretations in excerpts. I engaged in reflexivity throughout the study to consider the ways in which I could or may have influenced the research process. This was assisted by keeping a reflective journal.

4.5.1.4. *Impact and importance*: this study has provided useful insights about perspectives upon self-disgust within psychological distress associated with eating, body shape and weight concerns. These were highlighted earlier when discussing the study implications. The findings will be disseminated to participants and the service in which the research took place. I also hope to disseminate the findings to the wider academic and clinical community.

4.5.2. Limitations

Despite attempts to ensure good quality qualitative research the current study has a number of limitations which are discussed below.

4.5.2.1. *Recruitment*: initially I hoped to recruit from two NHS ED specialist services through the clinical teams. However, response to this recruitment strategy was slow. This may have been related to using team members as gatekeepers for recruitment. Clinicians may not have had the capacity within their meetings with potential participants to inform them of the research. Although efforts were made to extend recruitment to Beat and Student Minds, as mentioned in chapter two, due to the study time constraints recruitment was limited to one NHS service. It is therefore acknowledged that the generalisability of the present findings is limited. It is also acknowledged that recruiting via the clinical team may have resulted in sampling bias (e.g. who they approached to discuss the study with and how they explained the study). However, this may have been minimised through discussing the inclusion and exclusion criteria with the team. Although participants were informed that their decision to participate or not in the study would not affect the care they received from the clinical team, it is possible that some participants may have felt obligated to participate when approached by members of the clinical team.

4.5.2.2. Sample: although the sample size was adequate for data saturation (Guest et al., 2006) and the identified themes were applicable to the majority of participants, a larger sample size could have been useful in providing support to the representativeness of the identified themes. Another possible limitation is the use of a relatively heterogeneous sample. The sample consisted of women with different eating problems and at different stages of engagement with treatment. As discussed in chapter one, the present study took a transdiagnostic view of eating problems which has received empirical support (e.g. Fairburn & Bohn, 2005; Fairburn et al., 2003). Moreover, the shared experiences across the participants' accounts suggest that the diversity in eating problems diagnoses did not reduce the representativeness of the data. However, the relative small sample size and homogeneity of participants in terms of gender means that the findings may not be generalisable to the wider ED population, and may not apply to men.

4.5.2.3. Method of analysis: although TA was the deemed the most appropriate method of analysis for answering the research questions (as discussed in chapter

two), it has been argued that there is a lack of guidelines in relation to what it is and how it is done (Boyatzis, 1998). Moreover, its theoretical flexibility makes it difficult to maintain consistency between analyses. TA aims to generate an understanding of patterns of meaning across the data set (Braun & Clarke, 2006), and therefore it was deemed the most appropriate method to explore the perspectives of women who experience psychological distress associated with eating, body shape and weight concerns upon self-disgust. Additionally, as discussed in chapter two, TA is considered a foundational method providing useful information for further research. This is particularly pertinent to the research topic as there remains still little research exploring self-disgust, particularly qualitative research.

4.5. Reflexivity

As discussed in chapter two, reflexivity is an important aspect of qualitative research. Reflexivity was considered in chapter two, where I acknowledged aspects of my context and experiences that could have influenced my position in relation to the research. Further reflections are provided below.

During the recruitment process, I experienced a number of difficulties in recruiting participants which were partly expected due to the sensitive topic, but nevertheless made me question the feasibility of the study. Reflecting on the reasons I had selected the topic in question and having on-going discussions with my supervisor was important in keeping hold of the enthusiasm and persevere with recruitment. In conducting the present study, I was aware of the dual role as a researcher and trainee. In particular, I was aware of my tendency to respond therapeutically when seeing individuals in emotional distress, and therefore I was mindful not to turn the research interviews into a therapeutic session. However, sometimes it was particularly difficult to listen to the accounts of worthlessness and hopelessness expressed by some participants and remain in the researcher role (e.g. not reflect back and recognise participants' personal strength and resilience). Taking time to reflect on my role and my own personal reactions to the interviews was important to find a way of balancing both clinical and research roles. I draw on my clinical skills and experience to foster engagement and

manage potential risk issues (e.g. disclose of suicidal ideation and planning) while holding a position of curiosity. While my clinical knowledge and experience helped me to understand participants on a professional level, I found that some of the participants' accounts resonated with the stories I had heard on a personal level. This might have affected the answers gained from the participants as I may have assumed a certain understanding. However, being aware from the early stages of data collection that this could compromise a position of curiosity I sought to always ask for confirmation or elaboration. I also sought to ask open questions throughout the interviews to ensure participants voice was heard.

I also reflected on how my position as a health professional may have impacted on the way in which participants interacted with me and what they chose to share. I was mindful that some participants might have viewed me as being an expert on the topic under investigation and perhaps not talk about aspects of their experiences in a detailed way. However, I was also aware that at times participants could be avoiding thinking or going into detail about particular aspects of their experience of self-disgust to protect themselves. Moreover, I was also mindful to introduce myself as not being part of the participants' clinical team as being perceived as an internal staff member might have impacted on the content and nature of the interviews. This seemed important as participants assumed that I worked in the service (e.g. they would often ask me about waiting times for psychological treatment and particular appointments within the service) which could potentially bias their responses in terms of what they may have chosen to share or keep to themselves.

Reflecting on the interviews, I realised that although participants used the word 'fat', I did not use it during the interviews. I wondered whether this was because of my own assumptions about the term being somewhat derogatory particularly given participants' accounts of negative experiences. I also wondered whether by not using the term 'fat' I was in a way minimising participants difficult experiences or whether I was colluding with avoidance at some level. Through listening to participants accounts of their experience of self-disgust, I developed an appreciation of this pervasive yet often 'hidden' emotion, and become determined to disseminate the findings of this study.

4.6. Conclusions

This study aimed to gain a better understanding of the emotion of self-disgust by exploring the perspectives of women who experience psychological distress associated with eating, body shape and weight concerns. The findings emphasise that self-disgust appears to be understood as a distressing and prominent emotion within eating related problems, with cognitive-affective aspects congruent with an emotion schema, which may be experienced in conjunction with other emotions such as sadness and anger. The study findings suggest that participants employ a number of strategies to help protect themselves from feelings of self-disgust, including calming breathing, acceptance, distraction and avoidance from the self or aspects of the self that are viewed and/or experienced as disgusting. Overall, the findings emphasise the potential usefulness of an increased clinical awareness of the emotion of self-disgust to support psychotherapeutic assessment, improve informed formulations and deliver tailored interventions. The current findings also provide a foundation for future research on self-disgust. It is hoped that the present findings will contribute to better outcomes for individuals experiencing psychological distress associated with eating, body shape and weight concerns by raising awareness of the significance of self-disgust, and providing ideas for consideration in therapeutic interventions such as integrating compassion focused techniques.

