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'An existential phenomenology of eating disorders in older people: An ontological reflection and analysis'

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INTRODUCTION

This thesis is an interdisciplinary project of philosophy, specifically the use of an existential phenomenological method, applied to a health and social care topic under the broader research theme of 'wellbeing'. It will take the form of an ontological reflection and analysis of eating disorders in older people, based on a phenomenologically oriented methodology, supported by a foundation of primary philosophical texts and more 'traditional' philosophical scholarship.

Outlining the Research Questions

Central to this endeavour are three research questions about the topic which will structure the project:

1. What do we understand about eating disorders as phenomena?
2. Is the dominant psychiatric approach to eating disorders problematic, and if so, how?
3. Can a phenomenological method be useful when trying to understand the phenomenon of eating disorders?

These questions will help guide and catalyse my philosophical evaluation and create deeper understanding of eating disorders, the unique experiences of older people with eating disorders, the phenomenological method, and embodiment. Bringing together my background in academic philosophy with my work experience in health and social care, I have sought to create an interwoven and mutually beneficial 'symbiosis' of disciplines.

Framing the research questions within the topic

Eating disorders, as a broad category, are psychiatric illnesses which involve difficulties and distress around food and eating, the body, weight and self-perceived body image. Most commonly, disruption can be seen in eating behaviours which are, as a result, detrimental to health and wellbeing in different ways. This includes the person's physical health (such as malnutrition, osteoporosis or heart failure), medical complications caused by the behaviours themselves (such as severe dehydration, stomach problems, oral and dental issues), as well as their psychosocial wellbeing (such as anxiety, obsession, compulsion and emotional distress). They are understood to have one of the highest mortality rates, for both natural and unnatural causes of death, of any psychiatric disorder (Sims, 2001). Substance abuse is suggested to have a similar mortality rate, followed by an increase in unnatural causes of death, namely suicide, for individuals with a diagnosis of schizophrenia and major depressive disorder.

The first medical developments of eating disorders which demonstrated their prevalence, and importance as a serious illness, began to appear within the last thirty or forty years (Garfinkel et. al., 1987; Scarano & Kalodner-Martin, 1994; Peterson & Mitchell, 1999). It is only within the past decade that the focus on eating disorders has gained momentum, both in clinical treatment and research contexts. More specialised diagnosis and treatment have become more accessible, especially in the UK and through the NHS (Treasure et. al., 2005), although there remains a severe lack of funding for mental health treatment more universally. When it is considered that some eating disorder diagnoses were not established until even more recently, for example Binge Eating Disorder (BED) wasn't added to the DSM-5 as a distinctly separate disorder until 2013, the medical world has had to adapt quickly to new knowledge alongside increasing rates of diagnosis.

Alongside the common understanding that eating disorders incorporate gender-specific factors, they are also recognised as illnesses which

disproportionally affect children, adolescents and young adults. Eating disorders in older people, although less prevalent, remain under-researched, and the demographic comes with its own norms around aetiology and clinical presentation. Many diagnoses are seen as co-morbidities with other illnesses, age-related health issues such as lack of mobility, appetite changes and body changes or are understood to be triggered by late life events such as divorce, bereavement or menopause (Tiggemann, 2004; Kally & Cumella, 2008). There is a clinical differentiation made between eating disorders in 'late-life' individuals who had a pre-adolescent onset of their illness, and those where the onset occurred in mid or later life (Mangweth-Matzek et. al., 2006). Similarly, there is a clinical distinction between eating disorders which continue for long periods of time (such as severe and enduring anorexia nervosa, SEED-AN), and those which are present for shorter periods (Robinson et.al., 2015).

Some of the central themes found in the medical conceptualisation of eating disorders concerning the body include physical appearance (such as attractiveness, thinness, fatness), body image and body dysmorphia. Research into this important aspect of eating disorders covers issues such as negative body image, self-image, maladaptive beliefs, preoccupation with the body and misperceptions of body shape or size (Lewis & Cachelin, 2001; Levine & Piran, 2003; Darcy & Lin, 2012). Although there are different approaches to the role of the body within eating disorders, the vast majority demonstrate the commitment to a division between internal cognitions and external influencing factors, and that there is an interaction between the two. Some authors recognise that body image 'examines the body as both a personal and social domain, located at the intersection of the individual and various social systems' (Levine & Piran, 2003: 63), this is demonstrative of the subjective/objective distinction.

Further context of the topic and relation to the research questions

With reference to each research question in turn, a more comprehensive account of their context will provide the starting point for the trajectory of the project, and the argument of the thesis.

1. What do we understand about eating disorders as phenomena?

The categorisation of eating disorders has changed considerably over the last few decades as more criteria have been added and additional diagnostic labels identified. In the most recent version of the International Classification of Diseases (ICD-11, 2018), and the most recent version of the Diagnostic and Statistical Manual (DSM-5, 2013) respectively, the following criteria are given for eating disorders:

> 'Feeding and Eating Disorders involve abnormal eating or feeding behaviours that are not explained by another health condition and are not developmentally appropriate or culturally sanctioned. Feeding disorders involve behavioural disturbances that are not related to body weight and shape concerns, such as eating of non-edible substances or voluntary regurgitation of foods. Eating disorders include abnormal eating behaviour and preoccupation with food as well as prominent body weight and shape concerns.' (ICD-11, 2018)
>
> 'Feeding and eating disorders are characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning. Diagnostic criteria are provided for pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, and binge-eating disorder'(DSM-5)

In the ICD-11, diagnostic criteria are given for those that are outlined in the DSM-5, but other additional labels have been created, such as avoidant/restrictive food

intake disorder to replace the 'feeding disorder of infancy or early childhood' previously published in the DSM (Al-Adawi et.al., 2013), and broadening other criteria, such as binge-eating disorder, to reduce the use of the 'unspecified ED' category (Al-Adawi et. Al., 2013).

A recent meta-analysis of 36 peer-reviewed studies undertaken by Arcelus, Mitchell, Wales and Nielsen in 2011 concluded that 'individuals with eating disorder have significantly elevated mortality rates, with the highest rates occurring in those with AN [anorexia nervosa]. The mortality rates for BN [bulimia nervosa] and EDNOS [eating disorder not otherwise specified] are similar'. There are of course considerations to be made about some factors relating to the findings of this review, such as the cause of death of the individuals in each study, their psychiatric co-morbidities and changes in their clinical presentations over time. However an identified correlation between the diagnosis of an eating disorder and an increased mortality rate is an obvious indication that it is a pressing health issue. Statistics published by NHS Digital (previously The Health and Social Care Information Centre) in 2014 suggest there was an 8% increase in eating disorder related hospital admissions in 2013 (HSCIC, 2013), a trend which the PwC's report, 'The costs of eating disorders: Social, health and economic impacts' (undertaken on behalf of UK eating disorder charity Beat), identified as a 34% increase, an approximate 7% increase each year since 2005 (PwC, 2017).

Non-medical, and overlapping, approaches to understanding eating disorders have grown concurrently with the medical approach, stepping in and providing an alternative source of research into what they are and how they can be treated. Perspectives range from the psychosociocultural to the biological, the political to the behavioural and cognitive, many of which have become increasingly acknowledged as aetiological components of eating disorders (Polivy & Herman, 2002; Culbert et. al., 2015). Arguably, the most well-known non-medical

conceptualisation of eating disorders is the feminist critique of patriarchal influences, such as gender norms and the pressure of women to achieve 'thinness', along with other sociocultural pressures around beauty, age and women's bodies more generally (Bordo, Bruch, Orbach, Wolf). Research by Holmes has shown that feminist theory can even be incorporated into the treatment of eating disorders, based on interviews with female eating disordered patients about their illnesses (Holmes et. al., 2017).

2. Is the dominant psychiatric approach to eating disorders problematic, and if so, how?

Eating disorders remain one of the most complex and varied in terms of clinical presentation, especially in relation to life stage and over time. Consequentially, the ability for practitioners to be able to diagnose and treat eating disorders both quickly and effectively is paramount to tackling the illness and helping people to recover, and stay in recovery. The commitment to preventing non-empirically substantiated conceptualisations of eating disorders is becoming increasingly more pressing, and there is increasing agreement that misconceptions 'should not continue to shape our concept of this disorder' (Micali & Hebebrand, 2016: 1151).

Despite this reality, the medicalisation of eating disorders remains problematic, and should be examined more closely and more robustly. Running parallel to this medicalisation is a very strong lay view of eating disorders, and this view is deeply rooted in a number of persistent assumptions about their causes and 'motivations'. This is recognised by the European Society of Child and Adolescent Psychiatry, as discussed in their article on the draft ICD-11 diagnostic criteria of eating disorders, as a stubborn 'lay view' which continues to influence public perception:

> ‘In addition, we speculate that both our fascination and frustration with these patients leaves us with no other explanation than that ‘refusal’ represents the core feature of the disorder, and along similar lines that the patients are in “denial of the seriousness of the current low body weight” (DSM-IV). Unfortunately, this speculation has highly influenced lay views of anorexia nervosa, resulting in public perception that individuals with anorexia nervosa are to blame for wilfully ‘causing’ their disorder.’ (Micali & Hebebrand, 2016: 1149)

In one study by Crisp et. al., more than a third of the lay individuals interviewed stated that they thought people with eating disorders ‘could pull themselves together and had only themselves to blame’ (2000: 50). Unfortunately this is a common judgement which plagues the vast majority of psychiatric illnesses and forms part of a wide discourse around mental health, but which is prominent in general attitudes to eating disorders specifically. The nature of medicalisation, which still separates the subjective and objective perspectives of the body, can arguably be seen to further entrench this unhelpful misunderstanding about the nature of eating disorders.

Looking more closely at the epistemological problems around the medicalised body which has been briefly mentioned so far, its weakness lies in the lack of examination of how the body is experienced. If it is considered that the body, whether subjectively or objectively, implicitly or explicitly, is fundamental to the definition of eating disorders, then this is an issue that should be examined in as much depth as possible if we are to arrive at a clearer picture of the phenomena. An ever expanding multidimensional view of eating disorders is being formed, but there is enormous scope for the expansion of studies around the body and embodiment, rather than continuing with the limited medical

conceptualisation of the body. This is beginning to be reflected in some research on eating disorders, for example by Sanz and Burkitt, who suggest that there is a need to move beyond the current 'broken dialogue' we have, 'between nature and society, between men and women, between pathology and normality, between doctor and patient, and between anorexia as illness and human experience' (2001: 49).

3. Can a phenomenological method be useful when trying to understand the phenomenon of eating disorders?

Phenomenology is concerned with things in the world as they appear within consciousness, and this consciousness is inescapably embodied and situated in the world, a shared human reality. The phenomenological method is one which seeks to remove pre-judgements and pre-knowledge of a phenomenon so that it's 'essence', more simply understood: its existential structure, as it appears to the person's conscious mind (which exists as a lived body within the world). These pre-judgements include, but are not limited to, epistemological frameworks such as dualisms between mind and body, or subject and object, as well as cultural themes, scientific paradigms or the researcher's personal experiences. In this respect, the researcher is not applying any kind of 'template' to the phenomena, but instead accessing the foundational existential themes (spatiality, corporeality, temporality, relationality) which mediate the way in which all things in the world appear to our conscious, experiencing selves (Van Manen, 2014). The individual can be understood, from a phenomenological perspective, as being an existing, embodied, 'in-the-world' being, whose experienced phenomena have meaning only when understood in unison.

After identifying the points at which other perspectives on eating disorders are potentially problematic, in particular the limited nature of embodiment within

the medical model, an existential phenomenological method will allow a new understanding of the phenomena to be brought forward. There is also a possible line of enquiry into whether the phenomena themselves are constituted by a certain kind of embodiment, a kind of existential aspect to eating disorders that has been omitted from the majority of studies. The description that MacLeod gives of a person with anorexia being 'someone who doesn't know how to live except by non-eating' (1981: 182) resonates here, and this is a perspective that will be considered throughout the thesis. If indeed they are illnesses that incorporate the person's way of being and lived experience, a phenomenological method has the ability to engage with this. Although a philosophical reflection alone would be able to provide an analysis of the embodiment of eating disorders, the use of a sound existential phenomenological method, which has a strong, sound epistemological base and follows an clear methodological strategy.

The problem in summary

To summarise the issue that has been outlined above, the dominant psychiatric conceptualisation of eating disorders is problematic because it overlooks the body as something lived by the individual, in an existential respect. There is also a lack of research into the experiences of older people with eating disorders, and this lack of consensus on these illnesses demonstrates a gap in our present knowledge.

The response in summary

To summarise the response that this thesis will make, it is through the use of an existential phenomenological method that the epistemological limits of the medical model will be highlighted, and an alternative philosophical account offered. The research project will also create new qualitative data on the

experiences of eating disorders for older people to expand our understanding of such complex illnesses.

How the thesis will proceed

The thesis will follow the typical structure of a qualitative research project so as to appropriately frame the generation of data which was undertaken, and an ontological reflection and analysis will be undertaken throughout.

Chapter 1 is a conceptual review of the literature on eating disorders which will 'map out' the knowledge and understanding that already exists on the phenomena. In this chapter I will identify and examine the different conceptualisations of eating disorders including their limitations in relation to the motivation for the project.

In Chapter 2 I will provide an account of the methodology that will be used for the qualitative interviews. This will include the basic rationale, justification and expected outcome of the existential phenomenological method, followed by a robust explanation of the method's epistemological foundation, development and historical context. I will outline the requirements for the planning and generation of data, standards for evaluation and ethical considerations which were undertaken.

Chapter 3 will take the form of my methods, including an explicit description of how I used the methodology within the project to create data about EDs through the use of phenomenological interviews with my research participants. This will include an explanation of the analysis process itself and the way in which the data were produced.

I will then describe the data in Chapter 4, which for a phenomenological method comprises of delineating the varied constituents of the phenomena as

they begin to emerge from the analysis, followed by outlining the essential and universal features of the phenomena.

Chapter 5 is a discussion on the data which were revealed by the phenomenological method, firstly in relation to the foundational philosophical literature of the methodology, then in reference to each conceptual perspective seen in the literature (as outlined in Chapter 2). It will also include a reflection and analysis of the methodology and the experience of using the philosophically informed method to undertake qualitative interviews.

The final section of the thesis will be the Conclusion, in which I will return to the three research questions stated above and report a summarised account of my findings overall. I will also suggest some areas for future research which could benefit from further development, beyond the scope of this thesis.

CHAPTER 1: A CONCEPTUAL REVIEW OF THE LITERATURE

Introduction

Eating disorders are a diverse, multifactorial illness which are increasingly understood as a configuration of risk factors, symptoms, clinical presentations and causes. A conceptual review of the available literature was undertaken to try and identify general areas of consensus about the phenomena at an ontological level. In other words, an investigation into what the literature says that eating disorders *are*. It must be noted that any literature incorporating the genetic and neuroscientific research around eating disorders has been excluded in this instance. There is a lot of emerging investigation into the role of genes in the development and aetiology of eating disorders (Bulik, 2005; Davis et. al., 2008), as well as the neurobiological factors (Frank, 2015; Kessler et. al., 2016) which give an invaluable insight into other areas of knowledge which were previously unexplored.

Interestingly, the genetic factors of eating disorders has been explored within twin studies, as it provides an opportunity to draw comparisons between two genetically similar or identical individuals. A review of twin studies on eating disorders by Bulik et. al. concluded that although there is 'observed familiality for both [anorexia and bulimia]…due to the rarity of the condition, we remain limited in the conclusions we can draw regarding genetic and environmental contributions to the aetiology of anorexia' (1999: 16). Nevertheless, as a qualitative research project, these areas of research are beyond the scope of this thesis and would not add to the validity of the reflection and analysis on the phenomena.

Section 1.1: Biological/Medical model

Clinical Knowledge and the medical model

Biomedical approaches to eating disorders, and to mental health as a whole, describe the 'malfunction' of a healthy psychological norm, subscribing to the idea of reductionist psychopathology. The trend in clinical research seems to suggest that the cause of eating disorders is complex, and that identifying empirical data which can then be mapped in terms of its apparent structures and causal relationships, will increase treatment success (Kearney-Cooke & Steichen-Asch, 1990; Lewis & Cachelin, 2001; Ahern et. al., 2008; Mitchell et. al., 2014; Luca et. al., 2015). Psychomedical approaches, such as that of Bruch, propose that individuals with anorexia nervosa 'misuse the eating function', and that 'having no control over their eating, quite obviously means that the hunger awareness has developed in an inappropriate way' (1980: 39-40). This view of typical and atypical, or pathological, aspects of eating disorders seems to be the catalyst from which other approaches, such as sociocultural, feminist, biopsychosocial and philosophical approaches, have risen in critical response.

The medical model appears to be the most commonly accepted standpoint of many psychological studies on eating disorders, many of which make reference to the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a source against which data can be measured (Ngai et. al., 2001; Reyes-Rodríguez et. al., 2011; Smink et. al., 2012; Pike et. al., 2013; Luca. et. al., 2015). The most recent edition of the Manual, the DSM-5 (2013), states that 'Feeding and eating disorders are characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning. Diagnostic criteria are provided for pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, and binge-eating disorder'.

The categories identified by the DSM are in constant states of revision, and the terminology of syndromes 'not otherwise specified' is a common way of

articulating the presence of illnesses that are awaiting categorisation. Even as recently as the previous edition, the DSM-IV, the symptomatology of anorexia nervosa included amenorrhea (an abnormal absence of menstrual periods), which was not coherent with clinical presentations of anorexia in those who were not categorised as anatomically female. In the case of this particular symptom, the increase in research on the epidemiology of eating disorders in non-female individuals led to the amendment of the DSM, as a response to the breadth of data which are still emerging. Another example from work by Pike et. al. states how the expansion of Eating Disorder Not Otherwise Specified (EDNOS) categories 'and the articulation of the new category of Avoidant Restrictive Food Intake Disorder (ARFID), it is likely that a significant percentage of childhood EDNOS cases will be more specifically diagnosed in the future' (2013: 2).

The findings of such studies are presented as examples of the complexity of both symptoms and diagnoses. Ngai et. al. (2000) completed a phenomenological study of anorexia nervosa with Chinese patients in Hong Kong which challenged the typical/atypical typology of anorexia nervosa. They identified how each patient's explanation of food refusal suggested four diagnostic variations of 'fat phobia', concluding that 'fat phobia in anorexia nervosa is not an immutable core symptom [of anorexia nervosa]', but that 'attributions for food refusal may represent a point of entry into the dynamic interpersonal processes and changing symbolic meanings of the illness' (2000: 316). Consequently, the suggestion for future research and medical practice is to incorporate these other malfunctions of psychopathology, so that the symptom of fat phobia is no longer a symptom, but a 'point of entry' to accessing and identifying the underlying symptom.

The outcomes of this kind of evidence-based method are challenged by researchers such as Dana and Lawrence (1988) in their work on bulimia, a response to Bruch's work on anorexia published the previous decade:

> 'Hilde Bruch in her classic textbook on eating disorders, published in 1974, makes little distinction between anorexic women who vomit and those who do not...This omission on her part is, of course, not at all surprising. She spent many years studying those young people with eating problems who were referred to specialist clinics. By definition, the women we are interested in, the ones with secret eating problems, will not show up in those settings.' (1988: 21)

They make the point that clinical presentation and research findings alone do not encompass the phenomenon of eating disorders in their entirety. The specialism of clinics can be seen as providing treatment based on expertise in a particular diagnosis, but Dana and Lawrence suggest that this may lead to insular knowledge that privileges the medical model. Arguably, this focus on 'evidence' is an attempt to reduce, or remove, the probability of bias in the diagnosis and treatment of eating disorders so that greater outcomes can be achieved for patients who may be in great physical and emotional distress. In terms of understanding the epidemiology of eating disorders, the goal of the medical model meets some methodological issues when it is accepted that 'eating disorders are relatively rare among the general population and patients tend to deny or conceal their illness and avoid professional help' (2012: 406).

Aside from the epistemological issue outlined above, Sanz and Burkitt (2001) state that this clinical view of an individual diagnosed with an eating disorder claims 'full certainty' of the individual's ill body, and 'the anorectic and her body is treated, in this context, as an object for medical research and practice' (2001: 49). The role of the body is an important aspect of the biomedical approach to eating disorders, as reflected in the literature, and this is examined further in the next section of this review. But in the context of the medical model, the body viewed as object, Sanz and Burkitt claim, negates the patient's subjectivity, not in

terms of its ontology, but as a denial of its epistemic position. The patient's subjective reasoning is seen as biased in comparison to the certainty of the medical gaze, therefore it is viewed as a probability which must be removed to ensure the clinical evidence is valid:

> 'So while [clinicians] are trying to build multidimensional models [of anorexia], these do not include the dimensions of the lived body, nor do they take account of the fact that the body lives in culture...Because of this, as in most empirical models, the perspective of the scientist is taken to be universal and a-historical, a God's eye view of the world which can comment on the true nature of a patient's reality and then, given that the patient's perception of reality is different, can classify that perception as not according with true reality. The patient's perception thereby becomes classified as 'distorted'.' (2001: 43-44)

Some texts, such as Hepworth's analysis of anorexia nervosa (1999), criticize how this epistemic monopoly on legitimacy 'has produced disciplinary divisions, ideological dogma, inadequate multiprofessional collaboration, the separation of expert from public discourse and the privileging of psychomedical science' (1999: 129). This echoes the position shown by others, such as Robertson (1992) who see this 'certain' knowledge as being created in a social process which doctors and medical staff are part of, during their encounters with patients (1990: 20).

This is a deconstructionist approach to issues around knowledge, knowledge creation, as well as the political and ethical elements which arise. By identifying 'ways of thinking about anorexia nervosa [that are] reproduced and entrenched' (1999: 128) within the way anorexia nervosa is diagnosed and treated by clinical professionals, a space is created in which alternatives can be explored and the imbalance between types of knowledge can be challenged:

> ‘The analysis of discourse and practice is significant because it demonstrates that phenomena are not simply the invention, idea or discovery of a historical period; rather, they have emerged through a set of interrelationships between knowledge, social practices and institutional authority.’ (1999: 121)

Illness, the body and psychopathology

The role of the body is, understandably, central to the literature on eating disorders, although this appears to be with varying value and ontological status. The importance of the body is not only the case for the medical model, but its importance in the psychiatric approach is central to the conceptualisation of ‘illness’ and subsequently, eating disorders as illnesses. The body of the patient is the material object which can be measured and observed to provide the empirical data in accordance with the medical model of illness, and this way of thinking is mirrored in the vast majority of research on eating disorders. These data are then used to plan and deliver appropriate treatment, the success of which is also clinically measurable. In the instance of psychological illnesses and their manifestation in bodily symptoms, it is accepted that these symptoms may not always mean that psychopathology is present or that the symptoms are undoubtedly caused by one particular illness over other comorbid illnesses.

This is demonstrated in research such as Smink, Hocken and Hock’s literature review of eating disorders, focusing on incidence, prevalence and mortality rates, in which they identify links between binge-eating disorder (BED) and obesity:

> ‘BED is often seen in obese individuals, but is distinct from obesity per se regarding levels of psychopathology, weight- and shape concerns and quality of life. BED aggregates strongly in families independently of obesity, which may reflect genetic influences.’ (2012: 407).

In this example, BED is said to be often seen in those who are also diagnosed with obesity and despite some overlap of a few measurable symptoms, there is no definitive correlation between both illnesses. In this instance, the symptoms of obesity are evidence of that particular disease, but the symptoms of BED, even though they are occasionally overlapping, remain a distinctly separate pathology from obesity. The gap in material data to which BED can be reduced must then be secured by identifying other possible 'material' evidence, in the form of genes. Seeing a relationship between BED and obesity is not considered as possible evidence that one 'disease' may instead be a symptom of the other, or that both diseases may be symptoms of other causes not yet identified. BED is catalogued in the DSM, and obesity has been defined as a disease by the American Medical Association, and all other data gathered on these phenomena is only considered valid if it can be measured against these empirically secured standards.

The medicalisation of eating disorders as mental illnesses with physical symptoms, at least when considered in terms of how they are diagnosed, is the common consensus amongst the literature that subscribes to the medical model (Kearney-Cooke & Steichen-Asch, 1990; Lewis & Cachelin, 2001; Carper et. al., 2010; Robinson et. al., 2012; Murray, et. al., 2013; Mitchell et. al., 2014). In evaluating the role of this materialist literature, the reality that eating disorders have a material effect on the body cannot be, and is not, denied by anyone researching within the field. However as Malson articulates, 'the biomedical construction of 'anorexia' is profoundly problematic, not because it acknowledges the physicality of the body, but because it constitutes the body and our embodied experiences in a particular way' (1997: 79). The biomedical literature categorises bodily functions as symptoms, and when they occur within the framework of an eating disorder, they become evidence that a psychological disorder is present in the patient.

The physical impact of eating disorders is well researched and the impact that eating habits have on the body are vast and sometimes severe (Bruch, 1980; Purgold, 1992; Thompson, 1994; Strother et. al., 2012; Pike et. al. 2013). There is no doubt that 'bodily activities' such as food consumption, nutrition, exercise, vomiting, restriction and other functions may cause health problems which require medical assistance. However as Hepworth differentiates, 'the management and explanation of anorexia nervosa are continually bound together within medical discourse because the physical complications arising from malnutrition require necessary medical assistance. The confusion surrounding the primary or secondary onset of physical symptoms within medical discourse continues to complicate the socio-cultural explanation of anorexia nervosa' (1999: 89). These physical complications also include a negative impact on the cognitive functioning as a result of hunger and starvation, a point which further entrenches what seems to be a self-sustaining illness:

> 'Recognition of the direct effect of hunger on the psychic function has brought us one step further to an understanding of how these seemingly well-functioning young women became transformed into 'overaged, shrunken, skinny-bony skeletonlike creatures' (to use one patient's self-description).' (1980: 18)

In addition to the body demonstrating the material reality of eating disorders within the medical model, the seemingly absent perspective of the patient, of their own body, is given consideration in some sources, but still from a functional, psychological perspective. The patient who is diagnosed as exhibiting symptoms of an eating disorder has a 'self-image' which is the result of their psychological function, but one which is *dysfunctional.* Bodily themes throughout eating disorder research are wide-ranging and intertwined, but the emergence of

pathologies relating to 'body image', 'body dissatisfaction' and other subjective assessments of 'shape', 'size' and 'weight' by the individual demonstrates further divides between what is considered typical and atypical, or normal and abnormal.

Eating disorders are a 'heterogenous group of complex psychiatric disorders', some of which are identifiable as early as childhood (Luca et. al, 2015), and 'clinical observations have reported associations between personality disorders and AN' (2015: 49). From the view of the clinician, the eating disordered patient has personality traits, attitudes and of course has reflective self-consciousness, but the illness from which they are suffering is a part of their embodied subjectivity. Subsequently, the individual's 'abnormal' mental state means that these aspects of their 'self' may be similarly 'abnormal', therefore their subjective epistemic position is 'disturbed'. To overcome this bias, any kind of self-image, or beliefs about the body that patients with eating disorders have, must instead be confirmed as pathological by the clinical observer, whose privileged epistemological position is objective, and therefore unbiased and 'normal'. As stated by Sanz and Burkitt in the case of anorexia nervosa, 'the woman's account of her anorexia is considered to be a biased or 'subjective' form of reasoning…her body is treated, in this context, as an object for medical research and practice. The subjects (doctors), detached from all objects (including the anorexic patient), fixes the object of the anorectic's body in its gaze, monitoring and knowing it with full certainty' (2001: 49).

More accurate clinical results can be achieved by more thorough analysis of the patient's psychological functioning, including any pathological body image attitudes, in keeping with the goals of a reductive medical model. A more multidimensional approach provides answers to some of the issues around measuring body image disturbance, which some medical researchers acknowledge does not address the complexity of how body image attitudes are formed by the

individual. One example of this theory being applied to prevention, discussed by Levine and Piran, states 'that various aspects of disordered eating, and especially negative body image, reflect transactions between cognitive and emotional processes "within" the person' (2003: 59). This challenge to the traditional biomedical view of eating disorders maintains a pathological view of the patient's psychology, but expands the understanding of the subjectivity as being necessarily embodied, socioculturally situated and the site of these cognitive and emotional 'transactions' between the inner and outer worlds: 'both a personal and social domain' (2003: 63). The mind is still viewed functionally, but ontologically the patient is understood as more than an objectified body placed in front of a clinician for observation.

In conversation with this biomedical perspective on the body, other literature on eating disorders, mainly that which is partially autobiographical and precludes much of the more recent biomedical research, gives an insight into the patient's view of their body and how their thoughts and beliefs are structured in relation to it. There are contrasts with the biomedical model, in terms of how the relationship with the body is seen as not straightforward, but this could arguably be seen as justification for eliminating the subjective bias of the patient, for only someone who was unwell would exhibit such behaviours and have such beliefs about their body image:

> 'These diverse studies are part of a context in which non-eating becomes merely a symptom of an illness, which can be used to explain the behaviours of a patient. The woman who starves herself may be choosing to abstain from food for many varied reasons which are not included in the current definition of the illness category anorexia nervosa.' (Robertson, 1992: 38)

Robertson puts forward the case that the psychopathological understanding of anorexia nervosa fails to address the issue that some individuals who do not have 'typical' eating habits, for example those who restrict their food intake, do not necessarily have any kind of psychopathology. The response of the medical model may be to suggest that these people may not be formally diagnosed, or that they have a disorder that would be diagnosed under the EDNOS category, but the behaviours they are exhibiting is categorically disordered and abnormal. Despite describing her lived experiences of her eating disorder, Robertson is not considered to have any kind of epistemic privilege about her illness because the foundation of her mental functioning is pathological. In her introduction, the author says 'I argue that, as a category of illness, anorexia was created because it made meaningful to the medical profession – not the starver – a set of symptoms and patterns of behaviour which were unreasonable and inexplicable' (1992: xiv). In categorising and judging which behaviours are acceptable and the causes of those behaviours, meaning becomes something prescribed by the medical model for the patient, and this is what Robertson's text challenges. It seems that in applying the biomedical approach, the individual is relieved of their power, whether that is over their body, their personal meanings and their actions, but this is incidental to the fact that the goal of medicine is to treat and prevent illnesses, such as eating disorders.

This power imbalance identified by the literature gives rise to a number of questions about the role of the body within the medical model, including how the patient makes sense of the conflicting situation they find themselves in. In this source, MacLeod references the work of Thomas Szasz, a psychiatrist and outspoken critic of the psychopathological foundations of psychiatry, who not only rejected the existence of mental illness, but also stated that psychiatry was based on moral control and coercion:

> ‘Szasz’s observation struck me with the force of revelation. And he goes on to ask some similarly pertinent questions: “To whom does a person’s body belong? Does it belong to his parents, as it did, to a very large extent, when he was a child? Or to the state? Or to the sovereign? Or to God? Or finally, to himself?” I recognised those questions as pertaining to myself at the time I became anorexic. What was happening to my body – not only the changes brought about by puberty, but the fact that the clothes it wore and the food it consumed were chosen for it by someone else – was a metaphor for what was happening to me as a whole person.’ (1981: 66)

Although this is an important ethical issue which will be returned to in a later chapter, in the context of the role of the body in eating disorder theory, it illustrates the reality that MacLeod and Robertson feel they have experienced, which is that their bodies were under a certain amount of control from other people. They show the reader how problematic, conflicting and questionable the medical model of eating disorders can be. In illuminating the role of the patient’s body as being within society, culture and the clinical gaze, as well as part of their own subjective embodiment, this brought with it the illumination of further causal relationships between these constructs which may not be compatible with a psychopathological view of eating disorders.

In this area of the literature, a dichotomy between eating disorders as individual pathology, or as socioculturally mediated pathology, seems to emerge. From this basic tenet, the role of the clinician is destabilised from its position of epistemic privilege, and further complexities add to the challenges put against the medical perspective. MacLeod captures this realisation in her description of her own research journey:

> 'It was only [when I discovered I had had anorexia nervosa] that I began to question the whole phenomenon in depth. In doing so I have found myself in frequent disagreement with others who have written on the subject. The relevant literature is all based on clinical experience and written from the point of view of the clinician or therapist who has necessarily been forced into making generalisations from the available data.' (1981: 10)

This fracture between two incommensurate ontologies is only one of the divisions that can be seen, and is articulated by Sanz and Burkitt as a 'broken dialogue between nature and society, between men and women, between pathology and normality, between doctor and patient, and between anorexia as illness and human experience' (2001: 49).

Further divisions continue to be put forward by others, for example Hepworth's discussion of how 'the psychiatric model relies on a dominant explanation of anorexia nervosa based on psychopathology that reinforces the dedifferentiation of women from anorexia nervosa' (1999: 123). Similarly, there is important discussion by Thompson on a multiracial focus in eating disorder research, which 'raises questions about the adequacy of the theoretical models used to explain eating problem':

> 'The biomedical model offers important scientific research about possible physiological causes of eating problems and the physiological dangers of purging and starvation. However, this model adopts medical treatments as strategies that may disempower and traumatize women, and it ignores main historical and cultural factors that influence women's eating patterns.' (1994: 4)

The fragile relationship between the self, the body, society and culture is explored in more depth at a later stage in this review as the divergence of perspectives are

wide-reaching and take a variety of approaches to studying eating disorders. However the medical model, even when it incorporates the influence of sociocultural factors on the individual, does not deviate from the reductive materialist view of mental illness in which eating disorders are psychopathological. The areas of the literature which highlight these divisions, dichotomies and 'broken dialogues' describe how patients are 'disempowered', 'traumatised', controlled and seemingly dehumanised by the medical interactions they find themselves within. If eating disorders are to be understood from this perspective, then can the medical model still be seen as providing diagnosis, prevention, and ultimately, treatment for these psychopathlogies?

Risk factors, influences and treatment

The discourse around treatment for eating disorders is understandably vast and important in its role, however it is the vital place of treatment within the medical model which becomes evident during a review of the literature. Because of the wide variety of approaches to eating disorder symptomatology and causes, the treatment suggestions are equally as complex and varied. Throughout this review, treatment should also be understood as what is often referred to in mental health as 'intervention', so this would include psychoeducational interventions, psychotherapeutic interventions and other psychologically informed therapies, as well as pharmacotherapy. There is a large amount of research that aims to identify 'risk factors' for the development, sometimes described as a 'trigger', of various eating disorders, so this will also be touched upon within this area of the review.

As has been seen, the different aspects of risk factors for eating disorders are well covered by the research, from the influences relating to 'body image' and the 'thin ideal' (Kearney-Cooke & Steichen-Asch, 1990; Lewis & Cachelin, 2001; Ahern et. al., 2008; Chisuwa & O'Dea, 2009; Heinberg et. al,, 2009; Becker, et. al,

2013), the role of the media (Khan et. al, 2011; MacLean et. al, 2014), or whether gender identity may be a risk factor (Heinberg et. al., 2009; Carper et. al, 2010; Engeln et. al, 2013; Murray et. al, 2013). The literature seems to show that not only was the symptomatology, epidemiology and pathology of eating disorders being debated, there is also a great deal of disagreement and further debate about exactly what influences eating disorders and whether it can be affected by any kind of 'intervention'.

The question of whether eating disorders are 'triggered' or exacerbated by culture and social influences is widely discussed. For example Kearney-Cooke and Steichen-Asch consider that 'culturally, men may be less subject to the factors which move women toward eating disorders, but they are not immune to the present emphasis on fitness and dieting or to the kind of underlying psychopathology which provides the foundation for the symptoms of eating disorders' (1990: 71). The eating disorder in this case is conceptualised firmly within the medical model and suggests that the 'immunity' individuals have may be varied according to their sex or gender, although the differentiation between these two categories is not clarified. In identifying these differences on a measurable scale, it is suggested that a coherent pattern may emerge, although when 'examining the personality profile of eating-disordered men' (1990: 67), the speculation over parental influences is not claimed to be evidence-based. The causal mechanism between the psychopathology and culture is not explicitly stated, but this is to be expected when the empirical evidence on eating disorders is still a point of debate (Nasser, 2007; Levine & Piran, 2003; Smink et. al, 2012; Mitchell et. al, 2014; Luca et. al, 2015).

One point raised by Sanz & Burkitt (2001), in their phenomenological analysis of the lived experience eating disorders, is the possibility that the biomedical conceptualisation of such pathology excludes the possibility of there

being any cultural influences, because of the methods they use to gather empirical data:

> 'For example the Body Image Distortion Syndrome test (BIDS), often used in the diagnostic criteria of anorexia nervosa, has functioned to emphasise the discontinuity between the anorectic and 'normal' perception of body image and body weight. In the clinical literature, the initial theorising of BIDS as a visual misperception clearly placed anorexia within the medical, mechanistic model of illness. The anorectic, then, is constructed as a person with an 'inner defect' that prevents them from forming a realistic image of their body.' (2001: 43)

These diagnostic tools are formulated from within this 'medical, mechanistic model' and will therefore only be able to provide 'empirical data' of this kind, a point which is an important area of discussion within the literature, and which further supports the challenges to the medical model which have already been highlighted so far. If eating disorders are investigated and diagnosed using tools which use a given 'reality' as a normal, typical baseline from which any deviations can be measured, the results will always be divisive.

Ahern et. al. did research using a non-clinical population of female undergraduates from the north of the UK (who were not further categorised beyond their age and gender) to investigate whether there was a relationship between their body mass index (BMI) and the attitude towards their own weight. They concluded that 'although body mass index did not moderate the relationship between implicit and explicit attitude measures in this study, the current sample was biased toward normal weight. Results may have been different if the sample had included more underweight and overweight participants' (2008: 304). Their use of BMI as a scale against which to compare participants' weight attitudes, as well as the differentiation between groups who were of 'normal' weights,

demonstrates this problematic and epistemologically 'insular' approach to biomedical research.

In addition to problems with how diagnostic tools for eating disorders are formulated, treatment also remains under discussion as well as leading further research within the biomedical community. Luca et. al. describe how international treatment guidelines recommend psychotherapy for patients with eating disorders, 'even though to date no evidence clearly supports the efficacy of any specific form of psychotherapy' (2015: 49). Eating disorders as a psychopathology are often described as being present with multiple co-morbidities (Bruch, 1980; Crisp, 1995; Chisuwa, O'Dea, 2009; Smink, van Hocken, Hock, 2012; Strother et. al, 2012; Weltzin et. al, 2012; Mitchell et. al, 2014), especially depression, anxiety, body image dysmorphia and others, although there is some limited discussion of these symptoms 'as a relatively common experience amongst women that is more complex, more variable and more widespread than many texts imply' (Malson, 1997: 83-84).

Some sources suggest that the presence of such co-morbidities is justification for pharmacotherapy as 'reasonable' in relation to eating disorder diagnosis (Luca et. al, 2015). This particular study, which was undertaken on late-life eating disorders, rightly identifies the problems that this may cause to late-life patients, for example who may have additional illnesses or already be on multiple types of medication. However, it is the high mortality rates associated with eating disorders such as anorexia nervosa and bulimia nervosa which provide the context within which treatment options are being assessed. The circumstances are described appropriately by Treasure when she considers the balance that needs to be struck between the benefits of drugs and the risks involved for patients:

> ‘Overall, for restricting AN, the benefits of drug treatment are small and need to be balanced by finding that a significant proportion of the mortality found in AN is a result of an overdose in antidepressant medication (Patton, 1987)...However, it is possible that once the biology of AN is more fully understood, then drug treatment may enable recovery to occur in some patients without the need for inpatient treatment.’ (1988: 130)

This perspective on pharmacological treatment is still recommended throughout the psychopharmacological community and amongst clinical professionals as an empirically-proven treatment for eating disorders (Aigner et. al., 2011; Flament et. al, 2012; McElroy et. al,, 2012). Evidence-based research continues to be undertaken on the effectiveness of medication, as a way to further identify how eating disorders can be treated, and also to provide evidence for the biological causes of these psychopathologies.

Section 1.2: Feminism, sexuality and gender

Gender forms a very large part of the discourse of eating disorders, and its role will be discussed in more depth in the following section of this review. Although the biomedical literature was shown to address the issue of gender in part (Lewis & Cachelin, 2001; Piran, 2010; Robinson, Mountford & Sperlinger, 2012; Räisänen, U & Hunt, K, 2013; Mitchell et. al, 2014), it is suggested by some, such as Robertson, that the biomedical view of the body may be biased towards a patriarchal perspective:

> ‘Women diagnosed as anorexic accept anorexia as part of the objective truth of various discourses – including medicine – which position them within the male form of subjectivity...Alternative ways of embodiment have been restricted or hidden by what is socially perceived as medical common sense. Perhaps the

> anorexic/self-starving woman selects the symptoms and behaviours when she presents to the doctor, who exchanges these for medical meanings about feminine embodiment.' (1992: 20)

This gives a useful example of how power imbalances based on gender categories can impact on the understanding of eating disorders when viewed from the biomedical position, as Robertson clarifies, 'the female body becomes the object of a medical gaze and discourse which reconstitute it as a body subject to normative medical criteria according to universalising medical principles' (1992: 40). The function of sex and gender is something that exemplifies further points of disagreement within the feminist literature, as this section will show, and explores yet more complexities of eating disorders as a phenomenon.

Current positions on EDs regarding gender

In recent years the study of eating disorders has broadened its focus from women to men and other gender identities. However the idea of biological difference between these categories is maintained, for example in Mitchell, Wolf, Reardon & Miller whose research into the ED psychopathology of US veterans concluded that 'EDs are influenced by the same underlying psychopathology variable in men and women, although the prevalence of these disorders may differ by gender' (2014: 8). Despite showing a contrast in 'internalising' dimensions in females (such as anxiety and mood disorders) and 'externalising' dimensions in males (such as substance abuse and antisocial personality disorder), both gender groups in Mitchell et al's study were identified as having 'tendencies toward negative emotionality and distress'. This differentiation is supported by similar research where men with eating disorders are found to have 'dependent,

avoidant, and passive-aggressive personality styles' (Kearney-Cooke & Steichen-Asch, 1990: 64).

The importance of body image is similarly considered in relation to gender, although the 'thin ideal' is said to be less commonly endorsed by straight men than by women (Heinberg et. al, 2009; Darcy & Lin, 2012). Marino Carper et. al draw attention to a high number of studies that support the claim that being gay is a risk factor for 'significantly higher levels of muscular dissatisfaction, drive for thinness, bulimic tendencies, dieting behaviours, and pathological eating attitudes and significantly lower levels of body esteem compared to straight men' (2010: 302), but it is not suggested whether bisexual men who have same sex relationships are similarly at risk. The literature also explores various aspects of individuals' sex, gender identity, gender roles and sexuality as areas which could affect the risks, symptoms and clinical presentation of eating disorders, which is in keeping with the move towards a multidimensional and complex model of eating disorders (Levine & Piran, 2003; Heinberg et. al, 2009; Darcy & Lin, 2012; Pike et. al, 2013; Sweeting et. al, 2015). For the medical model, gender is seen as a separate contributing 'factor' from the eating disorder itself:

> 'However, in clinical models the role of gender is merely a contributory or facilitating factor. The prevailing understanding is that culture provokes and gives a distinctive form to an already existing underlying pathological condition, which is medical in its origin.' (Sanz & Burkitt, 2001: 42-43)

As will be seen in this section of the literature review, the role of gender is indeed conceptualised by some as influencing a psychopathology, but others see eating disorders as an issue that arises from socially, culturally and politically perpetuated gender 'norms' and 'ideals'.

In terms of the epidemiology of eating disorders in individuals of any gender, gender norms are seen as a barrier to diagnosis, as well as clinical evidence on which to base treatment and support. As an example, MacLean et. al show with their research on newspaper representations of eating disorders in males, 'the smaller proportion of males generally identified in clinic-based compared with community-based samples suggests a "*community reservoir of undiagnosed men*"' (2014: 1). Followed up in further research shortly afterwards, the reporting of the phenomena within academic sources and mass media in the UK was seen as similarly difficult to clarify when considering gender 'because the figures are complex and confusing, and vary depending on the definition adopted (any ED, specific diagnoses or ED symptoms), whether based on community or diagnosed/clinic samples, sample ages, and finally, whether referring to prevalence (point, past year or lifetime) or incidence rates' (2015: 14).

Foundational feminist critiques

With regards to the literature forming a part of wider discourse on eating disorders, feminist critiques were arguably one of the first major challenges to the biomedical view of eating disorders, and 'these feminist analyses have clearly furthered understandings of anorexia by demonstrating the centrality of gender in relation to eating disorders' (Malson, 1997: 96). A woman's experience of their illness was seen through the lens of gender, specifically how their gender was part of their embodied reality. The lack of parity between genders in terms of their roles, opportunities and autonomy became suggested by feminists as a risk factor for developing an eating disorder, consequently highlighting the ways in which prevention programs can become more effective (Piran, 2010), but also demonstrative of the wider implications of a patriarchal society.

From the perspective of the medical model, the denial that women are suffering from any kind of illness and instead are simply experiencing the realities of being a woman could be alarming, not only to women as individuals but to society collectively. However this is not the intention of the feminist position, as outlined by Sanz & Burkitt:

> 'The feminist approach does not, then, deny the severity of the anorectic's situation but instead calls attention to the severity of the cultural situation that produced it, particularly for women...However, the unique configurations of each person's life will determine how actual women are variously affected. Although there is clearly heterogeneity of situations and responses, no one is situated outside the empire of normalising directives.' (2001: 45)

They go on to discuss Bordo's texts from the late 80s and early 90s, in which she critiques the political and social power structures of gender, womanhood and female embodiment. This is an attempt by Bordo to answer the question of why thinness and weight loss is such an apparent cultural obsession and how this relates to the phenomenon of anorexia nervosa: 'the connection, if explored, could be significant, demystifying, instructive' (1985: 228).

In response to Bordo, Sanz and Burkitt acknowledge how anorexia is a product of culture, in so much that the relationship individuals have with their bodies is mediated, both socially and culturally, and how bodies become normalised in terms of how they look, behave and exist in the world. The first of three axes that they describe is that of a 'dualist axis on which the body is felt to be separate from the experience of being a person and a mind' (2001: 45), and this also fits with the point made by Robertson about the biomedical view of women's bodies perpetuating patriarchal values. The further axes given by Sanz and Burkitt are 'a second cultural axis, that of control, where the body is seen merely as a

mute instrument to be controlled by the person…The third [axis] is gender/power, in which women are subjected to images of female beauty which include youthfulness, slenderness and, in some instances, a kind of boyish, lanky athleticism' (2001: 45).

The introduction of gender into the conceptualisation of eating disorders gave value to women's experiences as people with gendered bodies, as well as questioning the way in which knowledge is created and reinforced through the medical model. Others like Hepworth agree that feminist writers, such as Orbach (1987) and Bruch (1980), 'articulated the interrelationships between women's experiences of living in Western societies, the effects of a subordinate social position and the denial of food by women' (1999: 45). The extent to which these separate axes were accepted by feminist theorists varies vastly, and this can be seen in the literature when viewed as progressing over time, as historical social and cultural changes have occurred and as discourse has shaped the understanding of eating disorders.

Power structures and oppression

In the context of eating disorders, the power structures created by gender categories are seen to have influence in different aspects of the phenomena, including risk, symptoms and psychopathology. The feminist perspective wanted to give a voice to women and their experiences as a response to the dominance of patriarchal society and woman as Other. According to Robertson, 'each individual woman's psyche embodies patriarchal social relations' (1992: 50) which they both prepare to be oppressed by and rebel against. Finding themselves in a society that promotes and profits from concern with food, dieting, weight loss, some authors such as Wolf go as far as to say that anorexia is a strategy employed by women to protect themselves against sexual abuse: 'it also protects her from street

harassment and sexual coercion; construction workers leave walking skeletons alone. Having no fat means having no breasts, thighs, hips, or ass, which for once means not having asked for it' (1991: 199).

As there is currently more emerging research on non-female individuals with eating disorders, the discussion on gender categories is demonstrating a move away from a female-focused 'illness'. Engeln et. al. suggest that for research on body image specifically, focusing on women 'may reflect issues of construct validity rather than a true gender difference (or at least a large gender difference)' (2013: 300). The reality for women experiencing an eating disorder may indeed be influenced by these oppressive sociocultural gender values, but it may not necessarily be different to the way in which people with other gender identities experience their own gendered reality of an eating disorder. Robertson states how 'an understanding of the historical position of women and the way in which femininity is constructed can contribute to recovery from anorexia' (1992: 72), but this gender construction is something which is applicable to all genders, and therefore could prove valuable in understanding the role that gender plays in anorexia for all individuals.

The role of the body in the oppression of female individuals with eating disorders is highlighted in the literature, but an important issue regarding the body and its ontological position within society is raised by Malson:

> 'While such [cultural prescriptions of thin and passive femininity] are undoubtedly oppressive, their analyses rest upon a false dichotomy – the natural female body versus its social oppression in which 'the body' is understood as outside of (rather than as constituted in) culture.' (1997: 97)

The medical model seems to subscribe to this view of the 'natural' female body, one which functions in a particular way rather than one which exists as bound within culture, or indeed *constituted*. The medicalised body, the body of the patient which is prominently biological in its composition and clinical presentation, is one which underlies all of its external influences. It is a material object first and foremost, a kind of biological baseline, with which cultural and social factors interact and take effect. The point of critique and exploration here is that the body is not wholly reducible to its biology, or 'given nature', because these external influences realise the body within the world through an inseparable 'construction', with each factor adding to the constitution of the human being as a whole. As articulated by Malson in the previous section, the body is not only separated from the individual, but also separated from sociocultural values. These values can influence the individual, which can compromise the functioning of the mind and can cause pathological behaviours, thoughts and beliefs reflective of an eating disorder, but the body as observed by the clinician remains reducible to its materiality.

When exploring the role of the body in relation to gender, degrees of social acceptance and attractiveness is apparent within the theorising of eating disorders:

> 'Such dieting, consciously aimed at promoting attractiveness, in the event fosters powerful internal control mechanisms necessary to many developing adolescents, who enter a society bereft of structure in the way of agreed behaviour guidelines and codes of conduct.' (Crisp, 1995: 52)

This example views disordered eating as an attempt for the individual to adhere to social norms about being considered attractive, or 'fitting in' with seemingly

absent rules, something which can be seen as very conflicting for the individual to navigate. This desire to be accepted through demonstrating their complicity with sociocultural codes, despite the fact that their bodies are biologically determined and have an inescapable normative physicality, becomes the risk factor to which those with atypical psychologies can succumb. The separation between the body and the culture it exists within is maintained by this perspective, as well as upholding the materialist view of psychopathology. One point raised in response to this position is the differentiation made between women who develop eating disorders and those who do not, despite existing within the same sociocultural 'guidelines':

> 'So it seems that there is no convincing basis to continue with the assumed immunity theory of the *other* women...It is perhaps more to do with the degree to which women's expectations of themselves are reconciled with those of their society. It is the degree of concordance between society's and individual's values that is, in my opinion, important here.' (1997: 97)

Nasser is raising the important point that although individuals are influenced by sociocultural values, how they are taken on by each individual does not have a fixed result and this is dependent on how *concordant* their own values are with them. A woman's interaction with society's values, specifically values relating to their gender, can be in flux and form different parts of their identity, or may remain in some level of conflict with, without resulting in an eating disorder. These are the 'other' women Nasser refers to, and this challenges the reliance of the biomedical perspective on the body as viewed from an 'unbiased' biological position.

Female gender role norms and ideals

Sociocultural gender-based values discussed in the literature on eating disorders frequently addresses gender roles and their normative idealisation. Links are shown in some research between idealisation of female gender roles and abnormal eating behaviour (Luca et. al, 2015), for example the ultra-realised and ultra-thin 'Superwoman' ideal whose physique is almost beyond what is biologically attainable. Also explored is idealisation of female sexual roles, sexual appetite and its personal validity for young women (Maine, 1993). Maine describes how this unstable validity of sexual urges, intimacy, and hunger, is borne from the lack of a constructive paternal family figure at a stage of life where consolidation of relationships and identity are 'particularly critical, and a young woman's interests naturally turn toward men at this time'. Further conceptualisations discuss society's over-valuing of youthfulness, which also encompasses thinness, having a detrimental impact on mid- and late-life women (Pike et. al, 2013) and 'appears to be a factor implicated in the emergence and proliferation of EDs among women in mid-life and older' (2013: 3).

