A Foucauldian Discourse Analysis of 'Eating Difficulties' in Other Specified and Unspecified Feeding and Eating Disorders (OSFED/UFED)

GURBAANI BHALLA

2160419

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Abstract

The medical model appears to dominate the understanding of 'eating difficulties' in current literature and practice. This study set out to critique this pathologising lens by reviewing the concept of 'eating difficulties' in individuals who identify with symptoms of the diagnostic label of OSFED/UFED. The purpose was to understand how various ways of talking about 'eating difficulties' impact subjectivity and practice. The focus of this study was on the discourses mobilised in the context of this diagnostic label to better represent and understand this eating disorder diagnostic category in a humanistic way.

Six individuals self-identifying with OSFED/UFED were interviewed using a semi-structured interview. This was analysed using a Foucauldian Discourse Analysis (FDA) from a social constructionist position. The analysis identified five main discursive constructions set within a wider discourse: (1) Eating difficulties as a binary or rigid concept (2) Eating difficulties intertwined with fatphobia (3) Eating difficulties in relation to the OSFED diagnostic label (4) Eating difficulties as transdiagnostic (5) Eating difficulties as a spectrum. Given the prevalence of the medical model, the first four discursive constructions draw from the dominant biomedical discourse. At the same time, the 'spectrum approach' emerged as a counter-discourse resisting the privileged dominant understanding of eating difficulties. Overall, the construction of 'eating difficulties' through a biomedical discourse is argued to uphold problematic power structures and undermine the experiences of individuals who do not fit into rigid diagnostic labels and fall under the subthreshold OSFED/UFED label.

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Abbreviations

APA: American Psychiatric Association

BMI: Body Mass Index

CBT: Cognitive Behaviour Therapy

CBT-E: Enhanced Cognitive Behaviour Therapy

CoP: Counselling Psychology

DSM: Diagnostic and Statistical Manual of Mental Disorders

EDNOS: Eating Disorder Not Otherwise Specified

FA: Fat Acceptance

FDA: Foucauldian Discourse Analysis

FGD: Focus Group Discussion

HAES: Health at Every Size

HCP: Health Care Professional

IPA: Interpretative Phenomenological Analysis

NHS: National Health Service

NICE: National Institute for Health and Care Excellence

OSFED: Other Specified Feeding or Eating Disorder

TED: Threshold Eating Disorder

UEL: University of East London

UFED: Unspecified Feeding or Eating Disorder

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1 Chapter One: Introduction

1.1 Setting the Scene

The Diagnostic and Statistical Manual of Mental Disorders (DSM) has been pioneered as a gold standard, being one of the most critical documents for the diagnosis and classification of 'mental disorders.' Published by the American Psychiatric Association (APA), every new edition or revision has seen an increase in the number of 'disorders' established by this manual (Khoury et al., 2014). A central objective of this manual was to establish cut-off points between what is regarded as 'normal' from the 'pathological' in order to treat the people belonging to the latter category. This concept of 'pathological' is an arbitrary decision that is not always scientifically driven (Frances, 2013); its rampant 'creation' of 'pathologies' adds to the confusion about the potency of the DSM. This manual has a stronghold in influencing the mental health world, which further instigates this lens into the wider society. There has been an increase in pathologisation, making populations perceived as saturated with 'mental disorders' (Frances, 2013). In light of this, eating disorders have been a category often left at the mercy of this manual to define eating experiences in a way that totally removes all social, political or cultural aspects of this social yet profoundly personal experience of eating.

As a counselling psychology (CoP) trainee working with eating difficulties, I was often frustrated with the limited understanding that these diagnostic categories communicated, let alone how labels like 'anorexia' have been widely exploited in our colloquial language by being popularly associated with young, white female celebrities in media tabloids (Shepherd & Seale, 2016). I strongly oppose the idea of a 'normal' way to eat and, in personal and professional experiences, encountered a variety of eating difficulties which were uniquely experienced yet categorically defined with a medical lens. In line with counselling psychology values, I was disinclined to assume only one

way of knowing and was influenced by the several epistemological positions available in this field. The humanistic position adopted by our field has always endeavoured to respect the personal and subjective over the diagnosis (Lane & Corrie, 2006). I have always experienced this clash of managing these values while working in a space influenced by diagnostic categories. However, it is this fundamental lens of counselling psychology that has inspired me to carry forward the objection to the medical model and the DSM (Strawbridge & Woolfe, 2010) in an attempt to 'depathologise' eating difficulties. This is to build on a more humanistic understanding of one of the lesser known 'eating disorders': other or unspecified feeding and eating disorder (OSFED/UFED).

1.2 Background to the Research

It was at a workshop about disordered eating conducted by my placement provider that I first discovered how OSFED/UFED is so prevalent yet neglected in our community. Essentially, any individual who fails to fit into a traditional diagnostic box and struggles with eating was given this label. I wondered how this could easily pathologise many people yet underserve those who are not 'severe' enough and find themselves on long waiting lists or not be offered help at all. However, to even reach out for help, one needs to comprehend their eating difficulties as 'bad enough', which is difficult for the lesser-known labels. The current rhetoric of diagnostic labels made me question its usefulness and competence. As an aspiring counselling psychologist, I wanted to bring more attention to this topic from our humanistic value base (Strawbridge & Woolfe, 2010).

Within the current literature, there is sparse research on this topic, which has mainly been from a positivist lens. My critical perspective emerged from questioning the historical and epistemological assumptions of the medical model on the subject of eating. Inspired by my readings of Foucault, I set out to explore how 'eating difficulties' are constructed by individuals who lack clinical and research representation. My purpose was

to provide a non-traditional way of exploring eating that was more in line with what I wanted to contribute to the world of psychology and the social justice agenda of our field (Cutts, 2013; Tribe, 2019).

1.3 Overview of the Chapter

The first chapter aims to relay an understanding of the current literature on the diagnostic category 'other or unspecified feeding and eating disorder (OSFED/UFED)'. I will start by introducing my positioning in this research. I then present the literature review, which begins by providing a background on how eating became pathologised. This is followed by an expansion of the diagnostic history that runs parallel to the pathologisation of eating and bodies. Afterwards, weight stigma in the medical discourse will be examined, followed by a focus on OSFED/UFED in medical literature and how it has shaped this study. The review will finally address transdiagnostic and other alternative ways of addressing 'eating difficulties' in the current literature.

1.4 Positioning and Terminology

I am originally from a positivist quantitative research background where I was surrounded by language worshipping diagnostic manuals, and everybody had a 'measuring stick' ready to quantify any human experience. My own struggle with eating was never something I felt comfortable being 'measured' but rather more holistically understood. It was through my interest and interaction with counselling psychologists that I realised how certain knowledge could go unquestioned and complex human experiences reduced to just a label. My experience in this doctorate made me realise our way of understanding the world comes from our interaction with others (Burr, 2006). Perhaps this experience of a reality shift and the role of language in producing knowledge influenced my methodological decision to conduct a discourse analysis.

Throughout this thesis, I adopt a social constructionist epistemological stance. This approach acknowledges that the construction of discourses is dependent on social, cultural and historical contexts, which have real-world implications. Further explanation of my epistemological and methodological position is provided in Chapter 2.

To ensure quality in qualitative research, I have written this thesis in the first person to maintain transparency and acknowledge my positionality (Harper, 2012; Willig, 2013). With this, I intend to highlight that my role as the researcher is integral to this thesis, which is also a construction and not an 'objective' account.

Terms such as 'eating disorders' or 'disordered eating' are widely used in the field of research and beyond. However, given my position, I believe this term holds pathologising and stigmatising connotations. While I have chosen not to use this term when referring to my participants, I have used single quotation marks to emphasise their social constructionist nature. Finally, I have decided to use the term' eating difficulties' to use a less medicalised word to encapsulate the participant's struggle with food, eating and even their bodies.

1.5 Literature Review

1.5.1 Literature Search

The existing literature concerning 'OSFED/UFED' and 'eating' was reviewed using various databases such as APA PsychInfo, Medline, EBSCO and the generic search engine of the University of East London (UEL). The search period was from September 2023 to May 2024. During that time, various combinations of the following terms were used: OSFED OR UFED OR other/unspecified feeding and eating disorder OR EDNOS or weight stigma OR fatphobia OR higher weight OR eating disorders OR eating difficulty OR disordered eating.