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6. APPENDICES

Appendix 1 – Interview Schedule Version 2.0

The interview schedule will be piloted and reconsidered in consultation with the research supervisor. The interview schedule below provides a guide of the type of questions that will be asked in the interviews. The precise way in which the interview unfolds will be influenced by the participants' responses.

Participants will be reminded of confidentiality, the right to withdraw at any time during the interview, and the length of the interview (approximately 1-1.5 hours). They will also be reminded that the interview is being recorded and transcribed.

To promote engagement, ice-breaker questions will be asked before interview begins, such as "How was your journey here?"

Information gathering

1. How old are you?
2. How would you define your ethnicity?
3. How would you define your sexuality?

Information regarding eating disorders

4. Can you tell me which eating disorder were you diagnosed with?
5. How long have you been diagnosed?

I will now begin the main interview by asking about your personal experiences and understanding of disgust and positive emotions directed toward the self.

Self-disgust[1]

Disgust is an emotion that is universal to all humans. Many people report experiencing disgust about themselves which is known as self-disgust. I am interested in how you understand and experience self-disgust.

[1] Informed by the interview schedule used by Powell et al. (2014).

6. What do you understand by self-disgust?
Prompts: *What do you understand about the emotion of disgust in general? How about disgust directed towards the self?*

7. How would you describe your experience of self-disgust?
Prompts*: What is it like? Are there any thoughts, behaviours and/or feelings you associate with the experience? What kind of thoughts do you have when you feel disgusted with yourself? Do you feel any other emotions when you feel disgusted with yourself?*

8. What makes you feel disgusted with yourself?
Prompts: *Can you think of any specific times you have felt disgusted with yourself in the past or currently? What made you feel self-disgust then? Did any aspect of yourself (your physical appearance, personality or behaviour) made you feel disgusted?*

9. How do you manage feelings of self-disgust?
Prompts: *What do you do when you feel disgusted with yourself? How do you manage negative feelings directed towards the self? What helps you to cope? Is there anything that makes it harder/easier for you?*

Positive emotions directed towards the self
10. What do you understand by self-directed positive emotions?
Prompts: *What do you understand about positive emotions in general? How about positive emotions directed towards the self?*

11. How would you describe your experience of positive emotions towards the self?
Prompts*: What is it like? Are there any thoughts, behaviours and/or feelings you associate with the experience?*

12. Before we finish, is there anything else you would like to tell with me that I have not asked you?

Debriefing: What was it like talking about your experiences? Do you have any questions or concerns?

You can contact me and/or my research supervisor later if you have any questions. You can also contact your care clinician/team should you wish to or require support. Also, here are some contact details for support organisations should you wish to access further support.

Thanks for taking part in the study. As a recognition for your participation you have the option to enter a **prize draw to win an Amazon voucher worth £30**. Would you like to enter the prize draw? How can I contact you if you win?

Explain that contact details will be stored separately from consent forms and research data in a password protected database in a password protected memory stick/computer. Each participant will be assigned a number for the purposes of the prize draw, and the winner will be identified using the random number function in Excel. The winner will be notified shortly after the end of the study.

Would you like to receive a summary of the findings? *Open to be contacted to share findings with?*

Appendix 2 – Invitation Letter Version 1.0 (29/02/2016)

An exploration of self-disgust in females with eating disorders

My name is Fatima Marinho, I am a Trainee Clinical Psychologist conducting a research project as part of my Professional Doctorate in Clinical Psychology at the University of East London. I would like to invite you to take part in a research study that aims to gain an in-depth understanding of how women with eating disorders experience self-disgust. Disgust is a universal emotion which many people have reported experiencing about themselves, i.e. self-disgust.

Taking part in the study will involve talking about your understanding and experience of self-disgust. As an appreciation for your contribution to the study, you will have the option of being entered into a prize-draw for an Amazon voucher worth £30. The winner will be picked at random and notified shortly after the end of the study.

Before you decide if you would like to take part, it is important that you understand why the research is being done and what it will involve. Please take time to read this leaflet carefully. You do not need to decide whether or not to take part immediately.

Please ask me any questions. You can contact me on fatima.marinho@nhs.net. Otherwise you can inform your key clinician/care team that you would like to speak to me and I will contact you at the earliest opportunity.

Yours sincerely,

Fatima Marinho, Trainee Clinical Psychologist (15/11/2016)

Appendix 3 – Information Sheet Version 2.0 (26/07/2016)

Study Title: **An exploration of self-disgust in females with eating disorders**

The Principal Investigator: Fatima Marinho**,** e-mail: fatima.marinho@nhs.net
IRAS project ID: 205880

What is the research about?

This study aims to gain an in-depth understanding of how women with eating disorders understand, experience and manage self-disgust. Disgust is a universal emotion which many people have reported experiencing towards themselves, yet it remains an under-researched area. It is hoped that this study will enhance our understanding of this emotion, and contribute to the improvement of existing psychological interventions, thereby supporting those affected with eating disorders in a more effective way.

Why have I been asked to take part?

I am asking all women who are receiving support from this service to take part in this study.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you decide to take part I will ask you to sign a consent form. The consent form is a way of making sure that you know what you have agreed to. If you decide to take part you are still free to withdraw at any time without any disadvantage to yourself and without any obligation to give a reason. If you decide to withdraw from the research then any personal information you have provided will be deleted from the study. Any information that you have provided that is anonymous will remain in the study, and any further analysis that may be conducted for developing the research for publication. By anonymous information I mean information that no one, apart from myself, would be able to tell that has come from you.

The support and help you receive from your team will not be affected if you decide at anytime you do not want to take part in this study.

What is involved?

If you decide to take part, I will contact you to arrange a convenient time and place to meet. Taking part in the study will involve talking about your understanding and experience of self-disgust and positive emotions directed toward the self. The interview will last between 60-90 minutes, and will involve answering questions such as: what do you understand by self-disgust.

Location

Interviews will take place in a private room at X Trust.

Are there any disadvantages or risks to taking part?

It is not anticipated that you will be exposed to any risks or dangers as part of the study. However, it is possible that you might get upset when talking about your experiences either during or following the interview. If you do get upset, you will be offered an opportunity to take a break, to reschedule the interview for a different time or to end the interview if you feel unable to continue. You can contact your care team should you wish to or require support. I will also give you an information sheet with contact details for organisations that can offer support.