Critical evaluation of the role of women within a patriarchal society is valuable in understanding the power structures they exist within, and the way this then becomes woven into the realities of individuals with eating disorders is demonstrably a well-debated concern. Although the oppression that exists for women is a complexity of their ontology, the discussion of gender extends beyond female experience to other genders. As Maine included in her own work on gender ideals related to eating disorders, these ideals exist for men but may make them 'less likely to seek assistance…[they] also, have more acceptable ways to purge and to deal with their body-image problems. They can be obsessive in their exercise habits or they can choose to ignore fashion trends' (1993: 15).

Other genders: in contrast with female experience

The experiences of eating disorders in people of other genders, in males and others outside the male/female gender binary, demonstrate a variety of perspectives on the role gender has and its place within the conceptualisation of eating disorders. It is identified in the literature that the apparent 'feminisation' of eating disorders, whilst describing the unique situation of women, could be detrimental to men who experience eating disorders because of an implied social emasculation. Accepting that gender plays a role in how individuals experience eating disorders appears to have expanded the understanding of the phenomena, but as was seen with the multidimensional approach to eating disorders as psychopathology, as it becomes more complex it may also become more problematic.

Within the literature, examples of sexual and gender difference include MacLean et. al. who suggest the importance of 'a more neutral commentary [within the UK media] on the prevalence, careful scrutiny of terms and removal of those which emphasise EDs as gender 'anomalous' for males (Ed, 'young women's illness', vulnerable', 'sensitive', 'overly feminine', 'ashamed')' (2014: 7). Darcy and Lin state that 'there is also a lack of consistency in the literature on the frequency of some behaviours such as binge eating and purging, with some studies reporting higher frequencies relative to female comparison, and others reporting lower' (2012: 417). Some male individuals who experience eating disorders are described as having a 'lack of aggression' (Scott, 1988: 69), which possibly suggests that this lack of masculine traits shows a more similar temperament to that of a female. Similarly, Kearney-Cooke and Steichen-Asch describe how men 'tend to be closer to their mothers than to their fathers' (1990: 64) and display 'dependent, avoidant, and passive-aggressive personality styles', which could be interpreted as a negative evaluation of feminine, or unmasculine, traits.

Conceptualisations of eating disorders that ascribe to reducible gendered aspects, such as behaviour, personality and emotions, as well as biological differences, are trying to identify the empirical evidence on which the medical model is reliant for validity. As a result of identifying the specific triggers, causes and ways that eating disorders manifest, the goal of the biomedical approach when considering gender is to improve measurable treatment outcomes, as well as demonstrable prevention. Any research that focuses on similarities and differences between genders, in relation to the body of feminist discourse that emerged in the last century, may not yet be substantial enough to truly document the prevalence in other genders. Alternatively, the attempt to show differences between eating disorders in females and males may be in keeping with the social values it is tied into:

> 'If a male is diagnosed with anorexia nervosa this becomes a discursive problem because the dominant explanation of anorexia nervosa specifically links it with an ideology of femininity that has developed over the last century...the diagnosis of an overwhelmingly female condition in males is reconciled by the fact anorexia nervosa is in some way different in males.' (Hepworth, 1999: 78)

The problems this then creates is expansive, from the ways in which gender stereotypes may prevent raising awareness and perpetuate stigma for males (Sweeting et. al, 2015), prevent availability of successful gender-specific treatment (Strother et. al, 2012) and influence the ability of professionals to detect clinical presentations of eating disorders in men (Robinson et. al, 2012). It is also claimed that the measures used to diagnose eating disorders are developed using female patients, therefore both the research questions and interpretation are limited in their usefulness for men (Robinson et. al, 2012). From the biomedical perspective, 'there is a need for additional, methodologically rigorous qualitative research, to

learn more about what men want from ED treatment, what they have found helpful, what has made it difficult to seek help and the impact of the issue of gender in treatment, as viewed by the men themselves' (2012: 178).

Some of the research by Robinson, Mountford and Sperlinger, an interprative phenomenological analysis of male perspectives of eating disorder services, showed that 'there was a sense that having and ED makes men and women more similar that different, and that they face many of the same challenges in treatment' (2012: 182):

> 'There was also an idea that each individual faces his or her unique challenges which makes them different from everyone else, so it is irrelevant whether they are surrounded by men or women with EDs as they are not the same as any of them.' (2012: 182)

Given that this research is an analysis drawing on the lived experiences of male patients, it could be that their gender does not shape their experiences in the way other theorists propose. However conflicting data on this issue have been recorded, for example by Weltzin et. al. which stresses the importance of an all-male treatment environment for decreasing stigma and allowing men to 'experience appropriate emotional expression that is identified as strength rather than weakness' (2012: 451). It is not entirely clear whether this approach is challenging the gender stereotypes which are acknowledged as being detrimental to males with eating disorders, or whether they are unintentionally being reinforced.

Differences seen in men

Just as there are gender ideals for women which may be related to eating disorders, such gender ideals exist for male gendered individuals and shape the ways in which men's psychopathology is realised by the individual. Examples given include the role of 'body talk' amongst men and how this can pressure men into achieving a lean and muscular 'ideal' body (Engeln et. al, 2013), which is said to be exacerbated by the expectation of men to be more emotionally withdrawn and guarded than women: 'we should not be surprised to find men openly expressing their discontent about failing to "measure up"' (2013: 307). Because of the ideal male body being more obviously muscular, 'some studies suggest that men with EDs are more likely to engage in obsessive exercise (15,17,19,22) and have more psychiatric morbidity as a result of an ED (15,19)' (Räisänen & Hunt, 2013: 2), although there is an unclarified differentiation between the use of exercise for weight loss and muscle toning and the attempt to build muscle and overall mass (Levine & Piran, 2003). Negative body image is seen as being a motivating factor in both situations, but the relationship between body image and disordered eating behaviour is not understood as well as it is in female patients (2003: 57).

The ability for men to identify their own eating disorder is revealed to be a particular problem, one which has a number of possible causes. The idea that illnesses 'could theoretically be portrayed as 'gender appropriate' (eg, breast cancer in women), 'gender anomalous' (eg, multiple sclerosis)…can affect how symptoms are experienced, recognised and treated' (MacLean et.al., 2014: 2) and is rightly seen as a difficulty for individuals with eating disorders. Self-awareness of patients of different genders is not only related to gender stereotypes, but also the perceived social acceptability of an eating disorder diagnosis:

> 'Men *and* women recounted an inability in themselves and others to recognise their behaviours as symptoms of EDs but dieting and losing weight were conceptualised as more 'normal', unremarkable and 'socially acceptable' behaviours in young women...Women did not reject an ED diagnosis as a wholly inappropriate diagnosis for them unlike men, who did not come to consider the possibility of having an ED because of the inappropriateness of an ED as a socially available explanation for them *as men.*' (Räisänen & Hunt, 2013: 6)

This return to differentiation between 'typical' and 'atypical' behaviours throws up the same concerns with the medical model as was seen with its epistemological position, in that it is seen to be creating a standard of normal against which to measure all other behaviour. For it to be possible for individuals to see their diagnosis as 'appropriate' or 'inappropriate' is, in this case, referring to gender stereotypes that determine whether the individual's reality is normal or abnormal.

Gender identity and sexuality – further complexities

Research on the role of gender for people who do not 'fit' the commonly accepted gender binary, those of non-binary, transgender and fluid gender identity, is still not particularly common but steadily emerging amongst eating disorder research (Strong et. al, 2000; Strother et. al, 2012; Murray et. al., 2013). Likewise, research on the importance of sexuality for people who are non-heterosexual is in the minority, but may be increasing (Strong et. al, 2000; Heinberg et. al, 2009; Marino Carper et. al., 2010). The majority of research that focuses on gender still categorises on a male/female gender binary with little or no differentiation between gender identity, gender presentation or any respective fluidity for the individual:

> ‘In particular, it would have been desirable to have studied differences in dieting/dietary restraint (Stice et. al., 1994) and sex roles. It would be of interest to examine the role of masculinity and femininity within the gay and lesbian groups. Concepts such as “butch” and “femme” reflect the belief that within the homosexual communities there are dimensions of masculinity-femininity that further define subgroups. It might be expected that both the “femme” lesbian and feminine gay male would be more likely to experience social pressure for thinness and therefore be at greater risk of developing an eating disorder.’ (Strong et. al, 2000: 252)

Some, such as Strother et. al., make reference to the influence of “undifferentiated” and “androgynous” gender roles for males (2012: 349), but their research is focused on the specificity of the male experience, rather than disrupting or deconstructing gender beyond the normative conceptualisation (of a material, binary reality).

One particular source engages in an exploration of gender and sexuality for two transgender individuals and illuminates the fluid nature of their gender identities in relation to their eating disorders. Murray et. al. report how Patient Z’s eating behaviours changed depending on his gender and sexual identity, as well as their acceptance of masculine and feminine body ideals:

> ‘During this period [of sporadic binge episodes and frequent purging behaviours] Patient Z reported immense discomfort surrounding his emerging sexual orientation, and reported strongly endorsing a female identity which enabled Patient Z to experience his same-sex attraction as heterosexual, alleviating the subjective distress and internal conflict he experienced in his homosexual urges…As a result [of revealing his sexuality to his friends] Patient Z reported reduced ambiguity surrounding his gender identity, describing more comfort in identifying with a male gender identity. During this same period,

> Patient Z developed a desire for muscular development as opposed to emaciation, and started a muscle training regimen. Furthermore, this period was also characterized by Patient Z consuming greater quantities of food in support of his desire for greater muscularity.' (2013: 73)

As can be seen in the results of this gender-focused research, both individuals wanted to 'be' the body ideal they associated with each respective gender, which in turn would differentiate between the kinds of 'pathological eating behaviours' they participated in. It is not nonsensical for someone who wants their body to be larger and more muscular to eat increased quantities of food and perform more exercise. Identifying whether this kind of body ideal is masculine, feminine or elsewhere on the gender spectrum does not appear to reveal much more about the role of gender in relation to eating disorder symptomatology, simply that there is a connection. Arguably, it would not matter what the gendered body ideals were, those with such psychopathology would attempt to achieve them through the available means. The conclusion found by Murray et. al. was that 'both patients depicted reported that the variation in their eating disorder psychopathology was concordant with their preferred gender identity, suggesting that the construction of one's gender identity and the construction of one's body may be interrelated' (2013: 73-74).

The use of fixed gender categories is problematic as it does not necessarily represent the individual's reality and how they self-identify, therefore anomalies and seemingly erroneous evidence can be observed. In research by Heinberg et. al. on body image and eating behaviours of African American men who have sex with men (MSM), 'such work is complicated by the fact by the incorrect assumption that once someone has self-identified as a MTF (male to female) transsexual or transgender that they (a) assume an identity as male or female

and/or (b) that their identity is stable for all time…self-identity is a process and is fluid' (2009: 845). This acknowledgement that some people's gender and sexual identity exists on a spectrum, and is self-identified, is opening a discussion about related assumptions about gender and sexuality which could be a barrier to further understanding eating disorders and supporting those who experience them. Given that self-identified sexual orientation, rather than a particular sexuality, has been found to have more supporting evidence in relation to psychopathology (2009: 840).

Common within the literature were the themes of difficulties, pressure and stress felt by all gender groups, each to differing degrees and from varied suggested sources. Areas researched include: 'what men want from ED treatment, what they have found helpful, what has made it difficult to seek help and the impact of the issue of gender in treatment, as viewed by the men themselves' (Robinson et. al, 2012); the risk for African American men who have sex with men who 'may be at increased risk for difficulties [with eating] given that membership to two minority groups – African American and MSM – may result in greater stress due to Society's or internalized racism and homophobia' (Heinberg et. al, 2009: 845); the internalization of media messages about body image and attractiveness by gay men which suggests 'that gay men are more likely to accept media messages as reflective of reality whereas straight men make more of a distinction between the two' (Marino Carper et. al, 2010: 307); comparative research between US college students which demonstrated, in terms of the relationship between eating disorder symptoms and their gender identities and sexuality, 'no differences in eating disorder symptoms when comparing lesbians and heterosexual women' (Strong et. al, 2000: 251). The pressures and stresses outlined here are not necessarily specific to the genders and sexualities explored, but they are providing an insight into the realities of each individual at different points on a spectrum.

Given the myriad of gender identities, sexual identities and their fluid nature, the feminist perspective on eating disorders provides a critique of gender which supports this expansion beyond binary gender and fixed categories. Malson describes how the analysis and exploration of what she calls 'the thin/anorexic body' tells us something about gendered embodiment and 'has thus been shown to signify a multiplicity of subjectivities. Hence, the production and maintenance of this body can be understood as a management of subjectivity' (1997: 192). She subscribes to a 'Lacanian, feminist psychoanalytic theory', as well as the work of Foucault 'in which the category of gender is theorized rather than assumed, an individual-society dichotomy is transgressed and the nature and status of knowledges (about 'femininity' and 'anorexia') is problematized and politicized' (1998: 11). This concept of *multiple* subjectivities, and multiple knowledges challenges the epistemic position of the medical model, although it may not be a rejection of it completely. Instead, it remains 'problematized and politicized', directing the discourse on eating disorders, in this case in relation to gender, sexuality and the body, towards a critical engagement with the phenomena.

Body image and the 'thin ideal'

Issues surrounding the body and its physicality are prevalent in the eating disorder discourse around gender and sexuality, particularly the 'thin ideal'. The diversity in the literature which has been shown to reach beyond gender binaries and heteronormativity addresses a variety of 'ideal' body types, from the 'masculine bulky and hunky body' (Murray et. al, 2013: 72), complex male ideals 'such as "heroin chic", "metro-sexual", and "bodybuilder"' (Heinberg et. al, 2009: 840), 'phallic, muscle-bound masculinity (Malson, 1997: 106), or a cultural rejection of feminine body ideals in which the thin body 'may be construed as boyish. And, in appropriating the masculine, it thereby disrupts the gendering of the female

body' (Malson, 1997: 114), much in the same way that the 'boyish body…is little and childlike and *then* it is differently gendered' (1998: 114). There is also the media portrayal of the female thin ideal 'representing an unrealistic standard of thinness (tall, with narrow hips, long legs, and thin thighs) (Johnson et. al, 1989). This ideal stresses slimness, youth and androgyny, rather than the normative female body' (Hawkins et. al, 2004: 36). Variation can be seen between social and cultural norms, media standards and body image satisfaction, and understanding this variation is the focus of many studies - why do some individuals with an eating disorder value cultural ideals about thinness and others do not? Do those who do not identify with a normative 'feminine' physique instead value an androgynous or 'boyish' body because they are disrupting the female gendering of their bodies?

One interesting development seen in eating disorder research is not only the thin ideal and its importance for people of various genders, but the more recently identified 'muscular' ideal which idealises muscularity, low body fat and in some cases increase of body mass. As has been seen in the feminist literature, the focus on thinness has been interpreted in a variety of ways, from the desire for validation to the rejection of gender-based violence, but this is of course a critique of patriarchal oppression of women, which may not necessarily influence non-female individuals with eating disorders. Linked to this desire for a muscular body ideal are behaviours such as excessive exercise, weight training, but also use of steroids and hormones in conjunction with bingeing, purging and restriction:

> 'There is another aspect of substance abuse which is specific to males: the use of steroids or growth hormones...Steroids and other hormones are often used by men with body image concerns, which are greatest for those with a less than average weight for height. These men generally have a high drive for bulk, paired with a high drive for thinness or lean body mass.' (Strother et. al., 2012: 350)

This example is inconsistent with the feminist approach to eating disorders, although it may to some extent describe the reality experienced by women. The experiences of men who have been researched in these projects are not examples of oppression within a patriarchal society, but they appear to be responding to the same pressures and stresses associated with body ideals and sociocultural norms. The differences and similarities between men and women with eating disorders is considered to be under-researched and 'literature data on adult males regarding body dissatisfaction are poor' (Luca et. al, 2015: 52), especially research on less frequently represented sociocultural groups or those with less Westernized body image ideals (Khan et. al, 2011). The sociocultural differences between gender norms and the gendering of particular emotions, tendencies and behaviours may provide some direction for research, but there are certainly emerging examples of body ideals that do not fit with previously measured data. This increased diversity in body image ideals is identified in a number of sources as becoming a challenge to the medical model as it 'may lead to excessive variability and loss of possible effects' (Heinberg et. al, 2009: 845), therefore suggestions are made to further diversify the overall research scope (Strother et. al, 2012; Murray et. al, 2013).

Despite progression beyond gender binaries and heteronormative perspectives on eating disorders, as well as views of the body that are not rooted in Western values, the gendered body remains a point of critical discussion and there are voices that continue to challenge 'assumed' knowledge within the field. The feminist position suggests a type of sexual objectification of the female body which is then taken on by the individual, 'one consequence of such sexual objectification of the female body (e.g. through male gaze or media representations) is that girls and women are gradually socialized to internalize an observer's perspective of their physical self' (Tiggemenn, 2004: 33), thus

perpetuating the body as 'socially constructed as an object to be looked at and evaluated'. However this view appears to understand the individual from some kind of functionalist conceptualisation and does not acknowledge the individual as autonomous or self-reflective:

> 'However, [the feminist approach] puts more emphasis on the notion of the woman's body as signified rather than signifying: that is to say, it concentrates on how the female body has been signified in a male dominated culture with a largely male influenced ideology. There is less emphasis on the way that women actually live in their bodies as a means of expression...' (Sanz & Burkitt, 2001: 45)

These opposing ontologies of the body as 'signified' and 'signifying' articulate one of the problems arising from the feminist perspective, as well as one of the problems that can be seen with the medicalisation of the body, particular the female body within a patriarchal power structure. One possible solution to this, which Sanz and Burkitt suggest, is the imagining of a powerful female body created by women themselves: 'But what would a positive image of a powerful female body be like, one created by women themselves? This we don't yet know. And neither does the anorectic. When she looks for symbols of power, she finds the male not the female body image and this may be part of the problem she finds living in her body as a modern woman' (2001: 48).

Occurrence in the 'typical' population

Overall, the role of gender and sexuality in relation to eating disorders is seen as revealing not only the realities of individuals with eating disorders, but the realities of society as a whole. By learning that people with certain psychopathologies are susceptible to different aspects of social norms, including

body ideals, gendered behaviours, valuing of particular body shapes and the role of sexual identity, knowledge about the social norms may undergo identification and evaluation. But within the literature, the privileging of medical knowledge is demonstrated once again with the conclusion that eating disorders must in fact be more prevalent than anticipated, with many studies identifying the overlap in 'symptoms' in 'normal' or *non-clinical* populations:

> 'Perhaps more noteworthy was our finding of no significant interaction effects between the experimental conditions and diagnostic groups on virtually all of the dependent measures. This indicates that exposure to thin-ideal media images in our study heightened dysfunctional self-perceptions, negative emotions, and dysfunctional eating related beliefs and perceptions by relatively the same amount in both normal women and in women with eating disorders.' (Hawkins et. al., 2004: 46)

In this particular study, the 'normal' participants were sociology and psychology students at Utah State University, and the participants with eating disorders were students recruited from clinical practices and self-help groups within the university community. Although this sample would have been able to identify differences between individuals within a homogenous group, specifically female university students, this rests on assumption that their shared identities as female and students would reflect a similar correlation between their realities. The sample was also 92% Caucasian and no data were collected on their gender identity, sexuality or any other axes that could be seen as important parts of their realities. This may be the reason why the hypothesised division between the clinical and non-clinical population was not reflected in the data.

With regards to the shared attributes of women with eating disorders and supposedly 'normal' women, Nasser evaluates the very Westernised view of eating

disorders and its gender specificity by undertaking a comparative critique of what she refers to as 'the other women'. Her discussion of women spans a broad range of cultures and socio-political groups – Chinese, Indian subcontinental, Japanese, Egyptian, Muslim, Arabic, Egyptian and Arab feminist, Turkish, Black feminist and all 'other non-Western women' - and asks where these women fit within the ongoing debate about gender and eating disorders and whether they are 'immune or vulnerable' (1997: 66). She outlines five points seen in eating disorders discourse which are shared by all women, including the fact that fat is integral to womens' biology and that women are in conflict over their gender roles and the balance of feminine and masculine traits: 'Now the changes within culture have a global perspective, which means that these conditions could become universally prevalent…We will certainly be ill-advised if we continue to believe that there are isolate pockets of humanity that are remote from these forces' (1997: 105). Women are viewed as being different, but sharing basic fundamental experiences, and this is is where women's vulnerability to eating disorders may lie.

This paradox between those who do develop eating disorders and those who do not, despite sharing similar realities and having similar experiences, can be seen in some of the research and discussion but remains unclear in its conclusion. In the context of young girls' relationships with their mothers involving patriarchal gender expectations, Robertson gives an example of this when considering Orbach's feminist analysis (that girls who develop anorexia were seeking to conform to gender roles within an oppressive sociopolitical patriarchy): 'Not all conforming girls are anorexic. Why is this so? The mother-daughter relationship is problematic for many women and it would be of interest to survey the so-called normal population to see how adequately they believe their dependent needs were met' (1992: 50-51). This apparent inconsistency is addressed in Hepworth's interviews with health care workers on their construction of anorexia nervosa. She

reports how they adopted a functional concept of identity that was malleable, and observed that 'what was always unresolved in accounts that drew on social discourses of anorexia nervosa was the way in which anorexic women are both "like all women" (Dr. M) and "different"' (1999: 79). Malson outlines a kind of reflexivity, both epistemological and ontological, whereby women with eating disorders can exist in different ways whilst their individual subjectivities are simultaneously accounted for. Because their subjectivity is not fixed or consistently observable, this reflexivity allows for the treatment of women to be based on what their reality *is,* as well as informed by what her reality is *hypothesised* to be, according to the categories she can be placed into.

Dividing what is 'normal' from what is 'abnormal' is another example of the medicalisation of the female experience referred to previously, where the patriarchal medical model observes pathological behaviour instead of the behaviour of someone who is distressed in the face of oppression. Robertson states that the division between 'anorexics' and 'normal women' by feminist theorists subscribes to this same disservice:

> 'How is it that there is a single, unitary group of women with ascribed symptoms who are called 'anorexics' and analysed by feminists?...It could be argued that this is a different manner of challenging the hegemony of male knowledge, yet it employs means similar to those of the dominant male theorists...We must be careful not to get caught in the juggernaut of speaking *for* the woman being treated for anorexia, who is seldom the originator of the discourse, but is instead its silent object.' (1992: 54)

According to the literature, the feminist critique of the medical model does not appear to have made any kind of irrefutable challenge to what seems to be a perpetuation of the oppression of women. As can be seen in the varied research

considered in this section of the review, the categorisation and medicalisation of people's experiences of eating disorders continues to illuminate their differences and similarities, but they remain the 'silent objects' who are observable and measurable because they are still being spoken for, even by those who do not intend to do so.

Section 1.3: Psychosociocultural, race & ethnicity

Beyond gender and feminist critiques, other sociocultural concepts, some including a psychological perspective, are discussed in the literature, both as a supplementary approach and as an alternative (Gordon, 2001; Miller & Pumariega, 2001). Just as social gender norms and values could be seen as helping to construct various knowledges about eating disorders, 'these different institutional perspectives on anorexia not only constitute our understanding of girls' and womens' experiences, they also regulate those experiences' (Malson, 1997: 99), and these discourses do not describe reality objectively and 'are open to deconstruction' (1997: 91). Psychosociocultural analyses that consider gender, race, ethnicity, sexuality and other aspects of identity help to expand the scope of knowledge on the reality of eating disorders, but in some instances this perspective conflicts with the biomedical approach where they are still understood as psychopathological in their origin.

The continued privileging of medical knowledge and the reductionist framework was associated with criticism of psychosociocultural conceptualisations 'for not demonstrating clear scientific links with its onset and duration and were regarded inferior to theories constructed through biomedical hypotheses' (Hepworth, 1999: 53). Feminists of the 1970s and 1980s succeeded 'in articulating the need to examine society in relation to anorexia nervosa and the introduction of sexual politics…but was limited in its explication of how specific social, cultural

and ideological condition reproduced patriarchal societies and constructed subject positions for women' (Hepworth, 1999: 62). The influence of these different factors seems to remain a form of idealism and cannot meet the reductive materialism that a psychiatric diagnosis prescribes, despite its manifestation being one of the body and its physicality. Thompson suggests that exploring how we experience our bodies may illuminate how social influences are apprehended and incorporated into a person's sense of self:

> 'Unlike the term "image", which has a psychological, individual connotation, the etymology of "consciousness" links an awareness of one's social standing directly to social conditions...In a similar way, one's body consciousness is linked to one's race, gender and sexuality.' (1994: 18)

She identifies that people's experiences of embodiment are not universal, and 'the meanings people ascribe to their bodies and the social injustices that violate embodiment vary across gender, race, sexuality, class, religion, and nationality'. To understand a person's consciousness of their own socially-situated body, which is at the same time a physical manifestation of those social realities, creates a space in which these sociocultural norms *materialise,* although not in a 'scientifically reducible', observable way.

Class and consumption

Arising from the feminist conceptualisation of eating disorders, particularly anorexia nervosa, came the discussion of class and how it was intertwined with gender, power and patriarchal society. In the texts of the 1980s, most notably the work of Bruch, anorexia was seen as a middle and upper class phenomenon where 'financial achievement and social position are often high. The relatively few homes

of lower-middle-class or lower-class rating were upwardly mobile and success-oriented' (1980: 24). Continuing into the 1990s, anorexia was still viewed as developing from the affluent social classes, but as articulated by Wolf, it 'followed the familiar beauty myth pattern of movement: It began as a middle-class disease in the United States and has spread eastward as well as down the social ladder' (1991: 83). She describes its occurrence in Western American women as a 'backlash' to the patriarchal and capitalist systems that oppress them, to the extent that most women have a fixation on, or compulsive fear of, food: the epidemic of 'mental anorexia' is, according to Wolf, part of most women's realities.

Arguably, Wolf's perspective can be understood as figurative rather than a comment on anorexia as an illness, despite her use of medicalised language, because the criticism she is making is a political one: 'Women must claim anorexia as political damage done to us by a social order…Susie Orbach compared anorexia to the hunger strikes of political prisoners, particularly the suffragists…To be anorexic or bulimic *is* to be a political prisoner' (1991: 208). Crisp's perspective compliments this position by positing that individuals with anorexia are making an attempt to navigate the society they find themselves in:

> 'I see anorexia nervosa more as a psychologically adaptive stance operating within biological mechanisms. It is the particular state of starvation unique to the condition that meets the psychosocial needs of the person concerned.' (1995: 05)

Tied into this political analysis is the idea of consumption, which is expanded beyond only food, and the kind of consumerist society which has been accelerated within a post-industrial capitalist economy. With reference to Crisp's rejection of anorexia as psychopathology, Dyhouse discusses how women within a patriarchal society have also become consumers and are subsequently under added pressure

to consume. Eating disorders then become 'distortions of appetite' for food, just one of the appetites that they have as a consumer:

> 'These distortions seem to pervade wealthy societies bent on consumption…It is tempting to suggest that some [young women] feel *stuffed*, and lose their appetite in consequence. The intake of food is one area over which they can exercise power, and feel in control.' (2014: 221)

According to the literature in this area, there are indications that the pressures felt by women can be seen as increasingly complex, compounded, expansive and pervasive in almost every aspect of their lives. Within the psychosociocultural realm, the division between the psychological and the social remains a point of discussion and highlights the epistemological contrasts between them, as Hepworth expresses: 'The reluctance to seriously support social approaches are related to epistemological differences within the human sciences and to the historical absence of a social theorization of the relationships between social and cultural practices and individual psychology' (1999: 53).

Globalisation, epidemiology and migration

Beyond the view of eating disorders as an affliction of women in Western societies, some research aims to explore beyond this narrow understanding by taking a global perspective in an attempt to discover universal themes, as well as further diversity. Furthermore, considering the experiences of the individual, for example the influence of the media on body image, immigration (Pike et. al., 2013), generational patterns (Bruch, 1980; Wolf, 1991) and related psychosociocultural realities, the impact of these factors on the individual are explored from a global, historical epidemiological position. One part of the

conceptualisation of sociocultural norms is the body, particularly ideals surrounding body size, shape and how this fits with an individual's body image, and this is a theme which arises in the majority of the literature within this scope:

> 'According to the sociocultural model of EDs, culture influences attitudes towards body shape in general, and thus by extension body ideals, as well as an individual's eating behaviours and self-evaluation of their body (55).' (Pike et. al., 2013: 4)

Immigration and its impact on eating disorders is explored in a few different areas, such as risk, prevalence and prevention, many of which are included in research by Pike et. al. (2013) and form a good basis for the arguments in this area. The increased risk for eating disorders for people who are immigrating is observed, 'perhaps for women in particular, because of the stark contrasts in gender role and societal views of women among many countries' (2013: 5-6), which acknowledges the role of gender as an additional factor. Throughout their work this exploration touches on previous studies in a continuing conversation:

> 'For some time now, immigration has been considered a potential risk factor for EDs, with some studies suggesting that this risk corresponds to an individual's degree of acculturation. Findings from a recent study by Swami et. al. (64) examining body image among Zimbabwean women residing in Zimbabwe and an age-matched sample of Zimbabwean women who has immigrated to the UK support this hypothesis. Although both groups had statistically similar BMIs, Zimbabwean immigrants living in the UK had lower body appreciation and greater discrepancies between their actual vs. ideal weights as compared to Zimbabwean women living in their native country.' (2013: 5)

Comparative data seem to show that 'acculturation', or the ability and willingness to adapt to the cultural norms and practices of a new country, may correlate with risk factors for eating disorders, but it is still not clear whether it is the cultural norms themselves or the experience of immigrating which caused these individuals distress. The authors do touch upon this idea and suggest that 'more recently, recognition that 'cultures in transition' are associated with increased risk for EDs has inspired a re-examination of the process of immigration itself as a potential contributor to ED risk among immigrants. After all, immigration constitutes a distinct life event characterized by profound change' (2013: 5). Pike et. al. acknowledge that significant cultural transitions, such as 'industrialization, modernization and urbanization', similarly have a consequent effect on eating disorders due to the role they play in its risk factors and symptoms, although arguably this effect could be both negative and positive.

A genealogical perspective on eating disorders, including their historical contextualisation, is seen in the literature to varying degrees and from a broad range of positions. Just as the feminist theorists wanted eating disorders to be understood within the context of gender, culture and politics, they often used a historical approach to demonstrate how eating disorders had changed in tandem with cultural changes. Bruch made reference to 'the anorexic generations' of the 1960s and beyond who were influenced by diet culture and conformity (1980), the same group which are referred to by Wolf as 'the pornographic generations' who also found themselves in a culture of sexual violence, and degradation (1991).

In response, some authors such as Crisp clarified that these influencing factors for each generation may indeed have a role in how eating disorders are understood, but ultimately it is 'either the anorectic's simple incapacity to cope with the challenges presented, or else the implicit demand to "conform or else" required of her by her immediate environment and attachments in the face of

these same challenges to it' (1995: 62). Malson expresses a complimentary view which highlights the important role of the body in such a conceptualisation:

> 'We cannot, therefore, look to the female 'anorexic' body for the meanings or origins of anorexia. Rather, we must look to the discourses and discursive practices in which it emerged and is constituted. Because the body is not, for all its corpo-reality, a natural, transhistorical object.' (1997: 49)

The body in this instance is necessarily 'part of' its sociocultural and historical reality, but this is constituent and is at the same time created by other aspects of discourse, or other contexts within which the individual exists. This is consistent with Robertson's critique of the biomedical perspective, which subjects the female body to a medicalisation which then becomes both universalising and normative, and raises the same epistemological and ontological issues.

As with other themes within the literature, the direction suggested for the future is to expand the scope of global and genealogical research to address the multi-factored nature of eating disorders. Many varied suggestions are given for what this direction should be: Pike et. al. suggest exploration of the interconnection between eating disorders and obesity due to their overlapping sociocultural factors (2013: 6); Engeln et. al. advise that research on body image and body talk in men can extend to more varied ages, cultures and countries (2013: 306); Nasser stresses that a global perspective on eating disorders may be symbolic of a shared reality where human distress is shaped by different cultural forces (1997: 105). It is difficult to say whether eating disorders have indeed spread beyond the white, middle-class Western boundaries they were seen to have, or whether it is the expanding scope of recent research which has simply uncovered more data on the phenomenon.

Sexuality, ethnicity and age: intersections and arising conflicts

Continuing the reflection upon the socioeconomic and political influences on eating disorders, but branching out to encompass other intersecting categories, a more holistic view of the phenomenon becomes apparent. The sources that are seen to influence eating disorders are shown as interrelated and dynamic with a wide variety of thematic configurations between class, culture, gender, sexuality, age, ethnicity, race and beyond. Studies addressing this complexity include: higher rates of binge eating among ethnic minority groups and the rarity of anorexia nervosa among Black Americans (Pike et. al, 2013); binge eating as the most common eating disorder amongst Latino males (Reyes-Rodríguez et. al, 2011); an observed increase in eating disorders as fear of aging increased in mid-life and late-life women (Lewis & Cachelin, 2001); problematic body image issues and eating behaviours in African-American men who have sex with men and the links with high-risk sexual behaviours (Heinberg et. al, 2009). The majority of studies make reference to the need for further research which is able to access and observe these intersecting diversities, as a way of understanding how they trigger and 'shape' eating disorders.

There is a common division made between 'Western' and 'non-Western' cultures with both being portrayed as having comparatively positive and negative influences on the individual. Malson's critique of contemporary Western culture is that it is 'more deeply and complexly imbricated in those very damaging and distressing 'anorexic' practices that pervade so many women's lives' (1997: 193), which echoes the example of pervasive consumerism, arguably one of the possible realities of an economically developed, globalised Western world. This relates directly to the issue of population, particularly urban versus rural populations, which is addressed by Pike et. al. in their study which discusses the reconfiguration

of the 'typical' eating disordered patient, focusing on age and cultural demographics:

> 'Even where EDs are well established, population-based epidemiology studies are limited. Importantly, it must be emphasized that much of the research conducted in non-Western countries – including prevalence studies – typically involves samples of young, urban female, and to a lesser extent, gender-mixed adolescent and university samples. Consequently, rates of EDs in more rural parts of the developing world and among less-represented segments of society (e.g. urban uneducated) remain relatively unknown. Furthermore, within any one particular country, there exists variability in ED prevalence rates and considerable heterogeneity across the landscape of EDs as well.' (2013: 3)

Are the rates of eating disorder prevalence varied across different samples because the samples are varied themselves, or is it because there is not enough evidence, from an epidemiology perspective, to demonstrate any correlation or pattern in the results? This is one of the points of conflict that arises when a multifactored and complex view of eating disorders is adopted. It also seems to be the motivating factor for increased diversity of research, as opposed to evidence that there may instead be an epistemological issue at hand.

In the work of Chisuwa and O'Dea, the aetiology of eating disorders is related to specific Japanese societal norms and is also related to a specific type of social anxiety for which a huge number of university students, at least 30%, have been hospitalised. 'Taijin kyofu sho' is seen as a psychopathology in which the individual experiences severe and enduring interpersonal phobia and is associated with low self-esteem and body consciousness. As stated by the authors, 'Japanese culture has also been shown to place a strong emphasis on conformity to social norms and therefore Japanese people may be more sensitive to other's

evaluations of themselves, compared to that in Western society' (2009: 12). If this example is considered as a sociocultural mediation of people's body image and self-esteem, does it challenge the medicalised view of eating disorders as psychopathology, which exists as an observable, empirical data? The 'illness' is relating to social norms which do not exist in the same way in Western societies, so it becomes unclear whether the illness itself is different in this non-Western example, or whether it is an example of the medical model's limitations.

The negative influence of society and cultural norms, for example the difficulties and threatening experiences an individual has to try and survive and overcome, is highlighted as a possible factor in the understanding of eating disorders. Pike et. al. make reference to the increasing rate of divorce in North America and the older average age of individuals getting married (2013: 3), as well as a positive correlation between eating disorders and watching TV and other forms of media. The authors discuss whether these pressures and expectations have a detrimental effect, for example in the form of decreased body dissatisfaction and pathological eating, but their psychiatric perspective maintains that these cultural norms trigger a psychopathology, rather than the norms provoking some kind of solution or adaptive strategy in the individual. This idea that 'eating disordered behaviour' is a response to threatening or destabilising causes is seen in a few different sources and changes the perspective of eating disorders from 'malfunctions' to 'adaptive functions':

> 'Similarly, Piran (2007), through her consultation with schools in the area of body image, described diverse school "cultures" where, for example, cases of anorexia developed in relation to gang-based sexual violation, in relation to social power where weightism intersected with sexism, racism and classicism, or in relation to gender-based teasing and harassment in the context of a highly competitive privileged academic context.' (Piran, 2010: 187)

> ‘Talking with Latina, African-American, and white women – including both heterosexual and lesbian women – reveals that the origins of eating problems have little or nothing to do with vanity or obsession with appearance. In fact, eating problems begin as survival strategies – as sensible acts of self-preservation – in response to myriad injustices including racism, sexism, homophobia, classism, the stress of acculturation, and emotional, physical, and sexual abuse.’ (Thompson, 1994: 1)

In these examples, eating disorders are understood as ‘survival strategies’, or ways to exist within a society and culture which devalues, disempowers and attacks those who are not protected by different kinds of privilege. From a medical view of eating disorders as psychopathologies, certain eating behaviours are indicative of mental illness, but from the position of someone who has experienced any kind of threat which has impacted on them negatively, does choosing a method of ‘self-preservation’ indeed demonstrate a sensible choice?

Social constructions of the body

The influence of sociocultural norms on the body, specifically how the body is experienced and idealised by the individual, is conceptualised in the literature in similar ways to how the influence of gender norms was considered. Body ideals are identified as being varied across cultures, ethnicities and races, and although the ‘thin ideal’ is not present in all examples, the root issue at hand seems to be the body’s appearance and how it visibly conforms to these norms.

As was the case with gender norms, the media and the individual’s ‘exposure’ to the media is seen as a common focus through which to understand the impact of sociocultural factors. Some studies specify certain phenomena found in relation to the media, such as positive implicit associations with ‘underweight’

fashion models (Ahern et. al, 2008), or the impact of body ideal related adverts in fashion magazines as directly compared to non-body related adverts (Hawkins et. al, 2004). However their conclusions, respectively, demonstrate possible inconsistencies within expected results, for example that 'lack of association between IAT [Implicit Association Test] scores and body dissatisfaction, another core symptom, suggests that a positive implicit attitude toward underweight models is neither necessary nor sufficient to predict eating disorder risk' (2008: 302-303), or that 'although there are both theoretical and empirical reasons to believe that chronic exposure to the thin-ideal presented in the media may contribute to the development of eating disorders, most of the evidence to date is correlational or anecdotal' (2004: 37). The Implicit Association Test is a tool 'used to access attitudes and knowledge structures outside of conscious awareness and supplement our knowledge of explicit attitudes' (2008: 295) and the authors acknowledge that despite being based on 'cognitive structures', these self-report measures do not accurately reflect the individual's beliefs and attitudes.

Concerns about these discrepancies are similarly voiced in other studies, although it is not always explicitly stated whether a difference in sociocultural norms could be a possibility, as well as the problematic nature of the 'tools' utilised, such as the IAT. Ahern et. al. also used the SATAQ-3 (Sociocultural Attitudes Towards Appearance Questionnaire) to assess the sociocultural values held by each participant, but this questionnaire does not appear to differentiate between different sociocultural values. The participants of the study were recruited from a non-clinical population of women aged 16-24 who were either undergraduate at the University of Liverpool or sixth form students at an unnamed school in the north of England. It does not seem entirely possible that the questions, such as 'I compare my body to the bodies of people who are on TV' are able to adequately reflect the reality that an individual may not be seeing relatable

bodies when their gender, race, ethnicity or cultural norms are being represented. With this in mind, the authors' conclusion that 'this [correlation with personal ideals] suggests that IAT scores reflect a personal endorsement, rather than an awareness of cultural values' (2008: 303) arguably does not achieve a rigorous enough analysis of the phenomena.

In an attempt to address these kinds of issues in the study of eating disorders, analyses have been undertaken which take a more critical perspective of psychosociocultural factors and their complex and intersecting realities. In one study by Levine and Piran, the Critical Social Perspectives (CSP) model is utilised with the intention of incorporating this complexity: 'The CSP model examines the body as both a personal and social domain, located at the intersection of the individual and various social systems. This model recognizes that women's personal experiences of their bodies, as well as their practices towards their bodies, are anchored in and shaped by complex social systems that need to be clarified in order to guide constructive transformations' (2003: 63). Another similar example of this is seen in research by Khan et. al. in which a study of Body Dysmorphia Disorder (BDD) in young students in Pakistan was undertaken. It was concluded that women's concern about the size and shape of their thighs and breasts may be comparatively less than in Western studies because they may feel conflicted or hesitant to report concerns about body shape and attractiveness, specifically due to related conservative, Muslim sociocultural norms.

From a psychosociocultural perspective, the body often plays an important role when considering the power structures it is seen to exist within, as well as the different ways it exists as a 'site' or 'arena' of discourse. Malson views the anorexic body as 'a struggle over meaning':

> 'If we accept that the body is not the origin of its meanings, and that knowledge and meanings about the body are, rather, produced in discourse, then it follows that discourse is an arena in which these different meanings are asserted, contested, accepted, resisted and subverted.' (1997: 112)

Referring back to the CSP utilised by Levine and Piran, Malson's view is echoed in their study which identifies some analytic aspects unique to the CSP model. They go on to discuss how body image can be a subjective experience 'viewed as learned meaning system anchored in cultural discourses and power structures' (2003: 63), as well as the concepts of social inequity, objectification, social diversity and resistance to/collusion with dominant social discourses. Piran has also published research into the usefulness of a feminist perspective when assessing the risks of eating disorder development, the goal of which is 'the transformation of social systems towards the goal of equity, with an emphasis on the body being a site of rights, agency, and freedom' (2010: 183). This move away from the individual's 'abnormal' or 'dysfunctional' psychological functioning to a more sociocultural and political perspective shows a movement towards acknowledging that sociocultural norms can be challenged, maybe even changed, as a way which may indeed help those who are experiencing eating disorders.

One further point made within the literature, namely by Sanz and Burkitt in their phenomenological conceptualisation of anorexia, is an under-developed reflection on the autonomy of the individual when their embodied existence within culture is analysed. They make reference to Bordo's critical perspective where she sees the body as mediated by the norms it exists within, which then become normalised:

> 'In pursuit of their ideal body image and against the fact of their embodiment as adult women, most anorectics end up mutilating their bodies...Bordo remarks

> that the body of the anorectic is an illustration of how deeply power relations are etched on our bodies and how well our bodies serve them. Yet this is a view of humans as cultural dopes, hopelessly locked into the logic of power relations without a hint of the idea that these relations are actually lived.' (2001: 47)

According to the authors, individuals are influenced by the sociocultural norms and values that surround them, but not in an unaware, mechanistic way and not without self-consciousness, self-reflection and felt sense of their bodies. They reflect on the work of Merleau-Ponty's phenomenology of perception and embodiment, stating 'that identity is constituted around the physical body and the way in which we develop a feel for what our body is like, as sensed by ourselves and as visible to others: yet at the same time the feel and the image we develop of our body is also linked to how we learn to express ourselves symbolically within culture and the values that a culture places on certain body types, or parts of bodies' (2001: 46).

In adopting this conceptual perspective, the discrepancies outlined in the previous discussion are no longer necessarily anomalies in the data, but instead can be seen as representations of each person's unique reality. However these unique realities are not necessarily incapable of constituting a shared reality, as Sanz and Burkitt describe when they state that ''their perception of the totality of the field or topography of the world is enough to guarantee that each will have a universally similar perception of the perceptual field. Along with this, each person is also part of a social world and the joint human understanding of the field will also infuse the perception of each person, ensuring a reasonably common perceptual faith in reality.' (2001: 39). This view of anorexia shows a two-way interaction between the individual and the world, a realm in which their body is both the arena where cultural meanings are manifested, as well as the arena in

which they make meaning and engage with their realities. Being open to these broader conceptualisations of the human body and our bodily existence welcomes a new kind of insight where the individual can be understood as uniquely 'constructed' by their values and experiences, rather than the passive recipient of their influences.

Pathology of EDs within culture

Amongst the literature that explores psychosociocultural perspectives of eating disorders, there is an area of discussion which asks questions about the differences between those who have 'clinically diagnosed' eating disorders and those who do not. Returning to the problematic nature of the medical model and its division between 'normal' and 'abnormal', there are some who reject the individualistic nature of eating disorders and suggest that people are not suffering from an illness, they are instead experiencing a very common, almost expected, outcome of highly pressured, often fraught sociocultural influences. The perspectives are varied but address varous aspects of the problem: Hepworth rejects the labelling of people with anorexia nervosa as 'psychiatric patients' rather than citizens who should be supported to participate in society (1999: 122-124); research by Nasser stresses the 'increasing complexities of life' for women and suggests that eating disorders symbolically represent 'social disruption and cultural confusion' (1997: 97); the view that women are attempting to express themselves, their needs and experience of oppression is put forward both by Robertson (1992: xiii), who highlights the imbalance of power between men and women, and Wolf, who defends that eating disorders 'are sane and mentally healthy responses to an insane social reality' (1991: 198). Any research that takes a critical response to sociocultural norms surrounding race and ethnicity does not appear as common within the literature, and although there are issues that had

been mentioned previously, there seems to be a gap in terms of the oppression experienced by oppressed people within a world of other power imbalances.

The suggested direction that should be taken in future research is addressed by some of the authors with them often mentioning the unhelpful division between the individual and society:

> 'The separation between individual [internal causes] and society [external causes] and anorexia nervosa is particularly problematic…there is a lack of social theorization within medical psychiatric and feminist discourses about changing therapeutic practices.' (Hepworth, 1999: 89)

> 'Throughout this book I shall be questioning this notion of 'anorexia' as *individual* pathology and asking whether there might not be better ways of theorizing out own and/or others' experiences of eating and not eating, of losing and gaining weight, of being fat or thin.' (Malson, 1997: x)

In these examples, the individual who develops 'unhealthy' behaviours around food, and other behaviours such as exercise and vomiting, would be viewed with the same 'cultural dope' concept described by Sanz and Burkitt, without any critical challenge to the norms that exist within societies and cultures. The need for critical engagement with sociocultural norms appears to be the central message in a large percentage of the research, particularly the construction of new knowledge on eating disorders. Piran states the need for increased knowledge 'related to disordered eating and body experience in specific communities, such as schools, requires processes and conditions which facilitate the emergence of critical knowledge' (2010: 188). Similarly Hepworth comments on the particular role of diet and nutrition and its institutional pathologisation:

> ‘Among the proliferation of information and dietary guidelines that modern nutrition science offers to the public there are few analyses of the social practices that create healthy eating...Health care professionals’ discourse about food reproduces and maintains a narrow focus on eating explained in relation to scientific indices of nutritional content and weight regulation. This focus is central to medical discourse in the definition of normal and abnormal eating which subsumes the meaning of eating within a dominant framework of pathology’ (1999: 197)

Sociocultural norms surrounding food and eating are frequently referred to in various studies that adopt a biomedical perspective on eating disorders (Dana & Lawrence, 1988; Pike et. al, 2013; Robinson et. al, 2015) but what appears to be lacking is the critical approach to the social norms as they exist, rather than the individual’s interaction with those norms which they are then seen to internalise.

Section 1.4: Behaviour and cognitive processes

The psychological functioning of those with eating disorders is the focus of numerous empirical research projects. Psychiatric disorders are often seen as interrelated, or ‘comorbid’, and patterns in the data have been identified, such as connections between substance abuse and desire for weight loss (Strother et. al, 2012: 350-351) or the importance of existing psychiatric conditions or family history of abuse and addiction (Räisänen & Hunt, 2013: 1). Within cognitive psychology, behaviour is a response to external stimuli and gives some kind of generalisation about how human thought processes are structured. With regards to eating disorders, the literature is concerned with things such as preoccupation with body size and weight (Bruch, 1980; Ahern et. al, 2008), compensatory behaviours such as exercise and bingeing (Dana & Lawrence, 1988), or the wider category of ‘eating behaviours’ (Hollin & Lewis, 1988).

The reduction of observable behaviour to cognitive functioning, as a way to understand what is going on in someone's mind, is understandably seen as problematic and this becomes more apparent as the literature is evaluated. However, for some of the studies the issue is not a philosophical one, but an epistemic problem relating to eating disordered patients subjectively self-reporting their cognitive functions:

> 'While behavioural assessment is best carried out using a combination of observation and interview (Ciminero, Calhoun and Adams, 1986), perhaps in conjunction with psychometric scales such as the 'eating disorders inventory' (Garner, Olmstead and Polivy, 1983), cognitive assessment poses a special problem. The client is the only person who knows the validity of their report on their cognitions. Additionally, It is possible that aspects of cognition are not able to be reported as they function outside awareness.' (Hollin & Lewis, 1988: 111)

This example demonstrates that the issue does not lie in the existence of the cognitive functioning itself, but in the awareness, or consciousness, the individual has of these functions. One critic of the conceptualisation of eating disorders as cognitive dysfunction is Malson, who highlights the fact that 'the science of cognitive psychology seems only to have provided us with the knowledge that girls and women diagnosed as anorexic are particularly concerned about food and body weight' (1997: 81). The point that Malson wishes to make with this critique relates to the same problems seen in the medical model: if there is no measurable materiality to these cognitive dysfunctions, is it still possible to make claims about their causal structure and how they affect behaviour?

The link between cognition and behaviour

The links between cognition and behaviour which are specific to eating disorders are most commonly categorised into different psychopathologies, mainly because the clinical observation of an individual's behaviour appears to be the basis on which different disorders can be identified. The DSM categories of eating disorders are referred to throughout the literature with certain behaviours and cognitive functions being indicative of particular illnesses, although there are frequent overlaps between them. Different behaviours indicative of particular eating disorders are viewed as both simultaneously constituting, and separable from, the illness itself, at least in terms of its ontology. When describing methods which can be used during inpatient treatment, Hollin and Lewis suggest that interventions can be made to prevent antecedent actions and resulting behaviours, for example by monitoring bulimic patients after meals to prevent opportunities for vomiting, or planning particular 'incompatible' social activities during times that bingeing would normally occur (1988: 113). By intervening in the 'process' of behaviour in this way, the authors state that the intention of this is to clarify to the patient that it is the mechanism of the process which controls their behaviour, rather than a personal weakness or deficit.

In contrast to this, Dana and Lawrence highlight the similarities between bulimia, anorexia and BED, in which 'like the anorexic, the bulimic woman is terrified of becoming fat; like the compulsive eater, she is unable to control her eating' (1988: 23), but that the behaviour undertaken by a bulimic patient is different because her eating and vomiting 'can only properly be understood as one unified action'. From the perspective of Dana and Lawrence, it does not properly address the nature of bulimia if the behaviours are seen as separated into 'bingeing' and vomiting', because the unified nature of both actions together is 'vital' to understanding it. Another point raised by Purgold is that if compulsions to eat are communicated as negative and 'intrinsically bad, something to be "cured",

eradicated, got rid of', there becomes no differentiation between 'normal' compulsions to eat and nourish oneself and those which are 'abnormal', categorised within the behaviour of an eating disorder (1992: 50). The issue remains that pathological behaviour and cognitive dysfunction cannot necessarily be differentiated from normal behaviour and 'healthy' cognitive function, because the behaviours are not *intrinsically* so, it is only when viewed from the medical perspective of an eating disorder.

