PROFESSIONAL DOCTORATES

Eating Disorder Recovery: An exploration of the influence of sociocultural factors

Bale, Rebecca

Award date:
2022

Awarding institution:
Bangor University

Eating Disorder Recovery: An exploration of the influence of sociocultural factors

Rebecca Bale

North Wales Clinical Psychology Programme

PRIFYSGOL BANGOR UNIVERSITY

Submitted in partial fulfilment for the degree of Doctorate in Clinical Psychology

28/06/2022

Table of Contents

Eating Disorder Recovery: An exploration of the influence of sociocultural factors

Declaration

I hereby declare that this thesis is the results of my own investigations, except where otherwise stated. All other sources are acknowledged by bibliographic references. This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree unless, as agreed by the University, for approved dual awards.

Yr wyf drwy hyn yn datgan mai canlyniad fy ymchwil fy hun yw'r thesis hwn, ac eithrio lle nodir yn wahanol. Caiff ffynonellau eraill eu cydnabod gan droednodiadau yn rhoi cyfeiriadau eglur. Nid yw sylwedd y gwaith hwn wedi cael ei dderbyn o'r blaen ar gyfer unrhyw radd, ac nid yw'n cael ei gyflwyno ar yr un pryd mewn ymgeisiaeth am unrhyw radd oni bai ei fod, fel y cytunwyd gan y Brifysgol, am gymwysterau deuol cymeradwy

Signed: *R.Bale*

Date: 27.06.2022

Acknowledgements

Firstly, to the eight people who shared their stories with me and made this research possible, I am so incredibly grateful and privileged to have heard your stories, I hope I have done them justice. I know many of you talked about a desire for change as motivating you to take part, I hope this may go at least some way to making that happen.

Next, to Mike and Tamsin thank you for all your support and guidance throughout this process. Your insights and encouragement have been so helpful in getting me through the many hurdles that inevitably arose.

Thank you to my family and friends who have put up with my prolonged periods of retreat and silence, I look forward to spending some quality time with you all soon, uninterrupted by intrusive thoughts of word counts, citations, and abstract reviews. A special thanks to Gem for all the beautiful ways you have encouraged me over the last three years, and specifically in writing this thesis, your care packages and proof-reading skills have made so much difference.

To mum, thank you for all the ways you have loved and supported me throughout my life, not least for endlessly believing in my dream of clinical psychology and supporting me and Sim in our decision to move to North Wales. I can't wait to walk at Newborough and Llanfairfechan with you soon.

To Ezra and Ari, my beautiful boys, thank you for the endless distractions and disruptions over the last three years. Whilst I'm still not convinced that having children during training helps you find balance, you have certainly provided so much love and fun and been the best reminder of what's really important in life. I love you both very much.

Lastly, to Sim, this literally would not have been possible without your support, you have stepped up time and time again to get us all through what has undeniably been the most intense three years. Thank you for taking this adventure with me, I look forward to seeing what the next chapter holds.

Thesis Summary

This thesis explores sociocultural factors and their influence on eating disorder recovery.

Chapter one is a systematic review of existing research which explores religion and spirituality in the treatment of, and recovery from eating disorders. It aims to answer three questions 1. How is religion and spirituality integrated into treatment for eating disorders? 2. How does religion and spirituality benefit treatment of and recovery from an eating disorder? 3. What challenges does religion and spirituality present to recovery from an eating disorder and are there any risks to incorporating religion and spirituality in recovery and treatment? Nineteen papers were identified which include a range or qualitative and quantitative methodologies, exploring a number of religions and spiritual orientations, though Christian-Judeo faiths are the most represented. Religion and spirituality within treatment were largely viewed as acceptable and beneficial to participants and patients, particularly where they possessed prior religious beliefs or spiritual orientation. Amongst those with no prior affiliation or orientation, findings were mixed in relation to both acceptability, and perceived effectiveness or supportiveness. A small minority of patients with entangled religious beliefs and symptomology presented an additional challenge to treatment teams, and incorporation of religious leaders in teams was helpful in addressing these. Results are discussed in relation to current conceptualisations of religion and spirituality and clinical implications and future research directions are discussed.

Chapter two is an investigation into the experiences of recovering from an eating disorder within the context of diet culture in the United Kingdom. Eight adults who self-identified as having an eating disorder and either recovered or in recovery shared their experiences. Narrative methodology was used to analyse their stories to identify a master narrative which captured the challenges and processes of recovery within a society that privileges thin bodies and encourages weight control whilst discriminating against those in bigger bodies. Narratives captured the additional challenges diet culture poses to the complex challenge of recovery and identifies how developing a critical awareness of diet

culture supports people in changing their perspective to their eating disorder and increases motivation for recovery.

Chapter three is a discussion of the clinical and research implications of these findings. Particular attention is paid to the need to incorporate broader sociocultural factors into our understanding of eating disorder development, maintenance and recovery as encouraging people to become critical consumers of cultural forces and societal assumptions may go some way to addressing the common barriers of motivation and lack of insight in eating disorder recovery.

Chapter 1-Systematic Review

Exploring the influence and incorporation of religion and spirituality in eating disorder treatment and recovery

Rebecca Bale[1,] Dr Mike Jackson[2] and Tamsin Speight[3]

1. North Wales Clinical Psychology Programme, School of Psychology, Bangor University, Bangor, UK
2. North Wales Clinical Psychology Programme, School of Psychology, Bangor University, Bangor, UK
3. Specialist Adult Eating Disorder Service, Cartref, Bryn Y Neuadd, Llanfairfechan, Conwy, LL30 0HH

Corresponding Author: Rebecca Bale, North Wales Clinical Psychology Programme, School of Psychology, Bangor University, Bangor, UK. Email: rbb19ckl@bangor.ac.uk

---

This paper will be submitted to the Journal of Eating Disorders

Journal of Eating Disorders | Preparing your manuscript (biomedcentral.com)

Abstract

Eating disorders are serious mental health disorders and a global concern, recovery is a complex process and as such extensive research has aimed to identify effective interventions to treat these disorders. A growing body of research is exploring the association between religion or spirituality on eating disorder recovery, and the effectiveness of incorporating these into treatment. Whilst there is no consensus as to the conceptualisation of religion and spirituality and the extent to which they can be differentiated, promising effects and relationships are being identified. The aim of this review was to examine and synthesise research on religion and spirituality within eating disorder recovery and treatment. The results highlight positive perceptions of religion and spirituality in their recovery and treatment amongst participants, beneficial effects of spiritual well-being on treatment outcomes and buffering the deleterious effects of the eating disorder on broader mental health, and the importance of spiritual sensitivity and openness amongst staff and services. A small number of studies identify challenges and risks such as religious belief and symptomology entanglement which threatens treatment or faith, and negative perceptions of religious or spiritually oriented interventions amongst people of no prior affiliation or negative previous experiences. Implications and limitations are discussed.

Key words; eating disorders, spirituality, religion, eating disorder recovery, eating disorder treatment.

Introduction

Whilst once considered almost exclusive to Caucasian adolescent females in high income Western countries, eating disorders are now known to be a global concern (Pike & Dunne, 2015). “Westernisation” including increased exposure to the ‘thin ideal’ and diet industry (Papezova, 2002) industrialisation, globalisation, and urbanisation (Pike et al., 2014; Pike & Dunne, 2015) along with changes in diagnostic practises within these cultures (Hoek, 2016) are thought to explain the rise in global prevalence of recent years. Integrating eating disorder prevalence data is complex (Galmiche et al., 2019) and results of recent reviews are variable, with estimates ranging from 9% (Arcelus et al., 2011) to 0.1-1% (Saloni et al., 2021) though only anorexia and bulimia were included in this study. Variations in inclusion of diagnoses may reflect the diverse ways eating disorders are conceptualised between cultures and countries.

As understanding of who experiences eating disorders has broadened, so has insight into aetiology, which are now thought to be best understood through a biopsychosocial perspective (Maine et al., 2014). This recognises genetic factors (Mazzeo & Bulik, 2008), social factors including internalisation of the thin ideal, and cognitive factors such as personality and negative emotionality (Keel & Forney, 2013) that affect the development of an eating disorder.

Increases in occurrence of eating disorders amongst more diverse populations, and deepening understanding of their causes has created a cyclical process of challenging treatment and interventions to similarly diversify, which further expands understanding of factors relevant in their development and maintenance. For example, interest in how services effectively address eating disorders in members of the global majority (Acle et al., 2021) men (Strother et al., 2012) transgender individuals (Duffy et al., 2016;) and amongst the elderly (Mulchandani et al., 2021) have found contributing factors unique to each of these groups.

Similar observations have been made amongst other complex mental health disorders and one increasingly acknowledged avenue for exploration has been the

relationship between religion and spirituality, and mental health. A systematic review of 43 publications exploring religion, spirituality, and mental disorders found that 72.1% of included studies reported positive effects of religion and spirituality on mental health, whilst 4.7% reported negative effects (Bonelli & Koenig, 2013). When reviewed according to diagnosis, the effects of religion and spirituality were found to be 100% positive for dementia, suicide, and stress-related conditions, 79% positive for depression and 67% positive for substance abuse, mixed results were reported for schizophrenia, and no association was found with bipolar disorder.

Within eating disorders, religion and spirituality have been researched in relation to risk of eating disorder development. Akrawi et al., (2015) reviewed 22 studies exploring the relationship between religiosity, spirituality and disordered eating and body image concerns. Overall, they found that strong internalised religious beliefs, alongside a secure and satisfying relationship with God were associated with lower levels of disordered eating, psychopathology, and body image concerns. However, a superficial faith, characterised as a lack of internalised beliefs where religion was pursued for social reasons, acceptance, security, and status, coupled with an anxious or doubtful relationship with God were associated with greater levels of disordered eating and body image concerns. Whilst participants represented in this review were mostly Christian, Jewish including Orthodox Jewish, Muslim, Buddhist, and Hindu faiths were also included, as were participants with no religious faith.

Both Akrawi et al., (2015) and Bonelli and Koenig, (2013) discuss the wide variety of measures used by studies in their reviews as limitations. Akrawi et al., acknowledges that the multifaceted nature of religiosity and spirituality naturally increases the variety of measures used to assess these concepts yet prevents opportunities for inter-study comparison. Furthermore, Bonelli and Koenig questions how well spirituality has been differentiated from religion and stresses the need for future research to clearly define these terms, particularly in how they differ from one another. Koenig et al., (2008) describes how the definition of spirituality has expanded, having traditionally been used to describe a

deeply religious person to now incorporate superficially religious people, people seeking religion, those seeking well-being and happiness, and the completely secular person alike. They critique measurements as reflecting this trend, arguing they are heavily contaminated with questions assessing character traits, or mental health not spirituality. They even go so far as to state that spirituality should either be defined and measured in traditional terms or eliminated from use.

However, much research has sought to explore associations between both religion and spirituality and mental health treatment or other complex mental health disorders, which again provide insight into eating disorders. Over the last two decades spirituality has been viewed as more pertinent to the delivery of person-centred treatment approaches for mental health within the UK (Forrester-Jones et al., 2018). Leamy et al., (2011) proposed a conceptual framework for personal recovery from mental ill health which comprised three categories, one of which was the process of recovery which encompassed connectedness, hope and optimism about the future, identity, meaning in life, and empowerment. In this model spirituality is incorporated in finding “meaning in life.” A systematic review exploring the inclusion of spirituality in addiction treatments found that whilst spiritual treatments were not more effective than other treatments, elevated levels of spirituality and spiritual practices improved substance use outcomes and other areas of recovery (Garcia et al., 2017).

Furthermore, a strong body of evidence exists which states that people with lived experience of mental health difficulties want spirituality and religion to be incorporated into treatment (D’Souza, 2002; Macmin & Foskett, 2004; Harris et al., 2016). Spirituality was found to be important to most patients in these studies, and they wanted doctors or therapists to take their spiritual needs into account, but this did not routinely happen. Comparable results have been reported in relation to religious faith (Moss & Gilbert, 2007) where patients perceive their spiritual or religious beliefs to improve coping yet experience services as dismissive of their beliefs (Awara & Fasey, 2008). For some, this may be additionally painful, as they often already feel let down by their faith communities due to stigma or misunderstanding within them (Moss et al., 2007). Conversely, where

professionals are perceived to be genuinely interested in and aim to understand a patient's beliefs, even those that could be considered extreme, they were viewed to be more empathic and the relationships more meaningful (Macmin et al., 2004).

The Present Review

Considering the context discussed above, a growing body of research is being produced which explores the relationship between religion, spirituality and eating disorder recovery and treatment. As such, this review aims to identify and summarise this research, to our knowledge this is the first review focusing exclusively on religion and spirituality in treatment and recovery from eating disorders. The focus of our review is threefold:

- How is religion and spirituality integrated into treatment for eating disorders?
- How does religion and spirituality benefit treatment of and recovery from eating disorders?
- What challenges does religion and spirituality present to recovery and are there risks to incorporating religion and spirituality in recovery and treatment?

Method

Pre-Registration

To make the methodological process transparent, and prevent duplication of the review, the protocol was developed and registered with PROSPERO prior to beginning database searches, registration ID: CRD42022303456.

Inclusion Criteria & Exclusion Criteria

The review focused on the incorporation or utilisation of religion and spirituality in treatment of or recovery from eating disorders. A first task was to define what was meant by these terms, both religion and spirituality are recognised as multi-faceted and complex in nature (Spilka & McIntosh, 1996; Marty & Appleby, 1991). As such, existing research into religion and spirituality within mental health services were searched to find definitions used. Definitions used in a review into adolescent mental health (Wong et al., 2006) were eventually selected. Religiosity was defined as "one's relationship with a particular faith tradition or doctrine about a divine other or supernatural power" (Reich et al., 1999).

Spirituality was defined as “the intrinsic human capacity for self-transcendence, in which the self is embedded in something greater than the self, including the sacred and which motivates the search for connectedness, meaning, purpose and contribution” (Benson et al., 2003).

For a study to be included in the review it had to include participants with an eating disorder diagnosis of Anorexia Nervosa, Bulimia Nervosa, Binge eating Disorder, Other Specified Feeding or Eating Disorder, or Eating Disorder Not Otherwise Specified. Diagnoses could include formal diagnoses, for example given by a health professional, or following a clinical assessment, and self-identified diagnoses. Studies which spoke of only obesity were excluded. One study was an exception to this, Ronel et al., (2013) interviewed participants identified as ‘compulsive over-eaters’, however the decision was made to include this study in the review as when defining the ‘problem’ they discuss compulsiveness as relating to bulimia and anorexia. Similarly, a narrative review of over-eating (Davis, 2013) strongly suggests that overeating “may best be viewed along a dimension reflecting degrees of severity and compulsiveness and that the high end of the continuum marks the clinically significant impairment seen in binge eating disorder”, as such it is reasonable to assume that amongst their 20 participants, some would meet diagnostic criteria for binge eating disorder. Furthermore, given the high levels of shame and guilt associated with overeating disorders, it is likely people suffering with these disorders would seek informal support and therefore never receive a diagnosis. For these reasons it was felt the study should be included in the review. Table one presents the inclusion and exclusion criteria.

Table 1

Inclusion & Exclusion Criteria

	Eating Disorder	Religion/Spirituality	Recovery/Treatment
Inclusion	Eating disorder, disordered eating, or eating pathology primary diagnosis, > 50% participants diagnosed with eating disorder and explored independently from other diagnoses.	Religion/spirituality used to inform or guide intervention or is mentioned as part of process of recovery.	Focus of investigation relates to recovery or treatment.
Exclusion	Where participants were exclusively relatives, friends, carers, or professionals. Obesity with no comorbid eating disorder.	Mindfulness based interventions with no discussion of religious or spiritual orientation	Focus of investigation is aetiology of eating disorders.

Study Selection

The first author conducted a structured literature search in four databases in May 2022: MEDLINE, CINAHL, PsycINFO and PubMED. The Population, Intervention, Comparison and Outcomes approach (PICO; Liberati et al., 2009) was used to formulate search terms and aid the search process

The databases were searched, and duplicates removed. Title and abstract reviews filtered out papers that did not meet the inclusion criteria. Full texts were read to review for final inclusion, those texts included were assessed for quality appraisal and data relating to the research questions extracted. The search strategy is illustrated in figure one.

Search Strategy

The search terms were developed to include published data and can be seen in table two. Databases were selected based on their subject area and relevance to the review questions.

Table 2

Keywords and terms used in database search

Eating Disorder		**Religiosity /Spirituality**		**Recovery**
Eating disorder* OR Anorexi* OR Bulimi* OR Binge eating OR OSFED OR Other specified feeding or eating disorder OR EDNOS OR eating disorder not otherwise specified OR Disordered eating OR Eating Disturbance OR Eating pathology	***AND***	Religio* OR Spirit* OR Faith* OR God OR Buddhi* OR Christian* OR Jew* OR Jewish OR Judaism OR Hindu* OR Muslim OR Islam* OR Worship OR Church OR Catholic* OR Evangelic*	***AND***	Recover* OR Therap* OR Intervention OR Program* OR Journey OR Healing OR Lived experience OR Rehabilitat* OR Surviv* OR Reclaim* OR Conquer* OR Remission OR Cope OR Coping

Study Selection

Duplicates were noted and removed, and titles and abstracts screened against the inclusion criteria. Potentially relevant articles were screened in full during the second stage. A bespoke screening and inclusion tool was utilised to screen the full-text articles against the inclusion criteria. A selection of 100 titles and abstracts from the original pool of papers were checked independently by an independent reviewer, any disagreements were discussed until 100% agreement on papers that proceeded to the second stage of screening and those that did not was agreed.

Data Extraction

The data was extracted by the first author using a bespoke table, data extracted included:

Descriptive:

- Study design
- Where and when the study was conducted
- Sample size, demographics
- Aspect of religion/spirituality
- Eating disorder/disturbance

Analytical:

- Outcome measures

Assessment of Methodological Quality

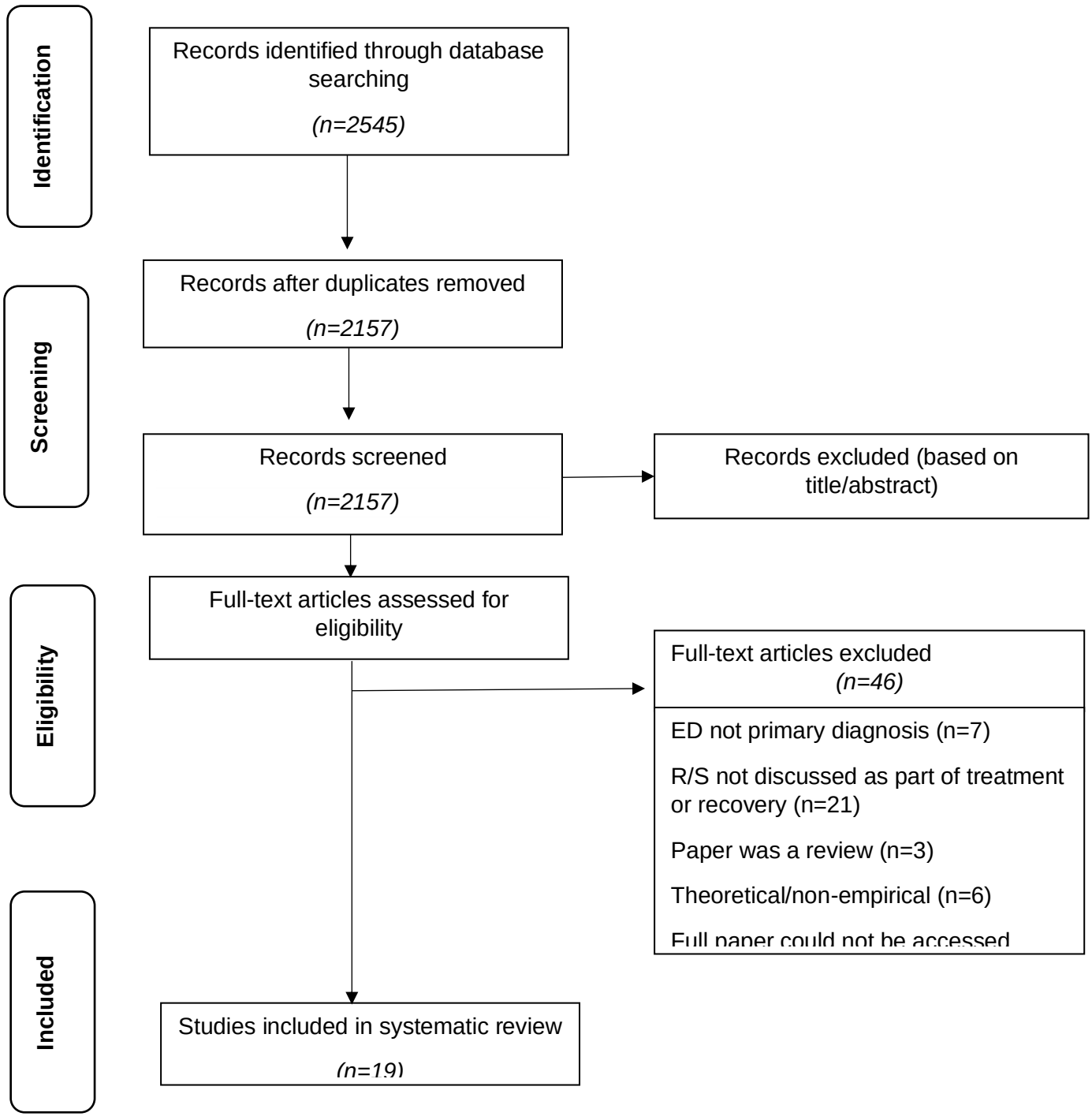
The Joanna Briggs Institute critical appraisal checklists for quasi-experimental studies (Joanna Briggs Institute, 2016a; Appendix A) case reports (Joanna Briggs Institute, 2016b; Appendix B) qualitative studies (Joanna Briggs Institute 2016c; Appendix C) and cross-sectional studies (Joanna Briggs Institute 2016d; Appendix D) were used to assess articles for methodological quality. The checklists consist of statements about research design and procedures with options to select ‘yes’ ‘no’ ‘unclear’ or ‘not applicable’.