The literature review was discursive in nature, and relevant theories and research were considered to identify gaps and make an argument based on the analysis. The literature was

then organised and grouped based on dominant discourses to allow the reader to follow the narrative being constructed.

1.5.2 How Eating Became Disordered

What we now know as the modern-day phenomenon of 'eating disorders' has been present and noted in history dating back to as early as the Hellenistic (323BC-31BC) and even medieval times (5^{th} – 15^{th} century AD) (Marks, 2019). Social and cultural concepts of 'purification' were pursued through hunger and denial of physical needs. Self-induced fasting or starvation were often pursuits of holiness and considered a spiritual practice usually occurring in young women. Labelled as 'Holy Anorexia', their single-minded pursuit of overcoming gluttony bears a resemblance to contemporary anorexic descriptions of women now striving for thinness (Bell, 2014).

What we have since come to understand and name as 'eating disorders' have been studied and theorised from different perspectives, but the medical and illness-focused frameworks have been most widely used (Malson et al., 2004). The first medical description of an 'anorexic' like illness was noted in 1689, after which the term '*anorexia nervosa'* was coined by an English physician in 1873 (Marks, 2019). Since then, the medical community started to report an increase in this 'new' disease and publications in the 70's raised public awareness of this 'disorder'. Hilde Bruch, in her book, The Golden Cage: The Enigma of Anorexia Nervosa (1978), made available to the public descriptions of anorexia as a potentially fatal disorder of "self-starvation" deemed difficult to treat and mainly impacting "pretty, intelligent girls from good homes" (p.179). These ideas were based on Dr Bruch's interpretation of the changing society at a time when extreme slimness was becoming a fashion standard, and feminism was inspiring women and girls to use their abilities for achievement, as well as the oral contraceptive providing "greater sexual freedom" (p. 9). With

this, she inspired early literature on anorexia with her writings focused on "weight correction" (Bruch 1978, p.129), portraying starving individuals as incapable of engaging in meaningful therapeutic work. As such, the patient's pursuit of thinness and the clinician's focus on weight restoration created the tone for objectifying the anorexic body in therapeutic work and initiated a discourse rooted in weight stigma.

In the 1970s and 80s, there was a surge in diagnosing anorexia in both the United States and Western Europe (Brumberg, 2000). With this, the prevalence of anorexia increased in the Western world at the same time these societies were embracing thinner ideals for female bodies. This led scholars such as Brumberg (2000) and Hesse-Biber (2007) to establish the role of cultural idealisation of thinness in promoting eating disorders. The final two decades of the 20th century witnessed a significant increase in public awareness of eating disorders. They were viewed to be affecting a broader demographic as well as linked with cultural trends that provided more freedom for women and girls but also worsened their anxiety. At the time, public awareness was being guided by the medical community and its interaction with the cultural discourses around women's bodies and freedom. A sociocultural understanding of eating disorders constructed with biomedical ones often blurs the line between what is considered normal and pathological. This shows how their interaction becomes a part of our subjective realities, experiences, and pathologised practices (Katzman & Lee, 1997). The pathologisation of eating and our bodies was done systematically through the development of diagnostic categories.

A pertinent component of this review is to highlight the transition and formation of different diagnostic labels as well as to identify weight stigma and power in the biomedical discourse. This will play a key role in our understanding of various other eating difficulty experiences apart from anorexia.

1.5.3 Diagnostic Development of Eating Disorders

The growing medical and public awareness of eating disorders was accompanied by the construction and continued revision of the diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (DSM). The DSM diagnoses millions of people and has been used by clinicians, researchers, lawyers, governments and the public for over 60 years (Demazeux, 2015; Poland, 2014). This manual was created to enable communication among clinicians by creating a common diagnostic language and a system of language. This resulted in constructing a narrative that imparts a sense of respect for those viewed as clinicians (Lakeman, 2014). The DSM-I in 1952 listed anorexia nervosa as a "psycho-physiologic reaction", which was followed by its revision in DSM-II as being referred to as a "feeding disturbance" (Marks, 2019, p.4). Bulimia nervosa was then introduced in the DSM-III, with the main distinction between them being weight. The next version of the DSM-IV and DSM-IV-TR (text revision) refined the categorisation of anorexia as restricting or binge-purging type and similarly for bulimia as purging or non-purging type, as well as adding compensatory behaviours like restricting or exercise. With this, the main identifiers of these eating difficulties continued to be weight and slimness.

In the fourth edition of the DSM, a new category was created called Eating Disorder Not Otherwise Specified (EDNOS; American Psychiatric Association, 2000). In the DSM, 'not otherwise specified' or NOS, by definition, means residual categories that exist alongside the specified disorders. EDNOS was a broad, heterogenous and ill-defined criterion for those who did not meet the strict criteria for anorexia nervosa and bulimia nervosa. Although it is the most common eating disorder seen in clinical practice (Button et al., 2005; Ricca et al., 2001), EDNOS was often most neglected by services and research due to its residual nature (Pincus, Wakefield Davis & McQueen, 1999). Additionally, the DSM-IV classification system can be considered problematic, with up to three-quarters of cases falling under the

EDNOS category (Eddy et al., 2010), thus leading to further neglect of individuals who experience eating difficulties, as well as pointing to a very limited definition and understanding of 'eating disorders'. The recent revision of the DSM-V aimed to make up for their previous shortcomings by introducing binge eating disorder (BED) as a distinct diagnosis, which resulted in the single largest drop in EDNOS cases—making anorexia nervosa, bulimia nervosa and binge eating disorder labelled as threshold eating disorders or TEDs (American Psychiatric Association, 2013). More importantly, the 5th (current) edition created new diagnostic categories in the eating disorder classification called Other Specified Feeding and Eating Disorder (OSFED) and Unspecified Feeding and Eating Disorder (UFED), which are both a revised version of EDNOS and are aimed to represent the EDNOS category better.

The diagnostic label of OSFED includes five heterogenous subtypes known as atypical anorexia (symptomatically meet the criteria for anorexia but are not underweight despite weight loss), low-frequency bulimia nervosa, low-frequency binge eating disorder, purging disorder (recurrent purging to influence weight or shape) and night eating syndrome (recurrent episodes of night eating after the evening meal or after awakening from sleep) (American Psychiatric Association, 2013). UFED applies to any other clinically significant presentations that do not meet the full criteria for a threshold eating disorder (TED). OSFED is currently the single largest category of eating disorders (Galmiche, 2019; NICE, 2017), yet it is the most underrepresented in literature (Byrom et al., 2022). This points to continued and further neglect of those fitting into the OSFED/UFED diagnostic label. Further, given the construction of this label in the DSM-V, it is more about exclusion from the threshold categories rather than a meaningful classification of its own. As described by Fairburn and Cooper, "the range of presentations is striking" (2011, p.3).

The rationale for this classification was to provide an enhanced clinical description and inform course and treatment options by recognising and defining patterns of symptomatology (Keel et al., 2012; Wilfley et al., 2007). However, due to its construction in the DSM, it is often misinterpreted as 'subclinical' or 'subthreshold' and lacks appropriate clinical attention (Todisco, 2018). While the clinical utility of this diagnosis is under question (Fairweather-Schmidt & Wade, 2014; Mustelin et al., 2016), it is also failing a large population of people that get cast away to a 'subthreshold, residual' category. This highlights the power of the DSM and medical discourse to define and label the experiences of individuals and dictate treatment access and clinician attitudes towards symptomatology. However, it is vital to consider the role of clinical and medical risks associated with severely low body weight, rapid weight loss or frequent purging, often accompanying threshold eating disorders that drive clinical decisions and attention. These risk factors, such as starvation and malnutrition in case of anorexia, avoidant and restrictive food intake disorder, or electrolyte imbalance and gastrointestinal damage in case of excessive purging, are some of the factors that increase risk in severe and enduring eating disorders (Voderholzer et al., 2020). There is an increased risk of death in threshold eating disorders due to the complications associated with these behaviours (Arcelus et al., 2011; Koch et al., 2013). Medical complications and risk factors of eating disorders can expedite first contact with services and healthcare professionals (Voderholzer et al., 2020). This can have an impact on determining clinical hierarchies and diagnostic labelling, which drives decisions around treatment and care.