Compulsion and habit

The theme of compulsive behaviours and habits as a cognitive function is referred to in some areas of the literature and encompasses a broad range of behaviours which are not solely to do with eating and food. Bruch, for example, describes how someone with anorexia will 'actually practice looking at themselves in the mirror, over and over, taking pride in every pound they lose and every bone that shows. The more pride they take in it, the stronger the assertion that they look just fine' (1980: 77). She describes the therapeutic work with individuals who have anorexia as 'difficult, slow, and at times exasperating' due to their ingrained habits, something which she relates to their need to 'build up a new genuine personality after all the years of faked existence' (1980: 149). This perspective relates to the conceptualisation of illness prior to the DSM-IV, in which these compulsive behaviours would no doubt be seen as 'neurosis', a category excluded from the DSM in 1980. MacLeod echoes this view of anorexia as a kind of neurosis, but argues that it also has an existential aspect:

> 'On the contrary, it is, like most other psychoneurotic syndromes, a positive strategy aimed at establishing autonomy and resolving what would otherwise be unbearable conflicts in the life of the sufferer. These conflicts are partially

> related to and arising from the anorexic's individual history and personality structure – that is, they are intrapsychic. But they are also existential, that is, related to being-in-the-world, which for human beings necessarily means being-in-a-body, and for women, being-in-a-female-body.' (1981: 11)

This approach to eating disorders moves away from the medical model in which an underlying pathology is the cause of observable symptoms, and instead uses a conceptual model, or idealogical model, in which to make sense of the individual's experiences. Personality, in some respects, mediates the way in which the individual apprehends and gives meaning to their 'intrapsychic' conflicts, but this approach still acknowledges the embodied, autonomous nature of human existence.

This interaction between cognitive function and personality is eluded to by some of the sources, and this is often expressed as 'tendencies' or 'personality disorder traits', another area of human psychology which has also been medicalised and pathologised. Strother et. al. identify the contrast between the prognosis for females with eating disorders, and males who 'may have better outcomes because of their tendency to want to "fix" problems' (2012: 352). Contrastingly, Räisänen and Hunt identify how the male participants in their study took longer to recognise their 'illness' and therefore 'had become reluctant to relinquish behaviours which they felt had a purpose and function in their lives, something they couldn't 'live without'…' (2013: 4). For Bruch, aspects of an individual's character which were disagreeable or challenging were articulated in a very paternalistic way, describing one of her patients as 'formerly sweet, obedient, and considerate, [whilst suffering from anorexia nervosa] she became more and more demanding, obstinate, irritable and arrogant' (1980: 2). Again in contrast, Dana and Lawrence report that in their experience, women who suffer from

bulimia 'are highly competent and successful at what they do. They tend to be copers; women who always manage to hold things together and get things done' (1988: 15). Given the varied differences in the personalities of each individual, it remains unclear whether these shared symptoms are demonstrative of an underlying pathological cause, as the medical model would suggest, or whether it is more in the vein of a moral judgement of behaviour which relates to social norms.

Personality and character traits

Looking in more depth at the discussion on personality traits, the role of the personality is evaluated, with certain traits being specified as a kind of 'red flag' for eating disorders. As will be discussed in the following section, personality is tied into the concept of identity, autonomy and how the individual asserts to 'be themselves', but there are some personality traits identified in the literature which seem to suggest they are demonstrative of the person's abnormal psychology. Although some theorists make reference to the necessary transitional life stages, for example teenagers moving into young adulthood, the 'givenness' of this stage is not fully supported by others. There is a sense that a judgement is being made on those personality traits that are unacceptable, or undesirable, like a set of implied social rules to which young women are expected to abide by. Whether this is tied in to the position reflected by the medical model, or whether it may in fact be more representative of the social context at the time the literature was written, it is a point which could be explored in more depth.

The possibility of anorexia as being a teenage rebellion for adolescents, faced with their unavoidable crisis of autonomy is suggested by MacLeod (1981: 65), whereas Bruch describes the anorexic mindset using the metaphor of a 'sparrow in a cage' who does not wish to display any kind of unique exotic

plumage, but simply wants to be 'free' and 'energetic' (1980: 22-23). Bruch's approach to her patients' personalities is that they are proud and dedicated to their 'supreme achievement' (1980: 6) of severe emaciation, as well as being narcissistic, shown in the mental abnormalities which they 'cherish as proof of their specialness' (1980: 13). She also claims that despite not wanting to display exotic plumage, the anorexic's increasing weight loss and duration of their illness entrenches their supposedly deluded belief that they are 'worthwhile, significant, extraordinary, eccentric, or outstanding' (1980: 74) because of their private world of anorexia.

Identity and 'life goals'

The identity of the individual with an eating disorder is conceptualised in a number of ways throughout the literature, particularly the themes of 'lacking' identity, destruction and construction of identity, and crisis and conflict. The contexts that these themes are situated within cover some of the areas which have already been seen as central factors of eating disorders, others which are mentioned for the first time: Hepworth ties in the social role of women to their own experience of their individual identity, where 'the explanation of social pressures on women to be thin is constructed in ways that privilege individual psychology over other explanations' (1999: 79) and for this reason, their constructed identity is always 'in crisis and the site where conflict is played out'; Hepworth also mentions the late nineteenth century comparison between the mental state of soldiers who injured themselves to avoid military combat and the similarly 'self-inflicted' actions of people with anorexia, an approach which 'continues to be conceptualized as emerging from the essential psychology of the individual, rather than from socially constructed experienced of individuals and their action' (1999: 44); links between identity, or self, and time concerns of those

with eating disorders describe how they are 'perpetually calculating time, feeling they were wasting time, that they had too much time, needed to fill time and that time was passing' (2015: 320-321), which became a source of constant guilt about their ability to achieve self-imposed goals.

The idea that a lack of identity is involved in the cognitive mechanisms of eating disorders is common and makes reference to different types of 'lacking' within the individual. As outlined by Malson, anorexia 'may then, be positively construed as a means of finding or making an identity for oneself or as itself constituting an identity' (1997: 147), although she acknowledges that there is an implication that a negative construction of the self relies specifically on an identity that is lacking. Similarly Robinson et. al. report that patients with Severe and Enduring Eating Disorders - Anorexia Nervosa (SEED-AN) describe a life without their eating disorder as 'an intolerable void', and the authors reveal how 'our participants appear to define themselves by the disorder' (2015: 321), their refusal to eat and denial of food demonstrating 'a considerable degree of self-loathing'. There is no mention of the particular ways in which 'typical' identities are formed, and although there may be a standard psychological theory which is not explicitly stated, it doesn't explain whether this kind of 'negative' construction is specific to eating disorders or to other psychopathologies. Neither does it mention whether this kind of identity formed in response to a lacking identity is something which occurs in those with 'typical' or 'normal' cognitive functioning. From the perspective of the medical model, it is likely to be considered a symptom indicative of underlying psychopathology and this is how it appears to be positioned within the literature.

Related to the theme of a lacking identity is the construction and deconstruction of identity within the conceptualisation of eating disorders. A particularly useful example of this is seen in some of the literature on bulimia,

throughout which the dichotomy between construction/destruction, control/loss of control as well as conformity/rebellion, is explored in an attempt to understand the reality of the patient with bulimia:

> 'In that space between the world of her inner reality and the constraints of the outside world, instead of creativity we find a self-destructive symptom. But the important point is that in the bulimic woman this space *does exist*.' (Dana & Lawrence, 1988: 109)

The idea of eating disorders, in this case bulimia, being an act of self-destruction that exists in a space between an inner and outer world support the idea of the individual as autonomous and engaged consciously with their identity and the world. There is differentiation made here between what is labelled as 'creativity' and what is the 'self-destructive symptom', a dichotomy which suggests another level of pathologising may be ocurring in this instance. Creating a dichotomous division in thoughts and behaviours creates an ontological separation between two opposites, within which the individual finds themselves. Within the discussion about identity and life goals, the possibility that a person would choose to behave in a way which could cause them pain or harm is not acknowledged as a socially acceptable option, so the implication here remains within the boundaries of 'normal' versus 'abnormal' behaviour.

When identity and life goals are considered from the complex ontological positions described so far, the individual can be seen as being faced with varied crises and conflicts, themes that are touched upon within the context of eating disorders. Conflict and crisis are described as occurring in a range of different ways relating to identity, including associations made with food, the act of eating itself and in relation to self-esteem and self-understanding. Dana and Lawrence

report how, for women with bulimia, food 'is not experienced as nourishing, but rather as poisonous. It is not satisfaction but danger that the bulimic woman associates with her food' (1988: 40). The food is seen as dangerous, as a poison that will damage and invade her body, an apt example of what could be viewed as a crisis. Interestingly, despite such an urgent and possibly fatal reality being faced by the bulimic woman, this is not enough to deter her from eating, as could be expected. This relates to the previously discussed idea of bulimic behaviour as being self-destructive as it is undertaken by the individual in spite of the perceived dangers of food.

Further crises and conflicts discussed in this area include self-judgement and low self-esteem, related to the idea that there was something negative about the individual's identity for which they must compensate:

> 'Many felt there was something unacceptable about them which had to be compensated for, for example being male when males have undesirable qualities, being someone that deserves punishment or being someone whose interactions with others have resulted in low self-esteem.' (2012: 181)

In this example, Robinson, Mountford and Sperlinger found that an individual's sense of self became the source from which crises may arise, in this particular example the category of gender norms is mentioned. This is outlined as being something exacerbated by interpersonal encounters, which in turn decrease their low self-esteem, or possibly compound a sense of low self esteem they already felt. From the perspective of an individual's identity and life goals, the idea that they are required to be 'acceptable' and 'desirable' does not appear to be related in any particular way to food or eating, and this is an interesting theme which is found throughout the literature. The expected human need to seek acceptance

and support from others in a social capacity, as well as in other interpersonal engagements, is not given as a benchmark against which these other thoughts are measured. Neither are these thoughts evaluated within a framework of previous experiences, for example whether they have been told or made to feel that they are unacceptable and that this is something they can reasonably anticipate to find in the judgements of others.

Masochism and self-punishment

The exploration of behaviour which demonstrates masochism and other forms of self-punishment has a place within eating disorder research, a large number of sources touching upon varied but interrelated concepts including self-neglect, restriction and self-damage. All of these things were conceptualised in relation to negative self-worth and a way in which these feelings were understood and 'managed'. 'Unworthiness' and 'self-loathing' were reported in individuals diagnosed with SEED-AN (Robinson et. al, 2015: 320), as well as the individual with bulimia 'revealing her own sense of something primitive, savage and uncivilized about her. But also, and more profoundly, her sense that something is deeply wrong with her, something which makes her defy all propriety and convention' (Dana & Lawrence, 1988: 75-76), an internalisation of social processes and contradictory messages. Similar descriptions include Bruch's account that 'deep down every anorexic is convinced that her basic personality is defective, gross, not good enough…all her efforts are directed towards hiding the fatal flaw of her basic inadequacy' (1980: 136).

What seems apparent here is the sense of urgency in the individual's attempts to 'defy convention', their 'directed efforts' to hide their perceived inadequacies, that they will go to any lengths to do so. When considered in relation to the anticipated expectations of others, as mentioned in the literature on

identity and life goals, the motivation for this to be achieved carried a similar sense of urgency and importance. Not only is the individual being judged for their social acceptance, normality and personality, they feel there are expectations for their identity, sense of self and human connections. The literature cannot escape from perpetuating these expectations through the valuation of various aspects of being, from the positive evaluation of 'conventionality', or the negative evaluation of 'failure' in their behaviour, thoughts and conduct.

Inappropriate and 'irrational' thoughts

The role of cognitive functions in the conceptualisation of eating disorders, as has been seen in the literature so far, relies upon a division between 'rational' and 'irrational' thoughts which echoes the 'normal/abnormal' dichotomy of the medical model. From this perspective, the 'bizarre' notions held by people with anorexia include 'the conviction that the food they feel compelled to gulp down cannot be integrated or would be damaging and therefore has to be removed from the body by vomiting' (1980: 84), a conviction which is seen by Bruch as being a behaviour which sits outside of what is normal or reasonable, hence it becoming something 'bizarre'. When analysing anorexia and behaviour from a cognitive-behavioural perspective, Hollin and Lewis outline how identifying specific thoughts that trigger negative emotions, when undertaking preparations for Cognitive Behavioural Therapy (CBT), can prevent such 'dysfunctional cognitive processes' descending into recurrent thought patterns which are demonstrative of 'abnormal' cognition. These processes include 'thinking errors, irrational and 'absolute' thoughts, inappropriate expectations, self-criticism, and the assumptions associated with such cognitions' (1988: 109), which may manifest in beliefs and perceptions of anything at all which is a part of the patient's world, from body size

and weight to food, eating habits or self-worth - they can manifest in an endless configuration of clinical presentations which differ from person to person.

References are made to the individual's intelligence, as well as competence in terms of understanding their own thoughts, particularly when it comes to refusal of treatment. Individuals suffering from an eating disorder are described by Purgold as not being prepared to 'accept the logic' that if they restrict the amount of food they eat during the day, they are more likely to feel compulsion to eat in the evening (1992: 48), a behaviour which is framed in contrast to '*enjoying* a light nourishing meal at an appropriate hour'. Although she accepts that these 'idiosyncrasies' of people with anorexia and bulimia may appear to be irrational from a non-clinical perspective, it is still viewed as irrational but understood as being *pathological* in its origin, specifically cognitive dysfunction. Rather than being seen as a willingly inappropriate thought, the biomedical model of mental illness applied in this instance suggests the individual is *unwillingly* inappropriate due to their abnormal cognitive processes, an 'illness' with which they are afflicted. Malson's critique of this construction of eating disorders, namely an individualistic construction focussed on cognitive functions and related behaviour, '(implicitly) draws on the biomedical construction of anorexia as a distinct clinical entity, seeking categorically to differentiate 'anorexic' from 'normal' cognitions' (1998: 83).

This topic gives rise to important questions when it comes to the patient's competence, not only in terms of how it is clinically assessed, but also the normative and ethical implications involved. This is addressed by Vollmann in his evaluation of values and emotions within competence assessment (2006) in which the MacArthur Competence Assessment Tool-Treatment (MacMAT-T - a diagnostic tool considered the most robust and widely accepted by the psychiatric profession for measuring competence) was used with eating disorder patients. He concludes that the MacMAT-T is not able to fully encompass aspects of cognitive

functioning that occur in eating disorder patients (2006: 289-290), advocating for the addition of semi-structured interviews, using grounded theory and self-administered questionnaires. However he outlines an important point about 'unreasonable or pathological values' and how he sees no 'importance for the normative construction of capacity' as to whether a person's competence is based on pathological values or not:

> 'Because of the effect that "pathological values" are values caused by a mental disorder is in itself not an ethical argument that these values are of no or limited normative importance. The concept of pathology and the definition of mental disorder are foremost descriptive tools.' (2006: 290-291)

According to his account, the concept of psychopathology is descriptive of the underlying biological disease, therefore a decision to disregard 'pathological values' from clinical assessment means the 'normative problem is shifted from the level of competence assessment…toward the concept of mental disorder and diseases'. Rather than disregarding these values, Vollmann's position is that the question of what *should* be done within the scope of competence assessment is not answered by making this distinction. For the proponent of a cognitive-behavioural conception of eating disorders, there is still an underlying illness which is the cause to which all measurable 'abnormalities' and 'dysfunctions' can be reduced. In this circumstance, the ethical implications of a clinical decision over another person's capacity, or competence to make decisions on their treatment, become problematic because it is based on the belief that a material illness exists within the patient.

Body image as the result of cognition

Body image and its role in the symptomatology of eating disorders is a dominant theme found across almost all approaches and disciplines (Kearney-Cooke & Steichen-Asch, 1990; Lewis & Chachelin, 2001; Levine & Piran, 2003; Tiggemann, 2004; Heinberg et. al, 2009; Piran, 2010; Khan et. al, 2011; Darcy & Lin, 2012; Becker et. al, 2013; Engeln et. al, 2013; Murray et. al, 2013). Some studies state how for some individuals with eating disorders, 'body image was a significant factor [in patients' behaviour]' (Robinson et. al, 2015: 321), whereas other authors such as Robertson acknowledge that claims about common symptoms, for example preoccupation with weight and fear of weight gain in anorexia patients, may in fact overlap with the thoughts of so-called 'normal eaters', specifically in relation to the concept of an 'ideal' shape (1992: 2). Some cognitive approaches evaluate cognitive schemas to identify the meaning that the patient prescribes to their explicit attitudes:

> 'Weight and appearance schemas are cognitive structures that code information about the meaning of being fat and thin (Vitousek & Hollon, 1990). Research into appearance schemas has relied largely on self-report data to measure explicit attitudes to weight and shape. This overlooks the automatic nature of schema activation (Tiggemann, Hargreaves, Polivy & McFarlane, 2004) and recent evidence that self report measures are not always an accurate reflection of attitudes and behaviour (Stice, Fisher, & Lowe, 2004).' (Ahern et. al., 2008: 295)

Because the patient is viewed as having attitudes and knowledge that are 'outside of conscious awareness', as well as self-reporting being seen as inaccurate representations of the patient's mind, diagnostic tools (those specifically mentioned are the Implicit Association Test, IAT, and Extrinsic Affective Simon Task, EAST) are seen as a way to increase accuracy. The evidence for this division

between explicit and implicit attitudes is not given, and it is stated in the results that the IAT in particular would not necessarily be able to distinguish between negative stereotypes of overweight and thinness ideals.

Other areas explored include the historical influence of Cartesian dualism within discourse, in which 'subjectivity is radically split so that the (bodily) experience of eating becomes dissociated from the experience of self' (Malson, 1997: 125), resulting in an imbalanced focus on how individuals *think* about food and eating, their minds separate from but interacting with their bodies. For the eating disordered patient, the overbearing dominance of the mind over the body, in terms of its material bodily needs, appears to deepen this mind/body disconnect:

> 'The thin body thus signifies a positively valued subject position of self-controlled, autonomous individuality. Yet this construction is also permeated by a theme of restricted control in which food and body weight feature as the *only* arenas in which control is possible.' (Malson, 1997: 122)

Beyond this evaluation of the role of body image, its complexity as a phenomenon is explored in a number of ways and is considered by many to require a multidimensional approach to achieve understanding.

One advancement put forward within the discipline of cognitive-behavioural psychology is the movement beyond the internal processes alone, 'rather than concentrating upon just these 'person' factors, they should be understood in relation to the individual's immediate environment as well as the culture in which they live' (Hollin & Lewis, 1988: 109). Referring to Bandura's social cognitive model (SCM) of reciprocal determinism, in which the individual, their behaviour and the environment work in an interrelated and multidirectional way,

Levine and Piran suggest that SCM can be useful to demonstrate the ways in which *negative* body image arises in those with eating disorders (2003: 59). The environmental factors, also referred to as sociocultural factors 'such as the glorification of slenderness by mass media and stigmatization of body fat and obesity by peers who engage in teasing and "fat talk"', are seen as something which not only contributes to the cognitive processes of the individual, in addition to their characteristics or tendencies, and their behaviour, but it in turn becomes something which is similarly influenced *by* the individual. It is a particular configuration of all three ('dietary restraint, binge-eating, and negative affect') which can result in negative body image, but 'in general, data from [studies assessing risk factors in EDs] confirm that negative body image is an independent predictor of disordered eating' (2003: 58).

It is suggested by Ahern et. al. that it would be beneficial to include 'other measures of attitude importance, such as the importance of appearance to the self concept, as moderators of the relationship between implicit and explicit attitudes' (2008: 304). Implicit associations, such as ideal weight and attitudes to body shape, are seen as related to explicit ways in which the individual tries to actualise their body image, but the relationship between them and how they are affected by other variables is not fully understood. One challenge to this approach, seen in Sanz and Burkitt's phenomenological conceptualisation, is that the cognitive theory of disordered eating excludes the role of the individual's perception as one which is valid: 'According to the affective/cognitive theory, it is not that women actually see themselves as fat, rather they evaluate what they see according to extremely self-critical standards (for example, because of a so called lack of self-esteem) (Szmuckler, 1995)' (2001: 43). As a result, the patient's perception of their own body is classified by the medical professional 'as not according with true reality' and as 'distorted' (2001: 43-44). This is an example of the same

epistemological problems that were seen to arise in the medical model, echoed this time in the way the individual's 'body image' is understood

As seen in their reflection on the SCM of body image, Levine and Piran outline how the phenomena is 'a multidimensional construct affected by multidimensional factors in the past and present' (2003: 59). Some of the more important aspects listed include the 'overvaluation' of appearance in relation to identity, perceived drastic differences with beauty ideals, negative 'maladaptive beliefs' about body shape and constricting behaviours relating to body dissatisfaction, but a comprehensive list of all the elements is not given. All of these examples are suggestive of an excessiveness or extreme version of typical thoughts and behaviours which are considered socially acceptable. Robertson comments on this as another act of medicalisation of the patient's behaviour:

> 'Psychonalytic explanations of self-starvation are part of a process of medical categorisation which removed the social factors of behaviour from the diagnosis and emphasises the intra-psychic origins of the illness.' (1992: 30)

The amount of influence society and culture can have on a person's body image is measured against a baseline expectation, something implicitly reflected in Levine and Piran's discussion of the SCM. As a proposed solution to improving treatment outcomes and risk prevention, the authors support a Critical Social Perspective (CSP) model of body image which 'examines the body as both a personal and social domain, located at the intersection of the individual and various social systems' (2003: 63), something they see as essential if the patient is to transform their thoughts and beliefs in a 'constructive' way amidst the complex social systems they exist within. The emphasis in this approach is on understanding the body as embodied, as well as being the site of power structures, discourses and

ownership, although the individual is still seen as interacting with their bodies and the world in a 'mechanistic' way.

Self-perception of the body as subjective

The literature relating to body image also addresses the way in which the body is experienced by the individual, mostly from a psychological point of view but also beyond this, especially when body image is viewed in relation to the idea of 'self image' and what their relationship is to one another. Encompassed in the person's perception of their body are perceptions of weight, body shape, size, thinness or fatness, desirability, how it fits with social and cultural norms, all of which are aspects of people's existence that have been seen to play a role in eating disorder symptomatology, treatment and risk prevention. The experience of one's own body has been separated into the two ways in which it can be apprehended: either through the individual's perception, or the external, material 'objective' view of the body. As has been seen in the literature previously, the medical model of eating disorders privileges the 'medical gaze', as well as ruling out the individual's perspective as biased due to its subjective position, and these issues are also seen in the literature on body image and self-image.

Wooldridge and Lytle look at Schilder's psychosocial perspective, who defines 'body image as the picture we form in our own minds' (2012: 372), and is therefore completely subjective and may not correlate with how the body appears to the outside world. They give an example of a study where the body ideals of men with anorexia nervosa and those in the control group were the same, but in contrast the men with anorexia reported that their bodies were a lot bigger than they were measured to be. The authors conclude that 'if this finding is robust, males with eating disorders might not need to be re-educated about the levels of body fat that are appropriate; on the contrary, it may be that their perceptions of

their own bodies require revision' (2012: 372). Similar conclusions were found by Khan et. al. who found that in Pakistan 'despite low rates of obesity, many university students, especially women, perceive themselves as overweight [8,11-14]. This is of concern, because inappropriate weight perceptions can lead to unhealthy behaviours including eating disorders [8.15-18]' (2011: 2). In both examples, having an 'inaccurate' perception of one's body, in terms of weight or shape, becomes a risk factor for someone developing an eating disorder.

Considering the scope of the literature seen thus far, it can be seen that the separation between internal cognitions and external environmental influences is not only an epistemic division, but also an ontological division between their subjective perception of their body image and society's 'ideals' - similarly an individual's body image can either 'fit' with its material, observable reality or it is incorrect. However it is suggested by Sanz and Burkitt that the phenomena is ontologically misunderstood:

> 'Body-image and self-image – the two must be interrelated if not identical – is to be located neither within the body, in its perceptual organs or cognitive processes, nor outside the body in culture and discourse. Instead, it is dependent on how these elements are interrelated in the course of a person's life.' (2001: 46)

Perception in this case is understood from the perspective of Merleau-Ponty, a position which is critical of the common belief that perception occurs in the mind, or brain, or that observation is able to validate the existence of a particular phenomenon. Instead Sanz and Burkitt propose that, as Merleau-Ponty claims, we all share, and participate in, a perceptual faith 'that the things of the world about which we speak really exist, and that this belief is prior to the beginning of any investigation' (2001: 39). Its validity instead comes from the fact that we all share

this implicit belief when we talk about phenomena, as well as sharing a perceptual field within which we have our own individual perspective at the same time as a 'universally similar perception'.

Section 1.5: Trauma, distress, conflict and shame

The understanding of eating disorders shown in the literature is that they are a difficult and distressing experience, and this does not fit solely with the medical view of a mental illness that can be treated and 'resolved' or managed. As has been discussed throughout the literature so far, eating disorders are viewed as manifesting in a broad range of ways that are measured in clinical terms including psychological effects, physical effects and ultimately their morbidity. In addition to these manifestations relating to the individual as a material body and mind, patients also find that their ways of eating have an effect beyond their health, such as jobs, relationships, families or interests. These impacts are also viewed, through clinical observation, as something that the patient either cannot observe themselves, or is not willing to accept, and the impact on all of these aspects is measured in terms of their *negative* effect.

Some perspectives describe how 'in a [toxic, starved] state, patients are not only unwilling to talk about what they feel, but they are actually not able to…' (Bruch, 1980: 11), therefore their malnutrition and emaciation has a physical effect on their mental functioning, this example being specific to anorexia nervosa. Others, such as Robinson, Mountford and Sperlinger discuss the need for patients to admit the truth about their illness, to both themselves and to others (2012: 179). Another aspect of experience for an eating disordered patient was the clinical encounter, in which they would report feeling not listened to, not cared for, offered something they did not want or even being traumatised (2012: 182) by professionals they were in contact with. Parallels are made between eating

disorders and drug use as having similarities, in terms of how they enable the individual to cope, as well as feeling like an addiction. Within the literature, eating disorders are reported as: 'being like an addiction…serving similar functions [to alcohol/drugs]' (Robinson et. al, 2012: 181), and eating disorder patients who had used eating as a response to stress 'began to use other drugs as they grew older, most continued to turn to food' (Thompson, 1994: 97).

What is lacking in the literature up to this point is the explicit discussion of the emotions that arise within the experience of an eating disorder - they appear to be more of an implied reality. Whilst thoughts and psychological states are identified and measured, such as fear of fatness, body dissatisfaction and low self-esteem, the nearest reference to emotions experienced is the recognition of 'tendencies towards negative emotionality' (Mitchell et. al, 2014: 8). Relating to the role of emotions are extreme experiences such as abuse, which can include physical and emotional abuse or neglect, and trauma, in which someone perceives a threat to their bodily integrity, self-integrity, or life (the two definitions often overlap). Other phenomena which arise in this area of the literature are distress, a state in which the individual resorts to 'maladaptive behaviours' in response to overwhelming stress, and shame, which is widely accepted as a 'social emotion', but is not unanimously established as such throughout the health professions. Distress and shame are aspects of psychological wellbeing which are commonly seen as the resulting symptoms of mental illness. It seems especially the case for the understanding of eating disorders that the role of distress and shame is limited, with the exception of shame surrounding the body and body image. More focus is given to their 'cause', as opposed to the experiences of distress and shame themselves, particularly traumatic events, as the next section will explore and discuss.

Sexual abuse and trauma

Sexual abuse is often theorised as being a cause, or trigger, for eating disorders and a behaviour that helps individuals mange the overwhelming feelings they have, especially stress: in her discussion on bulimia and bingeing, According to Strother et. al. 'a literature review of the correlation between sexual abuse and eating disorders revealed that approximately 30% of eating disordered patients had a history of sexual abuse' (2012: 348), leading to difficult issues around their identity such as their gender roles intertwined with their sexual orientation. In relation to this, Thompson reports how 'almost all of the women I talked with experienced trauma alone and, in many instances, had no choice but to endure isolation' (1994: 98) because they could then cope without having to disclose information about the abuse that was committed against them. The author also importantly reflects on the ways in which the sexual trauma her participants experienced was overlapping with other types of abuse relating to race, anti-Semitism, class, poverty, homophobia and emotional abuse either of themselves or family members, in fact almost half of them (1994: 7).

There is some gender division in this area of the literature when it comes to sex and gender norms, particularly in the valuation of women's experiences. The context in which sexual abuse has been researched may be further understood by considering the historical role of Freud's psychoanalysis:

> 'Freud's writings exacerbated, if not engendered, the confusion which continues to surround the relationship between sexual abuse, women and psychology...[e.g. Freud's theory of imagined sexual abuse in childhood]. Women's accounts continue to be undervalued within some therapeutic models and schools of research, and an extensive examination of the relationship between sexual abuse and eating disorders remains absent. This history continues to shape psychological research vis-à-vis sexual abuse, and engenders

> great reluctance to investigate its relationship with anorexia and bulimia nervosa.' (Hepworth, 1999: 49)

This dismissive view of womens experiences of sexual abuse seems incongruent with the high prevalence of reports seen by Strother et. al., so it may be the case that the issue is not being given enough attention in recent research. If it is true that sexual abuse, experienced by people of any gender, can have a great impact on the development of eating disorders, then it would be worth widening this consideration to a number of other areas of mental health research so that the effects of trauma can be understood in similar ways.

The kinds of trauma mentioned in the literature would undoubtedly be very distressing for anyone having to experience them, and the cause of both intense, overwhelming and complex emotions. In these examples, the subsequent distress experienced appears to continue over time, as something the individuals are required to 'endure' in an attempt to 'maintain' something about their current state, one in which they are able to cope. In relation to the *ongoing* nature of their distress, there are examples in the literature of specific traumatic events occurring in the past which marked the beginning, or source, of their emotions and related thoughts: Bruch discusses the anorexic patients she had met who 'remember a definite event or remark that made them feel too fat', (1980: 57) an event which was then seen as a trigger for their eating disorder; for midlife women, it is suggested by Kally and Cumella 'that midlife transitions, such as divorce, traumatic illness, empty nest syndrome, and loss of parents, siblings, or children may trigger ED onset…' (2008: 360); in Purgold's writing, patients with anorexia and bulimia 'experienced the loss of someone with whom they had a significant and trusting relationship' around the time that their disordered eating behaviours began (1992: 109). In contrast to this, there are many descriptions from authors across very

varied disciplines of how different traumas can build and increase over time until their stress reached a level that was intolerable (Thompson, 1994; Crisp, 1995; Nasser, 1997; Levine & Piran, 2003; Dyhouse, 2014; Luca et. al, 2015).

In the consideration of eating disorders as a coping response to trauma, an eating disorder may be one coping strategy amongst a number of others which can occur in isolation, or simultaneously as what the medical model would describe as 'comorbidities'. Returning again to the role of drugs and alcohol, individuals with eating disorders are said by Strother et. al. to 'often struggle with comorbid psychiatric disorders such as substance abuse…One connection to the use of substances is to control weight' (2012: 350-351), suggesting a shared, or interrelated, ontological reality between these phenomena. Self-harm, such as 'cutting, burning or damaging themselves' is suggested by Purgold to be the anorexic and bulimic patient's 'only way of handling the particular stresses or conflict with which they are faced…a temporary and sometimes imperfect release of the unbearable tension arising from unresolved conflict' (1992: 56).

With this considered, could it be possible that the need for multiple coping techniques is demonstrative of the individual's distress level, severity of their trauma or lack of alternative 'healthy' coping techniques? This may also provide an explanation for the varying severity of symptoms in each patient, because of the unique realities each of them has? Robertson gives the example of a patient with anorexia nervosa who, after receiving a diagnosis from a physician, stated that 'if I didn't have anorexia, I'd have something else. I've always been unhappy with myself, with my body' (1992: 68). For the author, this is an example of anorexia as a lay term 'which expresses a continuum of positions – from the deeply distressed woman who is hospitalised to the woman who, in response to stress, finds herself adopting and presenting the set of psychosocial problems that is currently deemed culturally appropriate'. When viewed from this perspective, this diagnosis

becomes a descriptive term, rather than a conclusion formed from empirical data for which the physician had material evidence. This challenge to the medical model of eating disorders, one which is informed by an understanding of trauma, then changes them from an illness to a useful survival tool, or as Thompson clarifies, 'logical, creative responses to trauma, and it identifies effective methods of healing' (1994: 2).

The body, shame and 'being a body in the world'

A philosophical account of the body and its corporeality, as they relate to shame, is a concept explored in some of the non-clinical literature on eating disorders. From this view, the 'ill' body is not an object upon which medical observation is cast, but instead a *lived* body which is both an object in the world (and within culture) and a subject which is both *its body* and *in its body* - 'The body oscillates in the polarity of being unnoticed or conspicuous…of being subject or object, being lived or being had' (Fuchs, 2002: 225). This approach to the body and shame is undertaken through Fuchs' exploration of Body Dysmorphic Disorder (BDD) where the individual experiences the 'corporealizing effect of shame', an intolerable manifestation of the other's gaze 'which the the patient feels immediately on his body' (2002: 235). This idea that the gaze of the other can be felt, and that the body is something shameful, is described by Wolf when she discusses reactions to compliments by women with anorexia: '…they feel that they alone really know just how repulsive is the body hidden from view. Anorexics are sure they are embarked on a quest that no one else can understand by looking at them. Self-denial can lock women into a smug and critical condescension to other, less devout women' (1991: 123).

This idea of the body being something seen by the gaze of the other, when considered alongside the kinds of pressures and norms outlined in the previous

sections on gender and psychosociocultural conceptualisations, a powerful conflict becomes a possibility for the individual. This precarious dichotomy is discussed by Dana and Lawrence in relation to bulimia:

> 'The ways in which women use their bodies as a major arena in which to exert some control over a life which is often experienced as out of control is only one of the issues to do with gender which we suggest determines the symptom of bulimia. The conflict centering on the body as both her most valuable commodity on the one hand and her most shameful and imperfect feature on the other is an intense one for many women.' (1988: 181)

Not only is the body a 'body in the world', it is an arena in which interactions of power occur between the subject and the world in which the body exists. The female body is prescribed social, cultural and political value and power, which for women in a patriarchal society are often *devaluing* and *disempowering*, at the same time as being something which is the source of shame, so the expectation is for the body to be both visible and invisible.

Returning then to the 'pathological body', seen in Sanz and Burkitt's philosophical reflection on anorexia, the separation between normal and defective perception of the body's reality is not workable because it does not consider how culture 'is seen as lived through the body' (2001: 51). From this perspective, if it is to be accepted that the body is the arena in which culture is lived, the individual's perception of this lived reality in the arena is a valid source of knowledge about this reality. It is also suggested by Fuchs that categorising certain bodies as atypical or defective may in fact increase the body's vulnerability to the gaze of the other:

> ‘The heavy. clumsy or injured body does not fit to what is appropriate or expected in a given situation and, therefore, becomes especially vulnerable to others’ gaze...The way our body is prereflectively lived influences the way we feel towards others, and vice versa.’ (2002: 225)

This increased vulnerability is the difference between what Fuchs describes as normal shame, in which ‘the patient’s thinking is “reflected”, introverted, and constantly revolves around the body and the self’, and dysmorphic shame. The individual who experiences dysmorphic shame is not able to ‘recognize [the gaze of the other] as not always being directed towards himself. Instead, he continues to see himself with their eyes, to feel ubiquitous, contemptuous gaze on his body – the gaze of *the Other*’ (2002: 235). Here, the individual feels the gaze of the Other, but that gaze becomes internlised as the view of their own body. Rather than oscillating between ‘being lived and being had’, the body becomes stuck as something which is had, resulting in a constantly shameful state.

Helplessness versus autonomy

The theme of ‘identity and life goals’ was explored within the literature on cognitive and behavioural understandings of eating disorders, and in relation to this the themes of helplessness and autonomy are present in other areas of research. For the individual to be autonomous is something which they either struggle to realise, try to deny and avoid, or that is taken from them by their illness. The anorexic patient is said to have a need for self-deception and misperception ‘as protection against the deeper anxiety, that of not being a worthwhile integrated individual capable of leading her own life’ (Bruch, 1980: 79), but eventually for those with bulimia and BED, this turns to a helplessness where they are ‘in the grip of a demonic power that controls their life’ (Bruch, 1980: 10).

This misperception can also extend to a misinterpretation of bodily sensations which confirms the reality that 'they suffer from an all pervasive conviction of being ineffective, of having no control over their own life or their relation to others' (Bruch, 1980: 39).

Within the themes of helplessness and autonomy is the question of whether these phenomena are chosen by the individual, or whether they play an active role, either realising them or resisting them. In her personal account, MacLeod reveals how 'there was nothing conscious or deliberate about my decision [to reject food]…All I knew was that my life was intolerable and that the only way not to be destroyed by it, or by 'them' as I called the adult, authoritative world, was to reject them and everything they stood for' (1981: 62-63), an example of her trying to gain a sense of autonomy in response to the authoritative power structure she found herself helplessly within. In other texts, the desire for autonomy is based on past experiences, seen in 35% of younger onset patients and 54% of older onset patients, where their lives involved 'strict parental control with few chances to individuate or to make personal decisions…Some reported that their parents managed the household in military fashion' (Kally & Kumella, 2008: 367). In all of these examples, the individual is seen to have experienced feelings of helplessness, whether in the form of the controlling power of their illness, the authoritative adult world or the actions of their caregivers.

The contexts within which individuals exist is viewed by some authors as an important facet in understanding eating disorders - it is these contexts which influence the individual, both negatively and positively, in their attempts to be autonomous and to cope with their distress. Nasser describes how an underlying human distress within eating disorders 'is caused by the loss of relation to the self, to the other, and the loss of one's ability to understand the prevailing system and be part of it' (2007: 106), and this cultural system is 'an ambiguous double-bind

culture that is felt to be both orderly and chaotic, coherent and fragmented, standardized and individualistic'. The individual finds themselves in a position where they have both an overwhelming distress and the need to live autonomously, two processes which may be at odds with one another or even mutually exclusive in their possibility. Although these unbearable conflicts can only be understood within the context of the individual's life experiences, as MacLeod discusses, the dichotomous relationship between them is existential:

> 'As life in general was unreal and remote – seen through a sheet of glass – so my own suffering seemed unreal…What was going on in my body was as unreal, as devoid of meaning, as were the events in the outside world. The two were part of one whole, a whole of which 'I' was no part. 'I' had shrunk to a nugget of pure and isolated will whose sole purpose was to triumph over the wills of others and over the chaos ensuing from their conflicting demands...Because [the anorexic patient's] fear is loss of control, her essential helplessness, any control that is less than complete is no control at all.' (1981: 108)

Rather than being just an attempt to feel control and be autonomous, this can also be seen as an attempt to *negate helplessness* - the description of the self as being 'pure and isolated will' which no longer feels embodied in the world, or a part of culture, seems to communicate the absolute necessity that helplessness and distress are avoided. MacLeod states that these conflicts 'are intrapsychic. But they are also existential, that is, related to being-in-the-world, which for human beings necessarily means being-in-a-body, and for women, being-in-a-female-body' (1981: 11). The individual's ontological reality of existing as an embodied consciousness in the world is something inescapable, as is the demand that they exercise their autonomy and exist within social and cultural power structures.

Existential themes and personal meaning

The inclusion of an existential perspective is seen in a small number of sources within the literature (Fox & Leung, 2009; Lejonclou & Trondalen, 2009) and also evaluates the role of the individual's personal meanings. There is some reference to the idea of fantasies, for example when Dana and Lawrence suggest that the bulimic patient 'looks forward to the day when she will be truly loved, when she will achieve the perfect relationship…this fantasy is linked to the day when her bulimia will miraculously disappear' (1988: 51), but the majority of sources make evaluative judgements about misperceptions of reality, or at least some kind of universal ideal of reality against which eating disordered realities are measured. For Bruch, young women with anorexia nervosa have a core issue of not being good enough, a cause of intense anguish and dissatisfaction with themselves, something that occurs 'in contrast to the fact that these girls come from homes that make a good first impression. Everything a girl can need for her physical wellbeing and intellectual development has been provided' (1980: 23). Robinson et. al. similarly express how SEED-AN patients, despite acknowledging 'that dining together was symbolic, a way of expressing affection, developing relationships and sometimes intimacy, these could never be realized in the midst of the disorder' (2015: 321), something they describe as the 'denial' of 'normal social intercourse' and an example of a 'hermitic lifestyle' which was a common narrative theme within their research.

In relation to this view of the eating disordered patient, there is a subtle suggestion that not only are social gatherings and interpersonal relationships expected to exist to a minimum level to be considered typical, but that they are something that are easy for the non-eating disordered, or 'normal', population to undertake. Arguably, not all people in the 'typical', non-clinical population experience expressions of affection or intimacy through dining together as

interpersonal relationships can be unpredictable, fraught or complicated. The meanings of such social gatherings can be different depending on the past experiences of the individual, particularly if they have experienced trauma or feelings of shame around social activities, interpersonal relationships and more specifically around food and eating. The description given by MacLeod of an individual with an eating disorder is 'someone who doesn't know how to live except by non-eating' (1981: 182), a contradictory state in which their attempt to live can become the cause of physical ill health and ultimately death. Within the context of their past experiences, their traumas, distress and constant social, existential and interpersonal conflicts, what may be observed clinically as 'abnormal' responses may instead be meaningful for the individual as a way to exist.

Section 1.6 - Age & Ageing

The theme of age forms a large part of the understanding of eating disorders and this is reflected in the literature from across many disciplines. The widely accepted social, or public construct of eating disorders, which perpetuates the specific theme of patients being young people, mainly female, who are either children, teenagers or young women, often exists in parallel to the academic literature and research findings that are frequently published. It is likely that the research that is undertaken relating to age is positioned in relation to this widely accepted understanding of the phenomena, because it has such strong discourse (Bruch, 1980; MacLeod, 1981; Maine, 1993; Ahern et. al, 2008; Chisuwa & O'Dea, 2009; Pike et. al, 2013).

The incidence of different eating disorders among different population groups are commonly separated by age: 'AN is relatively common among young women…there has been an increase in the high risk-group of 15-19 year old girls. It

is unclear whether this reflects earlier detection of AN cases or an earlier age at onset…Compared with the other eating disorders, BED is more common among males and older individuals' (Smink et. al, 2012: 412); 'The field of EDs has historically focused on the EDs of AN, BN and BED; however, children often do not present with symptoms identical to those observed in adults and adolescents. Instead, the most common ED symptoms observed in children are determined food avoidance, preoccupation with food, fear of weight gain and preoccupation with weight' (Pike et. al, 2013: 2); 'The most common eating disorder across aging is BED' (Luca et. al, 2015: 51).

Children and adolescents

Despite the epidemiology of eating disorders showing that eating disorders are very commonly diagnosed in adolescents and young people, there is discussion over the different causes or triggers. Most commonly in female patients, bodily changes that occur as part of natural physical development are seen as being at odds with the individual's 'desire for slimness. Normal development and changes are interpreted as "fatness"' (Bruch, 1980: 61). Surprisingly, this narrative about eating disorders being a response to changes in physique relating to puberty is not as central to the literature as may be expected. In contrast to this, there is some discussion on lived experiences of embodiment, for example in their research with young women, Levine and Piran argue for 'the validity and utility of examining the construct of *disrupted embodiment* (or *disembodiment*) rather than body image disturbance' (2003: 64) as a way to understand their experiences 'of growing up in a girl's and young woman's body'. Rather than the body being viewed by a medical gaze, the body as something that is lived and has meaning, is valued as central to how it is understood in the contexts of eating disorders.

The other areas of a young person's life in which they may struggle over power are also discussed, such as a household overly-focused on upward social mobility that creates a 'stressful and noisy struggle…[which] is only exaggeration of what was there all the time' (Bruch, 1980: 36-37), or the reality for some adolescent girls 'who, because of their economic dependence on their parents, are brought in for diagnosis and treatment' (Robertson, 1992: 35). Other aspects include the psychoanalytical psychology theory of object relations, where a child's psyche is dynamically formed in relation to significant others (or objects), the disturbance of which is seen by some theorists as creating a predisposition to developing anorexia nervosa. Wooldridge and Lytle report that, following on from the work of Bruch, 'modern dynamic formulations of AN cite disturbances in the early mother-child relationship that predispose children to develop AN during adolescence' (2012: 373), which in adolescent boys, who are given the social role of successful high-achievers, can trigger anorexia if their abilities or success becomes a source of doubt - the complexities of gender roles, social and cultural norms, or class-related norms such as the focus on social status and mobility, are not necessarily considered as causes in their own right.

Mid- and late-life

Increasingly, there is research that acknowledges the incidence of eating disorders in mid-life (approximately 40 to 65) and late-life (approximately 65 and above) as well as the differences between patients in this demographic and those who are adolescents or young people. Importantly there is a clinical distinction made between two groups of older eating disorder patients - early onset, which is a diagnosis that start in adolescence, then continues into, or recurs in, later life, and late onset which is diagnosed for the first time in later life. In terms of risk factors for late-life eating disorders, according to Luca et. al.:

> ‘Late-life eating disorders present some differences if compared to eating disorders occurred “in the typical age”: the studies analysing risk factors demonstrated less family history of major psychiatric disorders [67] and comorbidity [68] but more marital conflicts, separation or divorce [69].’ (2015: 51)

As can be seen, people who are classed as late-life have experienced more marital conflicts, separation or divorce, but this is not considered the case because they have more life experience - it is arguable that someone aged 65 is already more likely to have experienced marital conflict than a ‘typically-aged’ eating disorder patient in their teens or twenties. This is something about the phenomenon which is beyond the ‘medical observation’ and is not reflected in the data, an echo of similar problems seen in the previous sections. Other ‘midlife transitions’ which are hypothesised to trigger the onset of eating disorders in mid-life women are ‘divorce, traumatic illness, empty nest syndrome, and loss of parents, siblings, or children’ (Kally & Cumella, 2008: 360), although more immediate triggers, including health issues (2008: 372), were seen as more important for older patients, rather than body image issues which were important for patients of all ages.

The literature also explores the idea that for some late-life women the pressure to conform to social norms can decrease, resulting in lower levels of body dissatisfaction. For Lewis and Cachelin, the difference between these two groups of women is their motivation and behaviour:

> ‘These findings indicate that the sociocultural standards of body image and pressures toward thinness affect to a similar degree different generations of older women…although equally dissatisfied with their bodies, elderly women are less

> likely than middle-aged women to report doing anything about it, such as restraining their eating or engaging in other weight-related behaviours.' (2001: 36)

So as some women reach late-life, they begin to care less about conforming to the norms and pressures that they may have cared about before, thus decreasing disordered eating and drive for thinness, although their body dissatisfaction is said to remain at a similar level as mid-life women. It is suggested that this change may be due to a reduction in emphasis on physical appearance, as well as body image not being seen as a central part of the individual's identity: 'This allows a greater acceptance of the otherwise socially undesirable and largely uncontrollable age-related body changes which, in turn, means that older women are somewhat able to protect their self-esteem from their increasing deviation from the thin and youthful ideal' (Tiggemann, 2004: 38). Tiggemann says that this is achieved through 'cognitive strategies such as lowering their expectations or reappraisal, which increase their acceptance of their aging bodies and more importantly, serve to maintain their self-concept and self-esteem' (2004: 34). So from this perspective, the decision to reject the expectations is formed through a cognitive mechanism which the individual uses to control their thoughts and behaviour, almost like a 'self-help' or self-therapy which is used to cope with feelings of dissatisfaction. Another factor that is said to act as a 'protective role' against eating disorders for mid-life women is change associated with stereotypical 'female' identities: 'being mother, having a stable partner, having a secure career. These factors could reduce the attention given to "appearance", body image and aging by the women presenting [body dissatisfaction and desire for thinness]' (Luca et. al, 2015: 52). As a result of women no longer fitting the patriarchal

perspective of being reproductively or sexually 'available', the expectations of their body changes and their value based on physical attractiveness changes as well.

In a theme related to body image and body satisfaction, discussion between peers that reinforces sociocultural norms about the thin ideal is labelled as 'fat talk', a phenomena which is said to be directly related to body dissatisfaction and a negative impact on mental health in men and women (Levine & Piran, 2003; Becker et. al, 2013; Engeln et. al, 2013). Fat talk does not include discussion of other factors that relate to body image, it is exclusively focussed on thinness, although it is suggested that fat talk in men can also focus on muscularity, thus it is often referred to with the more general term of 'body talk' (Englen et. al, 2013: 307). In the context of mid- and late-life patients with eating disorders, Becker et. al identify a separate phenomenon, 'old talk', a form of body-image talk that reinforces or endorses youthful beauty standards. The researchers' questionnaire-based study concluded that 'due to its prevalence and association with body image and ED pathology, old talk should be addressed in future body image research, particularly among women in mid-older life' (2013: 11). In the same vein as the use of 'cognitive strategies' as outlined by Tiggemann, Becker et. al. highlight evidence that suggests late-life women may use similar cognitive mechanisms to cope with age-related expectations of their bodies, as well as those that are gender-related (2013: 2). This shows similarities to Mathieu's discussion of disordered eating across the life span, but rather than cognitive strategies, 'older women have developed more analytical thinking skills than younger patients, and can be more aware and accepting than younger patients of the numerous physical and emotional risks surrounding disordered eating and eating disorders' (2004: 1208).

Other theories about different aspects of eating disorders are viewed as examples of an increasingly complex psychopathology which, as has been

discussed in the first section on the biomedical model of eating disorders, is therefore multidimensional. Luca et. al. reference a number of areas for consideration: late-life patients 'may present with different clinical pictures if compared to younger patients', but it may also be they are 'embarrassed for having a "teenage" pathology' (2015: 52); that women become increasingly socially devalued 'with a growing sense of envy, loss and preoccupation with body image', as well as 'the need and control of attention' or undertaking disordered eating 'as an indirect suicide' (2015: 51); hormonal changes relating to the menopause may also be a factor, because 'it is in fact well known that sex hormones exert a fundamental role in the control of eating behaviours. Estrogens, in particular, reduce food intake, whereas progesterone and testosterone increase it, promoting bulimia and abdominal obesity' (2015: 52). Regardless of the pressures, influences and risk factors outlined in the consideration of eating disorders in mid- and late-life individuals, the reality that they are experiencing varying levels of distress in relation to these things are what maintain a parallel between their experiences and those of adolescents and young women.

Body dissatisfaction and thinness related to age

The issues of body dissatisfaction and drive for thinness have already been touched upon in the literature in this section, but their role in the conceptualisation of eating disorders goes beyond the risk factors and coping mechanisms discussed so far. When viewed through the lens of age and aging, body dissatisfaction and the drive for thinness relate to a number of aspects of the phenomenon and are strongly interrelated: according to Tiggemann, there is a correlation between body dissatisfaction and self esteem which is strongest in younger and middle aged women, aged 20 to 35 and 35 to 50 respectively, and older women aged 50 to 65 (2004: 34); generally, media representations of

women in the late-life demographic are often unrealistic in comparison to 'what a normal woman looks like when she gets older' (Mathieu, 2004: 1208), for example actresses and celebrities. One important distinction to make in this area of the literature is that the vast majority of research on mid- and late-life individuals is focused on eating disorders that involve food restriction, most frequently anorexia nervosa and bulimia nervosa, rather than other common diagnoses such as BED. It is identified by Lewis and Cachelin that BED 'which is often accompanied by obesity, may occur in older women (particularly those who are middle-aged)' (2001: 37), therefore further research in this area 'should be a clinical concern'.

For mid- and late-life individuals with eating disorders, a particular link is shown between a concern with aging and the desire for thinness. This is an issue that authors such as Lewis and Cachelin state 'is needed to increase our understanding of the relationship between concern with aging and disordered eating' (2001: 37), something which is seen as a problem in 'both women and men'. Returning to the sociocultural gender role ideals of women that value their youthfulness and beauty, for mid-life and older women these pressures can become much greater, either as they anticipate age-related physical changes or begin to experience them: Kally and Cumella state that from clinical experience, 'body dissatisfaction often increases with age, as the human body undergoes age-related changes such as wrinkles, graying hair, and weight gain' (2008: 360), as well as possible feelings of 'status loss in a modern, youth-oriented culture'; Luca et. al. similarly report how 'the signs of aging (wrinkles, hair loss, changes to body fat distribution) [83] and the emphasis given to appearance, self-care and body mass index, represent risk factors for body dissatisfaction [84]. The fear of aging has been positively related to disordered/disinhibited eating and drive for thinness in middle-aged women' (2015: 52). For women who are mid-life and older, the norms and pressures relating to gender still remain, but the pressure to try and

'address' or counteract the inevitable physical reality of their bodies aging becomes something that they may anticipate and feel anxious about.

Summary of concepts within the literature

As a brief summary of the points discussed, there are some significant and valuable areas which can be seen throughout the literature. There are also links between these aspects of eating disorders as phenomena and my pre-understandings, which will also be outlined as part of this concluding section of the chapter. In comparison to other psychiatric illnesses, eating disorders are one of the most complex and challenging to conceptualise, as well as having a very deeply entrenched social discourse. In this respect, it has not been straightforward to undertake a conceptual review of the related literature, but ultimately one which has provided a good foundation of the phenomena as they currently stand.