Results

Search results

Database searches identified 2545 citations (figure one). Following removal of duplicates, 2157 titles and abstracts were screened for inclusion, 65 full=text articles were screened for eligibility, 9 could not be accessed. Nineteen papers met all inclusion criteria on initial review.

Figure 1
PRISMA flow diagram for review



Study Characteristics

The 19 studies included, described in table three were published between 1999 and 2020, countries of origin include the UK (n=2) USA (n=15) and Israel (n=2). Most participants were female, with only one study including exclusively male participants. Most studies included adult participants; one study included exclusively adolescent participants. Religious affiliations included Christianity, Buddhism, Judaism including Orthodox Jewish, Jehovah's Witness, Mormon, Church of Latter-Day Saints, and Islam. Spirituality was conceptualised in a variety of ways including as the practise of spiritual behaviours such as mediation, non-denominational prayer, and yoga; connection between the body and soul, mind, and spirit; connection with nature or activism; and pursuit of connection with a Higher Power. Treatment settings included inpatient, outpatient and day treatment services; some of which were religious or spiritually affiliated. Studies described included treatments in which religious or spiritual psychotherapy was the primary intervention, and treatments which utilised such therapies in addition to treatment as usual or conventional evidence based treatments.

Study designs were categorised as qualitative (n=9) case studies (n=5) cross-sectional (n=2) or quasi-experimental (n=3) and Joanna Briggs quality assessment tools were used correspondingly (Joanna Briggs, 2016a, 2016b, 2016c, 2016d, appendices A-D) Overall the quality of the included case studies was moderate. Lack of sufficient demographic data (n=3) detail of interventions or treatment (n=2) were the most prevalent issues. Overall the quality of qualitative studies was moderate, however a significant issue for all studies (n=9) was a lack of statement clarifiying the researcher's position, or exploration of researcher on research and vice-versa. The checklist asserts that researchers should declare their beliefs and values and their potential influence on the study as it recognises the substantial role researchers play in qualitative research processess. Similarly, the checklist draws attention to a bidirectional relationship between the researcher, and the research, highlighting how the researchers role, and relationship with participants could influence their interpretation of the data, and how the research process itself can affect

the researcher, and again influence their interpretation. Overall the quality of quasi-experimental studies was good, though (n=2) lacked a control group. Quality of the cross-sectional studies was overall good, though (n=1) failed to identify or discuss how confounding factors were managed.

Table 3

Characteristics of Included Studies

First Author (Year)	Country of Origin	Aim	Method	Sampling	Aspect of R/S included	ED	Results
Bohrer (2017)	USA	Identify individual and ED-specific variables associated with treatment seeking.	Cross-sectional. Data extracted from CPES Measures: WMH-CIDI ED module. Computer-assisted SCID for DSM-IV. Religious belongingness assessed.	N=595 77.8% female 72.4% ethnic minority Mean age: 37.69	Religious belongingness	AN (29.7%) BN (32.3%) BED (48.1%)	Religious belongingness does not predict treatment seeking amongst adults with an ED.
Dancyger (2002)	USA	Compare development and treatment of ED between female adolescent Orthodox Jewish and other patients in same treatment.	Case studies with psychological measures: BDI, EDI-2, FACES-II, treatment and illness data.	Orthodox Jewish: N=8 100% Female 100% Caucasian Age range 12-18 years Other group N=72 100% female 94.6% Caucasian Age range: 12-18 years	Ultra & Modern -Orthodox Jewish	AN (n=5) BN (n=2) EDNOS (n=1)	Significantly longer admissions and rates of medication amongst Orthodox Jewish patients. Non-significant differences found between age of admission, first treatment, and onset; Orthodox parents sought treatment sooner. No group differences on treatment goal achievement.

Garrett (1997)	USA	Explore sociological reasons for recovery from AN.	Qualitative, semi-structured interviews	N=32	Spirituality. Range of R/S amongst participants: Christianity, Buddhism, Judaism, New Age psychology, environmentalism	AN (n=32)	Spirituality as a source of meaning which was fundamental to recovery. Spirituality used for meaning making of recovery process.
Hay (2013)	USA	Explore 'tipping points' in recovery from AN.	Qualitative, autobiographical accounts	N=31 (female=29)	Religious faith and spiritual relationships	AN (100%)	Spiritual relationships with deities, religious values and non-defined spirituality were discussed as similarly important to relationships with family and friends in recovery.
Henderson (2015)	USA	Test two conceptual models of the moderating effects of religious involvement on mental health.	Cross-Sectional, regression analysis. Measures: Dependent Variables; CES-D, Rosenberg Scale of Self-Esteem. Independent Variables; Eating Disturbance; Religion measured by questions rating religious attendance, religious salience, religious guidance,	N=2437 (100% female) Mean age: 34 years	Religion; organisational, non-organisational, individual religiousness.	AN BN BED	Eating disturbance linked with poor mental health. Religious attendance and prayer are protective against depressive symptoms. Prayer and religious salience positively associated with self-esteem. Religiousness offsets and buffers effects of eating disturbance on mental health.

			and frequency of prayer.				
Hertz (2012)	Israel	Explore attachment transformations for OA members.	Qualitative, semi-structured interviews	N=20, 100% female. Age ranger 26-62 years	Jewish faith Spirituality in context of OA	BED (100%)	Emotional recovery dependent on Spiritual recovery; new relationship with a divine entity, absent during illness, seen as secure attachment figure in recovery.
Lea (2015)	USA	To conduct in depth exploration of theistic, spiritually oriented ED treatment.	Case study with measures: Spiritual Intake Questionnaire, TSOS, CA-COM and 1 year follow-up measure: CA-COM and EAT.	N= 1 (20-year-old female)	Christian, LDS Spiritual interventions	EDNOS	Treatment led to significant improvements in distress, physical health and eating attitudes. Therapist spirituality and sensitivity essential for patient willingness to use spiritual interventions which were helpful in gaining commitment for behaviour change and finding meaning.
Marsden (2007)	UK	Examine relationship between ED and religion and treatment	Qualitative, semi-structured interview	N=10 (100% female)	Christian faith, explored religious background, current practise, perception of God, attitudes to sin & penance, influence of faith.	AN (n=9) BN (n=1)	Religiousness and symptomology entwinement presented challenges for treatment for both patient and treatment team. Inclusion of religious leaders in treatment was helpful in overcoming these challenges. Spiritual maturity linked with positive psychological changes but could threaten spiritual beliefs leading to loss of faith or treatment failure.
Matusek (2009)	USA	To explore process of recovery with	Qualitative, semi-structured interviews	N= 8 (100% female). Mean age: 33	Spirituality	AN (n=2) BN (n=1)	R/S used to make sense of recovery experiences. Faith and spirituality motivators for, and

		particular focus on turning points		years range 18-56 Narratives presented for N=3, aged 46, 24 and 57.			essential elements in recovery journey.
Morgan (2000)	UK	Explore interaction between religious faith and ED treatment	Qualitative, case studies	N=4, 100% female.	Christianity Jehovah's Witness	AN (n=3) BN (n=1)	Religiousness and symptomology entwinement presented challenges for treatment. Inclusion of religious leaders helpful in overcoming these. Transformation of religious beliefs from punitive to sustaining helpful. Religion and psychotherapy seen as incompatible leading to declining treatment. For others psychotherapy utilisation led to loss of faith.
Musleh (2017)	USA	Present conceptualisation with emphasis on religious and cross-cultural components of ED development and treatment.	Qualitative, case study including reporting of psychological measures: MER and Islamic Positive Religious Coping Scale, BSI, BDI	N=1, female	Islamic religious psychotherapy including Hamdan's Islamic cognitive restructuring techniques (2008).	BED	Religious psychotherapy helpful in creating behaviour change, increased closeness to God, and overcoming cultural barriers to treatment. Therapist R/S important to client.
Reneli (2020)	USA	Explore perspectives of ED patients who have experienced	Qualitative, semi-structured interviews	N=13, (12 female) Mean age: 30.1	Spiritual ceremonial healing	AN (n=8) BN (n=5)	Ayahuasca provides healing through connections with spiritual forces which was felt to be missing from conventional treatment.

		both conventional treatments, and Ayahuasca healing ceremonies.					
Richards (2006)	USA	Empirically evaluate effectiveness of spiritually oriented treatment approach for ED patients	Quasi-experimental. Randomised pre-test-protest control group design. Participants assigned to spirituality, cognitive or emotional support group in addition to treatment as usual. Pre-post-test outcome measures: EAT, BSQ, MSEI, SWBS, Weekly outcome measures: TSOS, EDSMS, OQ-45	N=122 (100% female, 97.5% Caucasian) Mean age: 21.2	LDS (n=84) Protestant (n=8) Catholic (n=7) Jewish (n=2) Non-specified other denomination (n=9) NASO (n=9)	AN (n=42) BN (n=47) EDNOS (n=33)	Spirituality group enhanced overall effectiveness of inpatient program more than cognitive and emotional groups, with larger differences noted between cognitive and spiritual groups.
Richards (2009)	USA	Illustrate how theistic approach can complement traditional ED treatment	Qualitative, Case Study with outcome measures EAT, BSQ, OQ-45, SWBS	N=1 Female Age: 23 years Caucasian	Christian, individual psychotherapy incorporating spiritual issues and spirituality group.	EDNOS	Spiritual therapy changed relationship with higher power, motivated use of spiritual interventions with positive outcomes on self-worth and symptom reduction.

Richards (2018)	USA	Explore how former patients perceived religion and spirituality as influencing their treatment and recovery	Qualitative, Semi-structure interviews	N=83 (100% female)	LDS/Mormon (48%) Protestant (20%) Roman Catholic (9%) Jewish (3%) NASO (20%) Spirituality group and adapted 12-step programme.	AN (35%) BN (40%) EDNOS (25%)	Spirituality helpful in recovery. R/S of treatment team and inclusion of religious leaders helpful and important to participants. Minority of participants viewed R/S as unhelpful, detrimental, or irrelevant.
Ronel (2003)	Israel	Explore OA members' transformation of worldviews.	Qualitative-naturalistic, Semi-structured interviews	N=88 (80 female) Age range 15-63 years	Spirituality. Majority of participants from secular-atheist backgrounds.	Compulsive Overeating (100%)	Spiritual focus can be initial barrier but through gradual change process of OA seen as helpful for everyday endeavours and recovery. Spirituality becomes increasingly existential over course of treatment.
Smith (2003)	USA	Empirically explore relationship between religiousness, SWB, and treatment outcomes	Quasi-experimental. Pre-test-post-test outcome data. Measures: EAT, BSQ, OQ-45, TOES; religious well-being subscale of the SWBS; intrinsic subscale of ROS.	N=251 100% female Mean age: 21.58 90% Caucasian, 10% African America, Asian, Hispanic.	LDS (n=162) Jewish (n=3) Protestant (n=11) Catholic (n=10) Religious affiliation unspecified (n=20) NASO (n-14)	AN (n=88) BN (n=68) EDNOS (n=75)	Intrinsic religious devoutness and religious affiliation were not significantly associated with reductions in symptoms. Improvements in SWB positively associated with other positive treatment outcomes.
Wasson (2004)	USA	Examine specific elements of	Qualitative, focus group and semi-	N=26 100% female	Spirituality, non-religious affiliated	BN (100%)	Spirituality bedrock of recovery though challenge for new members, modelling by other

		OA and role in BN recovery.	structured interviews	Age range: 20 – 59 years	prayer, and meditation		members helpful. Spiritual tools commonly used for recovery maintenance. Appreciation of individuality of spirituality.
Weltzin (2012)	USA	Explore critical issues in treatment of males with EDs	Quasi-experimental. Pre-test-post-test outcome data. Measures: EDI-3, EDE-Q Global, BDI, STAI-Trait, CAC	N=111 100% male Age range: 12- 60 years Mean age: 24 years 89% White 11% Hispanic, African American, Asian and Other	Spirituality groups Spiritual care consults Church attendance Spiritual literature	AN (60%) BN (24%) EDNOS (23%) BED (n=6)	Males significantly less likely to request or utilise R/S interventions but seen as helpful in meeting spiritual needs when accessed.

ED: Eating Disorder. LDS: Church of Jesus Christ of Latter-Day Saints. NASO: Non-affiliated spiritually oriented.AN: Anorexia Nervosa. BN: Bulimia Nervosa. BED: Binge eating disorder. EDNOS: Eating disorder not otherwise specified. CPES: Collaborative Psychiatric Epidemiology Surveys. WMH-CDI: World Mental Health-Composite International Diagnostic Interview. BDI: Beck Depression Inventory. EDI-2: ED Inventory-3. FACES-II: Family Adaptability and Cohesion Evaluation Scale. TSOS: Theistic Spiritual Outcome Survey. CA-COM: Clinically Adaptive Client Outcome Measure. EAT: Eating Attitudes Test. CA-TSC: Clinically Adaptive Therapist Session Checklist. Muslim Experiential Religiousness. BSI: Brief Symptom Inventory. BSQ: Body Shape Questionnaire. OQ-45: Outcome Questionnaire. MSEI: Multidimensional Self-Esteem Inventory. SWBS: Spiritual Wellbeing Scale. EDSMS. TOES: Therapist Outcome Evaluation Scale. EDI-3: ED Inventory-3. EDE-Q: ED Examination Inventory. STAI: State-Trait Anxiety Inventory. CAC: Compulsive Activity Checklist. CES-D: Center for Epidemiological Studies of Depression scale. SWB: Spiritual Wellbeing. R/S: Religiousness/Spirituality. OA: Overeaters Anonymous. ROS: religious orientation scale.

Findings of the review will be discussed in relation to the questions this review aimed to address; how is religion or spirituality integrated into treatment for eating disorders? How does religion or spirituality benefit recovery from an eating disorder? What challenges does religion or spirituality present to recovery from an eating disorder and are there any risks to incorporating religion or spirituality in recovery and treatment? Furthermore, whilst not an initial aim of the review, an area of interest identified through analysis was the ways in which religion and spirituality were defined and measured, observations will also be shared as they provide useful context in which to consider other findings.

How is Religion and Spirituality defined and measured?

Amongst the quantitative studies included in this review, religion and spirituality were conceptualised in a variety of ways, and a range of measures were used to assess these concepts in relation to eating disorder treatment and recovery. Three studies did not explicitly state what they meant by either spirituality or religion and conflated the two. In assessing religious belongingness, Bohrer et al., (2017) asked participants “How important are religious or spiritual beliefs in your everyday life?”. Similarly, Richards et al., (2006) describes the spirituality group within their study as “non-denominational consistent with Judeo-Christian topics such as spiritual identity, grace, forgiveness, repentance, faith, prayer, and meditation” which conceptualises spirituality in the sense of identity, and practises in the context of a Judeo-Christian religion. Weltzin et al., (2012) defines the spiritual interventions discussed in their study as including “voluntary spirituality groups, individual spiritual care consults, provision for offsite church attendance and access to spiritually based literature” yet does not further define what is meant by spirituality, and the incorporation of church attendance is suggestive of religion, or that the two have been blended.

On the other hand, Smith et al., (2003) more clearly define what is meant by intrinsic religiousness utilising Allport and Ross (1967) definition “people with an intrinsic orientation have internalized their religious beliefs and attempt to fully live what they believe”.

Furthermore, they define spiritual well-being according to Paloutzian and Ellison (1991) “people with spiritual well-being perceive that God loves them, gives them strength and support, and is concerned about their problems”. Within this definition, spirituality also seems to be concerned with relationship with a God, and therefore entwined in religious beliefs. Henderson and Ellison, (2015) conceptualise religion in relation to attendance at religious services, use of religion as a source of guidance, religious salience, and use of private prayer. However, in other sections of their paper, religion and spirituality are conflated, for example they discuss how religious attendance can develop spiritual character.

The conflation between religion and spirituality can also be observed in the measures used within these studies. Smith et al., (2003) and Richards et al., (2006) utilised the Spiritual Well-Being Scale (Ellison & Smith, 1991) which comprises two subscales; religious well-being which measures participants perceptions of God, and existential well-being which measures participants sense of purpose, direction, and satisfaction with life. Smith only used the religious well-being subscale. Smith also utilised the intrinsic subscale of the Religious Orientation Scale (ROS, Allport & Ross., 1967), one of the most broadly used methods in exploring the association between religious behaviour and health (Hunter & Merill, 2013). Questions in the ROS focus exclusively on attitudes towards religion and religious behaviours.

Henderson and Ellison (2015) and Bohrer et al., (2017) did not utilise existing measures in their studies. Bohrer et al., asked questions pertaining to variables representing religious belongingness, such as “How important are religious or spiritual beliefs in your everyday life?” which were used as observed indicators of a latent factor, as the questions in the religion section of the Collaborative Psychiatric Epidemiology Surveys (Heeringa et al., 2004) could not be summed to create a composite variable. Henderson and Ellison, (2015) similarly measured religion by questions relating to participants perceptions of the role of religion in their lives, and use of religious practises.

Similar observations were made amongst the qualitative studies. A small number reported on measures utilised with their samples. Lea et al., (2015) states using a spiritual

intake questionnaire, but does not provide further details, and the Theistic Spiritual Outcome Survey (TSOS, Richards et al., 2005) which includes a range of questions including feeling there is a spiritual purpose to life, and thoughts and feelings relating to God. This study discusses a theistic spiritual intervention, suggesting religion and spirituality are interconnected. Musleh et al., (2017) uses the Islamic positive religious coping scale. Richards et al., (2009) also uses the Spiritual Well-Being Scale (Ellison & Smith, 1991).

As with the quantitative studies, religion and spirituality were rarely defined and often conflated. In some studies, this was through the discussion or presentation of religion and spirituality simultaneously and interchangeably (Lea et al., 2015; Musleh et al., 2017; Richards et al., 2009; Morgan et al., 2000; Matusek & Knudson., 2009) for example, Richards et al., 2018 defined religion and spirituality as an integrated concept “by religion and spirituality, we mean the “beliefs, practices, experiences, or relationships that are embedded within both non-traditional, secular contexts and established institutional contexts designed to facilitate the sacred search” (Pargament et al., 2013, p. 17). Others were more explicit in their conceptualisation of religion as relating to their participants religious affiliation, for example Dancyger et al., (2002) explores the Orthodox Jewish religion in relation to eating disorder treatment, though they do not offer a definition of religion, similarly Marsden et al., (2007) explores Christian faith and the associated practises and beliefs and their influence in treatment.

For others, terms of spirituality were used to conceptualise participants experiences, which seemed to significantly overlap with experiences defined as religious in other studies (Hertz et al., 2012; Hay et al., 2013; Reneli et al., 2020). For example, Hay et al., discusses the importance of spiritual relationships in eating disorder recovery, yet the relationships described by participants are with God, Jesus, Jewish values, and a non-defined spiritual relationship, which arguably could just as readily be conceptualised as religious relationships.

Garrett (1997) offers a clear definition of spirituality “Spiritual forces, for Durkheim, were generated by the powerful human needs for connection with others and with the natural

world and by the need to account for one's own existence" (Durkheim, 1976) however they state that "the renewed interest in spirituality, which has accompanied both New Age phenomena and Christian Pentecostalism, heralds a revival in the study of his ideas" which appears to relate religion to spirituality.

It is clear from assessing the ways in which religion and spirituality are defined and measured, that they are both multi-faceted, complex concepts which arguably cannot be clearly differentiated.

Religion and Spirituality in Eating Disorder Treatment and Recovery

This review aimed to identify how religion and spirituality are incorporated into treating and recovering from eating disorders. The findings are organised firstly according to how intrinsic religion and spirituality factors affect treatment, and secondly according to how religion and spirituality are integrated into treatments and therapy. Intrinsic religiousness is characterised as a master motive, religion is an end it itself. As such intrinsically religious individuals view their religion as a framework for their lives, trying to consistently live by their religious beliefs (Masters, 2013).

Individual Religiousness or Spirituality-Results from quantitative studies

Bohrer et al., (2017) aimed to assess whether religious belonging predicted treatment seeking, whilst Smith et al., (2003) aimed to explore the relationship between intrinsic religiousness and treatment outcomes. Bohrer et al., used questions relating to religious belonging to measure this variable amongst a sample of 595 adults using data from a national survey. The methodological quality of this study was moderate. Smith explored the effects of religious devoutness and affiliation, utilising the Religious Wellbeing subscale of the Spiritual Wellbeing Scale (Ellison & Smith, 1991) and the Intrinsic Subscale of the Religious Orientation Scale (Allport & Ross, 1967) with 251 adult females, on treatment outcomes measured by symptom reduction. The methodological quality of this study was good. Neither found a significant relationship.