From a Counselling Psychology perspective, the stringent medicalised way of conceptualising and researching experiences can limit our ability to hold onto our humanistic-existential values to advance our profession (Strawbridge & Woolfe, 2010). Perhaps as a profession, we need to go beyond the medical model to understand, explain and better work with the eating difficulties of a large population of individuals who have been failed by the

diagnostic labels of OSFED/UFED. My ambition with this project is to build a stance against the medicalised language in our field while uplifting the discourse surrounding our profession about methodological pluralism to seek an expanded definition of 'evidence' (Howard, 1984). Therefore, the focus of this study will be on the 'residual' eating disorder category of OSFED/UFED and to advocate for a better understanding of the discourse and power structures around this diagnosis. I have endeavoured for this thesis to be laden with counselling psychology values, as this profession is able to recognise and hold the tensions caused by power in the mental health space and navigate the complexity around a medicalised discourse (Harrison, 2013). According to Foucault, power relations are submerged in the social arena from which we cannot escape (Foucault, 1980a). This, in turn, has implications for therapy with individuals experiencing eating difficulties, more so with those whose eating difficulties are labelled as 'unspecified or other', like in OSFED/UFED.

The medical discourse is the most prominent way of discussing 'eating disorders' as an 'individual' pathology but often neglects the sociocultural factors such as weight stigma partaking in the development of these disorders (Moulding, 2003). Medicalism does not exist outside of the construct of society (Turner, 1996), and the 'body' in the case of eating disorders becomes the subject and is seen as something that must be overcome (Gremillion 2002). Additionally, it also duplicates one of the eating disorder causal beliefs and thinking, where the body is perceived as an object to be controlled. This idea or concept of the body echoes in the medicalised treatment structure, which puts weight gain or loss and behaviour modification at the centre of therapy. This shifts the focus of the eating disorder to a change in weight- either gaining or losing it (Gremillion, 2002), which is not far from what the person has already been concerned about. This also explains the high rate of readmission or hospitalisation in eating disorders (Gremillion, 2002). While the DSM or other diagnostic manuals part of the biomedical discourse claim to merely diagnose and treat bodies, they

actually play a role in further perpetuating that our bodies, predominantly female bodies, can and should be controlled while also suggesting that it is by nature a hard thing to do. This concept further leads to slimness, diet, and exercise being idealised and associated with 'good' bodies with a sound work ethic and a sign of achievement (Gremillion, 2002). While this trend of slimness leads to dangerous ideals or views of femininity, it also, by default, stigmatises and excludes overweight and bigger bodies. This makes it important for us to shed further light on the interwoven relationship of weight stigma with eating disorders in the biomedical discourse and what that means for those with eating disorders of a higher weight.

1.5.4 Weight Stigma in the Biomedical Discourse

Anthropologist Rebecca Popenoe sheds light on the cultural conceptions of ideal bodies, especially for women and social status. She writes, "fat bodies are appreciated where food is hard to come by, and thin ones are admired in places where food is abundant" (2005, p.17). While historically, food abundance has been rare, many societies have shown a preference for larger female bodies. Often, these female bodies are seen as the ability of a man to provide resources in patriarchal cultures.

It is only relatively recently that a culture that idealises slimness has emerged. With the rampant medicalisation curating norms and structures in society, European and US physicians in the late 1800s started to distinguish fatness or corpulence away from the "civilised population" (Anderson, 2024, p.390). Larger bodies no longer being viewed as a sign of status; Leonard Williams, an American physician, argued that fatter women were a preference for savage tribes, and women of the Western world began to fight their tendency to gain weight. This impact can be seen in William's description of fat women as "repulsive sights degrading alike to their sex and civilisation" (Williams 1926, p.4). These examples bear proof that by the early 1900s, the medical community members had started to redefine

heaviness or fatness as an illness, with Life Insurance companies publishing reports to the public concluding- "The longer the belt line, the shorter the lifeline" (Schwartz 1986, p.159).

The word 'fat' as an adjective can also mean richness and abundance, yet this word, for many, is seen as an insult. While acknowledging that within many Westernised societies, the notion of the 'thin ideal' conceals intersectional complexities, there is still a demonisation of the bigger or fat body as well as those who are unable to conform (Nash & Warin, 2017). These representations of fat bodies are woven through the prominent biomedical discourse, which constructs and distinguishes various levels of adiposity or fatness as a health concern.

As described earlier, eating disorders have primarily been conceptualised as disorders of low body weight. However, there is piling evidence against its accuracy. With the most common eating disorders being binge-eating disorder and OSFED (American Psychiatric Association, 1980), there's a need to look at the implications of weight stigma in presentations that occur in people across a large and varied range of body types. While eating disorders are increasing in prevalence, this is particularly true for those who are of a higher weight and have stereotypically different bodies than the 'skinny ideal' generally associated with anorexia. Further, these individuals are under-recognised, unnoticed and often misdiagnosed (Ralph et al., 2022). This makes it more likely for them to be undermined or dismissed by clinicians and sidelined from treatment.

Weight stigma has been a significant contributor to the absence of higher-weight people, such as those with OSFED, not just being secondary in treatment access but also absent from eating disorder research, with the exception of binge eating disorder. Simply put, weight stigma or fatphobia, used interchangeably in this research, can be understood as the derogating association of higher weight with negative personal characteristics (Hart et al., 2021). In this research, weight stigma refers to an occurrence or experience of discrimination,

stereotyping or bias towards a person on the basis of their shape, size or weight (Academy for Eating Disorders Nutrition Working Group, 2020). As an extension, people can often incorporate these disparaging associations within themselves. This strong internalised fatphobia can then predict more significant levels of body dissatisfaction, poorer quality of life and greater eating disorder psychopathology (Wagner, Butt & Rigby, 2020).

Additionally, this has been seen and confirmed by systematic literature reviews where persistent weight-based stigmatisation and discrimination were seen beyond media portrayals but also in interpersonal relationships, employment, education and especially healthcare, including professionals working in eating disorder services across countries and cultures (Brewis et al., 2018; Pearl, 2018; Puhl et al., 2014). Those already marginalised by race, gender, class and sexuality are further dismissed for their eating difficulties (Fikkan & Rothblum, 2012). Consequently, this has adverse consequences as the interplay of direct and indirect discrimination and internalised fatphobia impacts the overall well-being (Pearl, 2018; Pearl & Puhl, 2018), as well as the development and maintenance of eating difficulties (Puhl & Suh, 2015).

Given how OSFED and UFED came to be from the reformulation of EDNOS, this category already bears the weight of marginalisation based on their 'subthreshold' nature as well as the ambiguity of the diagnosis. Further, being perceived or experiencing weight stigma or fatphobia by healthcare providers adds to disengagement from treatment and care (Mensinger, Tylka & Calamari, 2018; Phelan et al., 2015). Conceptualising and reducing eating disorders solely to weight standards can further exacerbate the use of language that is stigmatising and hinders a better and more person-centred view of a person's eating difficulty. This reductionist and positivist lens gears the medical view of eating disorders to be individualising, normalising and pathologising, which are still influential in therapeutic practice. Eating disorder formulations that are persuasive in psychological settings and

literature suggest that these disorders arise from low self-esteem and self-loathing (e.g. BjoÈrck et al., 2007), negative thoughts or dysfunctional core beliefs (e.g. Waller, 2003) or from sexual, physical or emotional abuse (e.g. Hodes, 1995). All these different types of formulations focus on individual and local factors of the person while taking attention away from the contextual power.

It is important to note that stigma and its impact are seldom limited to subthreshold eating disorders. Stigma towards disorders of eating prevails in all categories and is generally more distinct than stigma associated with other psychological difficulties like depression (O'Connor et al., 2016; Roehrig & McLean, 2010). While one of the focuses of this study is weight stigma, which is often experienced by individuals whose body differs from cultural norms (Brewis, 2014; Brochu & Esses, 2011; Lewis et al., 2011; Vartanian & Shaprow, 2008), there is a need to touch on stigma, discrimination and prejudices, which are still pervasive across various settings in all eating disorders (Brelet et al., 2021). Experiences and types of stigma also vary across eating disorder categories like anorexia or bulimia nervosa (Caslini et al., 2016; Crisp, 2005; McLean et al., 2014; Mond et al., 2004), making this a continued issue to be acknowledged and addressed in research and practice. Further, demographic characteristics such as gender, socioeconomic status, age, weight and ethnicity of the individual have a notable impact on the extent and experience of stigma (Ágh et al., 2016; Brelet et al., 2021; Lupo et al., 2020).