The medical model of eating disorders, as well as human illness more generally, demonstrates an absence of the patient's perspective and subjectivity, and more explicitly describes a dysfunction that occurs in relation to them. As a result, meaning is instead provided by the clinician which is able to overcome the dysfunctional perspective of the patient, but which risks the possibility of an imbalance of power or control over the patient and their body. Cognition and behaviour are central to the phenomena, especially the ingrained nature of eating 'habits' and the difficulty that results in trying to change or resolve them to allow for new approaches to food. There are many views on the triggers and causes of eating disorders, and despite there not being a coherent consensus, there are guidelines available which aim to provide a progressive yet empirically robust framework for diagnosing and treating different types of eating disorders as effectively as possible.

A strong link is described between the role of gender and eating disorders, especially anorexia, and this is the most widely expressed conceptualisation beyond the medical model. This mainly feminist critique has been very powerful in understanding of how gender norms contribute to eating disorders and challenging the role of normative values around gender and the body. This critical approach has also challenged how we understand factors of sexuality, class and psychosociocultural within eating disorders, giving a much more diverse spectrum of the phenomena overall. There is also an identifiable historical 'arc' to the development of eating disorders and the factors which appear in their current presentation, particularly around gender norms and body ideals.

Conceptualisations around the role of the body, such as perception of the body and body image, are a major theme within eating disorders, but the ways in which they present clinically are varied. Gender and age are factors which most prominently affect the role of the body, with the theme being strongest for women and body image, specifically the 'thin ideal'. More specifically, age is broadly separated into developmental concepts for younger people, and life-stage concepts for older people. For example, eating disorders are associated more with the development of the body and self in children' adolescents and young people, whereas in mid-life and older people, an association is more commonly made with life events or co-morbidities. One of the conceptualisations which is more consistent throughout aging and life stages are those concerning trauma and distress, as these are accepted as being influential factors across all ages. However their role is seemingly under-developed and they have received less frequent or in depth investigation than other factors, such as gender or body image ideals.

In relation to philosophical conceptualisations of eating disorders, there is a lot of investigation around the theme of identity and autonomy, but this is almost

entirely from a psychological perspective. There are also some existential explanations of the phenomena which suggest they are 'contradictory states of being' in which the individual is stuck, but these make up an incredibly small number of studies on eating disorders.

My pre-knowledge and pre-understandings of eating disorders as a whole do reflect many of these points from the literature. Although I am interested in the philosophical evaluation of eating disorders as part of human experience, trying to move beyond a medicalised view, my understanding of the medical perspective of eating disorders involves many of the factors outlined above. For example the cognitions and behaviours around food and eating, in particular how deeply ingrained they can become and the difficulty in changing them, was more at the forefront of my understanding than I realised. Similarly, the dominance of gender as an influencing factor has always been central to my understanding of eating disorders within the context of the medical model, but this has perhaps been less of a feminist perspective than is seen in the literature. Gender is of course a factor in eating disorders when there are persistent gender-based norms and values around the body, but I have always assumed that these norms and values also exist for men, although they most likely do not perpetuate the same bodily qualities (consider the thin ideal and femininity more broadly, or strong and muscular ideals and masculinity).

Overall, undertaking a conceptual review of the literature has helped me identify the areas in which my pre-understandings matched with the 'universal' understandings of eating disorders that form our current knowledge base. However in contrast, it has also allowed me to identify areas of my pre-understanding which were not necessarily an awareness of the phenomena, but an awareness of *what appears to be lacking* within current understanding of the phenomena. It has also been enlightening to see the diversity of research around

eating disorders, particularly the philosophical reflections, given the importance that the research topic has to me on a more personal level.

CHAPTER 2: METHODOLOGY

Introduction

Within this chapter I will identify the rationale, justification and expected outcome of the existential phenomenological method to make the case for its selection to explore the topic of the thesis. As a qualitative method, it is essential that the approach is both clear and consistent, apprehending well-defined phenomena and a 'sound anchorage in epistemology and methodology' (Dahlberg et. al., 2001: 25), but maintaining a sense of openness to the ambiguities, depth and richness of the phenomena.

Section 2.1: The research project

Rationale

Having undertaken a conceptual review of the literature on eating disorders, it is apparent there are a number of problems with the current understanding of the phenomena, both epistemological and ontological. Its problematic nature is complex and includes many different issues, some of which have been seen so far, others which I will go on to explore from a critical and phenomenological perspective in the following sections of this chapter. However, it is essential at this stage to make the initial case for a phenomenological method in response to the findings in the literature, which ultimately entails outlining the rationale and justification for the methodological framework of the thesis.

As was shown in the biomedical conceptualisation of eating disorders, any symptoms that occur within this paradigm are identified as evidence of a psychological disorder in the patient. This information indeed allows these symptoms to be clinically labelled and diagnosed, but this does not necessarily give us any more than a *medical* interpretation of the phenomena, for its scope is limited, as has been discussed in the previous section. The lived experience of

illness may indeed encompass the 'symptoms', but as described by Dahlberg et. al, 'an illness is far more than symptoms, diagnoses, and treatment; it is the loss of abilities and the interruption of harmonic, easy and unmindful living' (2001: 44). Not only does the 'ill' body challenge what is expected or 'appropriate' for bodies ontologically, it serves as a kind of mediator, shaping the way in which we engage with, or 'meet' the world. The way in which illnesses, such as eating disorders, are actually lived, cannot be captured empirically by the biomedical model, and this is a major point of criticism:

> 'This model of scientific inquiry has come under considerable criticism, from both those who see it as an idealized model of how scientific progress happens and those who see it as an inappropriate model for research, particularly social research. In the qualitative social sciences, research is often rooted in rather different epistemological traditions, which depart from one or more tenets of positivism, and often reject a simplistic form of realism.' (Green & Thorogood, 2014: 13)

Without acknowledging its epistemological limitations, particularly with regards to the nature of the body, the dominance of the biomedical model will remain a central point of debate amongst researchers. Despite this, it can also be seen as a catalyst for different research methodologies and valuable in its contribution to ongoing discourse.

Another important point which became apparent in the literature is the view of the body as object, something which is in itself disputable but creates further problems in the specific instance of eating disorders. As was discussed by Sanz and Burkitt, the medicalisation of the body negates the epistemic position of the patient, due to the fact the body is seen as a-historical, a-cultural and not 'lived', reinforcing the clinician's perspective as universal and correlating with

reality. In terms of the medical view of the mind, strongly rooted in the mechanistic psychological model, the privileging of the 'unbiased' clinician's view occurs twofold, firstly in its apprehension of the body as object, followed by the same negation of the patient's epistemic position which is seen as a biased, subjective knowledge of their own mind. When this approach is applied to mental illness, the reinforcement of their 'disturbed' epistemic position arguably occurs a third time because their minds, or brains, are functioning pathologically.

Considering these points in the context of anorexia nervosa, with particular reference to Hepworth's writing, these epistemic negations of the patient's position may contribute to what she describes as the socio-cultural explanation of anorexia nervosa (1999: 89) where the management and explanation are 'bound together within discourse'. The body remains a 'thing' which is not enmeshed within culture, as well as a thing which is 'owned' by the patient rather than being a constituent and inseparable part of their bodily 'self'. Their mind functions pathologically, so their self-perceptions, beliefs, thoughts and knowledges, particularly those relating to their body, the object, are all 'distorted', 'abnormal' and 'ill'. In addition, the cognitive effects of malnutrition are inseparable from their existing psychopathology, and their 'dysmorphic' view of their bodies demonstrates their mental dysfunction because their body is observable in the 'reality' of the clinic.

In all of these areas, the individual's autonomy is not considered, their existence in the world viewed as a mechanistic process which occurs as a response. The complex, meaningful and contradictory nature of how we experience and *participate* in life is not considered. Instead there is an implicit reference to a 'typical' ontological reality, including the way we experience and know our bodies, a 'normal', naturalistic way that our thought processes occur and are apparent to us, and an obvious, unchanging causal relationship between the

two. From the perspective of the phenomenologist, the paradoxical nature of existence is inescapable and epistemologically, needs to be acknowledged:

> 'It is thus, and not as the bearer of a knowing subject, that our body commands the visible for us, but it does not explain it, does not clarify it, it only concentrates the mystery of its scattered visibility; and it is indeed a paradox of Being, not a paradox of man, that we are dealing with here.' (Merleau-Ponty, 1964/1992: 136)

By accepting that existence has both 'visible' and an 'invisible' aspects, phenomenology, from a methodological standpoint, can account for this dimension of the patient's lived reality. Not only would this challenge the privileging of the medical model, including the subsequent medicalisation of the body and human experience, it would also deepen understanding of illnesses, such as eating disorders.

In terms of the epidemiology of eating disorders, as well as there being a 'heterogeneity of situations and responses' for people who experience them, 'the unique configurations of each person's life will determine how actual women are variously affected' (Sanz & Burkitt,2001: 45). This combination of 'typical' eating disorder symptomatology and the unique experiences of each individual is also summed up by the health care workers interviewed by Hepworth, who saw 'the way in which anorexic women are both "like all women"…and "different"' (1999: 79). From a clinical perspective, the presence of particular symptoms are indicative of a specific psychopathology, rather than being viewed as 'situations' or 'responses' which had any kind of meaning for the individual patient. The medical view of mental illnesses implies there is a normal or 'peak' level of mental health and wellbeing, against which all other variations are held as 'symptoms' of an abnormal 'psychopathology'.

The differentiation between 'healthy' and 'unhealthy', as well as other points on what could be viewed as a spectrum of health or wellbeing, do not necessarily reflect people's experiences, or their 'realities'. As was seen in Robertson's analysis of anorexia, the categorisation of this illness 'was created because it made meaningful to the medical profession – not the starver' (1992: xiv). Within a positivist paradigm, the fact that the diagnosis is not meaningful to the patient is not necessary - it must only be meaningful to the clinician, as their objective, unbiased view correlates with true 'reality'. However a phenomenological investigation of the same phenomena differs from the medical model in that it does not necessarily wish to achieve universality across its data. Instead it is the understanding of the phenomena, in this case eating disorders, as they are experienced by those for whom they *do* have meaning, which is important regardless of whether they are clinically 'abnormal'. MacLeod's reflection that an individual with an eating disorder is 'someone who doesn't know how to live except by non-eating' (1981: 182), not only considers the individual's unique life experiences, but also the paradoxical nature of existence itself.

Looking again at the points of rationale for the methodological approach of this thesis, the basic points of critique are all related to ontological and epistemological issues with knowledge and conceptualisation of eating disorders, particularly the biomedical model. One of the major problems with the medical model is that as an essentialist, naturalist, reductionist paradigm, it claims to 'provide self-evidential proof of universally perceived objective realities, instead of the more epistemologically modest concepts of perspective and argument' (Mason, 2002: 16). Rather than being presented as the medical interpretation of the phenomena of eating disorders, the privileging of this epistemological position remains dominant in all areas of discourse.

In response to this, the problematic nature of the phenomena raises a number of intellectually interesting points of discussion and questioning, which then become prompts to begin undertaking phenomenology's characteristic 'continuous creativity' of investigation in relation to the phenomena (Van Manen, 2014: 72). The overall aim of this research project is to examine the phenomena of eating disorders, as well as demonstrating the use of a philosophically informed qualitative method to explore this phenomena. In this instance, the rationale underpinning a phenomenological approach is consistent with what a phenomenological method will be able to achieve, the justification for which will be outlined in the following section.

Justification

In a move to clarify the choice of a phenomenological methodology, following on from the guiding rationale, a number of points provide justification. The medical view of eating disorders, as a natural science, is focused on evidence because this is essential for it to function as a paradigm, for example through diagnosis, treatment and recovery. As was discussed in Chapter 1: section 1, the goal of this approach is to reduce bias and improve outcomes for a larger number of patients. However it has already been said that the medicalisation of the body creates some of the issues seen in the rationale, not only because it views the body as a natural, mechanistic object, but because it also fails to recognise the body as a 'someone' who moves through the world in meaningful ways; they 'make sense of their place in the world, have views about researchers who are studying them, and behave in ways that are not determined in law-like ways. They are complex, unpredictable, and reflect on their behaviour' (Green & Thorogood, 2004: 13). This is, of course, not a denial of the biological materiality of the body, but the statement that 'the body is constantly perceived and constantly perceiving'

(Dahlberg et. al., 2001: 41), in a way that our existence in the world, through our bodies, is meaningful and dynamic. Beyond this philosophical challenge to the medical model, ongoing research into neuronal plasticity is beginning to reveal that the brain 'is structured epigenetically by the continuous interaction of organism and environment' (Fuchs, 2004: 189), rather than being a piece of 'apparatus' that exists in the world, processing sensory information that it receives. This shows a number of interesting avenues of inquiry in the context of consciousness studies and philosophy of mind, but in relation to the medical model of eating disorders, this gives weight to the position taken by phenomenology that the body is *lived*.

Beyond the problems that come from the medical view of the body, this has implications which further destabilise its epistemological foundations, including the objectivist nature of knowledge. As beings that exist in the world, who create meaning and hold knowledge in relation to themselves and the world, this raises questions about the possibility of multiple epistemologies. In accepting that there can be more than one epistemology, there will still be inconsistencies with the ontological position of the researcher, but to impose a method onto a phenomenon 'would do great injustice to the integrity of that phenomenon' (Hycner, 1985: 280). This in itself it not an issue per se, but being aware of what Marcel states is the 'meta-problematical' nature of knowledge is essential for any kind of epistemological inquiry:

> 'To postulate the meta-problematical...is to recognise that knowledge is, as it were, environed by being, that it is interior to it in a certain sense...from this standpoint, contrary to what epistemology seeks vainly to establish, there exists well and truly a mystery of cognition…[epistemology] perpetually presupposes it.' (Marcel, 1948: 8)

Within the natural sciences, objectivism is understood to be an unbiased, context-free position from which observation can be made, in the case of the medical clinician, specifically the body and/or the mind. But as Marcel puts forward, how can we come to establish knowledge about living, existing beings if neither the patient, or the clinician, recognises that they are existing 'beings', knowledge about which is similarly environed in this same 'being' and situated in a world (Ratcliffe, 208, p. 291; Wrathall, 2006, p. 39). Similar to the deconstructionist viewpoint taken by Hepworth when challenging knowledge of anorexia nervosa, it must be considered that knowledge does not have fixed and unquestionable facts, as it is portrayed in the natural sciences, because this is not the nature of knowledge. In the case of the body in medical contexts, this is even more apparent because the very beings whose presence is being ignored are the very 'articles' of clinical investigation.

In a similar vein, objectivism's refusal to acknowledge the role of the *researcher* as a subjective being who plays a role in the construction of knowledge during the research process is a failure to see something inescapable about research of any kind. As Dahlberg et. al. articulate, this 'irrefutable fact' about the nature of research being undertaken by a researching *being*, 'researchers are and cannot be anything else than subjects, i.e. living, feeling, thinking, acting, social and contextualized individuals' (2001: 339). These ontological assumptions, about the unavoidably social, context-laden 'reality' that we find ourselves within, are so taken-for-granted and fundamental to how we understand the world, 'it can be hard to see what there is to conceptualize' (Mason, 2002: 14). For phenomenologists, these multiple epistemologies, particularly those that are almost seen as common-sense, often those of the sciences, influence our interpretations in the form of suppositions, assumptions and predispositions (Finlay, 2011: 183-184). It is for this reason that many qualitative researchers, but

most integrally those doing phenomenology, instead commit to an ongoing scrutiny of their own assumptions as an acceptance of the pre-understandings they bring to the data they aim to research.

When it is said that the subjective role of the researcher is one of a thinking, contextualised 'being', it is also important that their ontology is understood in the context of their *human existence*. In this respect, the differentiation made between scientific research and every day 'research', such as noticing that our coffee tastes different from its usual bitterness and making changes to different variables (the type of coffee, how it is ground, whether the machine requires a repair, if there is a problem with limescale in the water), something most of us undertake frequently but would not consider to be 'scientific'. The difference in this kind of research, compared for example to a clinical investigation of a specific behaviour associated with eating disorders, is the *attitude* with which it is carried out:

> 'This attitude, in order to serve the scientific purpose, must be well-rooted in sound epistemology. All researchers must know *what* they are doing. They must know *how* the research should be carried out to accommodate the particular research object and in order for the results to be valid, objective and possible to generalize, and it helps if researchers know *why* the research is being done.'(Dahlberg et. al., 2001: 334)

This process of knowing what is being done, how and why, including the way in which these factors change, all constitute the practice of *critical reflection* and *reflexivity*. This will be outlined in much greater depth in the following sections of this chapter, mainly in sections 2 and 3, but as a central tenet of the phenomenological method, it is another point of justification that can be made in response to the rationale of this thesis. Just as the problematic nature of the

medical model of eating disorders has been highlighted so far, this same criticism is made by Thompson and Pascal: 'those who have adopted the mantle of reflective practice are critical of misguided attempts to apply engineering-type problem-solving approaches to human relations and 'people problems' – just as many social scientists have been critical of positivism and its attempts to apply natural science methods, principles and assumptions to human affairs and social issues' (2012: 313).

The next point of justification for the use of a phenomenological method, which relates specifically to the existential aspect of people's lived experiences, is that it is something inescapable, paradoxical and necessarily *embodied*. Existentially-informed research into health, illness and wellbeing often seeks to go beyond the medical and pathological (Finlay, 2004; Todres & Galvin, 2006; Ratcliffe, 2008; Ratcliffe, 2015) and explore the way in which people's individual meanings, relating to their existential ontology, are understood experientially. In his analysis of existential feelings within psychiatric illness, Ratcliffe sees existential feelings as constituting 'the general space of possibilities that shapes ongoing experience and activity' (2008: 121-122). They are 'bound up' in what we do, our bodily sensations, as opposed to 'something pre-formed that then enters into a relationship with body and world'. Finlay explains them as 'background orientations through which experience is structured' (2011: 20) and frame how we engage with the world, through our bodies, for example 'feeling fulfilled', 'feeling trapped' or 'feeling distant'.

It is important then to consider these kinds of feelings outside the context of health and illness, and look at how they are experienced to differing degrees, at different times throughout someone's life overall, not just during ill health. Ratcliffe addresses this when talks about the variation in 'healthiness' of an existential feeling and asks us to consider how 'the predominance of conceptions

of the world that do not acknowledge the manner in which we belong to it can, I think, be existentially unsettling for some people.' (2008: 289). He claims that all of our world, and our day to day 'feeling of being' is full of 'meaningful possibilities…imbued with a practical significance that intensifies and fades (2008: 285), something which is not often brought to the forefront of our epistemological investigations, or comprehended as part of our ontological reality. Methodologically speaking, these existential feelings are not captured by the medical model, but they do give us a deeper ontological understanding of the world we are trying to research:

> 'Existential feelings challenge dualisms of: self versus world, inside versus outside self, affect versus cognition, bodily versus non-bodily, subject versus object. None of these polarized ways of looking at the world apply to the way we find ourselves in it. *Self and world are experientially related*.' (Finlay, 2011: 21)

As the final point of the justification, something which is inseperable from the existential lived qualities of being, is not the way in which the body is medicalised and objectified, but that it is not seen as a constituent part of a person's existence, enmeshed in the world in a meaningful and complex way. As Dahlberg et. al. Explain, 'the human being does not "have" a body, but "is" her-his body' (2001: 42), something which is central to phenomenological and existential views of the body. The lived reality of the body is not only complex but difficult to articulate, especially as the term 'embodied' implies that it is the embodiment of *something*, as opposed to a self, or consciousness, which is in actuality what is being posited. The term 'bodily' may reduce this mind and body separation somewhat, but as a result of this difficulty there is often reference made to a multiplicity of bodies. For example Merleau-Ponty, although talking about the

same ontological phenomena, compares the two 'sides' of the body, 'the body as sensible and the body as sentient (what in the past we called objective body and phenomenal body)' (1964/1992: 137), which despite being the same physical body are separated by an ontological 'abyss' between the body 'In-Itself' and the body 'For-Itself'. By recognising that the way our bodies exist and are experienced, and that this is more complex than usually presumed, we can begin to look critically at these complexities and give a broader understanding of phenomena.

Outcome

So what are the outcomes anticipated from the use of a phenomenological method? The ontological and epistemological problems with a natural science approach, based on a reductionist, essentialist paradigm that does not acknowledge human subjectivities or the lived reality of the body, can be challenged by this method, not necessarily as a way to 'correctly' prove their scientific endeavours, but to embrace the problematic, dynamic and paradoxical nature of human life. Another outcome is to engage with a discussion about, and destabilisation of, the ways in which medical research is privileged in our understanding of human experiences, and whether this can in fact be detrimental either to those who are the recipients of psychiatric diagnoses or those who observe them. As was seen in various conceptualisations of eating disorders, attempts have been made to challenge our current knowledge of the phenomena, for example feminist, psychosociocultural and trauma-informed perspectives, but their failure to demonstrate scientific standards remained a major criticism of their 'inferiority'. If the only accepted standard of empirical research is that it meet those of the natural sciences, it could be argued that scientific research of human experience, human nature and our reality is not achievable.

It is discussed by Dahlberg et. al. that 'the scientific quality [of research] is valued by means of its levels of objectivity, validity and generality' (2001: 325) which is the motivating force behind trying to eliminate bias, such as the subjectivity of the researcher or 'influential factors' that are context-laden. For this reason human research, because we are thinking, inherently complex and contextual beings, frequently focuses on reducibility and 'natural', often biological, aspects of their ontology, for the very reason that it *can* be measured and observed 'objectively'. But here Dahlberg et. al. ask why this scientific paradigm is rejected completely by those undertaking social and human research: '...if one wants research results to be taken into account, results that have enough authority to affect the development and practise of health care, psychotherapy, education, social work etcetera, it has to be scientific – in the word's true meaning: a research result has to be objective, i.e. it cannot be a result that has occurred only by chance; the result should be generalized, i.e. it must be meaningful to more people than those involved in the study' (2001: 325). This misunderstanding of the division between science as unbiased, empirical research and social sciences as biased, unobjective research is one of the central tenets of phenomenological investigation, as explained by Van Manen:

> 'Phenomenology describes not the *factual* empirical but the *existential* empirical meaning structures of a certain phenomenon or event. Thus, a phenomenological study of secrecy does not focus on a particular culture or specific social group. Instead, phenomenology studies the existential meaning structures of the phenomenon of secrecy.' (2014: 348)

The way in which this empirical method differs, by studying the existential empirical meaning structures of a phenomenon, means that it is still possible to meet rigorous scientific standards, as well as expanding upon existing knowledge.

There is a common assumption that there is only one truly valid scientific method, but in response to this, researchers in qualitative methods such as phenomenology are demonstrating that instead, 'diversity of methods is sought and is dependent on the nature of investigation, the questions raised, and the purpose to be open to the phenomenon' (Dahlberg et. al., 2001: 157). This move away from the objectivism of human-focused science, what Merleau-Ponty describes as its 'liberation', he also sees as necessary if we are to research human existence, especially the body and 'whether the human body is an object, and hence the question whether its relation with exterior nature is that of function to variable' (1964/1992: 26). For him, objective thought, when within the realm of 'social psychology' should not be restricted in its use, but instead used as 'a first phase of elimination rather than a means of total explanation' (1964/1992: 24-25). These epistemological considerations are central to our understanding of empirical research, but also to our conceptualisation of eating disorders and the medicalisation of human experience.

As an interdisciplinary thesis of philosophy applied to health and wellbeing, the outcomes of such a research project is understandably one which contributes both to health research and the demonstration of a phenomenological method, and the project of philosophical discourse. By *doing phenomenology*, we are not only undertaking an investigation and reflection on the phenomena of interest, but also how the self, a phenomena which we apprehend during the process of *doing* phenomenological research, is an inseparable part of the complicated phenomenal 'lifeworld' we exist within: 'Such analysis provides poignant evidence of the ultimately unanswerable questions that characterize lifeworld experience and research' (Dahlberg et. al., 2001: 238). Our contemporary definition of philosophy is often portrayed by its foundation of critically questioning fundamental areas of existence, such as epistemology, metaphysics or ethics, an

attitude which is not unique to the discipline, but which is concerned with the study of general *problems*. This ability to look *beneath* what we know is possible by the use of *critical reflection*, something which is held to be an increasingly important factor when undertaking qualitative research. The development of critically reflective practice will underpin the methodological position of this thesis and will be clarified later in this chapter, but it should be shown here that such practice is vital, 'to look beneath the surface of a situation, to see what assumptions are being made, what thoughts feelings and values are being drawn upon…[including] such factors as power relations, discrimination and oppression' (Thompson & Pascal, 2012: 321).

There are many further implications, in terms of the scope and use of a phenomenological analysis of eating disorders or any other human phenomena, which demonstrate the breadth of impact such research can have, from the personal sphere, to the social, political and ethical. These are not necessarily to be viewed as repercussions we wish to minimise or eliminate, or only the concern of research into these specific topics, because social research is indivisible from the structures it exists in relation to. These implications can range from the personal and interpersonal, such as the embarrassment and alienation felt by the body seen from a critical and objectifying gaze, 'because we are not in control of what traits are ascribed to us' (Finlay, 2011: 31-32); the racial, political and socio-historical construction of identity for native Algerians under an oppressive colonial regime (Fanon, 1961/1990: 200-201); or the 'systemic' understanding of mental illness where subjective experience is not separate from the interaction between the human organism and its environment but instead '*is an essential part*' (Fuchs, 2004: 190). It is an important part of the researcher's role to be aware of and take responsibility for 'what are sometimes unstated purposes' of their research, like helping to push forward social change 'or a contribution to some wider political

effort' (Mason, 2002: 21). For many researchers, engaging with these broader issues and recognising your relationship with them, rather than trying to keep them from permeating your project, is a responsibility that should be made explicit and advocated for (Mason, 2002; Finlay, 2011; Galvin & Todres, 2013). This will be a guiding motivation and point of reflection throughout this research project and will be given further analysis in the philosophical examination of Chapter 4.

Section 2.2: The existential phenomenological method

Phenomenology and its historical context

To situate the project of phenomenology as philosophy (as opposed to a research method, which will be elaborated upon within the following sections), the contexts within which it must be understood relate mainly to Western science, both its epistemological and ontological underpinnings. It is the categorisation of human existence as separate to science which is the source of a dichotomy, an 'ontological and epistemological rift' (Dahlberg et. al., 2001: 329) established in Europe and North America over the last century which has created a radical division between them. One of the reasons for this division is the differentiation between objectivity and subjectivity, with the valuing of 'the objective cognition of the West…and what is left over ascribed to the illusions of Subjectivity' (Merleau-Ponty, 1964/1992: 24) leading to a position of objectivism, with all subjectivities also being reducible to 'objective' causes rather than 'magic or myth'. This particular paradigm within Western sciences that rests on 'questions of truth, rigour, objectivity, validity, reliability, as well as generality' (Dahlberg et. al., 2001: 332), a paradigm which has developed in collaboration with Western philosophy since the 17th century, has mechanistic rules and laws which allow for everything

to be predicted and measured precisely, including human existence, something which is seen as a source of crisis within modern Western science today:

> 'This way of understanding the world and sciences has made life easier, but at the same time it has delivered a scientific illness that has weakened the human sciences.' (Dahlberg et. al., 2001: 332)

This dichotomy is one of many that have been disputed by thinkers from almost every discipline, for example that of mind/body, rationality/emotion, nature/culture, with there being ongoing disagreement about 'whether or not it is possible or meaningful' (Mason, 2002: 15) to differentiate between them. Although there are obvious implications for research concerned with human experiences and mental 'illness', such as that of this thesis, the debate over these dichotomies is one which is ongoing, expansive and is part of a specific social, historical and cultural trajectory. However it can be understood that from a philosophical standpoint, phenomenology was developed as a new way to approach these long-running disputes and create a new kind of epistemological and ontological framework.

As well as representing a distinct school of philosophical thought, phenomenology is also a '*method for questioning*…producing cognitive and noncognitive or pathic perceptions of existentialities' (Van Manen, 2014: 29) which open, as possibilities or 'potentialities' during the questioning process. It is through this interrogation of these openings whilst doing phenomenology that the meaning structures of phenomena become visible to us; by returning to the 'things' of experience and moving beyond the natural scientific paradigm as Husserl proposed (1936/1954), the experience instead 'is *meaningful,* simply because it is an experience *of* the world' (Dahlberg et. al., 2001: 48). For Husserl,

the experience and the consciousness that experiences it are actively constituted in the process of subjective experiencing - not only does this allow an entry point to the meaning structures of the phenomena, it also allows the phenomenon to be understood as it appears within the structure of that consciousness (Husserl, 1936/1970). In other words, the subject and object in this phenomenological conceptualisation were no longer distinctly separate, as had been implied within the natural sciences, and it was through understanding the direct experience of the 'life-world' that one could come to understand the 'essence' of the phenomena (Giorgi, 2005: 80).

Phenomenology as a philosophy is a discipline which goes back to the things themselves and 'to approach the world as it is experienced, in all its variety':

> 'The things of which Husserl speaks, and which are the objects of all research, are not to be understood as existing solely in themselves (the main idea of realism). Nor can they be reduced to mere aspects of the subject's conceptual world (the main idea of idealism). In this way phenomenology solves the question of scientific truth as being a result of either realism or idealism, and can be said to function as a link between realism and idealism.'(Dahlberg et. al., 2001: 32)

So for Husserl, phenomenological inquiry does not aim to overcome the influences or biases of subjectivity to access the 'real', and neither does it claim that things only exist as subjective concepts in the mind of the individual. Instead the attitude taken by Husserl is seen as the foundation for a new epistemology that 'cuts through this dichotomy' and instead focuses on the *relationship* between the subject and object. Most vital to understanding this relationship is the role of consciousness as the very 'thing' that *does the experiencing,* and the phenomena that are to be studied 'must be understood in their given modalities, as

phenomena, that is, not as real existents' (Giorgi, 1997: 238). For the phenomenologist, the phenomena do not necessarily have to be 'real' in the metaphysical, realist sense, they are instead 'the objects of intuition to which consciousness is necessarily directed' and it is this phenomenal status that is of importance. In terms of how the mind is understood from a phenomenological perspective, it is 'accepted as in the spatio-temporal world, through identifications of the inner time of mental life with the temporal dimension of the space-time in which grass grows and of the motivational patterns in mental life with causal relations among natural objects' (Embree, 2011: 125). The mind is therefore seen to exist within the same spatio-temporal world as the body and other 'spatial' objects, but due to the essential categorisation of the body as *lived,* rather than the body as object, the possibility of reducing the mind to the materiality of the body has its problems and limitations for Husserl. This topic of a Cartesian mind/body dualism will be returned to in the final chapter of the thesis, but it is appropriate to touch upon this briefly here for the purpose of clarifying Husserl's basic phenomenological position.

So how is it that phenomenology 'goes back' to the phenomena, the things themselves, and what are the philosophical implications? It was again Husserl who laid the foundation of 'doing phenomenology' through his use of the epoché, or 'reduction', which were steps or procedures which could be applied by the phenomenologist as a way to access the 'essences' of phenomena, as well as the structures of these essences. As outlined by Finlay, these steps included '1) the epoché of the natural sciences; 2) the epoché of the natural attitude; 3) the transcendental reduction; and 4) eidetic reduction' (2011: 47). By performing these different reductions when investigating phenomena, Husserl was carefully examining the meaning structures of the world in addition to the meaning structures of the consciousnesses it is intertwined inseparably with, and this realm

of study is the 'lifeworld'. Although some of his statements on the lifeworld are debated as being contradictory, for example as being something 'constantly pregiven, valid constantly and in advance as existing' (Husserl, 1901/1970: 382) but which we must also put aside our belief in its existence ('the General Thesis'), it is generally accepted that 'phenomenology can be seen as tending towards being a realist, postmodernist project' (Finlay, 2009: 15). The most important function of phenomenology is to engage in the reduction, acknowledging the attitudes and values which are brought to the epistemological analysis by the researcher so that they can be withheld, rather than unthinkingly imposed or preconceived.

> 'Instead of living the world in our taken-for-granted attitude, and thus being unproblematically "present" to the things in it, Husserl wanted us to begin examining this very "presence", i.e. our relationship with the world within which we intentionally experience "the things" of the world.' (Dahlberg et. al., 2001: 54-55)

It is precisely because these attitudes are 'taken-for-granted' that it becomes important to examine the reflections we make about ourselves, the world and our knowledge, as well as the way in which we are 'present' in the world. In terms of the philosophical implications for phenomenology, the more existential aspects of the lifeworld can be seen in Husserl's work, and a move towards this existential approach was seen in the phenomenological theories that evolved as a result.

Existential phenomenology

The move towards the existential facets of the phenomenological lifeworld is often seen as occurring in European philosophy alongside the development of hermeneutics (Dahlberg et. al., 2001: 87), a discipline which is in fact encompassed as a methodological branch of phenomenology (Finlay, 2011). It is more specifically

the work of Heidegger that represents a philosophical 'turning point' for phenomenology wherein a more existential emphasis emerged and was concerned with the role of interpretation, language and the ontological status of the subjective 'being' as a being-in-the-world. With the human being as a particular type of Being for Heidegger, referred to by him as *Dasein* who finds himself 'thrown into the (pre-existing) world of objects, projects, relationships, language, culture and history' (Finlay, 2011: 50), the project of phenomenology was instead to understand the very 'being' which we are unable to escape from, specifically as a being-toward-death, with which 'there is a mysterious relation between language [and Being]' (Todres, 2007: 19). For Heidegger, if we are to understand the existence of anything, we must first understand what it means *to exist*, and this was his ongoing point of criticism of Husserl's work, despite acknowledging its influence on his own thinking.

Another existential thinker influenced by Husserl, as well as by Heidegger, was Merleau-Ponty who explored the role of perception, as understood within the phenomenological project, in part with the goal of achieving a level of assimilation between phenomenology and Gestalt psychology. Referring directly to the work of Husserl, Merleau-Ponty saw the objects, or things, of our consciousness having both interior horizons, within consciousness, and exterior horizons, in the world, which are part of 'a new type of being, a being by porosity, pregnancy, or generality' (1964/1992: 148-149) and which we, as subjects, are 'caught up, included within' through our perceptions. Not only was the role of perception central to his work, he later wrote about the intertwining 'chiasm' between the subject and the world, both of which are of the same 'flesh' and interconnected in a dynamic, ambiguous reality, an idea which has become particularly influential within lifeworld research methodologies. Although Merleau-Ponty's body of work was wide-reaching, from the experiences of dreams and the imaginary versus 'the

real' (1964/1992: 6 & 39) to the experience of the body and its properties as an object (1945/2014: 97), the intersubjective nature of human existence is one of the major themes. Just as Husserl focused on the relationship between subject and object as opposed to their differentiated ontological categories, Merleau-Ponty saw that the 'common intentional object' towards which two subjects are directed is part of their constituted realities and existence within the world:

> 'Alternatively, not the presence to oneself, but the directedness to a common intentional object is primary in the constitution of intersubjectivity in Merleau-Ponty's logic.' (De Preester & Knockaert, 2005: 7)

However the major difference seen in Merleau-Ponty's work was the idea of the subject as *embodied,* something which was not addressed to the same extent by either Husserl or Heidegger, and which was seen to better overcome the dichotomous subject/object divide of the natural sciences. The example he uses which best demonstrates this is that of two hands touching, where the hand is both touching and being touched, what he describes as a 'double belongingness…[which] reveals to us quite unexpected relations between the two orders' (1964/1992: 137). In this instance the body is, as he describes, 'a being of two leaves' which perceives itself as both an object and a subject in such a way that their distinction from one another is not possible due to their 'intertwined' ontological status.

Another prominent conceptualisation of existential phenomenology was put forward by Sartre, drawing again on the role of consciousness and the body, as well as the intersubjective nature of human existence and the role of 'the Other'. For Sartre, human existence *is* its phenomenal consciousness, its ontology,

therefore to understand consciousness is the only way which we can understand its existence in its totality:

> 'Consciousness in relation to this being stands in the mode of *being* this being, for this being is consciousness.' (1943/1996, p. 91)

It is the existential ontology of phenomenal consciousness which characterises his approach, and our awareness of this phenomenal ontology 'is of a non-reflective kind and does not involve positing of the self as an object' (Pivčević, 1970: 126), therefore I am not able to objectify myself or my consciousness and thus '*transcend* the world of objects'. What is also important for his theory is the inescapable freedom to which human beings are 'condemned' as it is this 'gap' in which the individual must realise themselves authentically as a 'being-for-itself' rather than living in what he terms 'bad faith'.

In addition to this phenomenal consciousness which we inherently *are,* our ontology is also one that is *embodied,* and this fundamental reality is the point from which he constructs his theory of the body. He speaks of the body having differing 'ontological levels', either as *my* body, a 'being-for-itself' which is me and inseparable from my consciousness, or a 'being-for-others' where my body is wholly body and without consciousness, 'since these two aspects of the body are on different and incommunicable levels of being, they cannot be reduced to one another' (1943/1996: 305). In its reality as a 'being-for-others', the body can be objectified by the 'Look' of the Other, an 'interruption' of my sense of self and a sense of shame, an experience in which 'he is discovered, judged and objectified - he becomes an object to the other and sees himself thus. Yet it is through this relationship with others that reflective consciousness arises' (Finlay, 2011: 60). So to

briefly summarise within the context of phenomenology relating to the body, for Sartre the body has three 'dimensions' of being:

> 'I exist in my body: this is the first dimension of being. My body is utilized and known by the Other: this is its second dimension. But in so far as *I am for others*, the Other is revealed to me as the subject for whom I am an object.' (Sartre, 1943/1996: 351)

Although he highlighted the complexities of the body and its lived reality as part of the human experience, other authors have taken issue with Sartre's simplistic view of how the body is experienced within particular sociocultural and historical realities, especially in relation to power imbalances and oppression. Both the work of de Beauvoir and Fanon provide useful examples here, in their respective theorisation of woman as she exists within a patriarchal system (1949/1997), and the reality of black embodied consciousness under racist colonial oppression (1961/1990; 1967/1986). These feminist and anti-racist accounts, which will be explored in the final chapter of this thesis, demonstrate the complexity and dialectical reality of the body and the need for ongoing, in depth interrogation of its epistemological and ontological foundations, beyond the natural scientific view that often fails to move beyond basic dualist assumptions. It is acknowledged, as was discussed in Chapter 1, that the very nature of what we know can be affected by different kinds of power imbalances, such as the patriarchal bias within natural science and objectivity reflecting a 'masculine worldview' (Green & Thorogood, 2014: 19); this is also seen in the 'definitive structuring of the self and of the world…[creating] a real dialectic between my body and the world' (Fanon, 1967/1986: 111) whereby the body's schema and way of moving through the

spatio-temporal world forms part of the composition of the self, in relation to the powers imposed upon it.

The existential phenomenological approach to the livedness of the body is valuable in terms of the separation of subject and object, which was central to the original motivation of phenomenology, as well as challenging 'taken-for-granted' realities about how the body is experienced. Finlay correctly states that phenomenology asks us 'to relinquish our conditioning and to bring together the polarities…Western science has taught us to split' (2011: 21), so instead of seeing a division between these opposing categories such as mind/body, subject/object or mental/physical, they are in fact 'intertwined', so the world does not exist 'out there' but is instead 'part of us and us of it'. Instead it becomes possible to look at this constant flux of inhabiting, structuring and perception of the intertwined world-body-self and begin to identify the different 'conceptual, perceptual and emotional layers' (De Preester & Knockaert, 2005: 5) that constitute our bodies, and our human existence.

Initial phenomenological methods

Phenomenology, as a philosophical endeavour, states that to understand human existence and the world we must move beyond dualist divisions which 'put the body in the world and the seer in the body, or conversely, the world and the body in the seer as in a box' (Merleau-Ponty, 1964/1991: 138). The phenomenological method itself came about in response to other theories of the time, mainly those of positivist psychology, which had been dominant within discourse throughout the 19th and 20th century. It is widely acknowledged that Husserl is the founding theorist of the phenomenological method, but as a 'murky and zigzag history that requires careful contextualisation' (Giorgi, 1997: 251), the role of Husserl's work and its true meanings are a point of disagreement and

differing interpretation. Although it is not possible to explore this topic in depth due to the limited scope of this thesis, an attempt will be made to provide a discussion adequate enough to show the philosophical beginnings of the method.

The project of phenomenology was originally referred to by Husserl as 'phenomenological psychology', intended to be a critique of the psychologism which was influential at that time (Giorgi, 2007: 251). His position as a 'descriptive psychologist' was later abandoned for a phenomenological one, and although it was never addressed by him explicitly, his phenomenology was neither transcendental philosophy nor empirical psychology but instead a philosophical contribution to philosophical psychology or philosophy of mind. Husserl wanted to show that 'the world, the totality of facts, is structurally dependent on, and inseparable from, an intentional object-constituting *consciousness' (*Pivčević, 1970: 92), his objective being to move beyond sensation alone, focusing on ways in which we engage with the world intentionally, addressing perception, desire and thought. Instead for Husserl, the separation between subject and object is a presuppostion of the 'natural attitude' which at first appears obvious, but in fact can instead be seen as an obscured, woven-together bind in which subject and object are 'permeating each other in a manner very difficult to understand' (1962/1977: 39).

Key to understanding how Husserl's ideas developed towards a methodological process is his 'transcendental turn', whereby he made the case for a new standpoint from which phenomenological analysis could be undertaken, that of the 'transcendental subjectivity'. The use of this term was 'to underline that this subjectivity was neither psychological nor 'existential' (in the sense given to it by the existential philosophers) nor subjectivisitic' (Pivčević, 1970: 92), the result of which is a transformation of the subjectivity (achieved by the epoché) from which general, transcendental facts about knowledge can be seen:

> ‘We go from the concepts in question for us, nature and mind, as concepts defining provinces of science, back to the world which precedes all sciences and their theoretical intentions, as a world of pre-scientific intuition, indeed as a world of actual living which includes world-experiencing and world-theorising life.’ (Husserl, 1962/1977: 41)

This ‘world of pre-scientific intuition’ is the realm that phenomenology wishes to encounter and explore, something that is beyond the psychological functioning of the mind and the wholly unique, subjective view of each individual - Husserl is in fact referring to the *lifeworld,* or ‘Lebenswelt’. His motivation for moving beyond the ‘provinces of science’ to that which precedes it is his rejection of science’s ‘objectivistic physicalism’ and its ‘false sense of *self-sufficiency*’ (Pivčević, 1970: 85-86), something which he sees as the assumed ‘natural-scientific truth’ within modern science. Scientists, who were ‘educated in the habitualities of abstractly symbolic natural-scientific thinking’ (Husserl, 1962/1977: 40) were instead taking this naturalistic conceptual framework ‘as if it was simply that which is given in concrete intuition’. It became apparent to Husserl that a form of scientism was becoming further embedded within our epistemological foundations and discourse, one which he did not wish to reject, but that he felt was a major crisis point within modern science, as well as an important point of philosophical concern.

The challenge being made to psychologism and natural science was also made by Merleau-Ponty, Sartre and Heidegger, all of whom took different divergences from Husserl’s original method of ‘doing phenomenology’, as was touched upon in the previous section of this chapter. Returning again to Merleau-Ponty, he took issue with the more recent work of psychology as a discipline, which he stated had ‘wished to constitute for itself its own domain of objectivity’

(1964/1992: 20) through its discovery of 'the structure of behaviour'. Rather than a division between subject and object, Merleau-Ponty wanted to explore the way the body and world were constituted and argued for an alternative approach which encompassed this dichotomy. This holistic and dynamic view involves the 'intermingling of sensory possibilities which describes the manner in which objects appear to us pre-reflectively in a worldly context' (Finlay, 2011: 54), acknowledging our embodied existence within the world as an ambiguous, enmeshed reality 'which both constitutes us and is constituted by us'.

For Merleau-Ponty, there were also too many 'samples of magical thought' within psychology which confused the representations of the body as capable of experiencing things in its own right, such as 'seeing' or 'suffering' as way to 'bring them back into the system of the real world as objects of science' (1945/2014: 97). He wanted to make clear that the creation, or 'genesis' of the body as object was not the entirety of its ontology but instead 'a moment in the constitution of the object, the body' (1945/2014: 74), and to resolve this 'dilemma of understanding' it was essential that we should move away from the objective world. By trying to remain objective, he stated, both the perceiving subject and perceived world would remain hidden to us, revealing to us 'either nothing of the subject or nothing of the object' (1945/2014: 74). This process of supposed 'purification…of all anthropocentric elements' from scientific investigation would instead serve to 'de-humanise' the study of the human experience to the point of a philosophical and epistemological crisis (Pivčević, 1970: 86).

So as we can begin to see, the phenomenological method grew from a critique of both psychologism and naturalism, both of which can be understood as the way of thinking 'of the time' in the Western world, and are instances of socio-historical and cultural tendencies for interpretation (Embree, 2011: 124). Similarly, the move away from the objectivism of positivist perspectives, such as the division

between researchers and their research objects, or 'being caught in the belief that research does not involve the researcher as a subject' (Dahlberg et. al., 2001: 31) is also dealt with by the use of a phenomenological method. Being aware of these perspectives as interpretive tendencies which have a context, rather than unquestionable and universal scientific methods, opens up new possibilities for undertaking research and generating knowledge whilst acknowledging its situatedness amongst human values such as social and political influences (Green & Thorogood, 2014: 65. Husserl warned that continuing to move towards a solely positivist position 'would sever science from the everyday world' (Dahlberg et al., 2001: 30), ultimately undermining the benefits that are anticipated from having such scientific knowledge, and this 'dehumanization' is what phenomenology wished to attenuate.

The phenomenological lifeworld approach

Lifeworld approaches developed as a variation on the phenomenological method, for as was discussed in the previous section, all phenomenology is indeed concerned with 'the lifeworld', but in a more implicit way than is made explicit within lifeworld methods. Human beings and all of the aspects of our ontology are first and foremost *human,* and for phenomenologists this is by its very nature a problematic, meaningful and endlessly enigmatic reality, but this does not necessarily mean that it cannot be approached in a scientific way. Instead for the lifeworld researcher, it is important for us to be open, critical and reflective about the existential nature of our lives as human beings, as well as embracing the ethical, intersubjective nature of existence (Finlay, 2011: 127). There is no doubt that other more objective empirical data, particularly within medical and health care, such as test results (examinations, blood tests, x-rays and imaging), grading systems and other tools, are integral to our knowledge, but 'understanding

humans and their existence can never be complete without the perspective of their subjective experience' (Dahlberg et. al., 2001: 42). This critique of natural science, as applied to human subjects, and its approach to knowledge can be seen as the basis for qualitative research methods and the work of social scientists, and phenomenological methods can certainly be seen to subscribe to this critical view.

For the lifeworld researcher, the ability to move beyond the privileging of one particular epistemology will enable them to 'enjoin a radical examination of our belongingness to the world before all science' (Merleau-Ponty, 1964/1992: 27) and let go of the fallacious belief that an objective 'view from above' can, and should, be the ultimate standard for scientific knowledge. It is important to clarify that natural science methods are not rejected completely, but their importance is seen as limited, for example their ability to bring 'a healthy scepticism to this "naive realism"', (Giorgi, 1997: 239) and work in a systematic way to identify the causes and conditions that create relationships and links between things (in the loosest sense of the word). It still remains problematic when this systematic, procedural approach is undertaken using epistemological frameworks that are based on certain ontological preconceptions, which Merleau-Ponty identifies as things such as 'world-being, thing-being, imaginary being, and conscious being' (1964/1992: 6-7). It is precisely for this reason that a lifeworld phenomenological approach, which concerns itself with the existential aspects of human experience, can generate knowledge of a particular kind that can be useful to *understanding* this reality:

> 'The sole attitude proper to a social psychology is to take "objective" thought for what it is, that is, as a method that has founded science and is to be employed without restriction, unto the limit of the possible, but which, where nature, and a

> fortiori history are concerned, represents a first phase of elimination rather than a means of total explanation.' (Merleau-Ponty, 1964/1992: 24-25)

As can be seen, it is not necessarily the contents of a person's experience which are of interest, but the 'substructures of consciousness such as the formation of perceptual meaning, action planning, temporal continuity or implicit memory' (Fuchs, 2004: 188). Although lifeworld research involves first-person accounts and lived experience, the essences of the phenomena and the meaning in these 'substructures' can tell us more about their '*form* and *building-up*', giving a depth and richness of knowledge of human experience. By moving beyond the idea that there is one more valuable ontological perspective that can give a kind of 'ultimate' universal knowledge about the world, researchers can also begin to critically evaluate their own position and context as something which should be reflected on and accounted for explicitly through dialogue or journal-writing (Hycner, 1985: 281), and for this reason lifeworld phenomenology can be clarified as 'more than merely empirical' (Giorgi, 1997: 236) rather than a rejection of empiricism. As Giorgi succinctly explains in his discussion of phenomenological methods within the human sciences, the aim of phenomenological investigation is not to 'explain or discover causes', but is instead to *clarify*, something which 'can lead to constructive change because there is often a discrepancy between what we are actually living and what we think we are living' (2005: 77). If we are concerned with the *content* of a person's consciousness, it does not make methodological sense to seek an analysis of the causes of those thoughts, perhaps using a strictly quantitative method. The strength of the phenomenological method is that it allows us to gain insight into the meanings that appear within the conscious mind, how they are structured and their subjective nature.

What the lifeworld researcher wishes to research relates back to Husserl's phenomenology which finds the *intentional* consciousness as part of the very structure of the world as they co-constitute one another as an intertwined totality. According to this theory, 'any experience is an inextricable amalgam of (a) a mode of consciousness, which may be by perception, imagination, memory, judgement, etc., or a mixture of these, and (b) a "content", that is, the thing perceived, the event imagined, what is apparently remembered, and so on' (Ashworth, 2015: 22), and it is 'that specific relationship with the world - our intentional relationship - that phenomenologists seek to describe when studying lived experience'. This dynamic and active relationship 'in which we experience the things and events of our world as endowed with meaning' (Dahlberg et. al., 2001: 49) is unique for us because of our reality as conscious, self-reflective human beings, but is also most often experienced in a taken-for-granted, unreflected way:

> 'In the lifeworld we are immersed in our existence, engaged in our daily activities. As we act in the world – doing, being, experiencing – mostly we do not reflect on what our experience means as we are in the '**natural attitude**'. Lifeworld just happens, it unfolds.' (Finlay, 2011: 125)

When we think of this lived experience in relation to the explanations that would be given to them by different disciplines, for example by the psychologist, the sociologist or the biologist, the data produced would not be inaccurate in any way, but in terms of how we experienced it, the 'what it is like', this would not be represented by such information, despite them being *true* according to objective parameters. These objective truths 'owe nothing to our *contact* with the things: they express an effort of approximation that would have no meaning with regard to the lived experience' (Merleau-Ponty, 1964/1991: 14), and this is because these

human experiences are *lived,* something that 'cannot also be considered "in itself"'. The lifeworld, then, is concerned with the *lived,* the *existential,* and the *human,* each one a constituent ontological layer which must be included in the investigation of the intertwined reality of self-body-world-others.

The lifeworld is concerned with our lived experiences, specifically its existential attributes, therefore all of our experiences are accepted as a part of that lifeworld whether or not they are 'real', for example dreams, hallucinations or illusions, and for this reason, phenomenologists are not asking us 'to consider whether what we see is not "false" (Merleau-Ponty, 1964/1992: 5). From the perspective of the individual, their phenomenal experiences are real in that they have experienced them, and regardless of their causes, they are part of that person's reality in the existential sense and have meaning for them. Psychiatric symptoms are a good example of this, and Fuchs talks about this when discussing Laing's view of schizophrenia, the example he uses being that 'even in the erosion of the constitutional processes, the patient still strives for a coherent world view, even though this may only be possible in the form of delusion' (2004: 192). In this instance, the lifeworld researcher would aim to explore the essential meanings and structures of those experiences to better understand how the subject makes sense of them 'to re-establish some form of coherence'. According to Merleau-Ponty, we all subscribe to a 'perceptual faith' that what we experience is 'real', and this faith also consists of a 'tolerance for ambiguity', 'a fundamentally preconceptual experience of a world that can never be absolutely divided between imaginary and nonimaginary (subjective or objective) phenomena' (Morley, 2003: 93). As a result of our perceptual faith in the systems and 'natural facts' of the world, Merleau-Ponty states, 'we have believed that this system could incorporate all things into itself, even the perception that has initiated us into it' (1964/1992: 26-27). If we begin to look at the real differences between the 'real' and 'imaginary', as well as

the other dualisms that have been challenged by phenomenology, as well as the problematic nature of perception as part of the human experience, it is possible to gain new insight to areas such as mental health diagnoses and psychiatric symptoms.