Conversely, Henderson and Ellison (2013) by far the biggest and most statistically robust study found that religiousness was protective against the harmful effects of eating disturbance on other aspects of mental health such as self-esteem and depression. Henderson and Ellison conceptualised religion according to religious practises such as attendance at services, and prayer, and attitudes towards religion, which was measured using self-rated questions with N=2437 adult females. Results indicated that whilst intrinsic religiousness may not predict treatment seeking or positive outcomes, it is protective against the deleterious effects of eating disorders on broader mental health.

Religious and Spiritually Oriented Approaches in Therapies

Religious and spiritually integrated approaches described in this review identified a variety of processes by which religious and spiritual beliefs, values and practises were incorporated into treatment or therapy.

Lea et al., (2015) presents a case study of delivering a theistic spiritually oriented treatment which describes 15 spiritual interventions utilised within and out of therapy sessions, including increasing spiritual practises and behaviours such as prayer and charitable service, and enhancing the patients experience of their relationship with God. Musleh et al., (2017) and Richards et al., (2009) also emphasise the importance of addressing the bidirectional relationship between the person and their Higher Power. For the patient described in Musleh et al's case study, therapy addressed the beliefs that seeking treatment for her illness was an act of negating trust in God which contributed to feelings of low self-worth and feelings of guilt (2013). Richards et al's study describes a similar process of using therapeutic processes to change the patients view of God from rejecting, to loving and accepting which helped the patient challenge their negative self-perception. False beliefs of the eating disorder were also addressed, where relevant with the aim of discovering and accepting alternative values congruent with Christianity. In each case, a combination of psychotherapeutic techniques and spiritual processes were used to achieve change, for example in Musleh et al., study Islamic cognitive restructuring techniques (Hamdan, 2008) and religious practises such as *tawwakul* were emphasised which helped to

increase and strengthen reliance on God whilst reducing feelings of guilt and *muhaseba* (Haque et al., 2016) an Islamic practise of taking account of one's own behaviours was utilised to fulfil a common therapeutic practise within the framework of the patients religion. For Richard et al's patient, improving her relationship with God, which in turn increased her own self-worth, led to an enhanced willingness to utilise spiritual practises encouraged within treatment such as prayer, meditation, reading scripture and journaling (Richards et al., 2009). For others, their relationships with God were positively changed by working in therapy to change relationships with significant others in their lives which caused feelings of shame and guilt deserving of punishment (Marsden et al., 2007). Several of these themes and aims were addressed in the spiritually oriented treatment group in Richards et al., (2006) study, which augmented treatment as usual with the guided reading of a spiritual self-help book and group sessions. Participants in this treatment group were given opportunities to expand their identity beyond that of their eating disorder to develop a spiritual identity, work on forgiving themselves and others, and learn spiritual practices.

Similarly, within Overeaters Anonymous a focus is on changing members views of the problem of overeating, from a lack of willpower or control to a physical, mental, and spiritual disease. This reconceptualization is experienced by members as changing the focus of treatment and recovery to acceptance and personal responsibility (Ronel et al., 2003). Spiritual recovery was defined by members as the creation of a relationship with a divine entity that had been missing during their illness. This divine entity was seen as a secure attachment figure, similarly to that between a member and a sponsor (Hertz et al., 2012).

Reneli et al (2020) explores a different approach to incorporating spirituality in the treatment of eating disorders by describing the experiences of people who had received conventional treatment and partaken in a healing ceremony in which they drink a psychoactive plant-based tea *Ayahuasca* and then engage in silent meditation. Participants typically experience a form of physical purging (vomiting, diarrhoea, crying, yawning, sweating, shaking), and altered states of consciousness (Barbosa et al., 2005). Participants described the ceremony as providing a form of "spiritual and existential introspection" and a

deep connection with a greater spiritual force which contributed to a sense of spiritual healing they felt was missing from conventional treatment.

Religion and Spirituality of Therapists and Teams

Various aspects of therapist, or treatment team's religiosity, or spirituality was discussed as important in six of the included studies.

Willingness, sensitivity, and openness amongst therapists and teams were discussed as being important in facilitating participants to discuss and develop their own religious or spiritual beliefs and practises (Richards et al., 2018) and create trust between the therapist and client which in turn led to a willingness and commitment to utilise the spiritual practises discussed within therapy (Lea et al., 2015). For the patient discussed in Musleh et al., case study, it was essential that religion and spirituality was incorporated into the therapy, and that the therapist shared their religious values.

The incorporation of religious leaders or figures within treatment teams was discussed as being helpful for overcoming barriers associated with religious or cultural factors or enhancing spiritually oriented treatments. For patients' whose religiousness and symptomology were entwined, the inclusion of religious leaders in the treatment team were helpful in challenging or reconceptualising their views of God or understanding of religious principles (Marsden et al., 2007) and supporting teams and patients to delineate faith and symptoms (Morgan et al., 2000). Rabbinic clergy are members of the day treatment programme described in Dancyger et al., (2002) study and provide guidance to teams treating Orthodox Jewish patients on observing religious and cultural practises such as providing *Kosher* meals and supporting patients and families to manage the practises of fasting that occur throughout the Jewish calendar and the weekend Sabbath meals. Participants in Richard et al., (2018) shared that the support of religious communities provided comfort during treatment, whilst the inclusion of religious leaders helped to reduce feelings of guilt about requiring treatment and allowed participants to focus on their recovery.

Benefits of Religion and Spirituality in Eating Disorder Recovery

Most participants and patients within the studies in this review had positive perceptions and experiences of religion and spirituality in their treatment and recovery, these perceptions are supported by the small number of quantitative studies which explored this relationship. The findings are discussed in relation to the importance of religion and spirituality, and the positive effects of incorporating religion and spirituality in treatment and recovery.

Importance of Religion and Spirituality in Treatment and Recovery - Findings from Qualitative Studies

Participants in six studies within this review explicitly spoke of religion and spirituality in terms of its importance or centrality in recovery from their eating disorder. This experience was shared across diagnoses, participants with anorexia and bulimia nervosa (Matusek & Knudson, 2009) described faith and spirituality as central to recovery whilst participants with bulimia nervosa described spirituality as the “bedrock of recovery" (Wasson et al., 2004).

Participants in Garrett, (1997) and Matusek and Knudson, (2009) studies described that having a sense of meaning in their lives was fundamental for recovery, and that spirituality was itself a source of meaning, with women in Matusek and Knudson’s study using their faith or spirituality to find roles for themselves which drew upon their faith or spirituality and provided a sense of helping others with similar difficulties. Similarly, for the participants in these studies, spirituality and religion were described as a lens through which people made sense of their experiences of the eating disorder and recovery, with 31 of the 32 participants in Garrett’s study describing recovery as a spiritual quest. Participants in both Matusek and Knudson, and Richards et al., (2009) studies viewed key turning points as interventions from God, or moments of spiritual clarity or connection, for example a “deep spiritual affirmation of God’s love for them” (Richards et al., 2009).

Even where religion and spirituality were not positioned as central or foundational to recovery, it was still emphasised as important for other participants. A theme of Hay and Cho (2013) research of 31 accounts of recovery from Anorexia Nervosa was “new or renewed

relationships" included within this theme was spiritual relationships, which for the participants who had spoken of these were considered as important as those with family and friends. Marsden et al., (2007) observed that for participants with a strong religious faith, spiritual maturation goes hand in hand with psychological changes. Furthermore, participants in Wasson et al., (2004) shared that the emphasis on spiritual recovery satisfied their spiritual hunger which they perceived as giving rise to the compulsive eating.

Positive Effects of Religion and Spirituality on Treatment and Recovery

Findings from the qualitative studies within this review discuss that participants and patients' perceived religion and spirituality to have positive effects on their treatment and recovery. For participants with a positive relationship with a God or Higher Power they were viewed or experienced as a source of resilience (Musleh et al., 2017) comfort and peace, and treatment was viewed as God's work or provision (Marsden et al., 2007). Similar experiences were discussed in relation to spirituality, which were credited as increasing connection with a God or Higher Power and improving self-worth (Richards et al., 2009) self-confidence, reducing anxiety and bringing meaning to life (Ronel et al., 2003). Spiritual behaviours such as prayer and meditation provided feelings of peace, calmness, and freedom from food obsession (Wasson et al., 2004), whilst spiritual healing ceremonies provided additional sources of comfort and healing beyond conventional treatments (Reneli et al., 2020). Where participants held strong religious beliefs that impaired their ability to engage in treatment or recovery, transformation of these beliefs allowed them to become sustaining which was helpful in symptom reduction (Morgan et al., 2000).

Richards et al., (2018) captured the experiences of patients who felt their eating disorder had been damaging of their religion or spiritual beliefs, and those who had negative experiences of religion or spirituality which had resulted in feelings of shame, guilt, or worthlessness. For most patients, religious and spiritually integrated treatment facilitated their recovery from their eating disorder by expanding their sense of identity and improving relationships with others including their Higher Power which facilitated healing, and provided perspective, hope and meaning.

The only study within this review to exclusively explore men's experiences of eating disorder treatment, states that men are significantly less likely to access or utilise religious or spiritual interventions than women, but where they do, they are experienced as helpful in meeting their spiritual needs in relation to recovery (Weltzin et al., 2012)

Positive Effects of Religion and Spirituality in Treatment and Recovery – Findings from Quantitative Studies

These positive effects are supported by the results of Smith et al., (2003) and Richards et al., (2006). Smith et al., found that whilst intrinsic religiousness was not associated with symptom reduction, improvements in spiritual wellbeing, the belief that God loves them, is concerned about their problems, and provides strength and support (Paloutzin & Ellison, 1991) during treatment was associated with reduced physical symptoms and conflict in relationships, and improved body image, eating attitudes and social performance. Richards et al., found that participants in the spirituality focussed group scored significantly lower on symptom and relationship distress, and significantly higher on religious wellbeing, global self-esteem, and body shape satisfaction than both the cognitive and emotion focussed groups. Compared to the cognitive group, participants in the spiritual group scored significantly lower on social role conflict and eating attitudes, and significantly higher on existential wellbeing. Perhaps unsurprisingly early improvements in spirituality were highest in the spirituality group.

Challenges of Religion and Spirituality in Eating Disorder Recovery

Whilst only a small number of studies identified challenges or risks of incorporating religion or spirituality in the treatment of and recovery from eating disorders, the findings of those that did can be organised into two related processes. Firstly, how aspects of religiosity or spirituality are associated with increased barriers to recovery, and secondly how processes of recovery, or treatment can threaten the religious beliefs of individuals.

Threats of Religion and Spirituality to Recovery

Amongst a small number of participants, intrinsic religiosity, particularly where religious beliefs were entangled with eating disorder symptomology, was seen as a barrier to

recovery (Morgan et al.,2000; Marsden et al.,2007). Beliefs about thinness or self-starvation as pleasing to God, and weight gain as sinful increased resistance to weight restoration, whilst beliefs in an afterlife promising closeness to God removed the motivating effects of fear of death due to their eating disorder. Furthermore, such beliefs posed a challenge to treatment teams in trying to disentangle such beliefs to address them, as discussed above the inclusion of religious leaders within treatment was helpful. Furthermore, Dancyger et al., (2002) queried whether stigma attached to cultural and religious values regarding mental health created preference for medical treatment accounting for the 100% of Orthodox Jewish patients prescribed medication compared to the 44.6% of other patients.

Contrary to findings discussed above, a small number of participants viewed spirituality within treatment as irrelevant or detrimental (Richards et al., 2018). Similarly, amongst new members to Overeaters Anonymous spirituality was discussed as a barrier to engagement, or cause for scepticism (Ronel et al., 2003; Wasson et al., 2004). In all three studies, these experiences were greatest amongst those who had prior negative relationships with Higher Powers, or for whom religion and spirituality had been a cause of conflict or distress within other important relationships.

Threats of Recovery to Religion and Spirituality

Paradoxically, a small number of participants within this review experienced recovery as threatening to their religious beliefs. For participants who had relied on God for healing or salvation, treatment was experienced as being failed by God which led to failure of treatment as discussed above, or loss of faith for one person (Marsden et al., 2007; Morgan et al., 2000). For one participant in Morgan et al., they felt psychotherapy was incompatible with their religious beliefs and chose to disengage, however it was observed that their religious beliefs provided containment of their harmful behaviours.

Discussion

Systematic review methodology was used to investigate how religion and spirituality is integrated into treatment of and recovery from eating disorders including the beneficial effects and the challenges and barriers to doing so.

The most researched religion was Christianity, though Judaism, Islam and Buddhism were also represented. Spirituality, whilst a broad concept encompassing a range of practises, values, and beliefs, was commonly defined amongst studies in relation to a person's capacity to embed themselves in something greater than themselves, which motivates a desire and search for connectedness, meaning, purpose and contribution, which echoes Benson et al., 2003 conceptualisation. The review represents a variety of study methods and samples from an N=1 case study, several qualitative studies, four quantitative including an N=2437 regression analysis, and intervention studies.

Summary of findings

This review found a variety of ways that religion and spirituality are incorporated into treatment, as most studies were conducted with populations of religious or spiritual people, the findings may be of restricted relevance for more secular cultures.

Saunders, Miller & Bright (2010) suggested a continuum based on their research into religion and spirituality within psychological care. They propose four categories, at one end of the continuum is "spiritually avoidant care" which they label untenable, at the other end is "spiritually directive psychotherapy characterised by an explicit attempt to maintain or change the spiritual and religious, beliefs and practises (SRBP) of patients." "Spiritually integrated psychotherapy" entails using the patients' spirituality and religion to ameliorate patients' emotional distress. They suggest as a minimum that psychologists should engage in "spiritually conscious care" with all patients. Spiritually conscious care is defined as "an approach that assesses SRBP in a respectful and sensitive manner to determine its general importance to a patient" and assesses the influence, if any on the presenting problem and the SRBP as potential resource for recovering. It involves the explicit evaluation of these issues throughout the assessment and treatment phases. Several studies (Musleh et al., 2017; Lea et al., 2015; Richards et al., 2006 & and Richards et al., 2009) appear to have qualities of both spiritually directive and spiritually integrated psychotherapy (Saunders et al., 2010). For example, Musleh et al., describes a spiritually integrated approach, yet describes using therapy to enhance the patients use of religious and spiritual practises and their

relationship with their God. Overeaters Anonymous could similarly be conceptualised as both, due to its emphasis on encouraging members without prior religious or spiritual beliefs to develop or adopt them. Dancyger et al., (2002) appears to describe spiritually conscious care where the religious beliefs are acknowledged and accommodated, but no mention is made of attempts to alter or utilise these within therapy. From participant perspectives, it seems spiritually conscious care is appreciated by most, with discussions of openness and sensitivity from therapists and teams viewed positively (Richards et al., 2018; Musleh et al., 2017; Lea et al., 2015).

Qualitative studies explored the lived experiences of people who have recovered from an eating disorder and the ways religion or spirituality have affected or been utilised within their recovery journeys (Garrett, 1993; Hay et al., 2013; Marsden et al., 2007; Matusek & Knudson., 2009; Morgan et al., 2000). Many recounted benefits of personal religion and spirituality, and experiences of it being incorporated in treatments. This is supported in the substantial quantitative study which found intrinsic religiousness protected eating disorder sufferers from the damaging effects of an eating disturbance on broader mental health (Henderson & Ellison, 2015).

Many of the studies included in this review discussed processes of searching for, or finding meaning both in life, and within the experiences of recovery, for example spirituality both provided a source of, and lens for finding meaning in experiences of illness (Garrett, 1997). This is an explicit component of Leamy et al., (2011) conceptual framework of recovery.

Whilst many studies report that religion and spirituality were seen as a source of comfort, peace, resilience and hope which enhanced willingness to engage with treatment and was often described as essential for recovery (Matusek & Knudson, 2009; Hertz et al., 2012; Hay et al., 2013; Garrett., 1997; Hertz et al., 2012; Ronel et al., 2003) a small number of participants shared negative experiences. Amongst people with no pre-existing, or negative prior experiences of religion and spirituality, the presence of these in treatments was viewed as an initial barrier (Ronel et al., 2003; Wasson et al., 2004) irrelevant or even

detrimental (Richards et al., 2018). Unfortunately, no further exploration of these experiences is provided within the study but may be relevant to consider in a secular population. Furthermore, entanglement of religious beliefs and eating disorder symptoms presented barriers to recovery and additional challenges to treatment teams and therapists (Marsden et al., 2007; Morgan et al., 2000). For patients who were unable to reconcile their religious beliefs with treatment, this led in one case to treatment failure, and in another to loss of faith (Morgan et al., 2000)

Limitations

A comprehensive evaluation of the methodological quality of the included studies showed that the quality of qualitative studies including case studies was moderate, whilst for quantitative studies it was good. Accordingly, findings of qualitative studies reported in this review should be interpreted with caution.

It is likely that studies in this review are affected by selection bias. Several papers report on participant experiences of treatments or therapies which were explicitly defined as spiritually or religiously oriented or occurred in spiritual or religious affiliated treatment settings (Lea et al., 2015; Musleh et al., 2017; Reneli et al., 2020; Richards et al., 2006; Richards et al., 2009; Richards et al., 2018). As such it is likely that participants within these studies had a preference towards such treatments or settings which increased the likelihood of positive perceptions of these.

An exclusion criterion for this review was studies published in any language other than English, which privileged studies published in Western societies, and the religious and spiritual beliefs and values most common within these. As such, there is no evidence from Non-Western cultures, or several major religions of interest. As such, the findings of this study have limited generalisability to other non-western societies and religions.

As discussed by Akrawi et al., (2015) and Bonelli et al., (2013) the wide variety of definitions, and measures used to assess these concepts is a limitation for this study. Bonelli questioned how well spirituality has been differentiated from religion, arguably within this review it has not consistently been, with religion and spirituality being conflated in most

studies. As such, the interpretation of findings is limited, as it is not possible to be confident that the studies in this review are reporting on the same construct. Whilst Bonelli and Koenig., (2008) discuss that spirituality has only been researched as a distinct concept relatively recently, arguably most studies in this review are more aligned with the traditional view, where spirituality is used to "describe the deeply religious person" (Koenig, 2008). Several studies explore religion including practises or qualities of spirituality upheld by participants.

Implications for Clinical Practice and Future Research

Difficulties in standardising definitions of spirituality likely reflect the highly individual meanings, values, and beliefs people possess which they understand as forming their spirituality. This review highlighted the importance of recognising and respecting the individuality of peoples' religious and spiritual beliefs and practises within treatments. Spirituality was conceptualised by all participants as a connection with something they considered greater than themselves, and included a religious faith, nature, activism, advocacy, the self, the soul, and animals.

Where clients already have religious faith or spiritual beliefs, incorporating these into therapy or treatment is likely to have positive effects. Similarly, based on the small number of studies in this review which included people without prior affiliation or beliefs, spiritually oriented interventions were viewed as largely beneficial and so it should not be assumed that this group of people would not benefit. However, professionals and services must be aware of the ethical issues and cautious not to proselytise patients, which emphasises the need for thorough understanding and respect of individual preferences. Conversely, where religious or spiritual beliefs were contributing to the maintenance of the eating disorder or distress, clear understanding and religious leader involvement was necessary for progress.

As such, the primary encouragement for clinicians would be to assess and talk to their clients about religion and spirituality. Openness and sensitivity of therapists were discussed as fundamental for client's own exploration and development of spirituality. As

existing research has consistently shown, whilst many patients in mental health services wish to be asked about their religious and spiritual beliefs, this rarely happens.

The question then is how we support clinicians in increasingly secular societies, in organisations and institutions which acknowledge the importance of religion and spirituality in their patients' lives, yet supply vague and unclear guidance and boundaries to do this?

Encouragingly, existing research shows that many professionals view these as areas relevant to their practise but report a lack of training. A second implication then is for an improved level or mandatory training for all professionals working in mental health, so at minimum spiritually conscious care is delivered. Connectedly, clearer guidance for staff about what is and, perhaps more importantly what is not considered appropriate in relation to discussing, encouraging, utilising, or even teaching religious and spiritual practises where clients express an interest.

This review, and the studies within it, arguably only begin to scratch the surface of what is undeniably a complex, multifaceted aspect of individuals lives which affects their mental health in several ways. Future research is necessary to develop our understanding of this relationship within eating disorders. Research into non-western societies, and other religions is needed to broaden our understanding and increase representation of the voices of those within these groups. Similarly, the experiences of people without prior religious or spiritual beliefs warrants further investigation in the context of the mixed findings discussed by the small number of papers to include this group in this review. Research into the experiences of currently under-represented groups including, older people, members of the LGBT+ community, and members of the global majority is also needed, as whilst traditionally eating disorders have been seen as a disorder amongst young, white women, it is clear this is not the case. Further knowledge and understanding of professionals' perceptions of religion and spirituality in eating disorder treatment, particularly the factors that prevent them from assessing and working with patients' beliefs, would be valuable in identifying the necessary remedies to increase these practises. Finally, a lack of clearly differentiated definitions of spirituality and religion continues to limit the validity of research into this area

and there is a need to remedy this or explore whether the two concepts can in fact be separated.