Eating disorders at any weight are serious, medically complicated, and associated with psychological distress (Appolinario et al., 2022; Sawyer, 2016;Whitelaw et al., 2018). Healthcare workers and medical professionals may be influenced by societal and cultural views on larger bodies and focus the treatment on a person's weight rather than their eating difficulty. Often, public health campaigns and media coverage talk about an 'obesity epidemic' or a 'war on obesity', which focuses not only on health 'risk' but portrays fatness as

a societal and economic burden (Gard, 2011). Fatness is depicted as an 'obvious' medical issue associated with poor individual health behaviours that are underpinned by ignorance and laziness, often narrowed down as – a failure to 'eat less and move more' (Nimegeer, Patterson & Hilton, 2019; Paul & Heuer, 2010). There is usually a moral value placed on healthy eating where foods are categorised into a 'good' and 'bad' binary (Wills et al., 2013), where 'bad' foods are associated with immorality and irresponsibility (Crossley, 2002). This moralisation of health, known as healthism, advocates for perfectionism in health in inherently imperfect bodies through fitness and diets. Healthism has shaped the belief that the responsibility and control of optimal health lies with the individual (Crawford, 2006). This encourages them to engage in self-surveillance as any illness would be deemed as their own fault (Cheek, 2008). With the rise of obesity as a social concern, there has been increasing focus on adopting healthier behaviour as a moral and social responsibility of the population to counteract obesity (Brown, 2013). Despite the consequence of weight stigma at the societal and individual level, many people, including health care professionals, continue to maintain the idea that stigma or 'fat shaming' is a persuasive and acceptable way to motivate people with larger bodies to alter their eating behaviour (Nath, 2019; Puhl & Heuer, 2010).

Health at Every Size (HAES) is a public health model and philosophy that has grown out of a need to challenge healthism and traditional weight management approaches and address weight stigma and bias in individuals with higher weight (Miller, 2005). Advocates of this model deem it less dangerous and more effective for weight management compared to more medicalised approaches (Robinson, 2005). The HAES approach takes focus away from measures of body weight and shape and instead promotes a "fulfilling and meaningful lifestyle" in which internally directed signals of hunger guide eating (Robinson, 2005, p.185). HAES directs us towards encouraging body acceptance and intuitive eating and supporting embodiment (Bacon & Aphramo, 2011; O'Keefe et al., 2010). Here, the aim is to develop

intervention strategies for obesity that do not restrict successful outcomes to body weight and might even exclude it as an evaluating factor (Miller, 1999). Instead, HAES focuses on promoting a healthy lifestyle, acknowledging individual differences in responses to treatment and determining the underlying causes of individuals' behaviours by exploring their feelings (Brown, 2009; Miller, 1999, 2005). HAES challenges weight stigma for people with larger bodies and attempts to disrupt the hegemony of the existing biomedical model that perpetuates healthism. Additionally, HAES enables us to take an "antistigma approach" to interventions by focusing on body acceptance regardless of shape, size or weight (Penney & Kirk, 2015, p.3). Utilising HAES in ED interventions, particularly for OSFED/UFED, might encourage healthier behaviours and minimise the scope of harmful behaviours that individuals might undertake when feeling negatively about their bodies.

Solomons, Davenport and McDowell (2023) provide insight into the intersections between eating disorders and fat acceptance (FA) movements by discursively analysing the construct of 'eating disorders' in FA online forums. They highlighted how the experience of eating disorders was different for people with a higher weight due to societal fatphobia. Their analysis uncovered anticipated preconceptions in the community such that eating disorders, and even anorexia, were only significant for those who were very thin. Living with an eating disorder, as well as what is 'acknowledged' as one, was different for fat people versus people of lower weight. Often, severe restriction and 'anorexic' like behaviours were seen as a good thing when you were of higher weight. Such behaviours that would otherwise raise concerns and diagnosis were often not only ignored but also encouraged by society for people of higher weight. Experiences of this stigma and discrimination were seen as present within professional systems that left people feeling even more vulnerable to further psychological and physical harm.

This brings in a further need to research and question how fatphobia is interwoven in the experiences and language of people with OSFED/UFED.

1.5.5 Understanding OSFED in the Biomedical Discourse

With the introduction of OSFED and UFED in the DSM-V as a replacement for the residual EDNOS category came the need for highlighting meaningful differences between the threshold and residual eating disorder categories to validate their clinical utility. For positivist quantitative studies, it is essential to establish clinical utility for a new diagnosis as it means the ability to infer its characteristics, aid treatment selection and provide diagnostic information (McGorry & Van Os, 2013).

Fairweather-Schmidt and Wade (2014) conducted a study in Australia which aimed to fill this gap by identifying any meaningful differences by examining the degree of impairment and risk factors between TEDs and OSFED. Adolescent female twins (N=699) were interviewed with the Eating Disorder Examination (Wade et al., 2008) on three different occasions, with a gap of 1.91 to 4.65 years between each data collection wave. Self-report measures of impairment and risk were also collected and found no significant difference between the two groups. They concluded the limited clinical utility of OSFED diagnosis for adolescents was anticipated due to the equal levels of impairment between TEDs and OSFED. This further challenges the 'subthreshold' nature of OSFED against TEDs.

This study has highlighted one of the problems of using the DSM-V for the eating disorder residual diagnostic category. The study's longitudinal design led to the exclusion of the OSFED subtype of sub-threshold binge eating because of its 'relaxed' criteria that posed difficulty in assessing impairment levels for data collection. Although, doing so reduced the probability of type 1 error. Another issue of studying eating disorder symptomology based on the DSM-V measure of body mass index (BMI) and eating/weight perception in adolescents

is that the different developmental levels influence the expression of ED symptomatology (Bravender et al., 2010). Thus, measuring symptomatology over a few years in adolescents is tricky. Furthermore, the reliability of self-report measures of BMI or eating disorder pathology can be questioned due to fear of shame or stigma, which displays a limitation of utilising a quantitative methodology in contextualising OSFED. However, the design and robust methodology give us insight into the limited clinical utility of OSFED as per the DSM-V and the equal level of impairment between TEDs and OSFED as reported by the participants.

Similarly, Withnell et al. (2022) focused on differentiating OSFED from threshold disorders based on clinical presentation and treatment outcome. The study was done at a community-based eating disorder treatment service in Ontario, Canada, with 172 individuals, of which 106 were diagnosed with a TED and 66 with OSFED. The majority of them were stated as white females, although descriptives about gender or race were not disclosed. Self-report questionnaires were conducted at intake and discharge to assess eating disorder symptoms, depression symptoms, psychosocial impairment and self-esteem. All patients were provided with manualised enhanced cognitive behaviour therapy (CBT-E). The results suggested similar eating concerns and restraint symptoms between OSFED and anorexia and bulimia nervosa, with no differences in global symptoms and body shape concerns. Lastly, no difference in self-esteem, depression scores or symptoms change over treatment was found between the diagnostic groups. While those with OSFED experience similar levels of eating disorder psychopathology compared to TEDs, there is still much to understand or pay attention to in current literature, which will consequently also be reflected in practice. The patient data in this study came from a naturalistic treatment setting, which is favourable for generalisability for quantitative studies; however, lacks a diverse sample. Selection bias should be considered in treatment settings research as individuals with less severe or atypical

forms of OSFED may not seek treatment. OSFED is also more prevalent in male and ethnic minorities who are less likely to seek help (Eddy et al., 2008; Thomas et al., 2009; Mitchison et al., 2020).

Both Withnell et al. (2022) and Fairweather-Schmidt and Wade (2014) have rightfully concluded that individuals diagnosed with the subthreshold residual category of OSFED experience the same level of psychosocial impairment and present with similar clinical concerns as TEDs. This builds the case for a more rigorous study of OSFED/UFED that accounts for the clinical heterogeneity of the diagnosis. In both the studies mentioned above, all eating disorders were collapsed into two broad categories of TEDs and OSFED, which fail to recognise the unique characteristics of each diagnosis. While the reductionist quantitative approach strives for generalisability and clinical utility of diagnosis, it also signifies the underlying power structures behind medical discourse, which are suited for clinicians' convenience for referrals, patient records and bureaucratic reasons. Critically analysing the impact of the discourses underlying quantitative research and medicalised practice can give space for co-constructing a client-focus narrative that studies subjectivity and existing power structures using rigorous scientific enquiry.