Are there any benefits from taking part in the study?

It is hoped that information generated from this study will help improve understanding of self-disgust in eating disorders, and contribute to the development of psychological treatment in the future. You may also appreciate having the opportunity to talk openly about your experiences.

As an appreciation for your contribution to the study, you will have the opportunity to be entered into a prize draw for an Amazon voucher worth £30. The winner will be picked at random and notified shortly after the end of the study.

Confidentiality of the Data

All the information you provide will be kept confidential. All paper information will be kept in a safe and secure place. The interviews will be recorded on a digital voice recorder and transcribed (typed word by word into text) for analysis. The recordings and transcripts will be stored securely in separate password protected

files on both a password protected memory stick and password protected computer. All names and other identifiable information will be changed in the transcripts to ensure anonymity.

The transcripts may be read by my supervisors at the University of East London, and the examiners who will assess my work when I hand in the research to be marked. No one else will be able to read the transcripts. The recordings will be destroyed at the end of the study. The anonymised written transcripts will be kept for five years, and might be used for developing the research for publication. Excerpts from the transcripts will be used anonymously as part of the thesis write up and may also be used in future journal publications. Every effort will be made to ensure that extracts from interviews are not identifiable.

It is important for you to know that if you disclose any information during the interview which suggests that either you, or someone else, is at risk of harm then I am obliged to inform your clinical team. This is because we want to make sure you and other people are safe. If this happens, I would always try to talk to you about this first.

Will the information I give be accessible to the care team within the Eating Disorders Service?

Only the researcher and her research supervisor will have access to the information you provide. The support and help you receive from your care team will not be affected if you decide to take part in this study, or if you decide at any time to withdraw from the study. If you feel any discomfort or distress, I would encourage you to seek support from your care team. I will also provide you with contact details of sources of support should you wish to access further support.

What will happen to the results of the research study?

The results and conclusions of the study will be written up as a doctoral thesis and may be submitted for publications in journals. You will not be identified in any publication. There is the potential that the research findings may be presented at conferences in the future, but again this would not include any information that could identify you.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, well-being and dignity.

Thank you very much for reading this information sheet and for thinking about this study. Please keep this information sheet for reference, and feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form prior to your participation.

If you have any questions or concerns about how the study has been conducted, or any other aspect of this research please contact the study's supervisor: Dr Katy Berg, School of Psychology, University of East London, Water Lane, London E15 4LZ. Telephone: 020 8223 4409, E-mail: k.l.berg@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mary Spiller, School of Psychology, University of East London, Water Lane, London E15 4LZ.

Tel: 020 8223 4004. Email: m.j.spiller@uel.ac.uk

Thank you in anticipation.

Yours sincerely,

Fatima Marinho, Trainee Clinical Psychologist (15/11/2016)

Appendix 4 – NHS Research Ethics Committee Letter

London - Surrey Borders Research Ethics Committee
Research Ethics Committee (REC) London Centre
Ground Floor
Skipton House
80 London Road
London
SE1 6LH
Telephone: 0207 972 2568

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

16 August 2016

Miss Fatima Marinho
Trainee Clinical Psychologist
Camden & Islington NHS Foundation Trust
University of East London
School of Psychology
Stratford Campus, Water Lane
E15 4LZ

Dear Miss Marinho

Study title:	**An exploration of self-disgust in females with eating disorders**
REC reference:	**16/LO/1262**
IRAS project ID:	**205880**

Thank you for your letter of 15 August 2016, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair in consultation with Ms Bongi Sibanda.

The Chair and Ms Sibanda acknowledged that you had taken the REC's concerns on board and consulted with both experts and patient groups.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager, Barbara Cuddon, nrescommittee.london-surreyborders@nhs.net.

Confirmation of ethical opinion
On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion
The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for NHS permission for research is available in the Integrated Research Application System, www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials
All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).
There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Letter confirming research registration]	Version 1.0	02 June 2016
Interview schedules or topic guides for participants [Interview Schedule]	Version 2.0	26 July 2016
IRAS Application Form [IRAS_Form_20062016]		20 June 2016
Letters of invitation to participant [Invitation Letter]	Version 1.0	29 February 2016
Other [Research Integrity Certificate]	Version 1.0	18 September 2015
Other [University Indemnity/Insurance Certificate 2015-2016]	Version 1.0	03 August 2015
Other [Cover Response Letter]		11 August 2016
Other [Letter from Research Supervisor]		28 July 2016
Other [Letter from Lead Clinical Psychologist (CNWL)]		02 August 2016
Other [Letter from Lead Clinical Psychologist (WLMHT)]		01 August 2016
Other [Letter from Beat]		10 August 2016
Other [Research Protocol]	Version 2.0	26 July 2016
Other [Sources of Information and Support]	Version 2.0	26 July 2016
Participant consent form [Consent Form]	Version 1.0	29 February 2016
Participant consent form [Consent Form]	Version 2.0	26 July 2016
Participant information sheet (PIS) [Information Sheet]	Version 1.0	29 February 2016
Participant information sheet (PIS) [Participant Information Sheet]	Version 2.0	26 July 2016
Referee's report or other scientific critique report [Feedback from University on initial research proposal]	Version 1.0	25 January 2016
Research protocol or project proposal [Final Version of Research Proposal]	Version 1.0	29 February 2016
Response to Request for Further Information		15 August 2016
Summary CV for student [CV (Chief Investigator)]		06 June 2016
Summary CV for supervisor (student research) [CV for Academic Supervisor]	Version 1.0	21 June 2016

Statement of compliance
The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review
Reporting requirements
The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback
The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/qualityassurance/

HRA Training
We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

16/LO/1262	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely

Pp Sir Adrian Baillie Chair

Email: nrescommittee.london-surreyborders@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: Professor Neville Punchard
Noclor, Central and North West London NHS Foundation Trust

Appendix 5 – NHS Research & Development Approval Letters

West London Mental Health NHS
NHS Trust

Miss Fatima Marinho
Trainee Clinical Psychologist
University of East London
School of Psychology
Stratford Campus
Water Lane E15 4LZ

West Mental Health Trust R&D Office
Trust Headquarters
1st Floor, Wing B
1 Armstrong Way
Middlesex
UB2 4SD

Tel: 020 8354 8738
Fax: 020 8354 8733
Email: research@wlmht.nhs.uk

20 September 2016

Dear Miss Marinho

Letter of access for research

As an existing NHS employee you do not require an additional honorary research contract with this NHS organisation. We are satisfied that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer. Your employer is fully responsible for ensuring such checks as are necessary have been carried out. Your employer has confirmed in writing to this NHS organisation that the necessary pre-engagement check are in place in accordance with the role you plan to carry out in this organisation. This letter confirms your right of access to conduct research through **West London Mental Health Trust** for the purpose and on the terms and conditions set out below. This right of access commences on **20/09/2016** and ends on **30/09/2017** unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