As is the case with other types of phenomenology, our existential 'being' is one which is bodily, or embodied, and this body is not only *lived,* but is inseparable from who we are, thus our experiences are all bodily in the ontological sense. Lifeworld research not only aims to turn our attention to embodied experiences and meanings, but to 'aim for fresh, complex, rich descriptions of a phenomenon as it is concretely lived' (Finlay, 2009: 6), including our embodied connection to the world and its meanings. For the majority of the time, our bodies are not at the forefront of our consciousness as we go about our existence within the world, and this is what is referred to by phenomenologists as the 'habitual body' (a term used by Merleau-Ponty): 'so food is to be eaten, a dog is to be walked, words are to be spoken, a lover is to be touched, a doorknob is to be turned' (Finlay, 2011: 55). Existential phenomenology also differentiates and makes comparisons between different modes, or ontologies, of the body, such as the habitual body and the 'objective' body (Sartre, 1943/1996; Merleau-Ponty, 1964/1992), or the healthy body and the ill body (Van den Berg, 1972; Leder, 1990), and the gendered or sexed body (de Beauvoir, 1949/1997; Young, 1980/2005). Instead of assuming the ontology of the human body, phenomenology reflects critically upon embodiment and its role within the lifeworld.

The body as a lived being is a vital consideration from a phenomenological perspective, and just as vital is the 'felt sense' of the body, such as the 'kinaesthetic, sensory and visceral dimensions' (Finlay, 2011: 30), all of which are interwoven with our 'emotional-cognitive, relational and social worlds'. Not only are our felt bodily senses part of our biological functioning, for the

phenomenologist they are essential parts of our perception, our intersubjectivity (or intercorporeality) and our existential ontology. Merleau-Ponty describes this interpenetrating ontological relationship as 'double belongingness' where the body is at the same time a seeing, perceiving being and a thinking, sentient being. Similarly for Fuchs, the body 'works as a "felt mirror" of the others. It elicits a non-inferential process of empathic perception which Merleau-Ponty called "transfer of the corporeal schema"…' (2004: 192), and in this 'interpersonal perception' our bodily expressions are 'resonant' with the bodily expressions of others and then 'in turn, [are] in resonance with our emotional states'. Just as we are co-constituted through our directedness towards a 'common intentional object', we are co-constituted in our perceived, bodily felt sense within the same reality or world, and this is what lifeworld phenomenologists describe as the radical ontology of the body-world which goes beyond common dualist dichotomies:

> 'Here [Merleau-Ponty] moves from an understanding of 'embodied consciousness' to 'intercorporeal being', suggesting that a kind of bodily experience and reflexivity eliminates the ontological dualism of body subject and body object. He pursues the twin metaphors of '**chiasm**' (crossing point such as between body-world, subject-object) and '**flesh**' (an ontological concept naming the elemental impermeability of our bodily inherence in the field of Being as a whole)' (Finlay, 2011: 56)

For natural science, being able to separate and identify these interacting parts of a being's ontology, in all its complexity and seeming immeasurability, would be essential to achieve an 'objective' conceptualisation of these bodily experiences. It is for this reason that lifeworld analyses are useful for understanding the difficult concepts of 'the flesh of the world' and the 'chiasm', which the phenomenologist

assert are by their very nature inseparable and paradoxical, enabling the researcher instead to penetrate the space of body-others-world.

Themes relating to *ambiguity* and *unknowingness* are commonly explored within the lifeworld project, for example in Merleau-Ponty's discussion of 'the visible and the invisible', Sartre's discussion of authentic human 'being' as manifested in its 'possibilities', or Finlay discussing the 'epistemological earthquake' that can occur during the phenomenological research process (2011: 231). This is precisely why the lifeworld method has developed as our understanding of the human experience has deepened, in response to the way that its reality unfolds to us, but also in an attempt to make sense of 'a world that is partly hidden and partly uncovered…an indefinite and open ambiguity where relations are always mutual' (Dahlberg et. al., 2001: 91). Merleau-Ponty states that it is because the visible aspects conceal those that are invisible, 'there is access to it only through an experience which, like it, is wholly outside of itself' (1964/1992: 136). This is the 'doing' of phenomenology that enables us to move beyond the 'natural attitude' of our everyday way of being in the lifeworld.

In conclusion, as a qualitative research method concerned with the project of a human, or 'caring' science, lifeworld phenomenology asks whether 'there is a plausible space for assertions of authentic selves and universal truths' (Finlay, 2009: 16), and it is the belief of lifeworld researchers that there could and should be. By *doing* phenomenology, the lifeworld becomes a valuable and accessible source in which we can 'find ways to understand our ontology' (Dahlberg et. al., 2001: 349) which do not reject scientific standards completely, but remain methodologically rigorous, critical, and with a philosophically-informed epistemological base, all of which are essential to avoid 'the risk of uncritically embracing a *realist* approach and claiming too much certainty when offering general accounts of essential structures of experience' (Finlay, 2011: 135). Lifeworld

research, and other methods borne from phenomenology, are summed up well by Wertz in his Husserlian 'call for a radicalization of the scientific spirit': 'We need a psychology of affirmation, not control; a psychology of witness and recognition, not test and measurement; a psychology of deep commemoration, not superficial prediction. Human presence, not a proliferation of instrumentation. Privacy, not intrusion. A psychology of embrace, not engulfment…This means humans science' (1986/2000: 165).

Blending a lifeworld method with Merleau-Ponty's phenomenology

This philosophically-informed research project has been shaped from a varied body of phenomenological research methods: this includes the reflective, empathic approach demonstrated in Linda Finlay's *Phenomenology for Therapists* (2011); some procedural guidance from Karin Dahlberg, Helena Dahlberg and Maria Nyström's *Reflective Lifeworld Research (*2001) and Van Manen's *Phenomenology of Practice* (2014). As a philosopher, I will also be drawing substantially from the original philosophical texts that informed the phenomenological method, mainly Maurice Merleau-Ponty's *Phenomenology of Perception* (1974/2014), and *The Visible and the Invisible* (1964/1992), in addition to Jean-Paul Sartre's *Being and Nothingness* (1943/1996) as a primary existential text. It is my intention to remain aware of the philosophical traditions from which my chosen research methods have developed (Finlay, 2009: 8), not only to ensure a strong epistemological base, but to explore the interdisciplinary nature of my research position and bring some additional insight to the discipline.

Making a choice about methodology can involve a creative blend drawn from different approaches, or beginning with a particular method they feel drawn to; to ensure the research being undertaken is scientific 'we need a wealth of methodological equipment and to carefully choose methods to suit the

phenomenon under study' (Dahlberg et. al., 2001: 333), as well as a coherent epistemological base. The dynamic and adaptable umbrella of methods found within phenomenology are constantly changed responsively, developed and flexed, not only allowing for 'ever widening arcs of inquiry', but to reflect the nature of the meanings and essences they investigate, one of their 'greatest strengths' (Finlay, 2009: 17-18). In addition, it is essential to keep in mind that if we wish to 'obtain rich information (data) about human existence we need rich methods' (Dahlberg et. al., 2001: 333) so that we can increase our understanding beyond what may have previously been known. As a way of avoiding the imposition of external ideas or values, a commonly held approach to phenomenological research is to take guidance from the phenomenon itself and let its unfolding lead the development of the study (Finlay, 2011; Van Manen, 2014). Because the meanings of the phenomena cannot necessarily be predicted in advance, the specific methods used can be identified using this creative blend to ensure the phenomena is embraced as it is within the lifeworld.

This process of 'designing' a qualitative research project is less systematic than the language suggests, instead involving a commitment to its 'characteristically exploratory, fluid and flexible, data-driven and context-sensitive' nature (Mason, 2002: 24). Dahlberg et. al. stress that lifeworld research is in every sense an *open* approach which cannot in fact be referred to as a method which has set rules, but is instead defined by 'a fairly well-defined phenomenon as the focus of the study and the above mentioned sound anchorage in epistemology and methodology' (2001: 25). The consistency of phenomenology's theoretical base and its clear, continual referral back to its philosophical roots not only ensures its scientific validity, but 'preserves the richness and beauty of the lifeworld' (Dahlberg et. al., 2001: 350) without compromising its depth and powerful meaning. The use of a *methodological strategy* as an epistemological

foundation, rather than a pre-set design, is said by Mason to be 'the logic that informs – although does not dictate – your decisions about what to do and how much it matters when things 'go wrong' as the research progresses' (2002: 30). She poses a number of questions to show the ways in which this strategy can be formed and brought together, whilst avoiding any kind of systematic guideline or 'blueprint':

> What are my research questions? Do they express or problematize my puzzle? Are they consistent? Are they coherent/transparent? Do they make intellectually interesting arguments? Do they allow open exploration? Will they allow me to generate further questions at a later stage? Are they worth asking and based on an understanding of the relevant background? (Mason, 2002: 31)

Using this kind of open, reflective questioning is something that should be done by the researcher throughout the research process, particularly in the early stages of exploring exactly what phenomenon they wish to investigate, as well as thinking critically about their motivations for doing the research.

As part of the task of developing a methodological strategy, including a strong epistemological base, taking a critical perspective of any taken-for-granted situations could involve challenging assumptions 'that may well be informed by prejudice and discriminatory discourses' (Thompson & Pascal, 2012: 321). Central to my own values and understanding of my role as a researcher, my own position in this thesis aims to recognise the different ways in which people are oppressed and marginalised, particularly in the context of psychiatric knowledge and psychiatry as a medical institution. Relevant examples of these power structures include Fanon's reflections on the classification of 'reactionary psychoses' in clinical psychiatry, as they relate to the realities of colonised black patients (1961/1990: 201-202); similarly in feminist phenomenology, women's femininity has been

considered part of their biological 'illness' or 'handicap', and 'it is in great part the anxiety of being a woman that devastates the feminine body' (De Beauvoir, 1949/1997: 356).

The position taken within this thesis remains most prominently, an existential phenomenological one, so my subscription is to 'the multiple 'voices' of things' (Finlay, 2009: 17), further tied to a conceptualisation of our shared human realities as existential, embodied beings. Further clarification of this will be given in Chapter 3 during the discussion of data analysis, as well as in the philosophical discussion of my findings in Chapter 4, but clarification is essential at this stage to explain where my strategy moves forward from. From an ethical perspective I believe that being aware of discrimination and inequality is not just a requirement of the phenomenological method, but part of my responsibility as a researcher and an individual who is working empathically with others. From a methodological point of view, these pre-understandings, whether they are in the form of assumptions or prejudices, are some of the 'natural attitudes' which need to be 'bracketed', or 'bridled', so that we can enter 'a new *way of being*' (Finlay, 2011: 47) - the integral role of bridling, or Husserl's epoché, will be attended to in the following sections of this chapter.

Phenomenological methods are concerned with lived experiences and existential issues, so how is lifeworld research different from other phenomenological approaches, and why has it been chosen for this particular project? To undertake lifeworld research is to ensure the focus 'remains within the phenomenological realm, that is, the realm of experience' (Ashworth, 2015: 22), the goal being to understand the phenomena's existential empirical meaning structures at the same time as deepening 'our understanding of human being and human experience' (Dahlberg et. al., 2001: 37). An essential part of this approach is that the world and human beings are intertwined in what Merleau-Ponty

described as the 'flesh' of the world, where they and the world are both of the same flesh, both constituting and constituted by meaning in a 'chiasm':

> 'The flesh (of the world on my own) is not contingency, chaos, but a texture that returns to itself and conforms to itself.' (Merleau-Ponty, 1964/1992: 146)

> 'In lifeworld research it is understood that all research and all researchers are in "the flesh of the world" and participating in the relationship between themselves and the world that they experience and want to describe. Researchers' residency in the lifeworld places them in the position of creative contributors to the meaning of the world.' (Dahlberg et. al., 2001: 96)

This creative contribution is not something specific to researchers, but explains the way in which we experience the world day-to-day, 'how our body and relationships are lived in time and space' (Finlay, 2011: 125) in meaningful, intentional ways.

Whilst there is a uniformity in attitude of lifeworld researchers, there are different approaches, or interests, regarding which elements are prioritized (Ashworth, 2015) and this is dependent on the unique goals and skills of the researcher. The existential dimensions of human experience are made explicit, including 'lived space…lived body…lived time…lived relations' (Finlay, 2011: 20), as well as other dimensions as preferred by the individual researcher, such as 'everyday environmental experience' (Seamon, 1979), 'lived cyborg relations…in the human experience of the existential of things and technology' (van Manen, 2014), or 'dwelling-mobility' (Gavin & Todres, 2013); rather than serving as a strict process or procedural guide for research, demonstrating awareness of these dimensions instead provides a framework, or sensitising guidance. With this in mind, some authors highlight the need for balance between a scientifically grounded *structural*

dimension and a more poetic *textural* dimension, such as Todres (2007; Todres & Galvin, 2006), whereas others take an attitude of sensitivity and openness, 'the mark of a true willingness to listen, see, and understand' (Dahlberg et.al, 2001: 98). The values of humility and respect, not only for the participants but also the phenomenon and the lifeworld it is 'intertwined' within, must be held as the guiding attitude during 'the process of retaining and empathic wonderment in the face of the world' (Finlay, 2009: 12). My own personal engagement with lifeworld methods is firmly rooted in a very open, empathically guided way of engaging with the phenomena and lifeworld, as well as a strong sense of its interpersonal nature and an embodied 'being with' participants during the research process.

One important aspect of phenomenological research is the role of the body and the nature of lived experience as, by its very definition, one which is embodied. As has been seen in Merleau-Ponty's thought, as outlined in the previous section, the body is inherently ambiguous, complex and is *more than* the objective view it is apprehended with in the natural sciences. It is an object that exists in the world, both for me and for others, but despite being referred to as mine, is also not something that I own. However it *is me* in the most intimate way, at the same time as being elusive to me, rather than immediately apparent to my self-awareness or initial perception: 'There are not in it two leaves or two layers; fundamentally it is neither thing seen only nor seer only, it is Visibility sometimes wandering and sometimes reassembled' (Merleau-Ponty, 1964/1992: 137-138). In this respect, the body exists at the axis of multiple epistemologies - the body as object, the body as sentient (or phenomenal), the body as subject, the medicalised body - the most problematic of which is its precarious reality as object/subject. Merleau-Ponty's view of the body is one of *double belongingness*, 'a being of two leaves, from one side a thing among things and otherwise what sees them and touches them' (1964/1992: 137). This view of the body's dual materiality being

'incomprehensible' is valuable in understanding our embodiment, because 'it teaches us that each [of the two leaves] calls for the other' (1964/1992: 137).

Finlay, in particular, makes reference to Merleau-Ponty's theory when she writes about 'the radical metaphors of 'flesh' (highlighting the elemental impermeability of our bodily inherence in the field of Being) and 'chiasm' (emphasising the interpenetration of body and world)' (2006: 6). This metaphor gives us an example of how the researcher, participant and world meet, simultaneously as subject and object in a 'chiasm', a bodily experience which cannot be anything but. Part of carrying out lifeworld research is the focus on this bodily aspect of lived experience which is usually taken-for-granted, and this awareness of the research encounter as *embodied* is something that resonates with me deeply. I also believe that these issues of embodiment, most importantly the way we inhabit our bodies and how this informs our knowledge of them, remain neglected in the medical model and subsequently impact on our understanding of eating disorders. I hope that bringing this to the forefront of my lifeworld method may help to critically evaluate the psychiatric, medicalised view of the body as a result.

As a methodological strategy for investigating the phenomena of eating disorders, as experienced by people in late-life, a philosophically-informed lifeworld perspective is able to highlight the complexities of the phenomena and if it is undertaken to a high standard has the 'capacity to present the paradoxes and integrate polarities' (Finlay, 2011: 136). Phenomenological analysis may also have a particular strength when applied to 'psychiatric' phenomena because it is able to identify the way in which lived experience is constituted and detect 'the critical points where this constitution is vulnerable and open to deviations which appear as psychiatric symptoms' (Fuchs, 2004: 188). Fuchs' theorising about the experiences of patients with schizophrenia as 'a shaking of the natural attitude, an

estrangement from the common and taken-for-granted reality' (2004: 191-192) brings to light further questions relating back to Ratcliffe's idea of the 'healthiness' of existential feelings. To what extent do we have a sense of reality, day to day, and should any of these feelings, however extreme they may appear to be, be seen as pathological rather than anomolous?

The methodological strategy of my thesis, including its epistemological 'anchor' of existential phenomenology, is evident enough at this stage to provide a framework upon which I can 'hang [my] understanding' (Finlay, 2011: 135). This is achieved through a robust philosophical base, an explicit focus on existential dimensions of the lifeworld and an approach guided by openness, empathic embodied presence and critical reflexivity. Some of the richer aspects of a lifeworld method will be delved into in the remaining sections of this chapter as the data generation and analysis are clarified, such as the potentially transformative act of researching that 'offer individuals the opportunity to be witnessed in their experience' (Finlay, 2011: 10); the particular skills, interests and values which will be needed throughout the process, since phenomenology 'requires sensitive interpretive skills and creative talents from the researcher (Van Manen, 2014: 141). Overall, what I hope to maintain throughout my thesis is a demonstration of the lifeworld method's depth, the strength of empathic philosophically informed research, and the 'communicative power of research that challenges, unsettles, and reverberates with our everyday experience of life' (Finlay, 2009: 15).

Scientific validity and the role of the researcher

Going back to the rationale and justification of the previous section - in particular how 'scientific' methods are differentiated from 'non-scientific' methods because they aim to remove the 'bias' of the researcher to achieve an 'objective'

view - the final stage of laying out our epistemological and ontological 'base' is to elucidate the role of the researcher in relation to the phenomenological method. According to Merlea-Ponty and his critique of the objectivism seen in the natural sciences, 'science believes it can soar over its object and holds the correlation of knowledge with being as established, whereas philosophy is the set of questions wherein he who questions is himself implicated by the question' (1964/1992: 27). As has been shown in the previous section, phenomenology is empirical in the sense that it is concerned with observable or *a posteriori* evidence, as well as having rigorous execution which is reproducible, despite being distinctly different to the natural sciences in that it situates us within the world we are trying to research. It is accepted that one of the goals of lifeworld research as an empirical method is to create knowledge that can be utilised in some way, whether that be by academics, policy makers, community members or professionals, therefore it remains important that 'the relationship between the phenomena that are to be investigated and the [true and precise] figures involved must be considered' (Dahlberg et. al., 2001: 330). Lifeworld research as an 'open-ended' method 'is challenging at the same time as it carries so many possibilities with it' (Dahlberg et. al., 2001: 26), and this reinforces the key role that a strong, sound epistemological base has within an effective methodological strategy.

Qualitative research is often viewed as being 'unscientific' in relation to other scientific methods which are considered of greater value, or the 'gold standard' of knowledge, a division which is based on a number of 'myths' and misunderstandings, across a number of disciplines. Green and Thorogood outline a few of these myths, one being 'that qualitative methods are more *inductive* than quantitative methods' (2014: 27), mainly because they are seen to generate theories as opposed to testing them, something which is undoubtedly problematic for qualitative researchers. However this dogmatic positivist approach, as has been

shown already in this thesis, is something phenomenologists and other qualitative researchers seek to distance themselves from, whilst at the same time demonstrating similarities in their logic across different epistemological traditions (Giorgi, 2005). For the phenomenologist, their research 'begins within the lifeworld as the concrete and lived, but often disregarded, existence in the world…something that is tacit also for science' (Dahlberg et. al., 2001: 34), a critical approach which not only acknowledges the 'ground beneath its feet' but proclaims that being *open* to this acknowledgement is where the natural sciences fall short. Instead of being its weakness in terms of validity, instead 'openness thus supports objectivity in research and the objectivity claims of human science research therefore relates to openness' (Dahlberg et. al., 2001: 337-338). From the perspective of those who do not privilege objectivist natural sciences, which view openness and sensitivity to the phenomena as the weakness of qualitative methods, it is precisely because of these 'subjectivist' weaknesses that they can begin to answer questions about messy, unquantifiable human experiences.

One of the processes which must be undertaken by the lifeworld researcher is *bridling,* an ongoing self-reflective action whereby the researcher's knowledge and beliefs are 'reined in from having an uncontrolled effect on understandings' (Finlay, 2011: 126-127). This is drawn directly from Husserl's 'reduction', also referred to by many phenomenologists as 'bracketing', the term bridling being more of an 'active passivity' than a firm 'bracket', that subsequently enables the researcher to take on a 'restrained, systematic, open scientific and careful' examination of the phenomenon. Being unaware of pre-understanding, prior assumptions and beliefs would mean researchers 'risk obtaining results that are primarily a reflection of their past experience or unrecognized beliefs' (Dahlberg et. al., 2001: 135), ultimately invalidating their creation of new knowledge or understanding by instead bringing their own theories into the data. It has

previously been misunderstood that bridling is another way of achieving objectivity by removing any 'subjective' input from the researcher (Green & Thorogood, 2014: 16), but it must be stressed that the action of bridling is an active and reflective 'attempt to '[reduce] the field which commands one's special focus of attention' (Finlay, 2011: 46). The ways in which bridling can be undertaken will be outlined in section 4 of this chapter, and there are different kinds of attitudes that can be taken to achieve particular 'reductions', but the epistemological importance of this imperative researcher's 'tool' must be established at this early stage.

The purpose of bridling is to allow the researcher to be present to the phenomena 'as it is' within the lifeworld, and although there is a later evaluative stage in which the generated data can be 'analysed', this creates the conditions required for the *essences* of the phenomena to reveal themselves within the research encounter. Although some explanation of essences has been given in the previous sections of this chapter with regards to Husserl's philosophical formulation, 'in order for this idea to be valid in empirical research, it has to be interpreted' (Dahlberg et. al., 2001: 245), mainly because a strictly procedural 'method' was never committed to by the early phenomenologists, and arguably this may not have been what the intended for the future of the discipline. But if we have to interpret the original philosophical sources, aren't we as researchers then required to take this theory and fit the phenomena into its design? This is characterised throughout the lifeworld research process not only in the interpretation of the original philosophical texts, but also when it comes to the analysis of essences and structures of meaning - how researchers choose to do this is considered a preference, but one which must be well-informed and epistemologically sound rather than undertaking it in an unplanned, improvised way. This discussion about 'whether phenomenology should be treated as a

science, an art, or both' (Finlay, 2009: 17) is addressed in Chapters 3 and 4 of this thesis, but the way in which interpretation is used by the researcher forms part of their ontological intersubjective position, as well as their ethical responsibilities, which will also be discussed in due course.

So if we consider that rather than the conceptualisation of lifeworld research involving the imposition of external ideas *into* the research process, by the researcher, it instead provides a new perspective which can be used to illuminate these essences which 'are there already, in the intentional relationship between the phenomena and us' (Dahlberg et. al., 2001: 247). Phenomenology is a new way of seeing, or a new 'lens', which does not put new objects in front of our eyes but instead allows us to see existing objects in a phenomenological way, and like most qualitative research this is based on the understanding that 'my world is laid out in terms of the objects and events that *matter* to me. I see my self in the experienced lifeworld.' (Ashworth, 2015: 26). Phenomenologists true concern with the project of philosophy and science was to try and solve the problems that they saw were becoming more entrenched within them, especially their epistemological implications for future progress:

> 'If the philosopher questions, and hence feigns ignorance of the world and of the vision of the world which are operative and take form continually within him, he does so precisely in order to make them speak, because he believes in them and expects from them all his future science.' (Merleau-Ponty, 1964/1992: 4)

By taking the philosophical groundings of phenomenology and its concern with the lifeworld, it is possible to create a more explicit 'way of doing' phenomenology which does not necessarily stand in opposition with science or the imposition of an 'external' paradigm. The generation of data, or new knowledge about human

experience, is possible because 'essences thus belong to the in-between world, that "single fabric" that connects us with everything else in the world, with other subjects or objects' (Dahlberg et. al., 2001: 247), a world that we as researching subjects are indeed part of and seek to affirm through doing phenomenology.

If the researcher is to engage in phenomenological inquiry which bridles their pre-knowledge, beliefs and preconceptions in an attempt to uncover essences, how do they account for the fact that we engage intentionally with objects in the world and are intertwined with them, both as subject/object and intersubjectively with other subject/objects, both part of the same ontological 'flesh'? According to Dahlberg et. al., it is 'when we attend intentionally to a phenomenon, when we understand that phenomenon and what it is, we are involved with essences' (2001: 246), for we have moved beyond the 'natural attitude' and our taken-for-granted unreflected mode of being within the lifeworld. Studying both the 'act' of conscious awareness, the 'noesis', and the objects of consciousness, the 'noema', as they are lived, brings intentional structures to the forefront of our awareness during the research process, and this is something that can be applied either to our own experiences through self-reflection, or the experiences of others by making a slight shift in focus:

> 'The intentional structures are important to understand if we want to understand meanings of the world, how they come to be and how they can be understood. Intentionality supports the experience and completed for example the seeing and the immediate grasping of a situation or an object, integrating appresentations with actual presentations.' (Dahlberg et. al., 2001: 51)

When researching a phenomena through the lived experiences of other people, the researcher as a subject/object within the flesh of the world does not see another person's experiences as a resource to be tapped into, because the

lifeworld is seen as an inherently intersubjective human reality with a 'uniqueness…which constantly instils novelty and unpredictability' (Hycner, 1985: 300) in a reciprocal co-constitution of meaningful existence, is what defines the goal of phenomenological research. Giorgi gives a useful example to explain the endeavour of the phenomenologist, where Person A and Person B have the opinions of a painting being ugly and beautiful respectively - for the researcher 'no claim is made that the painting *is* in itself either ugly or beautiful, only its presence for the experiencer counts, and an accurate description of the presence is the phenomenon, and it usually contains many phenomenal meanings' (1997: 237).

As an active agent within the research process, first establishing the topic and scope of a research project, then undertaking analysis and producing written accounts and reflections, the researcher must recognise their role and influence in this construction. Qualitative research acknowledges that it is 'a joint product of the participants, research and the social context' (Finlay, 2011: 80), but the subjectivity of the researcher as a meaning-making individual with their own emotional and social world, motivations and experiences can also shape the research, which is not necessarily something to be avoided, but instead something to be addressed and questioned. As the phenomenological critique of objectivism has shown, it is not required for us to eliminate our subjectivity from our investigations, but we must remain cautious of 'how easily a researcher can unintentionally impose his or her own meanings onto research participants' experiences' (Ashworth, 2015: 21), and whether it is at all possible 'to produce knowledge for its own sake, without the constraints of policy or politics' (Green & Thorogood, 2014: 65). As a process fundamental to all qualitative methods, partly substantiated within the process of bridling within phenomenology, engaging in *critical reflexive analysis* is key to developing a sense of awareness about the

researcher's role, their relationship with their participants and their relational position to the phenomena.

Reflexive analysis, particularly critical reflection, is a significant responsibility of any qualitative researcher and has a very important role within lifeworld research. The aim of this crucial researcher's skill is to 'examine, critically and in a self-aware way, how the researcher, the context and the relationship between researcher and participants have influenced the data gathered and findings' (Finlay, 2011: 239), which is not only central to the scientific validity and epistemological parameters of the research, but also the ethical implications of their role:

> 'The researcher needs to avoid preoccupation with their own emotions and experience if the research is not to be pulled in unfortunate directions which privilege the researcher over the participant.' (Finlay, 2009: 13)

The navigation of such a precarious position, especially when faced with the changing and elusive reality which is the lifeworld, something which is pervaded with difficulties, dilemmas and conflicts, can be an enormous challenge to the phenomenologist, as to other qualitative researchers. However it is through the adoption of a well-informed 'phenomenological attitude', combined with ongoing critically reflexive analysis and self-reflection, which maintain 'a very deep respect for the uniqueness of human experience' (Hycner, 1985: 300). The phenomenological researcher can help to clarify their role by focusing on 'how the implicit and tacit become explicit and can be heard, and how the assumed becomes problematized and reflected upon' (Dahlberg et. al., 2001: 36-37), a guiding inclination which can not only strengthen their 'researcher identity' but also the research itself.

Becoming a reflective researcher, which is understandably essential to the lifeworld method, requires more than reflection about your role and responsibilities within the research situation, it also requires *self-awareness* in order for that reflection to take place. In a discussion of Merleau-Ponty's concept of 'radical reflection', Finlay draws our attention to the specific part of ourselves that we are trying to gain awareness of: 'self-understanding consists – paradoxically – in recovering our unreflective experience. Reflexivity is a partial attempt to overcome subject-object dualism and to focus on intentional conscious lived experience in a self-aware way' (2011: 80). There are many different components to our awareness and it can be influenced by a number of things, for example the 'intersubjective dimension [that] is a part of the total horizon that makes our world meaningful…thus [it is] a primordial notion of being' (Dahlberg et. al., 2001: 58), our emotions, moods or simply our bodily felt sense. Whilst being able to identify the different states of awareness that we exercise as part of our conscious engagement, this does not involve an exhaustive documentation as part of the research process:

> 'Objectivity and validity based in self-awareness does not simply mean the struggle of knowing one's self better. It also means to be conscious about the limits of self-awareness.' (Dahlberg et. al., 2001: 341-342)

What matters most is recognition of self-awareness coupled with recognition of its *limits,* in addition to continued reflection and re-reflection over time 'so as to move beyond the partiality of our previous understandings' (Finlay, 2009: 13) and ensure that our present experience is not being predetermined by past interpretations (Giorgi, 1997: 240).

The final aspect of the lifeworld researcher's role as it relates to scientific validity is the prioritising of *empathic openness* as a way to engage with the phenomena and allow it to be illuminated, both during the research 'encounter' and the data analysis period. Whilst a scientific approach to the empirical project is crucial during the development of the methodological strategy and the laying of an epistemological base, what is required in the *doing* of phenomenology is 'an aspiration for sensitive openness, a concern for elucidation, and a purposeful leaving aside of expectations and assumptions' (Dahlberg et. al., 2001: 96). By embodying these values, the researcher is being open not only to the lifeworld and its phenomena, but its possibilities of meaning, our empathic, intercorporeal engagement, even moving beyond spoken meanings in the form of our bodily understanding, what Todres describes as the 'more' (Todres, 2007). By approaching human research in an explicitly *human* way, with all of its ambiguities, paradoxes and intimate, intercorporeal reality, we are able to move beyond the limitations that result from valuing paradigms which erase our messy 'humanness'.

Section 2.3: Data planning and generation

Sample

Following the epistemological and ontological 'groundwork' as it were, what has been described as the establishing of a solid 'base' that supports the development of a *methodological strategy*, the next task involves the particulars of how the research data is going to be generated. This stage focuses on a number of facets and involves the formulation of questions which explore the varied aspects of the phenomenon, but throughout which the researcher is 'constantly mindful of one's original question and thus [is] steadfastly oriented to the lived experience' (Van Manen, 2016). Although it is understood that the phenomena itself will guide the direction in which the data analysis will take, the lifeworld

researcher must engage in varying levels of reflection on the project they are undertaking, not only as a way of establishing their pre-understandings and the epistemological issues around the phenomena, but importantly to demonstrate academic and scientific rigour of the empirical project. As an empirical project, lifeworld research is located alongside other qualitative methods on the boundary between science and art, a balance which draws similarities to the blending of theoretical knowledge with professional practice. For the phenomenologist in particular it is essential to see the synthesis of the philosophical ideas and the 'doing' of phenomenology rather than the application of the theory to the practice, which 'is proposed in place of the traditional approach of applying theory to practice, as if theory (in the guise of technical rationality) holds the answers to the questions that practice situations generate' (Thompson & Pascal, 2012: 314).

Finlay lists a number of challenges and decisions that form part of the planning stage: 'choosing a topic and research questions' - this will be undertaken in the early sections of Chapter 3; 'sensitizing to the topic through self-reflection' - after some initial discussion in Chapters 1 and 2, this is done in more depth in Chapter 3; 'locating existing knowledge' - the conceptual literature review in Chapter 1 has clarified the broader contexts of the phenomena of eating disorders, but exploring my existing knowledge as a subject will be done in Chapter 3; 'deciding methods of data collection and analysis' - the rationale and justification of the method are given in Chapter 2; 'gaining ethical approval' - securing ethical approval was undertaken and is outlined in section 3.2 of Chapter 2; 'recruiting and engaging co-researchers' - recruitment methods are outlined in section 3.2 of Chapter 2; 'setting up appropriate support systems' - section 3.4 of Chapter 2 provides some discussion of this, the specific procedures stated explicitly in Chapter 3. These have been used for guidance and will be referred back to throughout the thesis so that the development of the methodological strategy

remains coherent both to the researcher during the act of researching and the audience.

If one is to undertake phenomenological research, there are a number of requirements that must be met for that project to be categorised as 'phenomenological':

> '1) A focus on lived experience and meanings; 2) The use of rigorous, rich, resonant description; 3) A concern with existential issues; 4) The assumption that body and world are intertwined; 5) The application of the 'phenomenological attitude' 6) A potentially transformative relational approach.' (Finlay, 2011: 15-16)

All of these requirements have been discussed in sections 1 and 2 of this chapter, but they will also be *demonstrated* in the *doing* of phenomenology that has taken place within this research project, as well as in the subsequent data 'analysis' and extended philosophical examination. As has been clarified in the previous section, lifeworld research makes an explicit case for existential themes, which in the case of this thesis will be directly informed by the influential philosophical texts of existential phenomenology. However this will be explained in more depth in chapter 3 as it will be discussed in relation to the interviews, data generation and meaning structures of the phenomena as they relate to existential themes. In this respect, Chapter 2 gives the context and reasoning behind the 'intellectual puzzle' at hand, whereas Chapter 3 will give an account of the empirical 'doing' of phenomenology through the research encounter (the interviews), the data generation (the interviews and the process of *bridling*) and the exposition of essences and meaning structures of the phenomena (the 'results' or 'findings').

Choosing a topic or 'puzzle' which can be developed into further research questions can happen in a number of ways and may not necessarily come to light

in an expected or predictable way, but the researcher must be able to identify this. Whether the topic is something the researcher has a personal interest in, or may be prescribed by an external body as an area in which further insight is required, 'the challenge is to find a topic and a research question(s) that is *relevant* and *interesting* and is also *do-able* given your time constraints and the other practicalities you may face' (Finlay, 2011: 182). It is also very possible that the topic or research questions may not be obvious to the researcher at the beginning of the project 'given the flexible and evolving nature of qualitative research design' (Green & Thorogood, 2014: 42), something that is also common to the PhD thesis in particular because it is so closely tied to the researcher's professional and academic development. Other areas in which questions must be asked include potential availability of data which are appropriate to the project, the use of methods or their combination, as well as asking whether they are able to reveal what it is about the phenomenon we wish to explore (Ashworth, 2016). For this research project, the considerations and questions that were asked in the topic identification stage will be outlined in Chapter 3 as an elaboration on the rationale and justification of the method given in section 1 of this chapter.

Recruitment and participants

Within the parameters of a lifeworld research project that involves interviews, planning their execution raises a number of questions: How many participants will be required and is there a maximum or minimum number? Who do you want to recruit, in terms of their demographics or selection criteria? Where will the interviews take place? How will you ensure confidentiality and what protocols must you follow to ensure the ethical guidelines are adhered to? The list is not exhaustive and may develop during the interview process, particularly as it is likely that issues will arise which may not have necessarily been anticipated in

advance. Phenomenological inquiry, by its very nature, is not research which is looking for *universality of results,* and this is vital to remark upon because it is a point of criticism that is often made against it. In a similar vein to hermeneutic research, phenomenological results 'are always contextual; research results, as meaning, are always infinite' (Dahlberg et. al., 2001: 343), therefore it is not necessarily required to use a large sample size 'as we are not aiming to get a representative range' (Finlay, 2011: 191), something which is an unfamiliar idea to the majority of empirical researchers. The reason is that the *essences* of the phenomena are not valid due to their observed recurrence in the experiences of multiple subjects because their *meanings* and meaning *structures* are instead understood as relating to shared existential 'qualities' of our human reality. Although there is debate within the qualitative research community about whether generalisations can be made from phenomenological data (Dahlberg et al, 2001; Giorgi, 2005; Finlay, 2011; Van Manen, 2014), the suggestion by Van Manen is that there is importance in asking 'how many examples of concrete experiential descriptions would be appropriate for this study in order to explore the phenomenological meanings of this or that phenomenon?' (2014: 353). This provides a starting point from which the researcher can move forward and begin to plan their research project, as well as indicating an epistemic issue which could be evaluated through a later stage of philosophical examination.

Before undertaking any forms of recruitment, it is essential to ensure the appropriate ethical approval is gained through a recognised research ethics committee, which means they must meet particular internal and external governance guidelines, dependent on the type of research being carried out. For research with human subjects, ethics committees 'attend to core principles of minimizing risk, doing no harm, being competent and treating people fairly and with respect' (Finlay, 2011), values which manifest in procedures such as gaining

informed consent (Green & Thorogood, 2014: 70), a statement of intention from the researcher and a commitment to strict confidentiality rules 'as a key criterion for ethical practice'. For the interviews undertaken as part of this thesis, ethical approval was gained from the Faculty of Health and Social Care Research Ethics Committee at the University of Hull (Appendix A), a peer-reviewed application which included a comprehensive account of the proposed project, inclusive of a research data management plan, participant information sheets and templates of consent forms. The process of securing informed consent, understood to be a dynamic process 'ensuring that participants understand the nature of the project, what the research will involve, the limits to their participation and the risks they may incur' (Finlay, 2011: 189), including the option to withdraw from the study up until the data analysis stage, in addition to ensuring confidentiality, will be explained in more detail in Chapter 3.

The practical considerations of the interview planning stage and its need to maintain high ethical standards, specifically in relation to informed consent and confidentiality, mean that potential participants must be, first and foremost, *informed* - the researcher needs to articulate the research project in a way that enables people to understand both the procedure that will be taking place and the *further implications* of the research. They must be given information about the participation being voluntary 'and that they, whenever they want and without any explanation, can withdraw from the study' (Dahlberg et. al., 2001: 202), but it is important that the researcher also ensures that the provision of information does not leave the participant *over*-informed (Kvale, 1996: 113) in a way that may have an unintended influence. For this reason, the researcher must remain mindful of their relationship with participants in terms of their power, influence and ethical responsibilities as human subjects, things which must be kept in mind during the pre-interview stages where the participants are being asked to make a decision

about participating. It is also widely understood that during the research of peoples' experiences, especially topics relating to health, wellbeing and illness, that difficult, sensitive or traumatic issues may arise, and this is something the participant must be made aware of if they are to provide informed consent:

> 'While a participant may agree to be interviewed, it is difficult to predict what is going to happen in the interview. It is likely the interview is going to touch on sensitive issues. The individual needs to know this and understand that personal revelations, and the understandings research can bring, can be unsettling. At the same time the researcher needs to ensure that any such risks are minimized.' (Finlay, 2011: 189)

The commitment to confidentiality and privacy forms a central part of this informed consent, not only as a demonstration of trust, but also to allow participants to 'reveal their identities in confidence' (Dahlberg et. al., 2001: 202-203). Issues of confidentiality will be elaborated upon further in the following section of this chapter, as well as in Chapter 3 in the context of anonymization of results, a task which raises further issues that the researcher must navigate during transcription and data analysis.

Data collection through phenomenological interviews

Once ethical approval has been secured, participants have been recruited and informed consent has been initially established, the researcher must give thought to how many interviews will be undertaken, as well as their duration and *where* they will be held. Giorgi suggests that three interviewees are sufficient for phenomenological analysis, which Hycner agrees should be entirely adequate 'given the vast amount of data that emerges from even one interview' (Hycner, 1985: 295). Due to the unstructured nature of the phenomenological interview and

the desire for the phenomena to take its own direction towards being revealed and articulated (Dahlberg et. al., 2001: 186), it is preferable that researchers remain flexible about the duration of each interview whilst remaining attentive to the needs of the participant, as well as the richness and depth of lived experience required for the subsequent 'data generation' phase. An extended section of one of the anonymised interview transcripts will be appended to give an example of the interview structure and flow (Appendix E).

Van Manen highlights the need to think carefully about conducting interviews in a suitable setting because 'people are more inclined to remember and tell life stories when the surroundings are conducive to thinking about these experiences' (2014: 315), as opposed to giving an account of their *lived experience*. Just as the tone, mood and atmosphere must be considered, the convenience of the chosen venue should also be factored in to the planning stage. Using this research project as an example, the needs of my participants, as those aged 60 and above, had to be considered from additional perspectives including their mobility, accessibility of the interview venue and their general standards of wellbeing in relation to their age, being mindful that they may not be able or want to engage in long intensive interviews.

The phenomenological interview can be seen as a realisation of the intercorporeal, intertwined 'chiasm' between subjects who co-constitute meanings, each other and the world, so this phenomenological attitude characterises the 'doing' of lifeworld research interviews and is very much concerned with the existential aspects of the 'encounter' itself. Just as the body is central to the phenomenological method as a whole, so it is central to the *research encounter* as a meeting of two embodied subjects, something that can be focused on as a point of reflection and awareness and which Merleau-Ponty views as essential because the body is 'the sole means I have to go into the heart of the things, by making

myself a world by making them flesh' (1964/1992: 135). Not only should the researcher make themselves 'flesh', there is also the 'relevance and importance of researchers attending reflexively to the body of *both* participant *and* researcher' (Finlay, 2011: 37) as a way to engage in openness that is sensitive to the thoughtfulness required in contingent, ethical, and relational situations' such as that of the phenomenological encounter (Van Manen, 2014: 269). As a result, the researcher is able to better understand the experience of the participant when they 'tune in' to their embodied presence and physical expression, what Finlay describes as beginning to 'touch [their] subjectivity' (2011: 38) which can deepen understanding and the ability to 'hear' the other.

Similar to the fact that interviews on health topics should be anticipated to move into sensitive areas of conversation, acknowledging the research encounter as an act of vulnerability and trust, mainly by the participant but also to a lesser extent by the researcher, allows the researcher to respond to any instances of imbalance between them 'which can affect the informants and make them nervous and unwilling to reveal anything of their lifeworld' (Dahlberg et. al., 2001: 102). In the preliminary stages of contact, these communications can be useful opportunities to begin building rapport, therefore 'it is often important to develop a relationship of personal sharing, closeness, or friendliness before opening up the topic of research' (Van Manen, 2014: 315). Not only does the researcher have to be accepting of their position of power within the research relationship, it is beneficial if efforts are made by the researcher 'to be open and share some of their own personal experiences' (Dahlberg et. al., 2001: 102), which can help if participants are feeling particularly nervous, unsure or reserved. It is especially crucial that phenomenological research concerned with health issues not only understands the delicate, emotional nature of human experience, but that 'the individual - potentially unwell, vulnerable or damaged - has to take the challenging step of

deciding to work actively with the therapist/researcher' (Finlay, 2011: 192). In this instance, the researcher will need to gain the participant's trust, which 'they also need to deserve', as well as respectfully gaining the participant's trust within a precarious situation that wishes to balance empathy and respect with encouragement to reveal their experiences.

There is a particular kind of openness that the phenomenological researcher is expected to engage in that reflects a climate of 'being with' the participant in the research encounter, as opposed to 'taking data from', suggesting an attitude of *self-disclosure* of thoughts of experiences that is often referred to in qualitative literature as 'open-heartedness':

> 'Besides a result of a cordial climate, the effect of such openness could also be that the researcher is perceived as genuine and trustworthy, thus leading the way for the informant to relax and talk. In addition, a researcher's capacity for open-heartedness – an ability to engage with others – models self-disclosure for informants.' (Dahlberg et. al., 2001: 102)

By 'modelling' self-disclosure, the researcher is demonstrating their own vulnerabilities as a way to establish trust, as well as leading by example for the participant in relation to how their conversation may be characterised - as one that recognises and values 'the subjective interconnection between the researcher and the researched' (Finlay, 2009: 6-7). Open-heartedness ties together the required interwoven skills of empathy, listening, reflexivity and engagement, not only with the participant but also *with the phenomena,* where 'instead of mastering the situation, [the researcher] allows her/himself to be mastered by it' (Dahlberg et. al., 2001: 101). Demonstrating embodied open-heartedness should be undertaken in an engaged, paced, reflective manner 'without breaching limits beyond which objectivity and integrity are compromised' (Dahlberg et. al., 2001:

102), thus it requires a tentative, cautious approach throughout the data gathering phase.

For the phenomenological interview to provide the best possible environment, in terms of the participant articulating their lived experiences, the interview must remain 'open' for the phenomena to take shape, but the researcher also plays a role in structuring the encounter as a space for bringing phenomena to light. Although semi-structured interviews can be useful in later encounters, more loosely in the form of prompts that they want to return to, rather than set questions, allowing the interview to be unstructured is a way of enabling the right kind of 'space'; Van Manen suggests 'it is better to think of the interview as a conversation than as "interview". Conversations require the right kind of atmosphere and tone' (2014: 315). An unstructured approach viewed as a conversation balances the power somewhat between researcher and participant, although an inescapable balance will always remain, therefore the researcher's empathic openness and attentiveness become increasingly crucial:

> 'Rather, a researcher's task is to cultivate a productive dialogue that addresses the phenomenon as deeply and thoroughly as possible. With this goal in mind, questions and comments should be a matter of the researcher's spontaneity and commitment during the interview, but all the time lead by the phenomenon.' (Dahlberg et. al., 2001: 187)

The researcher brings structure in the way they 'encourage interviewees to tell personal and details stories about themselves' (Green & Thorogood, 2014: 75) which can be achieved through building a sense of rapport and a carefully developed atmosphere, skilfully balanced with a spontaneous and fluid 'guiding' that takes cues from the phenomena itself. Finlay discusses the importance of the researcher's use of intuition when it comes to 'allowing' the conversation to

progress in whichever direction it seems to go, and 'providing you stay reasonably focused on the research topic being investigated, and your participant is content to proceed, these diversions should probably be allowed' (2011: 199). Key to facilitating this open, phenomena-led approach is the researcher's ability to anticipate or assume a particular response or meaning, rather than pushing the conversation towards their own 'view' of the phenomena, and this can be seen as a kind of 'unknowing' attitude. There are also instances where the researcher may *sense* when there is an area of experience the participant may have some resistance towards delving into, and in these moments the researcher can use their felt sense and intuition to identify whether they are comfortable looking deeper at these resistances. It can be seen in the results of the interview that 'when such self-awareness is clear, the questions formulated to guide the research is more likely to lead to genuine knowledge' (Dahlberg et. al., 2001: 190), and this is essential for the lifeworld researcher who aims to understand the phenomena as it is lived rather than through the application of an external theory or idea.

The lifeworld interview requires the researcher to remain constantly reflexive, engaged and *existentially aware* throughout all stages of the planning, execution and analysis of the research encounter. This challenging yet rewarding way of 'being with' the participant is what allows meaning to 'blossom' out of the encounter, the context of which has been *tended to* by the researcher 'to open up the space to attune to and nurture this blossoming of meaning' (Finlay, 2011: 197). If the interview is seen as an opportunity to *take* what is needed or wanted from the participant, as if they were a source of information which can be extracted and collected by the researcher, not only does this have great ethical implications, it also stifles the phenomena, both in its failure to be revealed and its ontological status within the 'flesh' and the 'chiasm'. Instead, the researcher's goal 'is to get into that moment and know how it was or is experienced by the person

emotionally/cognitively/bodily and in the context of their life' (Finlay, 2011: 197), and only then can the lived meaning of the phenomena be understood.

The data collection process

As has been demonstrated in the previous section, the role of the researcher in the research encounter, particularly their *presence* as an embodied subject, forms a major part of the phenomenological lifeworld method. Leading on from this, the execution of any kind of phenomenological interviews requires certain considerations focused on reflective tasks such as embodied listening and the use of imagination, as well as practicalities such as general preparation guidelines and the generation of adequate descriptions. For the phenomenological researcher, as with many other qualitative research perspectives, the research interview, or conversation, is viewed as a process of '*generating* data…where meanings emerge and are co-created through reflection and dialogue' (Finlay, 2011: 197). Keeping this at the forefront of their mind will help the researcher refrain from dominating the conversation in any unintended way, as well as framing the encounter as one which can encourage its flowing, unfolding nature at the same time as ensuring it is successful from an empirical point of view.

Preparations for data gathering involve practical and logistical planning, as well as intellectual and emotional preparations which will continue throughout the research project. Things the researcher is responsible for include: creating the correct environment in the conversation space 'thinking in terms of your participant's comfort, ease and emotional safety', allowing time at the end of the interview 'to debrief' choosing the right time of day can influence the mood and the participant's willingness to talk in depth, therefore 'having a coffee or meal together creates the atmosphere as well as the time-space to explore the

experience', or simply choosing a venue that 'feels right' (Van Manen, 2014: 315). Time constraints can put limits on the amount of time available for the researcher within the wider context of their project, and although it is important that the process is not rushed or forced through, it is of course 'inevitable, even at a simple level when, during interviews, we are selective about which questions/answers to follow up' (Finlay, 2011: 219). Here it is the ability of the researcher to be empathically present with the participant, in the ways which have been discussed in this chapter, which will allow rich, lived experiences to be revealed, as opposed to increasing the length of time that is allocated for interviews.

Reflection is another skill that must be employed by the researcher, as well as being a process that manifests in their actions and decisions during the research conversation and afterwards:

> 'Taken literally, reflective refers to the process of thinking about the work we undertake – that is, we reflect on our actions either at the time (reflection-in-action) or at a suitable opportunity thereafter (reflection-on-action).' (Thompson & Pascal, 2012: 319)

The use of reflective practices, such as journaling, forming reflective questions or allocating specific periods for reflection, are some of the ways in which researchers (and other practitioners) can engage in openness and awareness, although there is debate over its specific definition or feasibility of reflective practice itself (Schön, 1983; Finlay, 2008). The qualitative researcher is often seen as being required to move beyond reflective practice and also be *reflexive,* a term which describes a critical awareness of the ideological or historical contexts which influence the way in which knowledge is constituted (Steier, 1991; Hertz, 1997), thus the reflexive researcher remains able to utilise their full knowledge base, act consistently with

their values and identify opportunities for development (Thompson & Pascal, 2012: 319). Being able to reflect on presuppositions and values to this extent 'demands an awareness of one's entire intellectual and emotional response to the situation and to those who have let us into their lives' (Dahlberg et. al., 2001: 108-109), something which characterises the qualitative researcher's attitude. However for the phenomenological researcher, this mode of reflection and reflexivity is taken to a deeper level of engagement through their *bridling* in relation to the different epochés, as outlined in section 4.1 of this chapter, and although it is a distinctly different way of apprehending the research data, it involves the researcher's same critical evaluation and awareness skills.

In the moment of the research encounter, balancing the phenomenological attitudes such as openness, empathic listening and embodied awareness, the researcher must remain both a sense of *immediacy* and *responsiveness* to the participant and the phenomena. A sense of immediacy is 'more likely to prompt the openness that is necessary for gathering in-depth data' (Dahlberg et. al., 2001: 108), and this is achieved when both individuals are deeply present to one another and the phenomena in focus, allowing it to emerge without any kind of forced direction or anticipated meaning. If the phenomenologist exercises these qualities and skills, the research becomes an oscillation between empathic, intersubjective 'nearness' and reflective 'distance' so that the interview, as it is happening and unfolding, does not lose its objectivity about the interaction as well as the context of the interview' (Dahlberg et. al., 2011: 108). What can be utilised as part of this movement between nearness and distance is 'an intersubjective process of imaginal self-transposition and mutual identification' (Finlay, 2011: 209) where the researcher's understanding of themselves, as subject, and the participant, as Other, are similarly intertwined in their presence and openness to one another in a relationship of mutual support 'that comes from two individuals who are present

for each other' (Dahlberg et. al., 2001: 189). Remaining responsive to the phenomena and the encounter allows the researcher to let its meaning 'blossom', but it is also the researcher's decision as to whether any divergences from the phenomenological focus should be directed back, as well as ensuring they keep returning to the participant's concerns, 'using the matrices of that person's world-view in order to understand the meaning of what that person is saying, rather than what the researcher expects the person to say' (Hycner, 1985: 281). This matters not only from the perspective of the empirical data, but also the ethical concerns around respecting the participant's lived experiences.