Conclusion

Initial findings from evaluation of treatments for eating disorders that have used various elements of religion and spirituality suggest that whilst not without challenges, they are largely viewed as helpful by recipients, and contribute to positive treatment outcomes both for people with religious or spiritual backgrounds, and those without. Similarly, for people who have recovered from eating disorders who have drawn upon religious or spiritual beliefs or practises they are seen as a source of strength, coping and deepening self-identity. Furthermore, people who have recovered from eating disorders use religion and spirituality to make sense of their experiences, which in turn solidifies their recovery, sometimes leading them to share their beliefs and practises with others. Findings from this review emphasise the importance of thorough assessment of religious and spiritual beliefs, and the benefits of spiritually conscious care. Future research evidence should focus on broadening our understanding of the relationship between religion, spirituality and eating disorder recovery and treatment by including other religions, under-represented groups and exploring professionals' views.

References

Acle, A., Cook, B. J., Siegfried, N., & Beasley, T. (2021). Cultural considerations in the treatment of eating disorders among racial/ethnic minorities: A systematic review. *Journal of Cross-Cultural Psychology*, *52*(5), 468-488.

Akrawi, D., Bartrop, R., Potter, U., & Touyz, S. (2015). Religiosity, spirituality in relation to disordered eating and body image concerns: A systematic review. *Journal of Eating Disorders*, *3*(1), 1-24.

Allport, G. W., & Ross, J. M. (1967). Personal religious orientation and prejudice. Journal of Personality and Social Psychology, 5, 432–443

Arcelus, Jon et al. “Mortality rates in patients with anorexia nervosa and other eating disorders. A meta-analysis of 36 studies.” Archives of general psychiatry 68,7 (2011): 724-31. https://doi.org/10.1001/archgenpsychiatry.2011.74

Awara, M., & Fasey, C. (2008). Is spirituality worth exploring in psychiatric out-patient clinics?. *Journal of Mental Health*, *17*(2), 183-191.

Barbosa, P. C. R., Giglio, J. S., & Dalgalarrondo, P. (2005). Altered states of consciousness and short-term psychological after-effects induced by the first time ritual use of ayahuasca in an urban context in Brazil. Journal of psychoactive drugs, 37(2), 193-201.

Beck, A. T. (1987). Steer R. Beck depression inventory manual. *The Psychological Corporation*.

Benson, P. L. (2004). Emerging themes in research on adolescent spiritual and religious development. *Applied Developmental Science*, *8*(1), 47-50.

Bohrer, B. K., Carroll, I. A., Forbush, K. T., & Chen, P. Y. (2017). Treatment seeking for eating disorders: Results from a nationally representative study. *International Journal of Eating Disorders*, *50*(12), 1341-1349.

Bonelli, R. M., & Koenig, H. G. (2013). Mental disorders, religion and spirituality 1990 to 2010: a systematic evidence-based review. *Journal of religion and health*, *52*(2), 657-673.

Cooper, P. J., Taylor, M. J., Cooper, Z., & Fairbum, C. G. (1987). The development and validation of the Body Shape Questionnaire. International Journal of eating disorders, 6(4), 485-494.

Dancyger, I., Fornari, V., Fisher, M., Schneider, M., Frank, S., Wisotsky, W., ... & Charitou, M. (2002). Cultural factors in orthodox Jewish adolescents treated in a day program for eating disorders. *International Journal of Adolescent Medicine and Health*, *14*(4), 317-328.

Davis, C. (2013). From passive overeating to “food addiction”: a spectrum of compulsion and severity. *International Scholarly Research Notices*, *2013*.

D'Souza, R. (2002). Do patients expect psychiatrists to be interested in spiritual issues?. *Australasian psychiatry*, *10*(1), 44-47.

Duffy, M. E., Henkel, K. E., & Earnshaw, V. A. (2016). Transgender clients’ experiences of eating disorder treatment. *Journal of LGBT Issues in Counseling*, *10*(3), 136-149.

Durkheim, E. (1976). The elementary forms of the religious life. London: George Allen and Unwin. (Original work published 1915)

Ellison, C. W., & Smith, J. (1991). Toward an integrative measure of health and well-being. *Journal of Psychology and Theology*, *19*(1), 35-45.

Fairburn, C. G. (2008). *Cognitive behavior therapy and eating disorders*. Guilford Press.

Fairburn, C. G., & Beglin, S. J. (1994). Assessment of eating disorders: Interview or self-report questionnaire?. *International journal of eating disorders*, *16*(4), 363-37

Freund, B., Steketee, G. S., & Foa, E. B. (1987). Compulsive Activity Checklist (CAC): Psychometric analysis with obsessive-compulsive disorder. *Behavioral assessment*.

Galmiche, M., Déchelotte, P., Lambert, G., & Tavolacci, M. P. (2019). Prevalence of eating disorders over the 2000–2018 period: a systematic literature review. *The American journal of clinical nutrition*, *109*(5), 1402-1413.

Garcia, S. D. O., Babarro, J. M., & Romero, M. T. (2017). Spiritus contra spiritum: Including spirituality in addiction treatments for recovery, a systematic review. *Univ J Psychol*, *5*(2), 66-87.

Garrett, C. J. (1997). Recovery from anorexia nervosa: A sociological perspective. *International Journal of Eating Disorders*, *21*(3), 261-272.

Garner DM. Eating Disorder Inventory-2. Odessa, Florida: Psychol Assessment Resources, 1991

Garner, D. M., Olmsted, M. P., Bohr, Y., & Garfinkel, P. E. (1982). The eating attitudes test: psychometric features and clinical correlates. *Psychological medicine*, *12*(4), 871-878.

Ghorbani, N., Watson, P. J., Geranmayepour, S., & Chen, Z. (2014). Measuring Muslim spirituality: Relationships of Muslim experiential religiousness with religious and psychological adjustment in Iran. *Journal of Muslim Mental Health*, *8*(1).

Hamdan, A. (2008). Cognitive restructuring: An islamic perspective. *Journal of Muslim mental health*, *3*(1), 99-116.

Haro, J. M., Arbabzadeh-Bouchez, S., Brugha, T. S., De Girolamo, G., Guyer, M. E., Jin, R., ... Vilagut, G. (2006). Concordance of the Composite International Diagnostic Interview Version 3.0 (CIDI 3.0) with standardized clinical assessments in the WHO World Mental Health surveys. International Journal of Methods in Psychiatric Research, 15(4), 167–180. https://doi.org/10.1002/mpr.19

Harris, K. A., Randolph, B. E., & Gordon, T. D. (2016). What do clients want? Assessing spiritual needs in counseling: A literature review. *Spirituality in Clinical Practice*, *3*(4), 250.

Haque, A., Khan, F., Keshavarzi, H., & Rothman, A. E. (2016). Integrating Islamic traditions in modern psychology: Research trends in last ten years. *Journal of Muslim Mental Health*, *10*(1).

Hay, P. J., & Cho, K. (2013). A qualitative exploration of influences on the process of recovery from personal written accounts of people with anorexia nervosa. *Women & Health*, *53*(7), 730-740.

Heeringa, S. G., Wagner, J., Torres, M., Duan, N., Adams, T., & Berglund, P. (2004). Sample designs and sampling methods for the Collaborative Psychiatric

Epidemiology Studies (CPES). International Journal of Methods in Psychiatric Research, 13(4), 221–240. https://doi.org/10. 1002/mpr.179

Henderson, A. K., & Ellison, C. G. (2015). My body is a temple: Eating disturbances, religious involvement, and mental health among young adult women. *Journal of Religion and Health*, *54*(3), 954-976.

Hertz, P., Addad, M., & Ronel, N. (2012). Attachment styles and changes among women members of overeaters anonymous who have recovered from binge-eating disorder. *Health & Social Work*, *37*(2), 110-122.

Hoek, H. W. (2016). Review of the worldwide epidemiology of eating disorders. *Current opinion in psychiatry*, *29*(6), 336-339.

Hunter, B. D., & Merrill, R. M. (2013). Religious orientation and health among active older adults in the United States. *Journal of religion and health*, *52*(3), 851-863.

Joanna Briggs Institute. (2016a). *The Joanna Briggs Institute critical appraisal checklists for quasi-experimental studies.* critical-appraisal-tools - Critical Appraisal Tools | JBI

Joanna Briggs Institute. (2016b). *The Joanna Briggs Institute critical appraisal checklists for case reports.* critical-appraisal-tools - Critical Appraisal Tools | JBI

Joanna Briggs Institute. (2016c). *The Joanna Briggs Institute critical appraisal checklists for qualitative studies.* critical-appraisal-tools - Critical Appraisal Tools | JBI

Joanna Briggs Institute. (2016d). *The Joanna Briggs Institute critical appraisal checklists for cross-sectional.* critical-appraisal-tools - Critical Appraisal Tools | JBI

Keel, P. K., & Forney, K. J. (2013). Psychosocial risk factors for eating disorders. *International Journal of Eating Disorders*, *46*(5), 433-439.

Kessler, R. C., & Üstün, T. B. (2004). The world mental health (WMH) survey initiative version of the world health organization (WHO) composite international diagnostic interview (CIDI). *International journal of methods in psychiatric research*, *13*(2), 93-121.

Koenig, H. G. (2008). Concerns about measuring “spirituality” in research. *The Journal of nervous and mental disease*, *196*(5), 349-355.

Lambert, M. J., Burlingame, G. M., Umphress, V., Hansen, N. B., Vermeersch, D. A., Clouse, G. C., & Yanchar, S. C. (1996). The reliability and validity of the Outcome Questionnaire. *Clinical Psychology & Psychotherapy: An International Journal of Theory and Practice*, *3*(4), 249-258.

Lea, T., Richards, P. S., Sanders, P. W., McBride, J. A., & Allen, G. E. (2015). Spiritual pathways to healing and recovery: An intensive single-N study of an eating disorder patient. *Spirituality in Clinical Practice*, *2*(3), 191.

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British journal of psychiatry*, *199*(6), 445-452.)

Liberati, A., et al. (2009) The PRISMA Statement for Reporting Systematica Reviews and Meta-Analyses of Studies That Evaluate Healthcare Interventions: Explanation and Elaboration. British Medical Journal, 339, b2700.http://dx.doi.org/10.1136/bmj.b2700

MacMin, L., & Foskett, J. (2004). “Don’t be afraid to tell.” The spiritual and religious experience of mental health service users in Somerset. *Mental Health, Religion & Culture*, *7*(1), 23-40.

Maine, M. D., Samuels, K. L., & Tantillo, M. (2015). Eating disorders in adult women: Biopsychosocial, developmental, and clinical considerations. *Advances in Eating Disorders: Theory, Research and Practice*, *3*(2), 133-143.

Marsden, P., Karagianni, E., & Morgan, J. F. (2007). Spirituality and clinical care in eating disorders: A qualitative study. *International Journal of Eating Disorders*, *40*(1), 7-12.

Masters, K. S. (2013). Intrinsic religiousness (religiosity). *Encyclopedia of behavioral medicine*, *1*, 1117-1118.

Matusek, J. A., & Knudson, R. M. (2009). Rethinking recovery from eating disorders: Spiritual and political dimensions. *Qualitative Health Research*, *19*(5), 697-707.

Mazzeo, S. E., & Bulik, C. M. (2009). Environmental and genetic risk factors for eating disorders: what the clinician needs to know. *Child and adolescent psychiatric clinics of North America*, *18*(1), 67-82

Morgan, J. F., Marsden, P., & Lacey, J. H. (2000). “Spiritual starvation?”: A case series concerning Christianity and eating disorders. *International Journal of Eating Disorders*, *28*(4), 476-480.

Moss, B., & Gilbert, P. (2007). Flickering Candles of Hope: Spirituality, Mental Health, and the Search for Meaning: Some Personal Perspectives. *Illness, Crisis & Loss*, *15*(2), 179-191.

Mulchandani, M., Shetty, N., Conrad, A., Muir, P., & Mah, B. (2021). Treatment of eating disorders in older people: a systematic review. *Systematic Reviews*, *10*(1), 1-20

Musleh, S. (2017). Eating disorder of a Muslim American'hijabi'woman: Case study and cultural formulation. *Journal of Muslim Mental Health*, *11*(2).

O'Brien, E. J., & Epstein, S. (1988). *MSEI: The multidimensional self-esteem inventory: Professional manual*. Psychological Assessment Resources, Incorporated.

Olson, D. H., Bell, R., & Porter, J. (1982). FACES 11: Family Adaptability and Cohesion Scale.

Paloutzian, R. F., & Ellison, C. W. (1991). Manual for the spiritual well-being scale. *Nyack, NY: Life Advance*.

Papezova, H. (2002). History of services for eating disorders with regard to political and women's situational changes in the Czech Republic. *European Eating Disorders Review*, *10*(2), 79-84.

Pargament, K. I., Mahoney, A., & Shafranske, E. P. (Eds.). (2013). APA handbook of psychology, religion, and spirituality: Vol. 2. An applied psychology of religion and spirituality. Washington, DC: American Psychological Association

Pike, K. M., & Dunne, P. E. (2015). The rise of eating disorders in Asia: a review. *Journal of eating disorders*, *3*(1), 1-14.

Pike, K. M., Hoek, H. W., & Dunne, P. E. (2014). Cultural trends and eating disorders. *Current opinion in psychiatry*, *27*(6), 436-442.

Radloff, L. S. (1991). The use of the Center for Epidemiologic Studies Depression Scale in adolescents and young adults. *Journal of youth and adolescence*, *20*(2), 149-166.

Reich, K. H., Oser, F., & Scarlett, W. G. (1999). Spiritual and religious development: Transcendence and transformations of the self. *Being human; 2: Psychological studies on spiritual and religious development*, 7-24.

Renelli, M., Fletcher, J., Tupper, K. W., Files, N., Loizaga-Velder, A., & Lafrance, A. (2020). An exploratory study of experiences with conventional eating disorder treatment and ceremonial ayahuasca for the healing of eating disorders. *Eating and Weight Disorders-Studies on Anorexia, Bulimia and Obesity*, *25*(2), 437-444.

Richards, P. S. (1996a). The eating disorder self-monitoring scale (EDSMS). Technical report. Orem, UT: Center for Change.

Richards, P. S. (1996b). Therapist outcome evaluation scale: Technical Report. Orem, Utah: Center for Change

Richards, S. P., Berrett, M. E., Hardman, R. K., & Eggett, D. L. (2006). Comparative efficacy of spirituality, cognitive, and emotional support groups for treating eating disorder inpatients. *Eating Disorders*, *14*(5), 401-415.

Richards, P. S., Caoili, C. L., Crowton, S. A., Berrett, M. E., Hardman, R. K., Jackson, R. N., & Sanders, P. W. (2018). An exploration of the role of religion and spirituality in the treatment and recovery of patients with eating disorders. *Spirituality in Clinical Practice*, *5*(2), 88.

Richards, P. S., Sanders, P. W., McBride, J. A., & Lea, T. (2014, August). Bridging the research-practice gap with a clinically adaptive internet-based outcome system. In *annual convention of the American Psychological Association, Washington, DC*.

Richards, P. S., Smith, M. H., Berrett, M. E., O'Grady, K. A., & Bartz, J. D. (2009). A theistic spiritual treatment for women with eating disorders. *Journal of Clinical Psychology*, *65*(2), 172-184.

Richards, P. S., Smith, T. B., Schowalter, M., Richard, M., Berrett, M. E., & Hardman, R. K. (2005). Development and validation of the theistic spiritual outcome survey. *Psychotherapy Research*, *15*(4), 457-469.

Ronel, N., & Libman, G. (2003). Eating disorders and recovery: lessons from overeaters anonymous. *Clinical Social Work Journal*, *31*(2), 155-171.

Saloni Dattani, Hannah Ritchie and Max Roser (2021) - "Mental Health". *Published online at OurWorldInData.org.* Retrieved from: 'https://ourworldindata.org/mental-health' [Online Resource]

Saunders, S. M., Miller, M. L., & Bright, M. M. (2010). Spiritually conscious psychological care. Professional Psychology: Research and Practice, 41(5), 355.

Smith, F. T., Hardman, R. K., Richards, P. S., & Fischer, L. (2003). Intrinsic religiousness and spiritual well-being as predictors of treatment outcome among women with eating disorders. *Eating Disorders*, *11*(1), 15-26.

Spilka, B., & McIntosh, D. N. (1996, August). Religion and spirituality: The known and the unknown. In *American Psychological Association annual conference, Toronto, Canada*.

Spielberger, C. D., Gorsuch, R. L., Lushene, R., Vagg, P. R., & Jacobs, G. A. (1983). Manual for the State-Trait Anxiety Inventory (Form Y). Palo Alto, CA: Consulting Psychologists Press.

Strother, E., Lemberg, R., Stanford, S. C., & Turberville, D. (2012). Eating disorders in men: underdiagnosed, undertreated, and misunderstood. *Eating disorders*, *20*(5), 346-355.

Wasson, D. H., & Jackson, M. (2004). An analysis of the role of overeaters anonymous in women's recovery from bulimia nervosa. *Eating Disorders*, *12*(4), 337-356.

Weltzin, T. E., Cornella-Carlson, T., Fitzpatrick, M. E., Kennington, B., Bean, P., & Jefferies, C. (2012). Treatment issues and outcomes for males with eating disorders. *Eating disorders*, *20*(5), 444-459.

Wong, Y. J., Rew, L., & Slaikeu, K. D. (2006). A systematic review of recent research on adolescent religiosity/spirituality and mental health

Chapter 2- Empirical Paper

Exploring the experiences of eating disorder recovery in the context of diet culture

Rebecca Bale[1,] Dr Mike Jackson[2] and Tamsin Speight[3]

1. North Wales Clinical Psychology Programme, School of Psychology, Bangor University, Bangor, UK
2. North Wales Clinical Psychology Programme, School of Psychology, Bangor University, Bangor, UK
3. Complex and Enduring Eating Disorder Service, Betsi Cadwaladr University Health Board, Bangor, UK

Corresponding Author: Rebecca Bale, North Wales Clinical Psychology Programme, School of Psychology, Bangor University, Bangor, UK. Email: rbb19ckl@bangor.ac.uk

---

This paper will be submitted to the Journal of Eating Disorders

Abstract

Eating disorders are complex mental health difficulties, recovery rates are highly variable, and research suggests that definitions of recovery significantly differ between those delivering and those receiving services. Current conceptualisations of eating disorder aetiology and recovery take a biopsychosocial perspective, though many argue that the sociocultural factors are not equally represented or sufficiently integrated in mainstream treatments. One such sociocultural factor is that of diet culture, a master narrative of values, beliefs, ideologies, and discourse that privilege those who have or can achieve a body that meets the thin ideal, whilst discriminating against those that cannot. This study used narrative methodology to explore the experiences of eight adults who had recovered from an eating disorder within the United Kingdom. Participants were asked to reflect on their recovery and how they felt diet culture had impacted this. Findings highlight the additional challenges diet culture poses to eating disorder recovery which is seen as counter-cultural in the context of dominant discourses promoting bodily and dietary control. Development of a critical awareness of sociocultural context and an ability to challenge or reject this was a turning point in many participants recovery. Implications and limitations are discussed.

Introduction

Diet Culture

This study explores the experience of people in eating disorder recovery by considering their personal narratives in the context of social 'master narratives'. Master narratives are culturally dominant narratives or positions that are regarded within societies as the appropriate ways to experience and behave in the world (Thorne & McLean, 2003). The rules, ideas, values, and concepts which make up this narrative and dictate how the world ought to be conceal patterns of domination and submission that include and privilege some whilst necessarily excluding others. This echoes Gramsci's idea of hegemony (Gramsci, 1992 cited in Smith, 2010) in which one group dominates over another with ideology, propagating values, and norms through social institutions such as schools, courts, churches, and the media. Gramsci argues that these institutions socialise people into these ideologies to such an extent that the dominated group comes to view them as common sense and therefore does not question or challenge them.

Within Westernised cultures one such master narrative is that of 'thinness as the ideal' (McCarthy, 1990) which affords individuals 'thin privilege' as thinness is equated to desirable attributes of self-control, discipline, and health (Musolino et al., 2016) fitness and wellbeing. (LaMarre & Rice, 2016). Those who can achieve thinness are afforded cultural capital (Bordieu, 1986, cited in Calussen & Osborne, 2013) whilst those who do not fit this ideal experience weight bias, stigma and discrimination that limits access to equitable healthcare, education, employment, and leisure opportunities (Frederick, Saguy & Gruys 2016).

This narrative is supported by complex rules and values around food, body image, and exercise. Dietary choices are equated to morality (Musolino at al., 2016) foods deemed to be 'healthy' are labelled as 'virtuous' and 'good' and food deemed to be 'unhealthy' labelled as 'sinful' or 'naughty'. People, women particularly, are told that their bodies are projects to be taken care of, that careful attention should be paid to appearance and weight as means of signalling moral virtue (Pond et al., 2010). Beliefs about the controllability of

weight and appearance have been conflated to ensure the responsibility remains within the individual whilst structural influences such as privilege, status or affluence have been minimised or excluded from diet and health discourse (Aphramor, 2005).

Unrealistic promises of sustainable change drives people to engage in diets that have a low success rate, with even the most 'successful' diets only reporting sustained weight loss in 5% of cases (Noel & Pugh, 2002) and sustain a multi-billion-pound industry ("Fat Profits" Peretti, 2013).