You are considered to be a legal visitor to **West London Mental Health Trust** premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through **West London Mental Health Trust**, you will remain accountable to your employer **Camden and Islington NHS Foundation Trust** but you are required to follow the reasonable instructions of your nominated **research supervisor** in this NHS organisation or those given on her/his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with **West London Mental Health Trust** policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with **West London Mental Health Trust** in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on **West London Mental Health Trust** premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with

patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and the Trust prior to commencing your research role at the Trust.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

West London Mental Health Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.
Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or suitability to work with adults or children, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the NHS organisation that employs you through its normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

Maria Tsappis

Maria Tsappis
Research Co-ordinator

West London Mental Health Trust, Trust Headquarters, 1 Armstrong Way, Middlesex, UB2 4SD

Tel: 020 8354 8358 | Web: www.wlmht.nhs.uk

Letter of access appendix - List of projects

Study Title: An exploration of self-disgust in females with eating disorders **R&D reference: MARFW1601** **REC reference: 16/LO/0262**		
Study duration:	**Start date: 20/09/2016**	**End date: 30/06/2017**
Letter of access duration:	**Start date: 20/09/2016**	**End date: 30/09/2017**
If any information on this document is altered after the date of issue, this document will be deemed INVALID		

West London Mental Health Trust, Trust Headquarters, 1 Armstrong Way, Middlesex, UB2 4SD

Tel: 020 8354 8358 | Web: www.wlmht.nhs.uk

1st Floor, Bloomsbury Building
St Pancras Hospital
4St Pancras Way
London, NW1 0PE

Tel: 020 3317 3045
Fax: 020 7685 5830
Email: contact.noclor@nhs.net
www.noclor.nhs.uk

15 November 2016

Fatima Marinho
Trainee Clinical Psychologist
Professional Doctorate in Clinical Psychology at the University of East London
Camden and Islington NHS Foundation Trust
St Pancras Hospital
4 St Pancras Way
London
NW1 0PE

Dear Fatima Marinho,

Employer: ***Camden and Islington NHS Foundation Trust***
Accountable to: **Mathew Pugh**

As an existing NHS employee you do not require an additional honorary research contract with this NHS organisation. We are satisfied that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer. Your employer is fully responsible for ensuring such checks as are necessary have been carried out. Your employer has confirmed in writing to this NHS organisation that the necessary pre-engagement checks are in place in accordance with the role you plan to carry out in this organisation. This confirms your right of access to conduct research through the trust(s) identified in the box below, for the purpose and under the terms and conditions set out in page 2 & page 3.

Study Title: Self-disgust in eating disorders Version 1.0 **R&D reference:** 205880 **REC reference:** 16/LO/1262		
Letter of access duration:	**Start date: 15/11/2016**	**End date: 01/05/2017**
Central and North West London NHS Foundation Trust		
If any information on this document is altered after the date of issue, this document will be deemed INVALID		

Yours sincerely,

Mabel Saili
Research Management & Governance Manager

Appendix 6 – University of East London Ethics Approval

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants
BSc/MSc/MA/Professional Doctorates

REVIEWER: Dr Anna Stone

SUPERVISOR: Dr Katy Berg

COURSE: Professional Doctorate in Clinical Psychology

STUDENT: Fatima Marinho

TITLE OF PROPOSED STUDY: An exploration of self-disgust in females with eating disorders

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY
(Please indicate the decision according to one of the 3 options above)

Approved with minor amendments

Minor amendments required *(for reviewer)*:

Please check that the DBS certificate is current and its validity will cover the duration of the research.

Major amendments required *(for reviewer):*

ASSESSMENT OF RISK TO RESEARCHER *(for reviewer)*
If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

- [ ] HIGH
- [ ] MEDIUM
- [x] LOW

Reviewer comments in relation to researcher risk (if any):

Reviewer *(Typed name to act as signature)*: Dr Anna Stone

Date: 22nd December 2016

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):* Fatima Marinho
Student number: U1438321

Date: 9th January 2017

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

PLEASE NOTE:
*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel overseas to collect data, even if this involves the researcher travelling to his/her home country to conduct the research. Application details can be found here: http://www.uel.ac.uk/gradschool/ethics/fieldwork/

Appendix 7 – Consent Form

Consent Form Version 2.0 (26/07/2016)

1 copy for participant and 1 for investigator file

Study Title: Exploring self-disgust in females with eating disorders

Name of Researcher: Fatima Marinho, e-mail: fatima.marinho@nhs.uk

IRAS project ID: 205880

Please initial box:

1. I confirm that I have read the information sheet dated 26/07/2016 (version 2.0) about the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me. ☐

2. I understand that my involvement in this study and particular data from this research will remain strictly confidential. Only the researcher involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed. ☐

3. I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. ☐

4. I understand that should I withdraw, the researcher reserves the right to use my anonymous data in the write-up of the study, and in any further analysis that may be conducted by the researcher. ☐

Participant's Name (BLOCK CAPITALS) Participant's Signature

…… ……

Researcher's Name (BLOCK CAPITALS) Researcher's Signature

…… ……..

Date: ……..…….

Appendix 8 – Sources of Information and Support

Sources of Information and Support Version 2.0 (26/07/2016)

Thank you for taking the time to participate in the study. As you know, your clinician at the X Eating Disorders Service is aware of this study, and you can talk to them about how you feel following participation should you wish to or require support. You can also access the **X Trust urgent advice line number: X**.

There are also a number of national organisations and helplines that you may find helpful. These include:

Beat, the leading UK charity for people with eating disorders and their families, which provides information, help and support. Their helpline staff have received a comprehensive training programme, and are there to listen. They will offer information about sources of help available. Beat also has an email service and an online one-to-one service.

Help for Adults

The Beat Adult Helpline is open to anyone over 18 who needs support and information relating to an eating disorder. Helpline: 0345 634 1414
Website: www.b-eat.co.uk Email: help@b-eat.co.uk

Help for young people

If you are 25 or under, you can call the Beat Youthline: 0345 634 7650.
Email: fyp@b-eat.co.uk

Both helplines are now open Monday to Wednesday from 1pm to 4pm. They are aiming to return to normal hours of operation as soon as possible. If you need support outside of these hours, you can email their Helpline staff (details above) or access their Message Boards.