Attentive, engaged listening is an essential ingredient in the qualitative interview which must not be neglected, for example due to reliance on recording equipment such as voice recorders or video cameras, for it is in the intersubjective relationship and *presence* that cannot be replaced:

> 'This kind of listening involves slowing down and dwelling with the other. Involves listening *in silence* to the 'voice' of the other. In that silence something *more* is born. The 'more' goes beyond the words said. And there is always more... Phenomenological research rejoices in the product of attentive listening; the product of 'being with' an Other.' (Finlay, 2011: 209)

In this space where 'openness and empathy emerge', the embodied and intersubjective space, the 'chiasm' of which researcher and participant are both 'flesh', their relationship to one another is characterised by a connection with one another, rather than an alterity. This connection is what the phenomenological researcher is most concerned with, both from an epistemological and ontological perspective, and it is by its very nature a bodily space - this ability to use the bodily senses and responses reflexively creates the opportunity to see new meanings in participants' lived experiences. A vivid example given by Finlay is in

her conversation with Jenny, a mental health therapist who described her experience of dealing with a predatory patient, during the analysis of which Finlay describes 'a growing sense of foreboding in the pit of my stomach…my skin creeps in response to his creepiness' (2011: 39). In this reflexive and intuitive way of analysing the interview, paying attention to the body whilst paying attention to the thoughts and feelings of the participant as they experienced and recounted it, it becomes a powerful tool which provides 'a heightened sense of one's own mortality and vulnerability' (Dahlberg et. al., 2001: 109). These bodily responses and felt sense form a part of our everyday way of being in the world, part of our human existence, and by bringing these 'cues' into awareness, deeper insight into the phenomena becomes possible.

Section 2.4: Generating data about the phenomena

Evaluation and analysis of data

A thorough evaluation of the phenomenological method has been made in the previous sections of this chapter so far, establishing its epistemological and ontological foundations, beginning with its philosophical roots then moving to its use as a methodology, including the lifeworld method as a further specialisation. The point which has been stated about what characterises phenomenology as a distinct method is that 'research which does not have at its core the description of "the things in their appearing," focusing on experience as lived, cannot be considered phenomenological' (Finlay, 2009: 9). This kind of research is also typified by a concern with ambiguity, contradictions and layers of complexity within experience, in addition to an acceptance of results as unavoidably contextual due to the nature of experience and meanings themselves (Dahlberg at al., 2001: 343). The inclusion of fundamental existential themes, what Van Manen refers to as 'existentials', are 'helpful guides for reflection on our research: '*lived*

space (spatiality), *lived body* (corporeality), *lived time* (temporality), and *lived human relation* (relationality or communality)' (Van Manen, 2014) - this list can also encompass other themes that are selected by the individual researcher as an 'entry point' into the lifeworld, as in the examples described in section 2 of this chapter. With these basic tenets in mind, it is important to be clear about the standards for evaluation in phenomenology when it comes to 'data analysis', therefore trying to outline the actions that will be undertaken throughout the project, without committing to the design of a systematic 'guide'. This is what will be laid out in this section of the chapter as a continuation of the methodological strategy.

Standards for evaluation in phenomenology

Working with essences is a key part of the phenomenologist's approach and attitude, so it is not possible to discuss essences without first clarifying that 'in a genuine phenomenological sense it is not possible to talk about the essences of their phenomena: essences *are* their phenomena, that phenomena *are* their essences' (Dahlberg et. al., 2001: 247). An essence is ontological identical with the phenomena, not a duplication, but as the very being that make the phenomena what it is 'in that without them, a different phenomenon would be involved' (Finlay, 2011). Dahlberg et. al. use the example of horses to illuminate how a phenomenon has an essential 'what it is', but with 'inner horizons' and 'outer horizons' of structured meanings:

> 'In other words, one could say that an essence is always understood against its horizons, the phenomenon's inner and outer horizons...In this example, the horses' colour could be understood as the phenomenon's inner horizons, and thus a background against which the horse essence figure stands out. Part of that

> background is also the outer horizons, i.e. the horse field, the stable and the paddock, that all belong to the horse milieu and help us understand horses as horses...The stable can also be made a figure again the field, the horses and the manor-house as background...Against this background the stable building also obtains its meaning as a sufficiently large and functional building for the group of horses' (2001: 251)

So when the phenomenological researcher apprehends their data, they are looking to identify the *essence* of a phenomenon and will be presented with the various 'horizons' that relate to the phenomenon, set within the context of the person's lifeworld and other lived experiences. Although it may seem apparent to someone who has knowledge of a horse and has a feeling of the *what it is* of a horse, or its 'horse-ness', being able to articulate what this 'horse-ness' is may seem elusive and difficult without making reference to the phenomena's horizons. The ability to explore the meaning structures of a phenomena and uncover its essences relies on the researcher's ability to *bridle* their pre-knowledge and pre-understandings, in combination with an empathic, embodied openness, beyond the everyday taken-for-granted 'natural attitude'.

There is a distinction to be made between the kind of reflection employed by the philosopher in contrast to the phenomenological researcher and this is often rooted in the fact that researchers are dealing with *other people's* descriptions of their lived experiences, rather than reflections on their own. For phenomenological researchers such as Finlay, it is understood that 'we must modify philosophers' ideas when applying them to empirical and psychological research' (2011: 74-75), and this is precisely why a strong epistemological and ontological foundation is imperative for a phenomenological project:

> 'In my view, a phenomenological method is sound if it links appropriately to some phenomenological philosophy or theory, and if its claims about method are justified and consistent' (Finlay, 2009: 8)

Part of the research project's methodological strategy is to ensure that all areas of the research relate coherently to the underpinning philosophy to ensure it is indeed 'justified and consistent', which will be demonstrated throughout all stages of this thesis. Further exploration of the difference between philosophical phenomenological reflection and lifeworld research reflection will be interrogated in section 5 of this chapter, especially the possibility of extending from empirical caring science research results to philosophical examination (Lindberg et. al., 2016). Remaining for now with the lifeworld research project at hand, the researcher's search for essences can be seen to rely on the bridling of different presuppositions whilst 'holding on to a stance of non-judgemental acceptance, wondering openness and respectful empathic dwelling' (Finlay, 2011: 79) and this is how they will be apprehended within this thesis.

To enable the researcher to engage with phenomenological essences, they are required to employ the process of *bridling* their pre-understandings, pre-knowledge and other assumptions about the meanings of lived experiences, described by Dahlberg et. al., as 'a preconceived meaning of common prejudices related to the studied phenomenon':

> 'Accordingly, when something is understood *as* something we are already using a kind of pre-understanding – even if we do not use the label of pre-understanding for this implicit act. In the texts of the above named philosophers [Heidegger, Husserl, Gadamer], pre-understanding is conveyed as an unavoidable and necessary precondition for being able to gain knowledge. Pre-understanding as well as both explicit and implicit understanding of different

> forms is to be understood as the pre-theoretical, non-critical, taken-for-granted knowledge about something that rules, especially, the natural attitude. If we want to be more certain about what really present itself to us, as researchers want, it is time to adopt a scientific approach to pre-understanding.' (Dahlberg et. al., 2001: 139)

Returning to the example of the essence of 'horse-ness', it becomes clear how the understanding of the phenomena is located within this 'natural attitude', because of the unavoidability and necessity of its preconditions - as pre-theoretical and non-critical'. This preflective experience is what the phenomenologist wants to access and understand, an attitude which is so difficult to achieve because it is how our embodied consciousness forms knowledge in relation to the world, through perceiving and *meaning-making*, further entrenched by 'the remaining positivistic dominance of science, which prescribes a one-and-only method' (Dahlberg et. al., 2001: 97) that leads us to view 'events or objects as something that already has an obvious meaning'. This can become quite apparent when we consider the different epistemological paradigms that exist, between which 'the diamond that is a girl's best friend can become in the geology laboratory purely a sample of crystalline carbon and a pet can become a zoological specimen' (Embree, 2011: 122-123).

So the essence of a phenomena can be revealed to the researcher, but as has been shown, it is not seen or understood by us in isolation and 'cannot be revealed to us in another way than in its totality and its relationships with its particulars…characterized by a reversibility that replaces the ontological dualism that has dominated most philosophy of the western world' (Dahlberg et. al., 2001: 250). This relates to Merleau-Ponty's conceptualisation of all phenomena existing as part of the 'flesh of the world', which are simultaneously constitutive of and

constituted by one another, therefore the essence that a phenomena ontologically *is* only exists to us as its totality, in other words encompassing its inner and outer horizons, and as its particulars, in other words its duplicated instances within the world. This is how it becomes possible for the phenomenological researcher to deepen their understanding of a phenomena through a smaller amount of data, for example in fewer participants across less broad demographics, because the unique contexts and infinite variations of lived experiences do not deviate from their fundamental meanings.

The process of intuiting this specific aspect of a phenomenon is what Husserl refers to as the *eidetic reduction,* or *eidetic epochè*, and this is formative of the phenomenological method as an attempt 'to intuit consistent or fundamental meanings - the essence of what appears in our consciousness' (Finlay, 2011: 48). This process can be achieved through a shift in attention, from other modes such as perception or expectation, to focus on the 'overlooked' mental processes used in the experience of a phenomena (Embree, 2011: 122). According to Finlay, this combination of bridling and pre-understandings can be used as a 'source of insight' by executing a dialectic movement between them (2009: 13) as a way to try and see the essence of the phenomena, although Husserl's original theorisation of the eidetic reduction has been criticised for detaching the phenomenologist from the 'face-to-face' encounter (Lee, 2014). Despite this, the ability for lifeworld research to ask questions about how our pre-understandings affect our understanding, or how we can remain open to phenomena in relation to an aspect of our knowledge that is so unavoidable and necessary, gives it a great relevance to the project of the caring sciences.

The term 'epoché' in actuality refers to the phenomenologist's mental operation, whereas the term 'reduction' is a specific reference to their change in attitude as a result (Embree, 2011: 120), however these are often referred to

interchangeably. There is of course discussion around the use of bracketing, particularly its misunderstanding 'that the phenomenologist is standing in some absolute and totally presuppositionless space' (Hycner, 1985: 281), but instead it should be seen as an acknowledgement of the very complex, multi-layered and interconnected taken-for-granted attitude which 'is not only worldly, factual, and cultural, but also intersubjective (Embree, 2011: 123). This is partly the reason why some phenomenological researchers utilise the term *bridling,* as is the case within this thesis, because it disengages any pre-understandings from how the phenomena is revealed in the research encounter without ignoring its existence. Finlay describes bridling as 'a slowed down way of looking *forwards* towards understanding, rather than looking backwards at bracketing pre-understandings' (2011: 127), enabling the researcher to perform an epoché to try and apprehend essences, but using an almost *relational* approach with regards to gaining insight.

Beyond the eidetic epoché are a number of different reductions which can be used within the phenomenological attitude as a way to reflect upon different types of pre-understandings that the researcher may have. It is suggested by Ashworth (1996) that there are three foundational presuppositions which the phenomenological researcher should bridle, as outlined by Finlay: (1) scientific theories, knowledge and explanation; (2) truth or falsity of claims being made by the participant; and (3) personal views and experiences of the researcher which would cloud descriptions of the phenomena itself.' (2009: 12). What is of interest to the lifeworld phenomenologist is how a person experienced a particular phenomenon as lived, therefore assessments and 'reasons' for their perspectives are not of interest, or any evaluation of the objective 'realness' of what happened as it is accepted that the phenomena was real and has meaning for the participant. There is very useful discussion of possible epochés written by Embree (2011) which not only shows the broad range of different epistemological

frameworks that must be considered, but also suggested epochés relating to a number of different disciplines which should be considered:

Theoretical Epoché - Suspension of things as 'practical' or 'aesthetic' (e.g. useful, attractive)

Solipsistic Epoché - Suspension of the existence of Others (awareness of own embodied consciousness)

Psychological Epoché - Suspension of existence of the psyche

Psychiatric Epoché - Suspension of the psychiatric model

Naturalistic Epoché - Suspension of view that things are concretely 'natural' (naturalism is instead a cultural pattern of interpretation)

Other suggested epochés from Embree include those for economics, class-related expectations, age-related expectations and cultural anthropology (2011: 125), and he suggested that it was important for phenomenologists to consider these and other possible epochés. However he recognised that it was the *theoretical* and *psychological* epochés that may be of most value to the phenomenological researcher, 'the former in prompting reflection on foundations in science-based disciplines and the latter in resisting imperialistic tendencies today that are currently spreading from cognitive science' (2011: 125). Being able to reflect and become aware of pre-knowledge and presuppositions, particularly in relation to systemic inequalities and discourses which can be maintained and reinforced through knowledges, is crucial for the researcher when they are looking to analyse the described lived experiences of others, at both an empirical and an ethical level. This is something that will be given ardent focus throughout this thesis in accordance with my own values as a researcher.

If phenomenological research is concerned with the revealing of essences and the bridling of pre-knowledge and presupposition, how is it to account for the issue of communication between two subjects during the interview, and how can the researcher know if they have correctly identified the essence of the phenomena? This is a divisive issue within the phenomenological research community where differentiation is made between *description* and *interpretation,* and it is crucial for phenomenologists to respond to this dilemma when creating their methodological strategy. Although there are some phenomenologists who do not separate description and interpretation entirely and instead consider them as existing on a continuum or spectrum (Todres & Wheeler, 2001; Langdridge, 2008), it is more commonly maintained that each approach has its place 'and cannot be reduced to one another' (Giorgi, 1997: 241) regardless of how they may be situated within the methodological scope of phenomenology. Descriptive phenomenology, inspired by the work of Husserl, is concerned with description in the sense that it is 'of its meaning, based on the experience of "the thing"' (Dahlberg et. al., 2001: 242-243) and is 'an indication of what the subject was present to, and not necessarily that the description is an objective account of what really took place' (Giorgi, 1997: 244). Interpretive phenomenology, inspired by the work of Heidegger, is often associated with hermeneutics and seen to follow 'the hermeneutic turn' within phenomenology, and takes the view that because our understanding cannot be separated from *language*, 'it is only through language (and thus interpretation) that our Being-in-the-world becomes manifest and can be understood' (Finlay, 2011: 52), therefore the researcher 'must aim for discursive language and sensitive interpretive devices that make…analysis, explication and description possible and intelligible' (Van Manen, 2014: 26).

Just as the phenomenological attitude must be engaged at all stages of the phenomenological project, the researcher's position within the descriptive-

interpretive continuum must be established and remain coherent with the philosophical texts from which it is developed. One of the reasons for this is that two of the main differentiating factors between descriptive and interpretive phenomenology are 'in how the findings are generated and in how the findings are used to augment professional knowledge' (Lopez & Willis, 2004: 72), so in order to maintain empirical validity and consistency throughout the project, the researcher's position must be clarified from the outset. My own position as a researcher is settled within the descriptive phenomenological tradition, although I have tried to take additional guidance from a number of primary philosophical texts, and my aim is to '[describe] a phenomenon and its meanings without interpretation, explanation or construction…the ambition [is] to be honest to and stay close to the data' (Dahlberg, 2001: 241). I feel it cannot be denied that interpretation may be undertaken 'to contextually grasp parts within larger wholes' (Wertz, 2005) as part of a more encompassing attitude of deep *empathy,* multiplicity of possible meanings (Finlay, 2006) and the somewhat unsettling absurdity of the human phenomenal ontology, especially in relation to health and wellbeing (Sartre, 1943/1996; Marcel, 1948; Van den Berg, 1972). This approach has been evolved in response to my own philosophical position and in particular my own open nature by embracing the texts that have 'spoken' to me, ensuring that I am not only fully engaging with my analysis, but ensuring it 'comprises an element of wonder: discovering the extraordinary in the ordinary, the strange in the taken for granted.' (Van Manen, 2014: 298).

Lifeworld phenomenological analysis, in its effort to uncover essences and meaning structures as they are constituted in lived experience, values 'the ambiguity, ambivalence and paradoxes of human experience' (Finlay, 2011: 232) and strives to account for these within its analysis, for 'it is here that poignancy and resonance is found'. Just as the phenomenological researcher does not make

assumptions about meaning, they ponder upon descriptions of the phenomena 'and want the indefiniteness to last as long as possible' (Dahlberg et. al., 2001: 241). Similarly, they must hold back from searching out the answers too quickly or forcefully as this will 'foreclose the emergence of a deeper level of understanding' (Dahlberg et. al., 2001: 110), therefore they must be willing to remain 'in the dark', suspended in a state of 'not knowing' which defines the phenomenological attitude. By accepting this state of *unknowing,* like the 'invisibility' of human existence as described by Merleau-Ponty which can be found in both ourselves and others (Dahlberg et al, 2001: 92), the phenomenologist is able to gain insight and understanding in a way that may not necessarily *answer* the question the experience poses, but shows us that *there is* a question to be asked. Just as Fanon describes the Algerian soldier suffering from impotence following his wife's rape, who eventually exclaims how 'she's tasted the French', it was only in this moment, where the invisible was made visible, 'that we reconstructed the whole story. The weaving of events to form a pattern was made explicit' (1961/1990: 206). Instead of looking to confirm *truths* in lived experiences, or confirm things that are already known to us, phenomenology asks the researcher to strengthen the outcome of their project through their openness, and it is for this reason 'we hope to be touched, surprised and to have our horizons expanded' (Finlay, 2011: 208).

Ethical considerations

The research relationship between the researcher and the participants are characterised by an imbalance of power which is unavoidable, yet arguably necessary. The researcher directs and makes decisions on the project, 'initiates and controls contact and holds professional knowledge' (Finlay, 2011: 218), therefore the uneven nature of the relationship is somewhat inevitable, despite their roles as co-constituents in the lifeworld and its meanings. The participant's role as a

subject/object, one which is characterised by their ontological reality as *Other,* is one which preserves their alterity and holds it there as something towards which 'we have an ethical responsibility to respect and be open to' (Finlay, 2011: 78). This spontaneous and intuitive act of *being with* the other involves 'becoming fascinated with and immersed in the other' (Finlay, 2006: 2) through an existential similarity of ontologies, similar to Sartre's conceptualisation of 'the 'first attitude' towards others whereby 'I want to stretch out my hand and grab hold of this being which is presented to me as *my being* but at a distance' (1943/1996: 364). The participant is other and must remain other, despite sharing the same human ontology, so as to avoid 'assimilation' of their freedom. This will be expanded upon in the philosophical evaluation outlined in Chapter 4, but it shows the 'transformative…potential power' (Finlay, 2011: 190) of lifeworld research for both researcher and participant, the reason for which it must be approached with due care and respect.

Taking part in research has the potential to give us new understandings and to change us, both positively and negatively (Finlay, 2011: 24; Green & Thorogood, 2014: 74) and the possibility of both should be kept in mind throughout the process. A participant who shows reluctance to talk about something that 'feels too dangerous' (Dahlberg et. al., 2001: 204) must be listened to and given this respect as there is a lot at stake for them, but this is also precisely what can pay off in positive, transformative experiences of research. The reality is that a certain level of upset or difficulty may be part of the process of re-experiencing lived experiences, particularly when it comes to sensitive topics surrounding health as it can involve reflection on one's own vulnerability and mortality (Dahlberg et. al., 2001: 109). In response, the researcher should be prepared to embody 'compassionate, sensitive, attuned care and ethical attention…to support them positively' (Finlay, 2011: 209) as an ongoing part of the

researcher role, as opposed to simply as a reaction to an instance of distress for the participant. Just as there is the real possibility for participants to be re-traumatised by the recounting of lived experiences, researchers are vulnerable to *vicarious traumatisation* and must keep this fact in their awareness so that they can recognise any signs and employ appropriate '*self-nurturing* activities' in response, such as 'maintain[ing] health work-life boundaries [using] connection with others…as an antidote to the isolation and alienation experienced' (Finlay, 2011: 193). It is also important to frame the possible difficulties of those taking part in research in relation to the very valuable positive possibilities, things that can make research participation beneficial to both participant and researcher, for example that their experiences can go on to help others 'in some productive, constructive way' (Finlay, 2011: 224), often as practice-related implications for people who are caring for someone with those same experiences, for example carers of people with Alzheimer's disease (Galvin & Todres, 2013: 63).

CHAPTER 3: METHODS

Introduction

The previous chapter outlined the epistemological foundation of the phenomenological research project, its methodological framework and the way in which it is scientifically rigorous, in keeping with the required standards of empirical, qualitative research. Chapter 3 will give a practical and explanatory account of how the methodology was used to engage in phenomenological interviews with the research participants to create data about the phenomena of eating disorders in older people. As is standard for a phenomenological project, this consists of how I identified and bridled my pre-knowledge and pre-understandings, conducting the interviews and completing their transcription.

Section 3.1: Beginning the process

As outlined in the previous chapter, the goal of phenomenological research is to deepen understanding and elucidate the individual's lived experience of the phenomenon and human being more generally, rather than seeking a 'truth' which can be validated objectively (Hycner, 1985: 295). This is achieved through progressive examination of the data, using empathy, intuition and embodied 'feeling in', as well as iterative written versions that seek to evocatively 'language' the phenomenon as it is lived (Finlay, 2011: 298), ultimately uncovering 'the make-up, or way of being, of any given structure in its form of meaning (Spinelli, 2006: 2). Although this process is referred to by most phenomenological researchers as analysis, as it will be throughout this thesis, it should be understood as a less rigid, systematic endeavour, (despite it being framed as a partly procedural task) which is to be viewed more loosely as work undertaken using 'lifeworld descriptions that come from interviews or participation in lifeworld events' (Dahlberg et. al., 2001: 233) that focus on the phenomenon of eating disorders in older people. Working

with the data iteratively, and following guidance from other phenomenological researchers, helps to clarify and make sense of the meanings that are emerging so that they can be apprehended, 'mapped out' and organised, then presented either in written format or even using more expressive, creative ways.

To recap some of the points made in the previous chapter, before outlining the specifics of the method which was used for this analysis, the vital components central to phenomenological research are the bridling of pre-understandings, use of the reduction to access pre-reflective meanings, engagement of the phenomenological attitude and a consistent openness to the lived experience of the phenomenon. The guiding ethos which ties together these components is commitment to the phenomenon in its *concreteness*, where 'the descriptions reflect the details of lived situations rather than hypotheses or opinions about, explanations of, interpretations of, inferences, or generalizations regarding the phenomenon' (Wertz, 2005: 171). The ability of the researcher to achieve a finite phenomenological reduction is not possible due to our role as co-constituents in the world and its meanings (Merleau-Ponty's intertwining of flesh and chiasm), which is explained by Finlay both in relation to the reduction (2014: 125) and the entangled involvement of the researcher's subjectivity during the research (2009: 12). This shows the importance of reflection and reflexivity, as skills which the researcher must tactfully employ, in addition to the ambiguous and non-dualist nature of the phenomena as they are experienced within the lifeworld:

> 'Whatever variant of phenomenology, the task remains profoundly dialectical: researchers need to straddle subjectivity and objectivity, intimacy and distance, being inside and outside, being a part of and apart from, bracketing the self and being self-aware, and so on. Phenomenology champions a holistic nondualist approach to life, and this philosophy needs to be mirrored in its methodology.' (Finlay, 2014: 124)

What is rich, complex and contradictory about our experiences is what the phenomenologist is looking to discover in a way that destabilises, surprises and moves them, rather than that which 'is often very trivial or in such a broad range as to be meaningless' (Hycner, 1985: 299). It is from this anchored epistemological position that the phenomenological project can emerge, take form and facilitate a new way of profound understanding. The remaining parts of this section are an account of the procedure followed throughout the analysis, with the results of the analysis forming section 2.

Section 3.2: Pre-understandings

To begin the research project, I began by identifying my pre-understandings of the phenomenon through a combination of self-reflection, examination of existing literature and exercises in self-awareness as a way to locate my existing knowledge. Undertaking a conceptual literature review of eating disorders gave me the opportunity to locate myself within the existing knowledge of what eating disorders are, as well as expanding my understanding of the epistemological and ontological positions that exist in relation to eating disorders, mental illness and the surrounding philosophical issues. Throughout this period I posed myself a number of questions to help reflect on what I thought, and what I was aware of knowing or believing about eating disorders: What makes eating disorders different from peoples 'typical' relationship with food and eating? How are eating disorders the same, or different, from other psychiatric diagnoses? Do I feel the existing literature confirms my pre-understandings of eating disorders, or does it challenge them? What am I trying to understand about eating disorders in older people? Keeping these questions in mind throughout this process, in addition to writing and summarising my thoughts regularly as a way to 'work out'

and reflect on my awareness and understanding, was one of the first steps towards adopting the phenomenological attitude.

My interest in eating disorders in older people also existed previously as part of my own lived experience. My mum, now in her 60s, has had an eating disorder for the majority of her life (and all of my life), something which has shaped our intimate relationship and been the topic of many conversations and events throughout our respective lives. I had reservations about my ability to successfully separate my own pre-knowledge of the phenomenon from that which would be disclosed by my participants, but overall I believe that my closeness to the phenomenon gave me a source of immense empathy which would elevate the level of openness I was able to achieve, both throughout the interview encounters and the data analysis. Being able to manage the possible overlap between empathising and 'merely engaging in a misguided form of projective identification of countertransference' (Finlay, 2006: 4) was an issue which, at the beginning of what was to be my first phenomenological research project, provoked anxiety and doubt. I found that it was through familiarisation with the phenomenological method, most influentially the work of phenomenologist and Integrative Psychotherapist Linda Finlay, which showed me that 'our 'horizons of experience' (e.g. temporal horizons of our past experiences and future anticipations) are implicated and penetrate any perception of the world we may have' (2011: 52) due to our embeddedness in the world, therefore our understanding '*depends on* us recognizing our pre-understandings and historicity'. Although the bridling of my pre-understandings varied in difficulty at different stages of the project, I believe that I have been successful in 'continually and self-critically question[ing my] understanding' (Ashworth, 2015: 21) to ensure that I was always slowing down and 'looking *forwards* towards understanding, rather than looking backwards at bracketing pre-understandings' (Finlay, 2011: 127).

Section 3.3: Interviews and collection

Alongside the review of the literature, an application for ethical approval was made to the Research Ethics Committee within the Faculty of Health and Social Care at the University of Hull and this was granted, following minor amendments, in July 2016. As part of the application, an eating disorder charity in Hull (SEED) had been approached as a facilitator for identifying and making contact with potential participants, and because of the rich data anticipated from the lifeworld phenomenological approach, it was established that two participants was an appropriate number for the project. Due to the age requirements, it was anticipated that there may be issues with engaging suitable participants, but in contrast to this the very small number of participants required increased the likelihood of successful recruitment. The founder of SEED took an active role in identifying and making initial contact with two participants, both of whom agreed to take part - one female participant aged 60 (Poppy), and one male participant aged 86 (Paul). After making phone and email contact with Paul and Poppy and chatting about the interviews, I sent them an information sheet about the project (Appendix B) and a recruitment poster (Appendix C) so that they could take some time to consider their participation. During this time I found two suitable venues, one in a village close to where Paul lived and the other in a village near to Poppy. I then arranged a time with each of them so we could meet face to face, begin to get to know one another and for me to evaluate their capacity to consent.

After speaking with each of them and disclosing some of my own experiences as a way to build rapport and trust, both Paul and Poppy completed a written consent form and agreed on a date for the first interview. I completed two interviews with Paul which were recorded using an encrypted digital recording device, the first interview lasting approximately 45 minutes, the second lasting approximately 60 minutes. With Poppy we had three interviews, the first lasting

approximately 90 minutes, the second lasting 80 minutes, the third lasting approximately 70 minutes, all of which were also recorded with an encrypted digital recording device. Although written consent was gained at the beginning of the interview period, consent was understood by both Paul and Poppy to be a dynamic process which allowed them to make decisions about participation or disclosure of information throughout the interviews and at any stage up until transcription.

Engaging in the conversation with Paul and Poppy with the phenomenological attitude was challenging, exhilarating and dynamic as I tried to embrace and truly *feel* my felt bodily responses to their lifeworld descriptions through my 'embodied empathic presence', and our emotional 'being-with' one another as the conversation unfolded. My first interview with both Paul and Poppy was completely unstructured so that an open, welcoming space could be tended and attuned to, in which I responded empathically to their experiences and attentively engaged my attitude of 'unknowing'. Immediately after each interview, I took the time to listen back to the recording as a way to re-experience it with as much immediacy as possible, allowing it to 'settle' and let myself get a feel for the conversation as a whole, without having to focus too much on what was being said. On the evening before returning for my second interview with Paul, and my second and third interviews with Poppy, I listened back once more to the previous interview, identifying points at which I felt drawn in to know more, points that moved and stirred me, or simply points about facticities in their lives which could be elaborated upon, which I then used as a very open yet semi-structured baseline to help guide the next conversation.

Section 3.4: Transcription

I planned to transcribe interviews myself as 'a practical and immediate way to dwell with the data' (Finlay, 2011: 229), something I also decided to undertake after the 'data collection' was completed in its entirety, rather than after each interview was completed. It is possible that I may have had some apprehensions about beginning the analysis, but I felt very aware of the emotional investment I would be undertaking throughout the process, so this felt like my way to ensure I was prepared and available to the encounters that I had had with Paul, and with Poppy, as if I was leaving a 'space' in which I could reflect before opening myself to their lifeworlds and the phenomenon. Doing the transcription was long and challenging, but it was important to me for them to be as authentic and as close to the original conversation as possible, therefore I made sure to 'reproduce reliably the precise words used by the interviewee, including any slang words, stutters, hesitations and interruptions' (Green & Thorogood, 2014: 208). Although I knew that it would not be possible to capture the encounters in their totality (Dahlberg et. al., 2001: 234), transcribing what was said as closely as possible to the recording, as well as notes and comments about any facial expressions or gestures made by either one of us, was one of my priorities during this early stage of the analysis.

I began with the process of empathising by listening to the recordings of our conversations, trying to get a feel for their ways of being and begin to settle in to their lifeworld as they were describing it. As I continued to engage in an intuitive 'feeling into' the other's experience, I let myself be drawn to particular moments in the encounter that were resonant and marked them in the written transcript, as well as trying to bring into awareness my initial thoughts and feelings. I listened to the recordings a number of times, on some occasions listening to the parts I had marked out and been drawn to in isolation, other times trying to listen to the entire conversation and empathise as if for the first time,

undertaking a dance 'between intimacy and alterity' (Finlay, 2006: 8) as a way to uncover new understandings. This iterative engagement with both the recordings and the transcripts evolved into a collection of written notes, passages and an exploration of my emotions in response to Paul and Poppy's experiences. This was an imaginative process which was directed towards the experiences of each participant and the phenomenon, allowing a broad range of meanings to present themselves, and to 'accumulate an ever increasingly adequate description' of the phenomenon (Spinelli, 2006: 6).

To catalyse my data generation and create 'entry points' into the lifeworld, I turned to the fundamental existential themes (what was described in section 4 as 'existentials', termed by Van Manen) to encourage these meanings to become visible. Some of the examples given by Finlay as 'points to interrogate analysis' were of great value for me at this stage and formed a kind of reflective framework:

> 'What does it mean to be this person? Who does s/he think s/he is? What does s/he think about? (self-identity)
> What is his/her subjective sense of embodiment? (embodiment)
> Where does he/she experience his/her day? Are some places safer than others? Does he/she feel closed in? Is there a feeling of 'insidedness'/'outsidedness'? (spatiality)
> How does s/he experienced his/her day? Is it pressured, rushed and speeding by? Boringly slow and endless? Discontinuous? (temporality)
> How does s/he experience relating to others? Who are the significant people involved and how their relationships impacted? (relationships)
> What drives the person? What motivates them? What gives their life meaning? (project)
> Is there any discourse/language being used that seems significant and reveals either personal or shared cultural meanings? (discourse)

> Is there a mood/tone attached to the phenomenon? What background 'existential feelings' are being expressed such as 'feeling distant', 'fretful', 'fulfilled', 'cynical' or 'yearning'? (mood as atmosphere)' (Finlay, L, 2011: 230)

As I began working with the data, it became apparent that the historical context within which certain events had occurred, either the experiences of my participants or those of their family members, was as fundamental to their lifeworld as the other themes and was also closely interwoven with the theme of 'discourse'. Another specific issue which I felt came up quite prominently with my male participant Paul was his experience of the geographical area, which again was interwoven with the historical context of his lifeworld. For this reason, I not only looked at the theme of spatiality, but the geographical *place* which is meaningful and intersected with Paul's social situations and 'everydayness' (Seamon, 1979: 668). It was only by including these themes and the 'matrices of that person's world-view' that I was able to better 'understand the meaning of what that person is saying' (Hycner, 1985: 281) without bringing my own expectations into the process.

One of the most effective techniques I used to 'dwell iteratively in the data' (Finlay, 2011: 45) was the use of 'mind-mapping' software, particularly in the later stages of analysis, as it allowed me to see the meaning structure of each participant's lived experience in different ways and ensure the resulting description was as 'rigorous and trustworthy' as could be. Visually, this non-linear representation enabled me to undertake the tripartite analysis, 'a movement between the whole - the parts - the whole' (Dahlberg et. al., 2001: 236) in a way which I found complimented my personal reflective and reflexive tendencies and created some very powerful moments of engagement and re-experiencing of the phenomenon. By creating a mind-map for each participant, it was almost as if I

was able to map the phenomenon's constituents as they were experienced within that person's lifeworld and begin to consider its boundaries. However most importantly, being able to view them on one 'page' and add to their detail throughout the process, such as their related existential themes or multiplicities and paradoxes of meaning, facilitated my continuous movements between 'closeness' and 'distance', the 'reductive-reflexive dance, stepping away from initial assumptions and understanding' (Finlay, 2011: 81) as a way to bridle the natural attitude, for example by 'avoiding assuming before there is evidence that one aspect of a phenomenon is more significant than others' (Ashworth, 2015: 23). Continuing this 'difficult, continuous, iterative, layered and paradoxical' process (Finlay, 2008: 79), thus allowed me to reflexively reflect on variations and similarities which clarified the overall structure and character of the phenomenon in terms of its constituent parts, its essential and universal features.

Section 3.5: Summary of practicalities in the analysis stages

Despite the analysis process being deeply rooted in an empathic, embodied response to the participants' lifeworld experiences, moving creatively and reflexively between different layers and stages of analysis, a short account of practicalities will be outlined here. Guidance was taken from Van Manen (2014) and Finlay (2011), and to help in the summarising of the process, and reference is made to Hycner's guidelines for analysis stages (1985) to make these as explicit as is possible. There is also a table showing an example Representation of Analysis (Appendix D) to give a more visual representation of how the data moved from one stage to another following iterative and reflexive 'feeling in' to the data.

Gaining a sense of the whole

For the first stage, I would make sure to listen to the recording in its entirety as soon as possible after the interview, allowing myself to 'anchor into' the

overall sense of the encounter, and the lifeworld as it was primarily revealed. Reflection on the phenomena was not exercised intentionally at this stage, although there were aspects which were prominent within the recordings.

Transcription of each interview followed, during which I allowed aspects of the phenomena to appear and began to engage in inquisitive reflection. My bodily felt sense, as it related to my empathy and intuitive responses, was prominent in these moments, and began to disclose variations in Paul and Poppy's lived experiences in a very 'raw', present sense.

Drawing out key points and themes

Using the written transcripts alongside the audio, I began to write notes and reflections relating to the phenomena and the encounter itself as a way to begin loosely identifying meanings and their structures. Much of this annotation was done onto copies of the transcripts themselves so that phrases or sections could be specified.

The next part of this stage was, in hindsight, the most effective, which was to use 'mind-mapping' software to create a two-dimensional visual 'map' of each participant's lifeworld, parts of which represented the phenomena, and others which touched upon it but perhaps provided contextual data, or data about overlapping parts of other phenomena. By laying these 'maps' out (across my dining room table, or living room floor), it became easier to move between the parts and the whole, a process which was supplemented by returning to the transcripts and recordings as a way to 'feel into' their lived experience and subsequently 'draw out' key points and themes.

Universal essences and constituents

The drawing out of themes and essences of the phenomena is difficult to articulate and describe, and it was indeed a paradoxical, continuous process which required a blend of reflection, deep empathy and self-awareness. Bridling pre-

understandings and engaging the epoché became more challenging at this stage, and it was the most draining, and enduring part of the process. Once the essential features of the phenomena were identified, the delineation of each participants' experiences felt like coming full circle, finding myself back at the beginning of the process, but instead with an awareness of what my intuition and reflection had been discovering in those moments. The final stage of the analysis process was in the writing of the chapter itself, as this was where a more substantial and exhaustive 'languaging' of the phenomena was able to be realised.

CHAPTER 4: FINDINGS

Introduction

This chapter will give an account of the data which was drawn out from my existential phenomenological analysis, and will take the form of a guided *feeling-through* for the reader. This feels like the most appropriate way to stay close to the meanings of the phenomenon, allowing them to reveal themselves in the same way for the reader as it did for me as a phenomenologist (albeit at a more accelerated pace and with a more linear trajectory). I will begin with a biographical narrative account of each participant, then describe the constituents of the phenomenon as they began to emerge, finally arriving with the essential and universal features. Then there will be a section for discussion not only of the phenomenon and the data, but also the process and my embodied response.

Section 4.1: Biographical narratives of participants

Paul

Paul was aged 86 at the time of our conversations, born in 1930 in a village in the north of England where he still lives. He states that he was born 'out of wedlock', an indication that his father and mother were not married, and his father, who was unknown to Paul until his later life, had a wife and children of his own. Paul has never found out any further information about potential half siblings with whom he shares a father. He was raised by his mother and extended family including his mother's mother, his aunties and uncles, in a large house in the village. One of nine children, he also lived with his younger brother and sister, who he later revealed were his half-brother and half-sister. He lived at home until getting married and buying a house in the village, around age thirty five, where he went on to have three sons of his own.

Paul had originally become interested in crafts, engineering and working with his hands in his teens, then continued trading and doing repairs from his workshop at home, which he still does to the present day and is devoted to. He and his wife divorced after she decided to end the marriage and left him for another partner, which happened after thirty five years of marriage, when Paul was around seventy years old. This impacted him immensely, and he struggled with suicidal thoughts and heavy drinking, and was taken into the care of the village doctor. His youngest son and his wife came to live with him in the house immediately after his wife left, and still live in one half of the house which is large enough that they have separate parts of the house to themselves. One of his sons lives in a village close by, the other lives in Greece, and Paul has six grandchildren, and his half-brother and half-sister also live in the nearby area.

Eating and issues with food began for Paul when he was a teenager, and he describes himself as a 'moody' type of person who was 'depressed' during this time. He described a specific night which he identified as the beginning point of his problematic relationship with food - on this occasion he noticed that eating a 'proper' meal improved his mood, and he then went out to enjoy a very memorable evening of dancing and socialising. Paul said he started to develop concerns about his digestion and he experienced bad feelings in his stomach, so he slowly changed the types and amount of food that he ate until his diet was limited to 'chocolate, milk puddings, light eggs, things like that'. He was seen by a psychiatrist at a local hospital where he was given a 'truth serum' as treatment for his depression and eating problems, but this had no effect.

Eating in front of other people became increasingly difficult for Paul, and he talked about this being an issue with his family when his sons were all very young - he would go and sit alone in another room while his wife and children ate together at the dining table. Paul and his wife didn't ever go out to eat together,

and he feels this contributed to the breakdown of his marriage, although he did occasionally go out to eat with a group of male friends at various pubs. On these occasions he felt it was possible for him to eat with them because they all drank alcohol, something which has always helped him relax, but it was still a struggle even under these circumstances. Eating is confusing to Paul, in particular chewing and swallowing, and he has concerns over his digestion because of a feeling of firmness in his stomach.

Since living on his own, Paul still has these same issues around food and eating, but finds he is able to eat a more varied diet because he accepts the need to look after his health in his old age. He grows vegetables in his garden and cooks for himself most days, although on occasion he eats with his son and daughter-in-law who live with him. He described being an active person in his teens and twenties, playing football and going out dancing, as well as being in the armed forces. At the time of our conversations, he stated that his doctor said he didn't appear to have a problem with eating and food because his weight was within a healthy range, and Paul described himself as being 'a little overweight, if anything'. Despite his difficulties with food, he said that in the context of his life overall, he was very happy day to day and remained incredibly interested in his work, keeping busy with workshop repairs and trips out. Paul stated that 'mealtimes aren't everything', and he considers himself very lucky to be so independent and mobile.

As well as being interested in his crafts and repairs, Paul said that he enjoys watching TV and films, and goes out almost every day in his car to visit local places, particularly seaside towns on the east coast. He recently had the company of a cat which had passed away, so his son had bought him a new kitten which was only a few months old. Paul sees his family regularly, including his half-sister and brother, his sons and his grandchildren, as well as Skyping other family in

Australia. At numerous points in our conversations, he stated how he had so much knowledge and so many memories from over the years, 'I could write a book'.

Poppy

Poppy was 60 at the time of our conversations and was born in the North of England in 1955, with a twin sister, Eve. Along with her older sister Amanda, the three siblings were raised by her mum, Jean, and her dad in a house on a cul-de-sac in a small village, and Poppy attended the local primary school followed by an all-girls grammar school in the local area. Her time spent at the family home was dominated by neglect and abuse, and although this did continue into her later life, she moved out at 18 when she went to university in London, her sister Eve moving further up north. Around age 20 they both returned to the family home for a brief period, Poppy then got married and moved in with her husband Colin in the village nearby. Eve lived in another village not far from her marital home, her older sister moved down south, and Poppy went on to have two daughters, Tina and Miranda, and a son, Elliott, as well as a grandson, James.

Poppy had originally begun a joint degree in nursing with accountancy, but did not complete her nursing qualification, so went on to work in accounts for a large firm, as her dad had done. At age 49 her dad fell and broke his spine, as a result of which he was quadriplegic, so her mum became his full time carer at their family home, although Poppy took on most of the responsibility for this due to her mum's abuse and neglect towards her dad. Then when her children were young, Poppy's husband went to prison and they were forced to sell their house and move to council accommodation, so she retrained as a teacher. Still caring for her dad, and also her mum who spent numerous periods of time as a psychiatric inpatient, her dad eventually died as the result of her mum's neglect and abuse. Her husband Colin returned home to the family from prison, and they continued

raising their children and Poppy worked as a Special Educational Needs teacher, a role about which she was very passionate. Around five years ago, following repeated psychiatric admissions and involvement from social services and the police, Poppy's mother went into a nursing home, then was taken into hospital due to ill health and eventually died age 87. Poppy and her family had been planning their daughter's wedding around this time, and Miranda got married two days before Jean's funeral.

Issues around food began for Poppy in her childhood, and she remembers a particular incident around age seven where her mum had made a picnic for a day out to the countryside, and Poppy threw some sandwiches into a hedge in response to her mother's abuse. Mealtimes were described as volatile, and all three children experienced constant yet unpredictable periods of food restriction and force feeding as controlled by their mum, so they would go from having no food one day, to being forced to eat large amounts the next day. Although she describes times at which she was at a very low body weight right through from her early twenties, Poppy did not receive treatment for an eating disorder until she was in her late 50s, despite having been admitted for inpatient psychiatric treatment following her dad's death in the years prior to this.

Poppy was athletic and played lots of sports, excelling in hockey, so had always done a lot of physical activity, but when she went to university and her food restriction became more severe, she described doing more aerobic exercise such as running up flights of stairs. All throughout her childhood and adolescence, both parents criticised her for being ugly and fat, criticisms she also received from other adolescents when she was at secondary school, and she began a restrictive diet when she was a teenager. During her teacher training she cycled long distances, and remains very active at the age of 60 and regularly goes cycling,

swimming, walking and to the gym, apart from a recent period following surgery on her foot.

Poppy is a vegetarian and is cares about the environmental and social impact of her food, as well as growing food on her own allotment, which she donates to a grower's association, she enjoys cooking for her and Colin most days. They regularly visit their daughters, including their grandson James who was born only a few weeks before the research sessions began, as well as Skyping with their son who lives in Singapore. Poppy and Colin have a dog and enjoy holidays together abroad, and she has a number of interests, such as reading and literature, plus sewing and making her own clothes.

Section 4.2: Constituents of the phenomenon

Following the phenomenological conversations about their experiences of eating disorders, both participants disclosed a broad variation of experiences, which touched upon all existential themes and were united in their underlying essential constituents. However in contrast, they were also richly saturated with the theme of embodiment and bodily felt sense, which was more prominent than any of the other themes and was central to the understanding of the phenomenon as a whole. This will be explored in more depth in the discussion section of this chapter, as well as in the philosophical examination in Chapter 4.

Section 4.3: The essential features

Within the phenomenological conversations had with each participant, the essential features of the phenomenon described by them can be separated into the following areas:

1. Bodily vulnerability/lack of bodily integrity, feeling 'frozen', 'muted', a sense of a lack of vitality

2. *Not being 'at home', or 'settled into' the body*

3. Eating and food as an attempt to control moods and emotions

4. Food is a battle, struggle, an ordeal, feels like being on a 'knife edge'

5. Age gives perspective on past experiences, but the illness is ingrained and absurd

Delineations of the phenomena

I will 'language' each of these essential features in turn, beginning with the universal meanings seen in the phenomenon as a whole, followed by the delineation of these features as they appear for Paul and Poppy as variations within their respective lifeworlds. In the following section, I will then give a brief overview of the phenomenon including its delineations and overall structure.

Paul and Poppy's own words will be used as transcribed throughout, and these transcriptions are written as verbatim as possible including non-verbal communication (written in square brackets), pauses (shorter pauses written as an ellipsis, longer pauses written in square brackets) and physical gestures (written in square brackets). Communication made by me during the conversation are written in parentheses, in addition to the punctuation as outlined above.

Section 4.4: Delineations of the phenomena

1. Bodily vulnerability/lack of bodily integrity, feeling 'frozen', 'muted', a sense of a lack of vitality

Universal

There is a sense of the body's possibility of being exposed - to the world, to the look of the Other, to physical danger - an existential feeling which characterises the overall sense of reality. The body's existential vulnerability is

heightened, and is felt as both an ontological and existential *precariousness*. The risk of damage or distress is elevated, and the body's integrity is experienced as *compromised*, *diminished*, *fragile*, *dulled by a lack of vitality*. The embodied self is characterised by a *frozen* or *muted* state, its aliveness moving between being *held* back by the self, and *pushed* back by the world, where one does not appear to be wholly ontologically separable from the other.

Paul

Paul has anxieties over being unable to digest, both in relation to the discomfort of the physical sensations felt, 'a big lump' and 'a bad feeling', and the consequences this could have on his health. This felt sense of bodily vulnerability changes in its emphasis depending on his desire or appetite for food as well as the types of food he eats:

> *'If I eat…normally with an appetite and enjoy it…then I feel…different again'*

> *'I just got the er…stupid impression that I couldn't digest things…(mm)…that er, that er…that went on for a few years but I mean, now I eat, everything normal (mm)…err…just find it difficult eating, and I f-…I'm always…an hour, getting over it…(yeah) yeah…(yeah)…always sort of get…er, a bad feeling in me stomach, mostly'*.

The difficulty and panic of eating, as something he has anxiety and distress towards, is not *overcome* through the act of eating itself, and the 'ordeal' is something that lingers and which it takes time 'getting over it'. During Paul's descriptions of these moments, I felt his anxiety as an energetic nervousness in my chest and stomach, a sensation which was uncomfortable to sit with.

Being watched when eating was a panicking experience for Paul, a very urgent sense of exposure, like a spotlight suddenly being switched on. He describes the task at hand as being impossible, although not in its most literal sense, but it seems instead as an expression of feeling powerless, impotent. He describes this panic in a bodily way - 'I shall be sweating' - and his fear is observed by others and the world, also an unsettling confirmation of how he exists as a *being-for-others*:

> *'It's when people…are with me and watching me and, you know…'*

> *'…this particular time which sticks in my mind I remember, this fella saying to me, you eat as if you don't want to do it, Paul (mm). I was frightened to eat…(yeah)…you know.'*

Paul seems to feel anxiety and panic about his ability to physically eat, a *holding back of himself*, a cautiousness, but this is tied up with a felt sense of possible danger or distress, the world *pushing him back* and threatening, or challenging him, 'an ordeal'.

At the time when Paul is eating, he describes how any kind of interruption or sudden presence of someone during a meal would be devastating:

> *'If anybody comes and I've got to talk to them…(Yeah while you're in the middle of having a meal?)…oh! That's terrible'*

> *'But if anybody comes to the door, which they do and I'm a craftsman, they come…if I'm halfway through a meal oh hell I…get in hell of a state'*

In his description of what would happen, getting 'in a hell of a state', there is a sense of turmoil, of distress, even *falling apart*. He demonstrates a self-awareness of being in the midst of this aspect of his lifeworld, 'horrible int it', as if the experience is both something he participates in whilst also being paradoxically removed from. There was a sense of Paul empathising with himself in this moment, with a sense of sadness but also disbelief - 'int it' - as if he saw himself alongside me, as the Other, and was giving this disclosure as a way to let me see into his lifeworld.

The characteristic of ontological precariousness and existential vulnerability was enmeshed with Paul's feelings about being born out of wedlock, and he stated explicitly that 'I think that would be one of the causes' of his eating disorder:

> *'Sarah – Yeah it sounds like that's, had quite an impact on (yeah…), your life (…it did, yes…) you know (…I would think so yeah), and how you felt, mm… Paul – I would think that would be one of the causes (yeah)…'*

With his existence contextualised as one of *illegitimacy*, Paul describes a sense of his embodied space in the world being *ill-fitting*, the source of other people's pain, or an *unwelcome manifestation* of something undesirable, as if his existence itself was *shameful*. My bodily response was an experience of sorrow, being brought to tears, as if I was present with Paul as a child, and I felt the urge to console him:

> *'…that I haven't mentioned is, which didn't help (mm), I was born out of wedlock…(okay)…I never knew me father (ah)…and I think, that didn't help because I can remember in the village where I grew up, the local postmaster, (mm) his son, and we played football together later on (mm), when I was*

about five and I can remember it…he came to me in the street and said, me mother says I haven't, to play with you Paul Smith because you're bad…I remember that…isn't that terrible.'

'And I mean in th-, when I was born, anybody like me, it was, it was tremendous thing (yeah). Me Mother used to, must have gone through hell (mm), oh definitely (for people to know and…), in those days (yeah)'

'But she must have suffered, er…when I was little (mm…not an easy thing…), mmm (…for her to go through, yeah…yeah)…no….no I often feel sorry for her now but er (mm)…'

'…and I used to look at me stepfather, even though he was, good with me (mm)…and I used to think he doesn't like me because…it, I'm proof…that she's been with another… [pause] another man. That's my…way of thinking (yeah)…which was very likely wrong, I don't know…(that's how you…) that didn't help (…understood it to be, yeah)…at all, no.'

This existential feeling, of *what* he is, *how* he came to be, colours Paul's overall sense of reality and feels very present within his lifeworld, but there is also a contradictory sense of disbelief, of doubt over this perception 'which was very likely wrong'. This *ill-fittedness*, this *fraudulent integrity* of his being and his bodily self, becomes *emphasised* in the act of eating, of facing food, the feeling of being muted, passive, *disarmed*.

Poppy

Poppy describes how her emotions are always held 'tightly in a corner', otherwise she would begin to cry and never be able to stop. By keeping busy, a rushing-by sense of time is a distraction from this, just as balancing between rules about food repress her emotions:

> *'so I think underneath there I normally, gad around cause I'm quite happy I think underneath I'm actually quite sensitive'*

> *'so I think underneath, I think probably cause I am, everything has to be controlled cause I think if I don't, I'd probably end up crying all the time (mm)…[Poppy laughs]'*

Her aliveness seems very intentionally held back, as if she is the one *muting herself* in response to her emotions, the sense of them being 'tightly held' has a visceral, bodily quality. I was able to sense an emotional pain in Poppy, which I experienced rising up in my chest and my throat, which I understood to be a deep sadness and grief, almost a sense of anger. This aliveness and vitality, these emotions, seemed as if they had the ability to cause immense distress, as if they could *engulf* Poppy, but they were also potentially meaningful for her to reflect upon: 'and I think a lot of the time I keep myself active…and don't think about things perhaps I should think about (mm)'. She does also describe instances in her childhood and adolescence where her aliveness and emotions were *pushed back* by the world, more specifically her parents:

> *'…no it, yes it, we were never allowed to express it was because there was always that fear of unpredictability (mm) we never knew, when the fuse would blow (mm), so you couldn't afford to be expressive (yeah), we couldn't*

afford to have opinions (mm), in case they didn't, go down well (yeah), and that was it (mm). Sooo…so no that was the environment we were brought up in (mhm)…'

'You know it was…but I think also we weren't allowed to, get in touch with our emotions either (mm)…which is important (mm)… you know we just repressed them.'

