Lived experiences of binge eating and access to care in the New Zealand health system

A thesis presented in partial fulfilment of the requirements for the degree of

Master of Science
In
Psychology
(Health Psychology)

at Massey University, Albany, New Zealand.

Jennifer Chloe Ann Parsons

2022

Abstract

This research inquiry sought to explore lived experiences of binge eating in New Zealand. Previous narrative research on eating disorders, has focused primarily on populations with Anorexia Nervosa or Bulimia Nervosa, and no New Zealand research could be found that provided narrative voices of people that self-identified as binge eaters, or had received a Binge Eating Disorder (BED) diagnosis. The purpose of this research is to provide a step towards filling the narrative gap in current literature, and to improve understandings of binge eating. A secondary focus, was to understand how participants navigated New Zealand primary care pathways. There were two parts to the study. Part one took a narrative inquiry approach, completing semi-structured interviews with eight participants who had self-identified binge eating. Allowing participants to self-identify created a space to discuss a range of experiences outside of BED diagnosis. The research took a Narrative Analysis approach, guided by a Social Constructionist epistemology, and drawing from Feminist, Foucauldian and Stigma Theories. Part two consisted of a quantitative survey sent to General Practitioners in New Zealand, and twelve complete responses were received. Key findings included the importance of protective factors, experiences of stigma, and a lack of adequate treatment pathways. Recommendations included improving education in areas of nutrition, disordered eating and mental health. Protective factors are described that could establish personal frameworks of care for binge eating in future. Stereotypes of eating disorders, alongside DSM-5 criteria (APA, 2013) were perceived as barriers to treatment. The findings suggest that diagnosis and recovery journeys for binge eating are not linear, and that recovery itself is subjective. Participants' accounts present narratives that move away from ideas of having to reach a place of medical diagnosis and recovery for experiences to be valid. The importance of improving primary care eating disorder pathways in New Zealand is evident through the voices of interview participants and General Practitioners, with participants advocating for improving care structures in New Zealand, with focus on earlier intervention and cultural relevance. This research has provided insight into personal experiences of living with binge eating, and difficulties navigating primary care systems.

Acknowledgements

Without the support from the wonderful people who volunteered their time and personal stories for this study, it would not have been possible. To the eight interview participants, I thank you with all of my heart for your honesty, wisdom, and for trusting me with such personal stories. To Āwhina (pseudonym) I thank you for your cultural knowledge, and wish you all the best in your future research with and for Māori.

To the General Practitioners, who took time out of their day to answer my surveys and send supportive messages, thank you.

Thank you to Dr Kathryn McGuigan, my supervisor and someone I now think of as a true friend. I would never have finished this without your help and guidance, or thought it possible to take on the next challenge of internship. I really do not have words for how grateful I am for your support, knowledge and positive attitude throughout. You believed in my ability to write this, even when my writing was just a mess of words and colourful post-it notes.

This university journey has been a long one, that I couldn’t have done without the support of those closest to me. To my sisters, Katie & Abbie, thank you for always being my greatest cheerleaders. To my mum Di, and dad (Dr) Dave, for the endless advice and proof reading. Thank you all for reminding me that what I was doing was worthwhile when I needed it most, and for always having faith in me.

To my amazing friends who have been there for me during this journey, thank you for always understanding when I disappeared for weekends of writing instead of socialising, and for your words of support and encouragement. To my dog Honey, for being by my side for every late-night writing session, and getting me out in the fresh air when I needed a break.

To my partner Sam, thank you for giving me a place to call home, for the late-night cups of tea as I sat glued to my computer screen, and most importantly for always supporting my dreams.

It truly takes a village, and I would not have been able to complete this alone. I hope the hours and days I spent writing, reading, crying, and thinking, have added something good to the world. Please read this thesis as it is intended, with love and deep gratitude, and a hope that it can take a step towards improving the future for anyone struggling with disordered eating.

In loving memory of friends that passed away in 2021, as a reminder that every day is precious.

Table of Contents

Contents

Abstract ii

Acknowledgements iii

Table of Contents iv

List of Figures vi

Chapter One – Introduction 1

  Research Rationale 4

Chapter two - Literature Review 8

  Disordered Eating - A Brief History 8

  Disordered Eating - The New Zealand Context 11

  Disordered Eating - The Social Context 14

    Feminism 14

    Foucault 15

    Stigma 16

    Social Media & Diet Industry 17

    Medicalization of Health and Disordered Eating 20

  Binge Eating Disorder (BED) 21

    Aetiology of Binge Eating Disorder 22

    Treatment of Binge Eating Disorder 27

  Research Aims 33

Chapter Three - Methodology 35

  Epistemology 35

  Theory 36

  Narrative Approach 38

    Recruitment 40

    Participants 41

    Ethics 43

    Reflexivity 44

  Narrative Interviews 46

  GP Data Collection 47

Chapter Four - Analysis 49

  Analysis Steps 49

Chapter Five – Findings 54

  - Part 1) Lived experience 54
    - Origins of disordered eating 55
    - Personal journeys of Disordered Eating (Binge Eating) 60
    - Interpersonal relationships 60
    - Recovery, Management & ‘Living with it now’ 86
  - Part 2) GP Data 103
    - Descriptive statistics results 103
- Chapter Six - Discussion and Conclusions 105
  - Summary of Key Findings 105
  - Implications 107
  - Conclusions and Recommendations 115
- References 118
- Appendices 142

List of Figures

Figure 1 - Google Image Search "Binge Eating Disorder" 19
Table 2 - Participant Recruitment Data 42
Table 3 - GP responses to questions about BED 103

Chapter One – Introduction

Eating Disorders (EDs) are defined as severe psychological disorders, characterised by a persistent disturbance of eating-related behaviour that significantly impairs physical health or psychosocial functioning (American Psychiatric Association [APA], 2013). For disorders such as Anorexia Nervosa (AN) and Bulimia Nervosa (BN) this can result in excessive concern about body weight and shape, high levels of body monitoring and preoccupation with appearance (Adams et al., 2017; Zeigler-Hill & Noser, 2015). Positioned within a western biomedical lens, such categorisations of EDs exist within social constructions of health that are continually adapting over time. As a result, diagnostic criteria for EDs have steadily become more specific, allowing for a greater range of disorders to be included in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM–5; APA, 2013) with their own diagnostic criteria's, extending understandings of disordered eating outside of traditional AN and BN conceptualisations.

Binge eating is one concept of disordered eating that has developed in terms of scope, definition and diagnostic credibility over the course of recent history. Previously categorised under Eating Disorder Not Otherwise Specified (EDNOS), Binge Eating Disorder (BED) was introduced as a standalone eating disorder (ED) to the DSM-5 in 2013 (APA, 2013). Characterised by recurrent episodes of extreme overeating (bingeing) BED is conceptualised as bingeing without correctional behaviours present, however can be accompanied by periods of food restriction or dieting (APA, 2013). During episodes of binge eating, individuals display cognitions focused on food and eating behaviours that can negatively impact on mental wellbeing, quality of life and health outcomes. For diagnosis of BED, criteria include binge eating episodes occurring at least once a week for 3 months, where a large amount of food is eaten rapidly in a discrete amount of time (APA, 2013; Marzilli et al., 2018). Feelings of distress, shame, disgust and loss of control are associated with experience of BED and included as factors in diagnosis (APA, 2013; Eating Disorder Association of New Zealand [EDANZ], 2021). Long term mental and physical effects can include; social adjustment issues, impaired quality of life and increased medical morbidity (Hudson et al., 2010; Wonderlich et al., 2009). BED alongside other EDs, also has high levels of comorbidity with additional mental health disorders, such as depression and anxiety, and increased likelihood for presence of suicide ideation (Agüera et al., 2021; Baxter et al., 2006; Keski-Rahkonen, 2021; Ministry of Health, 2006).

The 2006 *Te Rau Hinengaro: The New Zealand Mental Health Survey.* (Ministry of Health, 2006) provides the largest survey data for EDs available to date for New Zealand. Unfortunately, this data is somewhat limited in scope, as it was gathered before inclusion of BED in the DSM-5 (APA, 2013), and therefore only includes AN or BN as specified EDs. Still, it provides a basis from which we can begin to conceptualise prevalence of EDs in Aotearoa New Zealand. For any ED (AN, BN or not otherwise specified), lifetime prevalence was found to be 1.7% in 2006, this would result in approximately 87,000 people living with an ED in 2021, adjusted for recent population statistics (Ministry of Health, 2006; Statistics New Zealand, 2021). Lifetime prevalence rates also suggested that EDs are at least as common for Māori, as prevalence in general populations, with even stronger likelihood for Pacific populations (Baxter et al., 2006; Lacey et al, 2020; Ministry of Health, 2006).

While data on prevalence for BED in New Zealand remains extremely limited, recent global data, gives strong indication that prevalence of BED is on the rise. In an Australian study, Mitchison et al. (2017) found that prevalence of objective binge eating (OBE) increased six-fold from 1998 (2.7%) to 2015 (13.0%). While in a global study, Qian et al. (2013) estimated lifetime prevalence of BED at 2.22%, higher than either AN (0.21%) or BN (0.81%). Bagaric et al. (2020) found lifetime prevalence for BED to be 0.74% and 1.85% for Australian males and females respectively, slightly lower than BN prevalence. The Australia and New Zealand Academy for Eating Disorders (ANZAED) in 2018, estimated prevalence of 1.5% for BED across Australia and New Zealand. A World Health Organisation (WHO) global study conducted in 2013, found country-specific lifetime prevalence estimates for BED of 1.4% – 1.9%, higher than BN, describing both BED and BN as a public health issue globally (Kessler et al., 2013). The DSM-5 (APA, 2013) cite a Twelve-month prevalence of BED among US male and females adults as 0.8% and 1.6% respectively (Hudson et al. 2007). From the available data, BED appears to be more prevalent in western industrialised nations (APA, 2013; Kessler et al., 2013; Qian et al., 2013). Taking this into consideration, population estimates could place New Zealand prevalence at anywhere between 0.74% and 2.22% of the national population, affecting between 37,900 – 113,800 New Zealanders for BED alone, higher than current mainstream media estimates of 103,000 cases across New Zealand for all EDs (Recovered Living, 2020). With such rapidly increasing statistics, BED is now widely regarded as the most common of all EDs globally (ANZAED, 2018), despite the significance of the problem identified across the literature, there is a surprising lack of research for BED internationally, and even less in New Zealand.

Limited care options currently present for EDs and BED. Disparities often exist for access to support and diagnosis that favour those with higher socio-economic circumstances and those of Caucasian ethnicity (Mulders-Jones et al., 2017; Sonneville & Lipson, 2018). This is in contrast to the reality of living with disordered eating, where symptoms appear to be distributed equally across levels of socioeconomic status, and where disorders such as BED, may be more prevalent in minority ethnic groups such as Māori (Baxter et al., 2006; Lacey et al., 2020; Ministry of Health, 2006). Māori are a population under-represented in both inpatient and outpatient settings for ED care, making up less than 10% of those receiving treatment in the Waikato region of New Zealand (Hansen et al., 2021) compared with17.1% of the population of New Zealand being Māori (Statistics New Zealand, June 2021). National data from *Te Rau Hinengaro: The New Zealand Mental Health Survey* also indicated that Māori comprise only 7% of the population receiving specialist ED treatment in New Zealand (Lacey et al, 2020; Ministry of Health, 2006), highlighting a need for improved, universal access to specialized services, and training in healthcare to improve detection and diagnosis of EDs across diverse groups, to combat barriers for people who do not conform to traditional ED stereotypes (Mulders-Jones et al., 2017). This scope of BED, somewhat breaks the mould of stereotyped perceptions of EDs as affecting only young white, middle class women (Marks, 2019), an important factor to consider when looking at current statistics for ED treatment in New Zealand.

For those that do receive a BED diagnosis and access to care, current recommended treatment for adults is ED focused cognitive behavioural therapy (CBT-ED), an approach that has shown proven effect with both BN and BED populations (Agras & Apple., 2008; Brown & Perry., 2018). Alternate or concurrent treatment approaches, include pharmacotherapy; utilising medications such as lisdexamfetamine, approved for use in the treatment of BED in the US (Levitan et al., 2021), or including antidepressants or anti-anxiety medication as part of multidisciplinary care alongside CBT-ED or other therapeutic interventions. Such use of medications is perceived widely as an important component of treatment (Levitan et al., 2021; Peat et al., 2017), and multidisciplinary treatment approaches are recommended in guidelines from ANZAED (Hurst et al., 2020), and the National Institute for Health and Care Excellence [NICE] (NICE, 2020).

Improving access to care, especially when facing the reality of increased demand on mental health services as a result of the impacts of COVID-19, is a further area of high importance, with current limited data. A New Zealand based analysis of effects on service utilisation during COVID-19, found that from 2019 to 2020, an increase in demand for EDs services was present alongside worsening severity of ED symptoms (Hansen et al., 2021). Evident across both child and adult populations in the Waikato, data demonstrated increased proportions of first-ever ED-related admission, and child and adolescent outpatient services saw an average 60% increase in referrals per month following lockdowns (Hansen et al., 2021). Recent New Zealand media reports support such findings, announcing double the admissions for EDs in Auckland during the pandemic, and a 30% increase in admissions for the Wellington region. A private clinic in Auckland also advised a 10% year-on-year increase in service demand for ED support, aside from pandemic-related demand increases (Hansen et al., 2021; New Zealand Herald, 2021; Radio New Zealand, 2021).

Research Rationale

Despite advancements in focus, studies on and understandings of binge eating remain in relative infancy, compared with other EDs such as AN. For BED specifically, early research focused on the relationship of BED to eating disorders such as AN and BN. More recent research has emphasised the links between BED and obesity, moving on from seeing binge eating behaviours as purely sub-set element of other EDs (Marks, 2019; Wonderlich, 2009). Although almost equally present in men and in women, BED studies share a commonality with broader scope disordered eating studies in that research predominantly conceptualises college age women as particularly high-risk groups for extreme weight-control strategies, and often only include Caucasian, female populations, with a mean age of 18 to 25 years (Adams et al., 2017; Woodward, 2019; Zeigler-Hill & Noser, 2015). Typical onset trends of disordered eating symptoms, with or without full diagnosis criteria, are said to occur between the ages of 14 – 25 years, and approximately 13% of adolescent’s experience some form of disordered eating (Culbert et al., 2015), however data has shown delayed symptom development and diagnosis in older cohorts for BED (Culbert et al, 2015; Galmiche, 2019). More research is needed with participants both under 18 and over 25 years.

Research for BED also needs to focus on understandings of disordered eating in men and ethnic minorities. In addition, there needs to be critical awareness of how historical inequalities may be prevalent in study groups, that can leave minority groups somewhat invisible. For instance, one study found that men represent approximately 21% to 27% of general ED cases (Wei et al., 2020) and between 30% - 40% of individuals with BED (Qian et al, 2013; Westerberg & Waitz, 2013). However, men are often overlooked in studies due to such focus on female populations. Resulting inequality among participant cohorts could be down to many factors. Firstly, it appears to be more socially unacceptable for men to be seen as having an ED in society (Boysen et al., 2014). Secondly thin ideals placed on women may result in higher social acceptability for male bodies to present with greater levels of body fat, or to be classified as obese than for women (Keane, 2014), a factor that may allow for easier means of hiding binge eating practices, as male bodies are traditionally under less direct scrutiny. Thirdly the understandings around ED aetiology and symptomology may be prefaced by a lens of female attributes given the historical view present for other EDs such as AN and BN, traditionally seen to affect, white affluent females (Boysen et al., 2014). Studies in the context of male disordered eating could provide valuable insight into the roles of social expectations, life stressors and self-worth that are also applicable to men, and in cases where men are trying to gain weight to meet a desirable muscular physique, such as seen in “Bigorexia” (Wei et al., 2020) may be increasingly at risk of falling into dangerous binge eating patterns.

Much ED research is also completed reflexively after diagnosis, limiting findings for symptomatic individuals that do not meet diagnosis criteria, but may reach sub-threshold ED levels, leaving them potentially at high-risk of developing future disorders (Wacker & Dolbin-MacNab, 2020). This approach is at odds with the consensus that earlier treatment intervention is most effective (Marks, 2019). Therefore, including study cohorts that reflect wider populations outside of clinical subjects is important in determining how to extend positive support and treatment at earlier stages. Strengths of studies such as Woodward et al. (2019) Zeigler-Hill & Noser (2015) and Adams et al (2017) is the inclusion of non-clinical populations, which allows for data from participants who have not met diagnostic criteria.

Binge eating research is also lacking in minority cultures, especially outside of WEIRD populations. A study that included a predominantly African American populations, found that African American adolescents had less body dissatisfaction and consequently less negative self-worth views than white counterparts (Sutter et al., 2015), something deemed to be a protective factor for disordered eating. New Zealand based studies, although limited, have shown that indigenous Māori and other minority populations are, at a minimum, equally likely to suffer from BED and other disordered eating as Pākehā populations, but are less likely to be diagnosed and receive care (Lacey et al., 2020), a gap that requires further investigation and rectification in future research, and may also provide insight into protection factors for different populations. Given these findings, studies need to include more ethnically diverse cohorts to improve understandings of differences than are present in majority of ED studies publicly available today.

As demand increases for BED diagnosis and treatment, without greater understanding of effective and realistic treatment options, the risk of medicalized approaches to treating BED as an extension of weight loss becomes more apparent (Cooper et al., 2020; Levitan et al., 2021; Surgernor, 2020). It is important to improve understandings of the aetiology behind BED, to ensure that treatment approaches are suitable, effective and tailored to individual requirements. This process needs to happen alongside a cultural shift in how we perceive and understand EDs within the conceptualisation assumptions made about 'others' bodies, based purely on physical understanding of external beings. Out-dated notions such as 'fat people can not have an eating disorder' are intrinsically tied to other stereotypes such as being fat equals being gluttonous and lazy (Marks, 2019; Vigarello, 2015). These notions are harmful and have impeded progress in ED research and understanding outside the traditional anorexic body architype that is habitually presented as the physical manifestation of what it is to live in a body with an ED (Marks, 2019).

Thankfully, through public platforms such as social media, incorrect preconceptions of EDs and larger bodies are being pulled apart, analysed and reconstructed from the voices of lived experience. The 'health at every size' (Bombak et al., 2018; Carbonneau, et al., 2017) movement and broader 'self-love' movements (Smalling, 2020), show eating behaviour narratives being challenged and feminist-based progress that allow us to analyse more critically the social structures that frame bodies in western society. The landscape of research and conceptualisations of who is the 'expert' and the 'subject' needs to be tilted to align with such understandings, to promote qualitative research that can provide meaning and support important changes in research dialogues.

The focus on experimental methods to look at efficacy of treatments or aetiology of BED also limits the lived experiences and 'voices' for people with disordered eating. While important, current information does little to improve understandings of what it is like to live with disordered eating in daily life, which can affect self-perceptions and efficacy beliefs, mental wellbeing, and navigation of social, family and work life. As disordered eating is often associated with feelings of guilt and embarrassment, this can lead to high levels of secrecy and in turn result in individuals feeling lonely and isolated (EDANZ, 2021). The best way to understand such thought processes, are through self-reports that can provide in-depth narrative examples of disordered eating behaviours, including binge eating. Qualitative methods can capture voice and understandings of how disordered eating impacts daily life and potential recovery. This can be seen in works of Amy Pershing & Chevese Turner (2019) in *The Journey to recovery and beyond*, focused on BED, and earlier works on Bulimia such as *Creating bodies* by Katie Gentile (2007).

The range of data that is available in New Zealand and globally, demonstrates that BED affects a wide range of cohorts, across ethnicities, age and weight ranges, and whilst BED is increasing in prevalence, the transition from symptomology to diagnosis appears extremely limited. Not only is data limited for diagnosis, it is near impossible to locate robust data that demonstrates public or private service use rates, outside of medical weight loss surgery. in New Zealand and globally there appears little research available that examines how individuals have managed disordered eating symptoms when not being treated at a clinical level (Wacker & Dolbin-MacNab, 2020). Limited data that is available focuses predominantly on post-DSM-5 diagnosis, for example understanding lived experiences of therapy treatment, where personal voices are often lost in midst of searching for affective medical approaches (Applequist, 2014; Conti et al., 2017).

It is from such inspiration that this research study came to exist; to be a part of capturing voices in a way that can play a part in moving forward BED (and wider ED) research, treatment and overall understanding; to provide a place for those who are most knowledgeable to give a voice to how their experiences shape them, and how this may support a framework for improved diagnosis and care in New Zealand and beyond. These are somewhat broad ambitions for a master level thesis, and throughout this research there has been a conscious awareness of the limited scope this study can offer. However, the hope that this research can provide a step towards filling a stark gap in current available New Zealand literature motivates this study.

Chapter two - Literature Review

Disordered Eating - A Brief History

Binge eating practices are present throughout historical dialogues where narratives of status and wealth accompany early depictions of socially acceptable gluttony. Demonstrated by the rich and powerful, ideas of indulgence are intertwined with obesity and worn as a badge of wealth and health (Vigarello, 2015). Concepts of health began to intertwine with ideas of morality with the progression into the modern era starting with the renaissance in the 15th century. Shifting social ideas were in part supported by increased medical knowledge, including new conceptualisations of the obese body (Nutton, 1997), seen as increasing the risk of having a short life. Criticisms of fatness take on a new meaning; bigness which was previously portrayed as a symbol of status, begins to be rejected by the wealthy and noble. “Larger” physical traits in art and literature begin to be depicted as means for exclusion or entertainment, a sign of lack of class and intelligence, and indicative of sin (Vigarello, 2015). Women in particular but also men, began to wear clothes that reduced the appearance of size, especially around the waist, such as corsets (Vigarello, 2015).

During the 17th Century, a focus on medical experimentation begins to shift placement of disease to within the body, where previous religious ideas are replaced with medicalised concepts reflected in terminology changes such as the shift from Holy Anorexia, to Anorexia Nervosa (Bemporad, 1996; Pearce, 2004). As an illness, medical descriptions of Anorexia are evident from as early as the late 1600’s, including medical accounts of anorexia by Richard Morton in 1689, often described as the first cases of modern AN (Marks, 2019; Pearce, 2004). Throughout these times, supervised diets, administered by physicians, are evident at both ends of the eating spectrum. These ranged from restricting eating and administering sleeping patterns for those deemed too large; to feeding regimes and limitations of activities for those too skinny (Vigarello, 2015). No rules or guidelines around what qualified as too little or too much was available, leaving it predominantly contextual to the time. As a result, equally critical version of the fat and skinny person existed, somewhat mirroring modern-day society where meeting body ideals becomes a minefield of not being too fat or too skinny.

Disordered eating has historically been associated with the feminine body. Social contexts of the 19th Century, saw the natural variety of the female body systematically ignored in favour of the slim ideal, evident through literature of the time (Silver, 2002). Ideas of morality that link with eating behaviours and body presentation continued throughout the 20th century, reflecting concepts of the female body as unpredictable and disorders as exemplification of female fragility (Bemporad 1996; Burns, 2004). Such standards of beauty seen in high society, provide a hypothetical bridge from which to understand women's experiences of body expectations and the "tyranny of slimness" (Silver, 2002, p. 26) that continue to be present in the 21st century. In both eras ideals of beauty continue to concern men and women, often describing the female body through the lens of the male gaze, where a fear of fatness is evident, and slimness is placed at the forefront of societal ideal of female beauty (Silver, 2002; Vigarello, 2015).

In the early 20th Century, there is an apparent reduction in published works that add new concepts of AN and other disordered eating practices. However, between the 1960's and the 2000's there was exponential growth in the study of first AN and later BN (Marks, 2019). The first observational study outlining binge eating as a disorder, was provided by Stunkard in 1959; Hilde Bruch provided the first modern descriptions of AN in the 1960's, with body image disturbance and weight phobia emerging as central themes, largely unexamined in earlier texts, as well as presenting ideas of obesity and AN, where she proposed they share common psychological and societal determinants, offering a humanistic integration of the understanding of the development of over eating (binge eating) and undereating, in the context of societal idealization of thinness (Marks, 2019). Such depictions were presented before BED was fully conceptualized, and described the phenomena of compulsive overeating in direct conflict with fear of fatness. (Bruch, 1973; Bruch, 1978; Marks, 2019). Recognition of symptomology and severity of such disorders was increasing rapidly, and growth in research was framed within the sociocultural transitions of the era, predominantly the rise of feminism (Marks, 2019), where the 1980's marked a shift away from traditional psychoanalytical treatment approaches, towards early conceptions of cognitive behavioural therapy (CBT) and family-based therapies (FBT) for AN and BN, and later BED (Cooper & Fairburn, 2009; Marks, 2019).

Theories surrounding such an increase in disordered eating focused on the impact of the skinny ideal, during a cultural shift of social roles and expectations, especially for women who had grown up in the post-1960's era. Feminism inspired new freedoms, including bodily autonomy (Marks, 2019), and these new-found freedom and feminist exploration continued into the 1980 and 1990's where there was a significant increase in public awareness and perceptions of disordered eating, with the death of musician Karen Carpenter in 1983 placing a cultural marker for a wave of disordered eating dialogues in popular culture (Marks, 2019). With women trying to find their way in a world that is rejecting outdated societal norms, the benefits of freedom also put new pressures on women to achieve more and do more. This was also the time that the categorisations of disordered eating broadened to include BN in the DSM-III, and where EDs were recognised as a stand-alone criterion, rather than their previous conceptualisation as a psycho-physiological disturbance in the DSM-I, or a Feeding Disturbance in the DSM-II (APA, 1985), supporting the research efforts of psychologists at the time to differentiate how EDs were approached and treated in comparison to other psychological conditions.

Heading into the 21st Century, the last 50 years of ED research, has demonstrated an extreme trajectory of growth and published papers (Hay, 2017). BED research, unfortunately, has not shared the same path of growth as work in AN and later BN, or the same attention in the mainstream media. Although present and acknowledged in the context of modern disorders since the early 1990's (Devlin, 1996; Marks, 2019), and conceptualised as an obesity related phenomenon as far back as Stunkard's accounts of binge eating in 1959 (Stunkard, 1959), it was only presented as a stand-alone, diagnostically outlined ED with the reclassification of the DSM-5 in 2013 (APA, 2013). However, the earlier version DSM-IV revised (APA, 1994) did include a subset-scale to diagnose BED, which narrowly missed full inclusion as more research was required on effective diagnosis and treatment efforts. Post-2013, definitions of AN, BN and BED have remained relatively consistent, and research in the last decade has demonstrated an increase in inclusion of BED in wider eating disorders studies, alongside BN in particular (Agras, 2008; Bagaric et al., 2020). Discussions around the importance of increasing BED as a focus of research in its own right are evident (ANZAED, 2018), and debate of research that focuses on BED in relation to obesity and surgical weight loss poses important questions of where diagnosis and treatment endeavours should place key emphasis (Cella et al., 2019; Keski-Rahkonen, 2021; Surgernor 2020).

Disordered Eating - The New Zealand Context

The New Zealand landscape of disordered eating research, at the time of writing, offers little to improve knowledge of what it is like to live with binge eating. To date, this field has focused predominantly on AN and BN, centered largely within the medical realms of diagnosis and treatment options. Binge eating, particularly within its relatively recent classification as a DSM-5 disorder in 2013 (APA, 2013), is an area that requires additional scholarship and focus, to move somewhat out of the current shadows of perception as the less glamorous sibling of AN and BN, with limited inclusion in the disordered eating research community. Current qualitative literature that is available for binge eating, is generally included in generalized ED studies, and limits voices primarily to individuals who have been received a diagnosis of BED, missing voices of those that may not be able to access such care, or do not fit within the frameworks of traditional eating disorder categories, creating an inequality of voices within qualitative research which this research looks to address.

New Zealand history, culture and eating are intertwined, with colonisation impacts on Māori in Aotearoa, who were subject to body scrutiny and policing from Pākehā (European) populations following colonisation in the 19th Century. Viewed and defined through a lens of Western European culture, Māori were depicted unfavourably in relation to appearance, habits and appetites (Rountree, 2000). The arrival of European settlers saw Māori shamed and punished for displays of body nudity and untamed hair, seen as representations of moral degeneracy. A focus on transforming Māori women and restricting sexual expression is evident (Gentry, 2015), a perspective linked to the 'proper' female etiquette and body ideals in western society. Essentially, missionaries of the time, wanted to "clean, clothe and control the Māori body" (Gentry, 2015, p. 52). Additionally, Māori cultural expression through body and dress, were exploited for entertainment purposes, especially face moko (Gentry, 2015), presenting culturally white washed representations of Māori, to European audiences, absorbed into Pākehā notions of New Zealand culture, glossing over full Māori history, while claiming favoured tikanga Māori elements as representative of new age New Zealand (Gentry, 2015). Subsequently, western, Christian ideologies were framed as central, including ideas of beauty, practices of food, culture and cleanliness, and perceived correct eating etiquettes, taking place of many sustainable indigenous food practices, and traditional body freedoms, leaving Māori living in a state of poverty, deprivation and marginalisation (Mutu, 2019; Sebastian & Donelly, 2013). The results of such traumatic experiences, stripping Māori of bodily autonomy and identity, continue to have generational impacts on health and mental wellbeing of Māori in post-colonial society (Pool, 2016) including the field of disordered eating.

In the 21st Century, Aotearoa New Zealand presents as a bicultural society, where impacts of colonisation are a key component of considerations for providing equal care under Te Tiriti o Waitangi (The Treaty of Waitangi) requiring consideration in research and medical care, providing a unique cultural context in which to consider aetiology, diagnosis and treatment of disordered eating (Hayward, 2012; Ministry of Health, 2020). Within current definitions provided by the DSM-5 (APA, 2013), disordered eating remains conceptualised within western frameworks of understanding, which presents limitations in applicability to other cultural perspectives on mental health. Even so, what were once seen as white, western disorders, predominantly affecting middle-class young women are now internationally recognised to affect a much broader cohort, although research populations continue to lack diversity (Lacey et al., 2020; Lydecker et al., 2018). As understanding and treatment have become more ingrained and sustained, statistics for AN and BN appear to have tapered off to a continuous level in regions such as North America and Europe over the last 20 years (Galmiche, 2018). However only looking at western nations and frameworks that depict predominantly recognised EDs such as AN and BN, paints a somewhat of an inaccurate picture of the reality of scope in which EDs, such as binge eating, continue to grow across cultures and diagnostic areas.

Evidence has also been presented that obesity is a risk factor for EDs (Striegel-Moore & Bulik, 2007). Cultural minority populations such as Māori and Pacifica, make up a disproportionate percentage of the New Zealand population who are classified as overweight, and who live in lower socio-economic areas, experience more relative food poverty and less access to nutritionally dense foods (Ministry of Health, 2006). Despite higher prevalence for obesity and poverty, and equally likely levels of disordered eating, Māori are a population currently under-represented in both inpatient and outpatient settings for ED care (Hansen et al., 2021; Lacey et al., 2020). As a direct result of colonialism, high geographical displacement of Māori exists in present day New Zealand; Māori and Pacifica are more likely to live in lower decile and rural geographical locations that do not have high distribution of ED services, skewing available statistical data for EDs, and fair distribution of access to treatment (Lacey et al., 2020; Mutu, 2019), highlighting a need for improved, universal access to specialized services, and training in healthcare to improve detection and diagnosis of EDs across diverse groups, to combat barriers for people who do not conform to traditional ED stereotypes (Mulders-Jones et al., 2017). Equally, Māori are more likely to have other mental health conditions, which have a high comorbidity rate with disordered eating patterns (Ministry of Health, 2006). More data is required to get a clear picture on how Māori in particular are affected and potentially missed in health care efforts to treat disordered eating, particularly BN and BED which are hypothesised as being most at risk for Māori, with higher rates of BN seen for Māori than non-Māori in one sample study (Lacey et al., 2020; Ministry of Health, 2006). Other cultural considerations in disordered eating conceptualisation in the New Zealand context, include social perceptions and offerings of kai (food) as signs of respect, value and aroha (love). Sharing of food in such a way, has a rich and important history, but little is known about how such practices may transition into realms of disordered eating in some cases where self-care and emotional support may also be conceptualised through food.

COVID-19 continues to influence all aspects of lives in New Zealand. Impacts of COVID-19 for EDs include social isolation alongside food and financial insecurely, enhancing already problematic relationships with food and worsening ED thoughts and behaviours (Spigel et al., 2021; Touyz et al., 2020). New Zealand has seen a rise in the number of ED related cases since COVID-19, evident across both child and adult populations (Hansen et al., 2021). Broader Mental Health Data from the New Zealand Ministry of Health, shows an increasing trend over the last 15 years in utilisation of mental health support, this includes data for disordered eating, however for the most part these statistics are unavailable at an extrapolated level. Although such data does not explicitly reference ED utilisation of services, they are captured within this broad data set, and government data from year ending June 2018 calculates people seen by ED teams at New Zealand mental health service providers across all age groups at 1585 individuals, (110 male, 1475 female), with highest rate of treatment for ages 15-20 years (Ministry of health, 2021). Making up less than 1% of all mental health clients (186,968) seen in 2018/2019, despite government legislation set in 2012 that set targets to provide higher levels of care for EDs in New Zealand (Ministry of health, 2012), and a submission from EDANZ in 2018, requesting increased support and access for Eating Disorder care, that includes improved specialist knowledge for diagnosis, referral and treatment (EDANZ, 2018). In light of the use of government mental health services increasing between 2005 and 2020, it would be unwise to assume that disordered eating in New Zealand remains stable, or well treated, especially with high comorbidity with anxiety and depression, conditions that have both seen a rise in treatment seeking behaviours in recent years, and in the face of COVID-19 (Ministry of Health, 2019).

Disordered Eating - The Social Context

Shaped through medical discourse, knowledge that exists in relation to the body, has a basis in biomedical practice, where study of anatomy provides an objective reality of body as parts. However, the philosophical claims we make about knowledge; how brain and body are connected, cultural practices with food, how we eat, socialise and feel around food, is very different to that reality of the body as a biomedical object (Foucault, 2002; Miller, 1990). A different lens is required when conceptualising such intricacies. This section discusses the theory and social, cultural and political dynamics important to BED; including Stigma, Foucault and Feminist theories.

Feminism

Feminist Theory, conceptualises information as highly subjective and interpreted within a social context (Chamberlain, 2014) and seeks to explain the lives of people who are marginalized by their identities within social categories, such as sexuality, gender, weight or disability (Radtke, 2017). Feminist theory is a viewpoint complimentary of the social and cultural nature of disordered eating, as it rejects overtly accepted societal views, to actively question current social power structures present in both wider society, psychology as a field, and within the research setting itself (Lorraine Radtke, 2017). Taking a feminist theoretical approach assists in unpacking social constructions of gender roles, and perceived social acceptance of some eating behaviours and EDs over others, through questioning how disordered eating information is being communicated within communities, medical facilities, universities and wider social media, and how these subjective interpretations may impact individual behaviours, and also research practice. In this way, feminist theories have already made distinctive contributions across ED literature (Burns, 2004; Holmes, 2016; Wacker 2020) and in public health narratives in New Zealand (Curtis, 2016) and can equally add positively to binge eating discussions. Important feminist constructs in relation to ED research include objectification, self-surveillance, body-management and striving for the thin-ideal (Burns, 2004; Piran, 2010; Rubin et al., 2004). Taking such a critical feminist disposition, can help to extend current understandings of binge eating, that have predominantly been shaped in relation diagnostic discourses, internalised gender stereotypes, and power structures in professional-patient relationships (Fichter & Quadflieg, 2007; Hay, 2020; Keane, 2014).

Foucault

Foucault and later discourse theorists, believe that no form of knowledge is objectively neutral (McDowell, 1995) and there must be distinction between real objects, such as the physical body, and knowledge created about the object, such as body expectations. Miscellaneous, sometimes conflicting levels of discourse, function across society for multiple reasons. Foucault theories allow questioning of discourse creation, the interests that key messages serve, and the relations of power they uphold, such as concepts of the social body, objectification and the male gaze. (Andrews, 2012; Miller, 1990). This social reality is characterized by operations of power, in relation to how power and history of previous 'worlds' have shaped knowledge of the world today. These forms of knowledge creation, impact on medical models and doctor patient relationship hierarchies that are created and upheld in modern medical systems, where the authoritative figure of the doctor or medical professional, is perceived to hold the knowledge of the biomedical model of the body (James & Porter, 1994).

Armstrong maintains that Foucault's formations offer the most comprehensive and powerful accounts of the success of creations and recreation of body and invention of diseases. For example, how EDs have been adapted and recategorize over time, to reflect social changes, and shifting gaze of medical science and reorientation of medical power. Part of this understanding of social constructions of body is presented within how the medical professional has a right to deem body as abnormal based on biomedical roots in modern social sciences (Armstrong, 2015). In this way, discursive communication itself can be a form of oppression. Building on these notions, Armstrong (2015), states that power is something that represses blocks and seals. therefore, it's possible to liberate people and give them back their true identities, which have been removed through processes of alienation and removal of power.

Foucault's theories of power and knowledge, and how they are used as a form of control through societal institutions (Foucault, 2002; Miller, 1990), are evident in how the body is socially constructed, where bodies exist as both physical objects and political entities (Foucault, 2002) and where discourse about bodies, is neither conceived as being true or false in an objective sense, but taken as perspective definitive of the society, group, or institute of the time (Miller, 1990). In such settings disciplinary power, is concerned with creating power mechanisms around a body that constitute and maintain it (Foucault 2002; Armstrong, 2015). Such disciplinary power is evident in how medical and social messages objectify the body and constitute and maintain the narratives that society sees as truths, especially in western concepts of body ideals, and how narratives, such as feminist critiques, are placed against these power dynamics when discussing concepts of body that go against such mainstream views (Rubin et al., 2014).

Stigma

Goffman defined stigma as disapproval of a person as they deviate from social norms and the impact of this is a lack of social acceptance (Goffman, 1986). Stigmatisation of people with EDs has been shown consistently (for example; Brelet et al., 2021; Foran, 2020; Hollett & Carter, 2021) often with negative implications such as increasing symptoms, furthering distress and stopping people seeking help. This can result in increased complications of care, which in turn predicted greater symptom severity (Brelet et al., 2021). Stigma and EDs plays out differently from other mental illnesses with often a lot more blame associated with EDs, such as lack of self-discipline. The extent of ED stigma plays out across family members, work places and health professionals with all groups more likely to display adverse reactions to EDs. Much of the stigma comes from weight related stigma with obese bodies and morbidly underweight bodies most likely to be stigmatised (Brelet et al., 2021).

Courtesy stigma, or ‘stigma by association’, involves public disapproval evoked as a consequence of associating with a stigmatised individual or group (Phillips et al., 2011). Harmful cognitive stereotypes of EDs, include notions of personal responsibility and control, negative character traits, gender attribution and questioning of disease severity. Research has highlighted that people with BED were less like to elicit negative comments from others in relation to binge eating behaviours, but were most likely to be help responsible due to lack of willpower (Brelet et al., 2021). Where people with BED, have been described as having a less desirable personality traits compared to others. These include attributions given to binge eaters as weak, lazy, careless and self-destructive (Brelet et al., 2021). Attributions have negative emotional connotations, which lead to negative behaviours towards people with binge eating. In many cases, such stigma can be subtle, unintentional actions that remain due to unchallenged assumptions based on ingrained stereotypes.

For many people with binge eating, they are also affected by weight related stigma, which can leave people feeling categorised as socially outcast and less desirable or valuable. Guidelines promote that intervention for BED is not weight loss focused (Hurst et al., 2020, however there is an assumption made in literature that weight loss is a focus for all people that are treatment seeking, reflecting a social stigma that all people with BED present in larger bodies, and is part of the overarching problem with stigma that is present in relation to weight and BED. People with EDs also suffer from personal stigma, where such public ideas of weight, control and personal responsibility can lead to negative reflections of the self, low self-esteem and categorisation of self as an isolated other in society (Corrigan & Rao, 2012). Stigma predicts negative outcomes for people with EDs, where more frequent experiences of stigma resulted in higher levels of ED psychopathology and greater avoidance of treatment seeking (Brelet et al., 2021).