Samaritans:

Confidential support for people experiencing feelings of distress or despair.

Free Helpline Number: 116 123 (24-hour helpline) Website:

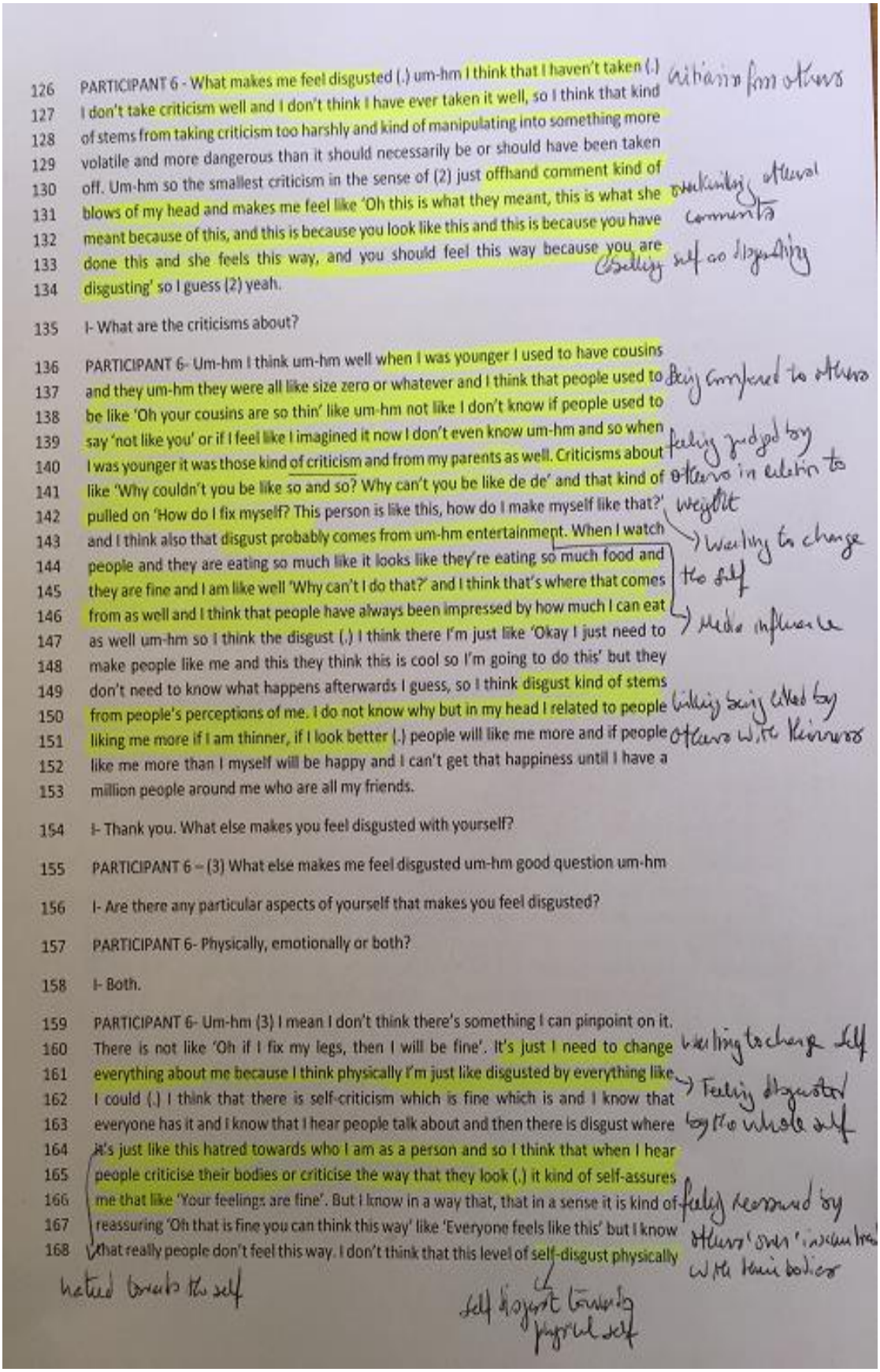
www.samaritans.org.uk

In an emergency please contact your GP or go to your nearest A&E department.

Appendix 9 – Transcription Notation System (adapted from Braun & Clarke, 2013)

I:	Indicates interviewer is speaking
(.)	Indicates a short pause of a second
(number**)**	Indicates a longer pause, e.g. (5) for 5 second pause
((inaudible**))**	Indicates inaudible speech. When some can be heard single parentheses were used to indicate best guess, e.g. (ways of life)
(laughs**)**	Indicates laughter
xxx	Indicates identifiable information has been removed to ensure anonymity
'text**'**	Inverted commas indicate when a person provides an apparent verbatim account of the speech or thoughts of another person or their own thoughts or past speech, e.g. I said 'I don't know'.
<text**>**	Indicates a brief interjection when another person is speaking, e.g. 'I will ask you about your experiences of this <OK> before'.

Appendix 10 – Example of Coded Transcript Excerpt



PARTICIPANT 6 - What makes me feel disgusted (.) um-hm I think that I haven't taken (.) I don't take criticism well and I don't think I have ever taken it well, so I think that kind of stems from taking criticism too harshly and kind of manipulating into something more volatile and more dangerous than it should necessarily be or should have been taken off. Um-hm so the smallest criticism in the sense of (2) just offhand comment kind of blows of my head and makes me feel like 'Oh this is what they meant, this is what she meant because of this, and this is because you look like this and this is because you have done this and she feels this way, and you should feel this way because you are disgusting' so I guess (2) yeah.

I- What are the criticisms about?

PARTICIPANT 6- Um-hm I think um-hm well when I was younger I used to have cousins and they um-hm they were all like size zero or whatever and I think that people used to be like 'Oh your cousins are so thin' like um-hm not like I don't know if people used to say 'not like you' or if I feel like I imagined it now I don't even know um-hm and so when I was younger it was those kind of criticism and from my parents as well. Criticisms about like 'Why couldn't you be like so and so? Why can't you be like de de' and that kind of pulled on 'How do I fix myself? This person is like this, how do I make myself like that?' and I think also that disgust probably comes from um-hm entertainment. When I watch people and they are eating so much like it looks like they're eating so much food and they are fine and I am like well 'Why can't I do that?' and I think that's where that comes from as well and I think that people have always been impressed by how much I can eat as well um-hm so I think the disgust (.) I think there I'm just like 'Okay I just need to make people like me and this they think this is cool so I'm going to do this' but they don't need to know what happens afterwards I guess, so I think disgust kind of stems from people's perceptions of me. I do not know why but in my head I related to people liking me more if I am thinner, if I look better (.) people will like me more and if people like me more than I myself will be happy and I can't get that happiness until I have a million people around me who are all my friends.