The possibility of her emotions causing distress and damage is experienced within the context of the bodily experience of her emotions *being felt*, ontologically enmeshed with the context of a painful retaliation, a punishment, from the world. Being with Poppy as she disclosed her experiences of not being acknowledged, not being heard and her emotions being ignored, deeply connected to a part of my own sense of self that was agonising, at times almost overwhelming, and the urge to step in and 'catch' her, offer her that validation, rose up repeatedly throughout our conversations.

There is also an aspect of eating and food which she describes as a way in which to alter the size and shape of her body to ensure its acceptability, as well as the *reassurance*, the *fleeting relief* and *comfort* of conforming to that acceptability, as if her existence as a being-for-others and a being-for-itself needed to be ontologically congruent. Even within the context of contradictory gazes of the Other, Poppy had an uncomfortable sense of being unacceptable in both instances:

'I, I had to keep them up with a belt, because (mm) you know the smallest size they still slip off me (mm), so he made some comment that, you even need a belt to keep your trousers up and was quite rude the fact that I wasn't

(ohh)…bigger (right)…and I thought well, actually I'm the heaviest I have been for a while [laughs]'

'this girl kept saying oh you're so slim you know to wear that! [smiles] I never see meself as that at all (yeah)…and I find that quite a shock when somebody says that (mhm)…to me, cause I regard myself as twice the size I am…(yeah) so when somebody actually says oh you're so slim thinking, but I'm not…'

Her sense of her body's acceptability and her ability to conform to these standards seems to echo her experience of the body having a heightened vulnerability, as if the body, the self, is *unestablished*, a sense of being inherently *inadequate.* In contrast, Poppy describes wanting to reject this acceptability standard - 'I would just love to let go and think…it doesn't matter cause nobody actually notices…what anybody really looks like' - an expression of her insight, a glimpse of the nuanced ontological puzzle in which her aliveness seems to be both *held back* by her, and *pushed back* by the world.

Unacceptability existed in the context of Poppy's physical presentation within the world, her 'looks', where fatness and ugliness was also indicative of *lack of control,* a source of *shamefulness*, including not only the perception of fatness and ugliness by herself and/or others, but the *possibility* of these attributes. This state in which fatness and unacceptability is a possibility feels *intolerable* to her, but also *inescapable* and very present in many aspects of her lifeworld, most prominently as part of her embodiment but also her relationships, temporality and identity:

'it's how I am, it's ridiculous isn't isn't it cause I might get fat…'

'I think that I wrote it down the phrase that you used you said you were the, you said oh I was the fat ugly clever twin (yeah), and she was the skinny thick twin
Poppy: That's what my father called us.'

'I used the food as a kind of, I've always been conscious about me body weight, I always think I'm fat (mm), now I think I'm grossly overweight (mm), I always watch everything I eat (mhm), every meal...I can't have that extra bit I don't put that in (yeah), you know, and I see, myself as being fat...'

'which again reinforces that voice if you're too fat you can't do that and get control and...(yeah, so that's) and then if I'm thin I'm in control if I'm fat I'm losing control.'

There are shared aspects between this inescapable, *unbearable* state and the sense of *untetheredness*, or *baselessness* experienced by Poppy, in the midst of which she attaches herself to an ontological anchor. However this anchor is not experienced as being safe or sheltered from the possibility of fatness and unacceptability - the sense of exposure, being vulnerable to this possibility remains, and she does not disclose any recognisable felt sense of stability, security or *homeness* within her lifeworld. Does the possibility of escape to a safe base exist, and if so, what, or where, is it for Poppy? Is it understood solely in relation to its ontological 'distance' from fatness, loss of control and shame?

Dialectically tied to the meanings of fatness was thinness, which was experientially characterised as control, reassurance, increased certainty and stability, yet still imbued with a felt sense of fear of any amount of deviation, both away from thinness and towards fatness. The feeling of being existentially exposed

and afraid, characterised by the same feeling of panic and urgency seen in relation to the tightrope, is not eliminated by thinness, but becomes tolerable, manageable for Poppy. Thinness is not a safe, homely place for her, but it is experienced as more *hospitable* than being not-thin, a *way of being* which brings congruence to other distressing existential conflicts and consequences, which are subsequently quietened, kept at bay. There are interruptions to this safer, *retreated* state, most often in the form of observations and judgments made by others, both those who are close and those who are strangers:

> *'I was coming home, one lad…you know how awful boys are, they got off the school bus boys upstairs with the girls downstairs (oh, okay), and he's said oh tree trunks legs next to your sister, or something when we were out somewhere, and that was it (mm), so then I was only about, twelve thirteen I reme-, I had a boyfriend at that time (mm), and I cut out all carbohydrate which in those days, (mm) sort of late sixties, was really ah, nobody knew about carbohydrates (yeah) and things…'*
>
> *'Coupled with my dad calling me that I think.'*

These 'challenges' which interrupt Poppy's lifeworld, in the context of her being in a place she has retreated to for refuge and respite, can be characterised as *penetrating*, *threatening* and *invasive* - they challenge the implicit structure of her lifeworld, an epistemological and ontological *intrusion*. There is a similar sense of existential *illegitimacy*, a lacking of *integrity*, in both Paul and Poppy's accounts, but this is felt much more prominently in Poppy's descriptions.

2. Not being 'at home' or 'settled in' to the body

Universal

The body is not a place that feels *like home* and has a sense of being *unfamiliar*, *insecure* and something which access to is *elusive,* or *ungraspable*. The felt sense of the body is hollow, lacking, where it cannot be distinguished between whether the body is not *viscerally present*, or if there is instead an inability to fully feel the body's sensations - it may be only one, or both. Simultaneously, the body as object is characterised by a sense of *insecurity*, a *lack of valid space* within the world where it is similarly not a place that feels *like home* to the body where it can *settle in* - an existential *trespasser,* an *unwelcome guest*. The perspective of the body as object within the world is more prominent within their descriptions than the body as subject, to differing degrees.

Paul

There is a disconnection from his 'inner' body, and body-as-subject, characterised by a sense of its 'thing-ness' - 'always sort of get…er, a bad feeling in me stomach, mostly', 'I'm struggling I've got a big lump in me stomach'. Within the context of his anxieties of being able to digest, this 'lump', or 'bad feeling', is experienced as something unknown to Paul, something uncanny and elusive, but viscerally felt within his body and which poses a threat to his bodily integrity. In a variation of this feature, Paul also describes a kind of *self-removed awareness* of the process of chewing, whether to chew and how it is physically undertaken, but also as the intentional precursor to swallowing and digestion:

'*Do you chew it or do you just swallow it*'

'*but if I start chewing it…err, I-I get to be that I don't think I can swallow it*'

In this variation, Paul describes his feelings of confusion, his inability to *insert himself into* his embodied experience as a *subject*. In this instance, the feeling of disconnection becomes more apparent to him in his attempts to feel *connection* to his inner body, leaving him bewildered, inhabiting what feels like an *in-between space*.

Paul's sense of embodiment in relation to eating is described as *odd*, *confusing*, perhaps something not immediately apparent to him and which he is curious about, it is a *puzzle*. Both the act of eating, in terms of chewing and digestion, and the act of eating as it is viewed by others, has an almost *unnatural* quality to it, a sense of it being somehow nonsensical or cryptic:

> '*I once read in an article somewhere it said…you had to eat deliberately…(right)…that sort of confused me so I…(mm)…so I'm still bloody confused about it*'

> '*You'd get so confused you don't know whether you're hungry or not*'

> '*Do you chew it or do you just swallow it*'

The overall mood of eating, for Paul, is one of *peculiarity* - this seems to waver between, or be blended with two ontological layers: peculiarity about the physical action of eating itself, and peculiarity relating to his self-awareness and the fact that he finds eating peculiar at all. As was outlined in the delineations of the first essential feature for Paul, specifically what seemed to be a 'self-removed awareness' of his body, this 'in-between space', a peculiarity in which his body is not *felt,* is an ontological space.

There were times in the past that Paul ate enjoyable 'proper' meals and he felt alive, nourished and experienced a lightness of mood, something he recalls vividly and is characterised by a felt sense of being *supported* or *lifted,* in some way *restored from a state of lacking:*

> *'…and I'd found out that I was in a good mood, if I'd had a real enjoyable meal…(Yeah). So I tried to eat, like, properly to be in a good mood…(Mhmm). That's how it started and I remember it vividly…(Okay). So you start to eat…to try to get in to one of these moods and it eventually…gets to the bloody stage when you can't eat (Mmm).'*

> *'That's what started it (mm)…I-I…as I said before I think in your teens boys and girls, get very moody and that and I was very…err, I don't know…very, depressed and that (mm)…and I noticed…sometimes I was in a real good mood, and I noticed that I was in a good mood because I'd had a nice meal…(mhm)…so I, stupidly thought if I eat prop-, a nice meal I'll be in a good mood (mm)…and it, went from there (yeah)…'*

> *'I can't remember what I had, no…but I remember I had a, a very enjoyable meal (mm) and I felt good'*

His description of the vividness of the memory relates to its visceral quality, as if Paul feels more present within the experience in an embodied way. There is a sense of elation, warmth and an almost dream-like feeling, and I can see Paul dancing, surrounded by people and music, like a suspended moment which is buoyant. In relation to the proper meal he had eaten earlier in the night, this is something *settled* within him, *anchoring* him within this feeling of enjoyment and

celebration which is carrying him along. Has the enjoyment of his meal welled up and 'overflowed' into the rest of his evening? Into him and his lifeworld? Through his attempts to repeat and recreate these feelings and mood, they were fleeting, changed in their felt sense as if fading over time. This enjoyment and fulfilment slipped beyond him as he has tried to chase them, until he became stuck in his state of sadness and lacking, *inert*, where food no longer lifts him in the way it once did, 'and eventually…gets to the stage when you can't eat'.

Poppy

In contrast to the sense of being muted or frozen, her experiences overall appear to be lacking in bodily sensations, as if they are elusive or out of reach, characterised by confusion, unawareness, and there is little mentioned of their presence throughout Poppy's lifeworld. Is this because her bodily felt sense is numb or absent? Or is she unable to access her bodily felt sense because her vitality and aliveness is being held back?

> *'…was wrong because I wasn't hungry…(right okay)…and it was wrong because…you shouldn't eat unless you're hungry…(okay…so if you'd) so it was…(yeah, so) but a lot of people could eat it anyway.'*

> *'Well I wouldn't…have breakfast today cause I've pigged myself all last week, (yeah) but I can still fit into me trousers so I can't have done, so, today…wouldn't dream of having breakfast I need to get back on the…sort of, strictness again (mhm), and I'll probably have very little lunch and very little tea (yeah)…to sort of, get back in control again.'*

Hunger and appetite are more prominently characterised as *temporal* or *identity-related* aspects of her lifeworld, and there is a deliberate process of *weighing-up* what she has or hasn't eaten, or what exercise she has done or is yet to do, as a more removed, intellectual action than a response to her bodily sensations. There is a similarity with the *holding back* of her aliveness, her emotions, that her hunger is there, but somehow not at the forefront of her experience:

> *'Sarah: I was, I was gonna ask you like do you wake up and feel hungry, on the days that you don't...eat breakfast?*
> *Poppy: Oh yeah. I could have had breakfast this morning but I had an [inaudible] for a start I haven't had chance (mm), but after all I ate last week I thought no...'*

The body is not completely absent, but *elusive,* instead casting a kind of ontological shadow within her lifeworld, giving an indication of its presence from wherever it is being pushed or held. When I felt this elusiveness in Poppy's lifeworld, I visualised the shadow not as a shadow cast on the floor or a wall, but as a silhouette seen through the glass panel of a door, like a figure waiting at the door for it to be opened - a body 'knocking at the door to come in'.

Poppy's descriptions of her fearful experiences, most prominently those in childhood, disclosed a sense of the body being an unsafe realm, a place in which she was vulnerable to pain, distress and injury - it was *risky* being in her body. Similar to the felt sense of 'heightened vulnerability', or diminished integrity outlined in the first essential feature, this variant of the second essential feature is instead understood in terms of spatiality, as it relates to embodiment, within Poppy's lifeworld. Similarly to the feeling of not being at home within the body alongside the 'double layer' of the body not being at home in the world, this sense

of 'homeness' is closely phenomenally related to a sense of 'safety' and has this same doubling - she does not feel safe and secure within her body, and her body does not feel safe and secure within the world. This aspect of her experience is amplified during a period of illness where she had tonsillitis and she was sent up to bed to recover:

> *'I just used to sit upstairs in bed away from them (yeah)…it was safer (yeah), I felt awful up there'*

Despite being on her own in her room whilst suffering with 'an awful sore throat, head and, high temperature and headache', Poppy states explicitly that 'it was safer' to be in her bed alone, despite this solitude being 'awful' - being ill and suffering in this moment seems to create a feeling of being conflicted, having two desires or needs that appear to be incompatible - the need for the safety that being alone brings, and the need for comfort and nurturing. This incompatibility feels *wrenching*, as if she is *churned up,* and there is a sense of her having no option she can take, yet a sense of urgency to seek a resolution to this emotional turmoil between *safety* and *soothing*.

Another instance in which Poppy reveals the felt sense of her body is in her description of judgements or evaluations around her bodily needs, for example on some occasions when she feels hunger. Despite the body being elusive and partly absent within this experience - a 'silhouette at the door' - its presence is apparent to her, and is met with a kind of partially detached judgement. She talks about what she 'does with herself', which gives a sense of an ontological double-layering of the self as subject and object:

…'so it is so the other thing you do is control what you do with yourself really (yeah, yeah)…and punish yourself probably (mm), because you are that horrible person, so if you do feel hungry you deserve to feel hungry'

Her description of this 'punishment', which may be 'deserved', is not only felt as a judgement made by her upon herself, but also a sense of the judgement made *by the world* - it is instead manifested within her lifeworld by her, the ever-present observer. The experience of hunger and Poppy's response to it feels as if it is characterised by *failure*, as is she is forced to *give in* to an undeniable truth, an existential deficit for which *she must atone*. Her hunger and her self, the intended recipient of the punishment, are viscerally felt in one ontological space - phenomenologically constituting the body which she *is* - and in this moment the body feels paradoxically both present and absent as subject, and as object within the world.

One moment Poppy describes is a delineation that creates a contrast with the feeling of unsafeness and vulnerability of her body, both in itself and within the world, is learning to ride her bike, 'that freedom' - there is a sense of joy and mastery of the self and the body's capability, which is exhilarating, satisfying - it *swells* into the world energetically. There is still a sense of vulnerability present, but this is an *aliveness* rather than the anticipation of possible injury or distress. It is as if the riskiness is experienced again, but instead with a different phenomenal hue - perhaps as if it is being experienced in a *major* rather than a *minor* key:

'Poppy: Yeah, (yeah) just kept pushing and I remember getting splinters in my hands and I was determined to get off on this bike…and I did it [smiles]
[Sarah laughs]
[Both laugh together]

Sarah: Yeah…that's amazing isn't it?

Poppy: [laughing] Yeah it's funny the things you remember, that freedom.'

I can see Poppy outside in the fresh air, her feet keeping her steady and repeatedly launching her forward along the ground with her bike, her sore palms gripping the handlebars tightly, and she is determined. This memory has a vividness, similar to Paul's memory of going the dance, in that it brings with it a visceral quality, the same sense of elation that I feel from my abdomen, radiating outwards into my limbs, up along my back - as I imagine her feet pushing her along, I can feel the concrete of the pavement under the soles of my feet as she builds energy, *velocity*. In this experience, her body is not only more present, more felt, it is fundamental. Is this instance of joyful mastery within Poppy's lifeworld as exceptional as it appears? It is as if through this mastery, her vitality and aliveness is not being held back, and she is not only able to access it, but it is a quiet uprising, a celebration.

3. Eating and food used to create a separation from the world, or a 'space'

Universal

The act of eating appears to be a doorway, or an instrument through which the self and world interact, with the possibility of each one connecting with, and affecting the other. This interaction is characterised by an increased risk which relates to existential vulnerability, and there is a temporal sense of *disquiet*, or *dread* which relates to mealtimes, their inevitability and consistent recurrence. Within this dynamic ontological space between the self and world, there is a specific interpersonal layer which is indicative of the *communal phenomenology* of food - the experience of eating extends beyond the phenomenal experience of the subject to encompass the presence of the perceived Other. Although Paul and

Poppy have different experiences of eating, they are similar in that they are trying to create a sense of stable ground, a *place* in the world (as opposed to a sense of *dislocation*), using food.

Paul

By removing himself from the presence of others, Paul found respite from the difficult experience of eating. Eating alone is described as *quieting* or *calming*, blended with a sense of *failure* or 'falling short' and sadness about this - having a place in which to retreat and withdraw from uncomfortable encounters with food, and especially the feeling of exposure he described when being around, or watched by, other people:

> *'I mean I was in hospital once with something and, they came, me youngest came to vi-, well they all came to visit me (mm). When he came an-and they'd brought the meals, they obviously didn't know because he kept saying to me eat yer dinner dad! (mm) But I wouldn't, not (yeah) when they're there…'*

> *'Well my wife I told you before, tried to get me to eat with them (mm) but I wouldn't I, well I tried, I did try (mm) but I got into hell of a state…(mm) and I used to go into one of the other rooms, eat on me own, and…then I was alright'*

His experience of eating with others is both simultaneously difficult and enjoyable - 'I've never enjoyed a Christmas dinner, er, in me life I don't think (mm…yeah)…and we've had some wonderful dinners (mm)…but I can't enjoy it, when there's a crowd of them there…' - and there is no explicit separation of the dual aspects of the experience. The *relief* and *disappointment* are overlaid, bleed into one another in the

moment and they are described by Paul as a kind of 'bittersweet' phenomenon. There is also an element of absurdity, the exclamation of his 'stupidity' bursting out in his descriptions, as well as a feeling of gladness or joy at his defiance.

Poppy

With food and eating, Poppy describes being able to 'control that little inner me by…blocking out the rest of the world', as if she is feeling *crowded,* or *smothered* by the world, which is trying to affect her, *push her*. In that moment of blocking out the world through food, there is a sense of c*larity* in relation to her bodily self, a feeling of *respite* and *quietness*, a state of *intimacy* with this 'little inner me' which is precious, and fragile, but at the same time this is tied up with anxiety. At the moment Poppy used this phrase, it resonated so strongly with what I felt was my own little inner me, my human vulnerability which is deeply hidden away, and I felt a connected, empathic encounter with Poppy. It is as if the world and the Other have become overpowering, a *domineering* presence within her lifeworld by which her aliveness, her self, is *compromised:*

> *'Day to day, I think I do it all the time…you know, what was that something happened and I thought, that's it I'm not having that…ermm, did something happen on the ship and I thought…[pauses] right I'm not having dessert then, (right) and it was almost, cause I was cross about something…annd I forget what it was actually…[pause] and I thought…right I'm not having that'*

Throughout her descriptions, meals were anticipated by Poppy with *anxiety* and *nervous energy*, and this energy was present almost consistently throughout her day with minimal respite. Unlike Paul, who was able to create an ontological 'space' for himself to manage his difficult experiences with food and find relief, no such space seemed present for Poppy, as if food dominated her lifeworld,

enveloping her, *tyrannising* her. This consistent pressure felt like a *heavy, suffocating presence* which encroached on all other aspects of her life and self, leaving her nowhere to retreat to. Imagining this constant shadow cast over Poppy's lifeworld, knowing it would remain present with no end in sight, gave me a feeling of *tiredness*, complete *exasperation* at the prospect of having to endure it. Feeling into this experience, I am drawn to Poppy's previous description of having to stay in control otherwise she would 'start crying and never stop', and I get this same sense of futility, of constant pressure. It is as if she is carrying a mountain which is buckling her legs with every step, but the only alternative is to give in and finally be crushed under its weight.

4. Food and eating are a battle, struggle or challenge, 'a knife edge'

Universal

Food and eating, particularly mealtimes, are experienced with a feeling of disorder and conflict for which Paul and Poppy must prepare, brace themselves - they anticipate that facing this will be a 'battle' or 'struggle', something which will threaten them at an existential level or result in annihilation, perhaps of the embodied self. In the midst of this threatening dilemma, this 'knife edge', there is a motivation to find some kind of shelter - either certainty about how to withstand its destructive energy, or a place which it is unable to reach.

Paul

Whilst eating, whether alone or with others, he refers to his attempt to slow down so as to remain more attentive, established, not to 'lose grip', which happens within the context of the precariousness he feels. He describes how 'I've sort of got to concentrate when I'm eating', as if his awareness is narrowed to the task at hand, to the food and his body. He reduces his immediate lifeworld, shrinks it

down so that it is only him and the food, *the meal at hand*, which has a sense of Paul *absorbing himself* in it. Could this be Paul *holding himself back* from the world, pulling back or retreating from the ordeal? Similarly, this slowing down is present in his description of strangeness and confusion when he eats - as a subject *who is aware of itself eating*, but also as an object *aware of being seen eating by the Other*. In withdrawing from the world, reducing himself so as to become absorbed, it is as if his absence from the world becomes more noticeable to himself and the Other, heightening a sense of *detachment*, or *unconnectedness*. He is exposed and not entirely *in the world*.

When Paul describes eating at home, as he does now, and wanting to lock the door, this felt as a kind of *satisfying misdeed*, a small *triumph:* 'Oh hell, definitely (yeah)…I'd prefer to lock the door and…not anybody in (mm)…[smiles]'. This satisfaction about the imagined victory of shutting out the world was a glimmer of energy, *vitality*, which was starkly contrasted with the more usual dulled, diminished characterisation of his embodied self within his lifeworld. In seeking the separation that he needs to endure his encounter with food, he has to face the unavoidable detachment from others, but the relief he achieves through this is a worthwhile goal. He has found a place that the disorder and conflict is not able to reach, and in achieving this, he seems accomplished and defiant.

Poppy

In relation to the universal features, one of the dominant aspects of Poppy's lifeworld is that food and eating are characterised by her being on a tightrope, where rules around food and repression of appetite give her a sense of stability and certainty in the midst of anxiety. The risk of falling from the tightrope feels as if it is imminent, the sense of existential precariousness characterised by *urgency*, *panic,* that the consequences would be devastating. Within this context,

achieving certainty and security through what she eats eases the anxiety about falling from the tightrope, but there are also feelings of additional anxiety around having her 'coping' strategies, her ability to balance, being removed:

> *'Poppy: Yeah, well since, I've had me foot operation I used to run every day you see (okay), I'd run twenty miles…(gosh) but since my foot operation, and that's what's getting me now because I'd run to keep me weight down, and I can't run (okay), so I think I'm really fat and it's been a, since June it's been…*
> *Sarah: Right…I was gonna ask how, do you feel, differently like now that you're in this situation…*
> *Poppy: Yes very anxious Sarah! [laughs]*
> *Sarah: Okay [smiles] okay…*
> *Poppy: No, since June (yeah) I feel very anxious I haven't got that control to…(right) you know eat a bit more and not worry (yeah), cause I could run, the next day, fifteen miles and it wouldn't matter…(yeah) but I can't do that now [smiles]'*

In a contradictory way, the 'tightrope', as an ontological metaphor, is both the thing which creates the instability, a manifestation of her existential precariousness, and the tool which she uses to *keep a grip* on the sense of stability and certainty. Her tightrope is an *anchor* to which she can attach in the midst of feeling *untethered,* or *baseless*.

5. Age gives perspective on past experiences, but the illness is ingrained and absurd
Universal

Both Paul and Poppy describe their eating disorders as being established within their lifeworlds, that they have become so deeply settled and 'rooted' they are almost *unchallengeable*, with a sense of *permanence*. The realisation of how

absurd this seems, a sense of ridiculousness at the fact they have issues with food and eating that are so *unmoveable,* and that this realisation is not enough for the issues to be overcome. Their ages provide them with many years' experience of their eating disorders and a sense of wisdom about them, but at the same time their inability to change is almost unbelievable, *unfathomable*. How can they have such in depth understanding yet be so 'in the dark'?

Paul

For Paul, within the context of the bittersweetness he experiences in finding a place out of reach from his eating disorder, he acknowledges to me, and himself, how ridiculous this is. He describes how 'I could eat in a blumming corner…stupid!'. His voice increases in pitch and volume each time, almost like pressure escaping, and it is comical. Paul raises his eyebrows and we both smile. Going and sitting in a corner to eat is *ridiculous*, absurd and has a felt sense of shame, something I empathised with and shared in that moment with Paul, and there was a small sense of relief, a brief *lightness* within our encounter. He repeats the phrase, 'stupid, int it!' on a number of occasions, each time with the same comical exasperation, and I sense that this response has become more frequent, and more absurd for Paul over the years. Although there is a brief respite in this absurdity, it is at the same time deeply sad that this is part of his lifeworld, and this is felt as a very gentle *grief for his possibilities*, or *wounding acceptance* - 'I shall never change'.

Poppy

Within Poppy's lifeworld, there is an increased sense of the *permanence* of her eating disorder and at times it feels phenomenally inseparable from other experiences which have caused her distress or pain. Her acceptance of its unmoveable nature is *matter of fact:*

'But erm but I think once it's there it's there (mm)…really (mm)…and I think most folk have…had any sort of eating disorder will always say this do you find they say the same? (mm) That it never really goes? (yeah)
Sooo…[whispers] there we go.'

Her age and the duration of her problems with food are stated explicitly, 'I'm sixty!…(mm)…Isn't it crazy?', and to hear this out loud is jarring, and there is a moment of embarrassment for me in hearing those words from her, yet I do not sense this in her. Is the embarrassment or shame not there for Poppy, or is it deeply *buried away*, held at arms' length because it is too much for her? There is a comical aspect to her descriptions which is less absurd than Paul. When stating how 'crazy' her behaviours are within the context of eating and exercise, I asked Poppy what would happen if she did as she suggested and 'let it all go'?:

'Dunno…probably have a heart attack through stress and die! ([Sarah laughs])
[both laugh together]'

In sharing this laughter with Poppy, I was able to glimpse the impossible absurdity that her eating disorder created within her lifeworld, an inconceivable impasse, entwined with her mortality. This moment between us had a sense of both immediacy, and timelessness, and was at its heart, the laying bare of our human selves.

CHAPTER 5: DISCUSSION

Introduction

Following the data analysis, a number of comparisons can be made with the original literature reviewed in Chapter 1. As the literature review is a conceptual one about the different assessments of what eating disorders are, as an ontological question, then the retrospective discussion undertaken here will reflect this. An evaluation will be performed with reference to original philosophical sources, followed by a review of the concepts from the literature to identify any similarities or contrasts with the concepts found within the interview data. This should provide a substantive overview of the phenomena and how it is positioned within current understandings. The final section of the discussion will focus on the methodology of the existential phenomenological project, specifically the anticipated outcomes from chapter 2, section 1, and an evaluation of the method is presented. Conclusions drawn from the project overall will be outlined in the final chapter, along with further possible directions for research which will be identified.

Section 5.1: Philosophical literature

Eating disorders as a problem of being

There are a number of studies which take an existential perspective on eating disorders, including many that use a phenomenological method (Fox & Leung, 2009; Lejonclou & Trondalen, 2009), but I wasn't able to identify any qualitative studies which provide an *ontological* reflection and analysis of the phenomena itself. Nevertheless there are a few personal accounts, most notably that of MacLeod and her own experience of an eating disorder, which does give a phenomenological account and strikes a chord with the problem of being that arose in the data. MacLeod states that an individual with an eating disorder is

'someone who doesn't know how to live except by non-eating' (1981: 182), with another description of bulimic patients by Dana and Lawrence stating the individual fantasises about 'the day when she will be truly loved' as this will resolve her bulimia once and for all (1988: 51). These two aspects of the lived experience of an eating disorder, *not knowing how to live* and *wanting to be loved* show similarities with what was revealed in both Paul and Poppy's respective lifeworlds. The need to be 'truly loved' can be viewed in this example not as a romantic desire, or the desire for a particular kind of love - it is the *need* for security, validation and acceptance by others, and the world.

Forming secure love and attachment is a basic physiological requirement for survival, rather than a desire, and Poppy makes reference to Bowlby's attachment theory (1988) herself within the data - 'so never had that attachment like the Bowlby you know with the mother…(yeah), annnd, erm…that's how it starts'. She also states matter-of-factly, at the most affecting point of our encounter, when with her mum in hospital when she died, and there was an overwhelming sense of *grief* at her not having that with her - 'but I actually said that to her…all I ever wanted to do was to love you and you just didn't let me…bless her…'. This sense of grief in that moment was characterised by *loss*, *despair* and *existential pain*. The concept of there being a lack of love ties directly to the issue of not knowing how to live, or *be,* because it could suggest our ontology is shaped or boundaried by certain kinds of experiences. When considering that more recent conceptualisations of attachment identify how attachment affects our sense of self, sense of the world and sense of others (Ainsworth et. al., 1978; Bowlby 1988), the way in which this relates to existential phenomenological approaches becomes apparent. This raises a number of questions about eating disorders as a 'way of being', such as how this lack of love impacts on being, and how it presents within the lifeworld. It also demonstrates

the importance of this concept within the phenomena, in addition to supporting the validity and accuracy of the data through the way they fit with MacLeod's own lived experience.

A lack of an ontological space/opening

What has become apparent through the data is that Paul and Poppy are trying to answer their problem of being with the only ways of being they know, through their experiences, and unless they inhabit a new way of being, their problems with food will continue. Paul's experience is experientially cerebral, as if he is looking for a solution or *answer* to his ontological predicament within the same disconnected 'in-between' in which he is suspended. Interestingly, this idea of ontological boundaries and *finding space* is demonstrative of the horizons of consciousness seen in the phenomenological texts examined in the Methodology (Chapter 2), notably Merleau-Ponty's description of them being 'a new type of being, a being by porosity, pregnancy, or generality' (1964/1992: 148-149). As beings that are connected to the world and others within an ambiguous reality, which is in flux, we form and are part of the same 'flesh' we find ourselves within, and for Poppy and Paul this may be the underlying 'problem' to which they are trying to find a solution. Ratcliffe gives the example that when looking at a knife, you can *see* its sharpness and ability to injure you, but 'the senses are intermingled in so far as actualities for one sense are presented alongside possibilities for that sense and for other senses' (2008: 131). These horizons represent *possibilities* and *potentialities,* which from the perspective of someone who cannot tolerate ambiguities can understandably be anxiety-inducing - for example they would be a challenge to Poppy's lack of autonomy and existential affectiveness, a gust of wind whilst on her tightrope. Ratcliffe also talks about the ways in which existential feelings like these can be 'characterized by a passivity before potential

happenings…the world becomes an oppressive possibility space over which one has no influence, before which one is helpless' (2008: 136). In terms of the 'lack of control' which is very commonly understood to be the overall feeling of people with eating disorders, understanding this as an existential feeling that characterises the world is a helpful way in which to frame the phenomenon.

Searching for an 'ontological space'

Existing within a limited ontological space and apprehending its horizons, a situation that gives rise to anxiety, results in both Poppy and Paul attempting to resolve this distress, within the possibilities of what is available to them. The self, the world and the other, existing as the flesh/chiasm, are phenomenally intertwined in a way that they co-constitute one another, and the boundaries of each are not distinct or able to be defined in a fixed or certain way. Within this context, food takes on an *instrumental* role - as something that can be used as a vehicle for gaining control and autonomy. As Warin identified in her ethnographic phenomenological study of anorexia, food was seen by her participants as a 'substance which connected them with objects and other people' (2003: 89). This is also strongly interwoven with the experience of anxiety, discussed in the following sections of this chapter, and the way in which we inhabit bodies within the world.

Food, then, becomes phenomenologically intriguing in that it has a very particular position within reality - it is not solely part of the world, but also can *become part of the body* when it is ingested. In *Phenomenology of Perception*, Merleau-Ponty dedicates separate chapters to different aspects of the body's problematic constitution: 'The Body as a Sexed being', and 'The Body as Expression and Speech' (1945/2014). Our hunger and drive to eat is something as essential to human reality as sex and expression, and it is the most basic and literal

form of sustenance required for our bodies to exist at all. Perhaps the drive to eat and nourish oneself is taken to be such an inevitable function for us to perform, that it is viewed more as a kind of reflex, a function of the body. But eating disorders challenge this assumption, and subsequently the view of eating as a 'given' illuminates another aspect of the body's constitution that is problematic.

Existential distress and shame

Another theme present within the data which can be compared to the philosophical literature are the experiences of shame and existential distress, which were seen in both Poppy and Paul's data in varying ways. For Paul, his way of being was largely defined by his being born out of wedlock, as if other people could intuit his illegitimacy simply by observing him, or by him being present to their gaze. This fits with the view proposed by Sartre, that 'my shame is a confession' (1943/1996: 261) because shame can only be felt through the recognition of the Other, to be seen as what one *is* - 'To apprehend myself as seen is, in fact, to apprehend myself as seen *in the world* and from the standpoint of the world' (1943/1996: 263). Paul's illegitimacy is how the world sees him, and he experiences shame when apprehended by the Other's gaze, and he cannot deny that he is not the one being seen, therefore his being is *confessed* as such. It is not the Other who defines, or 'carves out' Paul's being in the midst of the world, instead it 'comes to search for me at the heart of my situation' (1943/1996: 263). It is Paul's view of himself, as he would be viewed by the Other, which in turn constitutes part of his being, and this is the nature of his *recognition.* Paul describes the possibility of being seen eating as 'terrible' and that he would be in 'hell of a state', something terrifying and anxiety-inducing for him to anticipate, and which as a result comes to the forefront during mealtimes.

The felt sense of anxiety - an existential feeling

One of the main concepts from the data that relates to the existential phenomenological literature is the felt sense of anxiety by both Poppy and Paul, and from a philosophical perspective it is indicative of a very typical aspect of human reality. Van den Berg outlines this in his reflections on illness and existentialism in 'The Psychology of the Sick Bed', where he suggests 'it is certainly not just a coincidence that in our time so much is being thought and written about anxiety and dread' (1972: 49-50). Paul describes a hard feeling in his stomach, which confuses and puzzles him, similar to what Gadamer describes as 'an oppressive sense of constriction, with sudden exposure to the vastness and strangeness of the world' (2004: 153). The feeling of anxiety is as if *we feel the world in ourselves*. It is a shift in the balance of our awareness, pulling us away from our actions as affective - our bodily awareness takes over, despite our actions continuing (Leder, 1990) something seen in Paul's experience of eating being 'a struggle'. The sense of anxiety for Poppy was much more intense, more constricted and a feeling of being right *on the edge* of something which was overbearing - the description of being on a tightrope not only demonstrated her being precariously balanced between two conflicting sides, it was almost as if she was holding her breath whilst on the tightrope, and this was the feeling of anxiety - *bated breath*:

> 'I discover my hands becoming clammy, my voice beginning to crack…Try as I might to focus on my talk, my attention is pulled back to these physical manifestations…This anxiety is undoubtedly mine, but is also something from without, fighting my efforts at mastery.' (Leder, 1990: 84-85)

Anxiety and increased bodily awareness is not only the cause of this 'pulling' that Leder describes, it also results from it - it is a bidirectional force which, like our own existence in the world, 'both constitutes us and is constituted by us' (2011, Finlay: 54). When faced with this rising up of anxiety, provoked by food and eating, being able to 'conquer' food and eating to find a solution to the problem of anxiety and existential distress becomes the goal.

This existential feeling of anxiety in which we *feel the world in ourselves* not only characterises the experience itself, but has a fascinating new meaning when we look again at the 'in-between' phenomenological position of food. Just as food is something which 'crosses' a phenomenological boundary from the world to the body, when it is eaten and imbibed, the felt sense of anxiety is experienced within the body as if *it has been flooded, engulfed or filled up by the world*. It is not just inside us as if we are a vessel, but it is taken into ourselves and the feeling is *present* within our body, our flesh, our *being*. Svenaeus rightly identifies that food inhabits a liminal space between the self and world, stating that 'food is the major foreign thing that enters into your body: if you control food you will also be able to control the body, make it more of your own, so to speak' (2013: 87). What is in contrast to the research data is that Paul and Poppy do not need to control the body, or self, exclusively (such as when Poppy describes wanting to hold back the 'little inner me'), but there is simultaneously a need to control *the world*. Phenomenologically speaking, there isn't a distinct ontological separation between self, world, other and body, and with this in mind, the 'in-between' nature of food is exemplified in Svenaeus' argument.

Our bodies are the physical, material place in which felt sense exists, 'the organ of anxiety' (Trigg, 2016: 67). Merleau-Ponty's being 'of two leaves' can be seen here, and there is similarly a link to Zaner's 'body uncanny' which he describes as a body of 'inescapability' (1981: 50). For Poppy in particular, the body

is indeed something from which there is no escape, no respite, but it is not wholly unfamiliar or viewed as something separate, or 'thing-like'. It is rather experienced with this sense of *uncanniness* – what Zaner succinctly describes as being both 'intimately alien, strangely mine' (1981: 54), a paradoxical sense of the *intimately familiar* and the *unnervingly alterior*. Freud's interpretation of 'the uncanny' invokes more of a sense of 'creeping horror', or dread, something 'hidden but has come to light' (1955: 241), and this seems to suggest a more dramatic, or energetic response at the moment it is experienced. This relates to the felt sense of anxiety, perhaps a mild sense of panic, raised heart rate, the sensation of galloping thoughts within the head, and the stomach. At the same time, there is something about the experience for both participants which is completely mundane, everyday, which in fact gives this uncanniness of the body a more lingering, infused presence within their lifeworlds.

In terms of how this relates back to food and eating, Paul and Poppy each have, in their own way, a sense of feeling the world in themselves, an uncanny body from which they are unable to escape, at the same time as feeling food as being 'taken into themselves', and it is similarly inescapable, for the sheer fact of survival alone. In his phenomenology of anxiety, Trigg gives an account of this which demonstrates the failing of the medical model of eating disorders, in this respect:

> 'Uncanniness is not an accident of bodily existence nor is it an affect peculiar to certain psychopathologies. Rather, we find it as a permanent structure of self-consciousness, which is never eliminated, except through the procedure of concealment' (Trigg, 2016).

This 'concealment', or in some cases 'evasion', appears to be the function that an eating disorder serves within the experience of anxiety for Paul and Poppy. Food begins as something which appears to offer relief from feelings of anxiety and distress, but which eventually perpetuate this anxiety by reinforcing the paradoxical 'inescapability' of the body. Is the mundane experience of uncanniness indicative of a general existential 'sensitivity'? Both participants describe themselves as 'sensitive', or 'moody', and this may account for their being attuned to the uncanniness that characterises this aspect of human embodiment which is 'a permanent structure of self-consciousness'. If this sensitivity is a mode of being for Paul and Poppy, then this may give some insight into the development of their eating disorders.

Section 5.2: Discussing the data in relation to the conceptual literature review

Biomedical/Medical model

The data about Poppy's lifeworld reveals many indications of her mental ill health and emotional wellbeing, but she states that she wasn't treated for an eating disorder until making contact with a local eating disorder charity who supported her to re-engage with mental health services. Despite being hospitalised for her mental health, when she was under the care of psychological services, as both inpatient and outpatient, she was never informed of an eating disorder diagnosis. If she had been diagnosed unknowingly, she did not receive any treatment. This suggests, as outlined by Dana and Lawrence, an instance where lack in specialisation by mental health professionals has resulted in a missed opportunity for diagnosis (2012: 406). Poppy was 'below the radar' of mental health services when her restrictive eating disorder began in her teenage and young adult years, but it is likely due to less advanced psychiatric knowledge in the 1970s, as well as the social and cultural stigma of the time. However even

when Poppy was in her 50s, only a decade ago, she was hospitalised for her mental health and wasn't diagnosed with an eating disorder from her clinical presentation at that time. She did describe an occasion three years ago when she remembers 'going to see, the GP and, I was about six stone, and I told her about it, and she said [abruptly] well you're anorexic aren't you? She said I can't do anything about it I can't give you the drinks cause you won't drink them'. With such generalised measurements being used indicators for the specific illnesses, such as eating disorders, this either demonstrates an issue with the specialisation of services, or an epistemological issue with the symptomatology of eating disorders. It also demonstrates a terrible failing in the clinical assessment of eating disorders where they are diagnosed but treatment is not offered, something which relates to the idea of them being deeply entrenched and resistant to treatment.

Returning to the point made by Robertson about medical labels being meaningful to medical professionals, rather than sufferers, the interview data demonstrates that Poppy's symptoms and behaviours were not necessarily 'unreasonable and inexplicable' (1992: xiv). Throughout the interviews, she was able to discuss her eating disorder in great depth, reflectively, and with brevity. The existential phenomenological data also showed that she viewed herself as being *on a tightrope*, caught in a precarious place between two conflicting sides. She even exclaimed how 'crazy' her eating disorder and circumstances were. Upon revealing the meaning that eating and food had within the context of her lifeworld, I would describe them as neither unreasonable nor inexplicable. There is no question that she was in a state of distress and was in need of treatment and support, but according to the biomedical model, her clinical presentation would be suggestive of Poppy having some level of 'flawed' perception or understanding that constituted her eating disorder. It is as if there is in fact a functional conceptualisation of her eating disorder, which fits with the 'coping tool'

perspective and has enabled her to survive the tightrope she finds herself on. This kind of 'survival function' is antithetical to the view of the body's 'survival function', its homeostasis and materiality, but for the medical conceptualisation, there is no room for these conflicting realities, and this is precisely where pathologising occurs. A person who is motivated by anxiety to restrict, binge or overeat, whether through 'choice' or otherwise, is defined by the medical model as a person who has a psychopathology. What this account fails to comprehend is that there is instead another survival function, that of existential survival, in the meaningful, emotional sense, which is driving the 'organism'.

There were a number of similar experiences revealed in the data of both participants, with regards to Paul's lifeworld, but they had different manifestations to those of Poppy. Like Poppy, Paul wasn't diagnosed with an eating disorder when it began in his teens, despite going to see a psychiatrist and undergoing assessment with a 'truth serum' for his low moods. Even though was this a much earlier historical period, the 1940s, which would have undoubtedly left him 'below the radar' in a similar way to Poppy, he did undergo assessment as a young man and was similarly not diagnosed with an eating disorder. However, his experience in his later years, when he was reviewed by a doctor about his eating habits, was that clinical presentation did suggest that he had an eating disorder, but that 'it was too deeply rooted'. Poppy describes a similar assessment made by her psychologist, Mr Bradley, that her eating disorder is 'so deep in [her] psyche no matter what…' and that she feels she will 'never, ever be free of it' because it is based on 'damage' that occurred in her formative years. The idea that it is somehow *deeply rooted* suggests, in the most simplistic way, that it is a part of who they are and their baseline psychology - it is *pathological.* Is this an example of the limits of biomedical conceptualisations? If the 'illness' goes deeper into the

individual's being and reality, an increased depth of meaning, demonstrated in the existential phenomenological method, with help move beyond this.

Paul's doctor concluded that he was not 'unwell' because his weight was not of concern, and he was in fact 'a little bit fat', and because it was so 'deeply rooted' in him, there was not much that could be done to treat him. Given that Paul's eating disorder has impacted on his life in negative ways, including his immense distress about being seen eating, and the close relationships it has broken down throughout his life, his symptoms do not seem to fit into the biomedical conceptualisation of an eating disorder 'based on clinical experience and written from the point of view of the clinician or therapist' (MacLeod, 1981: 10). It was apparent that Poppy was of a much lower weight, and at the time she came to interviews she was visibly very thin (something maybe less noticeable due to her 5' 1" height and petite frame). Comparatively between Paul and Poppy, their 'clinical presentations', in my non-medical opinion, suggested Poppy would have been diagnosed, whereas Paul would not, but this was not the case for either of them.

Feminism, sexuality and gender

There are many examples of the 'thin ideal' revealed by Poppy, and she often talks about not wanting to be 'fat', 'greedy' and 'out of control'. There are also specific instances, such as the comment by boys on her school bus mocking her 'tree trunk legs next to [her] sister', where she experienced judgments that appear to perpetuate gendered norms. This comment was identified by Poppy as something quite memorable which impacted on how she felt about thinness and her desire to lose weight. Throughout the course of her life, thinness has been central to her sense of wellbeing, her self-worth and her 'acceptability'. Interestingly for Poppy, this is separated from the concept of *attractiveness*,

something she identifies as being a social and cultural norm relating to gender, and she is very accepting of the fact she's 'not…a Kate Moss or…', instead feeling satisfied with her abilities. There are also contradictory elements in her experiences, for example when she is reflecting on her eating disorder and the rigidity of her 'rules', stating that 'it doesn't matter what you look like does it (yeah), unless it's a threat to your health'.

The pressure to conform is both present and absent, as if Poppy knows that there is a social and cultural pressure, but also knows that there isn't. This suggests a more *human* complexity where contradictory, or dialectical knowledge or beliefs can exist within eating disorders, an aspect captured through the phenomenological method. Both Paul and Poppy *know* that they should eat, and this was seen in their experiences of having had eating disorders their whole lives. This was contradictory to the point of *absurdity*, and both of them laughed about this during our encounters. The most profound example of a dialectical knowledge or belief is the paradoxical relationship between physical nourishment for survival, and emotional, existential survival through 'disordered' eating. Both participants stated that they knew they 'had to eat' to survive. A phenomenological perspective reveals to us the way in which eating disorders are an attempt to survive in a way which could never be identified by a psychiatric evaluation, because it is fundamentally antithetical to the paradigms of 'illness', 'health' or 'wellbeing'.

Poppy states in the interviews how she noticed 'the pretty girls' and the 'not so pretty ones', but there is no explicit mention of *thinness* being associated with beauty. In the instance of the comparison made with her twin sister by the boys on the bus, this comparison was very affecting for her, and she described how this was when she began restricting food to intentionally lose weight and be thin. This seems to be an example of how the 'degree of concordance between

society's and individual's values' (Nasser, 1997: 97), in relation to gender norms around attractiveness and thinness, has an effect on disordered eating, and is one of the factors as to why some women develop eating disorders. It is especially illuminating in Poppy's case because she is a twin, a factor which has been investigated by a number of studies from a biological perspective (Fairburn et. al., 1999; Kortegaard et.al., 2001), but which would be interesting to look at in terms of gender norms specifically.

The sex and gender differences seen in the characteristics of men and women, as shown in the review of the literature, are occasionally seen in the data, and both participants' experiences fit within this framework. Paul certainly displays a more 'avoidant' approach to his struggles with food (Kearney-Cooke & Steichen-Asch, 1990: 64) by wanting to eat alone, not going out for meals or locking the door. Other than this, Paul's experiences tend to conflict with the majority of the literature around eating disorders in men. The idea that generalising eating disorders as a 'female illness' leads to men finding it difficult to accept their disordered eating and seek help (Räisänen & Hunt, 2013: 6) is not true of what Paul described. There is certainly a possibility that the assessment of his clinical presentation, more specifically his weight and body shape/type, could be an example of a gendered bias, but there is no sense of there being a barrier due to his being male. The fact that he had attended for psychiatric assessment when a young man, as well as being assessed by his doctor more recently, demonstrates a certain level of him addressing his eating disorder. However, it is important to consider that the difficulties and distress he experiences are of a considerable level, possibly suggesting his eating disorder as a 'coping mechanism' is sustainable for him long term.

There are no instances of body image issues seen in the data from Paul's interviews, and body shape, appearance and attractiveness are not mentioned by

him throughout the conversations. He talks very explicitly about the role that food has in affecting his mood and how he feels, but even as a young man playing football and socialising at clubs and dance events, there is no mention of normative pressures around his body and appearance. Unlike the 'body talk' discussed by Engeln et.al. (2013) as being a common source of a gendered social pressure, this is not the case for Paul, and was not at any stage of his life. Apart from the comment about his doctor's assessment of his body and being overweight, the majority of what he discloses relates to his body being visible to others while he eats, and its functionality. There are no instances of Paul feeling he failed to 'measure up', or making any comparisons about his body with other men, and the only comparison he makes is about *how* he is supposed to eat, in a way that meant he can swallow and digest food. This can be understood as an investigation into the task of eating, rather than a comparison between himself and others, and he observes others as a way to try and 'figure out' and replicate the way in which they eat meals.

Within the literature there is also a suggestion that for men with eating disorders, there is a gendered stigma around the 'appropriateness' and 'normality' of men who experience them. The implicit point made is that men can find the label to be emasculating because eating disorders are viewed as only socially acceptable to women (Räisänen & Hunt, 2013: 6), but the data analysis shows that this is not an issue for Paul. He seems to hold a lot of internal conflict about what his eating disorder *is* and the *reason* for it, rather than feeling any stigma around it which relates to gender, or any other social categories. There is one instance where he describes feeling emasculated as a young boy when his mum used to treat him in what he sees as a more feminine way, 'spoiling' him and making him wear his curly hair quite long because he looked 'like a little lass'. However, this is not something he necessarily associates with his eating disorder, and the only

additional mention of feeling socially unacceptable is when he had to travel home on the bus when he was in dirty overalls, after working in the factory.

Psychosociocultural, race & ethnicity

Something which is very influential on the psychosociocultural norms around food for Poppy is her parents' Catholicism, particularly values involving personal morals, guilt and sacrifice. This is slightly different to the example used in some of the literature, such as Bruch's observation about eating disorders, namely anorexia, being less often diagnosed within lower-class homes, and the ones which were would be 'upwardly mobile and success-orientated' (1980: 24). Poppy does describe being under pressure from her family to perform well and achieve good grades at school, in addition to the fact she was sent to a grammar school which would be considered a route to upward social mobility. The difference for Poppy is that she describes school as a 'release', but where she was given a similar structure to the one she had at home, particularly a time structure ('then we do this lesson the break is at this time lunch is, so I've grown up in a time regulated…brain frame (yeah), really'). The data does not demonstrate that success or achievement is part of her eating disorder, but rigidity and temporal structure is prominent, 'so everything is measured in time probably yeah'.

The main motivation for Poppy and her sisters attending university was partly their desire to improve their socioeconomic status (Poppy had originally done a degree in economics with a nursing component, and briefly worked as an accountant like her dad ('…HATED it…'), but the main motivation was to move away from their abusive home and gain freedom. Unfortunately for Poppy, this freedom was difficult for her and she struggled being separated from her twin sister - 'going to university that's when, I was just so ill it was untrue (mm) because I'd been given no basis for which to, have an opinion on (yeah)…you know….which,

is dreadful'. It is as if the social and moral values she has been given from her Catholic parents gives her structure, but partly at the expense of her self-esteem, autonomy and wellbeing. Her eating disorder worsened very quickly when she went away to university and her weight dropped to around 5 stone. At this time a university warden referred her to a GP as they had concerns for her health, where she was diagnosed with depression and prescribed antidepressants. Malson's point about the body not being 'for all its corpo-reality, a natural, transhistorical object' (1997: 49), is a conceptualisation which would allow for a more in depth understanding of Poppy's low body weight at this time by taking into consideration the historical context she was existing within as a woman with an eating disorder.