Social Media & Diet Industry

The social connotations that come with body size, and the efforts of members of society, particularly female, to fit with expectations of attractiveness set by others is important for disordered eating. A complex evolution of social acceptance and denial of certain body types, and the architype of diets, sets the foreground for the multibillion-dollar diet industry that feeds on increasing body scrutiny and heteronormative body monitoring that exists in the 21st Century, where beauty standards continue to reflect the political and economic interests of the times (Bacon, 2010). In such a way "the stigmatised gaze is socially orientated" (Vigarello, 2015, p. 26) for it is the social construct of what it means to be fat rather than being fat itself, that changes in the face of social requirements and ideals.

For disordered eating and BED weight stigma is common, and social stigma towards those in larger bodies and fat discrimination can intensify feelings of shame and hiding of disordered eating. In the year 2021, there is a portrayal that society has moved on from toxic diet culture and the skinny idea of the early 2000's. In some ways, this is true with "body positivity" searches on google at a record high in 2021 and continued narratives in public media spaces that centre on discounting predominant diet cultures and promoting body acceptance (Bombak et al., 2018; Carbonneau, et al., 2017; Google Trends, 2021). However, the reality is that body scrutiny remains highly prevalent, if more subtle than earlier generations. Women and men are fed messages of expectations of their bodies. For every instance of positive change, we can equally find continued negative messaging, in particular aimed towards the younger generation. Photos and videos that show body check ins, cosmetic and weight loss surgery updates and "what I eat in a day" reels are frequent place in today's social media realm

(Casale et al., 2021; Walker, 2021), that continue to reconstruct socially accepted ideas of body and gender.

Publications profiting off shaming and comparing the bodies of women are still available in the mainstream. Especially for women, minorities and disabled groups who may not conform to western views of beauty and value, the digital age has increased comparison with unachievable body ideals. Alongside scrutiny in mass media, photoshop and filters are the new method of enhancement online, setting unrealistic standards of beauty. Cosmetic surgery statistics have also increased substantially since 2012 (Valina & Sessa, 2020) and the fitness industry, especially in online spaces, promotes a range of ultimately unhealthy body messages to men and women framed as health-promoting (Blackstone & Herrmann, 2018). This is impacting children from younger and younger ages, particularly awareness in young girls of the thin ideal (Blowers et al., 2003).

Binge eating messaging online uses stereotypes of fat and gluttonous people eating extreme amounts of junk food and images are also predominantly centred on the female body, reiterating gendered stereotypes of EDs (Figure 1). Contrastingly, images of the slimmer body, represent health and recovery, a narrative reiterated in BED treatment and research, where weight is often measured as a marker of success in overcoming BED, despite recommended treatment showing little evidence of impacting weight (Cooper et al., 2020). Even when binge eating feels relatively under control, weight appears a central theme in how individuals continue to perceive themselves as worthy, linked with theories of self-worth and social messages (Adams et al., 2017; Sutter et al., 2015). On the other end of the scale, those who fit a healthy body idea, can be overlooked and find it hard to categorise themselves as truly having BED, feeling like their disorder is not serious enough to meet treatment criteria, despite evident importance of early intervention (Treasure & Russell, 2011).

Figure 1 - Google Image Search "Binge Eating Disorder"

Note. This Figure shows a collection of image results from a google image search using the terms "Binge Eating Disorder" retrieved 8th August 2021.

Narratives of social expectations that are internalised and played out on the body, can exploit feelings of inadequacies about bodies and health for monetary gain, and reflect layers of power and patriarchy. Recent feminist work has invested in socio-cultural understandings of body and eating distress, particularly in relation to media influence and use of social media (LaMarre & Rice, 2017; Levine & Maine, 2010; Piran, 2010; Holmes, 2016). The view expressed widely in critical feminist approaches to EDs is that EDs should not be reduced to disorders of purely body image, but understood as complex integration of cultural messaging and societal expectations that hold power. Critical feminist reflexivity may offer a form of protection from feelings of body dissatisfaction, and improved understandings that body narratives do not serve the individual, but wider social systems. This is seen in dialogues of activism of the fat acceptance movement, and explorations of ''body positivity'' and ''body confidence'' that combat social ideas of "body terrorism" (Bombak et al., 2018; Carbonneau, et al., 2017; Smalling, 2020). At the same time, although feminism is seen as offering the tools for criticising cultural body ideals (and imagining new ones), it does not always ''neutralize the impact'' of social discourses (Liimakka, 2013, p. 8). Feminist research by Wacker (2020) illustrated how the sociocultural context contributes to the development of EDs, but can also provide protective factors for women including; having people who provide emotional and tangible support and who challenge the eating disorder, a personal sense of agency, and engagement in community activism (Wacker, et al. 2020).

There is much work to be done around the complex intersectional relationship between media (social and other) and within different cultures to understand both the positive and negative aspects of media. Those with BED or other ED will likely go on-line and it is important that they can engage and include themselves in a positive way, a way in which can help them feel empowered and build supportive communities.

Medicalization of Health and Disordered Eating

The 21st Century development of psychiatric diagnostic criteria for EDs has changed the landscape of medical and lay perceptions of disordered eating quite drastically in a relatively short period of time. Development of medical concepts in modern western nations, has reconceptualised what disordered eating is, the value it holds and the fear it projects. For EDs in general, the focus of professionals is often on weight (weight restoration for AN, weight loss for obesity) and BMI becomes a marker of whether patients are eligible for referral for forms of treatment. What these power dynamics look like within institutions such as medical centres, shapes levels of care received for binge eating, especially when presenting in bodies categorised as obese. BED in larger bodies continue to hold more social stigma and such social stigma traverses into medical care, where public health discourse conceptualises obesity as a disease epidemic, treated with weight loss (Gotovac, et al., 2018). This leaves many people living in larger bodies feeling unheard and disparaged by medical professionals, when serious symptoms and condition are often overlooked and attributed to weight, rather than alternative biological or psychological causes, enhancing stigma through omission of contexts in which obesity exists. Subsequently, large treatment gaps exist in healthcare for people with EDs, despite evidence which indicates that individuals with EDs consult GPs more frequently than those without (Hay et al., 2019; Linville et al., 2012).

In medical care, power dynamics exist between the knowledge that clinicians hold regarding diagnosis and care pathways for EDs and their patients who are looking for support, creating hierarchies of power in patient-GP relationships (Foucault, 2002). These hierarchies often result in GPs being seen as gatekeepers to care. Despite this perception, current health structures often limit the power GPs have to provide sufficient services for ED diagnosis and care. In a 2012 study by Linville et al., 59% of providers did not feel like they had the skills necessary to intervene with EDs, and 77%

of respondents reported they had patients with EDs they could not treat, indicating time constraints and lack of skill as primary reasons. Results also indicated weight stigma in assessment, with 68% of GPs indicating that they did not think to screen for an ED because it was not the presenting concern, and close to 60% of providers agreeing that when weight was within the normal range, it prevented providers from diagnosing an ED (Linville et al., 2012). Such findings provide evidence that the power dynamics patient perceive between themselves and their GP to control the narrative of diagnosis, both exist and are enhanced by stereotyped views of ED. However, GPs may be somewhat powerless in interactions where they do not have sufficient resources or knowledge to offer appropriate care options. Therefore, two very different subjective realities may be present within such a dynamic, that leave GPs to focus on object of the patient's body in treatment, such as offering methods of weight loss.

Alongside this, the biomedical frameworks from which medical professional are primarily trained, privilege biological answers to complex aetiological questions, that often present in EDs. Weight criteria very much shape the care of those with BED, generally centred on extreme measures such as surgical intervention, especially if medication and diet approaches have been tried with limited success. Consequently, this may add to increasingly high statistics for obesity interventions such as Bariatric Metabolic Surgery (BMS) that have clearer treatment parameters and fit eloquently within the disease epidemic model of obesity care (Garrett et al, 2020). BMI criteria still present for weight loss intervention, and in parallel to how weight is seen as a barrier to diagnosing ED, BMI criteria also reduces access for surgery to those with highest BMI and comorbidity ranges. This can leave already marginalised groups feeling further excluded from mainstream care, and left with limited options for intervention for weight or disordered eating.

Binge Eating Disorder (BED)

Binge eating as a behaviour, has been listed as a prodromal symptom for both AN and BN, as well as a stand-alone disorder in the DSM-5 (APA, 2013). In a small population study, 83.7% of participants diagnosed as AN, and 100% of participants diagnosed with BN also engaged in binge eating (Stice et al, 2021). Such findings, demonstrate a significant cross-over in binge eating behaviours across the spectrum of AN, BN, and BED (Cooper & Fairburn, 2009; Fichter & Quadflieg, 2007). In particular, diagnostic crossover is common between BED and BN, with around 15% of BED clients meeting criteria for bulimia nervosa after just two years (ANZAED, 2018). Symptomatic crossover can add complexity when determining aetiology factors, and to provide accurate diagnosis of one ED over another, especially for individuals who sit within weight ranges classified as normal. Understanding aetiological influences on BED and development patterns could improve treatment and recovery rates and reduce long term negative physiological and mental impacts.

Aetiology of Binge Eating Disorder

Eating Disorders present with complex, multifactorial aetiology that involve sociocultural, biological and psychological risk and maintenance factors (Culbert et al, 2015; Keski-Rahkonen, 2021; Striegel-Moore & Bulik, 2007). However, advancements in how EDs such as AN and BN are understood, have not sufficiently extended to newer categorisations of disorders such as BED. With developments in treatment methods such as CBT-ED, family therapy, behavioural and even medical interventions, often outpacing understandings of aetiology (Agras & Bohon, 2021; Heaner & Walsh, 2013; Marks, 2019) Consequently, debate remains around the complex integrations of biological, sociocultural and cognitive factors in the development of BED, and the aetiological importance of high levels of comorbidity with other psychological disorders, in particular mood, anxiety and substance use disorders (Hilbert, 2019; Keski-Rahkonen, 2021; Zeigler-Hill & Noser, 2015).

Current evidence suggests that BED symptoms develop gradually, and risk of onset across adolescence and early adulthood remain fairly consistent, compared with higher risk in lower age brackets for AN, BN and Avoidance Restrictive Food Intake Disorder (ARFID), (Galmiche, 2019; Keski-Rahkonen, 2021). Equally, BED trends demonstrate initial diagnosis slightly later in life, and demonstrated to be more prevalent in male adults than in male adolescents (ANZAED, 2018; Culbert et al, 2015; Galmiche, 2019). Such diagnostic patterns may reflect gradual stages of development, however such trends may also present evidence of additional sociocultural factors, such as increased ability to hide symptoms than other EDs, shame associated with having an ED that isn’t focused on, or resulting in weight loss (O’Loghlen, 2021) or incorrect public perceptions that correlate BED as a disorder exclusive to those with a higher BMI (Agüera et al., 2021).

Biological Factors

Across research, obesity, including in childhood, is presented as a consistent risk factor for developing BED for both adolescent and adult populations (Agüera et al., 2021; Hughes et al., 2019; Giel et al., 2013; Striegel-Moore & Bulik, 2007). Obesity is not the only biological indicator for BED however, and complexity surrounding aetiology remains across a range of weight criteria. Genetic studies suggest heritability of BED to be between 41% to 57%, independent of obesity, demonstrating that familial factors may extend beyond sociocultural influence alone (Hilbert, 2019). Additional biological factors in BED include the role of hormones, neurotransmitters and the central nervous system (Levitan, 2021).

Gene studies have indicated the involvement of dopamine and m-opioid receptor genes in the aetiology of BED, indicating that risk of binge eating may be linked regulation of the brain rewards system , where a hypersensitivity to rewards is present (Hilbert, 2019). Conceptualised in relation to impulsive and compulsive food consumption, dopaminergic release is associated with changes in motivational and control aspects of feeding, where the neurotransmitter serotonin is considered to have a key role in binge eating development. Serotonin derived from an essential dietary amino acid tryptophan, shows a significant reduced rate in people with excessive dieting and food restriction, such as anorexia patients. Decreased tryptophan has also been shown in a small sample of obese binge eaters, a find that may provide some biological explanations for differences in eating patterns for BED (Levitan et al., 2021).

A further biological factor considered, is a hormone secreted from the small intestine in response to food ingestion that regulates food intake by slowing gastric emptying and appetite inhibition in the brain, thus reducing activation in appetite-related brain regions. This hormone has shown to be reduced in obese patients, which may impact physiological cues that enable bodies to signal when they are full, or to stay sated for longer. This may in part, provide explanation for findings that weight loss surgery can inadvertently offer improvement in BED symptoms in some cases (Levitan, 2021; Surgenor, 2020). High levels of impulsivity also seen in BED suggest that binge eating may be associated with the dysfunction of dopamine and/or neurotransmission.

Oxytocin, is also receiving attention in research, seeming to have a strong effect on food consumption, implicated in regulating reward-driven eating, and is related to the addictive theories of BED and BN. In recent research, theoretical basis has been taken from addiction models, proposing that there are overlaps between neural circuits of reward and self-control for food and drug abuse, that may contribute to understandings of overeating and obesity (Small & DiLeone, 2013). These findings, result in a consensus that addiction models may be an approach worth adoption for some individual displaying binge eating, due to perceived compulsions, lack of control and neurochemical changes in brain responses, alongside similar genetic vulnerabilities seen in addiction (Balodis et al., 2013; Smith & Robins, 2013).

Social and Cognitive Factors

Interpersonal experiences, cognitions, and environment are believed to influence aetiology of BED. Factors that have been show retrospectively to enhance risk of developing BED include; negative affectivity, perfectionism, conduct problems in childhood, substance abuse, family weight concerns and eating problems, parenting problems, family conflict, and trauma or abuse (Cerniglia et al., 2016; Culbert et al., 2015; Hilbert, 2019).

In western cultures, external standards of beauty and moral narratives regarding food, influence perceptions of self against a sociocultural background of an idealization of thinness, influential in the rise of cognitions focused on body image and weight phobia (Hilbert, 2019; Marks, 2019; Zeigler-Hill & Noser, 2015). Theories of self-worth, propose that understandings of self-come from social knowledge and permeate into daily actions (Crocker & Wolfe, 2001) Social Comparison theory suggests that people have an innate drive to evaluate themselves in comparison to others (Tylka & Sabik, 2010) and Objectification theory suggests that over time, daily repeated exposure, (especially for women) to sexually objectifying experiences can lead people to internalise these social narratives in a process of self-objectification (Adams et al., 2017). This can result in body shame & surveillance and in turn negatively impact health and personal feelings of self-worth (Adams et al., 2017; Woodward et al., 2019). If individuals compare themselves to these social standards and do not perceive their body type to be ‘socially accepted’ this can negatively impact eating behaviours, such as binge eating. For BED, the internalization of the thin ideal has shown to predict onset for adolescent girls (Hilbert, 2019).

Aotearoa New Zealand’s history of cultural and intergenerational trauma, especially for Māori, is an important consideration for aetiology, alongside individual and family experiences of trauma. Research has showed that stress related to income, housing and global inequalities is higher for those in lower socioeconomic positions, and lower socioeconomic households are more likely to be overweight, statistics that are unfairly skewed towards minority populations such as Pacifica and Maori (Ministry of Health, 2008). Binge eating behaviour has been named as an event directly impacted by stressful life events as far back as 1959 by Stunkard. At an interpersonal level, impact of stress and trauma, especially in childhood, is a factor that has been positioned as influential for disordered eating aetiology. Research such as Albertsen et al. (2019), explores how greater childhood trauma is reported in women who also show higher levels of disordered eating, supported by findings from Romans et al. (2001) that also found higher rates of EDs in woman who had experienced childhood sexual abuse. Childhood relationships are important for food, due to key learning and adjustment phases during this time, and narratives of socially acceptable eating behaviours that are passed down through family generations and cultural norms. For children, there is often a lack of autonomy and control over their lives therefore certain eating behaviours, whether binging, restricting, purging, secret eating or otherwise, may provide an element of control and emotional regulation, especially in settings of discomfort or trauma (Cerniglia et al., 2016; Romans, 2001). Cerniglia et al. (2016), found that traumatic parental experiences, played a role in mental health for offspring diagnosed with BED, and showed different psychopathological risk of conduct issues in male and female adolescents with BED; girls were more likely to withdraw and internalise problems, whereas boys scored higher on externalizing problems and acting out. More research is needed in Aotearoa New Zealand around impacts of income, housing and other cultural inequalities across all EDs, to understand the levels these may impact on BED statistics.

At a personal level, Individuals with BED, have demonstrated consistent negative self-evaluations and self-perceptions in relation to body, eating behaviour and self-worth (Lo Coco et al., 2021). Research has demonstrated that individuals with disordered eating report significantly higher early maladaptive schema (EMS) where maladaptive and pervasive self-defeating or dysfunctional themes of memories, emotions, and physical sensations develop, often in the form of beliefs about the self or the world. Undercurrents of fear, shame, worthlessness and control are seen as cognitions that subsequently develop, and later transform into certain though patterns and eating behaviours. (Adams et al., 2017; Woodward et al.2019). For binge eating, mentally heightened states include high levels of anxiety, fear, self-loathing and sadness, alongside low self-worth.

Cognitive behavioural theory suggests that certain cognitive symptoms of disordered eating, may be more central than others depending on the disorder. In studies with patients with either BN or BED, results show that over-valuation of shape, weight, and eating were the most central symptoms (Maher et al., 2022). Because of historical social classifications of gluttony and greed, in cases such as BED where large quantities of food are consumed during “binges” (APA, 2013), unmoral or devious thought, can become internalised in a way that makes individuals feel they are not worthy of social inclusion, this can be internalised as signs of moral wrongdoing, leading to shame and hiding of binge eating, and additionally risk engaging in negative self-management measures, with over a third of binge eaters adopting additional inappropriate compensatory behaviours, such as purging, fasting or excessive exercise. (Stice et al, 2021). Understanding such cognitive processes, can improve knowledge of aetiology, however more gender and age diverse samples are required to support current data (Maher et al., 2022). Considering these findings, many studies present positive self-worth and improved cognitions as potential protective factors in ED aetiology. If perceptions of self-worth and cognitive processes of shame attribution are indeed related to aetiology, reducing shame and stigma provides the potential to function as protective factors against disordered eating (Espinoza et al., 2019). Additional research is required that explores the impact of such factors on BED specifically, rather than looking across the broader ED categories (O’Loghlen, 2021).

The interpersonal model of binge eating, promotes the idea that external pressures and negative perceptions of self (negative affect) are factors that influence and maintain binge eating behaviours, as they act as a relief from resulting negative emotions. Eating disorder symptoms then further exacerbate low self-esteem and negative affect creating a maladaptive maintenance cycle (Lo Coco et al., 2021; Raykos et al., 2017). This model allows for the theoretical exploration of the interrelations between social factors, negative affect and binge eating symptoms in aetiology (Raykos et al., 2017). Where unspoken expectations of bodies manifest directly in binge eating behaviours. These findings were supported by Woodward et al. (2019) who concluded negative feelings of self, may influence ED pathology via increased in shame that is displaced onto the body. For BED specifically, levels of shame included internal shame, external shame, body shame and binge-eating related shame (O’Loghlen, 2021).

Social and cognitive theories illustrate the influence of social factors, cognitions, media, trauma and self-worth attributions that may be contributing to pathology and maintenance of BED. Biological factors also seem to have a role in BED that is not fully understood as yet, but future research may support multifactorial treatment interventions that consider genetic influences and can include medications outside of a weight loss focus. ED research does point to a complexity of factors causing and maintaining diagnosed ED and disordered eating more generally, but to date much of the research has focused on AN and BN, is centred primarily on treating individual cognitions, and is extremely limited in the New Zealand context, which provides additional complexities given its colonial histories and socioeconomic inequalities across populations.

Treatment of Binge Eating Disorder

In New Zealand, eating disorder services are organised by regions across the country, with predominant services based in Auckland offered by Tupu Ora (Health Point, 2022) For ED treatment, referral is accepted from Community Mental Health Centres (CMHC), Child and Adolescent Mental Health Service (CAMHS) or by a hospital. Referrals direct from GPs or self-referrals are not accepted, despite the EDANZ website, and other health promotion agencies in New Zealand, promoting that the first step in seeking help for eating disorders is to visit your GP and ask for a referral to an eating disorder specialist (EDANZ, 2021). Additional barriers occur for BED specifically, including not being specified as a treatment area in available literature for ED regional services (see; https://www.healthpoint.co.nz/download,845128.do).

New Zealand rates for receiving BED treatment are unknown, however across all individuals with BED those receiving treatment is approximated at only 44% (Westerberg & Waitz, 2013) with diagnosis and treatment often underrepresented in non-obese populations. Equally, being classified as Obese, leaves individuals more likely to access weight loss intervention, than psychological care. This results in a distinct lack of access to recommended courses of treatment and care for BED across the board. In 2017, an overwhelming majority of people diagnosed with BN and BED surveyed in Australia were not receiving mental healthcare, despite frequent consultations with their GP (Hay, 2020). Findings supported by Hamilton et al. (2021) who suggest that individuals with EDs face substantial delays in accessing care, with only a small proportion receiving targeted treatment for their illness. Overall, the average length of delay between onset of ED symptoms and treatment-seeking was found to be 5.28 years. Latency to treatment-seeking was significantly longer for individuals with BN or BED compared to AN, with stigma rated as the most impactful barrier to seeking treatment (Ali et al., 2020; Hamilton et al., 2021). Such findings provide a limited view of whether principles of seeking help through primary care are practical to adhere to within a system of limited resources and mixed messages regarding care pathways.

Dingemans and Furth (2012) found that of participants diagnosed with BED, 29% were classified as non-obese and 71% as obese. Non-obese individuals were shown to be significantly younger and less likely to receive treatment. Severity of psychopathology did not appear to differ between BMI ranges. In such cases where BED does not present with comorbid obesity, this can lead health professionals to overlook BED diagnosis. This suggests that many people are at risk of being overlooked in assessment and therefore not receive any forms of treatment and signals the importance of focusing on pathology in treatment, rather than weight measures. This is reflected in the removal of specific weight requirements for diagnosis of EDs within the DSM-5 (APA, 2013), and removing weight from central focus in treatment, recently recommended by the ANZAED *practice and training standards for health professionals*. (APA, 2013; Hurst et al., 2020). This practice manual, recommends eight eating disorder treatment principles that practitioners across New Zealand and Australia should follow, including; that early intervention is essential; services must be evidence based; a personalised treatment approach is required for all patients, and education and/or psychoeducation is included in all interventions. (Heruc et al., 2020).

Evidence based services and treatment options recommended for adolescents and adults diagnosed with BED include therapeutic CBT-ED, guided self-help CBT-ED, or interpersonal psychotherapy (Heruc et al., 2020). Additional behavioural and family therapy interventions are listed as treatment options, but not specified for BED. Supplementary criteria are listed specifically for working with BED that include explaining that psychological treatments have limited effects on body weight, and to not offer medications as a sole approach (Heruc et al., 2020). These guidelines offer a positive step towards treatment approaches that move away from weight or medication focused intervention, towards more multidisciplinary care. However, this does not always translate into real world treatment seeking behaviours, where there appears to be substantial crossover between seeking treatment for BED and for weight loss (Cooper et al., 2020).

Psychological Treatments

Cognitive Behavioural Therapy (CBT) and later ED focused CBT-ED, is widely recognized as the treatment of choice for BN and BED, outlined in national guidelines such as the aforementioned ANZAED treatment guide, and the National Institute for Health and Care Excellence (Hurst et al., 2020; NICE, 2017). CBT-ED was considered the treatment of choice, with other key recommendations including certain forms of pharmacotherapy, interpersonal psychotherapy, dialectical behaviour therapy (DBT), and certain self-help approaches. (Grilo & Mitchell, 2010) CBT-ED works from hypotheses that low self-esteem and/or negative affect promotes dissatisfaction with weight and shape, eventually leading to loss of control of eating behaviours resulting in binge eating that can exist with or without compensatory behaviours. Interpersonal problems and other life stressors are viewed as triggers for binge eating, and in turn impact on contingencies of self-worth (Adams et al., 2017; Agras & Bohon, 2021; Lo Coco et al., 2021). The CBT-ED manual (Fairburn et al., 1993) describes how CBT could effectively treat BN and BED, with treatment in two key parts. First, to help patients control food intake and second, challenging abnormal attitudes towards food, shape, and weight and increase problem-solving skills, in this stage triggers for binge eating are also explored.

Continued research findings strongly suggest that CBT-ED have higher efficacy than other treatments for BN, and BED. CBT-ED and interpersonal psychotherapy (IPT) appear to be equally effective in BED specific research, and recommended for BED patients who present with low self-esteem and high eating disorder psychopathology (Agras & Bohon, 2021; Wilson et al. 2010)**.** However, criticism for CBT-ED is that it is not an easily accessible treatment for community use, due to the large time-frame and session commitment usually required, alongside potential high costs and limited access. Therefor other approaches, include self-led CBT, virtual appointments or a shortened version of CBT-ED are being considered, alongside alternative treatment modalities. (Agras & Apple, 2008; Agras & Bohon, 2021; Munsch et al., 2019). There is also a lack of evidence that CBT-ED has improved in clinical effectiveness in the last 15 years, prompting research of treatment in other practices (Agras & Bohon, 2021).

Alternative psychological treatments that have some exploration include individual emotion-focused therapy (EFT) placing a more specific focus on the role of emotion and emotional regulation, based on evidence that experience of negative emotions are among the most accurate predictors for the occurrence of binge eating episodes in BED (Clyne et al., 2010., Glisenti et al., 2021). Peer mentoring programmes have recently been trialled in Australia, to support transition after treatment to assist with recovery (Hanly, 2020). As well as guided self-help (GSH) programmes (Jenkins et al., 2021). Overeaters Anonymous (OA) And 12 step programmes have also been explored as an intervention for BED with the goal of addressing and reducing current low remission rates, high relapse rates, and treatment dissatisfaction, an approach that aims to address limited resources issues for ED treatment in general (Bray et al., 2021). Finally, Basic Body Awareness Therapy (BBAT), a psychomotor physiotherapy treatment addressing body experience, has also been explored for treatment in BED, especially in relation to binge eaters who also have trauma experiences (Albertsen et al., 2019).

Many approaches for BED treatment adapted to fit from other models of eating disorder care. Additional research is required to understand experiences of BED, in order to develop effective, fit for purpose treatment options. In New Zealand, Roberts (2018) began to explore feasibility of group Cognitive Remediation Therapy for adult eating disorder populations, suggesting integration of such programmes into current treatment, an approach that requires additional research, especially in context of BED, but may allow a positive solution considering restricted access to care programmes and resources currently available in New Zealand.

Medical Treatments

Although BED does not have defined surgical or medical solutions, the majority of those who seek treatment for BED also have accompanying obesity or are overweight (Cooper et al., 2020). BED has also been associated with an increased risk for the development of obesity, with high prevalence of binge eating evident for people who are classified as obese and seeking medical weight loss intervention (APA, 2013), and the two areas of care often end up highly intertwined. Such treatments primarily include Bariatric Metabolic Surgery (BMS), or weight loss medications (Cooper et al., 2020; Surgernor, 2020; Levitan et al., 2021).Data gathered from obese populations seeking BMS provide estimates of BED that vary from 3.4–41.5% (Surgenor, 2020). Internationally, 13% of obese adolescents undergoing BMS met diagnostic criteria for ED diagnoses and 27% reported a sense of loss of control (LOC) over eating. Overall, prevalence of BED in surgery candidates ranged from 2% to 49%, depending on assessment criteria utilised. (Cella et al., 2019; Surgenor, 2020), Nationally for New Zealand, annual BMS volumes increased in the public sector, from 34 to 516 between 2004 and 2017, with a similar increase evident in available private sector figures (Garrett et al., 2020) demonstrating an increase in BMS surgery numbers, alongside a decrease in median age of surgery recipients that correlates with data seen for increases in BED globally (Surgernor, 2020).

There is no unanimous conclusion across the research as to whether BED is contraindicated or not for BMS (Surgenor et al., 2020; Opozda et al., 2016). However, focus on weight is no longer recommended in good treatment practice for EDs (Hurst et al., 2020; APA, 2013). While there is evidence that quality of life can improve for BED patients after BMS, there is debate surrounding improvement long term, and whether such changes are better attributed to post-operative nutritional and psychological support than surgery (Opozda et al., 2016). For weight loss models of care in New Zealand, psychological support is provided as part of pre-assessment and post-surgical requirements, alongside nutritional guidance (Ministry of Health, 2017). In such ways surgical programmes are often inadvertently providing care to help people recover from disordered eating patterns, at the same time as adjusting to a new physiological capacity to eat food, and there is argument to be made that if such models were available outside of a surgical context they may have similar results in improving quality of life.

Patients may also present requesting medication options to support weight loss, which are readily available for short term use in New Zealand. Weight loss medicines available in New Zealand include orlistat (Xenical), phentermine (Duromine), liraglutide (Saxenda) and Contrave. Although not subsidised currently, information on weight loss medication is readily available on sites such as *Health Navigator New Zealand*, with use framed as health promoting (Health Navigator New Zealand, 2021). Genetic and biological determinants are often stated as a pre-dispositional factor for obesity, and while this is true, reducing obesity to a physiological entity only, risks missing other important psychological determinants. GPs in NZ have demonstrated support for weight loss medications due to increased BMI and improved medical markers that can present through loss of 5-10% (Schmiedel, 2020). If GPs are unaware of symptomology and treatment options available for BED and suggest medical weight loss intervention, there is the chance people may end up with long term physiological changes to manage as well as their disorder, or short-term medication related weight loss that does not support long term improvements in eating behaviours or mental wellbeing.

Combined Treatment Approaches

The ANZAED (2020) do not recommend medication as sole treatment for BED, however SSRI’s have been recommended for use as an adjunct therapy overseas, with current studies looking at applicability of medications in future BED treatment (Levitan, 2021). The first of which, lisdexamfetamine has already been approved for use with BED in US adults. Also used for treatment of Attention Deficit Hyperactivity Disorder (ADHD) lisdexamfetamine is thought to help regulate dopamine (DA) norepinephrine (NE) and Serotonin, elements involved in the regulation of appetite, hunger and eating behaviours (Guerdjikova et al, 2016). In America, the use of lisdexamfetamine medication has been shown to reduce binge eating episodes over short term use, and reduce risk of relapse in binge eating for adults over 6-month time period (McElroy et al., 2015; Peat et al., 2017). This medication is not yet available in New Zealand.

Additional research demonstrates that multifactor therapies may have benefit including dietary approaches alongside psychotherapeutic measures. Peat et al., (2017) researched pharmacological treatment for BED, alongside psychological interventions. When analysed qualitatively, both antidepressants and lisdexamfetamine alongside methods of therapist-led CBT or behavioural weight loss, revealed few significant differences between approaches, thus recommending that patients and clinicians can choose from several effective treatment options. Three recent studies by Cooper et al. (2020), Grilo et al., (2010), and Palavras et al., (2021), have also advocated for multiple approaches that look at both weight loss and eating behaviours. Although this somewhat goes against recommended guidelines, they argue that although the best available psychological treatments for BED produce good and lasting outcomes with regard to control over eating, they show virtually no changes in weight loss, yet control over eating and weight loss are both recognised as valued goals of those who seek treatment (Cooper et al., 2020). Cooper outlined a new treatment model to explicitly addresses the twin goals of cessation of binge eating and weight loss, integrating elements from CBT-ED, and cognitive behaviour therapy of obesity. Grilo et al. (2011), conducted studies comparing effects of behavioural weight loss therapy (BWL), presenting findings that alongside weight loss, the model also demonstrated a reduced binge eating. Argument for its implementation is that it usually requires less training than CBT approaches, and at the end of treatment, there was no between-group difference for remission of binge eating across the CBT-ED or BWL groups. At a 2-year follow-up in a different study reported by Wilson et al (2010) however, IPT and CBT were more effective in producing remission than BWL, indicating more information is needed on this approach. Finally, Palavras et al., (2021) investigated the efficacy and safety of introducing a weight loss intervention to the treatment of people with recurrent binge eating and a high body mass index (BMI). They found that weight loss interventions did not appear superior to CBT-E in promoting clinically significant weight loss, or reducing most ED symptoms. They also observed no harm and suggested future approaches target both the management of ED symptoms and high BMI concurrently.

Taking such a path towards combined weight loss and binge eating treatment would need to be one tread very carefully. This path could easily promote notions of self-worth that are tied with appearance contingency and weight loss rather than messages of improving health and recovery. This could negatively skew progress that is intertwined with weight, and once weight loss rewards cease, may encourage a relapse into negative eating behaviours (Opozda, 2016) . More research is required with New Zealand populations, to understand how such treatments could be used effectively and how to provide equitable access across different populations. Simply put, with current research findings it is difficult to confirm which multidisciplinary approach is best for BED in New Zealand demographics, however BMS appears to be growing in popularity.

Research Aims

The overall purpose of this research is to add to the existing literature available on experiences of disordered eating, in particular binge eating, by completing interviews that explore the lives of individuals who have self-identified as binge eaters and/or received a diagnosis of BED. The two key research objectives are firstly, to explore the stories of people who identify as having a problem with binge eating, and secondly to gain an understanding of the realities of accessing care and support for disordered eating in Aotearoa New Zealand. This research uses narrative approaches to explore lived experiences of self-identified binge eating. Hearing people's stories and how these are positioned in relation to their life experiences, may improve understandings of situational impacts on likelihood of binge eating, and 'high risk' times of life, such as adolescence and impactful life transitions such as leaving home, or having children. Personal accounts of binge eating can provide insights into how eating disorders are developed, and later sustained through cognitive narratives. Semi-structured interviews were chosen, to allow a space for individuals to open a dialogue about binge eating, with an intent to contribute to improving knowledge and reducing stigma. Individual voices provide insight into experiences that, although individualized, tell stories that can reflect experiences and social structures that a wider cohort of individuals living in New Zealand may encounter. The secondary purpose, to improve understandings of how those who identify as binge eaters, navigate care pathways in New Zealand for diagnosis, support and treatment, focuses primarily on the interview participant voice, whilst also drawing on a small sub-set of quantitative data from General Practitioners (GPs) working in Aotearoa New Zealand. GPs are the gatekeepers in public care pathways for ED diagnosis and support (EDANZ, 2021, Mental Health Foundation of New Zealand, 2014). Such pathways can be ambiguous and unclear for both patients and their GPs. This study intends to provide insight into potential gaps of resources within this referral system, information that may improve understandings of barriers to care that exist, and the role that GPs inadvertently play in the gatekeeping of care.

Diagnosis of BED was intentionally not a requirement to participate in the study, as limiting the scope of research to those who have already been diagnosed with an eating disorder, may not truly reflect the scope of Binge eating prevalence, due to the seemingly limited ability to access care facilities, including diagnosis and treatment. With respect to the exploratory lens this research approaches from and the lived experiences of the interview participants, from this point forward, I intentionally use the term disordered eating.

Chapter Three - Methodology

The epistemological and theoretical understandings that have guided this research are; Social Constructionism, Feminist Theory, Foucault's Theories and Stigma Theories. Through a broad theoretical lens, I can critically examine constructs that are presented in narrative accounts to support the overall purpose of this research. There are two key research objectives; firstly, to explore the stories of people who identify as having a problem with binge eating, and secondly to gain an understanding of the realities of accessing care and support for disordered eating in New Zealand. To achieve this, two parts to the study have been undertaken. Part one, the primary focus, was semi-structured interviews with eight participants who had self-identified as experiencing binge eating behaviours. Part two, the secondary focus, consisted of an online quantitative survey for GPs working under the umbrella of ProCare Primary Health Organisation in New Zealand.

Epistemology

Social constructionism is the primary guiding epistemology in my research approach. Social constructionism approaches the nature of the world from the perspective that there is no one objective truth, but the truth of our worlds in interpreted within our social relationships and contexts in which we live and learn (Crotty 1998; Gergen, 2009). From a constructionist viewpoint, meaning is not adhered to an object, but is constructed through human practices, with meaning emerging through conscious engagement (Crotty, 1998).To understand why social constructionism was chosen as the guiding epistemology for this research, it is appropriate to also briefly introduce positivist epistemology, for two reasons. The first is how this objective epistemology has shaped and given meaning to EDs in western society, for it is a biomedical framework from which I will be analysing comparisons to individual accounts of experience in relation to binge eating and body weight. Secondly due to the inclusion of a short, quantitative survey element to this study, that was provided to New Zealand GPs for completion. Positivist epistemological assumptions are based on a belief that there is one true measurable reality (Chamberlain & Murray, 2017). This is the presiding view in western medicine. This approach can lead to power dynamics between practitioners and patients as to who holds the knowledge of illness and best treatment (Jones & Porter, 1994), thus creating gatekeepers to care through structured practice, playing out in ED interactions in care settings.

However, rather than requiring a separate epistemology for mixed-methods research Yardley & Bishop (2008, as cited in Chamberlain, 2014) propose that if quantitative and qualitative elements of research are completed from objectivist and social constructionist stance respectively, with recognition provided that insights gained from these different methods will not necessarily converge, then as researchers, we can accept the quantitative data element at face value, whilst also critically reviewing this information a part of larger subject whole, providing additional context and enrichment of the stories being told by interview participants.

Social constructionism, challenges objectivist perceptions, with the view that knowledge can only be ‘true’ within its social and historical context (Chamberlain & Murray, 2017). Such perspective allows space for interviewer and participant to co-construct the narratives, rather than search for an objective truth (Riessman, 2008). Social construction allows dialogues between participants and interviewers to be considered in analysis and shape the descriptions and meaning of retold personal experiences. Consideration is given to how participants use language and storytelling to position these experiences within their life, and equally how this is shaped by included interview questions. Social constructionism also encourages a critical lens through which to begin unpacking such meanings, to understand how individuals situate themselves in their worlds through stories (Riessman, 2008) and the wider contextual layers of power within society that such stories can convey. From this approach, as a researcher I can be aware of, and actively engage in, construction of meaning through interpersonal dialogues, allowing me to challenge assumptions about bodies and illness, such as those seen in medical care, whilst being conscious of the personal social and historical context that I bring to the interview setting, allowing for a richer narrative approach.

Theory

Stigma, Foucault and Feminist theories are placed as prominent theoretical underpinnings of my narrative analysis approach. In terms of my interviews and lived experiences, Foucault allows me to critically engage with how participants reflect taking power back for themselves in their stories, how they deal with the emotions associated with eating and how they monitor or identify their eating is disordered. Foucault (2002) proposed that subject is constituted by the rules of discourse and Armstrong (2015) connects this to concepts in the medical field, through looking at clinical techniques which doctors use to study the body as an object and become components in the productive assembly line through which reality is created around people's bodies. Discourse helps to place a lens on how bodies are objectified and fabricated within social realms and knowledge creation and power dynamics that exist and are perpetuated by medical structures and biopolitics, where western discourses of embodying femininity are intertwined with being and feeling, and where disordered eating is something that both occurs in private events, and has its meaning reconfigured in spaces between people (such as between patient and GP) (Burns, 2021). For this research, subjective groups include those who identify as binge eaters, who have their bodies socially constructed for them in many instances, against current institutional and medical knowledge that classifies EDs. BED is often invisible and overlooked through such narratives, and therefore the detection, and management of BED is linked with social justice and equity (Keski-Rahkonen, 2021).

Views of disordered eating presented within semi-structured interviews for this study, are not presented an objective claim of 'truth', but to represent a social group or individual who have experiences of binge eating, and can present a subjective version of their personal experience (Miller, 1990). Understanding such personal discourses of individual experience can provide a critical mirror of societal views, that either reflects or reject current social power structures, to add new layers of understanding that may fall outside the predominant narratives of what binge eating is conceptualised to be, to understand if power structures of research, knowledge creation and medicalized approaches are positive received by the community of interview participants.