I- Thank you. What else makes you feel disgusted with yourself?

PARTICIPANT 6 – (3) What else makes me feel disgusted um-hm good question um-hm

I- Are there any particular aspects of yourself that makes you feel disgusted?

PARTICIPANT 6- Physically, emotionally or both?

I- Both.

PARTICIPANT 6- Um-hm (3) I mean I don't think there's something I can pinpoint on it. There is not like 'Oh if I fix my legs, then I will be fine'. It's just I need to change everything about me because I think physically I'm just like disgusted by everything like I could (.) I think that there is self-criticism which is fine which is and I know that everyone has it and I know that I hear people talk about and then there is disgust where it's just like this hatred towards who I am as a person and so I think that when I hear people criticise their bodies or criticise the way that they look (.) it kind of self-assures me that like 'Your feelings are fine'. But I know in a way that, that in a sense it is kind of reassuring 'Oh that is fine you can think this way' like 'Everyone feels like this' but I know that really people don't feel this way. I don't think that this level of self-disgust physically

is right and so I don't know I feel like if I could chop and change my whole outer self with someone else I would 100% do it. Again with emotionally as well I don't feel like there is an aspect of me where I'm like 'Oh yeah that part of me is great, I will keep that'. It's just I like I look (.) I'm repulsed by who I am as a person um-hm yeah I feel like if I could completely chop and change my personality I would as well and I don't think that is a rational thought. I don't think that so yes so even though I am saying it, I'm just like 'Oh other people feel like this, it is completely normal'. I don't (.) I don't know it's so I don't think I can pinpoint where exactly disgust is body wise slash emotion wise. I just yeah, I just feel like I see what people look like and I kind of crave that kind of lifestyle. I crave how they look and so it's just like 'Oh if I (.) if my stomach or my legs looked like that, if I was able to do this in the gym', or 'if I was to do this running wise then I would be happy. That it is what happiness is and I wouldn't feel this way'. So it's just everyday it would be like a new niggling thought of 'Oh you need to change this, I need to change this' so there is no (2) I don't think there is a pinpoint.

Wanting to change how the self looks

feeling repulsed by the whole self

comparing self to others wanting to look like others

Constant thought about changing the self

I – And you mentioned your personality, are there any particular aspects of your personality that makes you feel disgusted with yourself?

PARTICIPANT 6- Um-hm I think (3) um-hm disgusted with myself personality um-hm I think that because of the disgust I'm very quick to snap so it's kind of like a catch twenty-two where the disgust has made me very on edge about comments and things like that, and I'm like so disgusted about that aspect of me so it's a bit um-hm so when people (.) I think that I'm very well I have been told that I'm very sensitive, so if someone says something like ((inaudible)) I'm unable to just take it as face value. I've to read into, I need to see and I kind of like completely screws with my head because it makes me undermine (2) everything that they are saying and it makes me undermine myself like someone can just say an offhand comment about me or just anything and I will be like 'Oh why do they say that? Why did they said that? Why do you think this? It's because they think this, because they want to do this, it's because they think' and it's kind of (.) it's just a comment and I'm unable to just process it as just a comment. I read too much in to it and also I think probably relationships wise, disgust comes there because I see (2) I'm disgusted with myself for being unable to have a normal relationship and I wish I could fix that part of me where it's just like fine. Like I don't have to be so disgusted with myself for not having normal relationships. I'm so attached to the fact that 'If I had these people as my friends, if I had these people in my life, then I would be happy' and I think I really let myself have it for not achieving those friendships and not achieving those relationships.

disgusted by own personality

Overthinking others comments

Not having normal relationships ↓ as elicitor of feelings of self-disgust

I – What do you mean by normal relationships?

PARTICIPANT 6 – Like in terms of platonic relationships just like friends that you can just go out with and just think (.) I feel that everyone, I feel that everyone in my life has always had like a best friend or someone they can talk to and I feel like that I don't have that, and I feel like (2) and that comes from also whenever I have had someone who I can get close to, I am just like 'Oh I'm a burden to her, I'm keeping secrets from her, she doesn't know about me, how will I explain my situation to her, she I mean nothing to her, she has better friends, she doesn't want to hang out with me, this is pity'. It feels like I would never be able to kind of break this like the platonic barrier which kind of takes me from (2) takes me from having a close friend. I feel like everyone I have ever been friends with has always been like 'You always keep me at arms distance'. I don't

finding it hard to get others get close ↓ feeling a burden

Appendix 11 – List of Initial Codes

1. Accepting self-disgust
2. Ashamed for comfort eating and gaining weight
3. Associating thinness with happiness
4. Avoid looking at the self
5. Avoid thinking/blocking thoughts
6. Avoiding intimate relationships
7. Becoming judgmental of others as a way of shifting focus from self
8. Being around overweight people as being both helpful and unhelpful
9. Being or feeling judged by others
10. Being repulsed by the self
11. Being sedentary
12. Being self-critical
13. Blaming the self
14. Body weight and gaining weight as disgusting
15. Calming breathing
16. Colouring
17. Comparing self to others
18. Critical negative voice
19. Diets
20. Discrimination in employment
21. Dislike of the self
22. Distancing self from others
23. Eating and overeating as eliciting self-disgust
24. Family factors
25. Feeling a failure
26. Feeling angry towards the self
27. Feeling angry with others/family
28. Feeling different from other people
29. Feeling disappointed with self
30. Feeling disgusted by own behaviour/actions
31. Feeling disgusted by the ED
32. Feeling disgusted by the whole self
33. Feeling frustrated with own ED difficulties
34. Feeling powerless and hopeless
35. Feeling trapped within the self
36. Feeling unattractive and unworthy of a partner
37. Feeling worthless
38. Focus on (own and others) body size
39. Food as comfort and a distraction
40. Food as the only coping mechanism
41. Food as unhelpful and one's enemy
42. Gastric band surgery
43. Getting a pet
44. Getting on with life