According to Hudelson's (2004) definition of culture 2the shared…(implicit and explicit) values, ideas, concepts and rules of behaviour that allow a social group to function and perpetuate itself" the master narrative around thinness as the ideal holds the status of a culture within western societies. One of the most active and influential, though by no means only, context in which this narrative is transmitted is the media (Bordo, 1993) and social media (Gelsinger, 2021). In such arenas this culture is often referred to as 'diet culture' and in recent years a movement of 'anti-diet culture' has grown in presence and influence across social media platforms (James, 2020).

Eating Disorders

Due to concerted research efforts over the previous three decades to acknowledge the influence of sociocultural factors in understanding the aetiology of eating disorders they are now widely accepted as biopsychosocial problems (Holmes et al., 2017). Current conceptualisations of eating disorders incorporate knowledge regarding temperament, neural circuitry, and neurochemistry from the biomedical paradigm and the sociocultural perspective focuses on messages received about gender, body shape and eating (Levine & Smolak, 2014).

Eating Disorder Recovery

However, despite widespread acceptance of sociocultural influences on eating disorder development, many still feel it is unequally represented or inadequately integrated into mainstream treatments (Holmes et al., 2017). Indeed, NICE guidelines acknowledge the psychosocial elements of eating disorder recovery, suggesting they pertain to 'weight and

shape' but fail to provide guidance or suggestions on how to address these in the treatment of anorexia, and when discussing bulimia nervosa, binge eating disorder, or other specified feeding and eating disorders such perspectives are not even mentioned (NICE, 2017). However, NICE recommended treatments for Anorexia Nervosa, such as the Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA, Schmidt et al., 2018) do acknowledge the influence of sociocultural factors and emphasise the importance of addressing these within treatment. Yet internalised weight stigma amongst professionals may be another barrier to participants receiving care which acknowledges social determinants of weight and health. Kinavey and Cool (2019) state that anti-fat bias is prevalent within psychotherapy professionals and often goes unexamined which is associated with greater frustration when working with overweight patients, poorer treatment outcomes, and weight difficulties more often attributed to behavioural causes (Puhl et al., 2013). Given that most professionals will also have been exposed to diet cuture throughout their development, it is unsurprising these biases have been internalised, yet as professionals they have a responsibility to address them to minimise harm to patients (Kinavey & Cool, 2019).

Several studies have focussed on sociocultural factors in recovery and identified themes and processes which allude to the impact of diet culture. A strong theme within the existing literature is recovery as counter cultural (LaMarre & Rice, 2016) whilst the eating disorder is seen as being consistent with cultural values and as such affords safety, recovery seems defeating and contradictory (Musolino et al., 2016). As such, research also suggests that people need to become cultural critics, aware of and able to challenge harmful cultural forces, such as the thin ideal and societal assumptions about gender roles (Hockin-Boyers & Warin, 2021; Venturo-Conerly et al., 2020; Holmes et al., 2017). Holmes et al., found that engagement with feminist ideology was experienced as helpful in this task, participants expressed feeling it should be included in treatment as it had an "obvious explanatory power." Due to the qualitative nature of these studies, it is difficult to assume a directionality of these processes, Venturo-Conerly et al., asserts it is by becoming critical of cultural forces

that women can recover, whilst Hockin-Boyers et al., implies it is the process of recovery that leads to empowerment of women.

Within this body of research, narrative methodology has been frequently used with recovery accounts taking the form of quests, often towards self-discovery including identity beyond the eating disorder, self-acceptance, and other ways of belonging (Garrett, 1997 & Moulding, 2016, Eli, 2018; LaMarre & Rice, 2016; Hockin-Boyers et al., 2021; Hardin, 2003)

Aims

To date, the limited but growing number of studies exploring what it means to recover from an eating disorder in a society obsessed with the pursuit of thinness have done so by applying a sociocultural lens to the analysis of participants answers to broader questions relating to recovery. This study therefore aimed to contribute to understanding by centring participants own sense-making of their experiences by explicitly asking them to reflect on their experiences of recovery in the context of diet culture. A qualitative narrative approach was selected to achieve these aims.

Method

Design

Narrative interviews and a single narrative inducing question was devised to allow participants choice and control over the sharing of their stories with as little influence from the interviewer as possible (Wengraf, 2001). This included allowing participants to see the question prior to the interview and an explanation about the open-ended style of the interview and question. The interviewer provided prompts in the form of summaries of participants answer so far, or open-ended questions to support the flow of the narrative where needed.

Participants

Inclusion criteria for participants were:

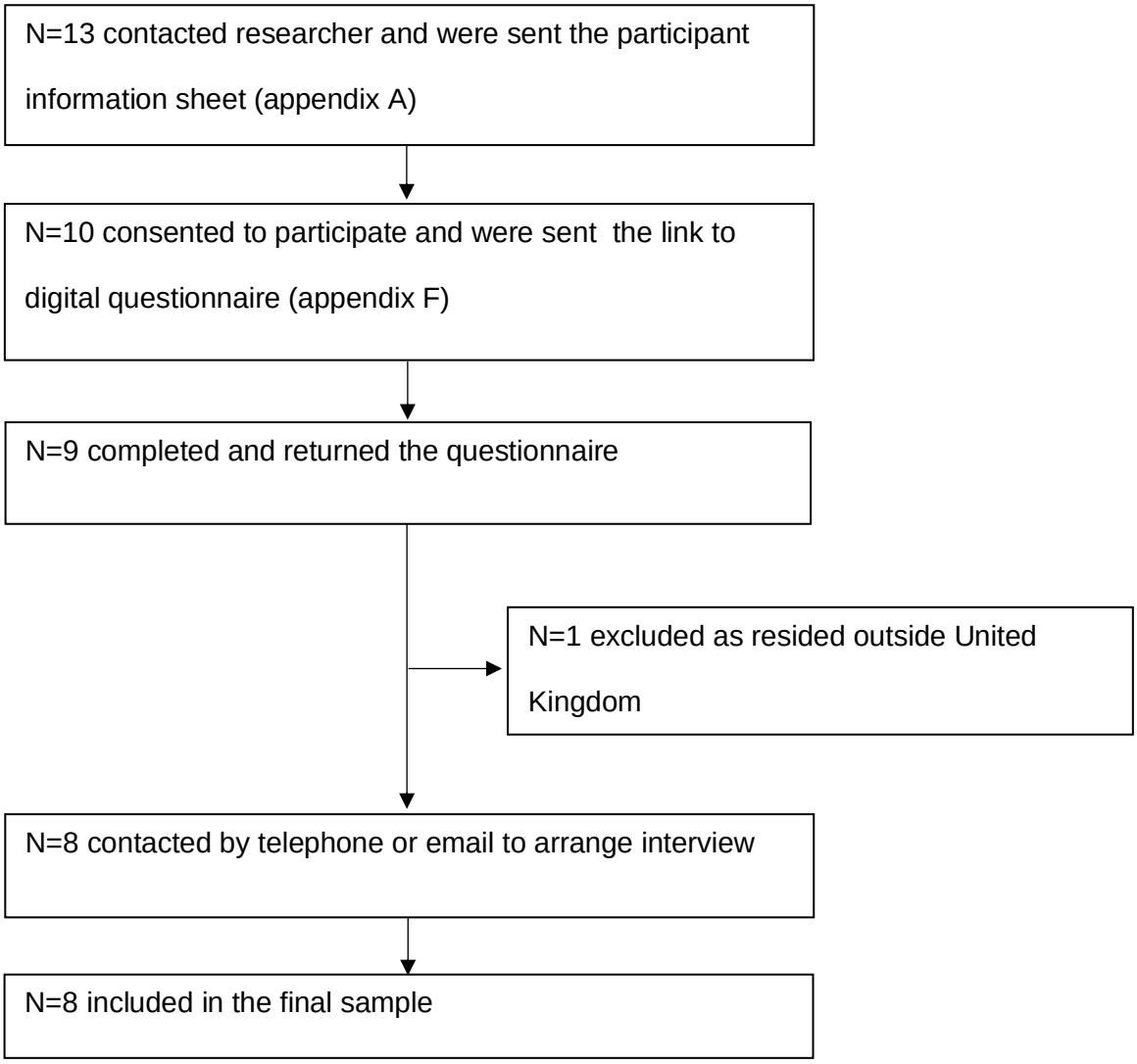
1. Aged 18 years old or over.
2. Self-identified as having experienced an eating disorder of sufficient significance that it impacted on their social, emotional, or other functioning.

3. Self-identified as in recovery or recovered from an eating disorder
4. Able to engage in video interview
5. Lived in the United Kingdom

Participants were recruited via social media; the primary researcher created an advert (appendix E) that was shared on their own social media platform along with relevant hashtags such as “eatingdisorderrecovery” and asked their ‘friends and followers’ to also share. The primary researcher also approached an eating disorder recovery advocate on Twitter with a ‘following’ of over 11,000 who agreed to share the study advert. The recruitment process is illustrated in figure 2.

Figure 2

Recruitment Process



The sample consisted of eight adults who self-identified as having experienced an eating disorder and either recovered or in recovery. Seven participants were female. Six participants were White-British. Participants differed in the eating disorder diagnoses and treatments they had received, see table 4.

Table 4

Participant information

Participant Pseudonym	Gender Identity	Age Category	Ethnic Group	Self-IDiagnosis	Formal Diagnosis	Age of Eating Disorder Onset	Recovery Status	Time in Recovery/ Recovered	Formal treatment received?
Jo	Female	25-29	White British	AN BN	BN	16 years	In recovery	6-7 years	Medication, individual & group CBT, (dropped out)
Anna	Female	25-29	White British	AN BN EDNOS	AN with BN tendencies	13 years	In recovery	2 years	CAMHS CBT from ED charity
Kay	Female	40-49	White British	AN BN	AN BN	11 years	Other	15 years	None
James	Male	25-29	White British	AN	AN	16 years	In recovery	3 years	Therapeutic Support Inpatient admissions on ED ward
Jenna	Female	25-29	White British	AN	AN	15 years	Fully recovered	7 years	FBT, CBT, Day Treatment
Sophie	Female	25-29	White British	AN BN EDNOS	AN	12 years	Partially recovered	5 years	CAMHS University support group ED counselling
Hayley	Female	18-24	White & Black African	BN BED	BED BN	16 years	Partially recovered	1 year	Counselling
Janet	Female	30-39	African	BED	BED	32 years	Partially recovered	1 year	Church Counsellor

AN: Anorexia Nervosa. BN: Bulimia Nervosa. BED: Binge Eating Disorder. EDNOS: Eating Disorder Not Otherwise Specified. CBT: Cognitive Behavioural Therapy CAMHS: Child and Adolescent Mental Health Service. ED: Eating Disorder. FBT: Family Based Therapy

Procedure

Participants engaged in one video interview between February and March 2022, two participants chose not to have their videos on during the interview. Interviews took place in participants' homes. Interview duration ranged from 35 to 70 minutes. The consent form was reviewed and discussed. Participants provided written consent to participate in the research, have their interview audio-recorded, and for the use of direct quotes in publications. Participants could pause or stop the interview, or withdraw from the study at any time, however their interview data could be not removed once it had reached analysis.

Participants were invited to share their experience of recovering from an eating disorder in the context of diet culture. The interviewer encouraged telling of their story by actively listening, and using brief additional questions or short summarising statements when appropriate. Interviews were audio-recorded and transcribed verbatim by the primary researcher.

Analysis

Wengraf, (2001) argues biographical narratives are "powerfully expressive…of the natures of persons, cultures and milieux" to researchers in uncovering "embedded and tacit assumptions, meanings, reasonings and patterns of action and inaction". However, as discussed by Elliot, (2005 p. 36) there is no "standard approach or list of procedures that is generally recognized as representing the narrative method of analysis" and rather it encapsulates a variety of approaches. Each approach shares a central assumption that people construct stories that are determined by both the context in which they are created and shared to make sense of their experiences (Elliot, 2005).

Lieblich et al., (1998) present two independent dimensions which can be applied to narrative analysis, "holistic" versus "categorical" and "content versus "form". These dimensions provided a framework for analysis which also incorporated other narrative analysis techniques, with a specific focus on social context (Wengraf, 2001).

Analysis was an iterative, rather than linear process, which occurred through several readings of the texts and listening to the recording's multiple times across stages:

1. Transcribing and anonymising the interviews. Whilst transcribing the researcher made initial comments on the transcription of insights and observations.

2. Listening to the audio recording whilst reading the complete transcriptions of the interviews again to immerse themselves in the interview. Whilst listening further coding of main themes and subthemes was completed.

3. Creating a "story summary" (Skippon, 2010) for each participant, seven participants opted to receive these to assess for accuracy, three provided feedback. During this phase a particular emphasis was placed on discerning the emotional tone of the narrative to incorporate into the story summary.

4. Considering all narratives together to identify common themes and subthemes between the narratives to create a "story-arc" (citation) or "master-narrative" (citation).

Additionally, each participant's narrative was assessed for coherence to explore the relationship between the form and content of narratives. For this study the Baerger and McAdams (1999) system was used. Unity and integration of self across time and situations is at the centre of their conceptualisation of coherence and their system comprises four dimensions; 1. orientation and 2. structure, is there sufficient background and structure for the reader to be able to follow? 3. affect and 4. integration, is the importance and meaning of experiences to the narrator clear to the reader?

Validity

Narrative researchers are "crucially a part of the data we collect; our presence is imprinted on everything we do" (Squire et al., 2013 p.36) therefore it is the responsibility of the researcher to consider how their own positioning, the positions of participants, and the intended audience impacts upon the conclusions reached and shared.

As such, several processes were followed to foster reflexivity. Firstly, the primary researchers kept a reflexive diary to consider their position and assumptions, and the influence these may have had on the analysis (see reflexivity statement).

Additionally, regular meetings were held between the researchers which discussed possible interpretations of data which highlighted how different positions impact upon this process and encouraged reflexivity.

Finally, as discussed, a story summary was created for each participant by the primary researcher. Participants were informed of this prior to consenting to participate and reminded at the end of their interview that they had this opportunity and asked whether they would like to see it. Six participants agreed they would, one said they did not, and another was unsure. Once the summaries were written the seven participants were contacted asking if they would like to view them, four responded asking to see them, three did not respond. The summaries were sent via email with an explanation of how they had been created, emphasising the efforts made to use their own words and sense-making whilst also acknowledging the nature of narrative research meant there would be evidence of the researchers own interpretations within in it as well. Participants were encouraged to take their time to read it, consider whether it felt meaningful and true to them, and offered the chance to arrange a video call to discuss. Of those who received them, one did not provide feedback, one emailed their responses indicating they were overall happy with the narrative and asked that one small detail be changed, another emailed to say they felt the narrative made sense and was true to them. The third shared feeling the narrative had powerfully captured their story and reading it had been an emotive experience which had created feelings of self-compassion. No participant felt it necessary to meet via video call to discuss further. The responses received were seen to validate the analysis.

Reflexivity Statement

As a woman with lived experience of recovering from an eating disorder within the UK I have first-hand experience of the very process I asked participants to discuss and reflect upon. Developing a critical awareness of diet culture was one of many turning points in my recovery, although similarly to the experiences of many participants in this study, it was not until much later in my recovery that I discovered diet culture. It is my lived

experience and conviction in the importance of developing a critical lens, particularly in relation to our consumption of diet culture that led me to this research project.

I am aware that my privileges as a white, cisgender, able-bodied, educated, middle-class woman whose body fits within the socially constructed definition of “normal” significantly affected how I experienced diet culture during my recovery, offering protection against the harm of discrimination or marginalisation. Therefore, I do not assume that our shared experiences equate to the same experiences.

No participant was made explicitly aware of this position prior to the interviews, though it is reasonable to assume some may have wondered. I am also aware that my position as a trainee clinical psychologist and researcher will have influenced how they related to me, and I to them, throughout the research process.

Results

All narratives were assessed for coherence which generated several salient observations.

Firstly, the narratives of participants in later or more stable recovery were largely more coherent than participants in earlier stages. Narratives had interwoven background information, shared insight into emotional experiences, and evidence of integration of these experiences into their sense of self, or broader meaning making. All participants used temporal and causal elements to structure their narratives, several organised according to developmental milestones or life stages.

Secondly, for most participants coherence improved following sharing of background information either through one large recount of development or course of eating disorder and recovery, or through elements being interwoven.

It was noted that participants frequently used second person tense during narratives which had the effect of disturbing coherence as it was unclear whether the events recounted were personal to them, or observations of global experiences of recovery. One participant in the early stages of recovery talked predominantly from this position and only when the

interviewer asked questions emphasising personal focus was language used which suggested more ownership over events recounted.

Results

To preserve the participants' narratives and maintain a holistic approach the following chapters contain all the elements of analysis, rather than being presented as distinct categories.

Due to the depth and richness of the data collected through the narratives, it is not possible to discuss all the identified chapters in detail. Therefore, the bulk of the results focuses on chapter three, as this was most relevant to the aims of the research. As the other chapters offer rich contextual information, they are described briefly in table 5.

Table *5*

Chapter Descriptions

Chapter Number and Title	Description
1. Laying foundations	Participants recounted experiences during development they viewed as predisposing them to developing eating disorders. Two primary themes of learning were shared: Firstly, that worth is tied up in physical appearance, often in context of gender-based norms and narratives, or weight-based bullying. Secondly, five participants spoke of inter-generational patterns of disordered eating which were internalised.
2. Having an eating disorder	Participants shared information about the course of their eating disorder, specifically how efforts towards, and actual weight loss had been reinforced by others. Participants with experience of being in bigger bodies spoke of the stigma they experienced, and the pressure they felt from others to lose weight.
3. Stages of recovery	The story-arc of the recovery journey created by considering all participant narratives together and identifying shared events and experiences.
4. What it means to recover	Participants described what recovery meant to them. They highlighted that weight stabilisation and symptom reduction was overemphasised within services which simplified complexity of recovering, their definitions were more holistic and involved self-discovery and striving for freedom.
5. Coming full circle	Though participants' narratives did not commonly reach a conclusive end, they shared reflections on past experiences and related these to the future which created a sense of circularity. For example, reflections on their own treatment and concerns for future of eating disorder services within the current context, and reflections on their own experiences as creating a drive for change which motivated them to action such as advocacy, participation in research, and working with mental health services.

Chapter Three: Stages of Recovery

3.1 Resistance.

Participants discussed how they felt a lot of resistance during early recovery. In some cases, this was attributed to the eating disorder, and perceived protection it afforded from negative evaluation by others that would come with weight gain:

"For me…the root cause is what other people think of me … the fear of gaining weight is you know very very scary because …I've got that really strong attachment that what other people think about me is the be all and end all and it's really important to the eating disorder" (James)

For others, their reluctance stemmed from feeling recovery was counter to cultural values and dominant discourse which made recovery seem confusing and pointless:

"I don't understand why what I'm doing is so wrong like we're told by the government to eat our fruit and veg get our five a day so I just don't understand why I'm being told that's not ok" (Jenna)

"…when your body is just about fitting what diet culture says is normal why are you going to recover, what is the point?" (Anna).

Anna likened her eating disorder cognitions to the practises she had seen on TV where adults would pay to have "someone screaming in their face" to encourage exercise, remarking "I've got it in my head for free why would I want to get rid of that when it's what they are looking for to make their life better".

The narratives of Jo and Sophie both eluded to a reluctance to let go of the thin ideal. Sophie clearly articulated her beliefs of what thinness would deliver, which demonstrated why it was difficult to let it go:

"…then I'll be happy, and I won't feel you know so bad, and I won't hate myself as much and everything will be easier." (Sophie).

Whilst Jo described having been aware of a shift in societies views towards bodies as being less attached to the thin ideal, she felt unable to give it up, stating that "this is my ideal not like diet culture or society." This seemed to create ambivalence for her, "I could go back on it but yeah still don't want to", she acknowledged "I did internalising it to like the nth degree at that point".

3.2 An Unacceptable Body

All participants discussed how their eating disorder afforded them or was partly driven by desire for a societally acceptable body, and recovery risked the loss of this body or required acceptance of an "unacceptable" body.

Several participants spoke of how the attitudes of others impacted on their own experiences of their bodies. As discussed above James felt fearful of negative evaluation were he to gain weight, whilst the experiences of Kay, Hayley and Janet seemed to corroborate his fears. They spoke of negative responses or attitudes from others when living at higher weights, including feeling pressure from others to lose weight and being body shamed which maintained their eating disorder behaviours and created emotions of shame, and disgust. Hayley articulated the differences in how she was treated by others depending on her body size "you tend to see things quite differently in the way strangers like treat you they treat you much better when you're skinnier" and attributed this to the beliefs people hold about fatness "people view fat people as being lazy."

Similar lived experiences were captured within literature Sophie had read, and she reflected how this awareness of others' perceptions of bigger bodies impacted on her:

"…no amount of … me not caring what other people think is gonna sort of like erase [that]… I think it has been really difficult to try and accept, my body, the way that it is now in the face of, sort of society and its obsession with with thinness" (Sophie).

Others spoke of their own internal judgments and criticisms of their bodies following weight gain and for Anna and Jenna how these intersected with societal narratives about weight control:

"I've put on this weight over lockdown and last year….and I'm fucking miserable" (Jo)

"…once you've reached a stable weight…the cognitions haven't gone away they're still there…your body shape has changed so you're left with cognitions hating your body and wanting to control your weight in a world that tells you should control your weight and if you don't you're lazy". (Anna)

"…it's very hard to restore weight and gain weight in a society that is telling us constantly that we value thinness we need to lose weight." (Jenna)

3.3 Developing a Critical Awareness

Participants spoke of becoming critically aware of diet culture, metaphors were commonly used to describe this, Sophie described it as seeing through a “façade” Hayley spoke of discoveries that “opened my eyes to everything” and Anna described learning about diet culture as “entering a whole new world”.