Power that exist in relationships is a further important consideration in this research. Although all manner of relationships can exist between persons and groups that are not in themselves power relationships (Miller, 1990), roles and expectations that are created within social settings and placed onto those relationships do by nature have consequences of exercising power. In this way, as soon as you place roles onto individuals, such as interviewer and interviewee, the power relationships shift in line with expectations placed on the roles you play within those situations. Foucault believed that every point in the exercise of power is a site where knowledge is formed (Foucault, 2002). Within the context of research, interviews are sites where knowledge is formed, and within this site, power dynamics are at play between the role of the interviewer and the role of the participant, it equally can allow a space where participants can feel they are taking back an element of power over their own eating discourse.

In disordered eating, feminist theory, is primarily concerned with the relationship between EDs and the social and cultural constructions of gender (Holmes, 2016), as well as the marginalisation of certain populations within social heirarchies of EDs themselves. In research, a feminist methodology is essentially about levelling the potential power imbalance between researched and researcher present in exploratory settings (Jones, 1996). Burns (2004) portrays the argument that anorexia exists as a category that women with bulimia may define themselves against, In my analysis section I utilize feminist theory to make a space in which I can extend this notion to how women and men define their experiences of binge eating against anorexia and bulimia as a third disorder within this hierarchy, In its portrayal and construction within a world that favors western ideals of beauty, binge eating is positioned at the bottom of such hierarchical eating disorder chains, for on the outset it goes against the traditional notion of EDs and the skinny ideal, two concepts that are intrinsically interwoven (Malson & Ussher, 1997), A somewhat polar understanding that comes from interviews is this skinny ideal is still very much at the mental forefront of binge eating behaviors in how self-shame at not being able to exercise self-control over eating, are linked to feelings of failure of self and society.

Narrative Approach

This research can be classified as mixed-methods approach but the predominant focus is on qualitative methods through narrative inquiry using semi-structured interviews, to form direct first-person accounts of individual experience of binge eating. Narrative interviews are “event centred” to depict human action and “they do not merely describe what someone does in the world, but what the world does to that someone” (Riessman, 2008, p. 22). Breheny (2013), postulate that it is important for the analysist to consider narrative as a theoretical approach in itself, and from there consider a structured methodological approach that centers on the question(s) of narrative that wish to be answered. For this study, narrative as a methodological process, considers at the center what is the ‘why’ for taking such an approach, that underlies the ‘how’ of narrative steps, in which I will outline the reasons for using a narrative approach and analysis.

Firstly, narrative inquiry emphasizes a connectedness and relationship between researchers, participants and the research topic, rather than expecting researchers to remain detached and objective, focusing instead on interpersonal connections within the context of meaning-making (Riessman, 2008). This is complementary the overall aim of this research; to gain insight into lived experiences for a population that have been described as under-researched in relation to longitudinal experiences, especially in young populations who are deemed most at-risk (Marzilli, et al., 2018). In previous studies such as Ali et al (2020), the authors discuss how primary barriers to help-seeking included denial and failure to perceive the severity of the illness, fear of losing control, and perceptions of stigma and shame. The disconnect between researchers and participants that is enforced in traditional scientific inquiry methods, can exacerbate these feelings of being stigmatised. The rapport building that happens naturally in an interview setting, can help to combat this through establishing trusting relationships, and empowering participants to share their stories and insights.

Secondly, narrative inquiry place focus on the depiction of stories to convey essential meanings (Riessman, 2008). One of the key goals of the research is to increase understanding of life experiences for individuals who self-categorise as engaging in binge eating. Narrative method allows for individual participants to take an auto-ethnographic approach to how they disclose their story within a natural timeline, as naturally people default to storytelling semantics when describing life events (Riessman, 2008) in the process they may unveil key personal themes such as; how binge eating initiates, why it continues, if it is perceived as a problem, risk to health or routine part of daily life. Through personal narrative, this method can portray experiences of binge eating, that can be linked to theories in a reflective way.

One of the key goals for this study, is to create a research space that can inform health providers for individuals with disordered eating, and support wider societal change, therefore utilising research methods that have been shown previously to have positive outcomes for participants and their communities, is supportive of ethical and empowering research, that allows participants to become collaborators, rather than subjects (Rohleder & Lyons, 2014). Finally, narrative places participants as a key component in the examination and interpretation of data, retaining the essence of persons within the final stories shared. To allow, to the best of my ability as a researcher, for communities to speak for themselves rather than be spoken for, and to enable data that is emotive, connected and focused on unveiling experience in a raw and empowering form (Moustakas, 1990).

Recruitment

Rather than limiting the scope of research to individuals who have received a diagnosis of BED, I intentionally decided to extend the pool of eligible participants to individuals who self-identified with binge eating behaviours, this allowed participants to have more say over how they identified their eating and the context in which they saw it as having an impact for them. This was done by using the DSM-5 criteria (APA, 2013) in the advertisements (see Appendix C).

Initially, I had intended to advertise the research on the EDANZ website however their representative politely declined this request. Therefore, poster and social media advertising was conducted. Posters were displayed on the Massey University Albany campus, in both the main library and recreation centre, with permission from the Massey University Student Association. The Mind Lab Auckland, also agreed to share a poster at their Auckland Campus, and an email copy of the poster was shared for them to distribute. Alongside poster advertisements, a Social Media Instagram account was created named *binge_eating_research_NZ* where two digitally adapted versions of the posters were shared via two separate post designs, both posted on 14th June 2021, the same day as printed posters were displayed on the Massey University Campus (Appendix C). A following third post was shared on this Instagram platform on 18th July 2021, providing information on New Zealand based ED support services, with recognition that social media is a public space, and the recruitment information, although not intentional, may be triggering for disordered eating in some instances.

This initial approach to recruitment was intentionally indirect, due to the sensitive nature of disordered eating and the risk of harm that it may cause to approach people directly. This may present some limitations in participant recruitment, as participation is voluntary and self-directed, however a benefit of this, as noted in relation to limitations of diagnostic criteria, is allowing individuals to choose how they personally identify with their eating behaviours. Some “Snowball Sampling” (Monaghan & Gabe, 2015) naturally occurred, where participants had heard about the research from others who were participating, especially across the social media advertising component. Recruitment through my place of work within in a Medical Centre was intentionally avoided, to reduce risks of inadvertent harm to patients, and to keep the quantitative and qualitative elements of the researcher as separate as possible.

The aim was to recruit a minimum of six participants as data saturation has been shown to exist in much smaller samples with qualitative data (Hennink & Kaiser, 2021). The focus was on depth of information, rather than sample size per se. As BED is an area of research lacking in New Zealand, especially without support of DSM-5 diagnosis for sub-threshold behaviours, and the aim of the study was to capture individual voices and experiences through narrative. I was unsure how much interest there would be for participation, or indeed if enough people to reach this minimum criterion of six participants would come forward for the research, However, I ended up with eight participants all recruited relatively quickly.

Participants

Prior to undertaking interviews information sheets were given to the participants that outlined the aims of the research and study process (Appendix A). The inclusion criteria only required that the participants were over the age of 18 years, self-identified as experiencing binge eating behaviours and be in a stable place to participate.

It is important to note, as this was a self-identified checklist, that in some cases other EDs such as BN, had previously been diagnosed. This did not appear to negatively impact on the final data set, or the richness of narrative stories, but rather added additional layers of information and complexities that gave complimentary depth to the overall research aims. One participant did withdraw before interviews commenced because of not feeling they were currently in a stable enough place of recovery to participate at the time, especially in the context of the Delta COVID-19 outbreak and lockdown during the second half of the interviews, from August 2021.

The following table provides an overview of the research participants, including first method of contact, although not all contacts who reached out to participate were included in the interview process, it was interesting to see the number of people interested in taking part in the interviews, considering the doubt I had initially, as to whether we would run into difficulties with recruitment. In total 14 individuals (13 female, one male) contacted me in regard to participating in the research, either via email or social media messenger. Of these 14 contacts, 11 individuals agreed to participate in interviews. Once interviews were scheduled, contacts were assigned an interview number from I1 – I10. One participant withdrew due to personal reasons before an interview date was scheduled, one further participant withdrew ahead of their interview date due to not feeling in stable place of recovery at that time (I10) and one further participant withdrew due to COVID-19 restricting ability to complete interviews in person (I5).

Table 2 - Participant Recruitment Data

Name	**Initial contact method**	**Happy to participate**	**Interview Number**	**Interview date**	**Interview location**	**Transcript Review (Zoom)**
C1	Email	N – withdrawn (personal)	[redacted]	[redacted]	[redacted]	[redacted]
C2	Email	Y	I2	24/07/2021	Massey University Albany Library	Y – Zoom
C3	Email	Y	I4	02/08/2021	Massey University Albany Library	Y - Zoom
C4	Email	Y	I1	05/07/2021	Participant Home	N – declined, shared via email
C5	Instagram Messenger	Y	I7	16/08/2021	Virtual Interview (Zoom)	N – no response
C6	Instagram Messenger	N - no response	[redacted]	[redacted]	[redacted]	[redacted]
C7	Instagram Messenger	N - no response	[redacted]	[redacted]	[redacted]	[redacted]
C8	Facebook Messenger	Y	I3	30/07/2021	Participant Home	Y – Zoom
C9	Instagram Messenger	N - no response	[redacted]	[redacted]	[redacted]	[redacted]
C10	Facebook Messenger	y	I9	22/09/2021	Virtual Interview (Zoom)	Y – Zoom
C11	Facebook Messenger	N – withdrawn (COVID)	I5	15/08/2021 (cancelled)	[redacted]	[redacted]
C12	Email	Y	I6	15/08/2021	Virtual Interview (Zoom)	N – declined, shared via email
C13	Email	Y	I8	22/08/2021	Virtual Interview (Zoom)	N – no response
C14	Email	Y – withdrawn (personal)	I10	01/10/2021 (cancelled)	[redacted]	[redacted]

Seven participants identified as female, and one as male. Ethnicity information was recorded at the beginning of interviews, four participants identified as Pākehā (New Zealand European), two as Māori, two as Other European, one as Asian, and one as Latin America. Participants could choose multiple Ethnicities for this question. All participants were over 25 years old at the time of participation, with majority (four) participants between 25 – 30, one participant who was between 31 – 40, two participants between 41 – 50 and one participant between 51 - 60 years of age. Participation was not open to anyone under the age of 18 years for this study. At the time of interviewing, no participants had received a medical diagnosis of BED, however one participant had previously been diagnosed with BN, one described themselves as a Binge Eater, Bulimic and Anorexic, and a further 2 participants, both female, had engaged with DSM-5 criteria and self-identified as having BED.

Ethics

This project was reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 21/24, with ethical approval granted in in April 2021. All research was conducted in accordance with principles outlined in the Massey University code of responsible conduct and the Massey University code of Ethics, which was thoroughly reviewed during the ethics application process, and referred back to as required during the research process. Key ethical considerations included autonomy and respect for person, potential harm and beneficence, alongside cultural responsibility outlined by principles of Te Ara Tika.

As New Zealand statistics suggests eating disorders are at least as common for Māori as non-Māori (Lacey et al., 2020), this likelihood of Māori participants being included in this research was considered ahead of time, and I was careful to approach all interviews in a cultural sensitivity manner, and with unconditional positive regard to my participants and within my research. I learnt and practiced my personal pepeha ahead of time, in case this was appropriate to have as part of initial introductions.

Culture also extends to the culture of EDs and public perception. As I approaches the interviews from the perspective of someone who does not have lived experience of binge eating or other EDs, consultation was sought with a member of Massey University Academic staff who had a high level of experience in the eating disorder research field, to ensure interviews were being approached in a respectful manner, for example ensuring I was up to date with current understandings, research frameworks and terminology in relation to EDs.

For participants to be able to provide informed consent, all relevant information was presented in plain language and understandable terms through the provision of an information sheet (Appendix A) to enable them to make a fully informed decision to choose to participate. I addressed the risk that was present for distress to participants, and advised to only participate if individuals felt they were in a stable place of recovery or management to do so.

Although some emotion was shown during a portion of the interviews, no high levels of distress were experienced, and emotive events were handled with care, for some participants this meant taking a short break, where we later returned to our conversations. For others, this emotion was embraced as part of their story, as a sign of strength and pride for the obstacles they had overcome. Participants were also advised they could decline to answer questions, or end the interview at any time, however this option was not taken by any of the interview participants.

To support participants, a list of free ED and New Zealand based mental health services was provided after the interviews. Any personal information or identifying aspects of conversation have either been given pseudonyms or edited accordingly to ensure anonymity for participants.

Reflexivity

It is important to consider relational factors that impact on information that may or may not be shared within interviews. People utilize stories about themselves and their past to bring understanding to their lives and the current moment, to relate and to connect (Riessman, 2008). Although all participants were recruited in the same manner, three participants were known to the interviewer ahead of time, through social contexts. Of these three, two brought up this relationship within the interviews in a positive light, in that it improved their ability to talk openly because of higher levels of trust. Being trusted to interview people I knew, was a privilege and I was cautious to be mindful of boundaries of confidentiality and appropriate questions within these interactions where a higher level of familiarity existed (McConnell-Henry et al., 2010). A further important consideration, is my status as an outsider to lived experience of binge eating. Presenting as someone outside of lived experience, has the potential to create barriers in conversation for those looking for connection. Research by people with lived experience, can at times, be better placed to illuminate participant experiences, a consideration brought to my narrative process and findings (Honey et al., 2020).

Although I do not approach the interviews from a perspective of lived experience of binge eating, my comprehension of the pressures that exist for female bodies, creates mutual knowledge from which I can approach interviews with predominantly female participants, in relation to how we construct our reality, body, illness and self within the context of society (Riessman, 2008). Equally, in my interview with the male participant, as a female interviewer, I approach from the perspective of being a member of a marginalised community, against male social norms, whilst remaining mindful that multiple layers of power and privilege can be in play at once (Keane, 2014). Whether overtly stated in interviews or not, these co-understandings of my position in society outside of the interview room, built on shared understandings of the New Zealand cultural that both participants and myself as an interviewer live and learn within, which can help to build rapport and a safe interview space, and I was active in my approach to ensure this was a space that felt comfortable and free of judgement (McConnell-Henry et al., 2010).

Drawing on feminist and Foucault constructs of power and equality that underpin research (Jones, 1996; Miller, 1990) there was active intent within the research process, to minimise power dynamics, through creating a collaborative research space. it was a conscious choice to ensure this research dynamic was far removed from traditional approaches of research as "an instrument of dominance, and legitimation of power elites" (Mies, 1983 as cited in Pilcher & Coffee, 2018). This also allowed me as a researcher, to be reflective of the power dynamics that exist in interview situations, and the cultural framing placed on not only the bodies of interview participants, but the same focus placed on my body as a female living within western societies. Throughout the process of my research, I continued to consider and engage with my own attitudes or understandings around disordered eating. Even the language I used and the direction of the research, from starting with a basis of very clinical parameters of BED, had to be reconsidered alongside participants stories and classifications of their own binge eating journeys, often outside the scope of diagnosis and alongside stories of additional disordered eating behaviour These views, challenged me to reflect on my own assumptions and the biomedical frameworks in which I myself have been conditioned and taught to understand the human body, especially in relation to obesity.

At the time of interviews, I was working as a Health Coach in a medical centre. Almost daily, I would be working with people who were struggling with weight, food and body image, usually under GP recommendations to lose weight or improve other biomedical health markers. Equally I worked alongside GPs and other medical professionals who present as truly caring for their patients, and trying to support them with their health journeys. This is a perspective that I bring with me into my research, and views of both sides of the interviewee and interviewer in research is an important context in how we engage in interview dialogues (Riessman, 2008). I was conscious that not everyone's experiences of GP care, would be in-line with my understandings of working in primary care. Equally the reflexivity I bring to this research, is important for me to bring into my working life as a Health Coach, where the same hierarchies in relationships and care experienced by participants, exist in my own interactions. Tailoring safe spaces at work, to safely discuss personal topics of body and eating, supported my ability to create such spaces in interviews.

Narrative Interviews

After responses were received from the poster and online advertisements, I contacted all interested parties via email, to send an information sheet with further details and criteria of the study. Once I received email confirmation that participants were happy with the information sheet and wanted to continue with participation, interviews were scheduled via email, with a calendar of available dates shared with participants to choose a date that suited them best.

Initially, all Auckland based participants were given the option to attend a face to face interview, either at an agreed location, such as a public library, or I could interview them at home. With the COVID-19 level changes and restrictions imposed during August 2021, the final two initial interviews with Auckland based candidates were conducted via Zoom. All interviews for participants residing outside of Auckland were conducted via Zoom, of which there were a further two. This meant a mixed-interview approach was taken overall, with four interviews conducted in person, two at Massey University Library and two at participants homes, and four conducted via Zoom video calls. Based on narrative principles, my interviews were semi-structured in nature (Appendix D), composed on open-ended questions that were adapted in order and prose to allow me to follow individual stories and allow natural flow of conversation (Riessman, 2008).

To create a safe research space, at the beginning of interviews I reviewed the information sheet that had previously been sent to participants, to reiterated the participants right to decline to answer any questions, take breaks as required or stop the interview at any time. Before I started recording, I asked interview participants to sign a consent form to be recorded, for in-person interviews, or asked participants to confirm they were happy to be recorded at the start of virtual interviews, where consent forms had previously been signed and returned by email ahead of time. I was conscious of participant body language, tone of voice and other physical cues that presented during interviews, allowing participants to take their time answering questions that were emotive, or to take breaks. I remained mindful throughout the interview of the potential to cause distress to participants, due to the nature of the topics being discussed. I intentionally approached all interviews with a non-judgemental attitude, and caring approach, ensuring I was in a frame of mind that could create and hold a safe space for participants, this included extended booking times for meeting rooms, arriving early to set up and ensuring I was not time-pressured on the day of interviews, to avoid any pressure being put on to participants.

All these approaches aimed to minimise power dynamics between researchers and participants, to create a collaborative research space. I remained conscious of the power-dynamic that still exists, and did my best to put participants at ease, especially at the beginning of interviews where nerves were higher. I found in most cases, the first few minutes of interviews participants showed some nervous behaviours, such as talking more quickly, moving frequently or avoiding eye contact, however after asking a few questions about them and orientating to the research, participants appeared overall to relax, and were happy to answer questions and engage in dialogue. At no stage in my interviews did any of the eight participants decline to answer any questions, however some did ask to take a break, or come back to questions they were unsure of. In these cases, I made a mental note of the question to come back to, to allow them to continue natural flow of storytelling, and come back to let them finish the thought process at another, more suitable interval. After all key interview questions had been asked and I felt the interviews had reached a natural end point, I asked participants if they had any questions for me, or anything to add to .Before leaving the interview I spent some time talking with participants, checking how they felt about the interview, and giving them some space to decompress. Once the interviews had been transcribed I returned the scripts to them all for comment and offered them a further catch-up. Three participants took this opportunity.

GP Data Collection

The 13-point questionnaire was distributed via a weekly clinical bulletin sent out by the ProCare Primary Health Organisation (Appendix G), with an embedded link that led directly to the host site where the questionnaire could be completed. This was shared twice to increase GP engagement, first on 24th September and later on 11th October 2021. The first section of the questionnaire included a page with information on the project and a confirmation of consent before GPs could answer the survey questions. The site collected all results anonymously, with an allocated survey number based on chronological date order to identify the survey participant and I collected the data sets directly from the site. This ensures anonymity for all GP participants. Questions were based around GP understandings of BED and other EDs, interactions with patients who had disclosed EDs, and knowledge and use off care pathways in New Zealand. The data set included one qualitative answer to allow GP feedback, and the survey findings are explored in more details as part of my finding's sections, to completement the main focus of qualitative interview data. This GP data set was collected to add depth to understandings of participant narratives of care, and also to improve understanding of how BED is recognised and referred within medical system, the list of GP questions is available in Appendix I**.**

Chapter Four - Analysis

My narrative Analysis primarily draws upon transcripts from semi-structured interviews, undertaken with eight individuals who self-identified as engaging in binge eating behaviours. Narrative has multiple forms of creation and interpretation, and steps were taken to draw from narrative analytical approaches that best my research aims (Riessman, 2008). For my analysis I drew on concepts of Dialogical/Performance Analysis and Thematic Discourse Analysis (Riessman, 2008; Rohleder & Lyons, 2014). The primary focus of the analysis was the stories being told, alongside the contexts in which they are interactively produced. Dialogical performance analysis takes a broad and varied interpretative approach to narrative making selective use of other narrative method steps, such as thematic and structural analysis (Riessman, 2008), but more so than other narrative approaches, the approach requires close reading of contexts, and pays particular attention to the influence of the investigator and social circumstances that surround such production and interpretation of narrative data (Riessman, 2008)

I then reviewed the transcripts to answer the over-arching question “how are particular versions of reality manufactured, negotiated and deployed in conversation” (Rohleder & Lyons, 2014, p. 226). When engaging in dialogues surrounding binge eating, participants utilised stories to take me (the interviewer), and the wider hypothetical audience, through a journey of living with binge eating. Including a secondary element of discursive and thematic analysis (Riessman, 2008; Rohleder & Lyons, 2014), where the interview transcripts themselves are placed as key objects of analysis, adds an additional layer of analysis (Rohleder & Lyons, 2014). This approach is supported within Riessman’s (2014) broad concept of Dialogical Narrative analysis. This method of providing an analysis framework is broader than some other fixed method steps to allow room for multiple analytical dimensions.

Analysis Steps

To support my dialogical and thematic narrative approach, throughout this process I drew inspiration from steps laid out by Murray and Sools in Rohleder and Lyons (2014). These steps are proposed to be used “flexibly and in an iterative process of going back and forth (Rohleder & Lyons, 2014, p. 138) and that it is up to the researcher in relation to the research context, to decide which steps and parts to include within their analysis process. Therefore, I did not follow these steps exactly, rather using them to guide my process with continuous reflection back to my underlying narrative approaches and subsequent theoretical aims of the data analysis; to both seek themes within individual stories, look across accounts of common interpretations, and decipher the co-creation of context within the interview process.

1) Transcription

Transcription is deeply interpretive process and an important first step in analysis. In constructing a transcript, we are not a neutral bystander, and the same information can be described very differently based on the frame of reference of the transcriber (Rohleder & Lyons, 2014). Within practices of transcription, it is important to proceed with caution in interpretation with consideration to language and context undertaken rather than just regurgitation of information (Chamberlain, 2014). All of the interviews were recorded and transcribed by myself as the researcher, taking care to acknowledge the co-construction of narratives through the relationship and question-answer dynamic within the interview-participant framework. Where appropriate and relevant, transcription captured additional context to support language, such as pauses, or laughter. Each interview was listened to multiple times and layers added to transcription with each review of the sound recordings. For example, layer one was transcription of words only, the second layer of transcription involved adding significant pauses and verbal cues, the third layer was to add side notes and commentary from what I as an interviewer noticed during interaction and memories associated with certain areas of text such as eye contact, posture, emotional composure, and to highlight key areas of notice such as timeline elements, key themes, areas for further exploration, and quotes. This process was an intricate part of the data analysis itself and important in reflexive practice

Interviews were listened to a minimum of three times for initial transcription, to ensure dialogue had been captured correctly, and to familiarise myself with the interview content. I engaged with the transcript materials until I felt individual participant experiences were comprehensively understood, revisited each recording as appropriate during an ongoing analysis process. From transcripts I built individual timelines and case study blurbs, to allow an intricate reflection on the data, whilst remaining mindful of limitations when relying on transcripts from one meeting, and to not reify the transcripts beyond what they are; a snapshot in time, a moment of explanation within a much wider context, where interviews provide only one source of knowledge in relation to phenomenon (Riessman, 2008). Timelines created from individual interviews, alongside key quotes, were shared with interested participants (Four) in follow up Zoom video calls. Individual participant depictions, were then gathered together and analysed as a group, until I felt that universal qualities and themes of the experience were thoroughly understood. To support this process, highlighted colours and post-it notes of key themes were used as a visual cue across the multiple transcripts, later combined into a mind-map to minimise duplicate themes and find core narratives (Appendix L) to present a vivid depiction of core meanings within binge eating experiences of individuals, alongside the collective group.

2) Narrative content Analysis

I then created a case study for each transcript staying as close as possible to participant words. A case title was then followed by a short introduction for each interview, to orientate readers to the participants, and bring their stories to life. Each Case title and introduction is shared in Appendix M, to provide an impression of the eight interview participants, and the individuals journeys they kindly and bravely shared with me during our time together.

3) Storyline Analysis

I then moved to a content and structural analysis to create life story timelines for each participant across childhood, adolescence, young adulthood, adulthood, present day and hopes for future selves. Ideas presented in individual stories around recommendation for future care, and considerations for communities were also captured here. Initially, these timelines were intended to be included in the appendices of this research, however as the process progressed, it was evident that individual confidentiality may be compromised due to the intricate nature of the timelines, so they were unable to be included, however a blank template example is available in appendices as an indication of how these were structured (Appendix K)

While these timelines were being created, voice notes were recorded alongside physically highlighting text into four key area; key themes, key quotes, topics that required further exploration, and timeline elements. As an adapted version of version of storyline analysis steps, the aim was to begin answering the questions of who are the main agents/characters in the stories (key themes), what acts/events have taken place (timeline), setting the scene (timeline), and purpose, intention, desired or feared goals, the ‘what for’ (to explore further) and the breach of stories (exemplified through key quotes) (Rohleder & Lyons, 2014, p. 141).

4) Interactional/Dialogical Narrative

In this stage, I looked at what happens to storylines during interaction, drawing from steps recommended by Reissman (2008) to get an understanding of how I was co-constructing narratives through dialogue interactions within the interview settings, how I asked my research questions and then presented follow up questions that intended to follow story flow being presented by the speakers, are important considerations here, as is my relationship and rapport built with participants during the interviews.

5) Contextual Analysis (Positioning of storytellers)

At this point, I aimed to “gain more insight by placing the narrative within the relevant wider context of stories in which individual stories are embedded” (Rohleder & Lyons, 2014, p. 144) In this stage, I looked at dialogue that reflected wider cultural narratives or discourses. It is important to note here, that such narratives were intentionally participant driven, rather than pre-conceived notions of narratives that I was looking to find in participant accounts. In such a way, the essence of the focus narratives within the data, are those that stood out as most prominent and important within individual accounts first, and then what they reflect on a wider scale, connecting back to literature and theory (Rohleder & Lyons, 2014), and at this stage, moving towards a more emic (research and theory driven) position, than the etic (participant driven) steps that have led to this point (Rohleder & Lyons, 2014).

6) Comparative Analysis

Comparative analysis of storylines, interactional patterns, and/or contexts were engaged with in this stage. Using previously created timelines, story summaries, key quotes and key discourse subjects that functioned as support data, I looked across key themes established in interviews, to allow me to position the individual stories within wider contexts. Differences and commonalities between storylines were compared at this point, with findings from this stage evident in the next findings section. Accumulating within this stage of cross analysis of the individual stories and stages of the steps beforehand, I could then present layered findings, where both etic and emic representations are concurrently evident to allow for "overarching conclusions about interactional patterns, local moral contexts, and conclusions about self and identity" (Rohleder & Lyons, 2014, p. 145) to come through the narratives, with theory presented alongside overarching personal stories and representations of groups shifting to central focus, whilst intentionally working to retain the narrative quality of individual stories.

Outline of findings

The findings begin with how the participants construct their origin (start of binge eating journey) stories. The structure is then focused on personal accounts of lived experiences and interpersonal relationships at the micro level, alongside socio-cultural influences on binge eating, access to care and support, and resisting or conforming to prevalent disordered eating narratives at the macro level. Each area of analysis explores how these experiences are reflective of living with, and recovering from binge eating.

Chapter Five – Findings

My analysis involved creating short case studies for each person with the intention to orient the reader to each case as whole, an important step in story analysis (Riessman, 2008). These introductions were initiated as part of the analysis process and were adapted to best orientate readers to the individual narratives and allow individual stories to come to 'life' (Riessman, 2008). It is suggested that the reader read these before moving to the findings (located in appendix L). The findings are then laid out in two parts. In part one, I cover origin stories for each participant and then move to explore key narrative themes of personal accounts of lived experiences and interpersonal relationships at the micro level, alongside socio-cultural influences on binge eating, access to care and support, and resisting or conforming to prevalent disordered eating narratives at the macro level. Each area of analysis explores how these experiences are reflective of living with, and recovering from binge eating and linked to relevant theories. In part two I briefly discuss the results of the GP survey.

Part 1) Lived experience

In an interview setting, natural story telling is somewhat siloed into the context of topics of mutual interest, where the setting itself shapes the narrative experience, and direction of conversational discourse. However, this somewhat unnatural setting does not diminish the power of storytelling. As lived experience was at the core of this research, the question *"Can you tell me about your experience with binge eating?"* was asked in the opening of interviews as a broad start point from which participants could chose a place that felt comfortable to begin their story. Although at different ages and phases of life, in most cases this question allowed participants to talk about their first experiences of binge eating, or the emotional and social contexts within which their binge eating occurs or is most prominent. It allowed a natural beginning for their stories from which the interview could continue, and began to produce dialogue on some of the key themes for individuals.

Origins of disordered eating

The beginning of journeys with Binge Eating were described by many participants as something that had occurred early on in life, with four participants re-counting experiences of what they perceive as disordered eating, binge eating or otherwise, from childhood. Such personal experiences were placed within context of key family relationships, such as parent or caregiver dynamics, or traumatic, emotional or transitional events, such as illness or troubles at school. These events were highlighted as impactful on childhood relationships with food, and for many are central in their storyline development of being someone who 'has' binge eating, as part of a reflected personal identity. Two further participants discussed childhood experiences with food but disordered eating behaviours predominantly presented in late adolescence and early adulthood. A further two participants did not discuss childhood eating, but placed the beginning of their journeys in the context of early adulthood life transitions, such as into a career and away from the family home, or into university education, where more personal autonomy and responsibility was evident. All of these origin stories will be briefly explored individually, before reflecting across l narratives for key themes.

Madilyn

Madilyn, in recalling events as an adult, can identify her patterns of bingeing from a young age, and the influencing factors of where it began. Madilyn ties her beginnings of binge eating to a key event of being unwell in hospital at a young age and for an extended period of time, this is in contrast to many other accounts where there does not appear to be one key event pinpointed as triggering binge eating, but rather larger contextual events at play. At the time she was not aware of labels or conditions that existed around eating, and her eating experiences appear more reactional to her surroundings, alongside pressures and expectations that have been placed on her body by 'others'

> *Ever since I was sick and didn't eat for like nine months then I was like encouraged to eat, eat, eat. uhm, but then after that it was like, Okay, you're eating too much and everything in my life was like, focused on what I was eating and like being made to do like a paper run to get exercise and stuff… from the age of, like 12 type thing 13…and so then I'd kind of like secretly eat like I'd have a paper run and I'd always get lollies from the dairy, but I'd secretly eat them before I got home so mum didn't know. [Madilyn]*

For Madilyn the origin centres on illness and parent-child dynamics, especially messaging from her mum around restricting food. A focus on her body size as “too small” and then “too big” reduces her to body as object, fitting within a medicalized ideology of being healthy. Being sick at a young age and ultimately losing a lot of autonomy over her body while in medical care, where for children often things are done to you rather than with informed consent (Thomson, 2001) was traumatic for Madilyn, leading to her searching for control over body and self, resulting in decision making through food, almost as a rebellion against the control others have had over her body for the majority of her life.

Āwhina

Although Āwhina does not specifically recall an origin event or trigger for her binge eating, like Madilyn, Āwhina places the start point of noticing her eating during childhood, relating her eating to a sense of comfort in times of trouble, and as an act of love and care from her Kuia, that is translated into feelings of comfort provided by food

> *“I couldn't tell you when it first started…But I can remember the first time I got suspended from school when I was 12 years old...And my grandmother felt sorry for me, my Kuia, and she bought me doughnuts. And I can remember eating those doughnuts and feeling so good. So, I was 12 and I was a fat kid, too. So, I think it sort of started back then. that, that's the first instance that I can remember.”*
> *[Āwhina]*

Āwhina describes food as bringing good feelings, implying ideas of comfort and acknowledges the positive intent form her Kuia in providing solace through food, an element of many cultures including Māori communities that surround sharing food with loved ones as a place of connection to one another (Johnson, 2017). Āwhina also identifies herself as a “fat kid”, placing focus on her body in terms of weight and acceptability of size from a young age. Because she was “fat” it was deemed unsurprising and somewhat expected that food was a large component of her childhood. She also discusses patterns of whānau dieting that had been presented throughout her lifetime, reflecting internalized knowledge of acceptable eating and dieting culture, highlighting practices and preoccupation with weight from a community and whānau perspective from a young age. Āwhina later contextualises such experiences within a cultural and trauma framework, linking her personal experiences with experiences of her wider community.

Charles

Charles, similarly positions his start point with binge eating as being in childhood, with themes of imposed food restrictions and rules in a more institutional sense through the dual settings of home and boarding school life.

> *for me, it kind of had always been like, an on and off thing…it actually started when I was like, really young. And there was like, a lot of reasons for that. Like, I went to like a boarding school…the food there was trash, it was really weird…but I remember getting home. And there would be like, snacks and like the "good food" and I remember as a kid…if I ate like, too much of it, I'd get in trouble…So it almost became like a sneaky thing. [Charles]*

Charles orientates himself in this setting as being impacted but his surroundings where food is beyond his control in many ways. Food is seen as "good" at home, in contrast with his eating behaviours at home seen as "bad" and something to be hidden \to avoid getting in trouble. He also mentions there were a lot of reasons for his eating behaviours relating to relationships with his mother, later in the interview. However, for Charles the experiences of transitioning between boarding school and home life were identified as a starting point for binge eating.

Olivia

As with other participants, Olivia attributes the beginning of her binge eating journey to childhood experiences;

> *I know exactly where it started…when I was a child...we lived on a farm and we had, there were six kids in the family…So my parents very much prescribe to the 'eat everything on your plate'… if I didn't eat for dinner, I had to eat for breakfast…so it was like a form of torture…I would hold some of it in my mouth and I would go to the bathroom…so by the time I was 11 I was, I was well bulimic…I did a lot of binge and then vomiting, because it was the easiest way to control food. [Olivia]*

These descriptions of hiding food and getting in trouble, suggest moral attributions placed on certain eating behaviours, reflecting ideas of wrongdoing and shame. Compared with other interviews, Olivia is the most direct in her portrayal that her practices of bingeing and purging, were related to gaining a sense of control, however mentions through the interview that this awareness of her food behaviours as a child came later in life, as she reflected on her childhood during her journey of trying to understand and recover from her binge eating and other eating behaviours.

Naomi

Naomi describes moving through multiple layers of disordered eating, participating in a range of eating behaviours, seemingly seeking for coping strategies and means to manage emotions. Although the exact time of life is not stated for when behaviours began, her description of finishing university and later comparisons to how she felt about food and body moving into her 30's, locates these experiences somewhere between her late teens and early adult years;

> *I went through a period of starving myself at the end of my… in the last year of my uni and that felt really good…And I guess one day I broke and ate, and then I felt like, I felt like a failure. And during that time, I was kind of struggling with um, with a bad breakup and um, yeah and I really like the feeling of binge eating, I like that feeling of, of fullness, you know, it's kinda almost like a hug from the inside. [Naomi]*

Her conceptions of fullness as a "hug" from the inside, is similar to Āwhina's accounts of comfort found in food, further demonstrating the emotional importance that food and eating can provide in times of distress. Her origin story is also different to other childhood accounts discussed so far, in that binge eating is concurrently introduced alongside times of mental distress and feelings of failure, indicated by positioning against a "bad breakup", and as a reaction the restrictive methods of starvation.

Eva

Eva discusses a complex journey of origin, centred on fitness physique expectations where pressure and restriction is placed by herself and her body to fit within idealised concepts of women in fitness. Eva described her journey with binge eating, alongside her transition to working in the Les Mills (gym) industry, pinpointing this as at time of major impact on her eatingand body views. She describes the pressures she put on herself, placing focus on her eating behaviours and taking ownership of this 'pressure' to fit within this health and fitness culture

> *I can't really pinpoint like what made me sort of start…I couldn't really say, but I guess it was kind of getting into Les Mills industry…putting a lot of pressure on myself… and just got really, really skinny. At the time I don't think it was intentionally, but who knows…and oh, wouldn't have been too long after that I just found like I would start eating…and it's probably taken me about, ah, three years to come right?" [Eva]*

This is reflective of wider cultural narratives that deem what it 'is' to be fit, and reducing health to body size, rather than physical capability. Generally, this means needing to meet a slim yet toned physique, perpetuated by media images and branding from gyms such as Les Mills.

Elsie

Working in the dance world, Elsie described how she began to feel pressure to confirm to bodily expectations placed on dancers, whilst struggling with the natural body changes of womanhood;

> *I guess the pressure probably came in um [pause, thinking] definitely when I started working professionally. And when you're much more like, you know you're in costumes that are revealing, and also, like, there's that more pressure of I'm being paid to be here. I'm being paid to do this, someone has an expectation of the product that they're getting in a sense that I am that, you know? like, me and my body, yes the dancing, as in the craft but also how I look is a part of that um, and so that was probably when the pressure really came on, because that also probably coincided with just like my body changing and me becoming a woman. [Elsie]*

The idea of revealing costumes, and pressures on bodies in the workplace described by Elsie and by Eva, are demonstrative of overarching views of women's bodies and fitting into the skinny ideals. Both also had to, at least in part, display their bodies as a form of product as either a fitness example or a vessel of dance in costumes. The social constructs of what it 'is' to be a dancer or a fitness professional, highly constrain ideas of what they describe as being acceptable bodies within these spaces. When Elsie talks about the transition into binge eating, alongside food restrictions that coincide with preparations for her dance shows, she clearly defines work contexts in which bingeing is most prevalent, alongside additional key life events where she feels like it started. For example, when she moved out of home and had the freedom to drive and be autonomous about her food choices, she also gained the ability to hide a lot more of her eating, reflecting themes of the impact of perceptions and practices of control over food across different life stages.

Paula

Paula's story stand outs in terms of origins, as unlike the other interview participants, her familiarity towards binge eating concepts or behaviours in the context of being 'abnormal' was somewhat absent within personal accounts, with part of her sense-making coming from reading the advertisement description of binge eating,

> *I've never, I've never talked about it, no…not about the overeating, no because…I guess, in a way I always knew that it wasn't right because I don't do that in front of anyone. I'm also definitely one of those people, um possibly because I've always struggled with my weight that. I'm not a big fan of eating in front of other people.*
> *[Paula]*

For Paula binge eating appears to be a side-category alongside a larger narrative of weight and participating in diet culture, normalizing her behaviours to an extent as something done by everyone, particularly women, but at the same time, realizing that maybe such food behaviours are not as normal as she would like to perceive them. Despite this differing lens, Paula does acknowledge that she really started to notice eating as being an issue from, around 19 to 20 years of age, but framed as an issue of weight. Similar to Naomi, Eva and Elsie, Paula places key development of dieting practices in early adulthood.

Personal journeys of Disordered Eating (Binge Eating)

From such origin points, there was a natural story-telling progression through personal journeys with sense making of binge eating towards present-day narratives. For most of the participants, binge eating was described as long-term behaviour that ebbs and flow in times of distress, marked with layers of narratives with self and with others. The next part of this chapter discusses experiences of living with binge eating focusing on key interpersonal relationships, and how these have positively and negatively impacted on participant experiences of binge eating, including relationships with medical professionals. Experiences of stigma, emotions, the role of social media and struggles with weight and food permeate as central themes. Throughout, different powers are at play within certain relationships, such as the mother-child dynamic, social and medical institutions, alongside culture and gender expectations, especially centered on body ideals.

Interpersonal relationships

Interpersonal relationships, especially with key family member, peers and health practitioners, play major roles in shaping individual journeys of disordered eating. An unexpected finding was how often relationships with mothers were mentioned, either as a contributing factor or as a supportive figure. The first part of this section discusses this dynamic. The second uncovers the role of social and community stigma in disordered eating.

Family – Mother Child Dynamics

For Elsie her mother was positioned as a contributing negative factor towards her relationship with food, where Elsie perceives her food to have been controlled by her mother.