45. Going to the gym/over-exercise
46. Having a positive attitude and outlook on life
47. Having thoughts of ending own life
48. Helpful to be with other people/friends
49. Imagining to be someone else
50. Impact of difficult life experiences on self-disgust
51. Influence of media
52. Influence of one's own ethnicity and culture
53. Isolating self
54. Labelling self as fat and disgusting
55. Lack of (or losing) control in relation to eating
56. Loathing of the self
57. Meditate
58. Mental health stigma
59. Negative attitudes and behaviour of others
60. Origins in childhood
61. Perceived change in self-disgust over time
62. Perception of self as not managing feelings of self-disgust
63. Perfectionism
64. Punishing the self
65. Purging as being an accomplishment
66. Pushing feelings away
67. Recognising own cognitive distortions
68. Religion as intensifier of self-disgust
69. Religion as a protective factor
70. Rumination
71. Sadness
72. Satisfaction from job/work
73. Seeing own appearance as disgusting
74. Self-disgust as unhelpful
75. Self-disgust as a transient experience
76. Self-disgust as an enduring emotional experience
77. Self-disgust as being overwhelming
78. Self-hatred
79. Sleep as helpful
80. Smell of food as eliciting feelings of disgust
81. Societal expectations and pressure to look a certain way
82. Suffering from or getting into depression
83. Taking painkillers to numb emotional pain
84. Therapy as helpful
85. Thinking about losing weight
86. Trying to be self-compassionate
87. Trying to feel better by acknowledging everyone has problems
88. Two versions of self (emotional and intellectual)
89. Two versions of self (private and public)
90. Using distraction as a coping strategy

91. Using make-up and clothes to feel better
92. Using self-talk as a coping strategy
93. Vicious cycle
94. Vomiting and exercising as ways of managing self-disgust
95. Vomiting as eliciting negative feelings towards the self
96. Wanting to be liked and accepted by others
97. Wanting to change the self
98. Wanting to love (like) oneself and gaining a sense of self-worth
99. Weight stigma

Appendix 12 – Examples of Coded Extracts

Code	Extract
Feeling worthless (Code number 37)	not feeling self-worth because I didn't feel that I had self-worth erm because I have been unemployed for such a long time and I felt like even when I first came here he said something and I said 'Oh I am not really doing anything really', and then he was like 'Well you are', he goes 'You are doing all the cooking, cleaning and you are paying all the bills'. And I had never had any self-worth from what I had because my family doesn't see that as anything. (Charlotte)
	if I'm having a bad day, they can spiral into more dark sort of things of not being worthy, feeling worthless. this particular issue feels like this mountain um-hm is the worthlessness that comes with it and often you feel like (.) I feel like yeah if I wasn't fat, if I didn't have this problem, if I didn't eat the way I ate, I would then be worthy of a partner, a decent life you know a normal life of a thirty-three year old (Nadia)
	Um-hm disgust at the way I feel emotionally because I feel very unworthy I guess is one um-hm for the way I feel. (Kiran)
	You feel like being worthless and I don't know it's difficult to explain. telling myself that 'You are disgusting, you are worth nothing. (Lucinda)
	Yeah, feeling like worthless and Gosh I don't know. just feel like 'honestly again' like (laughs) 'you are worthless, you're a disappointment'

	Yeah but I feel like I'm nothing. I'm worthless. (Amy)
Labelling the self as fat and disgusting (Code number 54)	I felt that I just had food and then just eat and feel 'Ah I'm a disgusting pig. Why can't I control myself? Why am I eating so much? Why can't I eat like normal people?' (Charlotte)
	Yeah, so if I overate and then I probably think 'You already ate more than you were going to eat you might as well eat everything because you are a pig'. (Joanne)
	They can spiral. They may start with 'You are disgusting' you know 'Look at you, you're horrible'. it may just be 'Well you know you are fat. (Nadia)
	Like you think about it all day like 'I'm a horrible person' and you start labelling yourself like 'I'm disgusting and fat or ugly'. So you label yourself with those words. Just thinking negative things about myself like, like how I was like such a pig or fat or thinking about like how it happened like how in all these days like you were like you are fat on those days. (Lucy)
	Um-hm you're really, really fat. You have gone fatter. Even though I haven't eaten anything or drank anything, you look really, really fat. Fat, fat, fat. That is going through my head. Fat, fat and go on and on, you look really, really ugly. You look disgusting. (Amy)
	telling myself that 'You are disgusting, you are worth nothing. (Lucinda)

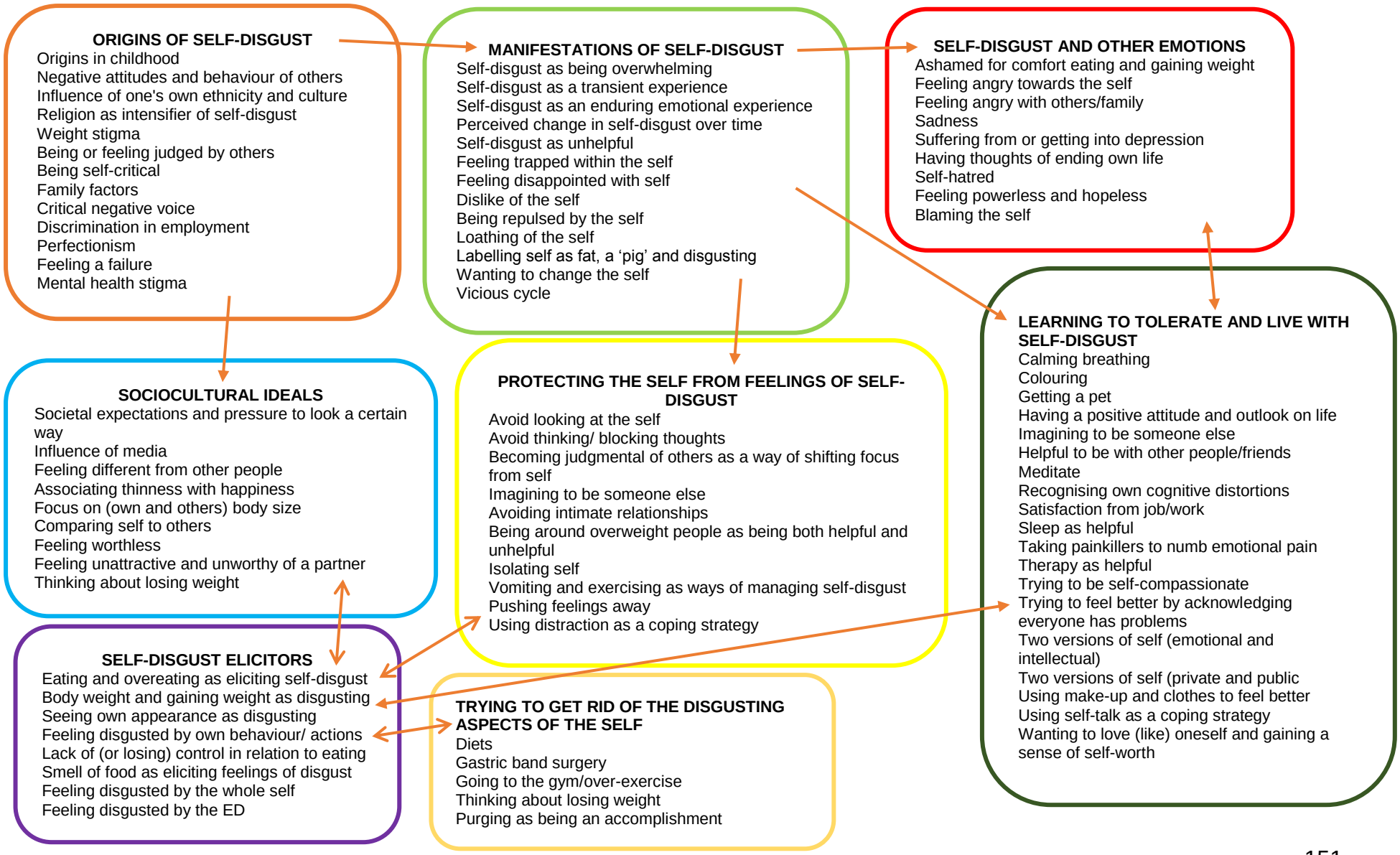
Appendix 13 – Initial Identification of Potential Themes