This process was seen as significant for most participants and Anna even expressed her belief that “if I’d known about diet culture earlier on I think I would have recovered quicker” as she shared that since learning about diet culture and “understanding that this is a toxic environment that is kind of perpetuating the stereotype that you need to be slim… starting to unpack that as not true and not sustainable and not ok is actually something that helps … you recover”.

For Sophie and Hayley realising the images represented in the media which embodied the thin ideal they had been striving for were not real increased their motivation to recover:

“…it withdrew my need of seeking validation and looking perfect because … it felt like you’re chasing something that’s non-existent” (Hayley)

“…I think realizing that that wasn't the case was also a big part of like OK well then, I need to get … this shit sorted out for lack of a better word” (Sophie)

For Hayley, this co-occurred with confronting the risks of her eating disorder, which pushed her to see an alternative:

“…you find that you might die like the model who died just for the sake of pleasing people whereas you could be healthy and comfortable with yourself.”

Participants also shared difficult experiences associated with increased critical awareness. Jo shared feelings of anger towards a plus-size advocate which she believed was because she was jealous of her freedom, whilst she was still so affected by her eating disorder. Whilst Kay, Anna and Jenna reflected on their sadness, shame, and guilt when recognising their own internalised biases or beliefs towards bigger bodies, and self-criticism when they felt pulled to give into diet culture. However, recognising a process of conditioning and internalisation seemed helpful in ameliorating these difficulties:

“…but it's still there in the back [of your head] which is really sad really sad and I'd be ashamed to think it, but I think possibly we might be conditioned to do that” (Kay)

"I don't think I recognise it internalised as much, I recognise its there but I always kind of put this blame on it somewhere else and actually I think I don't need to blameful of the internalised version" (Anna).

Furthermore, both Jo and Janet's narratives identified a difficult position where they were aware of diet culture and the harm it caused, yet felt unable to disregard it:

"…sometimes when I say I … want to be thin I tend to label the junks as bad then I try to focus more on healthy meals but at the same time I just find myself going back to the bad foods that increases shame and also guilt" (Janet)

"…reject these really stup- because I can tell myself that its stupid, but at the same time it's like well it might be stupid but what if what if, what if it is working" (Jo).

3.4 A New Position

As discussed above, the process of becoming critically aware of diet culture led to shifts in perspectives, and increased motivation for participants. Participants narratives alluded to a process by which this occurred, the discovery or adoption of alternative positions that were incompatible with diet culture and eating disorder beliefs.

For James and Hayley, who both spoke of how negative evaluation from or desire to please others maintained their eating disorders, reducing the worth they put in others validation and choosing themselves were significant in their recovery:

"[You] just need to come to a place where you choose yourself where you choose to be at a balance with everything you have to agree, like make a commitment to yourself" (Hayley)

For James, discovering an identity beyond his eating disorder, went "hand in hand with personal recovery" and through finding increased self-confidence he was able to be "more comfortable in doing eating disorder [recovery] related things."

Sophie, Anna, and Jenna all spoke of discovering or adopting positions that opposed diet culture, for Jenna and Anna they identified as being "anti-diet culture" and Anna also spoke of developing an interest in "wellness culture." Sophie described a "turning point" in her recovery as being at university and connecting with "critiques of beauty, femininity and society" whilst also

being exposed to women who were comfortable in their bodies and did not conform to the "traditional rules of femininity" which she described as discovering "another way to live".

However, Anna and Kay both spoke of difficulties with taking an anti-diet culture position. Jenna described it as being a "lone voice." This was echoed in Anna's accounts of feeling she was the only one who believed it which could undermine her own conviction "I have to remind myself it's real because I still fall into the trap of being like no you're the one sticking out" and likened having to continuously attest that diet culture was real to a "battle".

Both also spoke of how their position can be perceived by others, Jenna recalled being called "judgy" by a friend, whilst Anna expressed that she could hear people get "exhausted" with her. They both shared how difficult it is to hold this position when it is counter to the dominant position in society around them:

"…it's bloody hard to reject diet culture because it's not rejected in the world around you" (Anna)

"actually it's hard to kind of stand your ground sometimes" (Jenna).

For Kay, it was becoming a mother that changed her position to the eating disorder, she recalled a "shift" from viewing her eating disorder as "something clever" when she was younger, to something she was ashamed and frightened of upon discovering she was pregnant. She described this as creating a "dichotomy of priorities, I was no longer the priority this baby was the priority, I had to fight it really, really hard in a way that I didn't have the incentive to do before". Later, from her position as a mother to daughters she gained a new perspective in which she would try and "take a step back and look in as I would with my children" which "heightened" the cultural forces they were subject to as women.

Conversely, Jo discussed how a lack of exposure to "normal healthy behaviour that we could model" during her time at university had allowed her eating disorder to remain an "open secret" nobody commented on.

3.5 Conscious (Constant) Choices

Participants spoke of the conscious choices they had to make towards, or to sustain recovery. For some these were described as feeling constant, which was challenging to their recovery.

Sophie, James, and Jenna reflected on how increased responsibility during different forms of treatment required them to be more active in the choices they made. Treatment was mostly viewed as minimising the responsibility they felt for their recovery:

"…being told that I had to sit and finish a meal, you know, that to me, I don't really view that as part of my recovery because that was something that was sort of enforced upon" (Sophie)

"In a hospital it is still down to you but it's just you know professionals basically telling you what to do and there's not that much responsibility…you don't really have much choice" (James)

They spoke of how realising "I have to do this for myself now" (Jenna) either when they were discharged from inpatient to community treatment, or finished treatment increased the difficulty of their recovery yet was framed as being necessary for long-term recovery:

"I always viewed, recovery as like the things that I have … consciously made decisions to do" (Sophie)

"…it's 100 times harder but if you're able to manage it, and if you're able to feed yourself in the community then you're going to be able to sustain yourself in the long term" (James).

Several narratives reflected the increased difficulties of making these choices in the context of diet culture:

"…it feels like the easier option in some ways to go along with it [diet culture] … I think that's why it has to be a conscious choice, because otherwise I think I could so easily get swept away in it (Jenna)

"A big thing for me was getting out of habits of automatically buying like lower fat diet versions of things and…the push for those, I think has it's made food shopping quite difficult" (Sophie)

Hayley, who was early in recovery chose herself and to find a balance, she worked towards her recovery by making regular commitments which she referred to as "mini-goals". She described this early commitment as being "quite a struggle" not to "go back to the old habits."

However, Jo and Janet, both at earlier stages of their recovery, illustrated that making a conscious choice to recover was not in itself sufficient. They both described vacillating between wishing to lose weight which maintained their eating disorder, and trying to reject this striving and be comfortable in their bodies:

“You see this thin models then tell yourself I'm going starve myself and just look [like] them…then again, I scroll I see a chubby lady…now I feel like I want to look like this chubby lady so I get back into my comfort zone I continue eating” (Janet).

“…it’s sort of its like being pulled by two- two halves cause on the one hand y’know on the one hand I want to recover and enjoy my life and ... and on the other hand it’s like do you though or do you really just want to be thin again, the answer is the first one but also kind of the second one” (Jo).

3.6 Eating Disorders & Diet Culture; “it feels like it's a fight when you've already had to fight so hard”

In addition to the challenges of making choices towards recovery in the context of diet culture, narratives spoke of other challenges of maintaining recovery within this context. Anna and Jenna likened this to a fight:

“...having to almost bribe yourself to get better and then... push away diet culture alongside that …it’s absolutely exhausting … it can be a constant battle” (Anna)

“That is the main message, that it feels like it's a fight when you've already had to fight so hard” (Jenna).

Participants discussed diet culture’s influence in several ways. Firstly, the values and norms of diet culture endorsed eating disorder behaviours or cognitions:

“…the diet talk and the promotion of diets does further influence you and almost reinforces the the notion that you know dieting or restricting your intake with food is the the right way forward, it feeds into that eating disorder thought of you know you need to restrict your intake in order to be a better person or in order to be liked in society” (James).

Jo similarly described the eating disorder and diet culture as an “inner monologue” reinforced by “external people telling you what to eat and what to look like and what to do” which she described as “a pain in the ass”.

Anna described that despite actively trying to improve her relationship with exercise, she still experienced shame and guilt which she believed to be due to both lingering eating disorder cognitions which diet culture encouraged.

Anna and Jenna in their narratives described the overlap between diet culture and eating disorders as making recovery more difficult:

“…when they’re overlapping its bloody confusing so it’s so uncomfortable and difficult to be direct and distinct and say no that’s an eating disorder cognition and that’s bad we stop that when it’s both” (Anna)

“…it can feel a bit kind of not scary but feel a bit like oh maybe, maybe it is always going to be with you” Jenna).

Others spoke of constant reminders or triggers due to diet culture:

“…going into a shop and I kind of appreciate why the food traffic system light might of come in place, but again, being bombarded with the like red traffic light or whatever thing on food” (Jenna)

“…that's shame of just feeling like you go to the doctors and they're going to judge you… they’re not going to look at what's really wrong and they're gonna look at you being so overweight… I think that comes from that kind of global infiltration through to, you know, even to the doctor, even to everybody that you're talking to you know psychologists” (Kay).

“…but the introduction of things like calorie counts on menus I found really difficult because a huge part of recovery for me was stopping looking at calories, thinking about calories, any of the numbers associated with it so it's really difficult to sort of navigate” (Sophie).

Janet identified that diet culture’s values surrounding acceptable and unacceptable bodies underpinned her attempts to lose weight to be “loved by those people who feel they love thin people” which were a part of her binge-eating cycle.

Discussion

Summary of Findings

This study aimed to explore the experiences of recovery from an eating disorder within the context of diet culture. A narrative approach was utilised which centred the participants own sense-making of their experiences. By identifying the common, events, experiences, turning points and meanings within each participant's story, a master narrative was created which captured how the participants made sense of their recovery experiences within the sociocultural context of diet culture. The narrative is presented as chapters which illustrate the arc of their recovery stories capturing the impact of diet culture on an underlying process of stages of change.

During early recovery, diet culture was discussed as contributing to participants' resistance to recovery. Eating disorders were viewed as consistent with dominant cultural discourse, whilst recovery risked loss of safety, status, and cultural capital (Bordieu, 1986). This echoes the findings of previous research in which the counter-cultural position of recovery was described as defeating and contradictory (Musolino et al., 2016; LaMarre et al., 2016).

Narrative recounts of a later stage of recovery highlighted how attachment to the thin ideal within society, and participants internalisation of these values increased the challenges of accepting their bodies at higher weights following weight gain during recovery or letting go of striving for the thin ideal for participants in bigger bodies.

A key stage of change was developing a critical awareness of diet culture, which was a key turning point to evaluating the eating disorder and self differently. Participants were at different stages within this process, those earlier had less coherent narratives, and expressed greater ambiguity or ambivalence towards diet culture. Those later in recovery were critically aware of both the thin ideal and the over-conflation of controllability of weight, which was discussed as critical in creating motivation for change. The thin ideal was re-evaluated as unrealistic and unachievable, and behaviours to control weight deemed pointless. These findings echo those of Venturo-Connerly et a., (2020), Holmes et al., (2017) and Hockin-Boyers and Warin (2021) who identified that developing as cultural critics was helpful in recovery.

This stage of change was represented in narratives as a slow, gradual, and often painful process of confronting truths some felt they had always been aware of but prevented from

consciously acknowledging due to their buy in to the promises of acceptance, happiness, and an easier life through attaining the ideal body. The MANTRA model (Schmidt et al., 2011) captures this within the 'vicious cycle of anorexia' and proposes that individuals have difficulty contemplating 'letting go' of their eating disorder as they believe it serves useful functions in their lives. As impaired insight is known to be a significant barrier to recovery (Konstatakopolous et al., 2020) diet culture and its internalisation was discussed as a similarly significant barrier.

Narratives identified a next stage of change in which participants, now critically aware of diet culture sought or adopted a new and incompatible position, for example as "anti-diet culture" or cultural critics, centring themselves, and developing an identity beyond their eating disorder. For one participant, it was becoming a mother that created a shift of priorities and altered her position towards the eating disorder. This stage of change was reminiscent of the quest narratives captured in existing literature which conceptualise recovery as a journey to self (Garrett, 1997; Moulding, 2016).

Constant and conscious choices towards change were discussed as necessary for initiating and maintaining recovery, the counter-cultural nature of these choices was specifically cited as making this difficult. The pervasive presence of diet culture was described as triggering and created a sense in participants that it would be the easier option to slip back into old habits to conform to the dominant discourse.

Maintaining recovery in the context of diet culture was described as a constant battle. Participants spoke of the ways they felt they had to fight and challenge diet culture, which felt difficult, frustrating, and unfair after they had already fought so hard to beat their eating disorder. For some, diet culture was seen as one of the main barriers to recovery, or primary maintaining factors in their eating disorders.

Strengths, Limitations & Future Directions

A common limitation of eating disorder research is the homogeneity of samples by gender, age, diagnosis, or recovery status. As such a strength of this study is the relative diversity within the sample, which allowed for deeper understanding of how diet culture affects recovery by identifying shared processes between groups of individuals. This study also highlighted how diet

culture is experienced differently by people living at higher weights compared to those living in thin bodies. As diet culture is known to disproportionately target people living in bigger bodies, those from the global majority living in the UK, and people with disabilities, future research should explore the impact of diet culture at these intersections.

A further strength of this study was the validation cycle used to check for accuracy and meaningfulness of the participant's narratives. A risk of all qualitative methodology is over, or inaccurate interpretations of accounts by the researcher, this is arguably more pertinent in narrative research where the interviewer is positioned as a co-narrator. The process of encouraging participants to review and comment on their narratives minimised this risk and was seen as meaningful to participants.

A limitation of this study is that it may include self-selection bias, people who are already critically aware of diet culture are more likely to participate and see diet culture as a central element of recovery. However, as the aim was to articulate this position, diet culture aware people were the purposive sample.

Clinical Implications

Generalisations should be made with caution due to the qualitative nature of this research, however, it is arguably only through these methods that the lived experiences of people who have recovered will be centred to allow researchers to learn from their experiences. The narrative presented within this study constructed salient themes which emphasise the additional challenges and barriers the sociocultural context of diet culture has on eating disorder recovery and have important implications.

As discussed in the reflexivity statement my position towards the research and participants will have influenced data collection and analysis, it will similarly have influenced the reasoning of these implications. However, due to measures taken to ensure reflexivity, and validity of the narratives these implications are felt to be reasonable in the context and scope of the findings.

The findings of this study have many implications for individually targeted interventions, such as the incorporation of the conflation of weight controllability into dissonance-based

interventions (Stice, Shaw, Becker & Rhode, 2008), provision of follow-on groups aimed at developing patients' abilities as cultural critics to support long-term recovery, and the therapeutic value of constructing illness and recovery narratives. However, as the findings emphasise the significant role of the sociocultural context as increasing the difficult of recovery, the primary implications must speak to the broader changes necessary to address this.

The significant role of diet culture within these narratives does not negate current biopsychosocial conceptualisations of eating disorders and recovery but rather emphasises the social perspective, which has been arguably under acknowledged and utilised as a valuable resource within recovery.

Firstly, NICE guidance is individually oriented in its recommendations to address psychosocial issues as they pertain to the individual, failing to recognise these perspectives at all in relation to bulimia nervosa, binge eating disorder, or other specified feeding and eating disorders. Recommendations for eating disorder treatments should emphasise the value of acknowledging and educating about the significant influence of sociocultural factors, specifically the discourses, narratives and values incorporated in diet culture as increasing motivation for and sustaining recovery.

Secondly, as Gramsci's theory of hegemony (1992, cited in Smith, 2010 asserts, re-evaluation of ideas and ideologies held as normative and common sense within societies are fundamental in creating change. The anti-diet culture movement can be seen as trying to achieve these aims, with advocates striving to challenge dominant discourses. This movement is growing, however continued government endorsement of anti-obesity measures that minimise or exclude structural influences such as privilege, status, or affluence (Aphramor, 2005) continue to dominate the discourse around diet and health. Legislation requiring calorie counts on menus, and education curriculums teaching healthy living which emphasise the dangers of obesity and endorse dietary restraint are just some examples. Education regarding healthy living should acknowledge the structural influences above, deconstruct the false narratives around weight control, and expose the unreality of the thin ideal. As participants in this study discussed, and consistent with previous research, the narratives around weight loss within this society make it that weight loss will likely be

reinforced and be seen as valuable or helpful to the individual. As such, challenging the dominant discourse, and educating about less harmful alternatives to reduce the number of young people turning to dieting in the hopes of achieving acceptance, or relief from negative evaluation is of foremost importance.

Lastly, as participants in this study spoke of experiences of encountering internalised diet culture in health services and professionals, consistent with existing research (Kinavey & Cool, 2019; Puhl et al., 2013) training on diet culture and the encouragement of reflective practises to identify and address internal biases should be delivered to all health professionals, and particularly those likely to meet people with eating disorders. Further research may be beneficial to explore internalised biases amongst health professionals and potential effects of increasing critical awareness on clinical practise.

Declaration of interest: Due to the method of sampling, one participant was known to the primary researcher prior to their participation in the study.

Funding

None. This review was undertaken as part of a research project for the doctorate in Clinical Psychology (DClinPsy).

Reference

Aphramor, L. (2005). Is a weight-centred health framework salutogenic? Some thoughts on unhinging certain dietary ideologies. *Social Theory & Health*, *3*(4), 315-340.

Baerger, D. R., & McAdams, D. P. (1999). Life story coherence and its relation to psychological well-being. *Narrative inquiry*, *9*(1), 69-96.

Bordo, S., Diamond, I., & Quinby, L. (1988). Anorexia nervosa: Psychopathology as the crystallization of culture. *Women, knowledge, and reality: Explorations in feminist philosophy*, 388-418.

Bourdieu, P. (1986). The forms of capital. In J. C. Richardson (Ed.), Handbook of theory and research for the sociology of education. New York: Greenwood Press cited in Claussen, S., & Osborne, J. (2013). Bourdieu's notion of cultural capital and its implications for the science curriculum. *Science Education*, *97*(1), 58-79.

Elliott, J. (2005). Using narrative in social research: Qualitative and quantitative approaches. Sage

Frederick, D. A., Saguy, A. C., & Gruys, K. (2016). Culture, health, and bigotry: How exposure to cultural accounts of fatness shape attitudes about health risk, health policies, and weight-based prejudice. *Social Science & Medicine*, *165*, 271-279.Garrett, C. J. (1997). Recovery from anorexia nervosa: A sociological perspective. *International Journal of Eating Disorders*, *21*(3), 261-272.

Gelsinger, A. S. (2021). A Critical Analysis of the Body Positive Movement on Instagram: How Does it Really Impact Body Image?. *Spectra Undergraduate Research Journal*, *1*(1), 4

Gramsci A. (1992). Prison Notebooks Volume I. trans J. Buttigieg and A. Callarri. Ed Joseph Buttigieg. New York, Columbia University Press cited in Smith, K. (2010). Gramsci at the margins: subjectivity and subalternity in a theory of hegemony. *International Gramsci Journal*, *1*(2), 39-50.

Hardin, P. K. (2003). Social and cultural considerations in recovery from anorexia nervosa: A critical poststructuralist analysis. *Advances in nursing science*, *26*(1), 5-16.

Hockin-Boyers, H., & Warin, M. (2021). Women, exercise, and eating disorder recovery: The normal and the pathological. *Qualitative Health Research*, *31*(6), 1029-1042.

Holmes, S., Drake, S., Odgers, K., & Wilson, J. (2017). Feminist approaches to anorexia nervosa: a qualitative study of a treatment group. *Journal of Eating Disorders*, *5*(1), 1-15.

Hudelson, P. M. (2004). Culture and quality: an anthropological perspective.

James, M. (2020). "All Bodies Are Good Bodies": How Anti-Diet Culture Activists Use Instagram to Challenge Diet Culture Norms.

Kinavey, H., & Cool, C. (2019). The broken lens: How anti-fat bias in psychotherapy is harming our clients and what to do about it. *Women & Therapy*, *42*(1-2), 116-130.

Konstantakopoulos, G., Georgantopoulos, G., Gonidakis, F., Michopoulos, I., Stefanatou, P., & David, A. S. (2020). Development and validation of the schedule for the assessment of insight in eating disorders (SAI-ED). *Psychiatry Research*, *292*, 113308.

LaMarre, A., & Rice, C. (2016). Normal eating is counter-cultural: embodied experiences of eating disorder recovery. *Journal of community & applied social psychology*, *26*(2), 136-149.

Levine, M. P., & Smolak, L. (2014). Paradigm clash in the field of eating disorders: a critical examination of the biopsychiatric model from a sociocultural perspective. *Advances in Eating Disorders: Theory, Research and Practice*, *2*(2), 158-170.

Lieblich, A., Zilber, T., Tuval-Mashiach, R., (1998) Narrative Research. In Narrative Research. SAGE Publications, Inc. https://doi.org/10.4135/9781412985253

McCarthy, M. (1990). The thin ideal, depression and eating disorders in women. *Behaviour, Research and Therapy, 28*(3), 205.