> *a big point of contention was food… just like little things like if she say, did make a lunch or something what she would make from my brother versus me was so different. And that was something that I got really annoyed at and kind of my comment to her about and she just didn't understand [Elsie]*

Elsie experienced this as a child but also as an adult when she moved back home due to COVID-19, discussing a regression with food during this time, surrounding her experience of going to live in her family home, where she felt her food choices came back under the microscope of her mother's food perceptions. Elsie feels her mother positioned her relationship with food as something that is inherently wrong, does not fit how she perceives women 'should' eat, and ultimately puts pressure on Elsie to question her own eating behaviours, even when these are deemed acceptable for her brother. Elsie attributed this dynamic to her mother's own relationship with food reflective of ideas in social comparison theory, of the innate human drive to compare ourselves against others (Tylka & Sabik, 2010), plus her mother's gendered assumptions of feminine bodies and eating that align with wider social narratives of 'correct' ways for women to eat and present themselves,

> *…I definitely think her relationship with food has come from somewhere, she eats really healthy like, she's really healthy but I think to a level that, I don't know if she eats enough. [Elsie]*

This monitoring at home, translated into Elsie recognizing social situations where other people may also be in a position to monitor her food, and the pressure of trying to find a social balance of eating acceptably in public and eating that is acceptable around her mum. Through all these contexts of her life, it creates this perception that someone is always externally moderating or critiquing her body and food choices.

> *you go out and there's just like all this food out…, sometimes I'll kind of catch myself and I'm like okay no, I should probably like move away from standing at the food and go and socialize with other people and so, like, I guess there is just that awareness of it more than maybe I'd like there to be, you know? [Elsie]*

Madilyn also reflected on her relationship with her mother, who set food boundaries that somewhat reflect a lack of awareness around food and body messages. Madilyn discussed this in contrast to the intentional difference in the dynamics she creates around food with her own daughter

> *a big worry for me I guess was like handing down food hang ups which, I mean I definitely feel like my mum had a lot of parts to play and she's miserable about her weight all the time, but it's a gen - like it's that generation they all are. Like they're so obsessed and, you know, uhm I just I even said to mum and made her cry, and I was like, you're not ever allowed to talk about food in a bad way in front of [my daughter], you're never allowed to judge anything that she eats. [Madilyn]*

These narratives by Madilyn and Elsie's mothers, may be reflective of a generational understanding of food, including impact of availability of food across generations. Ideas of family food expectations are highlighted as an integral part of how participants feel about their eating, and begins to portray the existence of central story where characters such as parents, are perceived as gatekeeping food resources and influence food behaviours during the childhood stage of life. 'Finish your plate' cultures are explored by Madilyn, Olivia and Paula in similar ways when recalling their childhood family eating. Just like ideas of morality are presented with hiding food, these are also presented in terms of guilt and food wastage. Ideas such as these are ingrained, carried into food practices when they gain control of their own food choices as adults.

> *I also most definitely was raised in a family where you always finished what you, what you had on your plate. And we also, we always ate really fast. [Paula]*
>
> *like when we were little, and you'd always have to eat all your food before you left the table, or you weren't allowed dessert…and I had like this real hang up about like food wastage. But now I throw stuff out like, and it's fine, and I'm fine with it. Whereas before I like I, I'd feel guilty. And I'd be like, oh no, it's fine I'll just eat it. [Madilyn]*

Paula adds to this, reflecting on damaging generational narratives in relation to how her food journey has always been body and weight related. Paula links this to criticism she received from her mother throughout her life, and which continues into present day and has appeared to form the basis of her own relationship with her body and feelings of self-worth.

> *She [mother] would basically tell me on a weekly basis how, how big I was. And if I look back at the photos when she was telling me, I wasn't actually big [laugh]. I wasn't skinny. But I wasn't overweight…and, so I've always, always thought I'm never ever going to do that to my children, you know, and tell them their fat, it's, what on earth are you trying to achieve with that sort of thing, you know? …I absolutely hate my body I've never, ever liked the way I look…I don't want to*

> *completely blame my mother for everything because that would be really unfair, but I, I know that that plays a really big part of it.[Paula]*

For many of the participants, their mothers critiqued their body size, which may be reflective of their mothers own self-conscious concerns about food in relation to their bodies or stigma associated with parenting a child with a bigger body. The participants reflected that perpetuating such diet narratives and female body standards was very damaging in their own relationships with food and body confidence.

Transitions into motherhood were presented as key times of learning and growth in relation to food and body narratives. For some, it created a more positive relationship with their own body, and fostered feelings of self-love, and for others it encouraged them to change eating narratives and food behaviours in the home, to support their children. Four participants, Olivia, Naomi, Paula and Madilyn, describe how motherhood on some level, was a positive transition for their relationship with food.

> *I was really aware that when [daughter] was around the age that I was when I started like, you never comment on their weight or anything like that, because you are going to get eating disorders…my daughter does not have any issues… she's never had anything, food issues, based on the fact that I've never ever, ever shamed her [y] because I remember being shamed….because I was like, you can't put that on a child… you need to just let them, live their life. [Olivia]*

Naomi discussed the journey of motherhood and pregnancy as a key turning point towards a more body-positive mindset, and presents an idea of duplicity between the social expectations placed on woman's bodies, and the very natural meaning-making endeavour of a woman's body in having children. Carrying and having a child, and being responsible for a life within her body other than her own, played a role in changing how Naomi viewed her body, compared with previous social narratives of the thin ideal, or the 'fit' ideal that she felt she needed to achieve to be worthy. Through the process of motherhood, and love she feels as a mother, she finds true worth in her body.

> *going through that pregnancy and motherhood journey…really made me look at my body in a different way. You know, I started appreciating my body for what it can do rather than what it looks like and I know experiencing that unconditional love for my child…[Naomi]*

This positive conception of motherhood is also reflected by Madilyn, who presents a key turning point in relation to her relationship with food, as wanting to create a better eating environment for her daughter than she had growing up. Paula is also a mother trying not to continue patterns of negative body messaging with her daughters, that she received in childhood from her mother. Such role shifts of becoming a mother, create a positive impact on how women see and feel about their bodies and the food rules evident their own childhoods; these play out in future parenting techniques to create a new culture of food in the home.

> *being able to be more aware of like her [daughter] relationship with food as well…like when we were little, and you'd always have to eat all your food before you left the table, or you weren't allowed dessert…we have no reward system.[Madilyn]*

Charles, in comparison to the other participants, positioned his relationship with his mother as her being highly critical of him in all areas of life, not just eating. Charles described feeling pressure and lack of value from his mum on any of his achievements. After Charles left home he put on a lot of weight and he talked about how his transition to being 'fat' and other life events, left him feeling like he had ruined his life and let his mother down.

> *what had compounded the most I think was the sense of betrayal. in me, for me, you know what I mean?...And I kinda confirmed that when I realized just how fat I'd gotten…and this pervasive stance of like, I had ruined my life, then because I'd - my mom would call me crying and tell me I'd like ruined my life even though, like…now I look back on my life…I've done a lot of shit. Like, I've failed at a lot of stuff. But like, there's a lot of stuff that still, I think has value in that time. [Charles]*

There appears to be a critical voice that Charles presents that causes tensions in his relationship with his mother. This doesn't centre purely on weight, but weight becomes part of an overarching narrative of failure; that if you are larger, you have somehow failed at achieving your full potential, placing value and moral attribution within body aesthetics.

Āwhina doesn't directly discuss mother-child relationships, but frames familial influences in more of a community lens, where community practices of food and patterns of dieting seen growing up, she believes have impacted on her relationship with food in modern day. Āwhina discusses 'on' and 'off' dieting, which ties in with senses of self-value; when she is ‘on’ this includes a stringent diet and exercise plan, when she is ‘off’ is linked to times of stress and where binge eating reappears for Āwhina. These cycles are reflected in her family members, and her descriptions of such eating patterns place them as normative and something she is trying to break, rather than abnormal, in the context of her whānau eating cultures

> *I have inherited the trait that my whole whānau - so on my mum's side, her and her brothers we yo-yo diet. And we, we have this tendency to go fat, skinny, fat, skinny fat, skinny, fat, skinny and the whole lot of us do it. Not just me, but my cousins…but um, it's incredible how we've all got this really disordered eating, and it's either [pause] it's all or nothing. It's none or a hundred. [Āwhina]*

Wider family cultures with food are in-line with binge eating disorder understandings, where BED appears to run in families, and reflect both cultural and genetic influences. (APA, 2013). In addition, negative dialogue around food and eating can then cycle through generations, as almost a normative practice of body monitoring on women. From a feminist lens, this reflects the view that that female body remains a central place where gender roles continue to be embodied in relation to wider health narratives (Keane, 2014), that position women’s bodies as reflective of their roles within society under the male gaze, and as family caretakers. Equally, it provides a frame from which to critique why such narratives that place mothers as solely responsible for children’s weight and food, are still so prevalent in the 21st century. In such a way, the gendered body of mothers can lead to behaviours of body monitoring of self and child to fit acceptable narratives, to try and reduce experiences of stigma related to ideas of body size and appetite for daughters, that ultimately can lead to negative relationships with body image and food.

Community - Experiences of stigma

The previous section highlighted how family narratives can shape young children’s views of their self-worth, body image and value, as well as contribute to stigma towards eating practices and body commentary. Even well-intentioned comments about appetite or body changes, can have much larger impacts than seen on the surface. It’s important to clarify, that not all mother-child, partner or whānau (family) relationships are described negatively, and even within situations where experiences have been impactful, they are often described through a lens of humour and good intention. However, the narratives explored here, are done so to demonstrate the impact of such relationships in journeys of binge eating.

Some interactions with fathers and partners, illustrated a lack understanding and empathy in relation to eating and mental health.

> *my partner at the time was like, “well why?” you know [m], you know It's - life's not that hard, you don't have anything terrible going on….like my dad always used to say, “why don't you just stop” [laugh], and it's like well, I fucking would if I could, you know, like I didn't choose to keep eating and eating, and eating [laugh]. [Eva]*

> *“the only other person was like an ex-boyfriend, who was just totally not helpful, and not a nice person at all [laugh]… that was just a shutdown thing of like, well "you're the one doing it so stop doing it" type of attitude… or he said to me… "oh well just go to the gym." [Elsie]*

Dismissal of attempts to connect and receive support, even when unintentional, can further perpetuate levels of self-blame, and also that disordered eating is a problem that needs to be tackled alone. Some of the comments also re-iterate the focus on the body as the problem, such as placing the solution in going to the gym, simplifying recovery to fitting within body norms (Gotovac et al., 2020). Others, place focus on mental resilience and personal choices, where the solution should be a simple one, to just stop eating. Although somewhat simple statements, they support a dangerous underlying presumption and neoliberal discourses of personal responsibility, that ultimately binge eating comes down to personal choice . If a disorder appears to include a form of social behaviour that can be attributed to causation, regardless of the reality of “fault” social narratives quietly prescribe said blame to the individual, alongside moral judgements of goodness or sin (Vigarello, 2015).

Stigma around binge eating played out for other participants in numerous ways. For example, Madilyn in her nurse training, felt uncomfortable working with people with AN while seeing herself as a binge eater and overweight. This caused self-doubt in her ability to do her job as a nurse because of seeing herself as a “fat nurse” demonstrating how narratives about her body, then translated into doubts about her professional abilities.

> *I just want to be able to be a great nurse. And I don't think you can have a fat nurse…[Madilyn]*

Madilyn frames being overweight as meaning she cannot be healthy and work in healthcare, whereas working in the dance industry, Elsie describes the culture of work surrounding body image as an industry that focuses on bodies as objects of production.

> *it is more the culture around it than actually the individuals or what's actually happening that keeps that in check, but…one of my friends works for a really big company overseas and they quite literally have their measurements taken all the time…if those measurements change, you can get fired… but it's definitely on us like there's no, you're not guided on how to do that, you're not told how to stay healthy and eat nutritious food, it's just like [pause] look a certain way [Elsie]*

Dancing creates a culture of monitoring, body judgement and coercion to stay within acceptable dancer 'norms' or risk losing your livelihood, putting pressure on young women to maintain a type of body that may not naturally be attainable or healthy long term. Elsie describes how she adapted her behaviours over time, drawing a line for herself in terms of her restriction and bingeing, balanced around work and personal worlds; where needing food for fuel to perform for her job, is balanced with periods of restriction to meet weight requirements. When Elsie compares her own level of dieting intensity to other girls in the dance industry, she reflects that her current cycles with food may not be healthy, but in comparison to the dance industry overall, she presents a more sensible approach than a lot of her peers. The definitions of what a dancer must be to be successful; slim, petite, white, elegant, showcase wider perceptions of how we classify people by their bodies, and how women classify themselves against a lens of other women (Rubin et al., 2004).

Eva's role working in the fitness industry also demonstrates stigma towards body size. Eva reflects on how industry standards create pressure on her body perpetuated by herself and others. Eva considered these pressures as an important factor in being able to continue working in the industry long term.

> *… probably just the fact that I've still carried on in this industry [m]. Cause there was definitely a time where I was giving, giving it all up [Eva]*

Stigma around body size is illustrated in these workplace examples, that sit within wider cultural narratives that deem what it 'is' to be fit or healthy based on body size, rather than physical capability. Feminist literature has highlighted how normalised criteria for women's bodies imply women should be constantly aware of, and attending to, their bodies; women should suppress their bodily appetites; their bodies are texts through which their morals and values will be read, and are placed as objects and commodities that exist to serve others (such as the male gaze) (Rubin et al., 2004). This research suggests this gaze is not just related to gender. Health professions also present with stigma based on what healthy bodies should look, alongside workplace, self and public stigma that are all placed as contributing to disordered eating.

Self-stigma is further highlighted in how participants identify themselves in relation to their binge eating behaviours regardless of size, although social aspects of eating and body size complicate the narratives. Elsie (dancer) elaborates on how she feels about or views her social persona, among friends and family, for being known as the person who loves to eat and having 'in' jokes around that, but also being aware that such labelling, even in an affectionate way, can have negative affects when struggling with food relationships. Elsie self-describes as having a slim body so she is subject to less prejudice and more humour when she eats a lot. However, Elsie struggles with this and eating then becomes a shadow lingering over social situations, where she feels conscious of being someone who's known for her love of food. There's a dichotomy of pressure that she feels between keeping herself in a slim body, with the need to uphold this social representation as someone who loves to eat.

> *I have some friends who like know me and make comments all the time about like how much I eat and how much I love to eat and like I'm always the one that's at the food like haha…and it's like kind of funny like I can kind of be in on the joke and be like, "Aha, yeah that's me" [y] but then at the same time you kind of get a little bit aware of that [Elsie]*

Stigma played out differently for participants in larger bodies. Eating behaviours, and the values attributed to them lie within social constructions of health as either within or outside of an individual's control and regarding who is "to blame" for certain behaviours. Obesity has social constructions that place a high level of blame and responsibility on the individuals themselves (Hollett & Carter, 2021). These social assumptions both consciously and subconsciously shape the public reception of bodies. Such feelings of being out of place in a larger body in a social environment, is not one that is purely in the mind, but can result in actual differences in how people are treated. The stigma surrounding food behaviours and body stereotypes is tied to morality and neoliberal responsibility for health (Barnett & Bagshaw, 2020). For the participants in this study binge eating was hidden, shameful and subjected to prejudice and discrimination.

> *it's Shame…Because greed is not considered, you know one of those good character traits by society… [Āwhina]*

Stigma of binge eating also plays out in social media where these views are evident within online pro-eating disorder forums, praising anorexia and starvation methods, sharing tips and experiences that can ultimately be harmful for all audiences (Casale et al., 2021). In these forums, rather than offering places of support and understanding, people are often met with further stigma. While binge eating has an on-line presence there is a façade that binge eating is not undertaken, in a way that is not evident for restriction, which is generally praised as it gets them closer to goals of the skinny ideal. This leaves people with binge eating in particular, left out of community spaces for disordered eating, whilst meeting stigma in their daily life when existing in larger bodies.

> *on social media you know like [y], all that focus on fitness and, you know, health and all those fitness influencers, you know… at what point does healthy lifestyle become an eating disorder? [Naomi]*

Wider social narratives of what it means to be a binge eater, override other elements of personality that may be viewed positively, and do not adhere to the 'lazy' or out of control narratives that perpetuate how we see binge eating, especially in how this is positioned against 'acceptable' eating behaviours.

> *there's a lot of like shame and guilt around eating anything…and just like so many people have always made all these comments and they're like, "Oh you, but you eat so healthy" or were like "you don't really eat that much", and I'm like yeah, I do, just secretly. [Madilyn]*

> *It's such a shameful secret…I couldn't really discuss my Binge eating with people in the eating disorder world because you know you're all trying to maintain this drive towards this goal of starvation and weight loss. [Naomi]*

What is common among the participants accounts of binge eating is the secrecy and shame. Much of this is coming from stigma and misunderstanding around eating, food, and body image and conflicting information from all sources (including families, friends, workplaces and social media).

Stigma was also evident in interactions with the medical community. Part of this was attributed to a lack of understanding of BED presentations and the other was stigma around body size. The DSM-5 states that cross-over between BED and other eating disorders is uncommon (Agras et al. 2008; APA, 2013), however, stories of restricting and purging alongside bingeing were evident. Olivia's diagnosis of BN and Naomi's self-identified experiences of AN and BN alongside narratives of extreme restriction would not fit with current DSM-5 versions BED. These discrepancies between lived experience and diagnostic pathways, may be negatively impacting on people’s abilities to firstly self-identify their behaviours as disordered, or equally for medical professionals to be able to do the same, creating an additional level of stigma, that reduces individuals to “tick box” exercises, as described by Olivia.

> *they want to put you on in a box, it's either going to be Anorexia or Bulimia…and even when they do put you in that box. They're still not caring about your mental health…I mean, if you have something traumatic happen to you, binge eating might be your thing that you do, or it might be cutting, or something like that. You know, if somebody is cutting themselves they're gonna get help mentally. But binge eating they're not. [Olivia]*

Regardless of gender, those who have had the most stigmatizing experiences are consistently most reluctant to seek professional support (Ali et al., 2020; Hamilton et al., 2021) exemplified in individual accounts of feeling hesitant to discuss eating with GP or other medical professionals, out of fear of being judged. Stigma and stereotypes also impacted on participants who were not classified as overweight, being hesitant to request support as they did not fit the traditional stereotype of a binge eater. Often shame was discussed as a contributory factor to hiding eating behaviours for long periods of time, and for some people, our research interviews presented the first opportunity they’ve had to discuss their eating with anyone.

Education

The participants reflected on ways to address stigma and change attitudes. All the participants discussed how the education around food, eating and weight needs to change in schools, health settings and on-line. Educational approaches are viewed in interviews as needing to focus in three key places, firstly to improve food and body messages with children directly; secondly, an improved level of education for parents around food messaging; thirdly improved education on disordered eating for medical professionals and general New Zealand populations.

Strong advocation for improved education in schools was evident in interviews, especially for younger age groups. Many participants disclosed that for themselves personally, earlier education may have been extremely valuable

> *I just didn't have any education around food. At all. Like at all, it was just like good food, bad food…I didn't even think about why, why am I eating? you know, it's like I'm eating for all these other things, it's like I should be eating because this is what I need to live… [Elsie]*

Focus on nutritional value of foods in education was suggested by Olivia, Madilyn and Elsie, who all went through phases with food of not understanding why they were being told to eat a certain way, or what foods actually meant; Olivia in her treatment for BN, Madilyn in her childhood recover from illness, and Elsie in her cycles of eating around working as a dancer. They all reflected on a lack of education about nutrition in relation to food, instead they were just told they need to weigh a certain weight, or look a certain way.

> *it was never actually like somebody being like okay…why these foods are healthy, why your body only needs this many calories a day, like what even is a calorie? What even is a kilojoule? There was nothing like that. And then they didn't talk about or teach any of that at school either. [Madilyn]*

Changing such perceptions as early as possible was seen as highly valuable as their own relationships with food began to appear tumultuous from an early age. Others suggestions included; lived experience representatives talking to primary school children, education to improve emotional intelligence and increase feelings of self-esteem, and food literacy in relation to balancing "food as fuel" narratives alongside enjoyment within social and cultural occasions. Participants also discuss the importance of tangible support for low socio-economic families suffering from food poverty, where food scarcity is described as a risk factor, especially when it leads to 'finish your plate' cultures of eating, where children feel forced to eat.

> *if you're talking about it and you're open about it. It's uncomfortable and it's horrible and it's kind of a bit weird, but…it's real and it might resonate with somebody, and it might - we could sit in an room with 10 people and talk about this…there might be one person there that resonates with it and goes, "holy shit I can do this" and you could have essentially saved that person's life. [Olivia]*

When viewing education through the lens of interactions with medical professionals, themes of stigma and equality become of particular focus. There is a strong vocalisation against overall messages of body stereotyping that appear evident when viewed in the role of patient, where individuals feel reduced to their BMI range and body size, which is then viewed as problematic, requiring fixing with weight or obesity treatments. These views are then internalised in how participants communicate about themselves and their bodies as needing improvement.

> *GPs…They have no idea. I've seen two. And bless their cotton socks. I know what they're good for is giving out Panadol and Nurofen, and thanks for that. When it comes to psychological disorders. I think that they're able to screen for depression and anxiety but they just have no idea. [Āwhina]*

While disordered eating is often positioned within the individual, through dialogues we begin to see issues of social impacts and power dynamic presented through individuals trying to maintain socially acceptable standards that exist parent-child dynamics and social settings. Stigma is clearly influential on self-beliefs, public and social narratives,

This section discusses the participants relationship and narratives with their weight and food. There are complexities to both relationships which are linked to medicalised, feminine, and public and private bodies. Participants used a range of adjectives in relation to their body size such as skinny or fat, alongside more nuanced terms such as having a fit body or dancer's body. Regardless of which body size or shape they identified with, for many weight and food rules becomes a central part of their narratives of self and moral views of eating behaviours.

Body size and weight

Individuals that identified with the narrative of 'always' struggling with weight, such as Paula, placed weight as a problem that exists in tangent with binge eating. Alongside the impacts to self of being seen as overweight, and the cycles of dieting, they talked about this physical experience of weight loss and gain as becoming somewhat of a part of their identity.

> *if I was slim, um then I might have a happier relationship [laugh] with food, because then I wouldn't have that that thing that's like "ohh, I shouldn't be having this, or I shouldn't be having as much" [Paula]*

Paula suggests that to live in a smaller body would automatically improve her relationships to her body and food behaviours, and ultimately improve wellbeing. This narrative also reframes food choices as good or bad, giving a moral attribution to food that is based on context, with the message that if you are in a larger body then you don't have a right to enjoy food in the same way as someone who is slimmer. The ideal body weight was something that Olivia struggled with as well.

> *I did all the exercise. I did the food, I did all this stuff, but there was still nothing that fixed the underlying issue. There was nothing that fixed my why…the minute I stopped I put on weight again… So, I mean - I was never fixed. I was never at 'the right' point. [Olivia]*

Olivia managed to lose weight with restriction and reflects on how weight loss and restriction is positively received in society. Interestingly Olivia positioned this as the 'right' thing to do but not helpful for recovery or fixing her binge eating, and reflected on still feeling shamed by others for eating behaviours, regardless of size.

> *I remember being shamed. When I was big and little, I was still shamed. But um, mainly big. [Olivia]*

Equally, for those in the interviews that didn't identify as being overweight, such as Eva, Naomi, or Elsie, their narratives around fear of fatness and fitting into social skinny ideals remain heavily prevalent in discussions of food and eating. Elsie also touches on differences of experiencing binge eating in a skinny body, with her own descriptions of being 'lucky' that alongside these intense struggles with food, she was able to maintain her body type, and not have her eating impact on external concepts of her, or her work as a dancer.

> *"with dancing and stuff… that's definitely really skewed my body image, it definitely has and it's really added to having to navigate that in a particular way. But I like, I'm really lucky with the way my body works and my metabolism and stuff that I can maintain a pretty - you know relationship with food that maybe could be better, and still have that body image thing, like I think if I was maybe putting on weight at a faster rate than I had been previously that probably would have changed my relationship with food, but I think I kind of got away with it." [Elsie]*

This narrative does suggest that skinner bodies have less social stigma related to food, making binge eating easier to hide and deny when physical changes are not evident, but conversely make it harder to be taken seriously when seeking help for binge eating. Elsie doesn't contend with the additional pressures of weight gain as seen for others, but equally this comes with its own set of considerations. "Getting away with it" denotes a sense of denial of an issue as she can continue to hide any binge eating if weight change isn't evident. . There are multiple narratives in how she describes her experience; for one she is lucky, another she is trying to navigate what her body image means to her against her eating behaviours, and her discussion reflects internalised ideas that weight is a larger problem than the behaviours themselves, at least at this point of her journey.

Naomi reflects while her physical health (weight) was seen as managed she hid her mental health issues. From an external body perspective, it was a time in her life when others would have perceived her as being at her most 'healthy' reflective of feminist critiques of social health narratives where health has become a site for the moral performance of self, so as long as bodies meet socially accepted forms and presentations of 'good' behaviour they become automatically categorised as healthy, regardless of underlying mental wellbeing (Keane, 2014).

> *I remember back in my binge eating days, I was really fit I was. um, Yeah, I was still gyming…but I was very unhappy and kind of that just kind of shows you like the equal importance of physical and mental health. [Naomi]*

The complexity of "anorexia located within the skinny body" framed against "binge eating in the fat body" isn't an accurate perception according to the participants. Participants disclosed attempting to fight the binge eater identity and trying hard to meet the skinny ideal, or body expectations that have been placed on them by themselves and others, but not really knowing how to do so in a balanced way. These narratives show how the lived nature of restriction and binge eating are intertwined, where restriction for large periods is discussed at times of life when participants viewed themselves as overweight, and binge eating is prevalent in smaller bodies that externally are viewed as healthy.

> *people expected you to look a certain way, but because of what you're doing in the gym compared to what you were doing with at home was a lot different…I*

> *actually felt, yeah I found it was more detrimental really than anything…but of course that's probably the one thing that kept me, I wouldn't say small but smallish…because I was still exercising throughout that time [Eva]*

Charles discusses weight gain from a slightly different frame of reference than female participants. Where for females, the body pressures are presented as either precluding or existing alongside the binge eating behaviours, Charles viewed his weight gain as a sign of failure and of losing value because he was no longer viewed as attractive. Weight however, doesn't appear to be a central thought in his eating behaviours. Charles felt pressure to return to his previous body size, where he felt more accepted and valuable, but it appears that once at this 'accepted' level of weight there may be a reprieve from self-body criticism. This suggests that males may be subjected to less personal stigma when living in bigger bodies. However, this also suggests that men with binge eating problems, like women in smaller bodies, may not be helped unless they present in an obese body.

For the majority of participants, regardless of size, they are actively trying to avoid putting on weight and often present cycles of restriction and binge eating. Such conceptions of weight as focus issues, are framed in biomedical discourses and power dynamics that surround the body, and encase health in a system of weight scales and BMI criteria, that demonstrate preoccupation with assessing and regulating body size (Gotovac et al., 2018). This is seen at both ends of the spectrum in disordered eating more generally; for Anorexia, it is primarily the lowest body weights that receive treatment, focused on acute intervention when medically necessary, whereas other levels of ED care are often debated as to how and when treatment should be allocated (Geller et al., 2018). Equally with relation to Binge eating, from personal accounts it appears that only larger bodies have receive forms of treatment, albeit weight loss focused, reflective of evident high levels of BED seen in WLS candidates (Cella et al., 2019; Surgernor, 2020). Treatment at both ends of this scale centred on the body size as 'wrong' and needing to be either increased or reduced. This practice can be stigmatising for individuals trying to seek help, through categorising as either not bad enough, or providing tools that minimise the issue to the physical body.

The Medicalised body

Binge eating has low diagnosis rates in New Zealand and the participants all felt as if body size contributed to treatment options, lack of diagnosis and stigma around eating disorders. The implications of presenting in an obese body meant focus was placed on blame and weight loss by themselves and others. This focus on weight and supposed blame by medical professionals and society for being overweight contributed to all participants questioning their self-concept and identity.

Olivia was the only participant who disclosed an eating disorder diagnosis (BN), and used this process as a centre point of her lived experience story, and subsequent journeys within the New Zealand medical system;

> *I was diagnosed as Bulimic, many, many years ago, and then, I don't, I don't actually think I was really Bulimic because ah - mine was more just binge eating and it was all based around emotions and stuff like that so…[Olivia]*

Such statements that fight against a diagnosis, can appear somewhat contradictory to previous interview commentary where Olivia describes her childhood self as bulimic, however it highlights the nuances of disordered eating across subsets of behaviours, and importance of individual perspectives. Olivia also introduces the idea of binge eating as an emotional practice, in contrast to bulimia as a survival tool, positioning bulimia as something in her past against binge eating presented as an element of her current being.

> *I've always been a binge eater, always, always, always…even now I still do it a little bit. I try not to, I almost have to physically stop myself or just not have something… [Olivia]*

Similar to Olivia, Naomi struggled with categorisations of self across different eating disorder 'boxes'. it is unclear in her story, whether a professional diagnosis was present, or if through the interview she is unpacking her own personal classification across these different eating disorder realms, describing the presence of starving, binging and purging behaviours across different times in her journey;

> *[starving] definitely gave me a sense of self efficacy…like, I'm powerful enough to change, I'm powerful enough to make a difference…so I was torn yeah, it probably wasn't very healthy but you know like, that was a healthy message that I got from it, and then to go from that to binge eating, it's just, a huge fall from grace. [Naomi]*

Although she discussed versions of herself as being anorexic and bulimic in her personal accounts, the use of ‘they’ regarding Anorexics in the passage versus ‘we’ in relation to binge eating, places her affinity or self-categorisation as fitting primarily with a binge eating cohort, whilst exemplifying negative feelings she has about the behaviours, and placing binge eating at the bottom of a mental hierarchy of eating disorders, where anorexia is the pinnacle behaviour. The negative connotations she holds towards binge eating, appear to be internalised as elements of herself; that because she has undertaken binge eating behaviours she is therefore lazy, out of control and ‘failed’ her goal of becoming an anorexic.

> *anorexics are kind of like glamorized and glorified you know because they're like, they're gracious, they're beautiful, they're light…they can control themselves, whereas the binge eaters…we're slobs, we're fat, we're failures, we can't control ourselves [Naomi]*

Naomi’s perceptions of eating as a ‘lifestyle choice’ orientates control as being within the individual, in a way that Olivia explores in her experiences described in her origins story, in both how they feel out of control, and in how binge eating lives in tangent with stringent food control measures.

> *my body image, was just so warped, that I almost saw fat as a contagious disease… so like, I didn't even want to be near fat people for fear of catching fat or waking up fat one day [Naomi]*

Naomi was unique in her accounts of fat phobia and in the height of her binging and starving cycles created distance from “fat people” through fear of becoming someone in a large, criticised body. However, Naomi was not alone in not liking being in a bigger body. For example, Charles when he put on weight felt he had betrayed himself. Olivia, Āwhina and Eva disclose histories of intensive dieting, transitioning at times between living in larger and smaller bodies. Āwhina and Eva both describe feeling better about themselves and more like their genuine self is presented when in a smaller body, supported by Olivia’s accounts of feeling as though she was treated more positively when she was slimmer.

Olivia and Madilyn had the most experience with medical interventions in relation to weight, including experiences of either being denied or accepted for weight loss surgery, and both having been prescribed Duromine. What is an interesting contrast in these accounts, is that for Olivia, drug treatment was presented to her as an option, whereas Madilyn had to seek out such interventions from her GP.

> *I've been to lots of different doctors. I've been to dieticians…I've asked for surgery…and they've told me that I'm not fat enough…it's just circular, like it's just this thing and… nobody has ever, uhm sent me to get any form of counseling, there's - nobody gets it. ….[GP] gave me duromine…but I could still eat, so nobody addressed the eating…the weight was a byproduct of me binge eating, but it was never, it was never about that [Olivia]*

> *with the medical community…I never, ever thought that there was a way to seek help through them…I just thought that, you know every time I was going to see the doctor or something it was…just going to be more judgment…there was never, I'm actually going to go see my doctor to get help. Until I was like okay I'm going to try…, like I had the weight loss pills a few years ago, but it took me a year and a bit - about a year after I had [my daughter] to actually work up the courage to ask for them again. And I don't know why. And like my doctor was like great about it…it's like anything medically that I feel like I have wrong with me is all just blamed on my weight. [Madilyn]*

Madilyn found the thought of engaging with a GP as uncomfortable experience, where she senses her weight is seen as a place of ‘blame’ for health issues, in a way that isn’t presented for smaller bodies. Such narratives subtly place onus and responsibility on individual diet and lifestyle factors, even when seeking treatment for medical problems, or asking for advice. In healthcare experiences, this demonstrates presumptions that can come with size prejudice, and healthism narratives. Madilyn is also the only participant that has been offered weight loss surgery after years of seeing her GP about her eating and weight.

> *I started taking the um, the diet pills…which helped to kind of like kick my ass into gear, basically… and then I just was like, I think. I think it's long enough that I've actually been doing this, like the up and down weight thing so I went to her and I said Look, can you just refer me [for surgery]. And at the time they weren't taking*

> *referrals because of COVID… but then they emailed me like a few weeks ago saying I was accepted and they'll give me an appointment… [Madilyn]*

Even the participants (Elsie, Naomi and Eva) who identified as living in smaller bodies still felt the medical focus on was on weight, but as a reflection of missed opportunities of care, where issues with food are missed in smaller bodies. A lot of this narrative was positioned as BED not being understood even within the medical profession, where it is binge eating alongside poor food choices that leads to weight gain, and the weight is the focus of care.

> *honestly…there's still not that much awareness about it. It's always bulimia or anorexia, as sort of your eating disorders, you know, nobody says getting fats from binge eating and being out of control, they just say, getting fats from unhealthy food choices [Eva]*

Paula also discusses the topic of GP support by drawing a comparison between the acceptability of conversations regarding weight related medical conditions, such as diabetes, she's had with her GP, compared with never discussing her relationship with food. The participants paint a picture of topics that are or are not GP 'suitable'. Biological elements seen as located in the body, such as medication or surgical intervention for weight are accepted, but emotional relationships or struggles with food, such as disordered eating, remain taboo, linked to shame and fostering unspoken rules that as a society, we don't talk about that.

Relationships with food

Food is central to conversations around bingeing; often discussed indirectly, but always related to emotions. Narratives of actual binge events often go against somewhat stereotypical ideas that all food that is binged is high calorie food, or that there is a huge addiction to junk food at play, as portrayed in social media visuals explored in earlier chapters (Figure 1). While convenience foods are mentioned due to quick access and private consumption such as eating in the car, actual narratives around food choices are far more complex. For many, they are still trying to make healthier choices when they know they are about to binge. For others, any type of food available at the time will do, as it is the comfort or euphoria seeking, that drives eating patterns.

> *…I don't think my binge eating, is where I would say go to McDonald's and order like five burgers and just eat until I feel absolutely disgustingly sick, it's not that at all. It's more just like eating a whole extra meal… and I'm not hungry, there's no reason to do it…It's just like a secret meal. [Madilyn]*

Āwhina discusses how community settings are set up to help people fail when it comes to food due to impulse control. Many people reference McDonalds or Pizza as easy fixes for binge eating, or living in close proximity to either supermarkets or fast food outlets. This is an important consideration that may reflect higher occurrences of binge eating when food is more readily available, as there is no requirement to think or plan, rather the nature of food accessibility makes it easy to act on impulse and emotion.

> *the world has not been designed for, to stay thin, fuck it's hard…. I live in [town] we've got this entire strip of…street, and it's got um, nineteen. Fast food and bakeries and, yeah just, just places to get quick, easy, hypercaloric food. [Āwhina]*

Through such narratives we see that food is ultimately the vessel for behaviour, but the type of food is generally not a trigger for binge eating. Having said this, there are still narratives that come through around enjoying and loving certain foods. Finding enjoyment with food is inherently a human experience, and the complex thoughts of feeling guilty for enjoying food experiences, such as going out for dinner, because of previous binges, are damaging to individual abilities to engage in real enjoyment of foods. Instead, food becomes all-consuming, impacting not just on eating but socialising, work, thoughts and emotions. Joy of food is stripped away, replaced with emotional distress when in the throes of disordered eating, as every meal and mouthful now have a moral attribution attached. This is seen with stories from Elsie, Eva, Paula and Naomi in particular, who all discuss incidents with food where they minimise or avoid eating in public.

> *I didn't like going out at all. I hated being unplanned…I hated just been asked for dinner, I'd usually just come up with excuses, just for purely for the fact that I was trying to counteract for maybe five days ago binge or the night befores binge. [Eva]*

Food also begins to exist in patterns of reward systems for some, such as Elsie, where binge and restriction happens around work patterns. Elsie described how the role of work, allows for feelings of higher reward with food, because she's “earned it” through dance, but also recognises feelings of overconsumption and lack of control. These same attitudes towards food are mirrored in many diet cultures where foods take on moral values of good or evil, have points attributed to them, or place onus on earning treats or cheat meals;

> *when I'm restricting [m] like I'll be thinking about it a lot, like I'll be thinking about wanting food a lot and again food being something that has like a lot of like positive connotations in terms of that like, yeah like enjoyment that I get from food [y] so I feel like I'm not just restricting like nutrients but I'm restricting something that I enjoy doing… [Elsie]*

Due to such relationships with food, low feelings, or “the crash” after the high of binge eating, are described as highly emotions events, where feelings of guilt and regret begin to present. Food joy that comes with social settings or having a favourite food, appear to be intensified in episodes of binge eating in somewhat of a euphoric way, and then followed by extreme lows and self-depreciating thoughts, that lead back into passages of restriction and denial of social events and food enjoyment with others.

Social comparison when eating was mentioned by all participants. Descriptions of personal experience with food highlight a hidden culture of being away from “prying eyes” and judgement being a very real consideration in planning and executing binge eating, a secrecy that goes back as far as childhood for some, and where disordered eating is a very tightly kept secret. Binge eating is never seen by others, and rarely disclosed outside of key close relationships, such as a friend with experience of EDs, or through necessity when living within close proximity, seen for Eva when moving home due to COVID-19.

> *I didn't like the way I looked so my binge eating was always in secret, so nobody ever saw me eat. [Olivia]*
>
> *I don't think anybody ever saw me eating. Well, of course, eating but not like that, you know uhm, yeah you'd sort of just hide everything and act like it's all good and then as soon as somebody left or you're by yourself you'd just go full, full nuts [Eva]*

Paula’s story about camping with a family member, highlights how hidden many relationships with food are, and how for those managing disordered eating, this creates an incorrect perception of isolation and ‘wrongness’ of their behaviours because they do not fit traditional ED stereotypes

> *…while we were camping I realised, well to me it seemed like she had a really un- unhealthy relationship with food… unless you go on holiday with people or you go and live with them for some reason, you don't see people that, the majority of the day, so you don't - I mean it could be, for all I know a majority of my friends have really unhealthy relationships with food, but I wouldn't know [Paula]*

Seeing someone else’s food relationships in this context, appears to give Paula a form of positive reinforcement that maybe her eating behaviours weren’t so abnormal. Social comparison theory would suggest we do compare ourselves to others to make sense of the world, but when it comes to disordered eating often this lens looks at body objectification and role of social media (Tylka & Sabik, 2010). This research would suggest social norms of eating as well as type of food and body image are important factors in binge eating.

Mental wellbeing

Within the interviews, participants began to pose a natural question of whether binge eating is the central problem, or symptomatic of other underlying ideas, such as repressed trauma, or unacknowledged mental distress. Ultimately, struggles with mental distress were conceptualised by participants in two key ways: firstly, the perspective that binge eating leads to mental distress (section one), and secondly the view of binge eating as a symptom of wider mental health and other issues such as coexisting conditions (ADHD) or high stress situations, both historic and current (section two).