Further quantitative studies like Mustelin et al. (2016) have continued to emphasise the clinical severity of OSFED/UFED. The study concluded that OSFED/UFED failed to present as a meaningful diagnosis as it was unable to reflect the distribution of eating pathology among individuals in the community. One of the shortcomings of understanding OSFED/UFED in the heterogeneous terms of the DSM-V was that many studies were unable to incorporate all different subtypes of OSFED due to sampling difficulties such as excluding binge eating disorder of low frequency/duration or their eligibility criteria did not match the DSM-V guidelines such as low weight and amenorrhea for subthreshold and threshold anorexia nervosa (Fairweather-Schmidt & Wade, 2014; Riesco et al., 2018; Stice et al., 2009).

Most quantitative literature could not identify differences between OSFED and TEDs regarding eating pathology or risk factors (Fairweather-Schmidt & Wade, 2014; Krug et al., 2021). Further, studies aiming to find treatment outcome differences between OSFED and TEDs presented inconsistent findings (Fernández-Aranda et al., 2021; Schmidt et al., 2008). Lastly, Withnell et al. (2022) and Riesco et al. (2018) were the only studies that examined the outcome of widely used transdiagnostic CBT-E on OSFED patients and reported low motivation to change and high dropout rates. Perhaps this failure may be attributed to patients' disapproval of treatment experiences, and thus, further research is required to improve care for OSFED/UFED service users (Mahoon, 2000). Lastly, within the biomedical realm, it is vital to consider the insurgence of transdiagnostic models for eating disorders when applying clinical treatments like CBT-E that focus on the underlying mechanisms of such a heterogeneous group.

1.5.6 Transdiagnostic Models in the Biomedical Discourse

Categorical understanding of eating difficulties dominates the current discourse, but various other explanatory models of eating disorders have emerged, such as the transdiagnostic models. Transdiagnostic conceptualisations are focused on improving clinical outcomes by recognising and maintaining factors that are common across psychological disorders (Mansell et al., 2009).

Rooted in positivism, a transdiagnostic cognitive-behavioural model (CBT-E) proposed by Fairburn et al. (2003) constructs' eating disorders' as a cognitive problem based on a dysfunctional system of self-evaluation as a critical maintaining factor. Here, self-worth is dependent and defined by control over eating, weight and shape. Overestimation of the importance of these factors is what maintains behaviours like dietary restraint and reinforces

the 'core psychopathology' (Fairburn et al., 2003). Binge eating is understood as the loss of cognitive control while following stringent dietary rules that are difficult to maintain.

It is not surprising that this transdiagnostic model, based on CBT, has gained acceptance and become the leading treatment for these disorders (Cooper, 2017). Prior to the development of the OSFED/UFED label in the DSM-V, clinical cases often migrated from EDNOS to anorexia or bulimia nervosa (Fairburn, 2008). Still, this subthreshold category was not covered in treatment efficacy studies before the development of the CBT-E transdiagnostic model (Fairburn, 2008). This led to negligence in treatment recommendations for EDNOS, which this model has helped overcome. However, this approach is now so manually practised and mainstream that it potentially risks being applied in a stigmatising or reductionist manner (Branley-Bell et al., 2023). Given the entrenchment of fatphobia in eating disorder biomedical discourse, it is worth questioning whether the primary narrative of treatment should be control over eating, weight and shape. This can possibly place excessive emphasis on these factors, which can limit the scope of therapy and language. The 'eating disorder' spectrum has diverse presentations across eating behaviour and weight. It can be argued that transdiagnostic formulation cannot simply account for this diversity, especially in categories like OSFED/UFED that comprise a multitude of divergent eating patterns (Treasure et al., 2018).

An alternative viewpoint emerged opposing the DSM categorical approach and enhancing the transdiagnostic model of eating. Waller (2008) presented a 'trans-transdiagnostic' model of eating disorders that addresses eating disorders as anxiety-driven safety behaviours. In the current DSM categorisation of eating disorders, there is a big question about managing cases like OSFED/UFED that do not meet the stereotypes (e.g. Fairburn and Harrison, 2003; Turner and Bryant-Waugh, 2004). Categories in the DSM have

continued to expand (as seen in section 1.5.3); however, this continued approach of fitting people in categories or boxes does not offer to resolve the issue of subthreshold cases.

Waller (2008) proposed going further than Fairburn et al.'s (2003) transdiagnostic model and sought a more profound understanding of eating difficulties than overvaluation of eating, weight and shape. This was done by putting forward a vision of discarding diagnostic subdivisions but retaining the overall eating disorder category. Waller (2008) pitched relocating them into a wider 'anxiety disorders' category. This is based on considerable evidence of comorbidity between eating disorders and anxiety (e.g. Goddart et al., 2002; Pallister and Waller, 2008) and that anxiety often foreshadows eating difficulties (Bulik et al., 1997; Swinbourne & Touyz, 2007). Eating behaviours such as restricting, binging or purging that constitute eating disorders can be viewed as safety behaviours aimed at reducing the immediate anxiety (e.g. Pallister & Waller, 2008) but, in the long term, influence the maintenance and amplification of anxiety.

Waller's (2008) proposition of eating disorder as a sub-set of anxiety disorder suggested a more extensive re-organisation of these two disorders into a 'transdiagnostic' group with subdivisions based on the type of cognitions and behaviours that are clinically meaningful presentations. It is important to note that this is not a well-established working model like the transdiagnostic CBT model by Fairburn et al. (2003) but an interesting proposition that contributes to the variety of transdiagnostic models in the biomedical discourse. While this proposition challenges the current diagnostic categorisation, it is still rooted in a categorical model of understanding eating difficulties. One of the shortcomings of relying on a categorical model, be it the DSM or Waller's (2008) proposal, is the unresolved issue of meaningfully explaining atypical and subthreshold cases of OSFED/UFED. The transdiagnostic models, rooted in positivism, also maintain the power structures of a rigid biomedical model as well as its ability to define the threshold between normality and

abnormality. This also points towards the difficulty of transdiagnostic models in accommodating various eating behaviours and body sizes across the eating disorder spectrum.

1.5.7 A Spectrum Approach to Eating Difficulties

Contrary to the dominant understanding of eating difficulties as threshold disorders, an alternative discourse constructing eating as a spectrum has been ongoing. This has been motivated by the limitations of the current diagnostic model for providing a meaningful understanding of subthreshold symptoms like OSFED/UFED, previously known as EDNOS. Treasure and Collier (2001) discuss the idea of thinking of 'eating disorders' like a spectrum as the current medical model represents them solely as an impairment of mental health. Treasure and Collier (2001) argue that biological factors alone seldom give a balanced picture of distress and should be combined with various tiers of interpersonal, societal, cultural and environmental factors to develop a broad view of eating distress. The issue of mental health is broader than the absence of a 'disorder' or 'disease' but incorporates positive aspects and psychological resources that together shape the clinical presentation (Treasure & Collier, 2001). Building on this integrative understanding suggests that categorical divisions can be somewhat arbitrary when working with the eating-disordered symptoms in individual cases. Perhaps considering a spectrum understanding of eating might be a more appropriate and pragmatic approach.

There is no single leading spectrum approach to eating that is at par with transdiagnostic or diagnostic approaches at the research, clinical or national guidelines level. Having said that, the concept of eating as a spectrum, however this spectrum may be defined, is still present in language and literature about eating (e.g. Brooks et al., 2012; Miniati et al., 2021; Patton, 1988; Shisslak et al., 1995; Treasure & Collier, 2001; Oldershaw et al., 2011).