Moulding, N. T. (2016). Gendered intersubjectivities in narratives of recovery from an eating disorder. *Affilia*, *31*(1), 70-83.

Musolino, C., Warin, M., Wade, T., & Gilchrist, P. (2016). Developing shared understandings of recovery and care: a qualitative study of women with eating

Nice.org.uk. 2017. *Recommendations* | *Eating disorders: recognition and treatment* | *Guidance* | *NICE*. [online] Available at:

<https://www.nice.org.uk/guidance/ng69/chapter/Recommendations#identification-and-assessment> [Accessed 19 June 2022].

disorders who resist therapeutic care. *Journal of Eating Disorders*, *4*(1), 1-10.

Noël, P. H., & Pugh, J. A. (2002). Management of overweight and obese adults. *Bmj*, *325*(7367), 757-761.

Perreti, J. (2013, August 7). Fat profits: how the food industry cashed in on obesity. *The Guardian* retrieved from: https://www.theguardian.com/lifeandstyle/2013/aug/07/fat-profits-food-industry-obesity

Pond, R., Stephens, C., & Alpass, F. (2010). Virtuously watching one's health: Older adults' regulation of self in the pursuit of health. *Journal of Health Psychology*, *15*(5), 734-743.

Puhl, R. M., Latner, J. D., King, K. M., & Luedicke J. (2013). Weight bias among professionals treating eating disorders: Attitudes about treatment and perceived patient

Rocco. (2003). Qualitative Research Interviewing: Biographic Narrative and Semi-Structured Methods, by Tom Wengraf. Thousand Oaks, CA: Sage, 2001. 424 pp. $99 (hardcover); $33 (paperback). Human Resource Development Quarterly, 14(1), 117–122. https://doi.org/10.1002/hrdq.1054

Schmidt, U., Startup, H., & Treasure, J. (2018). *A cognitive interpersonal therapy workbook for treating anorexia nervosa: the Maudsley model*. Routledge.

Skippon, R.H. (2010). A narrative exploration of being a parent after childhood experience of being in care (Doctoral thesis, Lancaster University, Lancaster, England). https://ethos.bl.uk/OrderDetails.do?uin=uk.bl.ethos.552840

Thorne, A., & McLean, K. C. (2003). Telling traumatic events in adolescence: A study of master narrative positioning. *Connecting culture and memory: The development of an autobiographical self*, 169-185.

Squire, C. (2013). From experience-centred to socioculturally-oriented approaches to narrative. *Doing narrative research*, *2*, 47-71.

Stice, E., Shaw, H., Becker, C. B., & Rohde, P. (2008). Dissonance-based interventions for the prevention of eating disorders: Using persuasion principles to promote health. *Prevention Science*, *9*(2), 114-128.

Venturo-Conerly, K., Wasil, A., Shingleton, R., & Weisz, J. (2020). Recovery as an “Act of rebellion”: a qualitative study examining feminism as a motivating factor in eating disorder recovery. *Eating disorders*, *28*(3), 265-271.

Chapter 3 – Contributions to Theory and Clinical Practice

Contributions to Theory and Clinical Practice

The present research project sought to contribute to our understanding of eating disorder recovery by exploring broader sociocultural factors. The systematic review explored the various processes by which religion and spirituality are incorporated into treatment and effect recovery. The empirical paper explored the experiences of people who have recovered or are recovering in the United Kingdom with specific emphasis on how diet culture was perceived to effect this. This chapter considers the contributions of each of these papers to theory and clinical practice.

Implications for future research and theory development

The systematic review is to our awareness, the first to focus solely on religion and spirituality in eating disorder recovery. While a lack of standardised definitions of religion and spirituality confound the clarity of findings, the studies report primarily positive perceptions amongst participants towards incorporating religion and spirituality into treatment. Similarly, personal religion and spirituality were mostly conceptualised as helpful in recovery. However, for a small but meaningful minority, religious beliefs were entangled with symptomology which posed additional challenges to their personal recovery, and the teams working with them.

The empirical paper is the first to our knowledge to invite participants to share their recovery narratives with an explicit emphasis on diet culture. Whilst participants narratives differed in relation to the inter and intrapersonal factors that contributed to their eating disorder, and their recovery trajectories, there were clear shared experiences of how they perceived diet culture to have impacted upon them. Recovery in the context of diet culture was described as counter-cultural, with the pervasive and widely held narratives surrounding weight and shape increasing their difficulties in letting go of their eating disorder to move towards recovery. Furthermore, the reminders or evidence of diet culture within their daily lives required constant vigilance and conscious choices to avoid being pulled back into their eating disorder, which was often viewed as being the easier choice, which spoke to the significant challenge of maintaining their recovery within our culture.

Clarifying and Widening Definitions

As has been found in existing literature (Akrawi et al., 2015; Bonelli & Koenig, 2013) a limitation within the systematic review was the significant overlap, and lack of differentiation between religion and spirituality. Additionally, few studies explicitly defined how they conceptualised religion or spirituality in relation to their research aims or questions, which could be indicative of either a difficulty, or reluctance to differentiate the two. Koenig et al., (2008) critiques measures of spirituality and religion, arguing they are contaminated with questions relating to character traits, or mental health aspects rather than the concepts they claim to assess. They even state that spirituality should either be defined and measured in traditional terms, as describing religious people, or eliminated from use.

This is clearly an area that requires further research, with a focus on whether they are two distinguishable concepts or in trying to separate them are we weakening our understanding of an inseparable construct. A direction for research could be to explore how people with different religious and spiritual orientation understand spirituality and identify any aspects unique to those without a religious orientation who consider themselves to be spiritual.

Similarly, both papers suggest discrepancies in how recovery is conceptualised for those delivering services, and those doing the recovering, which aligns with existing literature into how different stakeholders define recovery (Bardone-Cone et al., 2018). According to the accounts of people with lived experience, current biomedical and psychological definitions are not sufficient in capturing the complexity and breadth of change that can or needs to occur within recovery. The systematic review captured the experiences of people for whom religious or spiritual beliefs were seen as fundamental, central, or necessary for their recovery, with accounts of recovery being commonly referred to as journeys and in one paper spiritual quests (Garrett, 1997). Participants in the empirical paper stressed the non-linear, sometimes lifelong process of recovery which continued long beyond weight stabilisation and symptom reduction. Indeed, for some the real challenge or work of recovery began after this, with participants discussing the increased responsibility

they felt on leaving treatment to maintain recovery. For some participants, what they perceived as inaccurate representations of recovery were cited as unhelpful as they created a pressure to recover in a certain or “perfect” way. Research that aims to enhance our understanding of recovery and improve efficacy of treatments needs to centre lived experiences and conceptualisations to accurately identify what is most meaningful and helpful to individuals receiving these treatments.

Seeking out Unheard Voices

In the systematic review, most studies included participants who did identify as either religious or spiritually orientated and so there was likely a sampling bias towards reporting positive perceptions and experiences. As such, we need to understand how religion and spirituality affects the development of, and recovery from eating disorders for people who do not have such orientations or affiliations. This is of particular importance as ethical issues arise if interventions aim to, or can be seen as proselytising, and so we need to know understand how acceptable the introduction of spiritual interventions are to non-religious or spiritual people.

Diet culture is known to particularly target marginalised groups including people in bigger bodies, the disabled, members of the LGBT+ community, and the global majority. Whilst diet culture is arguably most commonly viewed in contemporary society as a multi-billion-pound industry that promotes weight loss (Fat Bodies, Peretti, 2013), it has its roots in racism and misogyny (Strings, 2019). Strings discusses that fat-aversion was used to create a racial and social hierarchy by ‘othering’ Black people, Indigenous people, and other immigrants, whilst the creation of diet culture and the diet industry profited off this fatphobia and kept, primarily women, distracted. To fully acknowledge the oppression of diet culture we must seek out and centre those most disadvantaged, future research needs to explore intersectionality within diet culture and eating disorder recovery.

From the Other Side

A small number of papers in the systematic review represented the experiences and perceptions of staff and services, however these staff members primarily worked in religious

or spiritually oriented treatment centres and so may have been more likely to report positive experiences. Where they did not work in such services, patients' religion or spirituality was discussed as a barrier due to entanglement of beliefs and symptoms. To fully understand and begin to incorporate religion and spirituality into treatments or recoveries we need to understand the views and perceptions of those delivering the treatments. Prior studies in the USA have shown that whilst professionals view their patient's religion or spirituality as important, they are unlikely to regularly assess or address this within therapy or treatment (Delaney et a., 2007; Hathaway et al., 2004). A paper within the UK showed that trainee clinical psychologists expressed similar beliefs of its importance, yet a lack of awareness, confidence, training, and perceptions that their profession were largely disinterested meant most did not address such issues with clients (Begum, 2012). Repetition of the US studies within the UK would be valuable in understanding professionals views of the relevance of religion and spirituality in the treatment of eating disorders, and identify any barriers such as lack of training or confidence.

Similarly, we need to understand how critically aware of diet culture professionals working within eating disorder, and broader mental health services are. Kinavey and Cool (2019) argue that anti-fat bias is prevalent within psychotherapy professionals and often goes unexamined and causes harm to patients. Puhl et al., (2013) found that eating disorder professionals with stronger anti-fat bias more often attributed weight to behavioural causes, expressed frustration about treating fat patients and perceived poorer treatment outcomes. Anti-fat bias within broader health services and psychotherapeutic services places responsibility for change within the individual, ignoring the impact of social determinants on weight and health, further contributing to feelings of shame and failure when the individual is unable to achieve or sustain change. Research needs to critically exam professionals' views of diet culture and how it pertains to their work and their patients, and how confident they feel to address and work within this wider societal context.

Implications for Clinical Practice

Incorporating Sociocultural Factors into Treatment and Recovery

As discussed above, to incorporate both religion and spirituality, and diet culture awareness into treatment we need to understand how professionals relate to these concepts. A clinical priority should be supporting clinicians and professionals to become aware of their internalised anti-fat biases and equip them with values and critiques counter to dominant cultural discourse including weight inclusivity (Kinavey & Cool, 2019).

Similarly, clinicians should be encouraged to recognise and reflect on their own positions in relation to religion and spirituality to minimise bringing their own biases or beliefs into their relationship with the patient in an unhelpful way. Increasing confidence and competence in delivering spiritually conscious care as a minimum (Saunders et al., 2010) should also be a priority. Whilst arguably a particular challenge in increasingly secular societies many mental health patients feel their religious or spiritual beliefs are important to their recovery (D'Souza, 2002).

Findings of the empirical paper supported by existing research (Holmes et al., 2017; Venturo-Connerly, 2020; Hockin-Boyer & Warin, 2021) strongly suggest the therapeutic value of empowering people recovering from eating disorders as cultural critics. As such, the creation and implementation of a follow-on in recovery support group which educates members in dominant social discourse and equips them with critical skills and exposure to alternative narratives and positions could be effective in sustaining recovery in the long-term. As many participants spoke of the increased challenges associated with reduction in intensity of treatment, which was often decided based on weight stabilisation or symptom reduction, a therapeutic intervention at this point may be particularly valuable in supporting the gradual step down in intensity of treatment.

Lastly, whilst these papers highlight many meaningful implications and potentially valuable future directions for service delivery and individual intervention, they also highlight how central the role of our sociocultural context is to our mental health. This is not new, social determinants of mental health have been increasingly researched and acknowledged over recent years, however our increased knowledge is not filtering through to service delivery in a way discernible to those accessing services. A growing position within clinical

psychology is that our focus should be on addressing societal injustices and trying to ameliorate the harms of social inequities known to damage mental health. In the area of eating disorders, this would include challenging and opposing government policies aimed at targeting obesity, which are known to trigger those with eating disorders, and perpetuate the harmful narrative that individuals are ultimately in control and responsible for their health and weight whilst also arguing for adequate representation of sociocultural factors in models and treatments of eating disorders.

Personal reflections

It is with some anxiety that I begin writing my reflections of the research process, because for me it has been a very personal process, and I think there is still some doubt, or uncertainty that such things have a place within research. I think that is why I was drawn to narrative methodology, from the little I had heard and read it was acknowledged that the researcher would be present within the research, that their position would shape the research, and the research would likely shape them. This was not discussed as a limitation, and the task was not to separate or exclude researcher subjectivities but to make explicit where they interact and influence what is reported. Therefore, this part of my third chapter aims to explain my position in greater clarity, and share how I have managed this reflexively throughout the research process.

As a woman living within the United Kingdom, I have been exposed to diet culture throughout my development. During my adolescence I developed an eating disorder which I spent much of my teenage and early adult years recovering from. Through my personal and professional development, I have developed a critical lens which has allowed me to recognise the influence of my privileges in my experiences of recovery. As a white, educated, middle-class, cisgender female who fitted the physical stereotype of an eating disorder, I never had the validity of my experiences questioned, nor did I have to fight to access treatment or support. I was also lucky to have supportive family and friends who endorsed my recovery efforts. It was several years after leaving treatment and “achieving recovery” that I learnt about diet culture, becoming more consciously aware was a gradual

but significant turning point in my recovery. What I learnt explained why, despite having "done the work" and been in a stable position for many years, I still had not found the freedom from body scrutiny and the belief I should better control my weight that I'd been promised. Upon discovering diet culture I read, researched, and talked with others about what I was learning and I realised, it wasn't about me anymore, my ongoing struggles were reflective of the culture I existed in, which told me that as a woman it was my job to make my body fit certain standards to be acceptable to others, and myself. As I delved deeper still, I realised it was not just advertising, media, and the diet industry, this was a pervasive, systemic issue of discrimination and marginalisation. Needless to say, by this point I had become an anti-diet culture advocate myself.

Fast forward a few years and I found myself in the position of being given the opportunity to create and carry out a research project, and I knew instantly I wanted it to be exactly this, a study that explored the ways in which diet culture impacted on recovery. And just as quickly I felt the hesitancy and heard the uncertainty "is this just me, do I just want this to be the case so I can explain why it's still so hard…will other people see it?" However, through talking with my endlessly patient husband who had already heard my many anti-diet culture revelations and speaking with my best friend who had also experienced an eating disorder, and hearing her excitement and belief in the idea, I found the confidence to pursue the idea. I also wondered whether it needed somebody who had experienced it to ask the question. I knew there were many others who were asking these questions, who were using their experiences of eating disorders and recovery to build platforms to advocate for change and educate others, many of them had been a part of my own learning. But I also knew not many were in the position I found myself in. I know ending my teenage years in a specialist eating disorder service, and less than a decade later being close to finishing a doctorate in clinical psychology is not the typical trajectory, I know many never achieve sufficient recovery, and I know even more are not given a voice to discuss their experiences. My own exploration of diet culture has led to me believe issues of privilege are a significant reason for this.

Having stated my position and shared a little of my own “sense-making” I will now describe the ways I have practised reflexivity to make this explicit throughout the research process. Adopting a narrative approach feels an appropriate way to do this, by structuring my reflections along the timeline of the research process.

As already discussed, my idea for an empirical paper formed quickly, along with the doubts. To address my concerns that this was in fact an ego-centric project to validate my own experiences, I turned to existing literature on this topic to establish if there was a theoretical basis to the association I had begun to ponder between diet culture and challenges in sustained, long-term recovery. I was relieved to discover that “dominant cultural discourses” and their effect on “embodied experiences of gender and weight” was in fact a well-researched area within sociology and psychology. I was bolstered by the many research papers I read (and books I skimmed) and satisfied that this was in fact a well-known phenomenon within certain areas of research and academia.

The next step in my research process was finding supervisors and submitting my research proposal. My initial supervisor encouraged me to research other areas of eating disorders and recovery, in particular the COVID-19 pandemic and its effect on eating disorder patients. This was understandable given the relevance of this topic at that time, and I was very almost swayed. However, my sense was that these questions were already being asked, and much quicker than I would be able to. I also viewed diet culture as an equally relevant phenomenon at that time. During a time when millions of people around the world were dying due to a terrifying new virus, talks of the “quarantine 15” and post-lockdown weight loss diets and exercise regimes were garnering almost as much attention within our society. Returning to face-to-face contact following the lockdowns was commonly discussed by peers, colleagues, and patients alike as times of high anxiety for many reasons, but not least fear of negative evaluation based on weight gain. Thankfully I was supported in my decision to pursue my original idea, and my proposal was submitted.

Around this time, the pandemic and the death of George Floyd and the subsequent Black Lives Matter movement were highlighting the ethnic inequalities at all levels of

societies and within systems. Confronting my own internalised biases and acknowledging my own privileges during this time was a necessary and uncomfortable process. I began trying to educate myself further on the history of diet culture, which I knew to have its roots in racism which increased my conviction in the importance of developing a critical lens for cultural discourse, yet also developed another layer of doubt. At a time when there was such an emphasis on centring marginalised voices and having become more aware of the privileges that had gotten me to a position to even be completing a doctoral level thesis, I questioned whether it was right that I should be exploring an issue that has historically been seen as a white woman's issue at the expense of excluding others. I discussed this with some trusted friends and my academic research supervisor and came to the conclusion that diet culture and eating disorder recovery was an important area to explore, and as I was in this position, I should use it to try and contribute to the discussions that were happening whilst also holding and acknowledging my own limitations.

This process really influenced how I designed my research project. I decided I would be radically ideographic in my inclusion criteria for recruitment, acknowledging that diagnostic assessments, which often determine access to service, and treatment developments had been centred around thin white womens experiences and therefore prevalence rates do not reflect the true numbers amongst people outside of this narrow range. As such, participants who self-identified as having had an eating disorder, regardless of whether they had received a formal diagnosis were invited to participate. Furthermore, given that definitions of recovery were so different between people with lived experiences and those delivering services I took the same approach to defining recovery. I also knew that people with eating disorders who are not underweight (which is the majority) are less likely to access and receive NHS services, which led me to recruit outside of the NHS. Social media felt the logical choice as much of the anti-diet culture movement occurs on these platforms, and I hypothesised that where people were unable or unwilling to access services, they might turn to online communities for support and education.

Once I had received ethical approval I began recruiting via social media, in hindsight my recruitment method may have been my first failing in trying to be as inclusive as possible. I asked that peers and colleagues share the study advert, without acknowledging that most people who would see this advert through this method would be white, and I approached a white, albeit male, anti-diet culture advocate to advertise on my behalf. However, my final sample is comparatively diverse in relation to existing research into eating disorders and I was pleased to have heterogeneity in participants age, diagnosis, ethnicity, and gender.

I was particularly aware during data collection of the potential for my position to influence participants and the interviews. As such, I chose a methodology that emphasised participants as the experts in their stories and allowed them autonomy and control in telling them. Furthermore, I devised a single narrative inducing question to further reduce the chances of me guiding or shaping participants responses. Wherever possible, the only prompts I provided participants with to aid the telling of their stories was to summarise what they had said and ask them to expand and redirecting to the question. I kept a reflexive diary throughout the research process, recording my own emotional responses, impressions, or thoughts following interviews to increase make them explicit when it came to interpreting the interviews during analysis.

A key stage of data analysis was the creation of a story summary for each participant which they were given the opportunity to review. It was during this stage that my interpretations were expected to be a part of the analysis, I was supposed to be using a critical lens to understand their stories in the context they were telling them. This was another period of doubt and I continuously asked myself “is this what they said/experienced…or is it what I want them to have said/experienced?” Whilst a mentally exhausting process, I believe holding this question in mind did ensure that their experiences were central, and my interpretations secondary in meaning making. Sharing one (completely anonymised) story with my research supervisors allowed them to question me on how I had made certain decisions or reached certain conclusions. Justifying my decisions, or in some cases acknowledging my over-interpretation was a valuable practise that I then took forward

in creating the other summaries. Finally, and most importantly, the feedback I received from participants reassured me that not only were the narratives I had created reflective of their experiences, but they had also been meaningful too. Receiving feedback that the story summary, and participation in the project had given participants increased insight into their difficulties, and self-compassion was extremely rewarding.

Whilst writing up the results, some of my previous doubts came back, and many stayed throughout this phase. However, having heard the experiences of the eight courageous people willing to share their stories with me which so clearly highlighted the role of diet culture as a barrier or additional challenge to recovery, I finally put to rest that this was “not just me” but a very real shared experience that needed to recognised. My primary concerns during this phase were “am I doing their stories justice?” and “I know I can’t possibly be representing the complexities sufficiently.” The first I could address through ensuring participants voices were extremely present in my results, I tried not to make a point or statement without having a quote to support it. However, the second I have needed to radically accept as being at least somewhat true. My lived experience undoubtedly gives me insight into the experiences of recovery, and I believe that through reflexive practices I have fulfilled my responsibility as a researcher to consider how my positioning and the positions of the participants, had impacted upon the conclusions I reached. However, this paper did not aim to explicitly explore how diet culture effects the recovery experiences of those marginalised within society and whilst I could interpret participants narratives based on my theoretical knowledge and through a critical lens, it is likely I did not fully recognise or do justice to the complexities of recovery for the participants in this study for whom intersectionality posed additional challenges. That does not mean I won’t keep trying to understand these experiences, and if I am ever able to complete further research, I hope I would utilise the opportunity to seek out and amplify their stories.

Overall, in amongst all this doubt, uncertainty, and introspection, has also been a surprising amount of enjoyment and gratitude. I found hearing the participants stories and hearing their responses to my interpretations deeply rewarding. I know this project will

impact my clinical practise and I hope that it may have some small impact on those who read it too.