1) Binge Eating & Mental Wellbeing

> *Binge eating, I think it also leads to depression...some mornings, it was…pretty heavy you don't, you don't want to go to work…you kind of didn't really want to be there. I think I actually wrote…that down once…you just sort of feel like the, the world's sort of caving around you, so you've got to think that with binge eating, it's not just the food but it's also their mental state is, is quite damaged and quite low….so you've got to have some sort of support system for that. [Eva]*

All the participants mentioned feelings of shame, and isolation due to their binge eating. Binge eating is a lonely journey, where much of experience is hidden, subject to stigma based on body size, and where hierarchy of eating disorders contributes to feelings of isolation, alongside mental health experiences that in general can leave people feeling marginalised and alone. Naomi talks about how she felt very alone in her mental health with binge eating and compared that to her partner's recovery from drug addiction and Narcotics Anonymous meetings.

> *I've been to a couple of Narcotics Anonymous… and just hearing the story you know like hearing that - it's like when you're, yeah I guess like when you're a binge, binge eater, where like when you um, when you suffer from mental health issues, you know, you feel like you're the only one you feel like, you feel so isolated but, hearing all these stories from different people, all comparing common themes you realize that it's very common, and you don't feel so alone anymore. [Naomi]*

Causes of binge eating were mainly internalized and perceived as personal responsibility or lack of discipline. Common narratives were around negative thoughts of self, struggling to find something they are proud of in themselves, linking eating behaviours to negative character traits of self, feelings of failure, thinking they are weak, incompetent, or undisciplined, resulting in low self-efficacy and self-esteem.

> *I judge myself so poorly. But particularly when I'm fat oh fuck [sigh]. Yeah, there's not a lot of nice self-talk going on. [Āwhina]*

2) Binge Eating as a coping strategy for distress

The participants also reflected on binge eating as a symptom of other factors such as trauma, life events, co-existing mental health issues and social media messaging. This is framed around notions of stigma and understanding of mental illness and disordered eating.

Charles reflects such ideas of mental health in descriptions of anxiety, depression, social isolation and suicide rates among his male peers, all elements that are really impacted by lack of social connection, and gendered understandings around mental health that present the stable male body as the norm, and construct particular mental health disorders, such as eating disorders, within a feminine stereotype (Keane, 2014; Boysen et al., 2014). In contrast Eva views social stigma as improving for mental health, reflected in wider narratives of reaching out for help and support, and reduced negative perceptions around taking medications to support mental wellbeing,

> *I think that there's a lot a lot more in that [mental health] space these days, and so many people speaking out about it so many people on, we call them our happy pills. My mum and - my mum she's on them [y] - And yeah, just the different, like, who the hell cares? whereas before it was like, oh my God, you cannot be on those… it just makes a huge difference…. it's not a big deal. [y], whereas before, was - it was hugely stigmatized [m] and if you had anything like that, it was like wow, you're pretty weak. Whereas now, I'm like, go and get it. [Eva]*

These accounts demonstrate gendered views around changing mental health acceptability, appearing more so in Eva's account than for Charles, who described how his relationship with binge eating formed in a time where mental health remained a taboo subject that wasn't discussed, presenting barriers for him to form alternative coping strategies or engage in more positive narratives around mental health

> *when it got really bad. Like, I would still go back to that [BE]…And I think cause like, I never grew up with, like, a concept of like, mental health…I remember being fourteen and being like, "I think I'm depressed". And they're like "depression doesn't exist"… And so I think growing up with, like a conception of…you just have to get through it…… I don't think like the binge eating was like, just all of it. I think it was more like a symptom. Which is, what I understood about it, eventually. [Charles]*

All the participants discussed affect, eating and food. Including a positive aspect to this such as comfort from food which has played a role in many people's lives from a young age. Contrastingly, negative affect itself is often described as pre-empting binge eating episodes. Regardless of the emotion, binge eating was used to cope with and control life by all participants.

Naomi provides a powerful imagery description of the comfort that binge eating can provide, in her origin story she compares binge eating to feelings of having a hug from the inside. In the same way that Naomi describes comfort in food, she also references using alcohol as a coping mechanism. Whereas Charles talks about alcohol and drugs as not being his coping mechanism of choice, rather food is placed as the central outlet for emotions.

> *I used to call alcohol my guardian angel, you know like , because there was a wall between me and my pain…and I felt like binge eating, is probably the same. [Naomi]*

> *I've never been like a drugs guy… and some people just like, have a problem that like, they just they drink heaps, and it's just their thing, none of that was ever really my thing. [Charles]*

Naomi presented feelings of conflict between rational understanding that an eating behaviour was damaging to both her physical and mental health, but also recognizing how as a tool it helped her to cope, made her feel supported, and allowed her to put all of her emotions, difficulties and sadness into something she could control. This was reflected in narratives from other participants, such as Charles, Elsie and Eva.

> *binge eating kind of gives me something to focus on…it's something that I can, I can deal with it's something that I can…identify, something I can like grasp, really…so it kind of gives a shape to my grief and sadness. [Naomi]*

All participants disclose binge eating as being at its highest in times of low mood, trauma or at times of life transition. Specifically, for Madilyn and Olivia, postnatal depression was one of the main events where binge eating was at its worse.

> *I had postnatal depression…that was a lot of what made my relationship really bad with food [Madilyn]*

> *I got really bad postnatal depression, I lived with my mother, who was... a fucking nightmare, I was trying to work. I was trying to function as a human being. My ex-partner had hooked up with a chick that lived around the corner from us… it was just fucking hideous…So I - food was my friend.[Olivia]*

Stressful life transitions also played a role in binge eating occurrence, in particular leaving home, having interpersonal relationships that weren't supportive, or the ending of romantic relationships, described by Eva, Elsie, Charles, Paula and Naomi. These periods of high stress were identified as being 'triggers' for binge eating. On a more daily level, everyday life stressors such as work, life, studies, holidays and family commitments also played a role in times where binge eating appears to increase, participants also found they would get stuck in cycles of body negativity, provided through descriptions of body hate and embarrassment, that increased participation in binge eating, often alongside social withdrawal, and led to further feelings of body dissatisfaction, frequently resulting in engaging in periods of restriction, or less commonly purging, after binge episodes.

> *Sometimes, there is still the odd, odd occasion where if I am by myself or am really stressed, I'll definitely reach for something [Eva]*

> *even to this day…I was really, really good and I lost a lot of weight. From about this time last year [July 2020], to…like almost just before Christmas. And then I kind of just was like okay cool, it's Christmas like I'm not going to be really restrictive,[m] like and it's like, I have to be really extreme so it's like really, really restrictive. And then let's go back to eating. and just eating whatever I want… what I can't understand is, I'm like completely a control freak, so I don't understand it. I don't know why I can't control that one part of my life. [Madilyn]*

The messages presented of having somewhere for their pain to feel focused and to feel some level of control over body and mind, can be at odds with the feelings of disassociation that appear during binge eating episodes, and an important highlight of why restriction in binge eating plays such an integral role, a role that in much official BED literature is overlooked; where binge eating and weight are seen as intertwined, restriction appears to go largely unacknowledged within care approaches for BED (APA, 2013). Mental health is encapsulated throughout in how participants relate to food, for some the binge eating is seen as the central cause, and of for other binge eating is placed as a coping strategy when faced with an emotional reaction. Mental wellbeing as a whole was presented as something that had also been a long-term struggle for many participants. This is reflective of literature that shows high rates of comorbidity and suicide ideation for BED (Keski-Rahkonen, 2021), and may reflect a wider epidemic of deteriorating mental health.

Recovery, Management & ‘Living with it now’

While no participants had a formal diagnosis of BED there were narratives of recovery and self-management. This section discusses these; firstly, on medical interactions when trying to access care (physical and mental), then moving to community tautoko (support) and changing approaches to support. Secondly, I discuss other strategies that have helped participants. No participants described a particular end point where they felt or feel fully recovered, but rather present stories of treatment seeking, ongoing management and self-care.

Access to Care

All participants have engaged with seeking physical or mental health care at some stage in their binge eating journeys and all discuss there is no clear pathway to care. Barriers to reaching out for GP care exist, such as feeling like their concerns won't be taken seriously because of body size, or due to mistrust in the system that there won't be positive paths for treatment. All participants have also been subjected to stigma in these interactions. Stigma is prevalent through power structures that shape medical access and care availability in New Zealand. Located within a neoliberal societal structure, institutional changes and healthcare policies have advanced interests of finance, further dividing society into classes and resulting in resource scarcity and disparities, alongside increasing demands for decreasing health services (Barnett & Bagshaw, 2020; LaMarre et al., 2019). Such classes of care are reflected in participant narratives of privatised care access, where the financial privilege of being able to afford services appears to be the predominant route to intervention available for disordered eating.

> *I hope that there is access to care, because there isn't right now. Uh, there's certainly no support. Although Facebook tells me there's lots of support out there…But there's no social services available for people with binge eating disorder, There's nothing. God there's barely anything available for anyone with anorexia. It's just these, these psychological disorders, it's just, you know it's popped in the old, too hard basket…And unless you've got pots of money to go private…You get shoved down to the bottom of the list. [Āwhina]*

Barriers in the medical system are also apparent in that GP care isn't perceived as personal or familiar. Trusting relationships appear important in all areas of interpersonal relationships and recovery, and not having an allocated and trusted GP, can cause fear of being judged or not taken seriously by someone who doesn't know you, and only sees you for a short period of time. It is not uncommon for clinics in the Auckland region to be structured in this way, where patients see a range of GPs depending on availability at the time, partially required in a system that is designed for efficiency in neoliberal structures that position GP clinics as private companies with financial targets.

> *I guess probably I didn't speak to my GP because in Auckland, I never really had like 'A GP' it was always like different ones, so I never really had a relationship with any of them to feel like I could speak to them about that.” [Eva]*

Alongside structures of Primary Care, medical conceptualisations and diagnostic criteria of BED play into prevalent narratives of stigma, even in latest DSM-5 changes (APA, 2013). In diagnostic criteria for BED, restrictive behaviours are limited to subsets of explanation, stating that dieting may follow binge eating, but not that dysfunctional eating precedes binging, in comparison to bingeing concepts in AN or BN (APA, 2013). This is not reflective of many lived experience accounts of binge eating practices, especially considering that recruitment questions were based from DSM-5 criteria. Self-accounts describe behaviours that fit with diagnostic markers of BED, alongside other disordered eating behaviours. Āwhina, Eva and Olivia, all self-identify in interviews as having BED, and all three discuss periods of significant restriction alongside binge eating, that moves beyond normative descriptions of dieting.

> *it's just - it's exercise and eat 1000 calories a day, or it's eat 4000 calories a day and sit on the couch…when I refer to me being "on" which is me getting up at six, power lifting, going to CrossFit, running doing whatever [y] and eating, like, you know, good food, but not really a whole lot of it. That's what I consider healthy. [pause] I'm not sure if the rest of society would agree with me…because I track and measure everything that I eat…and It's like a switch…and I don't know what it is that gives me that kick up the ass to go Jesus look at yourself…but it happens…so now I have my 1000 calories and fast for 20 hours a day…I feel more disciplined, [pause] and that sort of reflects on everything else I do. [Āwhina]*

Participants also discussed other avenues of formal treatment. This included support for weight loss, depression, trauma, parenting and for Olivia treatment for BN and for Āwhina and Eva, seeking treatment for Binge Eating . Key medical professionals that are described in these treatment pathways include GPs, nutritionists, dieticians, counsellors and therapists. All participants engage with different personal approaches to treatment seeking and discuss what was helpful or ineffective. However, while there was acknowledgement that systems of care that allow for earlier intervention would be a protective factor for improvement and recovery (Wacker et al., 2020), there was awareness of a lack of resources.

Āwhina, Olivia, Madilyn, Naomi, Eva and Elsie all advocated that having more disordered eating specialists in nutrition (dieticians) and therapeutic spaces that have specialised training in BED, would create more inclusivity for binge eaters in treatment, alongside AN and BN. Through her experiences, Āwhina found that support services, even in the private sector were not adequately informed about BED, a situation that she hopes can be improved for others in the future. This was a sentiment reflected by Eva, when trying to access nutritionist care who also found services to be lacking in BED related knowledge and support strategies.

> *So there is a real shortage of psychologists, and the psychologists that I have been in contact with don't specialize in eating disorders. So, you know it's a bit of a rock and a hard place so when you go and try, and I'm in a really lucky position, I have the income to go and, to go private. [y] but I can't. [Āwhina]*

Āwhina also presents an instance of barriers to treatment in her descriptions of a conversation with her GP, within a narrative of having to advocate for her binge eating severity and need for treatment, ultimately not receiving support beyond words of encouragement, and ending up taking her own path of treatment; first with a psychologist, and then through self-management, alongside ongoing diet practices

> *I told her [GP]…I've got binge eating disorder, and I… I know I need to go and talk to someone about it, and. She congratulated me for having the insight to go and talk to a psychologist…and she [GP] said, well, have you ever tried being a bit kinder to yourself? I said when I'm kind to myself I give myself Magnum ice creams and cupcakes. So, no, I don't need to be kind to myself. And I said so never mind, I'll go and fix it myself. [Āwhina]*

Olivia described how over the years she had many conversations with GPs for support with both weight and for her diagnosis of BN. Having engaged in treatment across both focus areas, she describes feeling as though treatment at all stages primarily focused on weight; either gain or loss depending which body size she was presenting in, but ultimately reflected a lack of mental health support that she indicates as something that should be available, also viewed her treatment in health care interactions as leaving her placed in the “too hard” box, a sentiment reflected by Āwhina and Eva in their accounts.

> *it's almost like they [GP] want to give you a [eating disorder] label so that they can make you go away. So "oh, you've got a label cool, so you can fix it right?" …You don't have to see anybody, you don't have to talk to anybody. But you have to label so you, you're sorted… I um went to a doctor when I was living in [town], and said, I need to lose some weight I'm really struggling…I was like I'm really struggling with the exercise and I work full time and I've got a kid…So he gave me Duromine." [Olivia]*

Such narratives reflect notions that if it can be medicalised, it can be treated, and if it cannot be medicalised easily, that's where care options tend to stop. As demonstrated by Āwhina, gaps in treatment are attributed to lack of knowledge and resources to support EDs that fall outside of AN or BN, reflecting wider narratives of ED stigma and hierarchies of EDs in care (Brelet, et al., 2021). Aside from the critical medical level treatment, there's limited focus on the management of disordered eating. Such descriptions are important to understand within its wider social context of diet culture that places primary focus on BMI range, and not wider parameters of health. In medical care**,** there is discrimination evident in treatment for people based on body size (Browns-Bowers, 2017). This is highlighted by Olivia in regards to treatment approaches when she was living in a skinny body versus when she was living in a larger body

> *nobody gave me anything to make me eat either. Which was interesting. But they're the first to hand out pills when you're too fat. [Olivia]*

Improving access to care was presented as an important factor that individuals wish had been available for them. Recommendations from interviews included; increased accessibility to services and resources for binge eating and other EDs, mental health services as a protective factor, and improvement in GP dialogues, including culturally appropriate and New Zealand specific frameworks of care. Participants reflects on how GPs could provide appropriate support and care which was predominantly moving narratives away from weight to psychosocial and cognitive factors. Olivia highlights how conversations could have been positive for her, if engaged in a different way by her GP.

> *more of the why and probably something like, how about we actually get you to talk to somebody who understands - not naming it. Don't say…"You've got bulimia" [y], go okay, so you've obviously got some sort of issues with eating, don't even call it an eating disorder, whatever [y]. But, you've got some issues*

> *with eating and how about we actually get you to talk to somebody to figure out what those underlying issues are…you fix the underlying issues and all of this other residual shit goes away. But no one cares about that. Doctors don't care about that. [Olivia]*

Moving the dialogue away from weight could also allow more space for honest conversations with GPs and other health providers. Thoughts and feelings around food have a place in most of those conversations, and this shift may also help people in ‘normal’ sized bodies, be able to broach these topics with GPs more easily. When mental wellbeing becomes central to the conversations, weight becomes one of many factors, allowing conversations to shift towards holistic wellbeing.

> *I hope that it's like, more accessible, I hope that there's not like that people actually like talk about it and ask them questions. It's not just, okay, your weights high… your blood pressure's high or you're borderline diabetic or, you know, stuff like that and it's like okay well let's talk about why, [y] what's going on, like what are your eating habits, but like without… I guess it's hard to do without shaming people. [Madilyn]*

Mental health support was described as lacking across the board in relation to binge eating. However, positive access to mental health included having a place to talk about experiences of trauma (Olivia) work on depression, anxiety or low mood (Elsie & Naomi) or learning to manage conditions such as ADHD (Charles), all appeared to provide more positive experiences, which in turn supported eating behaviours around mood, more than portrayed accounts of reaching out of food-specific support.

> *I haven't really done any like active work in my relationship with food, but it's just in the relationship with myself becoming better. That, I think, yeah. It has impacted my relationship with food [Elsie]*

For Elsie, the transition into adulthood was a time where she begins to push for change in the dynamic between her and her mother, which is told through story and anecdotes of conversations they’ve had, where she places herself as being the agent of change, responsible for shifting the dynamics in their relationship around food, and discussed a time that was a pivotal moment in her journey with food

> *I guess just now as more of an adult and more aware of things that I'm starting to realise…I have said to her [mother], I was like just don't comment on what I'm eating or how I'm eating or when I'm eating like I just don't need that from you [Elsie]*

In her accounts of transitioning away from binge eating patterns, she highlights her changing values, prioritizing different aspects of her health, and the positive influence of becoming older and becoming more secure in herself. There doesn’t appear a key event or time where she can recall that influenced her to think differently, rather she describes it as more of a gradual change in personal growth, although binge eating remains something that is part of her life and eating, however the way it used to impact and invade her life was much more intense.

In these instances, improvements in relationships with food present as a secondary factor through improvements in management of their mental health. Therefor receiving support for their mental health in some contexts was helpful, particularly during life transition, moving coping strategies away from binge eating, and providing a form of care access that may not be tailored for eating behaviours, but is better received than support services that claim to be tailored to eating but often fall short.

Community

Theme of accessibility to care were re-occurring points from all participants, particularly a lack of designated places for binge eating support. Community group settings, where people can share experience and form supportive communities, led by people who have understandings of disordered eating, was highlighted as a protective factor. For such spaces to provide adequate services, it would be beneficial to not require people to have been given an ED diagnosis, to reduce gatekeeping of care seen in other areas of support. Health frameworks such as those seen in addiction spaces, were also viewed as having potential to be tailored to disordered eating spaces, as current networks of support outside of weight loss settings are lacking.

> *it'd be nice to first have a place where you can go to, to talk with others about it…and somewhere definitely New Zealand wide as well I think just makes a huge difference…Yeah, just, more, more accessible…and then maybe just a bit more. The range of knowledge, spread about binge eating. I think it's still just a bit swept under the rug as well. [Eva]*

Many of the interview participants disclosed wanting to help others as a key reason for their participation in this study. , and creating this community was conceptualised as important to recovery and management. While this advocacy for change was altruistic it also served a purpose in creating meaning from their experiences.

> *I hope that my journey is going to give me enough knowledge to help others, particularly in my community, where, you know, 80% of them, are overweight, obese or obese class two or three. Uhm, it's incredible. Even the kids are fat. It's horrendous. So yeah, I, I would like to think that I will learn from my mistakes. [Āwhina]*

The desire to support the wider Binge eating community, is reflective of a need for more safe spaces removed from fear of shame and stigma. This would allow people to fight against ED stereotypes, improve knowledge and understanding, make a difference, and for some provide self-education and understanding.

> *no harm in just trying to help out, you know, especially for future people who would go through it [binge eating] like, it was a really tough time. And if I can sort of help anybody else get through that a little bit easier, or a little bit quicker…that would be awesome. [Eva]*

Community involvement and activism can lead to finding worth outside of weight and appearance.(Wacker, 2018). Online spaces can provide places for community voices, where people experiencing disordered eating can make sense of and manage their health and own recovery journeys). Narratives on social media in relation to disordered eating and recovery, depict images of bravery that may inadvertently present messages of body profiling and stigma that reinforce ED stereotypes rather than creating inclusive spaces (LaMarre & Rice, 2017). Narratives portraying individuals as brave (similar to narratives seen in disability spaces), although warranted, continues to be reflective of the wider social narrative that is not acceptable to be struggling with binge eating, or to present bodies that go against the norm, such as fat bodies. Despite the stigma narratives that online spaces can perpetuate, they can also offer a space for agency, education and validation as seen for Madilyn

> *the only reason I know about it [BED] is…maybe like a year or so ago was that I started following somebody on Instagram. And that's the only reason I even was like, oh yeah, that's a thing…other than that, like, the eating disorders are, bulimia or anorexia…there really is kind of disorders for that other side of the*

> *spectrum…for low weight and for high weights…and I don't think a lot of people realise that. [Madilyn]*

Communities of support, in eating disorder literature, predominantly focus on communities of lived experience , however Charles demonstrates that other communities, such as comedy clubs, can provide connections and outlets that can support a positive recovery journey. For Charles, this helped him to engage and challenge narratives about himself and society in a forum in which he felt safe and seen, as an outlet for some of the darker feelings or emotions, and how through creating jokes it led to a realization that his relationship with food had begun to deteriorate again. t.

> *I've been doing like a lot of comedy shows. And I think like, just me as a person. Like, I'm always, I always have an affinity for like, the deep end, like the dark and like the fucked up. And, you know, my own life has certainly been turbulent. So, I think I've always been like, I've always talked about stuff… like, affected me, or like, my views on stuff… So, I was doing all these shows… but didn't quite notice just how like, the more I joked about it [eating], the more I was just like, Oh, this is actually something that actually bugs me. [Charles]*

To create sense of belonging, people must feel they have a place where they can connect and affiliate with people that support their identification in a positive way. As Allport puts it, categorization is inevitable and innately human, and "the sense of belonging is a highly personal matter" (Allport, 1954, p.36) therefor we place our own human experiences within categories, the same way in which medical practice categorises disease and disorder. Even fighting against such distinct categorisation is one in itself, as placing the self as 'other'. This complexity, can make it difficult to foster safe care spaces for people with disordered eating, based on prejudices that exist in relation to EDs that are both cause and consequence of such stereotypes (Dovidio, 2005).

Alternative approaches

Āwhina's story stands out from other accounts in how she presents her narratives of binge eating in relation to her community, challenging notions that binge eating is an individual problem, but rather reflective of macro social systems, acknowledging the wider epidemic and disproportionate levels of disordered eating she sees for Māori (Lacey et al., 2020). From this perspective, Āwhina's whānau and community take more of a central focus alongside personal accounts, as reflective of wider cultural issues around trauma, food and obesity. As she talks about her own experience, she continuously relates the concepts to experiences of her local whānau and community structures, presenting ideas as to why wāhine reach for kai (food), and how communities are structured to promote unhealth eating patterns, to demonstrate there's a wider context of binge eating within culture and community that challenges outdated notions that place disordered eating behaviours within the individual.

> *And so, particularly for my whānau there is um [inhale] a heap of sexual abuse. And that's where a lot of it was triggered from for them, not necessarily me. But I, I was ignored as a kid, and I think that's where I get it from. So to make myself feel better. I ate and ate and ate and ate…I've spoken to one cousin about it [m]. And I basically I just went through the diagnostic or the DSM-5. [y], and I said, so this is me, cousin, and I struggle with food and so. and then we got to talking and so does she and she reckons that, um you know, a couple of cousins, two doors up the papakāinga struggles as well, and it's unsurprising really because you know, sort of as a race Māori are getting fatter and fatter and fatter. [Āwhina]*

Āwhina challenges current models of care, aligning her experiences as a means to, not only support her own growth and recovery, but focuses on how this may also support Māori communities to do better together. Advocating for Kaupapa Māori lens and culturally appropriate approaches, focused on the importance of "kanohi kit te kanohi" (face to face) support. She presents an alternative viewpoint on how GP practices could be restructured to align with Māori models of health, such as Te Whare Tapa Wha (Durie, 1985)so that if one area of health is out of balance, then it can be supported by others to rebalance. The disordered eating then becomes seen as more than just an internal flaw, but a part of larger holistic health that can be supported by whānau, community and health care professionals to be renewed. Such approaches seem lacking in current care, where resources are extremely limited, especially in the face of COVID-19 structures of working that have led to medical care platforms transitioning to virtual care models in many instances,

> *So my doctor… She goes, Well I actually want a weight loss clinic, and what I want is a dietician/nutritionist, an exercise professional, her being the GP, and a psychologist, because she reckons they're the four cornerstones of weight loss… and I, I totally get that model, I said, yeah, but that's a very western model…and I said, so you're going to need. Um, a Kura Kaupapa approach. [Āwhina]*

Charles was also a point of difference being the only male participant and from Latin American heritage. Often disordered eating is framed in relation to the female voice, especially white, cis-gender, heteronormative bodies (Boysen et al., 2014). Charles' viewpoint is important in breaking down barriers for men in discussing and identifying with eating disorders, providing a perspective in which gender roles and social expectations of men ultimately impact on relationship with food and experiences of binge eating. Charles' experiences highlight different expectations for men, that permeate into perceptions of self and behaviours with food. He also describes a journey of ADHD alongside his experiences with binge eating, an important narrative when considering high comorbidity rates for mental health conditions with disordered eating, and the biomedical factors seen across both ADHD and binge eating in recent research (Bleck et al., 2016; Guerdjikova et al., 2016).

> *especially growing up…there was always this pervasive uh, you know, sentiment…and I was told this so many times growing up…you're a man, you're gonna have to provide for people, you're going to have to be the rock that people rely on…you don't get to have mistakes. Because everything you do in your life is a prerequisite for the next thing….Because the way that you are going to, like get through to people is by being valuable…[Charles]*

The narratives presented by Charles and Āwhina, ultimately reflect differences in social constructions and expectations for men and women across different cultures, but equally exemplified how disordered eating presents in similar ways such as secret eating, and feelings of shame.

'Living with it now' (personal strategies of care)

Participants generally view engagement in treatment as an ongoing journey, where once size fits all approaches do not work, and like binge eating, engagement with care ebbs and flows around times of higher weight, or higher mental distress. Because of this, many found themselves going outside of traditional primary care pathways, to find their own approaches to treatment and engaging in a range of different methods. Managing binge eating is presented as easier when individuals have worked on their mental wellbeing, have an improved knowledge of nutrition, and are in stages of life that they see as positive, such as being in a supportive relationship, having good friendships or becoming a parent.

> *I tried a lot of different ways so I tried um, to have like a healthy social media type account... I tried to get in touch with a nutritionist who said she'd been through the same thing but I obviously don't think that she had, [m] Because she just didn't seem to understand. Uhm, I tried reading books, the only thing I probably didn't try was actual, actual counselling, I obviously reached out to my friends and family. [Eva]*

One of the key narratives in Eva's account of overcoming binge eating were her changes in discourses around overeating versus binge eating behaviours. When comparing how she engages with food now, Eva presents a positive difference in emotional reactions and self-talk between the two modes of eating. Eva also credits having supportive relationships with her partner and family, as a positive factor in helping to reduce her binge eating.

> *definitely just proud as well that I've just overcome it. I just, I never thought I actually ever could, people always said that you can but at the time, you know, you're like, oh yeah, I've lasted a week and then you just sort of fall off the track again… I myself can now find a difference between overeating, and binge eating…and I don't tend to beat myself up about it either anymore, whereas binge eating, you do it, and then I'd most likely go to sleep and then in the morning, I was just such a mess that I'd, you know let myself do it [Eva]*

What has worked for others in reducing binge eating was allowing themselves to take restrictions away from food, and unlearn labelling of food as good or bad. This is exemplified by Paula, who although still describes weight and dieting as something that continues to play a role in her life, she also recognises how she is able to engage more in social eating than in the past, and find more enjoyment with food when framed as nutritious, valuable and enjoyable.

> *…I do think that I value, healthy food… and I yeah, I think that I've… Over the years, realized that foods not all bad, and that, that there is a place to really enjoy food…and I also know that I enjoy it more if I know that it's healthy. So yeah, I think that that's, that's definitely something that's, that's come out of that… [Paula]*

For Elsie, living with restriction and binge eating in a more positive way, is intertwined with managing her mental health, and her self-talk. Being able recognise the small wins with food, such as being able to eat more comfortably in social situations, approaching food with less guilt and being able to leave food when she is no longer hungry, are viewed as positive signs of improvement.

> *One would definitely be like…if I'm like going into a, you know…a kind of depressive episode or something…recognizing that food is a, is an outlet for me for that. And that it's in those moments, I almost like bypass all those other thoughts that I have about food…and I am so proud of myself in these moments of being like, I need this, my body needs this…I think I'm really proud of myself for that moment of being able to not have those thoughts of the "I should or I shouldn't, or "I want this, or I don't want this" like I think that's a moment for me…[Elsie]*

> *I bought a bag of lollies from the supermarket and I didn't eat it all in one go … I'm like oh I did it! like, you know [laughter] that's a win. [Elsie]*

For Charles, improvement in his mental wellbeing, alongside learning new ways to engage with himself, and to value himself helped him to re-engage with not only food, but his life in a more positive way.

> *the thing I'm proudest of, I think… there's that quiet bravery, I think that I found in deciding to reengage and genuinely being like, terrified for like, the first time in a long time, you know, because I was just like, yeah, I wanna engage in things, I wanna like experience things. I want to meet people. I want to do stuff. [Charles]*

For Madilyn, her experiences of binge eating were framed positively in how she now manages her eating and food narratives at home for her daughter, as well as reduced feelings of shame when she does engage with binge eating behaviours.

> *actually, being able to be more aware of like her [daughter] relationship with food as well…yeah, I guess, Just the way that I feed her … but also I guess like, not to be in denial…I definitely still have like moments of binges at the moment but there's less shame around them, and there's less hiding them, as well, like I'm being a lot more open with things…with the weight loss surgery as well [Madilyn]*

Olivia describes a long journey of self-discovery alongside her binge eating, where becoming more self-aware, and being able to talk about her experiences without shame . Like the other participants, being able to leave food, and changing narratives in her head from restriction, to moderation has helped.

> *I came out of it quite self-aware. Like, I know, like it's taken me a really long time to get where I am. But I, my biggest thing is I will talk about it… the fact that I will talk about it and I'm not afraid of talking about it…you know, and if you don't talk about it, people don't understand that there are other people out there with*

> *experience and then they think they're the only ones and that's when shit goes downhill...[Olivia]*

For Āwhina, her descriptions of binge eating placed these behaviours as a large element of her life, and continuous journeys towards management and recovery. At the stage of our interview, Āwhina presented as being in an “on” phase of dieting, whilst continuing to look for additional binge eating support, and engaging in online education such as BED podcasts and audiobooks, noting that she has more information now than she’s ever had about BED, and hoping this will help her continue to get closer to her goal of breaking ongoing cycles of bingeing and dieting.

> *God, I haven't done that [binge eating] in a month, so that's good…Yeah, so that's a win as far as I'm concerned. That's a win.[Āwhina]*

Mental health plays in many of these stories, a central role in journeys of treatment experience and later recovery or management of binge eating behaviours. For many it was through journeys of improving mental health, that participants discuss being able to improve their relationships with their body and their eating behaviours.

> *I now see like a counsellor, regularly…I haven't really done any like active work in my relationship with food, but it's just in the relationship with myself becoming better. That, I think, yeah. It has impacted my relationship with food [Elsie]*

Charles, Olivia and Āwhina also all describe engaging in therapeutic intervention with a therapist or counsellor, with mixed results, however Elsie and Naomi’s stories appears to of had the most impact on their eating practices. For Naomi, there appears an interesting dynamic at play in her description of feeling supported; through her family relationships and in her role as a mother, in a Narcotics Anonymous setting, and through other avenues such as support from psychologists and psychiatrists, demonstrating a positive example of having multiple levels of care available.

> *I saw some psychotherapists… I go see a psychologist, so yeah, so that really helped me work through you know…how to satisfy the emotional need without resorting to coping mechanisms. [m] And after I had my son you know I had to do a couple of parenting courses where they talk about attachment and stuff and I*

> *could start seeing parallels between myself and you know, I guess I can get in touch with my inner child, a little bit more [y] and sort of healing that. [Naomi]*

For Charles, his journey in treatment ultimately led to self-management and discovering his own path towards recovery, alongside changing his physical surroundings by moving city and re-engaging with family relationships

> *never said anything to a GP. I went to a counsellor a couple times, saw a psychologist once. But I think it was kind of my own hurdle, because I walked out of there feeling stupid, and then I was just like, I can do this by myself. [Charles]*

Personal Agency

For all participants living with binge eating, changing self-talk and relationships with food in positive ways was linked to increased personal agency. Research suggests that focusing specifically on a sense of **agency, empowerment, and connection with supportive others**, has consistently shown to have benefits against eating disorders (Wacker, 2018). Participants demonstrated this in a range of ways, including empowering themselves in conversations around medical care and personal treatment seeking, connecting with others such as parents and children in a positive way around food narratives, and improving self-talk and personal education. Re-claiming power over identity is also seen in how individuals present their own disordered eating journeys and conversations with others; for example, Olivia actively presents herself as having BED, instead of accepting narratives of BN provided by others, and Āwhina engaged with the DSM-5 diagnostic criterial, telling her GP that she has BED, rather than passively waiting for her GP to decide how to categorise her experiences of eating.

An element of personal agency explored is finding the courage to acknowledge that there is something that participants want to change in their eating behaviours, and that they have the power to do so. As part of improving their binge eating, participants present how they developed alternative coping strategies for themselves to take autonomy over their eating, presenting efforts of channelling feelings of power and control into other areas of their lives that they saw as a more positive outlet, such as personal health journeys, education, motherhood, careers and exercise.

> *think it's hard to give advice to young people, because you still have that mindset that the whole world's looking at you…I wish I could just say, just go talk to somebody. Like, it's not shameful. [Madilyn]*

How individuals begin to change their self-worth identities, impacts on how they decide to re-engage relationships, eating patterns and community. Altering how they place value on themselves, helps individuals to view themselves in a new and more positive way, and also increased levels of empathy and compassion with how they approach others. Moving value away from appearance and onto other areas of being is inherently difficult to do in a world that tells you differently daily, however, it is a factor that clearly plays into individual narratives about recovery and management of binge eating.

> *growing up, I guess, I had valued a lot based on results. But beginning to value myself based on inherent things I think… that quiet bravery to extend that compassion to other people…[Charles]*
>
> *I would just say it's…to do with my mind, my mind space. Since coming home [during COVID] having a partner…Yeah being with people, people around me who love and care for me... that was when I just found happiness I guess I don't know. [y] Yeah, I just felt better in myself [Eva]*

This section has highlighted that for many, steps that have been taken towards recovery have been through informal channels, self-referral, or as a secondary result of help-seeking for other areas of mental health. There are also mixed views on which intervention was helpful; for some, nutritionists were valuable, and others therapists, while GP support was viewed as supportive in terms of managing weight. However, majority of narratives present in this chapter, reduce GP capabilities for disordered eating to prescription of medications or surgical intervention, reflecting a wider view of discomfort and mistrust, not in the GP as individuals, but in the wider social systems. There is a perception before individuals even see their GP, that they will be unable to provide sufficient care pathways, and barriers exist that stop individuals for reaching out for care GP in particular.

Majority of participants also presented recovery as work in progress, still strongly tied to diet practices and weight culture. Participants naturally discussed factors of risk and protection as part of conceptualising their own personal journeys of management and recovery. Ideas of recovery included; ability to leave food, no longer hiding eating, being able to go out for meals, finding self-worth outside of body size, managing family comments on body size, no longer fearing food poverty, being able to stay in ‘on’ mode of dieting, improved knowledge of disordered eating aetiology and behaviours and being able to find other outlets for distress and emotions. In all accounts, participants generally discussed journeys of recovery in a non- linear fashion, where it appears that for most, living with and managing food thoughts and altering coping strategies for stressful situations, is a long term, ongoing process, that cannot be defined within a singular conception of “recovered”. Such narratives of recovery and multifaceted and continuous, reflect current research in the wider ED space such as LaMarre & Rice (2021).

Part 2) GP Data

Descriptive statistics results

I received results from 12 completed survey's and one incomplete. Of the responses 46% of the GP's had worked for 10 or fewer years and 54% had worked for 20 or more years. There were 54% aged 50 and under and 46% aged over 51 years, 76% identified as female and 23% as male.3% identified as NZ European and 90% work in Auckland regions with one from Counties Manukau and one from Silverdale.

The percentage of GP's who knew the diagnostic criteria for the different ED's are as follows; 44% knew Anorexia Nervosa, 39% knew Bulimia Nervosa, 13% knew ARFID and 4% knew PICA criteria. For Binge Eating Disorder, additional options were provided with 8% answering "yes" to knowing the diagnostic criteria, and 58% having "somewhat" knowledge of criteria, for a total of 66% with at least some knowledge of diagnostic criteria for BED.

Table 3 - GP responses to questions about BED

Question	Yes	Maybe	No
Used screening tools for BED	0	8.33	91.67
Had patients who you think are struggling with BED	91.67	8.33	0
Do you know the pathways to care for BED	33.33	33.33	33.33

Of the people who indicated yes to knowing the pathways to care for BED**,** 89% said they had used these pathways. Three quarters (75%) of respondents indicated primary care services would benefit from further information on BED. All GP's had referred a patient for bariatric surgery. This small sample of GP responses indicate more knowledge of diagnostic criteria, screening tools and pathways for BED (and other EDs) would be beneficial. What is very concerning is the number of GPs who believe their patients are struggling with BED but who have not screened for this. The other important finding is that bariatric surgery is seemingly more common than referring for psychological support.

There was one opened ended question at the end of this survey (Appendix I) and comments from this affirm the descriptive findings with one GP saying, *"We have minimal training and baseline idea* *of dx/mx"* . Another GP indicated youth might be getting all the attention and that adults might be "*under recognised*". However, the main issue in all eight comments was that the existing support for all eating disorders is very poor with comments such as

"Hard enough to get support for patients who are actually dying of anorexia nervosa".

"*referral process for Eating disorders is completely broken. It is taking months to even get a first assessment and patients need to be really, really unwell*…"

One GP has lived experience of BED and agreed with these sentiments, adding that unless patients have private health coverage, and even then, it is very difficult to get support. "Huge" waiting lists for secondary services and lack of knowledge and attention of the lesser known ED's such as BED were also mentioned. In summary, GP's seem to know services are available but they also know the waitlist are long and they know how hard it is people to get access. This access can seem to be even harder or at greater difficulty if living outside of the Auckland area, or other highly populated areas.

Chapter Six - Discussion and Conclusions

This study set out to explore lived experiences of binge eating to help improve understandings of living with binge eating, reduce stigma and explore barriers to accessing care. The participants were all based in New Zealand and self-identified as binge eaters, however no participants disclosed a diagnosis of BED. The outcome is that experiences discussed sit predominantly outside of the traditional scope of diagnosis and clinical treatment, consequently this research provides valuable insight into daily realities of living with and managing binge eating, adding to the field of disordered eating in a unique way. In this chapter, I begin with a brief summary of the key findings and then discuss the implications practically and theoretically in relation to protective factors, education, stigma, and access to care.

Summary of Key Findings

> *honestly…there's still not that much awareness about it. It's always bulimia or anorexia, as sort of your eating disorders, you know, nobody says getting fat from binge eating and being out of control, they just say, getting fat from unhealthy food choices. [Eva]*

Key findings were identified from origin stories, journeys of self-discovery and interactions in medical care. Interpersonal relationships were seen as an essential factor in binge eating origins, relationships with food, pathways to recovery and living well. Stigma and stereotypes in all interactions, primarily around body size, were impactful and contributed to participants non-disclosure of problems, hiding eating, causing shame and guilt and decreased sense of self-worth. An unexpected finding was how important and impactful the mothering relationships were for the participants in both being attributed to causing disordered eating, weight stigma, and how the participants who were mothers were using this to disrupt disordered eating and negative discourses around eating and weight. There was a consensus that there is a lack of understanding of binge eating regardless of weight or body size. In addition, EDs were seen as hierarchical with BED being low on the list.