In reality, eating difficulties are present in varied forms, and the dimensions underlying eating are fluid and can fluctuate bidirectionally between symptoms (Brooks et al., 2012). Additionally, the stringent lines between 'normal' eating and 'disordered' eating in the diagnostic models maintain the focus only on threshold eating disorders and neglect the symptoms of OSFED/UFED. Brooks et al. (2012) understood the difficulty of defining 'normalcy' from 'pathological' by building a spectrum model of eating. This model is based on an impulse control spectrum of eating behaviours focused on restraint and impulsive tendencies as a basis of eating presentation at a given time. Brooks et al. (2012) resisted adopting a notion of 'pure' normalcy of eating and that people with eating disorder symptoms may also, on occasion, have eating behaviours that may be considered out of the norm (such as binge eating during festivals). This model puts forward a diverse and less pathologising view of eating behaviours that accommodates symptoms of OSFED/UFED without delineating them into a 'subthreshold' or 'residual' category. The aim of this model was to detect restrictive or impulsive eating behaviours early and provide early-stage interventions before these behaviours cause further prolonged distress.

The Spectrum approaches discussed are considerate of the reductionist view and limitations of the DSM and medical model; however, their enquiry has been based on clinical experience and neurobiological findings (Brooks et al., 2012; Treasure and Collier, 2001). It can be argued that this is undoubtedly a counter to the current rigid diagnostic model but requires further development from an epistemologically diverse and humanistic perspective. These findings suggest that a spectrum and fluid approach to understanding eating difficulties can provide a more inclusive and meaningful understanding of OSFED/UFED. However, given the limited diversity of studies, further development is still required to make a strong case to counter the dominant biomedical discourse. Additionally, there is potential for changing power dynamics in a spectrum approach that avoids boxing people into categories

and allows for more freedom of movement between various eating behaviours without reducing their significance. In the case of OSFED/UFED, a new diagnosis was created to 'better' present the cast-away 'residual' eating symptomatology. This showcases the power held by the DSM to define and label individuals' experiences, behaviours and attributes in a hierarchy of importance.

In the current medical model, a diagnosis is found and treated rather than the individual. Thus, the individual becomes a "passive recipient of expert care" (Joseph et al., 2009, p. 38), contrary to the person-centred approach modelled by Counselling Psychology. This thesis is well placed to consider and hold these various approaches and discourses around eating difficulties for people with OSFED/UFED to construct knowledge laden with counselling psychology values that seek to oppose the medical model (Strawbridge & Woolfe, 2010). For this reason, it is important to expand this review and incorporate other opposing views to understanding eating difficulties, such as an intersectional feminist approach.

1.5.8 A Feminist Understanding of Eating Difficulties

Intersectional feminism asserts that social identity categories like gender, sexuality, race, and others are interconnected and overlap to reflect both system wide-privilege and marginalisation (Crenshaw, 2013). The biomedical approach used to understand eating disorders has been extensively criticised by feminist scholars. Under an intersectional feminist approach, eating disorders are viewed to occur as a result of socio-political problems (Woolhouse et al., 2012). In the current biomedical discourse, there is minimal focus on the intersectionality between eating disorders and race, socioeconomic class and able-bodiedness and its interaction with gender (Moulding, 2016; Murray et al., 2017; Thompson, 1994). A feminist approach takes a deconstructive lens in understanding reality by emphasising

examining the gender binaries and gender hierarchies that impact our interactions with the world and constitute our identity (Randall, 2010). Feminist authors advocate expanding the focus of therapeutic formulation to include personal-political relations in order to tend to the social context behind eating disorders in the first place (Guilfoyle, 2009). With these notions being brought to our attention, therapeutic professionals can now be participants in challenging these systems of power that exist in our shared reality rather than just working within them.

Feminist scholars have produced emanant literature contributing to a gendered and socio-political understanding of eating that opposes the current eating disorder diagnosis structure. They have critiqued eating disorder diagnostic labels as pathologising femininity and failing to acknowledge the socio-cultural factors that impact the development and maintenance of these eating disorders (Malson, 1995; Malson, 1998; Myers, 2015). While the further exploration of this discourse is beyond the scope of this study, it is essential to highlight the contribution of feminist research in challenging the medical model. This is essential as the biomedical discourse is riddled with fatphobia that continues to sideline eating disorders of a higher weight, such as OSFED/UFED. The realm of eating disorders, no matter the 'threshold', cannot be devoid of a socio-political aspect to it.

1.5.9 Methodological Critique

OSFED/UFED are challenging to study as they are a newly formed and diverse diagnostic category. The current system of the DSM-V focuses on 'symptoms' but fails to understand and cover the patient's meaning of 'symptoms' experienced (Eivors et al. 2003). It might be helpful to look at other methodologies as the quantitative methodology aided the construction of pathologising reductionist classifications. The pathologising lens of this model also transpires in the perpetuation of weight stigma and manualised transdiagnostic

interventions with a narrow scope of studying eating difficulties in OSFED/UFED. This is challenged by a spectrum understanding of eating that better incorporates OSFED/UFED symptoms, and an intersectional feminist approach highlights the socio-political and gendered aspect of eating behaviours.

Qualitative research methods such as discourse analysis, on the other hand, can be a helpful alternative to quantitative research and provide us with richer, more meaningful data that enhances our understanding of individual experiences. Additionally, this method allows us to understand eating disorders as a socially constructed phenomenon that occurs in interactive contexts (Wiggins et al., 2001) and perhaps requires a constructionist lens to conceptualise individual experiences. Possibly, this interpretation of eating difficulties in individuals with OSFED/UFED can elucidate the power of the medicalised discourse in current psychological settings that can have real-world implications (Foucault, 2002), such as influencing our social reality. Methodologically similar studies have highlighted the pathologising construction of eating disorders in medical settings as well as the inequality within the power relations between clinicians and clients (Malson et al., 2004). Unlike the medical perspective that makes claims about the 'truths' of eating disorders, a discourse analytic method allows us to purposefully study the construction of reality through language and its role in meaning-making.

1.6 Rationale

Considering the power dynamics surrounding our profession, this thesis aims to study eating difficulties in individuals with OSFED/UFED by utilising a Foucauldian Discourse Analysis (FDA) that accounts for 'power' in analysis and concedes inaudible speakers to be legitimate candidates (Cheek, 2004). Performing an FDA will inform the analysis of the role of language and discourse in our medicalised settings laden with unequal power relations.

I would also like to take a critical stance towards the positivist research roots of psychology that have struggled to provide an understanding of OSFED/UFED. The quantitative methodology has furthered the medical discourse and subsequently pathologised behaviour. My identity as a counselling psychologist has primarily grown by challenging the medical model in practice and incorporating humanistic values instilled in the doctoral programme. Evidently, the largest eating disorder category in the DSM-V is also the most misunderstood and under-represented in literature. Using an FDA aligns with my professional identity as it will do justice to my endeavours of understanding how the current medicalised language constitutes social reality, power relations and subject positions for individuals identifying with OSFED/UFED. Counselling Psychology is best placed to challenge the power structures behind the medical discourse of diagnosis. Critically analysing them may give space for a client-focused narrative. On a final note, I would like to present the research questions now.

The primary research question asks:

- How do people identifying with OSFED/UFED talk about their eating difficulties?

The secondary research questions are:

- What discourses are drawn on by the participants to talk about their experience of OSFED/UFED?
- What subject positions are justified by these constructions?
- What is the impact of these constructions on their understanding of treatment access and early intervention?

2 Chapter Two: Methodology

2.1 Overview

This chapter aims to provide the reader with an understanding of Counselling Psychology within a theoretical framework and reflections on epistemological and methodological choices for this study. This will be followed by procedural information covering ethics, participants, data collection and analysis. A note on reflexivity is also included at the end of this section. A Foucauldian discourse analysis (FDA) was used to fulfil the research questions. I align with a social constructionist position to best answer the question.

2.2 Positioning Counselling Psychology Within a Theoretical Framework

Historically, applied and counselling psychology was dominated by positivist research, producing quantitative studies aimed at prediction and control (Ponteretto, 2005). This narrow and pragmatic focus has been the basis of the biomedical model, resulting in the development of the DSM and the insurgence of pathologising language. This is contrary to our profession's humanistic-existential values (Strawbridge & Woolfe, 2010) and the narrative nature of work that sits more comfortably in the realm of qualitative research. Counselling psychology discourse is often centred around methodological pluralism. Our subsequent detachment from the positivist movement has allowed us to seek an expanded definition of 'evidence' (Howard, 1984). Embracing a relational and pluralistic approach enables us to hold various research perspectives and methods. This relational approach is reflected in our work exploring people's experiences in research and clinical practice (Kasket, 2016), thus allowing us to acknowledge the validity of various competing viewpoints. Counselling psychologists have long advocated for an expanded definition of evidence in less positivistic forms (e.g., Howard, 1984). This means paving the way for diverse ontological and epistemological positions than mainstream applied psychology.