Initial Theme	Grouped Codes
Origins of self-disgust	- Origins in childhood - Negative attitudes and behaviour of others - Influence of one's own ethnicity and culture - Religion as intensifier of self-disgust - Weight stigma - Being or feeling judged by others - Being self-critical - Family factors - Critical negative voice - Discrimination in employment - Perfectionism - Feeling a failure - Mental health stigma
Sociocultural ideals	- Societal expectations and pressure to look a certain way - Influence of media - Feeling different from other people - Associating thinness with happiness - Focus on (own and others) body size - Comparing self to others - Feeling worthless - Feeling unattractive and unworthy of a partner - Thinking about losing weight
Manifestations of self-disgust	- Self-disgust as being overwhelming - Self-disgust as a transient experience - Self-disgust as an enduring emotional experience - Perceived change in self-disgust over time - Self-disgust as unhelpful - Feeling trapped within the self - Feeling disappointed with self - Dislike of the self - Being repulsed by the self - Loathing of the self - Labelling self as fat, a ‘pig’ and disgusting - Wanting to change the self - Vicious cycle
Self-disgust elicitors	- Eating and overeating as eliciting self-disgust

	- Body weight and gaining weight as disgusting - Seeing own appearance as disgusting - Feeling disgusted by own behaviour/ actions - Lack of (or losing) control in relation to eating - Smell of food as eliciting feelings of disgust - Feeling disgusted by the whole self - Feeling disgusted by the ED
Trying to get rid of the disgusting aspects of the self	- Diets - Gastric band surgery - Going to the gym/over-exercise - Thinking about losing weight - Purging
Self-disgust and other emotions	- Ashamed for comfort eating and gaining weight - Feeling angry towards the self - Feeling angry with others/family - Sadness - Suffering from or getting into depression - Having thoughts of ending own life - Self-hatred - Feeling powerless and hopeless - Blaming the self
Protecting the self from feelings of self-disgust	- Avoid looking at the self - Avoid thinking/ blocking thoughts - Becoming judgmental of others as a way of shifting focus from self - Imagining to be someone else - Avoiding intimate relationships - Being around overweight people as being both helpful and unhelpful - Isolating self - Vomiting and exercising as ways of managing self-disgust - Pushing feelings away - Using distraction as a coping strategy
Learning to tolerate and live with feelings of self-disgust	- Calming breathing - Colouring - Getting a pet - Having a positive attitude and outlook on life - Imagining to be someone else - Helpful to be with other people/friends

	- Meditate - Recognising own cognitive distortions - Satisfaction from job/work - Sleep as helpful - Taking painkillers to numb emotional pain - Therapy as helpful - Trying to be self-compassionate - Trying to feel better by acknowledging everyone has problems - Two versions of self (emotional and intellectual) - Two versions of self (private and public - Using make-up and clothes to feel better - Using self-talk as a coping strategy - Wanting to love (like) oneself and gaining a sense of self-worth

Appendix 14 – Initial Thematic Map



Appendix 15 – Reflective Journal Extract

Reflections Made During the Recruitment Phase

Beginning of December 2016: When I started the recruitment process in October 2016, I was feeling hopeful about recruitment. I had good feedback from the initial team meetings at both recruitment sites which made me think hopeful about recruitment particularly given the relative small sample required. I've kept regular contact with local collaborators via e-mail and have been trying to schedule follow-up visits to the teams. Despite my recruitment efforts, the clinical teams haven't yet identified any potential participants. I'm concerned about recruitment particularly given the time constraints of the thesis. I've thought about what the issues might be (e.g. perhaps staff found it difficult to hold in mind the study due to the demands of their job) and have been trying to keep regular contact with the teams (via e-mail/telephone) but response has been poor. Feeling powerless and frustrated. My anxiety levels have started to increase with regards to deadlines and workload. Will seek supervision to discuss recruitment strategy and discuss options.

Reflections Made After Interview 1

End of January 2017: I was feeling both happy and anxious about having recruited first participant. The interview lasted one hour and half. The participant was very open about her experiences and she provided detailed accounts of her understanding and experience of self-disgust. I was mindful to not make assumptions based on my personal experience of being exposed to societal discourses and media portrayals of the ideal body type when she talked about her experiences of being bullied and judged by her body weight/shape. I was also careful to remain curious about her understanding of self-disgust and not let my familiarity and knowledge of the relevant literature to bias in any way my follow-up questions. I actively sought clarification of what she was saying or what she meant. I was also keen to ensure I explored all aspects of her experience of self-disgust by asking follow-up questions such as 'Is there anything else that….?' This elicited further descriptions of her experience which at times sounded a bit repetitive. This made me wonder whether I was asking too many follow-up questions and whether I was asking the 'right' questions. However, it became

evident throughout the interview that she had rich narratives around her experience of self-disgust, and that she wanted to share these with me. During the debriefing, she shared that in the last two years it had become easier for her to be open about her experiences and that she had reflected on her experiences during therapy. This made me wonder about what it may have been like if she had not had the opportunity to reflect and process her experiences before taking part in the study. I wondered whether the information gathered during future interviews may be influenced by whether participants have had therapy. I sought to remain mindful of this during future interviews as well as during the process of analysing the interview data.