It was clear that stigma is playing out across culture, gender and body size at all levels. Stigma from an interpersonal perspective, left many feeling misunderstood by peers, resulting in high levels of shame, isolation and fear of reaching out for support. Stigma was also evident in medical settings, where weight loss treatments were most evident for those who did reach out for support with eating behaviours. Stigma towards Māori bodies continues to make it harder to access ED care when the focus is on weight alone. Work cultures such as the fitness industry and dancing are also contributing to negative narratives around women's bodies in particular. This means men are overlooked in disordered eating as men are subjected to differing expectations around eating such as food volume, and acceptable weight. In effect, stereotypes of EDs and body size, alongside narrow boxes of diagnosis available in current DSM-5 categories were perceived as negatively impacting on ability to receive sufficient treatments.

An inequality to care across different forms of EDs and body sizes were also seen as barriers to treatment. GP pathways appear limited at best, supported by narratives from GPs themselves, that they have extremely limited options for helping patients with EDs across the spectrum. Access to care was for most, non-existent and for others ill-fitting to needs. Therapeutic intervention was viewed positively and effective in changing eating patterns, however this was often provided outside of the scope of disordered eating and rather focused on wider mental health. Certain nutritionist information was seen as valuable, but for others was framed as patronising and ineffective in helping with eating patterns. For most binge eating was a lonely journey, and long-term management for many is considered a positive outcome, rather than recovery. For many, improvement or recovery was only possible when there was a change in food attitudes and their own discourses around food, eating and weight.

The issues with the treatment used reflects the complexity of binge eating, both in eating practices and focus on weight as being indicative of health and the close relationship between eating and their holistic well-being. There were many relapses into binge eating and other disordered eating practices such as restriction, purging, and long periods of dieting, suggesting current BED DSM-5 criteria may not be nuanced enough (APA, 2013). For some, periods of binge eating were linked to situational stressors and for others poor mental health so binge eating was both present as a coping mechanism but also a signal of distress. Participants unanimously agreed that improvements to care in New Zealand are required, centred on earlier intervention and focus on preventative methods. Culturally inclusive assessment and treatment settings are required, and additional training for primary care and secondary care providers, such as GPs, nutritionist and psychologists was highlighted as a key area of focus to improve care access and reduce feelings of stigma.

Implications

Binge eating is understudied eating disorder, and an underdeveloped area of care in New Zealand. Participants advocate through their own experiences, for more lay and medical community education on what binge eating is, understandings of long-term effects and potential harm reduction approaches.

There was consensus that food education in schools needs improvement, not just from a nutritional perspective, although that was seen as lacking, but also emotional intelligence in relation to eating as a coping strategy, and emotional relationships with food. Thornicroft et al. (2016) determined that to reduce stigma and stereotypes adolescents benefit from direct contact with stigmatized individuals. This highlights the need for effective, sustainable prevention programs that can be delivered during critical windows of child and adolescent development. Peer education programmes, such as The Body Project in America, have found to increase engagement and strengthen prevention among young women, reducing key risk factors for disordered eating, (Vanderkruik et al., 2020). New Zealand appropriate versions of such programmes have potential to help change attitudes, support individuals with disordered eating, and provide peer support to young people with lived experience. Recent findings suggest awareness of behavioural presentations of ED, is low, which may stem from prototypical depictions of EDs in the media and existing education material (Blackstone et al., 2020). Health education around food, weight and eating focusing on observable, behavioural symptoms of EDs may improve peer identification in college students, and create more supportive environments (Blackstone et al, 2020).

The participants all discussed factors of risk and protection as part of conceptualising their own personal journeys and identified that there are key elements to helping themselves and others with binge eating. Wacker suggest utilising social–relational and social–political spheres of feminist theory to create a protective framework for those susceptible to disordered eating (Wacker, 2018, Wacker & Dolbin-MacNab, 2020). This framework promotes the inclusion of emotional and tangible support, voices that challenge disordered eating behaviours, personal agency and community activism, as protective factors that can assist in behaviour management and recovery for disordered eating (Wacker & Dolbin-MacNab, 2020). There is a clear need in New Zealand for tangible and realistic means of adaptation and support as well as ED education, management of wider social messages, and better access to care. Ideally there should be equity across all of these levels for disordered eating, particularly BED. In addition, support needs to address personal factors and relationships to help develop better relationships with food and eating.

Emotional and tangible support came from friends, family or peers who had experience of disordered eating, or supportive partner relationships. For some emotional support came from unexpected places such as participating in comedy shows or narcotics anonymous meetings. In addition, an on-line space to support BED specific to New Zealand was suggested. Such relationships and community spaces, allowed people safe places to recognise and identify behaviours they may have previously tried to ignore, help them to feel seen and to reduce feelings of shame and isolation. Isolation is a factor that can exacerbate and trigger binge eating behaviours (Allison et al., 2021), thus, informal and community settings of sharing, can be extremely important in helping people to feel they have a safe space to explore their behaviours without judgement, decreasing feelings of self-stigma and blame, that continue maladaptive cycles of binge eating (Lo Coco et al., 2021; Raykos et al., 2017). Formal support settings such as seeing a therapist, counsellor or nutritionist are also needed to help support disordered eating. This highlights the need for holistic, supportive community care structures in overcoming binge eating problems and challenges narratives that pathologizes individuals, minimising them to their eating behaviours, increasing social stigma (Brelet, 2021).

These findings advocate that for many, wider levels of mental health and community support, also seen in other research advocating for earlier disordered eating intervention are beneficial (Wacker & Dolbin-MacNab, 2020). It also highlights the importance of having the right support people who can approach eating dialogues in a way that is truly sensitive to individual needs. This is where finding alternatives methods of tangible support, such as lived-experience informed and inclusive website and social media spaces (Butterfly, 2022; FEAST, 2021; FEDUP, 2022) for disordered eating, or supportive Apps such as Love your Kite (Love Your Kite, 2022), may play increasing roles in creating digital spaces that provide education and support for young people, especially in a system where resources are limited. Clearly, a protective factor for binge eating is both formal and informal support systems, demonstrated in recent literature (LaMarre & Rice, 2017; Nilsen et al., 2020; Wacker, 2018) and through participant narratives.

An important finding from this research is the role of support people who can model positive eating behaviours and challenge disordered eating narratives. The analysis did point to the mother-child dynamic as being particularly important in both contributing to disordered eating through communicating their own feelings and potential insecurities about food and body weight, as well as a potential support in recovery when positive food support is evident. Intensive mothering ideologies and fear of judgement based on your child has been shown to influence mothering (Hays, 1996) and research in AN has shown the important of mothering (alongside family support) to AN development and recovery (Nilsen et al., 2020). This highlights the importance of family and community food messaging that challenge the critical food voice that places focus on weight and body, and biopedagogies that encourage constant self-management around food and bodily practices, especially for women (Wright & Harwood, 2009). In addition, feminists have a role to play in challenging mothering discourses, body narratives and healthism and neoliberal ideals of personal responsibility for health.

The findings from this research support Wacker's (2020) model of having good informal supportive systems with friends, family or others with lived experience (emotional support), a therapeutic support system (tangible support) and someone who presents a healthy image or goal with food and eating (challenges eating disorder behaviours) as these can actively support individuals with binge eating, despite still living within a cultural framework that places pressure on body image.

The women who had become mothers, were very intentional in their move to change generational cycles of food narratives and behaviours. This points to gendered expectations of women being responsible for food and being held accountable for their children's weight and eating behaviours. Modelling is form of learning for children, and childhood home environments and food role models are important due to key learning and adjustment phases during this time, and narratives of socially acceptable eating behaviours that are passed down through family generations and cultural norms (Jang et al., 2021). However, such views of mothers as solely responsible for food messaging and childhood weight measures, continue to be called into question in feminist literature that critiques such "obvious" assumptions that place personal responsibility on mothers for child food messaging, ignoring wider cultural factors and enforces silence through stigma (Holmes, 2016). Findings also point to health education and messaging around food both in formal settings such as doctors, schools and informal settings such as social media needing an overhaul.

Focusing specifically on a sense of agency, empowerment, and connection with supportive others, has consistently shown to have benefits against eating disorders (Bergsma, 2004; Zimmerman, 1995, Wacker, 2018). This research did demonstrate personal agency was important for the participants to gain back power, take control and challenge stigma. This was evident in searching for collaboration in treatment, seeking help from trusted peers, and taking responsibility for their own food behaviours. This was somewhat problematic in reality, as most were unable to find satisfactory options for support in treatment and often felt alone in their journeys, with many experiences of help seeking falling short of being helpful. Being able to vocalise needs and opinions safely, fosters development of a sense of personal agency, and collaborative approaches to recovery promote autonomy and are generally experiences received more positively than when individuals are not actively consulted in treatment plans (Nilsen et al., 2020; Wacker, 2018).

An important element of personal agency was having the courage to acknowledge that there is something that they want to change in their eating behaviours, and they have the power to do so. This was important for developing awareness of what they want to achieve and building self-efficacy beliefs regarding their eating, which in turn can positively impact self-esteem (Glasofer et al., 2013). Moving ideas of personal value away from appearance and onto other areas of being is inherently difficult to do in a world that tells you daily that value, particularly for women, lies in being able to fit the ideal body stereotype (Tylka & Sabik, 2010), however, re-evaluating how participants placed value on themselves, and disconnecting from messages from others, such as parents, partners or wider social messages, is a factor that clearly plays into individual narratives about recovery and management of binge eating, and can be viewed as a protective factor when participants were able to establish new depths of self-value, and valuing of others. It also appears that advocacy and wanting to help others was important in personal agency. This was altruistic, but also serves a purpose in creating meaning from their experiences. Such meaning making has been explored in other areas of eating disorder recovery, such as art therapy, where mediums to provide voices in a safe space, has shown to positively impact recovery, empowering clients to become advocates within their communities (Misluk-Gervase, 2020). The desire to support the wider ED community, is reflective of a greater need for more support services and safe community spaces for people to share stories and provide guidance.

Stigma around ED, BED and disordered eating are all areas that need to be addressed in relation to weight perceptions, nutritional and other food messaging, and perceived hierarchies of EDs in public narrative and medical spaces. Bodies speak in social codes where categories often stem from differences in physical appearance that are visibly salient (Davidio, 2005; Wright & Harwood, 2009). This research reflects how the nature of personal eating experiences, live within the complexity of the body as social concept, in particular how those in larger bodies are constituted as ‘less than’ in society, and how this complexity enhances feelings of social exclusion, and ultimately contributes to the creation of an epidemic of invisible illness. This body categorisation is highly evident in how differently AN and BED were portrayed by the participants, and experienced in social settings the family home and in medical care. Participants were acutely aware of levels of stigma towards disordered eating, body types and female food roles. This awareness, is reflected in wider ED research. For example, Brelet et al (2021) found ED stigma may lock people with EDs into a vicious cycle that decreases the likelihood of recovery. Brelet (2021) also found that clinicians have been found to express negative beliefs and emotions towards people with BED which translated into inequity in care, in some cases withholding care.

This research supports that people with binge eating are experiencing body stereotyping in the role of patient, where individuals feel categorised in a predominantly biomedical way, based on BMI measurements, placing their body as problematic and requiring fixing. For binge eating there is still a decided focus on weight as a measure of health from medical professionals and also within the participants themselves. This is a somewhat taken for granted practice in the western medical framework (Bacon, 2010), and is also internalised in how participants communicate about themselves and their bodies as needing improvement. The categorisation of bodies by size alone, misses important contextual information that can be far more beneficial in long term health, both mental and physical. Appropriately structured, cooperative contact (such as between individuals and others with disordered eating, or in the patient-medical provider dynamic), can begin to reduce prejudice, at least in part by reducing intergroup anxiety and threat, and begin to destabilise negative power structures that are built on perceptions of EDs that are at odds with reality (Davidio et al., 2005; Gremillion, 2003).

Self-stigma was also evident in this research, highlighted in how participants identify themselves in relation to their binge eating behaviours. Their causes of binge eating were mainly internalized and perceived as personal responsibility or lack of discipline, linking eating behaviours to negative character traits of self, such as thinking they are weak, resulting in low self-efficacy and self-esteem. This appears much more pronounced in research with BED than other EDs, with more views linked to lacking self-control and willpower (Cooper et al., 2020). Such self-views are evident through interview dialogues where negative thoughts of self are prominent, such as struggling to find something they are proud of in themselves. Levels of self-stigma encouraged some people to distance from others with eating disorders, or other traits viewed negatively through the lens of their own eating behaviours. Naomi in the height of her binging and starving cycles, through fear of 'becoming' someone who lived in an overly criticised body, created distance from "fat people". Alternatively, Madilyn in her nurse training, felt uncomfortable working with people with anorexia while seeing herself as a binge eater and overweight. Such fear of shame and stigma has been shown in other research. Chris et al. (as cited it Brelet, 2021) stated that a third of respondents in their study blamed people with eating disorders for their situation and found communicating with them challenging. This placement of blame, gives an illusion of personal control, creating "Us" and "Them" communities. It also is reflective of Burns (2004) model of comparison, where anorexia exists as a category that women with bulimia may define themselves against, and interview narratives have demonstrated how BED also falls into this hierarchical structure of social classification. Much of the stigma also perpetuates the narrative that binge eating is a fat person disorder, which is not reflective of the range of experiences or body sizes seen in this study. How we can begin to dismantle self and wider stigma links back to improving education and messages about health in public narratives.

Alongside changing stigma, New Zealand needs to strive for systems of care that allow earlier intervention for disordered eating. The optimum period of early intervention is outlined to be within the first three years of symptoms (Allison et al., 2021). Allison et al. (2021) supports a youth focused agenda for intervention in disordered eating, mirroring sentiments in this research. This is far earlier than seen across recent literature (Hamilton et al., 2021), and in many descriptions of participants who didn't start engaging in care (formal or informal) until adulthood despite narratives of early onset for most. Earlier intervention, has been shown in ED research and is widely viewed as a protective factor for improvement and recovery (Allison et al., 2020; Wacker, 2018), The participants advocated that having more disordered eating specialists in nutrition (dieticians) and therapeutic spaces that have specialised training in binge eating, would create more inclusivity for binge eaters in treatment. Through Āwhina's experiences she found that support services, even in the private sector, were not adequately informed about BED. Āwhina also advocates from more holistic and indigenous approaches to care for all EDs. This would be one way to have more collaborative approaches to care and promote autonomy, generally experiences received more positively in health care (Nilsen et al., 2020).

This research also suggests that access to care is recommended to be provided to anyone with disordered eating symptoms, regardless of if they fit DSM-5 criteria (Wacker & Dolbin-MacNab, 2020). Categorisations or “boxes” for EDs are not always helpful, and would be better focused on understanding the biopsychosocial elements and ‘why’ factors to provide treatment across subthreshold disorders. Over 80% of EDs have onset in youth (Garland et al., 2019 as cited in Allison et al., 2021), the ANZAED also support earlier intervention for EDs in New Zealand treatment guidelines (ANZAED, 2020). Approximately 13% to 17% of subthreshold eating disorders develop into clinical eating disorders according to DSM-5 criteria, though many with subthreshold symptoms continue to struggle without acknowledgment or support (Stice et al., 2009; Wacker & Dolbin-MacNab, 2020). Researchers have advocated for the use of the continuum hypothesis in conceptualizing disordered eating placing disordered eating on a spectrum, with normal eating on one end and clinical-level symptoms on the other, instead of sole reliance on DSM-5 criteria (Dennard & Richards, 2013; Graber et al., 2003 as cited in Wacker 2020). An approach supported through the narratives in this research findings. Working from such a framework, may provide a more beneficial base from which to create adequate care systems and gain understanding of the nuances that exist across categories.

Primary care GP’s are seen as gatekeepers to public care pathways for ED support in New Zealand. ED pathways can be ambiguous and unclear for both patients and their GPs, however findings from the short GP survey in this study, provide some evidence that for many GPs it is not so much an element of gatekeeping care, but rather having a lack of options for their patients. The GP narratives support participant voices that feel binge eating is overlooked in normalised BMI ranges, and supports views in wider literature, that medical experts require more resources and education to support people that present with BED (as discussed in the GP survey) and other disordered eating (as presented by interview participants).

A 2012 analysis of services and supports available in New Zealand for people affected by an ED established a clear need for building and broadening the range and effectiveness of available services. The greatest gaps exist in services for children and young people, and significant regional differences exist in access to eating disorders services (Ministry of Health, 2012). In such ways, support needs to be tailored at the social, disorder and individual levels. This is where Māori and other culturally appropriate frameworks of health can have visible impact in expanding reductionist, categorisation of disorders, through wider contextualisation of body, spirit, land and whānau (Durie, 1985). The overall theme for all of this support and access is it needs to be New Zealand centric, more accessible, culturally appropriate and relevant to the individual and context.

It is impossible to conduct this research, and not to consider the impact of COVID-19 on this topic; social isolation, increased screen time, excessive social media use and parental stress are all factors considered impactful for EDs (Allison et al., 2021). The pandemic has also highlighted the contradictory messaging between the fields of obesity care and EDs, with public health messages emphasising weight gain resulting from lockdowns, and social media focusing on weight loss and exercise (Allison et al., 2021; Spigel et al., 2021). This focus on exercise and weight loss, is a damaging narrative across EDs, such as BED where focus is placed getting back to 'normal' weight ranges post-pandemic, as if weight gain is inherently bad, perpetuating stigma against larger bodies and also overtaking the importance of improving mental health, prioritising the physical body ideals.

Australian data found that across 25 ED specific services, there has been a marked increase in presentations of both new and relapsing EDs during the COVID-19 pandemic with higher acuity and severity of presentations (Allison et al., 2021). Although New Zealand research data is widely unavailable in relation to COVID-19 ED statistics, according to news testaments from experts in the field this is an equally important epidemic for New Zealand, announcing double the admissions for EDs in Auckland during the pandemic, and a 30% increase in admissions for the Wellington region. (Hansen et al., 2021; New Zealand Herald, 2021). Aligned with data from Australia and the United Kingdom who have reported double the cases of urgent and routine referrals for child adolescent eating to service or services during COVID-19 (Spigel et al, 2021; Touyz et al., 2020). This is putting additional strain on already under resourced areas of care in New Zealand, reflected in individual stories of limited options, even when looking for private care. This will continue to be an issue in the foreseeable future as new variants of COVID-19 emerge.

Conclusions and Recommendations

This research has provided a space for individuals to share their lived experiences of binge eating, and captured a view of GPs working in Auckland regarding the care of BED. This study contributes to gaps in the literature through the provision of data and narratives that do not appear to be evident anywhere else in current New Zealand research, providing an in-depth understanding of binge eating across multiple perspectives, before diagnosis and intervention. This study hopes to have shed light on real experiences of binge eating, to challenge current stereotypes and assumptions that are made about weight and disordered eating. This is crucial in creating visibility for disordered eating across all body types, to enable effective treatment seeking and empathetic support services.

Throughout my research for this study, I was unable to find any New Zealand based projects that provided narrative voices of people that either self-identify as binge eaters, or have received a BED diagnosis. Both in New Zealand and globally there appears little research available that examines how individuals have managed disordered eating symptoms when not being treated at a clinical level (Wacker & Dolbin-MacNab, 2020). Limited data that is available focuses predominantly on post-DSM diagnosis, for example understanding lived experiences of therapy treatment, where personal voices are often lost in midst of searching for affective medical approaches (Applequist, 2014; Conti et al., 2017; Lacie et al., 2020). Such research limitations are especially apparent for men and minority groups, and particularly for BED in comparison to AN or BN which has been studied more thoroughly, however feminist critiques of lack of voice, and predominant research that favours epistemic value of researchers' knowledge are evident across the scope of ED research (Hussain et al., 2021). The research stories presented here, add valuable context and narrative of experience to this limited data set, from a binge eating perspective whilst also encapsulating how continuum of disordered eating behaviours exist within individual stories, and for those that may fit BED DSM-5 criteria, other sub-threshold behaviours present risk of being disregarded if diagnosis is given for one pattern over others.

The importance of improving primary care pathways in New Zealand for support and treatment is evident through the voices of interview participants and GPs. The EDANZ website promote that the first step in seeking help for eating disorders is to visit your GP and ask for a referral to an Eating Disorder Specialist (EDANZ, 2021). However, the pathways to care remain unclear for patients, and GPs have extremely limited resources to provide any assistance. This research has provided insight into the gaps of care within the primary care system, research that needs to be expanded on and considered in applicability for improving future access to care for EDs such as BED in New Zealand. It may also be impacting on increasing numbers of individuals considering weight loss surgery as a tool for managing weight and eating; if people do not know support pathways, or cannot easily access them, it can be easier to turn to medicalized pathways such as surgery that offer long term weight solutions.

Current research on binge eating and BED, remains very much in infancy in terms of depths and applicability, despite a long history. Future research would benefit from the inclusion of longitudinal studies and larger sample groups. An increase in qualitative, narrative data sets, especially in a New Zealand context, would allow for subjective participant narratives, giving depth to personal issues. Other areas of research such as addiction, have gained significant insight into individuals thought processes that have in turn supported patient care programmes (Fixsen, 2016). Alongside psychological wellbeing, there are other considerations regarding BED that require additional research and knowledge. There has been evidence that just as with obesity and mental health conditions, Genetics may play a factor in binge eating (Hilbert, 2019). People with BED also have a high chance of comorbidities such as depressive or anxiety disorders, or ADHD (Bleck et al., 2016; Keski-Rahkonen, 2021), regardless of BMI categories.

Extending the research to more diverse populations, for example Māori and Pacific culturally framed studies, people with comorbid conditions such as ADHD, or younger age demographic is an important step given the complexity and range of how binge eating presents. I was fortunate to have Māori views and knowledge shared in interviews, but this was still a minority voice, deserving of a more prominent platform and adequate research within cultural appropriate methodologies and frameworks. Future research should also consider how intersectionality (race, age, sexuality, gender) affects the presentations of binge eating for a range of different people, and how stigma in such spaces creates layers of privilege as to who is considered for diagnosis and treatment, for instance if your BMI is classified as obese you may receive treatment for weight loss, and if you are in a ‘normal’ BMI range, you are likely to go unnoticed.

The last publicly available outline for New Zealand Ministry of Health Plans for Eating Disorders were published in 2012 (Ministry of Health, 2012). Not only is the before changes to DSM-5 categorisations that now include BED (APA, 2013), but this marks a decade of research, information and potential increases in cases that are not captured by such policies, and appear to relate to a system that in

2022 is not providing adequate service accessibility across disordered eating, specifically limiting for non-critical, early intervention efforts, despite GPs best efforts to provide adequate care.

Evidence is mounting that the impacts of COVID-19 in the mental health space are significant and long-term (Allison et al., 2021; Hansen et al., 2021; Spigel et al., 2021), the impact of situations that have reduced normative protective factors for disordered eating through lockdowns and heightened states of insecurity around health and financial stability, cannot be overlooked. If prevalence of disordered eating is already at a place where resources are not sufficient, then it sadly appears this will be a problem that gets worse, before it can improve.

In all accounts, journeys of recovery for binge eating are not linear. This acknowledges people do not simply transition from binge eating to not binge eating, and that recovery itself is subjective. Individualism seen in neoliberal society, promotes a version of recovery not available to all. Such "choice" based framing of recovery ignores complex relational aspects of EDs and their care (Lester 2018; Lester, 2019, as cited in LaMarre & Rice, 2021). Participants' accounts present a possibility of carving out a space for recoveries that move away from ideas of having to reach a place of "full" diagnosis and recovery for experiences to be valid (LaMarre & Rice, 2021) . These factors are important in establishing personal frameworks of care, which can be at odds with short-term therapeutic treatment approaches that primarily focus on acute, high risk intervention. Key interpersonal relationships, such as with GPs, need to be robust and understanding of realities of living with binge eating, to support the personal agency of individuals looking for supportive care, especially in times of instigation or relapsing binge eating behaviours.

Understanding these protective factors in a New Zealand context, where access to care is minimal and where diagnosis for BED is rare, is particularly important. There is a clear need to get creative in ways to support people with binge eating, to empower them to support themselves, and educate people to build understanding communities that place protective factors around each other. Because large scale change in service structures are slow to action, and the landscape of care and support systems cannot possible adjust as quickly as what is evident in terms of need increase, especially in the face of COVID-19 considerations. More research on practical protective factors could help shape a new direction of care where individuals, families and in-group communities can provide some of the support alongside improving access to traditional types of therapeutic intervention and care services.

References

Adams, K. E., Tyler, J. M., Calogero, R., & Lee, J. (2017). Exploring the relationship between appearance-contingent self-worth and self-esteem: The roles of self-objectification and appearance anxiety. *Body Image, 23*, 176–182. https://doi.org/10.1016/j.bodyim.2017.10.004

Agras, S., Apple, R. (2008). *Overcoming Your Eating Disorder : A Cognitive-Behavioral Therapy Approach for Bulimia Nervosa and Binge-Eating Disorder, Guided Self Help Workbook*. Oxford University Press.

Agras, W. S., & Bohon, C. (2021). Cognitive Behavioral Therapy for the Eating Disorders. *Annual Review of Clinical Psychology, 17*, 417–438. https://doi.org/10.1146/annurev-clinpsy-081219-110907

Agüera, Z., Lozano-Madrid, M., Mallorquí-Bagué, N., Jiménez-Murcia, S., Menchón, J. M., & Fernández-Aranda, F. (2021). A review of binge eating disorder and obesity. *Public Mental Health 35*(2), 57. https://doi.org/10.1007/s40211-020-00346-w

Albertsen, M. N., Natvik, E., & Råheim, M. (2019). Patients' experiences from basic body awareness therapy in the treatment of binge eating disorder -movement toward health: a phenomenological study. *Journal of Eating Disorders, 7*(1). https://doi-org. 10.1186/s40337-019-0264-0

Ali, K., Fassnacht, D. B., Farrer, L., Rieger, E., Feldhege, J., Moessner, M., Griffiths, K. M., & Bauer, S. (2020). What prevents young adults from seeking help? Barriers toward help-seeking for eating disorder symptomatology. *International Journal of Eating Disorders, 53*(6), 894–906. https://doi.org/10.1002/eat.23266

Al-Busaidi, I. S., *Tania, H., Pitama, S., Lacey, C.* (2018). Māori Indigenous Health Framework in action: addressing ethnic disparities in healthcare. *New Zealand Medical Journal*, *131.*

Allison, S., Wade, T., Schmidt, U., Treasure, J., Bastiampillai, T., & Looi, J. C. (2021). Setting a youth-focused research agenda for eating disorders during the COVID-19 pandemic. *Australian & New Zealand Journal of Psychiatry, 1-3.* https://doi.org/10.1177/00048674211054743

Allport, G. W. (1954). *The nature of prejudice*. Addison-Wesley Pub. Co.

American Psychiatric Association. (1985). *Diagnostic and statistical manual of mental disorders* (3rd ed.). American Psychiatric Association.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Anderson, R., Gratwick-Sarll, K., Bentley, C., Harrison, C., & Mond, J. (2016). Adolescents' perception of the severity of binge eating disorder: a population-based study. *Journal of mental health (Abingdon, England)*, *25*(1), 16–22. https://doi.org/10.3109/09638237.2015.1057329

Andrews, T. (2012). What is Social Constructionism?. *Grounded Theory Review, 11*. 39-46.

Applequist, J. (2014). “The part too often left out involves the perspectives of patients”: helping health-care providers understand the material reality of the every day for individuals with eating disorders. *Journal of Medicine and the Person, 12*(3), 118-124. https://doi.org/10.1007/s12682-014-0186-1

Australia and New Zealand Academy for Eating Disorders. (2018). Bringing binge eating disorder into focus: The sidelined eating disorder. (2018). *Australian and New Zealand Journal of Psychiatry*, *52*(10), 917–918. https://doi.org/10.1177%2F0004867418797430

Bachner-Melman, R., de Vos, J. A., Zohar, A. H., Shalom, M., Mcgilley, B., Oberlin, K., Murray, L., Lamarre, A., & Dooley-Hash, S. (2021). Attitudes towards eating disorders clinicians with personal experience of an eating disorder, *Eating and Weight Disorders - Studies on Anorexia, Bulimia and Obesity,* *26*(6), 1881–1891. https://doi.org/10.1007/s40519-020-01044-w

Bacon, L. (2010). *Health at Every Size: The Surprising Truth about Your Weight*. BenBella Books.

Bagaric, M., Touyz, S., Heriseanu, A., Conti, J., & Hay, P. (2020). Are bulimia nervosa and binge eating disorder increasing? Results of a population-based study of lifetime prevalence and lifetime prevalence by age in South Australia. *European Eating Disorders Review, 28*(3), 260–268. https://doi.org/10.1002/erv.2726

Balodis, I. M., Kober, H., Worhunsky, P. D., White, M. A., Stevens, M. C., Pearlson, G. D., Sinha, R., Grilo, C. M., & Potenza, M. N. (2013). Monetary reward processing in obese individuals with and without binge eating disorder. *Biological psychiatry*, *73*(9), 877–886. https://doi.org/10.1016/j.biopsych.2013.01.014

Barnett, P., & Bagshaw, P. (2020). Neoliberalism : what it is, how it affects health and what to do about it. *New Zealand Medical Journal, 133*, 76 – 84. https://journal.nzma.org.nz/journal-articles/neoliberalism-what-it-is-how-it-affects-health-and-what-to-do-about-it

Baxter, J., Kani Kingi, T., Tapsell, R., Durie, M., & Mcgee, M. A. (2006). Prevalence of Mental Disorders Among Māori in Te Rau Hinengaro: The New Zealand Mental Health Survey. *Australian & New Zealand Journal of Psychiatry, 40*(10), 914–923. https://doi.org/10.1080/j.1440-1614.2006.01911.x

Bemporad, J. R. (1996). Self-starvation through the ages: Reflections on the pre-history of anorexia nervosa. International Journal of Eating Disorders, 19(3), 217–237. https://doi.org/10.1002/(SICI)1098-108X(199604)19:3<217::AID-EAT1>3.0.CO;2-P

Blackstone, S. R., & Herrmann, L. K. (2018). Extreme body messages: themes from Facebook posts in extreme fitness and nutrition online support groups. *mHealth*, *4*, 33. https://doi.org/10.21037/mhealth.2018.07.01

Blackstone, S. R., Sangiorgio, C., & Johnson, A. K. (2020). Peer Recognition of Disordered Eating Behaviors: Implications for Improving Awareness through Health Education. *American Journal of Health Education, 51*(3), 142–150. https://doi.org/10.1080/19325037.2020.1740120 CV

Bleck, J., DeBate, R., Levin, B. L., & Baldwin, J. (2016). Underlying Mechanisms and Trajectory of Comorbid ADHD and Eating Disorders: Proposing an Innovative Systems Framework for Informing Research. *International Journal of Mental Health and Addiction, 14*(4), 449–458. https://doi.org/10.1007/s11469-015-9593-7

Bliss, E. L., & Branch, C. H. H. (1960). *Anorexia nervosa; its history, psychology, and biology*. Hoeber. https://doi.org/10.1016/j.biopsych.2013.03.007

Blowers, L.C., Loxton, N,J., Grady-Flesser, M., Occhipinti, S. Dawe, S. (2003). The relationship between sociocultural pressure to be thin and body dissatisfaction in preadolescent girls. *Eating Behaviors, 4*, 229-244. https://doi.org/10.1016/S1471-0153(03)00018-7

Bombak, A., Monaghan, L. F., & Rich, E. (2018). Dietary approaches to weight-loss, Health At Every Size® and beyond: rethinking the war on obesity. *Social Theory & Health, 1*. https://doi.org/10.1057/s41285-018-0070-9

Boysen, G., Ebersole, A., Casner, R., & Coston. N. (2014). Gendered Mental Disorders: Masculine and Feminine Stereotypes about Mental Disorders and Their Relation to Stigma. *The Journal of Social Psychology 154*(6), 546–65. https://doi.org/10.1080/00224545.2014.953028

Bray, B., Rodríguez-Martín, B. C., Wiss, D. A., Bray, C. E., & Zwickey, H. (2021). Overeaters Anonymous: An Overlooked Intervention for Binge Eating Disorder. *International Journal of Environmental Research and Public Health, 18*(14). https://doi-org/ 10.3390/ijerph18147303

Brelet, L., Flaudias, V., Désert, M., Guillaume, S., Llorca, P.-M., & Boirie, Y. (2021). Stigmatization toward People with Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder: A Scoping Review. *Nutrients, 13*(8). https://doi.org/10.3390/nu13082834

Brownstone, L. M., Mihas, P., Butler, R., Maman, S., Peterson, C. B., Bulik, C. M., & Bardone, C. A. M. (2021). Lived experiences of subjective binge eating: An inductive thematic analysis. *International Journal of Eating Disorders, 54*(12), 2192 – 2205 https://doi.org/10.1002/eat.23636

Brown-Bowers, A., Ward, A., & Cormier, N. (2017). Treating the binge or the (fat) body? Representations of fatness in a gold standard psychological treatment manual for binge eating disorder. *Health, 21*(1), 21–37. https://doi.org/10.1177/1363459316674788

Brown, C. E., & Perry, K. N. (2018). Cognitive behavioural therapy for eating disorders: how do clinician characteristics impact on treatment fidelity? *Journal of Eating Disorders, 6*(19). https://doi.org/10.1186/s40337-018-0208-0

Bruch, H. (1973). *Eating disorders; obesity, anorexia nervosa, and the person within*. Basic Books.

Bruch, H. (1978). *The golden cage: The enigma of anorexia nervosa.* Cambridge, MA: Harvard University Press.

Burns, M. (2004). Eating Like an Ox: Femininity and Dualistic Constructions of Bulimia and Anorexia. *Feminism & Psychology, 14*(2), 269–295. https://doi.org/10.1177%2F0959353504042182

Burns, M. L. (2021). Rebecca J. Lester, Famished: Eating disorders and failed care in America. *Feminism & Psychology, 31*(1), 160–164. https://doi.org/10.1177/0959353521989535

Butterfly. (2022). *Eating Disorders Blog.* https://butterfly.org.au/blog/?category=experience

Carbonneau, E., Bégin, C., Lemieux, S., Mongeau, L., Paquette, M.-C., Turcotte, M., Labonté, M.-È., & Provencher, V. (2017). A Health at Every Size intervention improves intuitive eating and diet quality in Canadian women. Clinical Nutrition, 36(3), 747–754. https://doi.org/10.1016/j.clnu.2016.06.008

Carey, J. B., Saules, K. K., & Carr, M. M. (2017). A qualitative analysis of men's experiences of binge eating. *Appetite, 116*, 184–195. https://doi.org/10.1016/j.appet.2017.04.030

Casale, S., Gemelli, G., Calosi, C., Giangrasso, B., & Fioravanti, G. (2021). Multiple exposure to appearance-focused real accounts on Instagram: Effects on body image among both genders. *Current Psychology: A Journal for Diverse Perspectives on Diverse Psychological Issues, 40*(6), 2877–2886. https://doi.org/10.1007/s12144-019-00229-6

Cella, S., Fei, L., D'Amico, R., Giardiello, C., Allaria, A., & Cotrufo, P. (2019). Binge eating disorder and related features in bariatric surgery candidates. *Open Medicine, 14*(1), 407–415. https://doi.org/10.1515/med-2019-0043

Cerniglia, L., Cimino, S., Ballarotto, G., & Tambelli, R. (2016). Do parental traumatic experiences have a role in the psychological functioning of early adolescents with binge eating disorder*?* *Eating and Weight Disorders, 21*(4), 635–644. https://doi-org/10.1007/s40519-016-0303-7

Chamberlain, K. (2014) Epistemology and qualitative research. In P. Rohleder & A. Lyons (Eds.). *Qualitative research in clinical and health psychology* (pp. 9-28). Palgrave MacMillan. http://dx.doi.org/10.1007/978-1-137-29105-9_2

Chamberlain, K. & Murray, M. (2017). Health psychology. In *The Sage Handbook of qualitative research in psychology* (pp. 431-449). SAGE Publications Ltd. https://www.doi.org/10.4135/9781526405555

Christofi, M., & Michael-Grigoriou, D. (2017). Virtual reality for inducing empathy and reducing prejudice towards stigmatized groups: A survey. *2017 23rd International Conference on Virtual System & Multimedia (VSMM)*, 1-8. https://doi.org/10.1109/VSMM.2017.8346252

Clyne, C., Latner, J.D., Gleaves, D.H., & Blampied, N.M. (2010). Treatment of emotional dysregulation in full syndrome and subthreshold binge eating disorder. *Eating Disorders, 18*(5), 408–424. https://doi-org/ 10.1080/10640266.2010.511930

Conti, J., Calder, J., Cibralic, S., Rhodes, P., Meade, T., & Hewson, D. (2017). “Somebody Else’s Roadmap”: Lived Experience of Maudsley and Family-based Therapy for Adolescent Anorexia Nervosa. *Australian & New Zealand Journal of Family Therapy, 38*(3), 405–429. https://doi.org/10.1002/anzf.1229

Cooper, Z., Calugi, S., & Dalle Grave, R. (2020). Controlling binge eating and weight: a treatment for binge eating disorder worth researching? *Eating and Weight Disorders - Studies on Anorexia, Bulimia and Obesity, 25*(4), 1105. https://doi.org/10.1007/s40519-019-00734-4

Cooper, Z., & Fairburn, C. G. (2009). Management of bulimia nervosa and other binge eating problems. *Advances in Psychiatric Treatment, 15*(2), 129–136. https://doi.org/10.1192/apt.bp.107.004275

Corrigan, P. W., & Rao, D. (2012). On the gender of mental illness: stages, disclosure, and strategies for change. *Canadian journal of psychiatry*, *57*(8), 464–469. https://doi.org/10.1177/070674371205700804

Crisp, A. H., Gelder, M. G., Rix, S., Meltzer, H. I., & Rowlands, O. J. (2000). Stigmatisation of people with mental illnesses. *The British journal of psychiatry : the journal of mental science*, *177*, 4–7. https://doi.org/10.1192/bjp.177.1.4

Crocker, J., & Wolfe, C. (2001). Contingencies of Self-Worth. *Psychological Review, 108*(3), 593–623. https://psycnet.apa.org/doi/10.1037/0033-295X.108.3.593

Crotty, M. (1998). *The Foundations of Social Research : Meaning and Perspective in the Research Process.* SAGE Publications Ltd.

Crowne, D. P., & Marlowe, D. (1960). A new scale of social desirability independent of psychopathology. *Journal of Consulting Psychology, 24*(4), 349 -354. https://doi.org/10.1037/h0047358

Culbert, K. M., Racine, S. E., & Klump, K. L. (2015). Research Review: What we have learned about the causes of eating disorders - a synthesis of sociocultural, psychological, and biological research. *Journal of child psychology and psychiatry, and allied disciplines*, *56*(11), 1141–1164. https://doi.org/10.1111/jcpp.12441

Curtis, C. (2016). Feminism in psychology: Aotearoa/New Zealand and beyond. *Women's Studies Journal, 30*(2), 6–22. https://hdl.handle.net/10289/13032

Devlin M. J. (1996). Assessment and treatment of binge-eating disorder. *The Psychiatric clinics of North America*, *19*(4), 761–772. https://doi.org/10.1016/s0193-953x(05)70380-4

Dingemans, A. E., & van Furth, E. F. (2012). Binge eating disorder psychopathology in normal weight and obese individuals. *International Journal of Eating Disorders, 45*(1), 135–138. https://doi.org/10.1002/eat.20905

Dovidio, J. F., Glick, P., & Rudman, L. A. (2005). *On the nature of prejudice: Fifty years after Allport*. Blackwell Publishing. https://doi.org/10.1002/9780470773963.ch1

Driggers, E. A. (2021). 'The voice of the stomach': The mind, hypochondriasis and theories of dyspepsia in the nineteenth century. *History of Psychiatry, 32*(1), 85–99. https://doi.org/10.1177/0957154X20970749

Durie, M. (1985). A Maori perspective of health. *Social Science and Medicine, 20(5)*, 483–486. https://doi.org/10.1016/0277-9536(85)90363-6

Eating Disorder Association of New Zealand (2018).*Submission to the New Zealand Government Mental Health Inquiry***.** **https://www.ed.org.nz/files/EDANZ_Submission_to_Mental_Health_Inquiry.pdf**

Eating Disorder Association of New Zealand. (2021). *Binge Eating Disorder*. https://www.ed.org.nz/eating-disorders-explained/binge-eating-disorder/

Erwin, E. (2002). *The Freud encyclopedia : theory, therapy, and culture.* Routledge.