The literature that discusses psychosociocultural influences within eating disorders, as was outlined in Chapter 1, accepts that there are multiple interwoven influences which exist, and there is more frequent focus being put on the body (Gordon, 2001; Miller & Pumariega, 2001). This is a change in discourse which has undoubtedly occurred as it became recognised that it had generally been omitted from past investigations. Views similar to those of Levine and Piran, where body image can be 'viewed as learned meaning system anchored in cultural discourses and power structures' (2003: 63), are examples where an epistemological shift in the overall approach to understanding eating disorders is indicative of a trend, or direction. However, it is within the data drawn from Poppy's lifeworld that a theme is revealed which isn't widely researched in relation to the psychosociocultural perspective of eating disorders - that of *food* - and there are also examples in which there are entangled values relating to cooking, food, eating and consumption. One example Poppy describes, after being asked whether food carried meanings relating to money, was her granddad going to Catholic school where they baked bread for the poorest children. He was from an incredibly poor

family, but because there were children poorer than him, he was told by his parents 'you do not eat that bread you've had breakfast, you leave that for the children who can't afford it (wow), so there were always those rules, that again get passed down to (mmm) my parents…and everything…else really'. Poppy described how many of her extended family were killed or injured during the war ('my grandfather was shell shocked in the war, there was no money coming in (mm), he used to open the gates for the railways'), so these values and norms around food were perpetuated through the generations when each of them had to survive on the little they could afford. This also led to other rules around food where it was unacceptable, shameful and unfair, for any food to be wasted, such as when Poppy reveals how her mum 'wouldn't give me my, fish until I'd eaten my chips then I was too full to eat my chips cause when you're little and then so I'd get smacked for that [laughs] cause (and you wouldn't get to eat your fish) I wouldn't eat the fish'.

Although there is no question of the validity of Poppy's experiences when using a phenomenological method, the conceptual comparison with the literature is an example of how concerns about consumption and its social impact should not be viewed as merely subjective. As outlined by Dyhouse in her discussion of 'consumer appetite' (2014: 221) the economic and environmental consequences of food waste, overproduction and mass consumerism are becoming increasingly important and can impact on the individual's desire, or appetite, for food. When considering the biomedical conceptualisation of eating disorders, a thought or behaviour like this may be viewed as *pathological*, or in the very least an example of an exaggerated, *dysfunctional* approach to food. This is problematic, and I would argue that these aspects of the phenomena shown in the data demonstrate something essential to their understanding, which has been previously overlooked.

Social and cultural norms are less prominent within Paul's experiences, and there is less similarity with any of the points made within the literature. Unlike more general references to cultural norms of certain eras, like Bruch's reference to 'the anorexic generations' of the 1960s (1980), the data from Paul's interviews do not show this kind of psychosociocultural influence. Nonetheless, there is one very central experience that Paul explicitly said he thinks 'would be one of the causes' of his eating disorder, which is his being born out of wedlock. For a baby to be born to an unmarried couple in the 1930s was socially and culturally impermissible ('when I was born, anybody like me, it was, it was tremendous thing (yeah). Me mother used to, must have gone through hell'), and the stigma around this had a profound impact on Paul, his sense of self and his self-esteem. It is also the shame and anxiety around this fact, his awareness of it being known by others (Paul refers to this as his 'moodiness' and depression), which he realises can be alleviated through his eating habits.

In contrast to the poverty that Poppy describes as a part of her lifeworld during her childhood, Paul's experiences are different and suggest that he was not within this same socioeconomic group. He talks about being 'spoilt' by his family members, being allowed to stay home without working when he was a young man, as well as times he went to the family's big pantry to eat puddings and chocolate, foods which would have been expensive luxury items. There is an illuminating link here with Sanz and Burkitt's reflections on Merleau-Ponty and the 'constitution' of the body as 'the way in which we develop a feel for what our body is like', interwoven with 'how we learn to express ourselves symbolically within culture' (2001: 46). Paul's understanding of his identity and the symbolic meaning of his being born out of wedlock does show that these shared cultural meanings are influential, but more importantly it shows that it is done in a dynamic, *lived* way, not as 'cultural dopes…locked into the logic of power relations' (2001: 47) in

the way that Bordo suggests. Paul makes sense of the way in which he feels he is perceived by others in society based on his emotional states and bodily sensations. His feelings of emotional discomfort and anxiety about being *witnessed* - tied into his symbolic identity - were something he was first able to address using food, but then became exacerbated by food. For Paul, his eating disorder isn't about food the same way as Poppy's is, and he states that 'I think I shall [hesitates]…I think I must have had that type of mind that it was inevitable…(mm) that something would go…w-wrong…(right)…and it's come in to me with food…(yeah)…hasn't it'. He has not simply reacted in a mechanistic way to sociocultural influences, but he is an active participant in its constitution. This is an example of the 'struggle over meaning' that Malson suggests is occurring for the anorexic body, where knowledge and meaning are 'asserted, contested, accepted, resisted and subverted' in the arena of discourse (1997: 112).

There isn't an opportunity to evaluate more diverse intersections with race and ethnicity with the data of either participant, but there are certainly issues which have been a source of oppression for Paul, even if they are only related to stigma. He is a man of a much older generation that was a lot more socially conservative, so views around being born outside of marriage, particularly as the result of an extra-marital affair as he was, would be had severe social consequences for both him and his mum ('she must have suffered, er…when I was little'). The fact that Paul was very guarded about this information, and did not reveal it until the end of our final interview, gives some indication of its importance within his lifeworld, as well as the shame he feels about it. Had he consented to another meeting, feeling into this part of the phenomena with Paul would have undoubtedly given a more profound insight.

Behaviour and cognitive processes

The behaviours and cognitive processes that appeared in a review of the literature identified a few general areas including preoccupation with body size and weight (Bruch, 1980; Ahern et. al., 2008), and compensatory behaviours such as exercise and bingeing (Dana & Lawrence, 1988). These are the main kind of behaviours seen in the data from Poppy's lifeworld, but they were not limited solely to food and eating. This idea of having a *deficit,* or *duty* which has to be rebalanced is something that characterises all of Poppy's day to day activities. For example, she talks about collecting litter on the field and sorting out the stored items in her home, and she often talks about feeling she has to have a minimum amount of tasks to ensure she isn't falling short on contributing socially and domestically. MacLeod's point about anorexia being 'a positive strategy aimed at establishing autonomy and resolving what would otherwise be unbearable [intrapsychic] conflicts…but [they are] also existential' (1981: 11) fits with what is felt within Poppy's lifeworld. It is her way of *being* - both 'being-in-a-body' and 'being-in-the-world' - and an alternative way of being is not a possibility for her from her current position. Her way of being does not just permeate her lifeworld, she *is* her way of being, and *is* her body, something enmeshed with the world, with others and with herself. Is this perhaps what is being referred to by the clinical observation that Poppy and Paul's eating disorders are 'too deeply rooted'?

There is no doubt that Poppy's cognitive processes and behaviours around food, eating and exercise fit with those typical of anorexia, especially the temporal dimension, similar to Hepworth's description of 'perpetually calculating time, feeling they were wasting time, that they had too much time, needed to fill time and that time was passing' (2015: 320-321). She also fits the generalised eating disorder role of a 'coper' (Dana & Lawrence, 1988: 15), although this is more commonly associated with bulimia, and throughout her life she has been able to 'hold it together' through a number of very challenging events - the ongoing

abuse from her mum, her husband going to prison when her three children were very young, at the same time as completing her teaching qualifications and almost becoming homeless. However, there are also ways in which she does not fit certain generalisations, such as Bruch's account that 'deep down every anorexic is convinced that her basic personality is defective, gross, not good enough…all her efforts are directed towards hiding the fatal flaw of her basic inadequacy' (1980: 136). Poppy's self-esteem is contradictory in this sense, as she still perpetuates the evaluation given by her parents that she was 'worthless' and a problem, or burden, but she also understands that she does not have to accept this entirely. She did well at school, did well in her degree and was a successful teacher, and it is incredibly apparent from spending time with her that she is intelligent, very sharp and well aware of her abilities. Rather than being driven by inadequacy, it is as if she is driven by the sense of achievement, of success and *recognition* of what she works very hard for. One example of this is her anger and outrage at the claims of a woman she is acquainted with, who said she did a degree at Poppy's old university - 'I'm gonna say something I said, Miranda said does it matter I said it does! Cause I went to that university ([Sarah laughs]) and it was hard there! It does matter!' - she knows that she works hard. This kind of opposition between two aspects of her sense of self, and her self-esteem, is an example of the kinds of incongruous beliefs we can hold about ourselves and others, something which does not fit comfortably into a standard cognitive behavioural conceptualisation.

Unlike what is seen in the literature around behaviour and cognition, the data from Paul's interviews does not suggest any kind of severe compulsion or habit is part of his eating disorder, but he does have one or two habits around eating. He describes how when it is between meal times, or occasions where he eats, he is 'busy and happy the rest of me day', and there isn't a sense of anticipation or rumination like there is for Poppy. One possible compulsion he

seems to have is that of wanting to remove himself from others' sight when eating, something which he is able to overcome at times, for example when eating at the pub with his friends, something he has still managed to do within the past decade. Despite this, Paul's descriptions of his experiences do not seem compulsive, if we understand compulsion to be, from a psychological perspective, a kind of difficult to resist rule which must be followed to avoid subsequent distress. It is almost as if instead of being compelled to avoid food and having to fight this urge, it is his *struggle to eat* which he is compelled to carry on enacting. Each time he has a meal, he is able to eventually overcome his fear of eating, but this process is not a way to avoid distress - instead he is directly facing this distress by eating.

In this respect, there is also a contrast with the literature around the obsessive nature of men's disordered eating which has an important function 'they couldn't "live without"…' (Räisänen and Hunt, 2013: 4). The opposite is true for Paul, despite him showing a certain level of acceptance of his situation after such as long period of time. This may in fact fit more with the view of Strother et. al. who suggest men may have a better prognosis than women due to their willingness 'to "fix" problems' (2012: 352). Within his lifeworld, Paul's eating disorder is characterised as if it is a *puzzle*, or *riddle*, and he feels persistently aware of having to confront it during meals, without knowing the solution. Our conversations often involved Paul asking me questions, using me and my experiences as a mirror ('Have you ever met anybody…similar to that?'; 'Do you find you understand it a bit?'; 'What is your family member like?'; 'Can they eat in front of you?'; 'It's a similar thing then, isn't it?'). Given his life spent building and repairing mechanical items and woodworking, there is no doubt that Paul is, similarly to Poppy, very intelligent, highly-skilled and capable of complex levels of thought.

Paul's description of himself is that he is a 'moody type', and he believes there is something about his character which predisposes him to experiencing low moods and depression, something tied to his eating disorder and relationship with food. However, it is important to note that Paul did eventually disclose his experience of being born out of wedlock, and how this was likely 'one of the causes' of his eating disorder. Exploring Paul's experience of depression and low mood within the context of his lifeworld would help improve the understanding of their role within his eating disorder, but I feel that this would have required him to demonstrate a vulnerability he was not comfortable with. Returning again to the point made by Robinson et. al. about the individual's sense of self being undesirable, or unacceptable, this certainly fits with Paul's feelings about himself and the circumstances around his birth. However, it is slightly different in that he does not describe feeling this was something about him 'which had to be compensated for' (2012: 181) and he explicitly said 'I know it's not my fault', but he does feel shame and sadness around it. Because Paul lived in a small village and his peers used to make comments to him about his illegitimacy ('me mother says I haven't, to play with you Paul Smith because you're bad'), and there were many occasions throughout his life where the issue became apparent to other people ('and the teacher says…your essay today is, how does my Dad shave?…Well I thought, well how the bloody hell can I write that (mm…mmm)…so I, what I wrote in, my uncle….James writes…but the-, them things don't help you'; 'I can remember, when I went, to the city nearby for…for a job, and I had to take me birth certificate (mm), and…when I got back, I said to me mother, why isn't my fa-, father's name and she…broke down in tears (mm) so I, I never mentioned it any more'). I got a strong sense from Paul that it was the effect his illegitimacy had on his mother, as a result of the social and cultural stigma, which seemed to upset him more than the effect on his own self esteem.

Trauma, distress, conflict and shame

There are prominent indications in the data that traumatic experiences and high levels of distress formed part of the phenomena for both Poppy and Paul, but more markedly for Poppy. Her lifeworld as a whole was underpinned with prolonged experiences of distress and trauma which gave a sense of anxiousness, uneasiness and grief. Her abusive neglectful relationship with her parents began from her birth ('All my life, there's not one photograph of her holding us…(wow)…we were put, we were fed with a bottle on the pillow…(right…) not one photograph, and I scalded my arm at four…erm, I ran into my Dad when he had a cup of tea, (yeah) and all the skin came off it was a hospital job (oh gosh), called the ambulance but the worst bit for me it wasn't cutting the flesh off in casualty (mm), the worst bit was my mother holding me before I went into the ambulance').

Discussion about her experiences with her parents was interwoven almost inseparably with her experience of her eating disorder, particularly in relation to her sense of identity and embodiment, and this was demonstrated in the fact that when asked about her eating disorder, she discussed her childhood experiences. They mainly centred around physical pain, suffering, abuse, neglect, hunger and an uneasy sense of imprisonment within her family home, and there was little to no description of her own 'private' lifeworld, with school being her only respite. It was profoundly difficult to feel the immense trauma Poppy was subjected to. As outlined in the literature, Poppy did show a tendency 'towards negative emotionality' (Mitchell et. al., 2014: 8), which in the context of her life experiences I would not conceptualise as showing psychopathology, but instead a kind of *psychic* or *physiological wounding* - a wounding of the *being* or *self*. As was argued more comprehensively in Section 1.3.1, the biomedical conceptualisation of this

aspect of an eating disorder negates the view of the body as lived, therefore it cannot incorporate the meaning of such experiences to the individual.

Poppy mentioned a specific event which she said triggered her thoughts about her weight and fatness, and that was one of the boys on the school bus stating she had 'tree trunk legs next to [her] sister'. When compared alongside the literature, this chimes with Bruch's discussion on patients with anorexia whom she had met (1980: 57), and this marks, for Poppy, a remark which began her restrictive thoughts and behaviours around her body and food. However, when viewed within the context of her traumatic experiences and her *way of being* in the world (forcibly dictated to some extent by her mother), it is as if she has been made aware of something about her which is unacceptable and unworthy. Has she mistakenly correlated her feelings of worthlessness with what others view her as being unacceptable for - being fat - an example of a 'maladaptive behaviour'?

In contrast to this focus on fatness, Poppy also holds contradictory feelings about her body being too fat *and* noticeably thin, shown in the example of the American tourist she met with her husband while on their cruise ('I was wearing my yellow trousers this American guy came up to me and said…I, I had to keep them up with a belt, because (mm) you know the smallest size they still slip off me (mm), so he made some comment that, you even need a belt to keep your trousers up and was quite rude the fact that I wasn't (ohh)…bigger (right)…and I thought well, actually I'm the heaviest I have been for a while [laughs]'). This could be showing the kind of 'dysmorphic shame' talked about by Fuchs, where Poppy 'continues to see [herself] with their eyes, to feel ubiquitous, contemptuous gaze on [her] body - the gaze of *the Other*' (2002: 235). It was the comment by the boy on the bus which initially made Poppy feel she was fat, provoking shame in her, which she took on board, from then on seeing her own body in this same way.

Poppy recounted how her father used to reinforce this perspective by calling her fat and ugly, something she said impacted on her further.

One of the concepts looked at within the literature is the role of autonomy and control, particularly in early life and the role of the parent and domestic dynamics. As discussed by Kally and Kumella, there was a trend in the data that showed many eating disordered patients had experienced strict domestic rules and control from their parents 'with few chances to individuate or to make personal decisions' (2008: 367). For Poppy this was certainly the case, with her mother having rules for everything, both explicit and implicit, and her father acting in a way that supported her mother's dominant role in the household. As was discussed in relation to Poppy's upward social mobility and her going away to university, she had 'been given no basis for which to, have an opinion on' and found herself becoming 'very ill' as a result. It is as if Poppy had no real autonomy and could only replicate a sense of control by behaving within the self-damaging rules and dynamics she had experienced in the past.

This concept of autonomy also bears similarities with MacLeod's description of the anorexic patient whose deepest fear is 'her essential helplessness' (1981: 108), and therefore cannot relinquish even a small amount of what they perceive to be control. Bruch, in a similar vein, talks about the need of misperception to shield the anorexic patient from her deep anxiety of 'not being a worthwhile and integrated individual capable of leading her own life' (1980: 79). Poppy described this feeling as 'keeping it all inside' - this is what she ultimately described wanting to be in control of - *anything* and *everything* - a need which was absolute, but also in the midst of great conflict between the possibilities. The two sides of this dichotomy, autonomy and helplessness, both seem anxiety and panic-inducing for Poppy, so to remain in control and 'on the tightrope' may be the only ontological space she knows how to function within. She is unable to tolerate insecurity or

ambiguity of any kind, which is where her adaptability allows her to continue and keep 'existing'- doing what is necessary.

Continuing with the concepts relating to trauma, distress, conflict and shame, there are other instances within Poppy's lifeworld where she experiences conflict, such as what Nasser describes as 'an ambiguous double-bind culture' (2007: 106). She makes reference to the distress felt within eating disorders that arises when trying to make sense of, and fit into, the system (or world) that the individual finds themselves in, mainly because of its ambiguity as 'both orderly and chaotic, coherent and fragmented, standardized and individualistic'. This fits with what is seen in the data from Poppy's interviews, and also fits with her description of feeling she is on a tightrope, or knife-edge. Coming from a childhood and teenagehood which was characterised by everything having order and her having to follow the rules (often with extreme consequences) - such as her family dynamic and her grammar school experiences - stepping out into a world of ambiguity seemed to be something she could not tolerate, and had an immense impact on her mental health and wellbeing when she moved away from home to university. Moving beyond the abusive and neglectful environment of her home did not allow her to move beyond the effects of the abuse and neglect. It is almost as if Poppy's sense of being, of her body and the world is entirely structured around these childhood experiences, as if they had *fixed* or *frozen* them all in place, a kind of hostile, restricted reality which does not allow for deviation or escape. In this respect, can Poppy's eating disorder be viewed as a kind of 'survival tool' for the hostile reality she finds herself within?

The data from Paul's interviews relates to the literature on trauma much less than Poppy's, and his experience of trauma was much less pronounced. The distress he disclosed was mainly from his childhood, and directly relates to his shame about being born out of wedlock. His life is otherwise one of being well-

provided for, loved and cared for by a large family, and he is very financially successful, as well as having a family of his own which brought him great joy and happiness. However, being born illegitimately, as the result of an affair, is particularly affecting for Paul and he states that it is likely to be the underlying cause of his eating disorder. Looking once more at Nasser's description of the distress experienced within eating disorders, there does appear to be a sense of Paul losing his relation to both himself and the other, and the inability to 'understand the prevailing system and be part of it' (2007: 106). This reality that Paul finds himself not fitting into relates to him not fitting within stigmatising social and cultural roles, characterised by morality and shame. Despite being brought up by a very loving and supportive family, Paul still feels shame for the circumstances of his birth, and even considers the fact he was a reminder to his step-dad, and the world, that his mum had sex with another man. Similarly to Poppy, but in a less overbearing way, there are similarities with Fuchs' outline of 'dysmorphic shame', where the contemptuous gaze of 'the Other' is felt on his body, then adopted by Paul so that he experiences 'the corporealizing effect of shame' (2002: 235). The difference for Paul is that it is not a judgement on his body, such as his fatness or appearance, it is instead his *presence* within the world that he perceives is being judged, and in some cases it has led to comments being made by other people ('me mother says I haven't, to play with you Paul Smith because you're bad'). This is still a judgement on his body - *his being* which his body *is* and *has*. As demonstrated by the contrast between Poppy and Paul's lifeworlds, it does not necessarily seem to be the severity of the trauma, but how it is experienced and the meaning given to it by the individual.

Another point made within the literature is a comment made by a patient with anorexia nervosa, that 'if I didn't have anorexia, I'd have something else. I've always been unhappy with myself, with my body' (Robertson, 1992: 68). This is the

same sentiment expressed by Paul ('I think I must have had that type of mind that it was inevitable…(mm) that something would go…w-wrong…'), and he feels that his underlying emotional problems would have led to another kind of coping mechanism, 'and it's come in to me with food…(yeah)…hasn't it'. This suggests that although the eating disorder does focus on food and becomes structured around food and eating, it is something that ultimately serves a certain purpose in coping with distress which is not necessarily related to the body in aesthetic terms, or thinness and fatness. Given the underlying existential structure of the phenomenon that has been revealed within the data, this supports the view that for Paul and Poppy, their eating disorders may relate to existential distress, or crisis of existence, for which they had no alternative resolution at the time their disorder began. The difference for Paul and Poppy may be to do with the differences in the trauma they each experienced, in terms of severity and duration, in addition to other factors which have been outlined within this discussion. Overall Paul's lifeworld is characterised by a lot less conflict than Poppy's, and although there is still an anxiety around food and eating for Paul, he has a space outside of meals where he finds respite, a space which Poppy does not seem to have.

Age and Ageing

For Poppy, issues around food and eating began at a young age, although she differentiates this from the trigger of her restrictive eating when she was a teenager, as mentioned previously. Mealtimes were described as a fraught, explosive time as this is when her dad would return home, and any misbehaviours of the day were reported and addressed by her mum, usually by scolding and physical abuse. As identified by Wooldridge and Lytle, Poppy did experience disturbances in her 'early mother-child relationship' (2012: 373), with some of these centring around food because they were an interpersonal exchange

between family members ('annnd I remember going on a countryside trip I was about seven, and me mother had hit me or...(mm) [smiles] and she give me a sandwich, and I threw it in the hedge (I remember you saying this, yeah [smiles]), and looking at me, and I thought, good...(gosh) and that was my way of getting back at her...'). Food and its exchange within her family is a highly charged emotional interaction, including rejection, withholding, spoiling, restricting and moralising - Poppy and her siblings were beaten for dropping or wasting food; her mother would make them go without food for whole days while she was busy doing the laundry. This dynamic was not passed on to her own children, and Poppy appears to have made a concerted effort not to subject her children to what she experienced, but there are habits and behaviours around food which remain for Poppy.

There is a correlation seen in the reviewed literature, in Chapter 1, between the concept of ageing and the 'thin ideal' with what is present in Poppy's lifeworld, but there is a distinct separation for her between 'thinness' and 'attractiveness'. Despite this, she did not disclose any concerns about ageing in terms of her body and her self-esteem, and her motivation to avoid fatness was similarly not influenced by age. Considering the point made by Luca et. al. about late-life patients having a very different clinical presentation to younger patients (2015: 52), Poppy was assessed during different times in her life, and it was only when she was assessed in later life that she was given an eating disorder diagnosis, even though she was a much lower weight and more 'ill' when at university. She did not describe any embarrassment around having a 'teenage' pathology, and overall she was very accepting of her illness and how it manifested, as if she had learned to live with it in a way that was tolerable. It would be enlightening to reconnect with Poppy in a number of years as she reaches her 70s and 80s, to see how her physical health and age-related issues may change from where she is now in her

60s, as it is likely that if her health does deteriorate then this may impact on her eating disorder.

Within Paul's lifeworld, there were no concerns about ageing in terms of his body, his appearance and how this affected his eating disorder, but he did show some concerns for how his health would impact on his independence. If anything, Paul's age and his reclusive existence, which he is content with and enjoyed the solitude of, allow him to eat more easily. Because he has anxiety about eating in the presence of other people, this is something he does not have to do most days, unless someone comes to visit him about his repair business. His experiences do not fit with the general concepts seen in the literature to do with age, and it is likely that being a man in his 80s with an eating disorder is a very uncommon experience, particularly one which has spanned his entire lifetime. This aspect of the project overall is interesting in itself as a demonstration of how diverse and complex the realities of eating disorders can be.

Section 5.3: Reflection on my experience using the phenomenological method

Pursuing a qualitative research project using a phenomenological method was equal parts intuitive and unfamiliar. Having undertaken scholarship in philosophy, specifically an evaluation of Sartre's phenomenal ontology as a theory of psychotherapy, I was able to draw from the primary philosophical texts in a way which enhanced the existing body of work around the methodology, such as that of Finlay and Dahlberg et.al. Taking this knowledge and fitting it within the standards of empirical, scientific research was certainly more challenging, but I have succeeded in achieving a methodologically and epistemologically sound project. It was often a concern for me that my own lived experience of my mum's eating disorder, and my intuition about eating disorders being fundamentally rooted in existential feelings and embodiment, would somehow undermine my

thesis. I believe that it is instead a confirmation that I have the capacity to engage in the phenomenological attitude, a skill which I am committed to exploring and practicing. I remain committed to recognising my relationship with my own lifeworld experience, pre-knowledge and pre-understandings, taking responsibility for making these explicit, and using them as a valuable source of empathy (Mason, 2002; Galvin & Todres, 2013).

As a phenomenological researcher, I have subsequently developed my critically reflective practice in a way that is not only effective, but adds to the validity of my thesis and the knowledge I have generated around the phenomena. I feel that the use of an empirical study using qualitative interviews has developed my philosophical and critical evaluation skills in a profound and moving way, and I hope to continue this in my future research. For Paul and Poppy to allow me into their lifeworlds and share their experiences with me, their emotions, has been transformative for me, and I suspect for each of them. I feel deep gratitude for what I have had the opportunity to engage in, and it has given me such a strength of conviction in the usefulness of an existential phenomenological method, especially in relation to mental health research.

CONCLUSION

Having undertaken an ontological reflection and analysis of eating disorders using a phenomenological method, there are a number of conclusions which can be drawn. The research project has revealed new knowledge about the phenomenon, given a successful demonstration of the methodology as an empirical tool, and provided a broader knowledge about the body and human experience. In this Conclusion section I will address the research questions in turn to identify the ways in which the thesis has been successful, a critique of the method and its strengths, then an outline of the contributions made to knowledge by this thesis. Following this will be a brief outline of suggested areas for future study.

Re-evaluation of the original research questions

1. What do we understand about eating disorders as phenomena?

This thesis has shown that eating disorders are a *problem of being* which relates to the embodied experience of existential feelings, specifically anxieties, for which the eating disorder itself is a *retreat, coping mechanism* or *survival strategy*. This is typified by MacLeod's description that an individual with anorexia is 'someone who doesn't know how to live except by non-eating' (1981: 182), and this occurs within the felt sense of passivity, ineffectiveness, helplessness and an external oppression of their possibilities. The experiences of older people with eating disorders are still phenomenologically consistent with those of younger people, but there is a specific felt sense of absurdity about their predicament and behaviours, in addition to a deeper entrenchment of habits.

The themes offered by the existing literature, covering biomedical, feminist, psychosociocultural, behavioural and cognitive, trauma and shame-based and age-related conceptualisations, were all present within the phenomenological data

to varying degrees. One notable exception was the lack of gender-related body image issues for Paul, even in his lived experience from his teens and twenties. There is no doubt that all of these factors influence the ontological structure of eating disorders as phenomena, but they do not form part of their essence, or existential structure. Something which is taken for granted by both the medical model *and* the existential phenomenological approach, is that the process of feeding and nourishing ourselves is a function of the body which comes to us unconsciously, as if a 'given' that the organism will eventually be driven to satiate its hunger and gain sustenance. Eating disorders are a demonstration that this is not the case, and we must reflect critically on this reality of human being, specifically embodiment, if we are to help those who experience them.

2. Is the psychiatric approach to eating disorders problematic, and if so, how?

The flaw that has been shown in the psychiatric, or medical, conceptualisation of eating disorders is that it is based on a misunderstanding, or oversight, of the body and how it exists within human reality. The answer is not that the biomedical view of psychiatric illness and the phenomenological perspective are incompatible and one must be chosen - the answer is that they are not incorporating one another's approach in a way that is true to the phenomena. The 'lived body' is overlooked by the psychiatric view of eating disorders, as well as other pathologies, and this is incompatible and unsustainable if we are to fully understand what they are, and how they are experienced. Sanz and Burkitt describe this as a 'broken dialogue between nature and society, between men and women, between pathology and normality, between doctor and patient, and between anorexia as illness and human experience' (2001: 49). It is vital that this dialogue be reimagined and resolved, with a greater focus on humanisation and the use of empathy to 'feel in' to the lived experience of others.

There are paradigms, such as the medicalisation and pathologisation of eating disorders, which need to be revised, despite being so entrenched in our epistemological frameworks. For Merleau-Ponty, he felt it was important to understand that the objective, scientific view of the body is not the entirety of its ontology, but instead 'a moment in the constitution of the object, the body' (1945/2014: 97). It is important to look for the most complete, comprehensive understanding possible of eating disorders, and it is essential that our approach is not dogmatic, therefore we must acknowledge the limitations of each discipline. Although our bodies are more than merely biological and are constituted in multidimensional ways, as Zaner states, 'it is a biological, physical body, and this status cannot be gainsaid but must be directly confronted and understood' (1981: 48). For example, if we consider that ongoing research into neuronal plasticity is beginning to reveal that the brain 'is structured epigenetically by the continuous interaction of organism and environment' (Fuchs, 2004: 189), rather than being a piece of 'apparatus' that exists in the world, processing sensory information that it receives, it becomes apparent that there are alternatives which can be practical and helpful.

With regards to the response of the medical world, given that it remains the dominant paradigm within which eating disorders are treated, recognition that the 'dialogue' is not just broken, but in danger of drowning out the voices that show us the true reality of illness and wellbeing. We need to bring the lived experience of health and illness to the forefront of our awareness – and see that they are existential in the most fundamental way, and that these existential aspects of human experience are inseparable from what we see as 'medical'. With eating disorders in particular, the 'illness' that arises in the beginning is an existential one, that in turn can develop into an illness of the body as a result of the disordered eating.

3. Can a phenomenological method be useful when trying to understand the phenomenon of eating disorders?

By undertaking an existential phenomenological analysis of eating disorders in older people, new light has been shed on the existential structures of the phenomena that are fundamental to its understanding, and which could not be accessed by other approaches. Eating disorders use the arena of food, and the bodily activity of eating, to navigate an existential distress which the individual has no other mode of living through, as they are stranded within their way of being. As has been demonstrated, there is a core element of the ontology of eating disorders which 'goes deeper' into the individual's being and human reality, and it is in fact a 'problem of being'. An existential phenomenological method is able to identify these facets of human experience, I truly believe that an existential phenomenological perspective adds the missing component to eating disorders, and mental illness more generally, which can improve the way in which we help and support people with these diagnoses.

Critique of study and strengths

Undertaking an interdisciplinary thesis is a task which has, for me, been characterised by a confusing and inspiring sense of leading and following oneself simultaneously. Bringing together my vocational experience within health and social care with my background in academic philosophy has required the blending of two different realms of knowledge – 'switching between hats' as it were. Throughout the project I have undertaken constant revision, reflection and interrogation of my epistemological framework to ensure that it has stayed as close to my research questions and rationale as possible, so as not to stray too far into one discipline or the other overall. I believe that what I have achieved is a

well-rounded balance between a philosophical approach which goes adequately in depth to the primary phenomenological sources, and a social sciences approach which seeks to create useful, and replicable, empirical data.

There is a synergy between philosophy and the social sciences which is seen in phenomenological research and which blurs the boundaries between the phenomenologically-oriented researcher who is not a professional philosopher, and the 'texts by Sartre [which] contain concrete stories of events that he observed in situations around him' (Van Manen, 2014: 311). Both are concerned with prereflective experiential accounts, but are executed in different ways and make use of different sources. By taking the methodological guidance of Finlay and Dahlberg et.al., I have structured a qualitative research project which I believe has successfully functioned as a more 'procedural' approach (in its loosest sense) in comparison to what I would have undertaken within a purely philosophical thesis. Ensuring that I 'anchored in' to a solid philosophical base through the use of primary texts and my 'philosophical training' through my academic work, marrying this with a social sciences method has, I believe, allowed each discipline to mutually enhance the other synergistically within this thesis.

There can be no doubt, however, that despite the synergies between social science and philosophy, there are a number of tensions which cannot be minimised. Using phenomenology specifically as an example, there are epistemological issues around generalisation which arise within qualitative research studies, but are not considered within the realm of phenomenological philosophical inquiry. Despite being concerned with the same experiential accounts, a philosophical phenomenological approach is less procedural and arguably more likely to be based on literary or narrative examples (Van Manen, 2014: 349). For Merleau-Ponty, it is precisely the *contact* with things which remained important, as the desire to reach objective accounts 'that are authorized

by the variables or by the entities I have defined relative to an order of facts…owe nothing to our *contact* with the things: they express an effort of approximation that would have no meaning with regard to the lived experience' (Merleau-Ponty, 1964/1992: 14). This remains an issue within qualitative research approaches which I have touched upon within my methodology to an appropriate degree, but which relates to a much more expansive and historical trajectory within phenomenological research.

Overall, my wish has been to make a difference to people who have a lived experience of eating disorders and honour their voices, at the same time as giving a voice to the existential phenomenology I believe in so passionately as an imperative tool for understanding mental illness. The research questions which have led my thesis are important to ask because they allow us to understand eating disorders in an empathic, humanising way, and this has the potential to be transformative for the wellbeing of individuals. If it can continue to be shown that eating disorders are a problem of being, then approaching the phenomena in a relational way which concerns itself with *being* in the existential sense, is epistemologically and methodologically sound.

Contribution to knowledge

There are a number of contributions to knowledge which have been made within this thesis, both methodological and epistemological. These can be separated into four areas which have been created through an iterative process, as is shown within the research project overall:

1. The creation of new empirical data on eating disorders and adding to current discourse

By doing phenomenologically-oriented interviews, the data that have been generated was a completely new creation which did not exist prior to my research. Given the under-researched demographic of my participants, with Poppy a woman in her 60s and Paul a man in his 80s, creating new data on their experiences of eating disorders is extremely valuable in this respect. There is a discourse on eating disorders which is rapidly changing, becoming more complex in its multiple conceptualisations and individual presentations, and this thesis can provide another valuable strand to how we understand them as phenomena.

2. Adding to the philosophical discussion of the body and embodiment, illness and wellbeing

By including an epistemological base rooted in primary phenomenological and existential texts, as well as by extending my discussion to some philosophical reflection, this contributes to the philosophical discussion around the body and embodiment. By epistemologically interrogating and exploring the medicalisation of the body, this will help catalyse discussion within philosophy which is ongoing and seeks to better understand the way in which we inhabit and *are* our bodies and how they are situated within human reality and the world.

3. Demonstrating the application of the phenomenological method

Using a phenomenological method within a qualitative research project has demonstrated its use and the kind of findings which it can lead us to. Being able to outline my method and attempt to describe the process which I have gone through is something which is highly valued within phenomenological research specifically, due to its reflective nature. The conclusions I have arrived at in my thesis could potentially have been arrived at without empirical data if I were to use a literary or narrative account of someone's lived experience, but this would not

have been in such depth or breadth of understanding. It would also have been challenging to find the accounts of older people, and even if there were written sources available, because there is also no dialogue taking place, I would be limited to what was disclosed by the person within their fixed written account. As was shown in my findings, it is the interpersonal dynamic and 'being with' Poppy and Paul which led them to reveal very meaningful aspects of their respective lifeworlds over the course of our encounters, and this cannot happen with a text.

Areas for future study

Given the small number of studies which use a phenomenological method to explore the phenomenon of eating disorders in older people, there is scope for this to be carried forward in the future. Given the amount of data generated from such small numbers of interviews, it would be possible to gain a wealth of knowledge and understanding of eating disorders from even a small number of additional studies with older people. This endeavour can also be applied to research on eating disorders more generally, so that their existential nature as a 'problem of being' can be better understood. Phenomenological research is continuing to grow within the qualitative research sphere, seen in 'psychology, education, pedagogy, nursing, and medicine' (Van Manen, 2014: 312) but equally continues to be misunderstood and misevaluated according to different qualitative concepts and criteria of validation.

As was discussed in the Discussion (Chapter 4), there is good reason to anticipate that an investigation of the phenomenology of food and eating would provide a wealth of new and relevant understanding of eating disorders:

> '...despite his use of the word 'foreign' Svenaeus does *not* seem to be arguing that food may be experienced as uncanny; yet this idea is well worth exploring.' (Morris, 2013: 98)

> 'Surprisingly, there are few authors who explore the ways in which food is talked about and experienced by people with anorexia.' (Warin, 2003: 78)

> 'There is no discussion of the distinction of foods, and when, on occasion, the embodied sensations of food are mentioned, they are overlooked and subsumed into disembodied discourses.' (Warin, 2003: 78)

As this thesis has illuminated, food has a particular phenomenal quality and place in the world, something which may be overly simplified within eating disorder research, or is simply an area of knowledge that is yet to be explored more generally. The phenomenal ontology of food is richer, more liminal and certainly more meaningful within the lifeworld than we acknowledge, maybe something which is taken for granted, from a philosophical perspective. The relationship between our bodies and food has an existential meaning structure which goes beyond appetite, eating and nutrition. We need to examine this further if we are to better understand illnesses relating to consumption, such as eating disorders.

The data also suggests that further research into the role of the stomach within neuroscience, particularly its physiological structure around the vagus nerve which is defined as the gut-brain axis, may be helpful. The felt sense of anxiety, which was shown to be central to the ontology of eating disorders, is felt within the part of the body where the vagus nerve passes through, and there is research that already suggests there is a relationship between the gut and incidences of anxiety and depression, appetite and food regulation (Hussain & Bloom, 2012; Sam et.al., 2012; Foster & McVey Neufeld, 2013). Although the body is lived, something

which we must begin to incorporate into our conceptions of illness and wellbeing, it doesn't transcend its materiality, its biology, and this is the very place in which the *living of* the body takes place. The *lived* and the *living* organism which is the body remains a thing of two leaves, but it is not in the interest of human wellbeing to eliminate one of them from the branch.

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APPENDIX Appendix A

UNIVERSITY OF Hull

PRIVATE AND CONFIDENTIAL

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Faculty of Health and Social Care
Research Ethics Committee

T 01482 464680
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REF 228

13 July 2016

Dear Sarah

RE: A phenomenological lifeworld study of people with anorexia nervosa aged 60 and above

Thank you for submitting your interview schedule as per the condition(s) of your ethics approval for the above study.

I am happy and able, according to the Terms of Reference of the FHSC REC, to offer approval by Chair's action.

I wish you continued success with your research.

Yours sincerely

Dr Judith Dyson
Chair, FHSC Research Ethics Committee

cc file

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‘Lived experiences of eating disorders in those aged 60 and above’: A research project applying philosophy to health and well-being

Information for participants

My name is Sarah Warriner and I am currently studying for my PhD at the University of Hull. I completed my undergraduate degree in philosophy at the University of Hull, but I also have experience of working as a carer and in NHS administration.

My experience of working as a carer, and in other care-related areas, showed me how some of the themes I had studied in philosophy helped me deeper understand things about care, health and well-being. I am interested in questions about *what it feels like for people who are diagnosed with an illness*, *what it means to care for others*, and *the importance these insights have in how people provide professional care.*

By asking you about your day to day life, then **listening to your experiences** and how they make you think and feel, this may go on to help professional people (such as nurses, doctors, carers or social workers) **understand things from *your* perspective** when delivering care in the future.

I am planning to do interview-based research with two individuals, **one male and one female**, who have experience of an eating disorder and **who are aged 60 or above** (this would also include if you were aged 60 or above when you experienced an eating disorder, but you are now in recovery). If you would like to discuss the possibility of participating with me, you are welcome to contact me so that **I can give you further information and answer any questions** you have at this stage.

Please read the further information on the next page about the interviews, how the data will be used and what the next stages would be.

Thank you for the time you’ve taken so far, and I hope to speak to you soon.

Sarah Warriner

PhD Student Researcher, University of Hull

Please see overleaf for further information...

How will the interview process work?

It is expected that three interviews will take place, up to 90 minutes each, after which you will be provided with a copy of the interview transcriptions so that you can verify what has been recorded and written. Your participation in the project will be **completely anonymous** and I am the only person who will know your identity. I am also the only person who will hear the interviews, which I will record on a security protected recording device.

What happens to the research once you have finished the interviews?

Once we have finished our interviews together, **I will write up the transcripts and give them to you to look over**. The recordings and the transcripts will then be stored securely (in a safe that only me and my PhD supervisors, Professor Galvin and Dr Burwood, have access to) and I will use the data as part of my PhD thesis. **If you want me to describe this in more detail**, I am happy to do this either in writing, on the phone or in person (I can also provide written examples).

Who will see the research?

I am the only person who will hear the recordings of our interviews, and only I and my PhD supervisors will have access to the transcripts (they will be required to request access from me with a suitable reason as to why). When I complete my thesis and the research is published, **it will be available to other researchers and academic audiences,** but not to the general public. After the thesis is examined, it will be available to the general public through a database called Hydra. The original recorded and transcribed data will be deleted completely and the quoted text will only exist in a completely anonymous form.

Do I need to consent or sign anything?

As part of the information I have sent to you, there is a form that describes how you can be supported during the interview process and your right to withdraw. There is also a form that explains how I will assess that you have the capacity to give your informed consent. In addition, **there is the consent form which is kept as a record of your agreement to participate in the research project**.

Can I change my mind?

Yes, **you can change your mind at any stage of the project** and I will ensure that I give you regular opportunities to think about whether you would like to continue. If you choose to withdraw, you don't have to give any reason for this choice. Similarly, if I ask you any particular questions that you don't want to answer, for any reason, then **you are not obligated to answer them**, even if you have consented to take part.

Appendix C

UNIVERSITY OF Hull
Faculty of Health and Social Care

Looking for participants...

'Lived experiences of anorexia nervosa in those aged 60 and above':

A research project applying philosophy to health and well-being

Are you aged 60 or above and have a diagnosis of anorexia nervosa?

Would you be willing to talk about your experiences in a non-judgemental, non-clinical context?

If you are interested in participating, or can pass this information on to someone who might, please contact me, Sarah Warriner, to talk about the project and ask questions.

Email: S.Warriner@2014.hull.ac.uk, phone: 07486 045456

Appendix D

Representation of the analysis Concept or statement (Paul)	Key word or phrase	Concept/theme arising
'…this particular time which sticks in my mind I remember, this fella saying to me, you, you eat as if you don't want to do it, Paul (mm). I was I was frightened to eat…(yeah)…you know. I got it into me head that…I couldn't digest, I told you before I…(mm)…'	Fear when eating, confusion, feeling the observation/look of others	Frozen, muted The Other
'I once read an article somewhere it said…you had to eat deliberately…(Sarah – Right)…that sort of confused me so I…(Sarah – Mm)…so I'm still bloody confused about it… Then you read some articles where in your stomach there's a lot of vi- erm…I don't know what the…lot of viruses and things which (Sarah – Yeah)…I dunno, and that frightens me.'	Confusion, fear, eating is a puzzle to solve, frustration	The body as peculiar
'Well my wife I told you before, tried to get me to eat with them (mm) but I wouldn't I, well I tried, I did try (mm) but I got into hell of a state…(mm) and I used to go into one of the other rooms, eat on me own, and…then I was alright, but I- err…err you know I can't tell you any more, I-I…I'm not bad eating on me own (mhm)…I'm not bad eating on me own simple as that (yeah). Err, it's still a little bit of an ordeal but…erm…I'm…it's when people…are with me and watching me and (mhm), you know…	Barrier between self and family, connections blocked, isolation, solitude when eating, feeling relieved	

Appendix E

Anonymised interview transcript *[Taken from second interview with Poppy]*

Sarah: So what was it like going, going to Colin's parents' for, for Christmas?

Poppy: I couldn't I could never rel-, I mean they were lovely Colin's parents were lovely (mm), very warm, annnd...they were very sweet, but it wasn't home I never felt I belonged anywhere really (mm)...

Sarah: So you didn't feel at home...(oh god no) at your parents' home (no)...and not at, (no) Colin's home either?

Poppy: And I don't think when you've had that upbringing where you've never been allowed to be yourselves as teenagers we didn't, we couldn't go out we didn't have any clothes or anything...you haven't got through that, emotional intelligence (mm) dealing with things, I think it always holds you back in...(mm) I mean when you've had experiences like that...you think it's the norm as well (mm) because you don't know anything else...(yeah) so you carry those...with you as well (mhm)...so no you're always on a knife edge I think...

Sarah: Yeah, yeah you used the analogy of the uneven ground I think (mm) and you said (mm) about you know you plant those seeds in, your childhood and (yes) then you're always...you don't have that stability.

Poppy: No there's no stab- there was never any stability (mm...yeah)...but there you go.

Sarah: Mmm...So what happened after you, when you moved out then into this flat or wherever you (we moved in to the flat) went to live

Poppy: ...and then I was, erm...seeing Colin at the time (yeah), and so, we got engaged and then, my sister my parents bought my sister her own house in...the village nearby (okay), wouldn't buy help me at all because...

Sarah: This was your twin sister?

Poppy: This was my twin (ohh, right), wouldn't help me my mother HATED me, which I didn't realise so I couldn't understand why they didn't help me why they never, helped me it wasn't (mm) til we had family therapy with Eve, (mm) when I was thirty one, that I realised! (right) Everything slotted into place! (mm) So they didn't help me at all so I was left in a flat on my own in the village, and then Colin and I got married bought a house...(yeah) and carried on from there (mhm), but I didn't know if my mother would come to the wedding she said she wasn't coming to the wedding (mm) my sister was poorly at the time...and that was a nightmare...so I didn't know if she'd come to the wedding (mm), when we got to the wedding my father when it was his speech he said I've got nothing to say and sat down (mm, mm yeah you said), you know really horrible parents (mm), vile parents, I mean I went to Debenhams one lunch time and bought my wedding dress...(right) you know my mother never...participated in ANYTHING (mm)...you know, I was glad when it was over when we, we went to a hotel on the

coast for our wedding night before we flew for our honeymoon (oh lovely), and I was just so glad it was over (mm), and we'd actually got through the day (yeah) and it was a beautiful night, it was spring, like this (mm), it was beautiful...(yeah)...you know, and then...we went on our honeymoon (mm).

Sarah: So at the end of the day after the wedding your feeling was (relief) I'm glad (we've done it) that's over?

Poppy: Yeah, oh god yeah...(yeah) wasn't a day I ever remember (mm) enjoying at all, it was getting oh from the beginning from thinking oh my god, ermm...what's gonna happen...(mm...cause of your, I suppose your experience of like an uneven) well I didn't know if my mother (ground and) would turn up but, (yeah) the father I knew would be rude at the reception which he was, (mm) it was absolutely awful (mm), no respect for anybody...(yeah) so I was just pleased when it was over.

Sarah: And how did it feel once you were married then and you were living, with Colin an, like did that feel like...home?

Poppy: Yes that did more, better (yeah), and it was a battle cause in those days you didn't live with anybody so I didn't know what he was like so we had two years of arguing...([laughs] oh right) [Poppy laughs loudly] If I'd lived with him we wouldn't be married! ([Sarah laughs]) [Laughing} Both of from both aspects, you know just from mine from his as well ([Sarah continues to laugh]) so erm, that was interesting! ([Sarah laughs]) and only one, elderly parents, mother never going to work, living with grandparents expect I'd take up from where his mother took off from (yeah)...so we had a few interesting things ([Sarah laughs]), but he was really good cause I could explode cause it's learned behaviour like mum (mm), and I remember really shouting and throwing a boiled egg I told you didn't I (yeah!) and it hit the wall ([Sarah laughs]) [Poppy smiles] and he NEVER, my father used to be complicit in my mother's moods (right), Colin never did...he would, very gently, make it quite known, that was unacceptable (yeah)...but we'd have our tiffs and I made it quite known when...he was...being unacceptable with different things (mhm, mhm)...ermmm, but I suppose...I would, I didn't like it at the time, I probably argued back but then I'd take it on board which my mother never did (yeah) but there was nobody to tell her anyway (yeah)...you know so, and, Colin was the first time anybody showed me any love I think (mm...I really) so that made a difference.

Sarah: Yeah I really got that impression when I'd, when we were talking, about Colin before we were talking about food and you'd said erm, oh you know he just eats what he wants and, he's very different to me and it sort of went from there (mm) and, you know you, you'd really lit up and you were saying you know, oh and we argue but it doesn't matter and (yeah), and it...I could see like, such a difference between how you talked about that relationship, (mm) to how you'd described your relationship with your parents, and even with, you know your siblings and stuff when you said about, erm, your older sister and, that competition and stuff, and...

Poppy: I think Amanda my older sister only, she's only had Amanda to look after Amanda (mm), she's not had anybody Eve and I with being twins we've had each other (yeah), my elder

sister is very selfish she puts herself first time but...do you blame her (mm) because who else has looked after her Sarah? (mm, yeah) There's only Amanda she's been through three marriages [laughs] (right [Sarah laughs])...there is only Amanda who can look after Amanda cause nobody else really has done (mm)...you know so I don't, she's extremely selfish and Colin...is not terribly fond of her at all...(okay) because of it, but I can understand why she is but he's not had sisters so I don't think he's got that (mm), he hasn't got brother and sisters, you know (yeah) so I don't think he's got that, sort of sibling sort of understanding anyway (mhm), but he thinks the world of Eve but he's very, different about Amanda (mm)...but Amanda's had to be like she has to survive (yeah) bless her...(yeah) you know you've just got to accept folk...I think, (mm) you know but...Colin finds that he's a bit wary (mm) of Amanda...[laughs loudly] (yeah)...and she can explode like me mother (right), Eve said they were playing scrabble they'd been on holiday and she upended the board and went off and was really nasty my mother used to have really, awful comments, and Amanda said Eve was so upset she said oh, cause Eve was winning she said well look at you you're really smug aren't you winning, this was only about three years ago you just don't do it do you! And Eve was really upset, and she went [sighs] Amanda had a, paddy like my mother did (mm), but it's all learnt behaviour Sarah...(and you, yeah) you know and I probably (for you to recognise) still do things (yeah), that me mother did (yeah)...you can't just get rid of it (mm), but yeah Eve was...just mortified.

Sarah: Yeah...yeah when you erm ([Poppy laughs]), when you'd talked about Colin and you, and...I don't know it almost seemed like that relationship when you'd talked, everything that you'd sort of said about your family life was like, if something bad happened, there was a consequence and...you know you'd be punished and...you know that they...they didn't even want you there in the first place and that, idea of like...being rejected, like if you do something bad then you'll, you'll just be rejected and that's (mm), you know that's, what will happen...whereas when you talked about, Colin it was like that you can, have arguments and you can...say stuff to each other or, tell each other wha-, how you feel...but that...there is no, real consequence cause ultimately (no) like the, that you love each other and that's...like that...I saw like such a contrast between that, and all the other relationships that you'd, had you know with the family members and stuff maybe not so much with your, your twin sister but...

Poppy: We've argued once and that was (mm) over my mum...(but to, to) so yeah.

Sarah: ...for that, to be so different and you know for, that it...talking about it you were so...positive (mm) and like happy and...

Poppy: Well every night, when we go to bed, we always, we get into I mean I tend to, well we get into oh it's, like [smiles] this is, ([Sarah laughs]) we, we're Laurel and Hardy like last night ([Sarah laughs]), Colin goes to bed, I walk the dog and I do like a hot water bottle, so I have a hot water with a cup of tea don't want a cup of tea, so, Colin goes to the bed first, and is in bed, and then...the switch is by the bed head so I go in clean me teeth get ready for bed annd then, last night I read a bit...annnd, while I was having my cup of tea, then the light goes off, and then I tend to use my phone to read, (mhm) cause Colin doesn't like the, it's really bright the lights bless him he can't sleep (yeah), so ermm, the light went off, and then we say

goodnight, so of course we banged heads ([Sarah laughs]) because it was pitch black [Poppy hits her fist into her other palm], night dear CRACK! ([Sarah laughs]) So we bang heads, [Poppy laughs] and then, thaht goes on most nights [both laugh together], and in the morning, when we get up, we always give each other a kiss to say, good morning (mhm)...morning dear, morning! You know, it's like Laurel and Hardy it it's just ridiculous, and it's like...when we're on holiday did I tell you this we, when we go to different countries we speak different languages, almost, we sort of come from the same, so we, when we're in the Lake District we got into Scotland by mistake...(right okay [Sarah laughs]), so ah so Colin will pipe up [in a Scottish accent], aye I think we've taken the wrong roooad ([Sarah laughs]), cause it'd say Scotland [smiles] so then we'd have a conversation in Scottish see, when we go on the ferry to france as soon as we get off we both look to each other and go...bonjour! ([Sarah laughs]) as we get off the ferry, and then we talk in French in our, O level French together, and this is how we go to Ireland that we go to Wales and, so we have this ridiculous sort of, repartee between, and my twin thinks it's hilarious cause she says you're like it all the time! ([Sarah laughs]) We just have this sort of, witty repartee we chunter at each other but then we get over it (mhm)...you know Eve thinks we're ever so funny (mm)...you know...

Sarah: And that's a total contrast to what you'd said (a total difference) about (yes) oh I can't, I couldn't express myself at home (yeah) because you don't know what's gonna happen...