Regarding research, there are many competing ideologies of counselling psychology. This highlights our willingness to engage with philosophical tensions, the profession's potential for adaptability and thus, the formation of our distinct professional identities. I have come to understand that our field must take a step out of the box of interpretivism, phenomenology and positivism. We must critically analyse the biomedical roots of our profession, where that has placed us in terms of power, the relationship between discourse and people's subjective experiences, actions, and the material context where these experiences take place. Hence, taking a critical understanding of language to create a more conscious, person-centred and enlightened space for clients. In light of the above, I have engaged critically with various ontological and epistemological paradigms and reflected on the role of my own developing CoP identity and values in research and practice.

2.3 Social Constructionism

Upon reflecting on Willig's (2012) categorisation of how knowledge is produced (epistemology), it was easy for me to position myself with social constructionism as I believe reality to be 'co-constructed' and context dependent. Social constructionism is an epistemology that adopts a sceptical position and is interested in how people talk about the world and construct different versions of reality through language and discourses (Willig, 2012). Furthermore, language is considered to constitute rather than reflect reality in social relationships, where no two people construct reality similarly (O'Reilly & Lester, 2017). This epistemological position assumes that 'OSFED/UFED' cannot be known in a factual sense. Aligning with macro-social constructionism means focusing on how linguistic and social structures shape the social world (Burr, 2006). Hence, this thesis will place emphasis on the notion of power, which is assumed to be ingrained in cultural and historical discourses (O'Reilly & Lester, 2017).

2.4 Rationale for Methodology

The positivist and post-positivist roots of our field led to the use of randomised controlled trials (RCT), forwarding a medical discourse, pathologising behaviour and subsequently shaping the behaviour of individuals in Western societies (Arribas-Ayllon & Walkerdine, 2017). The power of the biomedical discourse lies in its well-accepted definition of what it means to 'have an eating disorder'. The diagnostic label changes in eating disorders (see section 1.5.3) and 'residual' categories like OSFED often fail to serve the 'patient'. This raises the question of paying attention to the relationship between institutions and discourses in administering and organising our social realities (Willig, 2012). This has inspired my methodological choice of an FDA.

Another methodology that was considered was narrative analysis. This analysis method examines how individuals make sense of the events in their lives and categorises the flow of experiences (Riessman, 1993). Narrative analysis piqued my interest as it's a systemic and straightforward way to understand the narrative structure, function, and implications of eating difficulties in OSFED/UFED. While narrative analysis helps connect micro-events to broader discourses to aid the construction of social experiences (Van Dijk, 1993), it is limited in its capacity to engage with institutional and societal disparities in power relating to language that can be overlooked while analysing daily narratives. Hence, using a Foucauldian discourse analysis with a social constructionist epistemological stance was chosen.

2.5 Foucauldian Discourse Analysis

FDA is a post-structuralist form of discourse analysis shaped by Michel Foucault's ideas (Arribas-ayllon & Walkerdine, 2017). Foucault's work focused on the relation of power, knowledge and discourse with one another, amongst which was uncovering the emergence of the modern notion of 'mental illness'. Given its historical and sociocultural context, the framing of 'madness' as 'mental illness' by psychiatry as an objective, irrefutable scientific

truth was the result of astonishingly problematic social and ethical standards. Thus, together, power and knowledge were understood as conjoint preconditions of possibility, in turn creating a framework for determining possibilities for how 'mental illness' can be expressed and spoken about. FDA, therefore, aligns with social constructionism and examines language and its role in the construction of social and psychological life using a lens of power relations (Burr, 1995; Willig, 2013).

Discourse in FDA is defined as sets of statements that construct objects and an array of subject positions (Parker, 1994). These constructions make available a way of seeing and being in the world. Discourses have substantial implications on the exercise of power as dominant discourses privilege versions of social reality that further validate power relations and structures (Willig, 2013). These dominant discourses often become 'common sense', but these can be challenged by alternative constructions, meaning counter-discourses emerge eventually (Willig, 2013). According to Foucault (1971), multiple discourses exist but in a hierarchical order, exposing more expansive systems of meaning within a society. Biomedical discourse appears intensely embedded within some cultures, making it challenging to recognise emerging alternative discourses (Willig, 2013). Hence, it becomes crucial for FDA to question power structures that facilitate the dominant discourse and perhaps even subdue the alternatives. Counter-discourses can be deployed to build a different stance than the medicalised language of the DSM for OSFED/UFED.

2.5.1 Key Foucauldian Concepts

2.5.1.1 Power and Subjects.

Power is commonly understood as either the power of the state or law, which is often interpreted as prohibitive and repressive (Foucault, 1996). Throughout his work, Foucault has presented complex, radical, and challenging ways of analysing power, such as at a micro

level (disciplinary power) and a macro level (biopower). Foucault describes power as an omnipresent network of force relations found in all social interactions. Power is considered to be exercised and not possessed.

The concept of disciplinary power arose from his work in Discipline and Punish: The Birth of the Prison (1979). Foucault was inspired by the Panopticon, a prison designed by Jeremy Bentham (Foucault, 2006). The Panopticon was designed so that the prisoners could not contact each other or see the supervisor as they were partitioned in their individual cells. Each prisoner "is seen, but does not see" (Foucault, 1991, p.200), leading to them self-regulating their behaviour due to the awareness of continuous monitoring. The structure of the Panopticon is a representation of a 'mechanism of power reduced to its ideal form' (Roberts, 2005), which defines the power relations that have diffused in the regular life of modern society. This 'Panopticism' is said to have formed our 'disciplinary society' (Foucault, 1991). Subsequently, individuals correct themselves even in the absence of an outside influence. This is known as self-surveillance (Foucault, 1991), where individuals become aware of their behaviour and discipline themselves initially because of the threat of retribution that may occur at any time and later because they get conditioned to follow the rules. Ultimately, individuals engaging in self-surveillance become the tools of their own subjugation (Foucault, 1991).

This concept of control and observation can be seen in our society in hospitals, workplaces, and schools, where research is even carried out to experiment and monitor humans. According to Foucault, doctors focus on the biomedical components of the patients' issues and filter out other aspects that do not fit into the biomedical paradigm (2003). This is called the medical gaze, and it ensures that clinicians limit themselves to narrow diagnostic criteria in the treatment process. This enabled us to compare the population's similarities and form norms and classifications, allowing us to diagnose and categorise individuals (Foucault,

1991, p.203). This shows how the generalisation of disciplinary power in psychological and psychiatric contexts resulted in the objectification of individuals into diagnoses, norms, and categories (Hoffman, 2011). This exercise and disbursement of power has essentially made humans ‘subjects’ who regulate their own conduct and subject themselves to control. The ways in which power functions through these disciplinary mechanisms and is then exercised in society are referred to as technologies of power (Foucault, 1978). The technologies of power ascertain how individuals or subjects conduct themselves in society and how they become controlled. Foucault added to this the concept of technologies of the self, which included the techniques and mechanisms with which individuals define themselves and create specific self-understandings (Foucault, 1991). Foucault also defined a power that operates on a macro level as biopower, which is exerted more subtly and provides controls and regulations to society. It is also internalised and contributes to the self-surveillance that the subject engages in (Foucault, 1979).

2.5.1.2 Norm and Normalisation.

Foucault understands norms as standards of behaviour that permit the evaluation of different forms of behaviour as 'normal' or 'abnormal'. The disciplinary power judges according to the 'norm'; thus, the figure of the "normal" acts as a "principle of coercion" for the figure of the abnormal (Foucault, 1979, p. 184). While 'norm' forms the model of perfection that functions as a guide of human activity, normalisation can be understood as the mechanism through which individuals are brought under these norms (Kelly, 2019). Essentially, norms are the institutionalisation of the 'norm' as it defines the standard that structures and defines social meaning (Taylor, 2009). The nature of normalisation implies the constant presence of deviance in adhering to the norms.

2.6 Procedure

2.6.1 Ethical Approval

Ethical approval was received by the University of East London's School of Psychology Research Ethics Committee (Appendices A-B). Ethical considerations were based on the key principles of ethical research as stated by The University of East London Code of Practice for Research Ethics (2020) and The British Psychological Society Code of Human Research Ethics (2021). All established ethical practices were adhered to throughout the study process.