Espinoza, P., Penelo, E., Mora, M., Francisco, R., González, M. L., & Raich, R. M. (2019). Bidirectional Relations Between Disordered Eating, Internalization of Beauty Ideals, and Self-Esteem: A Longitudinal Study With Adolescents. *Journal of Early Adolescence, 39*(9), 1244–1260. https://doi.org/10.1177%2F0272431618812734

Fairburn, C. G., Marcus, M. D., & Wilson, G. T. (1993). Cognitive-behavioral therapy for binge eating and bulimia nervosa: A comprehensive treatment manual. In C. G. Fairburn & G. T. Wilson (Eds.), *Binge eating: Nature, assessment, and treatment* (pp. 361–404). Guilford Press.

FEDUP. (2022). *Fighting Eating Disorders in Underrepresented Populations: A Trans+ & Intersex Collective*. https://fedupcollective.org/

FEAST. (2022). *Voices of Lived Experience of Eating Disorders*. https://www.feast-ed.org/voices-of-lived-experience-of-eating-disorders/

Fichter, M. M., & Quadflieg, N. (2007). Long-term stability of eating disorder diagnoses. *International Journal of Eating Disorders, 40*(S3), S61–S66. https://doi.org/10.1002/eat.20443

Fixsen, A. M. (2016). "I'm Not Waving, I'm Drowning": An Autoethnographical Exploration of Biographical Disruption and Reconstruction During Recovery From Prescribed Benzodiazepine Use. *Qualitative Health Research*, *26*(4), 466–481. https://doi.org/10.1177/1049732315576496

Foran, A.M., O'Donnell, A.T., Muldoon, O.T. (2020). Stigma of eating disorders and recovery-related outcomes: A systematic review. *European Eating Disorders Review*. *28*(4), 385–397. https://doi.org/10.1002/erv.2735

Foucault, M. (2002). *The order of things: an archaeology of the human sciences*. Routledge.

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. https://doi.org/10.1093/ajcn/nqy342

Garrett, M., Poppe, K., Wooding, A., & Murphy, R. (2020). Private and Public Bariatric Surgery Trends in New Zealand 2004–2017: Demographics, Cardiovascular Comorbidity and Procedure Selection. *Obesity Surgery: The Journal of Metabolic Surgery and Allied Care, 30*(6), 2285. https://doi.org/10.1007/s11695-020-04463-x

Geller, J., Isserlin, L., Seale, E., Iyar, M., Coelho, J., Srikameswaran, S., & Norris, M. (2018). The Short Treatment Allocation Tool for Eating Disorders: current practices in assigning patients to level of care. *Journal of Eating Disorders, 6*(1), 1–6. https://doi.org/10.1186/s40337-018-0230-2

Gentile, K. (2007). *Creating bodies : eating disorders as self-destructive survival*. Analytic Press.

Gentry, K. (2015). *History, heritage, and colonialism: Historical consciousness, Britishness, and cultural identity in New Zealand, 1870–1940*. Manchester University Press.

Giel, K. E., Zipfel, S., Schweizer, R., Braun, R., Ranke, M. B., Binder, G., & Ehehalt, S. (2013). Eating disorder pathology in adolescents participating in a lifestyle intervention for obesity: associations with weight change, general psychopathology and health-related quality of life. *Obesity Facts, 6*(4), 307–316. https://doi.org/10.1159/000354534

Glasofer, D. R., Haaga, D. A. F., Hannallah, L., Field, S. E., Kozlosky, M., Reynolds, J., Yanovski, J. A., & Tanofsky, K. M. (2013). Self-efficacy beliefs and eating behavior in adolescent girls at-risk for excess weight gain and binge eating disorder. *International Journal of Eating Disorders, 46*(7), 663–668. https://doi.org/10.1002/eat.22160

Glisenti, K., Strodl, E., King, R., & Greenberg, L. (2021). The feasibility of emotion-focused therapy for binge-eating disorder: a pilot randomised wait-list control trial. *Journal of Eating Disorders, 9*(1), 1–15. https://doi.org/10.1186/s40337-020-00358-5

Goffman, E. (1986). *Stigma : notes on the management of spoiled identity.* Simon & Schuster.

Google Trends (2021). *Body Positivity*. https://trends.google.com/trends/explore?date=today%205-y&q=body%20positivity

Gotovac, S., LaMarre, A., & Lafreniere, K. (2020). Words with weight: The construction of obesity in eating disorders research. *Health, 24*(2), 113–131. https://doi.org/10.1177/1363459318785706

Green, E. T., & Venta, A. (2018). Lack of implementation of eating disorder education and prevention programs in high schools: Data from incoming college freshmen. *Eating Disorders, 26*(5), 430–447. https://doi.org/10.1080/10640266.2018.1453629

Gremillion, H. (2003). *Feeding anorexia: Gender and power at a treatment center.* Durham and London; Duke University Press.

Griffiths, S., Mond, J. M., Murray, S. B., Thornton, C., & Touyz, S. (2015). Stigma resistance in eating disorders. *Social psychiatry and psychiatric epidemiology*, *50*(2), 279–287. https://doi.org/10.1007/s00127-014-0923-z

Grilo, C., & Mitchell, J. E. (2010). *The treatment of eating disorders : a clinical handbook*. Guilford Press.

Guerdjikova, A. I., Mori, N., Casuto, L. S., & McElroy, S. L. (2016). Novel pharmacologic treatment in acute binge eating disorder - role of lisdexamfetamine. *Neuropsychiatric disease and treatment*, *12*, 833–841. https://doi.org/10.2147/NDT.S80881

Hamilton, A., Mitchison, D., Basten, C., Byrne, S., Goldstein, M., Hay, P., Heruc, G., Thornton, C., & Touyz, S. (2021). Understanding treatment delay: Perceived barriers preventing treatment-seeking for eating disorders. *The Australian and New Zealand journal of psychiatry*, 48674211020102. Advance online publication. https://doi.org/10.1177/00048674211020102

Hanly, F., Torrens-Witherow, B., Warren, N., Castle, D., Phillipou, A., Beveridge, J., Jenkins, Z., Newton, R., & Brennan, L. (2020). Peer mentoring for individuals with an eating disorder: a qualitative evaluation of a pilot program. *Journal of Eating Disorders, 8*(1), 1–13. https://doi-org/ 10.1186/s40337-020-00301-8

Hansen, S. J., Stephan, A., & Menkes, D. B. (2021). The impact of COVID-19 on eating disorder referrals and admissions in Waikato, New Zealand. *Journal of Eating Disorders, 9*(1). https://doi.org/10.1186/s40337-021-00462-0

Hay, P. (2017). Fifty years of anorexia nervosa and other eating disorders in the Australian & New Zealand Journal of Psychiatry*. Australian & New Zealand Journal of Psychiatry, 51*(6), 555–556. https://doi.org/10.1177/0004867417704057

Hay, P. (2019). To go boldly where no scheme has been before : reconceptualising eating disorder diagnoses. *Australian And New Zealand Journal of Psychiatry*, *53*(4), 363-364. https://doi.org/10.1177/0004867418821430

Hay, P., Ghabrial, B., Mannan, H., Conti, J., Gonzalez, C. D., Stocks, N., Heriseanu, A., & Touyz, S. (2020). General practitioner and mental healthcare use in a community sample of people with diagnostic threshold symptoms of bulimia nervosa, binge-eating disorder, and other eating disorders. *International Journal of Eating Disorders, 53*(1), 61–68. https://doi.org/10.1002/eat.23174

Hays, S. (1996). *The cultural contradictions of motherhood*. Yale University Press.

Hayward, J. (2012). *'Biculturalism', Te Ara - the Encyclopedia of New Zealand.* http://www.TeAra.govt.nz/en/biculturalism

Health Navigator New Zealand (2021). *Weight loss medicines.* https://www.healthnavigator.org.nz/medicines/w/weight-loss-medicines/

Health Point. (2022). *Regional Eating Disorders Service.* https://www.healthpoint.co.nz/mental-health-addictions/mental-health-addictions/regional-eating-disorders-service-1/

Heaner, M. K., & Walsh, B. T. (2013). A history of the identification of the characteristic eating disturbances of Bulimia Nervosa, Binge Eating Disorder and Anorexia Nervosa. *Appetite, 71*, 445–448. https://doi.org/10.1016/j.appet.2013.06.001

Hennink, M., & Kaiser, B. N. (2021). Sample sizes for saturation in qualitative research: A systematic review of empirical tests. *Social Science & Medicine, 292*. https://doi.org/10.1016/j.socscimed.2021.114523

Heruc, G., Hurst. K., Casey, A., Fleming, K., Freeman, J., Fursland, A., Hart, S., Jeffrey, S., Knight, R., Roberton, M., Roberts, M., Shelton, B., Stiles, G., Sutherland, F., Thornton, C., Wallis, A., & Wade, T. (2020). ANZAED eating disorder treatment principles and general clinical practice and training standards. *Journal of Eating Disorders*, *8*(1), 1–9. https://doi.org/10.1186/s40337-020-00341-0

Hilbert, A. (2019). Binge-eating disorder. *Psychiatric Clinics of North America, 42*(1), 33–43. https://doi.org/10.1016/j.psc.2018.10.011

Hollett, K.B., Carter, J. C. (2021). Separating binge-eating disorder stigma and weight stigma: A vignette study. *International Journal of Eating Disorders, 54*(5), 755-763. https://doi.org/10.1002/eat.23473

Holmes, S. (2016). 'Blindness to the obvious'? Treatment experiences and feminist approaches to eating disorders. *Feminism & Psychology, 26*(4), 464–486. https://doi.org/10.1177/0959353516654503

Honey, A., Boydell, K.M., Coniglio, F., Do, T., Dunn, L., Gill, K., Glover, H., Hines, M., Newton Scanal, J., Tooth, B. (2020). Lived experience research as a resource for recovery: a mixed methods study. *BMC Psychiatry 20*(456). https://doi.org/10.1186/s12888-020-02861-0

Hudson, J. I., Hiripi, E., Pope, J. H. G., & Kessler, R. C. (2007). The Prevalence and Correlates of Eating Disorders in the National Comorbidity Survey Replication. *Biological Psychiatry, 61*(3), 348–358. https://dx.doi.org/10.1186%2Fs40337-020-00301-8

Hudson, J. I., Coit, C. E., Lalonde, J. K., & Pope, H. G. (2012). By how much will the proposed new DSM-5 criteria increase the prevalence of binge eating disorder? *International Journal of Eating Disorders, 45*(1), 139–141. https://doi.org/10.1002/eat.20890

Hughes, E. K., Kerr, J. A., Patton, G. C., Sawyer, S. M., Wake, M., Le Grange, D., & Azzopardi, P. (2019). Eating disorder symptoms across the weight spectrum in Australian adolescents. *International Journal of Eating Disorders, 52*(8), 885–894. https://doi.org/10.1002/eat.23118

Hussain, A., Dar, M., & Ganson, K. T. (2021). A Post-Structural Feminist Analysis of Eating Disorders Intervention Research. Affilia: Journal of Women & Social Work, 1. https://doi.org/10.1177/08861099211062942

Ivancic, L., Maguire, S., Miskovic-Wheatley, J., Harrison, C., & Nassar, N. (2021). Prevalence and management of people with eating disorders presenting to primary care: A national study. *Australian & New Zealand Journal of Psychiatry, 55*(11), 1089–1100. https://doi.org/10.1177%2F0004867421998752

Jang, M., Brown, R., & Vang, P. Y. (2021). The Relationships Between Parental Stress, Home Food Environment, and Child Diet Patterns in Families of Preschool Children. *American Journal of Health Promotion, 35(*1), 131–139. https://doi.org/10.1177%2F0890117120929541

Jenkins, P. E., Smith, L., & Morgan, C. (2021). Can early change in eating disorder psychopathology predict outcome in guided self-help for binge eating? *Eating and Weight Disorders - Studies on Anorexia, Bulimia and Obesity, 26*(7), https://dx.doi.org/10.1007%2Fs40519-020-01059-3

Johnson, E. (2017). *Kai and culture : food stories from Aotearoa* (First edition). Freerange Press.

Jones, C., & Porter. R. (1994). *Reassessing Foucault : Power, Medicine and the Body*. Routledge.

Jones, M. (1996). *Men and feminist research*. Routledge.

Keane, H.(2014). Feminism and the Complexities of Gender and Health. *Australian Feminist Studies, 29*(80), 180-188. https://doi.org/10.1080/08164649.2014.928192

Keski-Rahkonen, A. (2021). Epidemiology of binge eating disorder: prevalence, course, comorbidity, and risk factors. *Current Opinion in Psychiatry, 34*(6), 525–531. https://doi.org/10.1097/YCO.0000000000000750

Kessler, R. C., Berglund, P. A., Chiu, W. T., Deitz, A. C., Hudson, J. I., Shahly, V., Aguilar-Gaxiola, S., Alonso, J., Angermeyer, M. C., Benjet, C., Bruffaerts, R., de Girolamo, G., de Graaf, R., Maria Haro, J., Kovess-Masfety, V., Posada-Villa, J., Sasu, C., Scott, K., … Xavier, M. (2013). The Prevalence and Correlates of Binge Eating Disorder in the World Health Organization World Mental Health Surveys. *Biological Psychiatry, 73*(9), 904–914. https://doi.org/10.1016/j.biopsych.2012.11.020

Lacey, C., Cunningham, R., Rijnberg, V., Manuel, J., Clark, M. T. R., Keelan, K., Pitama, S., Huria, T., Lawson, R., & Jordan, J. (2020). Eating disorders in New Zealand: Implications for Māori and health service delivery. *International Journal of Eating Disorders, 53*(12), 1974–1982. https://doi.org/10.1002/eat.23372

LaMarre, A., Smoliak, O., Cool, C., Kinavey, H., & Hardt, L. (2019). The Normal, Improving, and Productive Self: Unpacking Neoliberal Governmentality in Therapeutic Interactions, *Journal of Constructivist Psychology, 32*(3), 236-253. https://doi.org/10.1080/10720537.2018.1477080

LaMarre, A., & Rice, C. (2017). Hashtag Recovery: #Eating Disorder Recovery on Instagram. *Social Sciences*, *6*(3), 68. http://dx.doi.org/10.3390/socsci6030068

LaMarre, A., Rice, C. (2021). Recovering Uncertainty: Exploring Eating Disorder Recovery in Context. *Cult Med Psychiatry*, *45,* 706–726. https://doi.org/10.1007/s11013-020-09700-

Levine, M. P., & Maine, M. (2010). Are media an important medium for clinicians? Mass media, eating disorders, and the bolder model of treatment, prevention, and advocacy. In M. Maine, B. H. McGilley, & D. W. Bunnell (Eds.), *Treatment of eating disorders: Bridging the research–practice gap* (pp. 53–67). Elsevier Academic Press. https://doi.org/10.1016/B978-0-12-375668-8.10004-X

Levitan M.N., Papelbaum M., Carta M.G., Appolinario J.C., & Nardi A.E. (2021). Binge Eating Disorder: A 5-Year Retrospective Study on Experimental Drugs. *Journal of Experimental Pharmacology*, *13,* 33–47. https://doi.org/10.2147/JEP.S255376

Liimakka, S. (2013). *Re-embodied: Young women, the body quest and agency in the culture of appearances* (Academic dissertation). https://helda.helsinki.fi/bitstream/handle/10138/38047/reembodi.pdf?sequence=1

Linville, D., Brown, T., & O'Neil, M. (2012). Medical providers' self perceived knowledge and skills for working with eating disorders: A national survey. *Eating Disorders: The Journal of Treatment & Prevention, 20*(1), 1–13. https://doi.org/10.1080/10640266.2012.635557

Lipson, S. K., & Sonneville, K. R. (2017). Eating disorder symptoms among undergraduate and graduate students at 12 U.S. colleges and universities. *Eating Behaviors, 24*, 81–88. https://doi.org/10.1016/j.eatbeh.2016.12.003

Lo Coco, G., Salerno, L., Ingoglia, S., & Tasca, G. A. (2021). Self-esteem and binge eating: Do patients with binge eating disorder endorse more negatively worded items of the Rosenberg Self-Esteem Scale? Journal of Clinical Psychology, 77(3), 818–836. https://doi-org/10.1002/jclp.23065

Lorraine Radtke, H. (2017). Feminist theory in Feminism & Psychology [Part I]: Dealing with differences and negotiating the biological. *Feminism & Psychology, 27*(3), 357–377. https://doi.org/10.1177/0959353517714594

Love Your Kite. (2022). *Love Your Kite: A practical App resources to support eating disorder recovery.* https://loveyourkite.com/

Lydecker, J. A., & Grilo, C. M. (2018). Comparing men and women with binge-eating disorder and co-morbid obesity. *The International journal of eating disorders*, *51*(5), 411–417. https://doi.org/10.1002/eat.22847

Madden, S. (2004). 'Anorexia Nervosa' – Still Relevant in the Twenty-first Century? A Review of William Gull's Anorexia Nervosa. *Clinical Child Psychology and Psychiatry, 9*(1), 149–154. https://doi.org/10.1177/1359104504039178

Maher, A., Cason, L., Huckstepp, T., Stallman, H., Kannis, D. L., Millear, P., Mason, J., Wood, A., & Allen, A. (2022). Early maladaptive schemas in eating disorders: A systematic review. *European Eating Disorders Review, 30*(1), 3–22. https://doi.org/10.1002/erv.2866

Malson, H.M, & Ussher, J. M. (1997) Beyond this mortal coil: Femininity, death and discursive constructions of the anorexic body. *Mortality,* *2*(1), 43-61. https://doi.org/10.1080/713685852

Marks, A. (2019). The evolution of our understanding and treatment of eating disorders over the past 50 years. *Journal of Clinical Psychology, 75*(8), 1380–1391. https://doi.org/10.1002/jclp.22782

Marzilli, E., Cerniglia, L., & Cimino, S. (2018). A narrative review of binge eating disorder in adolescence: prevalence, impact, and psychological treatment strategies. *Adolescent health, medicine and therapeutics*, *9*, 17–30. https://doi.org/10.2147/AHMT.S148050

McConnell-Henry, T., James, A., Chapman, Y., & Francis, K. (2010) Researching with people you know: Issues in interviewing, *Contemporary Nurse, 34*(1), 2-9. https://doi.org/10.5172/conu.2009.34.1.002

McDowell, J. (1995). Knowledge and the Internal. *Philosophy and Phenomenological Research*, *55*(4), 877– 893. https://doi.org/10.2307/2108338

Mental Health Foundation of New Zealand. (2014). *Eating disorders*. https://mentalhealth.org.nz/conditions/condition/eating-disorders

Mielewczyk, F., & Willig, C. (2007). Old clothes and an older look: The case for a radical makeover in health behaviour research. *Theory & Psychology, 17*, 811-837. https://doi.org/10.1177%2F0959354307083496

Miller, S. (1990). Foucault on Discourse and Power. *Theoria: A Journal of Social and Political Theory*, *76*, 115–125. http://www.jstor.org/stable/41801502

Ministry of Health. (2017). *Clinical Guidelines for Weight Management in New Zealand Adults.* https://www.health.govt.nz/system/files/documents/publications/clinical-guidelines-for-weight-management-in-new-zealand-adultsv2.pdf

Ministry of Health. (2008). *Future Directions for Eating Disorders Services in New Zealand*. Ministry of Health. http://www.moh.govt.nz

Ministry of Health (2019). *Mental health and addiction: service use – series.* https://www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/mental-health-and-addiction-service-use-series

Ministry of Health (2021). *PRIMHD – mental health data*. https://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/collections/primhd-mental-health-data

Ministry of Health (2020). *Te Tiriti o Waitangi.* https://www.health.govt.nz/our-work/populations/maori-health/te-tiriti-o-waitangi

Ministry of Health. (2006). *Te Rau Hinengaro: The New Zealand Mental Health Survey.* https://www.health.govt.nz/publication/te-rau-hinengaro-new-zealand-mental-health-survey

Misluk-Gervase, E. (2020). The Role of Art Therapy in Eating Disorder Advocacy. *Art Therapy: Journal of the American Art Therapy Association, 37*(4), 194–200. https://doi.org/10.1080/07421656.2020.1823783

Mitchison, D., Touyz, S., González, C. D. A., Stocks, N., & Hay, P. (2017). How abnormal is binge eating? 18-Year time trends in population prevalence and burden. *Acta Psychiatrica Scandinavica, 136*(2), 147–155. https://doi.org/10.1111/acps.12735

Moghimi, E., Davis, C., Bonder, R., Knyahnytska, Y., & Quilty, L. (2021). Exploring women's experiences of treatment for binge eating disorder: Methylphenidate vs. cognitive behavioural therapy. *Progress in Neuropsychopharmacology & Biological Psychiatry, 114.* https://doi.org/10.1016/j.pnpbp.2021.110492

Monaghan, L., & Gabe, J. (2015). Chronic illness as biographical contingency? Young people's experiences of asthma. *Sociology of Health & Illness, 37*(8), 1236-1253. https://doi.org/10.1111/1467-9566.12301

Moustakas, C. E. (1990). *Heuristic research: Design, methodology, and applications*. SAGE Publications Ltd.

Mulders-Jones, B., Mitchison, D., Girosi, F., Hay, P. (2017) Socioeconomic Correlates of Eating Disorder Symptoms in an Australian Population-Based Sample. *PLOS ONE, 12*(1). https://doi.org/10.1371/journal.pone.0170603

Munsch, S., Wyssen, A., Vanhulst, P., Lalanne, D., Steinemann, S. T., & Tuch, A.(2019). Binge-eating disorder treatment goes online – feasibility, usability, and treatment outcome of an Internet-based treatment for binge-eating disorder: study protocol for a three-arm randomized controlled trial including an immediate treatment, a waitlist, and a placebo control group*. Trials, 20*(1), 1–11. https://doi-org /10.1186/s13063-019-3192-z

Music, S., Elwyn, R., Fountas, G., Gnatt, I., Jenkins, Z. M., Malcolm, A., Miles, S., Neill, E., Simpson, T., Yolland, C. O., & Phillipou, A. (2021). Valuing the voice of lived experience of eating disorders in the research process: Benefits and considerations. *Australian & New Zealand Journal of Psychiatry, 1.* https://doi.org/10.1177/0004867421998794

Mutu, M. (2019). The Treaty Claims Settlement Process in New Zealand and Its Impact on Māori. *Land, 8*(10), 152. https://doi.org/10.3390/land8100152

National Institute of Mental Health. (n.d.). *Eating Disorders Statistics Reports for the US*. https://www.nimh.nih.gov/health/statistics/eating-disorders

National Institute for Health and Care Excellence. (2017). *Eating disorders: recognition and treatment.*https://www.nice.org.uk/guidance/ng69/chapter/Recommendations#identification-and-assessment –

New Zealand Herald. (2021, April). *Covid 19 coronavirus: 'Tsunami' of child eating disorders emerging after lockdowns in New Zealand.* https://www.nzherald.co.nz/nz/covid-19-coronavirus-tsunami-of-child-eating-disorders-emerging-after-lockdowns-in-new-zealand/M3ZHGQ4ICG72OUMRMFDOLN25CY/

Nilsen, J. V., Hage, T. W., Rø, Ø., Halvorsen, I., & Oddli, H. W. (2020). External support and personal agency - young persons' reports on recovery after family-based inpatient treatment for anorexia nervosa: a qualitative descriptive study. *Journal of Eating Disorders*, *8*, 18. https://doi.org/10.1186/s40337-020-00293-5

Nutton, V. (1997). The Rise of Medical Humanism: Ferrara, 1464-1555. *Renaissance Studies: Journal of the Society for Renaissance Studies, 11*(1), 2–19. https://doi.org/10.1111/j.1477-4658.1997.tb00008.x

Oakley Browne, M. A, Wells, J. E, Scott, K. M., & McGee M. A. (2006). Lifetime prevalence and projected lifetime risk of DSM-IV disorders in Te Rau Hinengaro: The New Zealand Mental Health Survey. *Australian & New Zealand Journal of Psychiatry, 40*(10), 865–874. https://doi.org/10.1080/j.1440-1614.2006.01905.x

O'Loghlen, E., Grant, S., & Galligan, R. (2021). Shame and binge eating pathology: A systematic review. *Clinical Psychology & Psychotherapy, 1*. https://doi.org/10.1002/cpp.2615

Opozda, M., Chur-Hansen, A., & Wittert, G. (2016). Changes in problematic and disordered eating after gastric bypass, adjustable gastric banding and vertical sleeve gastrectomy: a systematic review of pre-post studies. *Obesity Reviews, 17*(8), 770–792. https://doi.org/10.1111/obr.12425

Palavras, M. A., Hay, P., Mannan, H., da Luz, F. Q., Sainsbury, A., Touyz, S., & Claudino, A. M. (2021). Integrated weight loss and cognitive behavioural therapy (CBT) for the treatment of recurrent binge eating and high body mass index: a randomized controlled trial. *Eating and Weight Disorders - Studies on Anorexia, Bulimia and Obesity, 26*(1), 249. https://doi-org/10.1007/s40519-020-00846-2

Paterson, R. (2019). Binge eating disorder treatment controversies. *The Australian and New Zealand Journal of Psychiatry, 53*(4), 368. https://doi.org/10.1177/0004867419828492

Peat, C. M., Berkman, N. D., Lohr, K. N., Brownley, K. A., Bann, C. M., Cullen, K., Quattlebaum, M. J., & Bulik, C. M. (2017). Comparative effectiveness of treatments for binge-eating disorder: Systematic review and network meta-analysis. *European Eating Disorders Review, 25*(5), 317–328. https://doi.org/10.1002/erv.2517

Pearce, J. M. (2004). Richard Morton: origins of anorexia nervosa. *European neurology*, *52*(4), 191–192. https://doi.org/10.1159/000082033

Pershing, A., & Turner, C. (2018). *Binge eating disorder : the journey to recovery and beyond*. Routledge.

Phillips, R., Benoit, C., Hallgrimsdottir, H., Vallance, K. (2011). Courtesy stigma: a hidden health concern among front-line service providers to sex workers. *Sociology of Health and Illness, 35*(5), 681 – 696. https://doi.org/10.1111/j.1467-9566.2011.01410.x

Pilcher, J., & Coffey, A. (2018). *Gender and Qualitative Research.* Taylor and Francis. https://doi.org/10.4324/9781351062787

Piran, N. (2010). A feminist perspective on risk factor research and on the prevention of eating disorders. Eating Disorders: *The Journal of Treatment and Prevention, 18*(3), 183–198. https://doi.org/10.1080/10640261003719435

Pool, I. (2016). Māori Health, Colonization and Post-Colonization: Aotearoa New Zealand, from 1769. *Journal of Northern Studies, 10*(2), 19–43.

Psychology Today. (2021). *National Enquirer's Latest Fat-Shaming Cover Could Be Deadly. https://www.psychologytoday.com/nz/blog/weighty-truths/202107/national-enquirers-latest-fat-shaming-cover-could-be-deadly*

Qian, J., Hu, Q., Wan, Y., Li, T., Wu, M., Ren, Z., & Yu, D. (2013). Prevalence of eating disorders in the general population: A systematic review. *Shanghai Archives of Psychiatry, 25*(4), 212–222. https://doi.org/10.3969/j.issn.1002-0829.2013.04.003

Radio New Zealand. (2021, March). *Dying for help: Eating disorder treatment waiting lists months long*. https://www.rnz.co.nz/news/in-depth/438868/dying-for-help-eating-disorder-treatment-waiting-lists-months-long

Raykos, B. C., McEvoy, P. M., & Fursland, A. (2017). Socializing problems and low self-esteem enhance interpersonal models of eating disorders: Evidence from a clinical sample. *International Journal of Eating Disorders, 50*(9), 1075–1083. https://doi-org/10.1002/eat.22740

Recovered Living NZ (2020). *Eating Disorder Statistics.* https://recoveredlivingnz.com/statistics-and-outcome-data/

Riessman, C. K. (2008). *Narrative methods for the human sciences.* Sage Publications, Inc.

Roberts, M. E. (2018). Feasibility of group Cognitive Remediation Therapy in an adult eating disorder day program in New Zealand. *Eating Behaviors, 30*, 1–4. https://doi-org/10.1016/j.eatbeh.2018.04.004

Rohleder, P., & Lyons, A. C. (2015). *Qualitative research in clinical and health psychology*. Palgrave Macmillan.

Romans, S. E., Gendall, K. A., Martin, J. L., & Mullen, P. E. (2001). Child sexual abuse and later disordered eating: a New Zealand epidemiological study. *The International journal of eating disorders*, *29*(4), 380–392. https://doi.org/10.1002/eat.1034

Rountree, K. (2000). Re-making the Maori female body : Marianne Williams's mission in the Bay of Islands. *The Journal of Pacific History, 35*(1), 49-66. https://doi.org/10.1080/713682828

Rubin, L. R., Nemeroff, C. J., & Russo, N. F. (2004). Exploring Feminist Women's Body Consciousness. *Psychology of Women Quarterly,* *28*(1), 27–37. https://doi.org/10.1111/j.1471-6402.2004.00120.x

Russell G. (1979). Bulimia nervosa: an ominous variant of anorexia nervosa. *Psychological medicine*, *9*(3), 429–448. https://doi.org/10.1017/s0033291700031974

Schmiedel, O. (2020). Obesity and Weight-loss Management: A Radically Different Way of Managing Chronic Metabolic Diseases. *Research Review*. https://www.researchreview.co.nz/nz/Clinical-Area/Internal-Medicine/Diabetes-Obesity/Educational-Series-Obesity-and-Weight-loss-Manage.aspx

Severinsen, C., & Reweti, A. (2019). Rangatahi Tū Rangatira: innovative health promotion in Aotearoa New Zealand. *Health Promotion International, 34*(2), 291–299. https://doi.org/10.1093/heapro/dax075

Sebastian, T., & Donnelly, M. (2013). Policy influences affecting the food practices of Indigenous Australians since colonisation. *Australian Aboriginal Studies. 2013*(2), 59–75. https://doi.org/10.3316/informit.751898844731359

Silver, A. K. (2002). *Victorian literature and the anorexic body*. Cambridge University Press.

Small, D.M., & DiLeone, R.J. (2013). An Introduction to the Special Issue. *Biological Psychiatry, 73*(9). 799-801. https://doi.org/10.1016/j.biopsych.2013.03.007

Smalling, S. (2020). The Body is Not an Apology: The Power of Radical Self-Love (First Edition). *Integral Review: A Transdisciplinary & Transcultural Journal for New Thought, Research, & Praxis, 16*(2), 296–298.

Smith, D.G., Robbins, T.W. (2013). The Neurobiological Underpinnings of Obesity and Binge Eating: A Rationale for Adopting the Food Addiction Model. *Biological Psychiatry. 73*(9), 804 – 810. https://doi.org/10.1016/j.biopsych.2012.08.026

Sonneville, K. R., & Lipson, S. K. (2018). Disparities in eating disorder diagnosis and treatment according to weight status, race/ethnicity, socioeconomic background, and sex among college students. *The International Journal of Eating Disorders, 51*(6), 518–526. https://doi.org/10.1002/eat.22846

Spigel, R., Lin, J. A., Milliren, C. E. , Freizinger, M., Vitagliano, J. A., Woods, E. R., Forman, S. F., & Richmond, T. K. (2021). Access to care and worsening eating disorder symptomatology in youth during the COVID-19 pandemic. *Journal of Eating Disorders, 9*(69). https://doi.org/10.1186/s40337-021-00421-9

Statistics New Zealand (2021, June). *Māori population estimates: At 30 June 2021*. https://www.stats.govt.nz/information-releases/maori-population-estimates-at-30-june-2021

Statistics New Zealand. (2021, September). *Estimated population of NZ.* https://www.stats.govt.nz/indicators/population-of-nz

Stephens, C., & Breheny, M. (2013). Narrative Analysis in Psychological Research: An Integrated Approach to Interpreting Stories, *Qualitative Research in Psychology*, *10*(1), 14-27. https://doi.org/10.1080/14780887.2011.586103

Stice, E., Desjardins, C. D., Rohde, P., & Shaw, H. (2021). Sequencing of symptom emergence in anorexia nervosa, bulimia nervosa, binge eating disorder, and purging disorder and relations of prodromal symptoms to future onset of these disorders. *Journal of Abnormal Psychology, 130*(4), 377–387. https://doi.apa.org/doi/10.1037/abn0000666

Striegel-Moore, R. H., & Bulik, C. M. (2007). Risk factors for eating disorders. *The American Psychologist, 62*(3), 181–198. https://doi.org/10.1037/0003-066X.62.3.181

Stunkard, A. J. (1959). Eating patterns and obesity. *Psychiatric Quarterly, 33,* 284 - 295. https://doi.org/10.1007/BF01575455

Surgenor, L. J. (2020). Commentary on disordered eating symptoms and bariatric/metabolic surgery. *Australasian Psychiatry, 28*(2), 153–155. https://psycnet.apa.org/doi/10.1177/1039856219871869

Sutter, C., Nishina, A., & Adams, R. E. (2015). How you look versus how you feel: Associations between BMI z-score, body dissatisfaction, peer victimization, and self-worth for African American and white adolescents. *Journal of Adolescence, 43*, 20–28. https://psycnet.apa.org/doi/10.1016/j.adolescence.2015.05.002

Thompson-Brenner, H., Satir, D. A., Franko, D. L., & Herzog, D. B. (2012). Clinician reactions to patients with eating disorders: a review of the literature. *Psychiatric services (Washington, D.C.)*, *63*(1), 73–78. https://doi.org/10.1176/appi.ps.201100050

Thomson, L. (2001). Whose right to choose? A competent child's right to consent to and refuse medical treatment in New Zealand. *Canterbury Law Review, 8*(1), 145–186. https://search.informit.org/doi/10.3316/agispt.20022015

Thornicroft, C., Wyllie, A., Thornicroft, G., & Mehta, N. (2014). Impact of the "Like Minds, Like Mine" anti-stigma and discrimination campaign in New Zealand on anticipated and experienced discrimination. *Australian & New Zealand Journal of Psychiatry, 48*(4), 360–370. https://doi.org/10.1177/0004867413512687

Thornicroft, G., Mehta, N., Clement, S., Evans-Lacko, S., Doherty, M., Rose, D., Koschorke, M., Shidhaye, R., O'Reilly, C., & Henderson, C. (2016). Evidence for effective interventions to reduce mental-health-related stigma and discrimination. *Lancet*, *387*(10023), 1123–1132. https://doi.org/10.1016/S0140-6736(15)00298-6

Touyz, S., Lacey, H. & Hay, P. (2020). Eating disorders in the time of COVID-19. *Journal of Eating Disorde*rs, *8*(19). https://doi.org/10.1186/s40337-020-00295-3

Treasure, J., & Russell, G. (2011). The case for early intervention in anorexia nervosa: Theoretical exploration of maintaining factors. *British Journal of Psychiatry, 199*(1), 5-7. https://doi.org/10.1192/bjp.bp.110.087585

Tylka, T., & Sabik, N. (2010). Integrating Social Comparison Theory and Self-Esteem within Objectification Theory to Predict Women's Disordered Eating. *Sex Roles, 63*(1–2), 18–31. https://doi.org/10.1007/s11199-010-9785-3

Vanderkruik, R., Gist, D., & Dimidjian, S. (2020). Preventing eating disorders in young women: An RCT and mixed-methods evaluation of the peer-delivered Body Project. *Journal of Consulting and Clinical Psychology, 88*(12), 1105–1118. http://dx.doi.org/10.1037/ccp0000609

Valina, G., & Sessa, A. (2020). Current Trends of Cosmetic Surgical Procedures With the General Cosmetic Surgery Fellowships by the American Academy of Cosmetic Surgery. *The American Journal of Cosmetic Surgery,* 37(1), 5–13. https://doi.org/10.1177/0748806819852014

Vigarello, G. (2015). The metamorphoses of fat : a history of obesity. Columbia University Press.

Wacker, E. C., & Dolbin-MacNab, M. L. (2020). Feminist-informed protective factors for subthreshold eating disorders. *Qualitative Health Research, 30*(10), 1546–1560. https://doi.org/10.1177%2F1049732320921832

Wacker, E. (2018). Application of the feminist-relational model for the treatment of subclinical eating disorders. *Journal of Feminist Family Therapy, 30*, 71–89. https://doi.org/10.1080/08952833.2018.1426947

Walker, K. (2021). *Body Image and the Media*. Salem Press Encyclopedia.

Wei, B., Klimek, P., Pennesi, J.-L., & Blashill, A. J. (2021). Perceptual and attitudinal body image, disordered eating, and muscle-building behavior in college men. *Psychology of Men & Masculinities, 22*(1), 156–165. https://doi.org/10.1037/men0000290

Westerberg, D. P., & Waitz, M. (2013). Binge-eating disorder. *Osteopathic Family Physician, 5*(6), 230–233. https://doi.org/10.1016/j.osfp.2013.06.003

Wilson, G.T., Wilfley, D.E., Agras, W.S., Bryson, S.W. (2010). Psychological Treatments of Binge Eating Disorder. *Arch Gen Psychiatry, 67*(1), 94–101. http://doi.org/10.1001/archgenpsychiatry.2009.170

Wonderlich S.A., Gordon K.H., Mitchell J.E., Crosby R.D., & Engel S.G. (2009). The validity and clinical utility of binge eating disorder. *International Journal of Eating Disorders, 42*(8), 687–705. https://doi.org/10.1002/eat.20719 \

Woodward, K., McIlwain, D., & Mond, J. (2019). Feelings about the self and body in eating disturbances: The role of internalized shame, self-esteem, externalized self-perceptions, and body shame. *Self and Identity, 18*(2), 159–182. https://psycnet.apa.org/doi/10.1080/15298868.2017.1403373

Wright, J., & Harwood, V. (2009). *Biopolitics and the "obesity epidemic" : governing bodies*. Routledge.

Zeigler-Hill, V., & Noser, A. (2015). Will I Ever Think I'm Thin Enough? A Moderated Mediation Study of Women's Contingent Self-Esteem, Body Image Discrepancies, and Disordered Eating. *Psychology of Women Quarterly, 39*(1), 109–118. https://doi.org/10.1177%2F0361684313515841

Appendices

Appendix A: Participant information sheet

Appendix B: Participant consent form

Appendix C: Interview recruitment poster & Instagram post

Appendix D: Semi-structured interview schedule

Appendix E: Support resources

Appendix F: GP survey recruitment

Appendix G: GP survey information sheet

Appendix H: GP survey questions

Appendix I: Discourse analysis table

Appendix J: Mind maps from analysis

Appendix K: Glossary of Terms

Appendix A – Participant information sheet

School of Psychology
Massey University
Private Bag 102-904
North Shore
Auckland 0745
Tel +64 9 414 0800 ext 43116

Lived experiences of Binge Eating and access to care in the New Zealand health system

INFORMATION SHEET

My name is Jenny and as part of my Master of Science Thesis in Health Psychology I am conducting research on individual's experiences of binge eating.

Project Description

Binge Eating is a relatively unknown, and somewhat overlooked, eating behaviour, that can lead to Binge Eating Disorder (BED). The aim of this study is to create an understanding of daily life with binge eating; how it affects your perceptions of self, and explore the impacts on social, family and work life. I am also interested in how you have navigated primary care providers such as GPs, for support and treatment.

You are invited to take part in this study. Whether you decide to take part or not is your choice. If you do not want to take part, you do not have to give a reason. This Information Sheet will help you decide if you want to participate in this study. Before you decide you may want to discuss the study with other people such as partners, family, whānau, friends, or health providers.

Who can participate in this project?

Inclusion criteria

- Individuals over 18 years of age
- Self-identified as experiencing one or more of the following behaviours, at some stage in your life
    - eating an amount of food in a short period of time e.g. two hours, that is more than you think most people would under similar circumstances
    - Feeling unable to stop eating, or control what or how much you eat
    - Feeling bad about your eating
- You are not required to have an official diagnosis of Binge Eating Disorder (BED), to participate but if you do have a diagnosis you must consider yourself in a stable place of recovery to participate
- Have not had an official diagnosis of an alternative Eating Disorder (such as Bulimia Nervosa)
- Participants of any ethnicity are invited to participate, however; the interviews will be conducted in English.