References

Akrawi, D., Bartrop, R., Potter, U., & Touyz, S. (2015). Religiosity, spirituality in relation to disordered eating and body image concerns: A systematic review. *Journal of Eating Disorders*, *3*(1), 1-24.

Bardone-Cone, A. M., Hunt, R. A., & Watson, H. J. (2018). An overview of conceptualizations of eating disorder recovery, recent findings, and future directions. *Current Psychiatry Reports*, *20*(9), 1-18.

Bonelli, R. M., & Koenig, H. G. (2013). Mental disorders, religion and spirituality 1990 to 2010: a systematic evidence-based review. *Journal of religion and health*, *52*(2), 657-673.

D'Souza, R. (2002). Do patients expect psychiatrists to be interested in spiritual issues?. *Australasian psychiatry*, *10*(1), 44-47.

Ellis, É., & Bermúdez, J. M. (2021). Funhouse mirror reflections: Resisting internalized sexism in family therapy and building a women-affirming practice. *Journal of Feminist Family Therapy*, *33*(3), 223-243.

Garrett, C. J. (1997). Recovery from anorexia nervosa: A sociological perspective. *International Journal of Eating Disorders*, *21*(3), 261-272.

Holmes, S., Drake, S., Odgers, K., & Wilson, J. (2017). Feminist approaches to anorexia nervosa: a qualitative study of a treatment group. *Journal of Eating Disorders*, *5*(1), 1-15.

Kinavey, H., & Cool, C. (2019). The broken lens: How anti-fat bias in psychotherapy is harming our clients and what to do about it. *Women & Therapy*, *42*(1-2), 116-130.

Koenig, H. G. (2008). Concerns about measuring “spirituality” in research. *The Journal of nervous and mental disease*, *196*(5), 349-355.

Puhl, R. M., Latner, J. D., King, K. M., & Luedicke J. (2013). Weight bias among professionals treating eating disorders: Attitudes about treatment and perceived patient outcomes. *International Journal of Eating Disorders*. 47, 65–75. Crossref. PubMed.

Saunders, S. M., Miller, M. L., & Bright, M. M. (2010). Spiritually conscious psychological care. *Professional Psychology: Research and Practice*, *41*(5), 355.

Stice, E., Shaw, H., Becker, C. B., & Rohde, P. (2008). Dissonance-based interventions for the prevention of eating disorders: Using persuasion principles to promote health. *Prevention Science*, *9*(2), 114-128.

Strings, S. (2019). *Fearing the Black Body: The Racial Origins of Fat Phobia* (First edition. ed.). NYU Press.

Appendices

Appendix A: Quality assessment tool for case reports table

***Paper**, first author & year*	***Demographics clearly described***	***History described & presented as timeline***	***Current clinical condition described***	***Diagnostics tests/assessment methods** & **results** described*	***Intervention / treatment described***	***Post-intervention condition described***	***Adverse/ unanticipated events described***	***Takeaway lessons** discussed **?***
Dancyger 2002	N	Y	Y	Y	N	Y	Y	Y
Morgan 2000	N	Y	Y	N	N	Y	Y	Y
Musleh 2017	Y	Y	Y	Y	Y	N	N/A	Y
Lea 2015	N	Y	Y	Y	Y	Y	N/A	Y
Richards 2009	Y	Y	Y	Y	Y	Y	N/A	Y

Appendix B: Quality assessment tool for qualitative research table

Paper, first author & year	Congruent philosophical perspective & methodology	Congruent method & question/ objectives	Congruent methods & data collection method	Congruent method & interpretation of results	Statement locating research culturally/ theoretically	Influence researcher and vice versa explored?	Participants and voices represented	Evidence of ethical approval	Conclusion drawn flow from analysis/ interpretation
Garrett ,1997	Y	Y	Y	Y	N	N	Y	N	Y
Hay, 2013	Y	Y	Y	Y	N	N	Y	N	Y
Hertz, 2012	Y	Y	Y	Y	N	N	Y	N	Y
Marsden, 2007	Y	Y	Y	Y	N	N	Y	Y	Y
Matusek, 2009	Y	Y	Y	Y	N	N	Y	Y	Y
Reneli, 2020	Y	Y	Y	Y	N	N	Y	Y	Y
Richards, 2018	Y	Y	Y	Y	N	N	Y	Y	Y
Ronel, 2003	Y	y	Y	Y	N	N	Y	Y	Y
Wasson, 2010	Y	Y	Y	Y	N	N	Y	N	Y

Appendix C: Quality assessment tool for quasi-experimental research table

Paper, First author, year	Clear cause and effect variables	Were participants included in any comparisons similar?	Similar treatment/care, other than the exposure or intervention of interest?	Control group?	Were there multiple pre/post measurements of the outcome	Was follow up complete / differences between groups adequately described	Were the outcomes included in any comparisons measured in the same way?	Were outcomes measured in a reliable way?	Was appropriate statistical analysis used?
Smith 2003	Y	Y	y	N	Y	Y	Y	Y	Y
Weltzin 2012	Y	Y	y	N	Y	Y	Y	Y	Y
Richards 2006	Y	Y	Y	Y	Y	Y	Y	Y	Y

Appendix D: Quality assessment tool for cross-sectional research table

Paper, first author, year	Inclusion criteria clear	Subjects and setting described	Exposure measured valid and reliable	Objective, standard criteria for measurement of condition	Confounding factors identified	Strategies to deal with confounding factors stated	Outcomes measured valid and reliable way	Appropriate statistical analysis
Henderson 2015	Y	Y	Y	Y	Y	Y	Y	Y
Bohrer 2017	Y	Y	Y	Y	N	N	Y	Y

Appendix E: Study Advertisement

Appendix F: Participation Information Sheet

Eating Disorder Recovery & Diet Culture

PRIFYSGOL BANGOR UNIVERSITY

- North Wales Clinical Psychology Programme
- Programme Director: Michaela Swales
- Brigantia Building, Bangor University, LL57 2DG
- Telephone: 01248 388 365

Rebecca Bale

Study: Exploring the Experiences of Recovering from an Eating Disorder in the Context of Diet Culture

Invitation to take part in the study

Hello, my name is Rebecca Bale. I am a trainee clinical psychologist at Bangor University.

My supervisors and I are doing research about how diet culture impacts on eating disorder recovery.

We would like to invite you to take part in our research study. Participating in the study is completely up to you.

To help you decide, we would like you to understand why the research is being done and what your involvement would look like.

You have been given this information sheet because you have expressed an initial interest in participating. Please read this sheet carefully, it should take about 25 minutes. Feel free to talk to others about the study.

The first part of the Participation Information Sheet tells you why we are doing the study and what your involvement would include.

The second part will give you more detailed information about how we are conducting the study.

Summary of the Study

Why is the study useful? We want to understand more about the factors that affect an individual's recovery from an eating disorder. We can use this understanding to improve services for people struggling with such difficulties and inform policies that affect people with eating disorders.

What is involved? We would like to talk to people who identify as having had an eating disorder and who have either recovered or are in recovery. We will invite you to take part in an interview that will last for about an hour and a half. We will create a story of your experiences. You will be given the opportunity to read your story and provide feedback on it before we include it in the research. Providing feedback should take about half an hour.

Where will interviews take place? The interview and review of your story will be done over video conferencing software such as Zoom or Teams. If you are unable to use these technologies, we can discuss the possibility of completing the interview in person.

The interview will be recorded.

How long will the study last? The study will start in October 2021 and will be completed in June 2022.

What does the Study Involve?

What do we want to know and why? Eating disorders are complex mental illness with the highest mortality rates of all mental health conditions amongst adults in the UK. As such, understanding the processes, and factors that influence recovery from eating disorders is of major clinical and research significance. We want to understand peoples' experiences of recovery including their physical, emotional, and mental recovery. We are particularly interested in exploring how diet culture has affected this process. This study will help us to gather information and deepen our understanding as we will invite people who have recovered from or are in recovery from an eating disorder to share their story of recovery and how diet culture has impacted this.

Having this information will help inform decision making around issues relating to eating disorders including prevention, diagnosis, and intervention to support people affected.

Who are we inviting to take part? Anybody over the age of 18 years old who identifies as having had an eating disorder that significantly impacted on their emotional, mental or physical wellbeing.

We recognise that every eating disorder and recovery journey is different, therefore we equally invite participation from people who have and those have not sought/received, assessment, formal diagnosis, or intervention to participate.

Similarly, we welcome participation from people at all stages of recovery, including those in the early stages.

What will happen if you decide to take part? The study will be in four stages.

Stage 1. We will send you either a link to, or digital copy of a questionnaire which will gather information about your age, gender, and some brief questions about your eating disorder including the diagnosis or label you feel best describes your difficulties, when these began,

and time in/since recovery. The questionnaire should take no more than 10 minutes to complete, and you can skip any questions you do not feel comfortable answering.

Stage 2. We will then call you on the telephone to arrange an interview with you and answer any questions you may have. This will take no more than **15 minutes**.

Stage 3. We will contact you at the agreed time via the agreed teleconferencing platform to carry out the interview. The interview will last approximately **90 minutes**. If you are unable to use the video conference, we can discuss the possibility of completing the interview face-to-face.

If you would prefer the interview can be completed over two separate occasions.

At the start of the interview the researcher will ask you the following question.

"I am interested in understanding the experience of recovering from an eating disorder in the context of diet culture.

By diet culture we mean a set of beliefs that are upheld within our society that:

- *Values thinness and equates it to health*
- *Prioritises weight loss over wellbeing*
- *Sells weight loss as a way of 'improving' ourselves*
- *Labels certain foods as "bad" and others as "good" which can create feelings of shame or guilt*
- *Rejects and discriminates against people who don't fit the 'ideal of thinness'.*
- *Diet culture affects everyone, though it predominantly targets women, and discriminates against people from ethnic minority groups, people with bigger bodies, and people with disabilities especially.*

I'm interested in how diet culture may have affected your recovery. Please would you tell me about this?"

After asking this question the researcher will say as little as possible to ensure the interview gives you the opportunity to say as much as possible about your experiences of recovery and diet culture. You may be asked some prompts, or the researcher may summarise what you have said to help you in telling your story if it seems appropriate.

The interview will be recorded.

Stage 4. Within eight weeks after the interview, you will be contacted to give you the opportunity to receive a copy of the story we have created about your eating disorder recovery experiences, and we will ask you if you want to give any feedback. If you choose to give feedback, we will arrange a time to call and discuss it with you. The discussion will take approximately **30 minutes.**

Once stage 4 is complete we will not ask you for any further information. It will take approximately three months from the start of stage 1 to the end of stage 4. Once the study is complete, in June 2022, we will send you a summary of the research findings. If you are interested, you can request a full copy of the research thesis.

What are the benefits of taking part? You will have the opportunity to tell your story and reflect on your experience of eating disorder recovery and the impact of diet culture. You will have the opportunity to contribute to research that aims to improve the understanding of eating disorders and recovery.

At the end of the interview, stage 3, we will send you a shopping voucher worth £20. This is to compensate you for the time you have given to the study.

What are the risks in taking part? People can find discussing their lives, particularly topics relating to their mental health or difficulties upsetting. If you become upset during the interview, the interviewer will ask you if you would like to take a break or stop the interview completely. You can choose to stop the interview or withdraw from the research at any time without penalty to you. You will not be forced to talk about anything you do not want to.

Supporting Information

What to do if something goes wrong? If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions, you can contact Rebecca Bale rbb19ckl@bangor.ac.uk.

If you remain unhappy and wish to complain formally, you can do this by contacting the college manager:

Huw Roberts
College Manager,
School of Psychology,
Bangor University
Bangor
Gwynedd
LL57 2AS
e-mail huw.roberts@bangor.ac.uk

How will we use information about you? We will need to use information from you for this research project. This information will be your name and contact details, and any information you tell us about your recovery.

We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write all reports about the data in a way that no-one would be able to identify that you took part in the study.

What choices do you have about how your information is used? You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have (see *'What will happen if you do not want to carry on with the study?'* for more details).

We need to manage your records in specific ways to make sure the research is reliable. This means that we cannot let you see or change all the data we hold about you. However, you

will get the opportunity to see the story that has been written about your recovery experiences (see *'What will happen if you decide to take part'* for more details).

For details on how you can find out more about how your information on how your data is being used please see 'further information and contact details' the end of this document.

What will happen if you do not want to carry on with the study? You can withdraw from the study at any time, and you will not be asked to give a reason why.

If you change your mind before the interview, then we will remove your name and contact details from our database and will not contact you again.

If you change your mind during, or immediately after the interview, we will delete the interview and not use it. However, once the analyses of your interview have started, we will not be able to remove the information you have given.

If you do change your mind during the research, contact Rebecca Bale on rbb19ckl@bangor.ac.uk.

Will your information be kept confidential? Your confidentiality will be safeguarded throughout the study. The recording of the interview and all written information made will be kept securely on the Bangor University computer system and accessed remotely through a password protected laptop. The interview will be transcribed, all identifying details removed, and then the recording is erased.

All written information will remain on the Bangor University computer system for ten years and will then be deleted. You will also be given a pseudonym, and identifiers such as the names of places or health services will also be anonymised.

If you are interested in finding out more about how your information is used, please see the end of this document.

What will happen if you disclose harm, or potential harm, to yourself or others? If you disclose harm, or potential harm, to yourself or others then this would be discussed with you before being passed on to necessary services or bodies.

What will happen to the results of the study? Your story, along with stories of the other people interviewed will be used to answer questions about how diet culture impacts people recovering from eating disorders. This will be written up into a long report called a thesis. The study will also be written up and published in an academic journal. Any write up of the study may contain direct quotes from you. There will be no personal or identifiable details in any write up of the study, your name, and the names of people you talk about will be changed. Your exact age and the names of any places, including services, you talk about will not be included.

Who is supporting the research? The psychology department at Bangor University is supporting the planning and carrying out of this research.

Who has reviewed this research? He The study has been approved by the School of Psychology's Ethics Committee.

Further information and contact details

If you want further information about this research project e-mail Rebecca Bale:rbb19ckl@bangor.ac.uk.

If you want more information about how your data will be protected visit https://www.bangor.ac.uk/governance-and-compliance/dataprotection/documents/General-Public-Data-Protection-Privacy-Notice-Sept-19.pdf

Or ask the Bangor University Information Officer by e-mailing: gwenan.hine@bangor.ac.uk

Please feel free to discuss participating in this research with the people supporting you, including friends, family, or professional support.

How to get involved & Consent Process

If you would like to participate in this study please complete the consent form and return to rbb19ckl@bangor.ac.uk.

Appendix G: Consent Form

Eating Disorder Recovery & Diet Culture

PRIFYSGOL BANGOR UNIVERSITY

- North Wales Clinical Psychology Programme
- Programme Director: Michaela Swales
- Brigantia Building, Bangor University, LL57 2DG
- Telephone: 01248 388 365

v.2

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: Exploring the Experiences of recovering from an eating disorder in the context of diet culture.

Name of Researcher: Rebecca Bale

Please read the following statements and, if you agree, tick the corresponding box to confirm agreement:

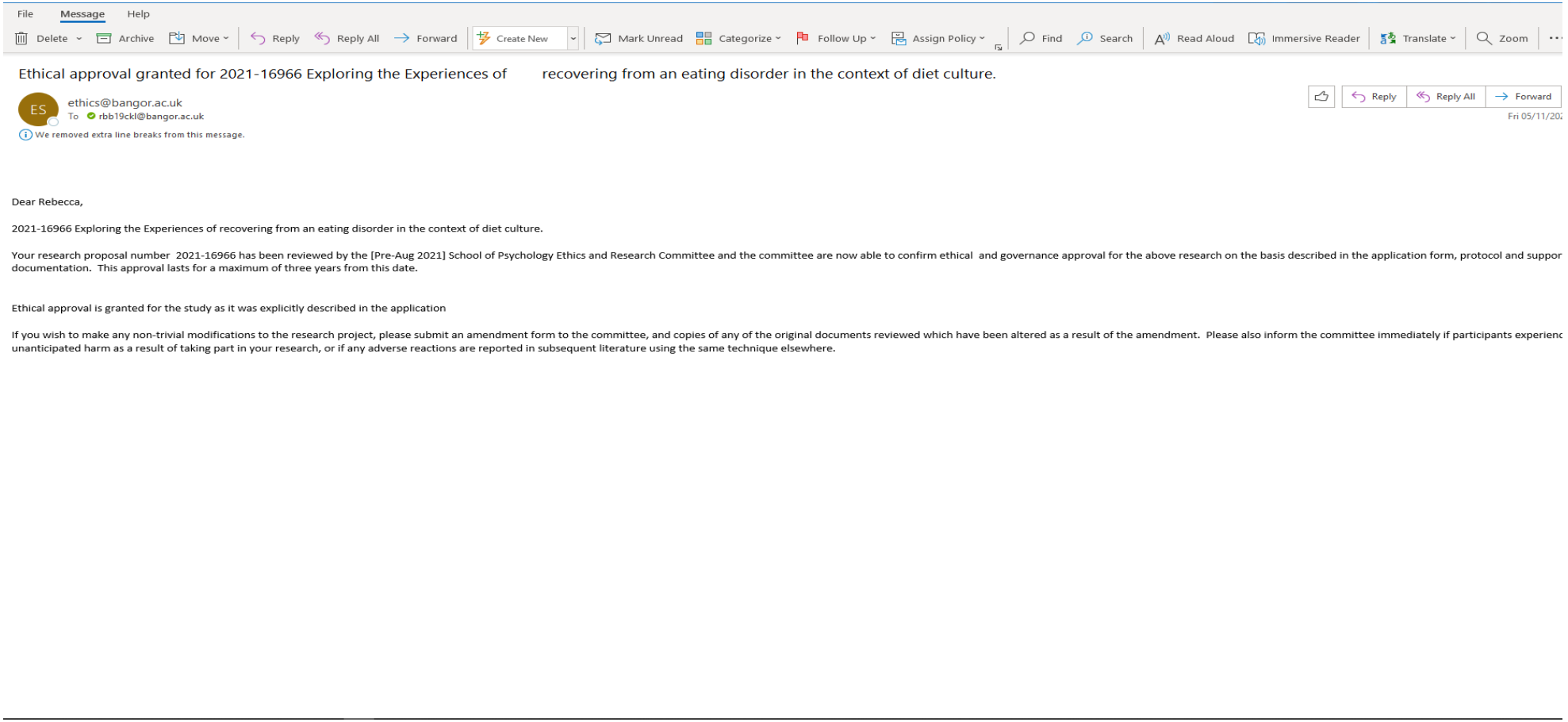
	Please initial
I am aged 18 years or over	
I confirm that I have read and understand the participant information sheet for this study and fully understand what participation involves.	
I confirm that I have had the opportunity to contact the researcher to ask any questions I may have.	
I understand that I have the right to withdraw my questionnaire at any time by contacting the Chief Investigator using the details on the participant information sheet and quoting the first 3 letters of my first name and last four digits of my mobile phone number.	

I understand that all the data collected in this study will be stored in line with GDPR and the Data Protection Act and will be stored in a confidential manner on a password protected computer for a period of ten years.	
I agree for my data to be used in future conference presentations and reports and understand that my data will be anonymous	
I understand that my participation in this study is voluntary and I am under no obligation to take part.	
I agree to be called by the researcher on the number below to arrange a time for the interview to take place.	
I freely agree to participate in this study.	
I agree to be contacted by the North Wales Clinical Psychology Programme to arrange receipt of payment. I am aware that this means they will see my name, this will not be shared with anyone and only used for this purpose.	

Please provide the best contact number for the researcher to call to arrange a time for the interview:	
Please state the first 3 letters of your first name and the last four digits of your mobile phone number this will be used to match your survey responses throughout the study:	

Thank you

Appendix H: Ethical Approval



File Message Help

Delete Archive Move Reply Reply All Forward Create New Mark Unread Categorize Follow Up Assign Policy Find Search Read Aloud Immersive Reader Translate Zoom

Ethical approval granted for 2021-16966 Exploring the Experiences of recovering from an eating disorder in the context of diet culture.

ES ethics@bangor.ac.uk
To rbb19ckl@bangor.ac.uk

We removed extra line breaks from this message.

Reply Reply All Forward

Fri 05/11/202

Dear Rebecca,

2021-16966 Exploring the Experiences of recovering from an eating disorder in the context of diet culture.

Your research proposal number 2021-16966 has been reviewed by the [Pre-Aug 2021] School of Psychology Ethics and Research Committee and the committee are now able to confirm ethical and governance approval for the above research on the basis described in the application form, protocol and suppor documentation. This approval lasts for a maximum of three years from this date.

Ethical approval is granted for the study as it was explicitly described in the application

If you wish to make any non-trivial modifications to the research project, please submit an amendment form to the committee, and copies of any of the original documents reviewed which have been altered as a result of the amendment. Please also inform the committee immediately if participants experienc unanticipated harm as a result of taking part in your research, or if any adverse reactions are reported in subsequent literature using the same technique elsewhere.

Word Count

	Excluding references, tables, appendices, etc.	Inclusive
Summary	412	412
Systematic review	8168	12151
Empirical Study	7606	8941
Total for main substance of thesis	16186	21504
Contributions and reflections	4065	4397
Title pages, declaration, acknowledgements, contents, word count	-	3692
Total	20273	29595