If you participate what will you be required to do?

If you wish to participate you will be invited to take part in one semi-structured interview (taking approximately one hour), at a time and place that we mutually agree on. Face-to-face interviews will be offered, but if you prefer (or due to COVID-19) these can be conducted on-line. The interview will focus on your experiences of binge eating.. Following this, I will email you the transcript giving you a chance to reflect on this and then I will invite you to a follow-up interview that will take place either via Phone call, or on-line. At this time, you can discuss any changes, withdraw, or add further information. This should take no longer the thirty minutes and is not compulsory. Due to the challenges of living with binge eating, I understand that it may be difficult to discuss your experiences. I do not anticipate harm or discomfort as part of this research however, I do acknowledge that it is a difficult subject. You do not have to talk to me about anything that you do not want, you can stop the interview at any time, and you have the right to ask questions.

In recognition of your time and contribution to the research, all interview participants will receive a $30 gift voucher for The Warehouse.

Data Management

The interviews will all be recorded on a voice recorder with your permission. The data will be stored securely and only the researcher and supervisor will have access to this information. Once the interviews have been transcribed you will be provided with a copy of your transcript, which you may edit and adjust if you feel necessary. To ensure autonomy, all identifying information will be removed from the transcript, the data and the write up of the research. However, there is the possibility that your response may be used in other research publications. All personal information and data will be stored on a password protected computer and on a Massey University hard drive until the research is complete in February 2022, and then it will be deleted. An anonymous form of your transcript and coding will be stored indefinitely in Massey H drive as the data saved to Massey University's network is backed up, maintained and managed, secure, replicated and protected against viruses.

Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- Decline to answer any particular questions
- Withdraw from the study at any time up until October 2021
- Ask any questions about the study at any time during participation
- Provide information on the understanding that your name will not be used unless you give permission to the researcher
- Be given access to a summary of the project findings when it is concluded
- Ask for the recorder to be turned off at any time during the interview

Please contact the research or supervisor if you have any questions about the project.

Contact details below:

Researcher:	**Supervisor:**
Jenny Parsons	Kathryn McGuigan
Jennifer.parsons.2@uni.massey.ac.nz	K.Mcguigan@massey.ac.nz
021 872 164	09 414 0800, ext. 43115

Committee Approval Statement

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 21/24. If you have any concerns about the conduct of this research, please contact Dr Fiona Te Momo, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800, x 43347, email humanethicsnorth@massey.ac.nz

Appendix B – Participant consent Form

School of Psychology
Massey University
Private Bag 102-904
North Shore
Auckland 0745
Tel +64 9 414 0800 ext 43116
Fax +64 9 441 8157

Lived experiences of Binge Eating and access to care in the New Zealand Health System

PARTICIPANT CONSENT FORM - INDIVIDUAL

I have read and I understand the Information Sheet. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw from the study at any time.

1. I agree/do not agree to the interview being sound recorded.
2. I wish/do not wish to have my recordings returned to me.
3. I agree to participate in this study under the conditions set out in the Information Sheet.

Declaration by Participant:

I ___________ [print full name]__________ hereby consent to take part in this study.

Signature: _______________________ Date: ________________

Appendix C – Interview recruitment poster & Instagram post

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

Have you Experienced Binge Eating?

You are invited to participate in research investigating individual experiences of Binge Eating that have become significant and/or problematic

Binge Eating involves consuming a large quantity of food, in a short period of time, often accompanied by feelings of shame and a lack of control. If sustained, these eating behaviours can lead to Binge Eating Disorder (BED).

If you have experienced the following, we would like to hear from you;

- **eating an amount of food in a short period of time e.g. two hours, that is more than you think most people would under similar circumstances**
- **Feeling unable to stop eating, or control what or how much you have eaten**
- **Feeling bad, sad, or ashamed about your eating**

We are looking to interview people over 18 years of age who are interested in sharing their experiences of Binge Eating. Participation includes one face to face or virtual interview, approximately one hour in length, and one phone call, approximately 30 minutes in length. To recognise your time and contribution to the research, a $30 'The Warehouse' voucher will be provided.

You are not required to have an official diagnosis of Binge Eating Disorder (BED) to participate, but if you do have a diagnosis you must consider yourself in a stable place of recovery

If you would like to participate, or hear more about this research, please contact Jenny Parsons;
Email: Jennifer.Parsons.2@uni.massey.ac.nz

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

Have you experienced Binge Eating?

We are looking for men and women, 18 years or over, to share their experiences of Binge Eating

If you have experienced any of the following, we invite you to participate;

- Eaten an amount of food in a short period of time e.g. two hours, that is more than you think most people would under similar circumstances
- Felt unable to stop eating, or control what or how much you have eaten
- Felt bad, sad or ashamed about your eating

For more information email: Jennifer.Parsons.2@uni.massey.ac.nz
*Participants will receive a $30 Voucher for 'The Warehouse'

Appendix D – Semi-structured interview schedule

Interview Guide – Semi-structured Interviews

- **Can you tell me about your experience with Binge Eating?**
  (when did it start, what has it been like for you, have you encountered prejudice)

- **What do you classify as a binge?**
  (where, when, how often/much, what food)

- **How do you feel when you Binge?**
  (emotions caused by BE, emotions/situations that trigger BE)

- **How do you perceive your relationship with food?**
  (what does food mean to you, how do you manage this relationship, do you get joy/comfort/pain/fear from food)

- **What do you know about Binge Eating as a Disorder?**
  (how did you learn about BED/do you use the terms Binge Eating and/or BED, do you think you have BED)

- **Have you been diagnosed with BED (or other eating disorder)?**
  (if diagnosed when/what was the process for you, who did you turn to for medical support, how do you self-identify as a binge eater/having BED, do you use and/or identify with these terms)

- **Do you discuss your BE with anyone?**
  (if so, why them/how/how do they feel about it and/or support you, are you part of any groups - in person or social media, receive any secondary or primary care support)

- **Did you seek support from your GP or other medical professionals?**
  (if so, what was your experience when you did this, did you feel support/prejudiced)

- **How do you self-manage your BE?**
  (what are your rituals/patterns/learnings, what has helped you, who do you reach out to, do you have any role models in the BE community)

- **Can you share any challenges or issues that you've faced?**
  (with family, peers, medical professionals, colleagues, how did you deal with/manage these, what has been the hardest part/most defining feature for you)

- **What advice would you give to others about Binge Eating?**
  (younger self/others who BE/community/GPs, what is one thing others could do to support you & others/BE community, what would you like others to know about BE)

- **What do you hope for in the future?**
  (with your BE and recovery, for others struggling, care and support services)

- **What do you think is a positive thing that has come from your BE journey?**

- **What are you proud of from your experience?**
  (how does taking part in the study make you feel)

- **Is there anything else you would like to add and/or ask me?**

Appendix E – Support resources

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

If the interviews raise issues that are particularly upsetting, I encourage you to use your personal support systems to talk through them. Often reliving an experience can be distressing, but sometimes there are benefits of talking with someone about it. Furthermore, your experience may help others who are experiencing something similar.

Eating Disorder Services

- **Eating Disorders Association of New Zealand (EDANZ);** https://www.ed.org.nz/
  - Advice on speaking with doctors
  - Resources & newsletter
  - Parent/carer support groups, including Zoom

- **Canopy Eating Disorder Services;** https://www.canopyeds.co.nz/
  - Free live chat & online courses, additional paid community courses & GP referral options

- **NZEDC – New Zealand Eating Disorder Clinic;** https://www.nzeatingdisordersclinic.co.nz/eating-disorders/binge-eating-disorder/
  - provides a list of free supportive resources including Apps & Ted Talks

- **Mental Health Foundation of New Zealand;** https://mentalhealth.org.nz/conditions/condition/eating-disorders
  - Information on Eating Disorders, resources and links to other support providers

- **Voices of Hope;** https://www.thevoicesofhope.org/
  - general mental health, with Eating Disorder related information
  - Posts and videos sharing lived experience

- **FEAST;** https://www.feast-ed.org/
  - Global network, family focused resources

- **Centre for Clinical Interventions;** https://www.cci.health.wa.gov.au/Resources/Looking-After-Yourself/Disordered-Eating
  – self-help page, disordered eating online workbooks

- **Eating Disorders Victoria;** https://www.eatingdisorders.org.au/

- **Love Your Kite App: https://loveyourkite.com**/
  - App designed to support recovery

- **FEDUP (Fighting Eating Disorders in Underrepresented Populations: A Trans+ & Intersex Collective)** https://fedupcollective.org//
  - Resources, Online Support Groups and Blog posts

Mental health services – where to get help

There's a range of resources and services available to help including phone and online services and information, as well as face to face support.

Most services are free, and provide information and confidential advice from trained professionals.

If you're told that there is a waiting time for a service, please still reach out and make contact. Other supports can be put in place – ask what you can try in the meantime.

- **Depression.org.nz – Free text number 4202**
  This website helps New Zealanders recognise and understand depression and anxiety.
  This website is part of a national public health programme, the National Depression Initiative. It includes The Journal – an online self-help programme.

- **Like Minds, Like Mine**
  Like Minds, Like Mine is a national anti-stigma campaign. The aim of this programme is to increase social inclusion and to reduce stigma and discrimination towards people with experience of mental illness.

Helplines

Below is a list of some of the telephone helplines or services available which offer support, information and help. All services are free, and are available 24 hours a day, 7 days a week unless otherwise stated.

Need to talk? Free call or text 1737 any time.

Talk to a trained counsellor or call:

- the Depression helpline – 0800 111 757
- Alcohol drug helpline – 0800 787 797
- Gambling helpline – 0800 654 655
- Healthline – 0800 611 116 – to get help from a registered nurse 24/7.
- Lifeline – 0800 543 354
- Samaritans – 0800 726 666
- Chinese Lifeline – 0800 888 880
  (for people who speak Mandarin or Cantonese)
- Youthline – 0800 376 633, free text 234 or email talk@youthline.co.nz
  (for young people, and their parents, whānau and friends)
- The Lowdown – visit the website, email team@thelowdown.co.nz or free text 5626 (emails and text messages will be responded to between 12 noon and 12 midnight)

For families, whānau, friends and supporters

- Skylight – 0800 299 100
  (for support through trauma, loss and grief; 9 am to 5 pm weekdays)
- Supporting Families In Mental Illness – 0800 732 825
  (for families and whānau supporting a loved one who has a mental illness)
- Mental Health Foundation – for more information about supporting someone in distress, looking after your mental health and working towards recovery **https://www.health.govt.nz/your-health/services-and-support/health-care-services/mental-health-services/mental-health-services-where-get-help**

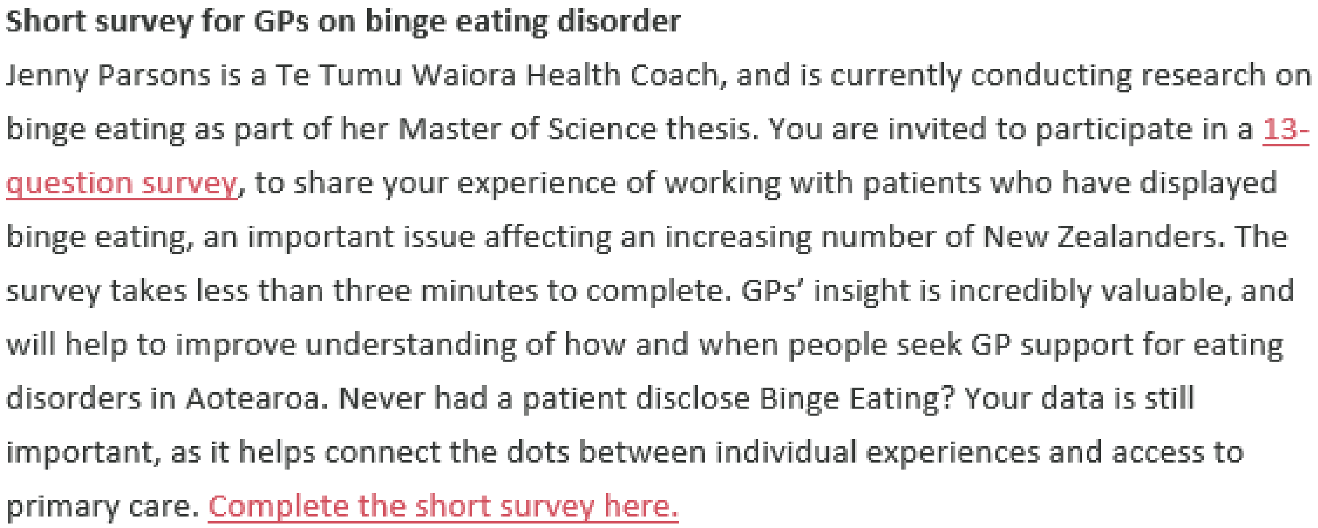
Appendix F – Participant demographic data

Table 2; Participant Demographic data

Demographic Information - SS Interviews	**Total**
Q1 What is your age?	
☐18-24	0
☐25-30	4
☐31-40	1
☐41-50	2
☐51-60	1
☐61-70	0
☐70+	0
Q2 What is your gender?	
☐Male	1
☐Female	7
☐Gender variant/non-conforming	0
☐Other …………………	0
☐Prefer not to answer	0
Q3 Please Specify your Ethnicity	
☐New Zealand European	4
☐Māori	2
☐Pacific Islander	0
☐Asian	1
☐Middle Eastern/Latin American/African	1
☐Other European	2
☐Other Ethnicity	0

Appendix G – GP survey recruitment

1) ProCare Clinical Directorate - Bulletin Announcement, Friday 24th September 2021.



Short survey for GPs on binge eating disorder

Jenny Parsons is a Te Tumu Waiora Health Coach, and is currently conducting research on binge eating as part of her Master of Science thesis. You are invited to participate in a 13-question survey, to share your experience of working with patients who have displayed binge eating, an important issue affecting an increasing number of New Zealanders. The survey takes less than three minutes to complete. GPs' insight is incredibly valuable, and will help to improve understanding of how and when people seek GP support for eating disorders in Aotearoa. Never had a patient disclose Binge Eating? Your data is still important, as it helps connect the dots between individual experiences and access to primary care. Complete the short survey here.

Appendix H – GP survey information sheet

School of Psychology
Massey University
Private Bag 102-904
North Shore
Auckland 0745
Tel +64 9 414 0800 ext 43116
Fax +64 9 441 8157

Lived experiences of Binge Eating and access to care in the New Zealand health system

GP INFORMATION SHEET

My name is Jenny and as part of my Master of Science Thesis in Health Psychology I am conducting research on individuals experiences of binge eating. As part of this research, I am also interested in seeing what GPs understanding of BED is, and pathways to care available for BED in New Zealand.

Project Description

Binge Eating is a relatively unknown, and somewhat overlooked, eating behaviour, that can lead to Binge Eating Disorder (BED). Characterised by recurrent episodes of binging, or extreme overeating, binging occurs when a person eats a large amount of food, in a short amount of time, usually marked by a lack of control (*EDANZ*, 2021). Limited data is available on how many people in New Zealand are affected by BED, however international data shows a prevalence in adult populations of 0.8 – 1.6% (Hudson et al. 2007). In New Zealand, eating disorders in general, affect approximately 0.5% of the population, with this number expected to grow (*Ministry of Health*, 2021). The primary aim of this study is to create an understanding of daily life with binge eating; how it affects perceptions of self, and impacts on social, family and work life through interviews with people with lived experience. A secondary aim is to explore current understandings of GPs of BED through a short survey.

You are invited to take part in the second part of this study. Whether you decide to take part or not is your choice. If you do not want to take part, you do not have to give a reason. This Information Sheet will help you decide if you want to participate in this study. Before you decide you may want to discuss the study with other people such as partners, family, whānau, friends, or health providers.

Who can participate in this project?

General Practitioners who are currently registered and working in New Zealand are eligible to participate. Your practice manager has been contacted ahead of time, and approved for GPs working at your place of employment to be contacted to take part in this research.

Inclusion criteria

- Working as a GP in New Zealand.
- Participants of any ethnicity are invited to participate, however; the survey will be conducted in English.

If you participate what will you be required to do?

If you wish to participate you will be invited to answer twelve questions related to Binge Eating on a short survey.

Your answers will be completely anonymous, even to the researcher, as you will be assigned a number in the survey portal and only ever known by this number. The demographic information collected will be time working as a GP, self-selected gender, ethnicity, age band and practice region. We will not be collecting practice information or any other information that could identify you.

You are under no obligation to answer the survey. However, once you have completed the survey you will be unable to withdraw your answers, as they are recorded anonymously.

Data Management

All data will be stored on a password protected computer and on a Massey University hard drive until the research is complete in February 2022. An anonymous form of data will be stored indefinitely in Massey H drive as the data saved to Massey University's network is backed up, maintained and managed, secure, replicated and protected against viruses.

Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- Decline to answer any particular questions
- Withdraw from the study at any time
- Ask any questions about the study at any time during participation
- Provide information on the understanding that your name will not be used
- Be given access to a summary of the project findings when it is concluded

Please contact the research or supervisor if you have any questions about the project. Contact details below:

Researcher:	**Supervisor:**
Jenny Parsons	Kathryn McGuigan
Jennifer.parsons.2@uni.massey.ac.nz	K.Mcguigan@massey.ac.nz
021 872 164	09 414 0800, ext. 43115

Committee Approval Statement

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 21/24. If you have any concerns about the conduct of this research, please contact Dr Fiona Te Momo, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800, x 43347, email humanethicsnorth@massey.ac.nz.

GP Survey Questions

Part 1 - Demographic Information

Q1 Time as GP - How long have you been working as a General Practitioner?

- 0-5 years
- 6-10 years
- 11-15 years
- 16-20 years
- 20+ years

Q2 Age Band - What is your age?

- 25-30
- 31-40
- 41-50
- 51-60
- 61-70
- 70+

Q3 Self-identified Gender - What is your gender?

1 Male
2 Female
3 Gender variant/non-conforming
4 Other ………………….
5 Prefer not to answer

Q4 Ethnicity - Please specify your Ethnicity

Ethnicity list (adapted from statistics New Zealand categories)

1 European
2 Māori
3 Pacific Peoples (Pacific Islander)
4 Asian
5 Middle Eastern/Latin American/African
6 Other European
7 Other Ethnicity

Q5 Region – Which region of New Zealand do you practice in?

--

Part 2 – Binge Eating Criteria

Q6 Do you know the Diagnostic Criteria for Binge Eating Disorder (BED)?

- YES
- NO
- SOMEWHAT

Q7 Do you know the Diagnostic Criteria for the following Eating Disorders?
If YES, please select all that apply

1 YES - Anorexia Nervosa (AN) Yes/no/somewhat
2 YES - Bulimia Nervosa (BN) Yes/no/somewhat
3 YES - Avoidant/Restrictive Food Intake Disorder (ARFID) Yes/no/somewhat
4 YES - PICA Yes/no/somewhat

Q8

a) Have you used screening tools for BED in your GP practice?

- YES
- MAYBE
- NO

b) If you answered YES to using a BED screening tool, please specify tool(s) used;

…………………………………………………………………….

Q9 Have you had (or currently have) patients who you think are struggling with Binge Eating?

- YES
- MAYBE
- NO

Part 3: Pathways to Care

Q10

a) **Do you know the pathways to care/support/treatment that are available for people with BED in New Zealand?**

- YES
- MAYBE

NO

b) **If you answered, YES have you used these pathways?**

- YES
- NO

c) **If you answered YES, please specify pathway(s) used;**

………………………………………..……………………….

Q11 Do you think Primary Care services (such as Medical Centres) would benefit from more information on secondary care services available for BED?

- YES
- NO
- SOMEWHAT

Q12 - While working as a General Practitioner, have you referred patients for Bariatric Surgery?

- YES
- NO

Q13 Any other comments?

e.g. suggestions for improvements in this area, the role of GP's in eating disorder support, current referral processes.

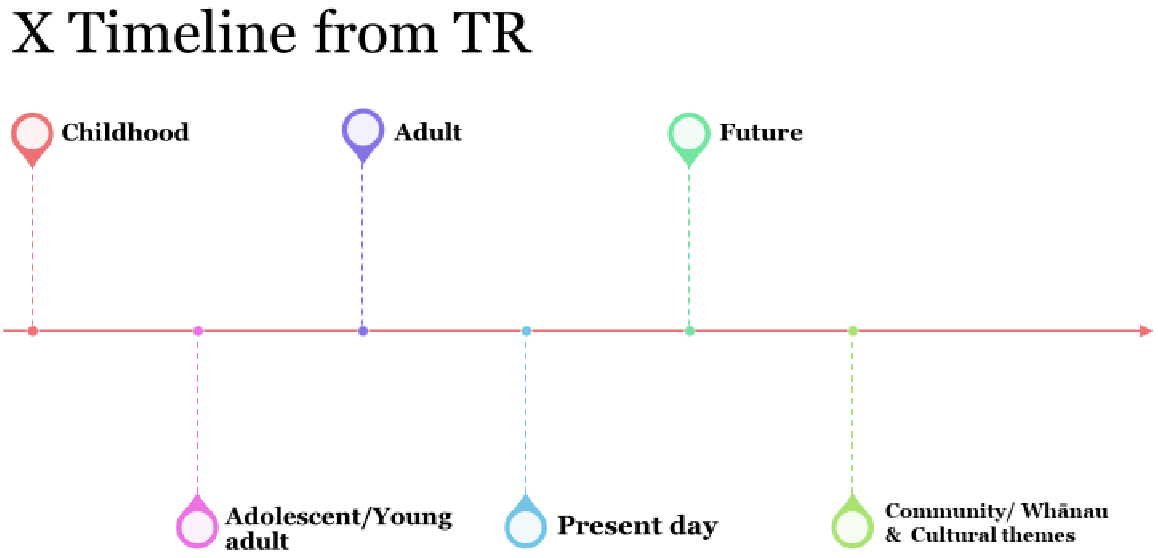
………………………………………..……………………….

Thank you for your time.

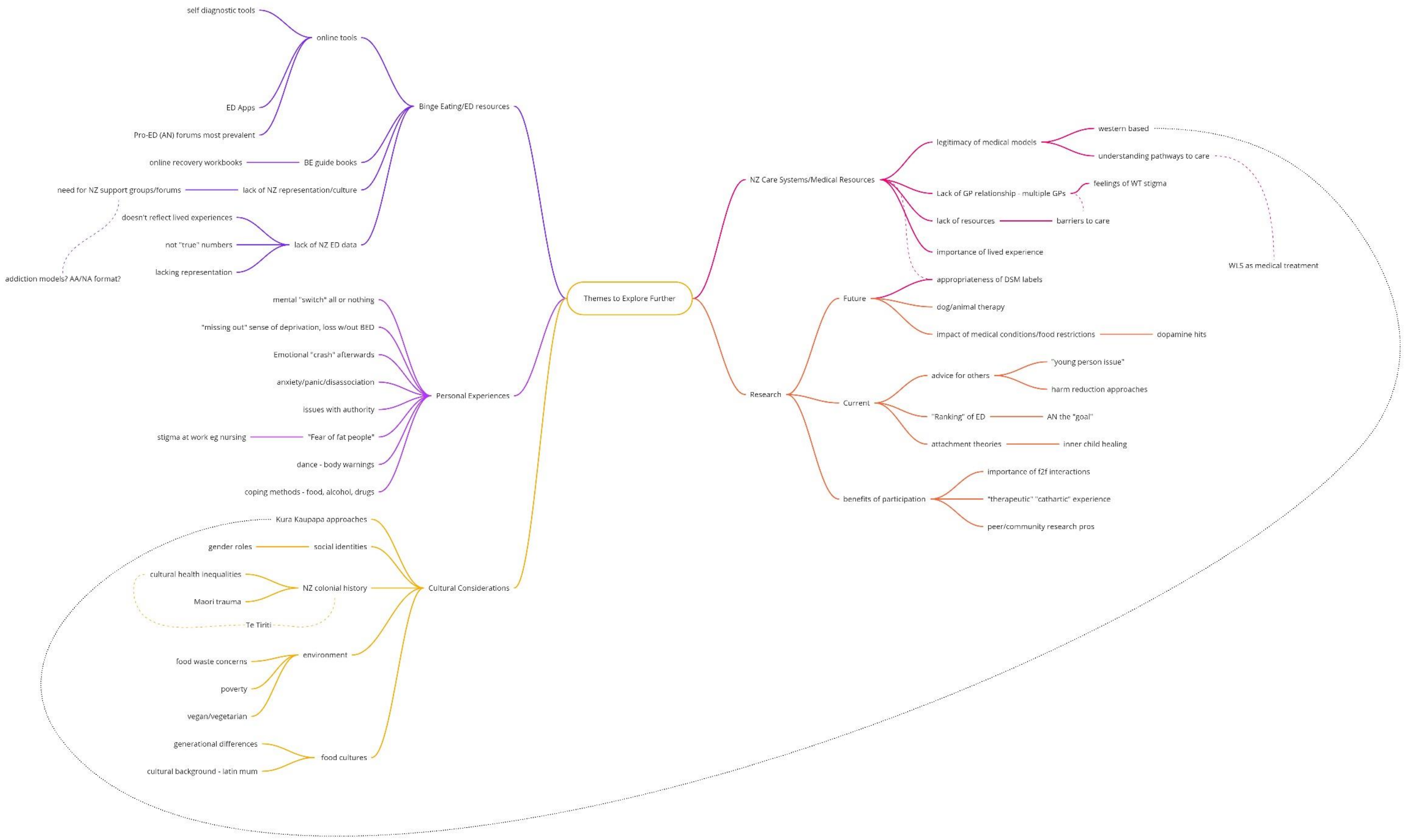
Appendix J – Discourse analysis table

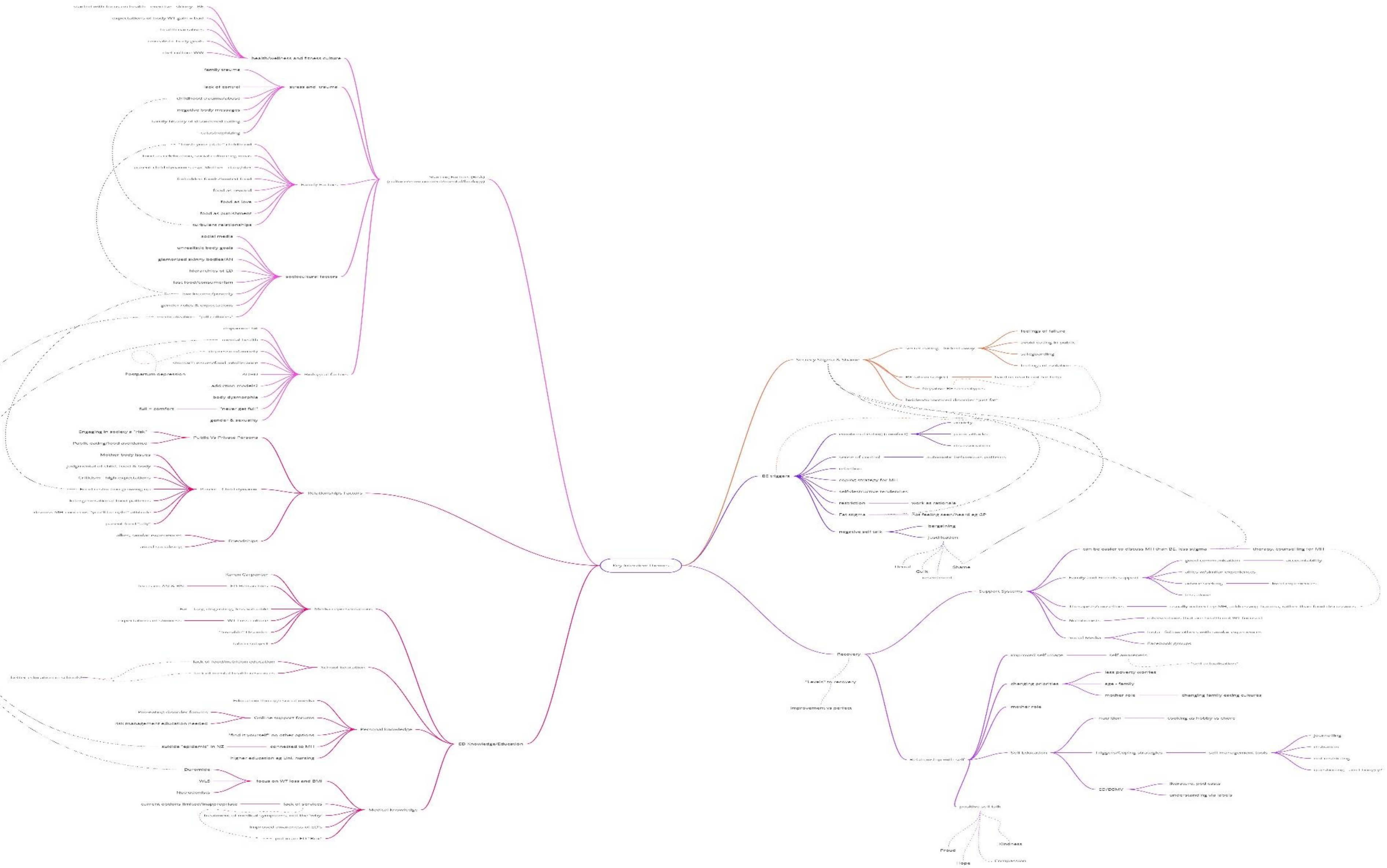
Discursive Construct	**Binge eating as coping strategy**	**"Fat" Body**	**Mother-Child**
Discourses	Psycho-social	Psycho-social/biomedical	Feminist theory
Function	Causes and relieves stress	Value based of physical attributes, places issue within the physical body	Intergenerational patterns of eating & body shame
Positioning	BE as a psychological response to stress and/or trauma	fat = lazy, less than, issue is WT rather than behaviours Fat = calories in vs calories out, biomedical process only/main function	BE as a reflection of relationships (formative) & social expectations on women's bodies
Practice	MH intervention based on building self-efficacy & heathier thought patterns/coping mechanisms (CBT-E?)	Medical interventions offered, e.g. WLS or medication	Breaking intergenerational patterns, breaking social expectations
Subjectivity	Self-blame, shame, guilt	Stigma, minimization of individual differences	Social pressures on women

Appendix K – Timeline Template from Transcript Review



Appendix L – Mind maps from analysis




Key Interview themes
Starting Factors (Risk)
(culture/environment/mental/biology)
health/wellness and fitness culture
started with focus on health - exercise - skinny - BE
expectations of body WT gain = bad
diet culture WW
stress and trauma
family trauma
lack of control
childhood trauma/abuse
negative body messages
family history of disordered eating
catastrophizing
Family Factors
"finish your plate" childhood
food as celebration, social gathering, love
parent child dynamics e.g. Mother - daughter
forbidden food/treated food
food as reward
food as love
food as punishment
turbulent relationships
sociocultural factors
social media
unrealistic body goals
glamorized skinny bodies/AN
hierarchies of ED
fast food/consumerism
low income/poverty
gender roles & expectations
Biological factors
mental health
depression/anxiety
stomach issues/food intolerance
ADHD
addiction models?
body dysmorphia
"never get full"
full = comfort
gender & sexuality
Postpartum depression
Relationships Factors
Public Vs Private Persona
Engaging in society a "risk"
Public eating/food avoidance
Parent - Child dynamic
Mother body issues
judgmental of child, food & body
Criticism - high expectations
intergenerational food patterns
dismiss MH concerns "you'll be right" attitude
Friendships
allies, similar experiences
avoid socialising
ED Knowledge/Education
Media representations
Karen Carpenter
ED Hierarchies
focus on AN & BN
Fat - lazy, disgusting, less valuable
WT loss culture
expectations of thinness
taboo subject
School Education
lack of food/nutrition education
lack of mental health resources
better education in schools
Personal knowledge
Education through social media
Online support forums
Pro-eating disorder forums
risk management education needed
"find it yourself" no other options
connected to MH
suicide "epidemic" in NZ
higher education eg Uni. nursing
Medical knowledge
focus on WT loss and BMI
Duromide
WLS
Nutritionists
lack of services
current options limited/inappropriate
treatment of medical symptoms, not the 'why'
improved awareness of ED's
put in an ED "Box"
Secrecy Stigma & Shame
secret eating - hide it away
feelings of failure
avoid eating in public
safeguarding
feelings of isolation
BE taboo subject
hard to reach out for help
Negative BE stereotypes
hidden/unnoticed disorder "just fat"
BE triggers
emotional eating (comfort)
anxiety
panic attacks
sense of control
automatic behaviour patterns
rebellion
coping strategy for MH
self-destructive tendencies
restriction
work as rationale
Fat stigma
not feeling seen/heard eg GP
negative self talk
bargaining
justification
Denial
Guilt
Shame
Recovery
"Levels" to recovery
improvement vs perfect
Support Systems
can be easier to discuss MH than BE, less stigma
therapy, counselling for MH
Family and friends support
good communication
accountability
allies w/similar experiences
advice seeking
lived experiences
Therapists/counsellors
Nutritionists
Social Media
Insta - follow others with similar experiences
Facebook groups
Relationship with self
improved self image
self awareness
"self actualisation"
changing priorities
less poverty worries
age - family
mother role
changing family eating cultures
mother role
Self Education
nutrition
cooking as hobby vs chore
Triggers/Coping strategies
self management tools
journalling
distraction
not restricting
questioning "am I hungry?"
ED/DSMV
literature, pod casts
understanding via labels
positive self talk
Proud
Hope
Kindness
Compassion

Appendix M – Case Introductions

Case Introductions

Eight participants were interviewed for this study, including seven females and one male. To protect their identity, all participants have been given pseudonyms and where appropriate, other personal details have been changed, for instance cities or places, to ensure protection of participant anonymity.

Madilyn – "I don't even like quiche…but I just want to eat"

for Madilyn, her journey with food started at a young age after an experience in hospital where she lost weight due to illness, and was told to re-feed, however this narrative changed when she was perceived as putting on too much weight, and then told to restrict and increase exercise. Eating treats became something that was done quickly and in secret. When discussing food, in many cases foods that she binges are not foods that are even particularly enjoyed, but centred on what is most convenient and easy to access at the time, such as bakery food. As Madilyn's journey developed over the years, relationships with food became one of emotion & comfort, with themes of restriction and secret binge eating. Having reached out for help from nutritionists and her GP, methods related toward WT management were the main focus such as Duromine medication and weight loss surgery referral, but binge eating itself is not a topic that Madilyn had discussed with others, until our interview, with predominant knowledge of binge eating coming from social media Instagram accounts. Madilyn's transition into being a mother, is an important consideration for her around food and the messages she passes down to her daughter.

Āwhina – "if I'm gonna get well, I'm gonna have to do it myself"

Āwhina's story is from the perspective of being in the middle of an ongoing journey with binge eating, and finding a lack of support services that for her felt helpful, including GP and therapist services. Her conclusion is that if she is going to get well she is going to have to do it herself and hopes that her knowledge and experience can help others in her community. Themes of culture and family are extremely prevalent in her story, and in her personal reason for wanting to improve her relationship with food, and break cycles of being "on" and "off" her exercise and food routines, reflecting a theme of restriction and binge cycles. She intentionally reflects topics of "Wāhine eating" and community obesity in her personal accounts, to exemplify the wider cultural issues she sees within her community, around trauma and food.

Charles – change is pretty easy… but only if you're not given a choice"

As the only male voice in this study, Charles presents a natural contrast against the predominantly female voice. His journey with binge eating, appears to begin at a young age, impacted by stringent food rules at boarding school, leading to over-eating and then secret eating at home to avoid punishment. This journey with food continues into adulthood, appearing to manifest in stressful situations such as when mental health is poor, or relationship issues are present. Charles felt pressure to confirm to social ideals about his role as a man, especially from him mother, and these feelings of resentment are described by Charles as manifesting in self-destructive behaviours, including those around food. Rather than using drugs or alcohol, Charles talks about food as his addiction, and comedy as means of managing mental health. His stories journey through binge eating beginnings, peaks and his current day journey towards both a better relationship with food, and better level of personal self-acceptance.

Olivia – "They want to put you on in a box"

In her interview, Olivia outlines a life-long battle with binge eating and mis-diagnosis or inappropriate care in medical contexts. Her first comment once the interview began was regarding her diagnosis with Bulimia many *years earlier. Her stories take us on a journey from relative poverty in childhood, where purging was used as somewhat of a self-care strategy to avoid foods that she felt forced to eat, to food becoming a more central character as a support during traumatic life events and struggles with mental health, ultimately culminated in her relationship with body and food coping mechanisms. Through medical systems, she was "put in a box" of Bulimia, which did not feel like the right fit, and did not help her to receive support she found beneficial in recovering from her eating behaviours. Alongside this, weight stigma and perceptions of her in a larger body, versus care she received while in a skinny body, put prevalent focus on her weight as the problem, rather than her underlying "why". Throughout her journey, nutritionist support and weight loss related medication were offered and tried, but ultimately did little to help with the cycles of restriction and bingeing described over the years.*

Naomi – "it's such a shameful secret"

Naomi's experiences range across descriptions of AN, BN and binge eating. Naomi contrasts the glamour and pedestal of being able to be seen as anorexia, framed as a goal to strive towards, in contract with the shame and disgust she feels when thinking of herself as a binge eater. This mental tightrope between eating disorder behaviours is a journey that has taken a long time to work through, supported with therapist intervention and finding support in Narcotics anonymous groups (when attending as a support person) alongside key life stages such as becoming a mum, playing a major role in changing her relationships with herself and with her body, where motherhood was able to provide the love and comfort that she had previously sought in both food and alcohol.

Eva - "people expect you to look a certain way"

Eva talks about the impacts if working in the fitness industry as really the start point of her journey with binge eating, and the pressure of working in an industry that places focus in the body. Eva would often find herself withdrawing from social occasions, through fear of eating too much, only to the eat far more in private and alone. She reached out for help from a nutritionist but it was ultimately not the supportive care she had envisioned, and in the end went through a journey of self-exploration, seeking online information and binge eating textbooks to understand her relationship with food. Travelling back to New Zealand during COVID-19, appeared to be a positive experience, and catalyst moment in improvement of binge eating while living with family, and being in a relationship with a supportive partner.

Elsie – "having a dancer's body"

Elsie's story of eating and food, is closely intertwined with her career as a dancer, and bodily expectations that are evident within the dance industry. Restriction and bingeing are both tools used around shows and in personal life when managing key life events or transitions. Elsie's journey of mental wellbeing, including working with a therapist, has improved her relationship with her body and food, but her eating behaviours have not been the prominent focus in her therapeutic journey. Another key focus for Elsie is the dynamic between herself and family, and how gender roles and food have impacted her view on "good" eating, as she deciphers her own comfortable relationship with food, alongside expectations of eating from her mother, and positive food role modelling from her father.

Paula – "If I was slim…then I might have a happier relationship with food"

Paula's interview can be described as one of self-discovery, where together we went through a journey of eating history and behaviours that range from dietary restrictions around health, such as ongoing stomach problems, to difficulties she feels towards eating in public, and how eating at home alone becomes somewhat of a safe space away from judgement. Paula's focus on food has always been weight related, and her personal journey with her body and diet culture is largely impacted by criticisms received from her mother, however until she saw the advertisement for this study, Paula had not reflected much on how these behaviours around food affected her emotionally and how such influences were connected. Within her own journey with food, she is conscious to bring different dialogues to conversations with her daughters and their weight and eating behaviours.

Appendix N – Glossary of Key Abbreviations

BED – Binge Eating Disorder

ED(s) – Eating Disorder(s)

AN – Anorexia Nervosa

BN – Bulimia Nervosa

ARFID – Avoidant/Restrictive Food Intake Disorder

OSFED – Other Specified Feeding or Eating Disorder

EDNOS – Eating Disorder Not Otherwise Specified

DSM-5 – The Diagnostic and Statistical Manual of Mental Disorders (5th Ed.)