All participants were provided with an information sheet (Appendix C), which allowed them to familiarise themselves with the study and make an informed decision about participation. This was followed by a consent form to complete (Appendix D). Participants written consent confirmed that they had received a full explanation of the research project, had the opportunity to raise any queries, and were aware that participation was voluntary with the freedom to withdraw at any time without any consequences up until the point of data analysis (three weeks post-interview); and that all transcripts would undergo a process of anonymisation and remain confidential to the researcher and supervisor. All identifiable information, such as names, ages, cities and genders, have been removed or replaced with pseudonyms during this process. Considering the significance of privacy, all data was stored electronically on a password-protected database. Given the study's nature, talking about their eating difficulties may have a possible impact, even while reflecting on their experiences during the interview. Considering my responsibility to minimise harm, a debrief letter (Appendix E) was provided. This letter highlights how the data would be used and, although not anticipated, contains resources to minimise any potential harm from participating in the study. My supervisor's and my professional contact information, as well as that of the Chair of The School Ethics Committee, were provided in the letter to monitor professionalism and ethical conduct throughout the interview process. An extension of minimising harm was also

to consider the impact of interviewing people's eating difficulties on myself. As somebody who has lived experience of disordered eating, I was mindful of my own well-being throughout the process of data collection. I continued to reflect on my journal, maintain contact with my supervisor, and, if/when needed, use personal therapy as a support to process my interviewing experience.

2.6.2 Participants

The description of the participants required is based on the current literature review and the practical scope of the study. It is important to consider that most individuals with OSFED are under-recognised by physicians in clinical practice and, due to their presentation, encounter other barriers like social stigma when seeking treatment (Thomson & Park, 2016). Individuals who do seek help perceive a higher cost of their eating disorder to their functioning and emotional regulation (Mond et al. 2009). This makes help-seeking and recognition of eating difficulty for those with OSFED/UFED even more challenging due to the absence of severe or visible physical symptoms (Thomson & Park, 2006). This makes their willingness to access care contingent on the mental health literacy of the community.

Additionally, the normalisation of the terms 'anorexia' or 'bulimia' in everyday language keeps any other 'subthreshold' symptoms like in OSFED and 'unspecified' symptoms of UFED in the margins. In the biomedical discourse, eating disorders are hierarchically categorised based on eating difficulties (Ison & Kent, 2010), with TEDs like anorexia taking the 'gold' position with the 'refusal' to maintain weight (LaMarre, Rice & Bear, 2015). Counselling psychologists must be mindful of power in the mental health space and navigate the complexity around such a discourse (Harrison, 2013). The profession's focus on reflexive practice and a transparent client-focused framework made it essential for this thesis to regard the notion of power in the realm of eating disorders. Hence, due to the nature

of the 'subthreshold/residual' diagnostic category, I understand that many individuals may not have gone through with seeking help for a diagnosis. Furthermore, requiring a clinician's diagnosis of OSFED/UFED to be included in this study is adjacent to perpetuating the medical model in establishing the legitimacy of an individual's eating difficulties. For this reason, participants are not required to have a formal diagnosis of OSFED or any other eating difficulty. Individuals identifying with the label "OSFED/UFED" or its subtypes were selected. It was essential to focus on the OSFED subtypes as they are derived from TEDs, which makes them more commonly used in language. This made the participation inclusion criteria more accessible by meeting the people where they are. This understanding was reflected on while designing the research poster (Appendix F). To stay true to the epistemology and CoP values I wish to inculcate in my work, it was vital to not approach this process from a 'clinician's point of view' of categorising participants into strict subtypes or diagnoses.

Additionally, participants should not have a diagnostic history of anorexia, bulimia nervosa or binge eating disorder. This is done to avoid the perception of 'subthreshold/residual' symptoms of OSFED to be misinterpreted as 'recovery' symptoms of TEDs. However, I was mindful of the vulnerability of the participants who are experiencing eating distress which has not been clinically recognised, diagnosed or even treated. It was essential that they were well informed and mental health support resources were provided in the debrief letter in case it was needed. Lastly, the study was inclusive to participants of all genders and must be aged eighteen or over.

Generally, qualitative research has a small sample size (Willig, 2008b). Typically, in a discourse analysis, a sample size of four to six participants is deemed appropriate (Parker, 2005). Therefore, 6 participants were interviewed, which was considered adequate for

providing transcripts that allow us to catch sight of commonly used patterns of talk when speaking of 'eating difficulties' in OSFED/UFED, including its subtypes. Greater data samples are more likely to simply add to the workload without providing more substance to the analytic outcome (Coyle, 2007).

2.6.2.1 Recruitment.

A purposive sampling approach was used to select and recruit individuals who identified their experiences as symptoms of OSFED/UFED. Standard invitations were sent to all participants, and written consent was received before commencing the interviews.

Two individuals were known through the university peer network and were approached with information about the study and their willingness to participate as they met the inclusion criteria. One participant was recruited through my own LinkedIn professional network, where the study poster was advertised. Three other individuals approached to take part in the study via the 'call for participants' website study page.

2.6.2.2 Profile of Participants.

Out of the total number of participants, three identified as female, two as male and one as non-binary—four participants identified as Asian and Asian British, and two as White British. The specific demographic details of individual participants, such as name, age, gender, or ethnicity, will not be provided in their profiles to further protect the confidentiality of the participants. However, I have decided to include the OSFED/UFED subtype that they have identified as their experience and whether the symptoms are currently ongoing, improved or no longer present. It is important to note that during interviews, participants described their symptoms more descriptively and experientially, unlike the rigid way the symptom subtype has been allocated below.

Moreover, their experiences often overlap with different types of eating difficulties. In the interviews, we explored their experience of OSFED symptoms as the nature of their eating difficulties, unconstraint from the categorisation of the diagnostic subtypes. This was intended to stay true to the epistemological and philosophical stance of the study. As the researcher, I often experienced this dilemma of categorising the participant's experiences into specific OSFED/UFED subtypes, which felt like colluding with medicalism. However, for now, symptom subtypes have been allocated for the reader's ease and to contextualise their eating difficulties using the language of the DSM. I will be reflecting on this throughout the research.

All participants will be addressed through the gender-neutral pronouns of "They/Them" throughout the rest of the study and have also been allocated neutral pseudonyms. Information regarding their age has not been collected, and therefore, both age and gender have not been provided below or addressed during the analysis. While this was done to further enhance anonymity, it disregards the role of gender and age in the participants' experiences which can be focused upon in a future study. Given the exploratory and novel nature of this research, the intention was not be limited by specificity and to allow diverse individuals to participate and have their voices heard.

Participant	Symptom Subtype	Current Status
Kai	Binge eating	No longer present
	Night eating	
Rowan	Binge eating	Ongoing
	Night eating	
Kit	Binge eating	Ongoing
Riley	Atypical anorexia	Improved
	Binge eating	
Phoenix	Night eating	Ongoing
Ira	Atypical anorexia	Ongoing

2.6.3 Data Collection

2.6.3.1 Interviews.

Semi-structured interviews (Interview schedule: Appendix G) were conducted via Microsoft Teams. All interviews were recorded and transcribed using the function embedded in the platform. Collecting data online provided the flexibility and convenience of interacting with participants spread out geographically in the UK. Interviews have been extensively used in discourse analytic methods but are constructed with a novel rationale (Potter, 1996). My goal was to achieve consistency and diversity while actively participating in the conversation (Potter & Wetherell, 1987). Discourse analytic interview aims to achieve a variety of opinions and stimulate discussions (Bondarouk & Ruël 2004).

I contemplated conducting a focus group discussion (FGD) as it might be a "less artificial" (Willig, 2013, p.31) way of procuring data while observing them construct meanings of 'eating difficulties' collectively. However, upon reflection, I chose to go against FGD for four reasons. Firstly, eating and eating difficulties are often intertwined with feelings

of shame and secrecy. Exploring this in a group dynamic might be distressing for the participants. Secondly, the topic's sensitivity and particular group dynamics might hinder some voices from being heard, thus restricting the exploration of unpopular discourses. Individual interviews allow each participant an equal chance to participate while feeling relatively safer with just the researcher. Another reason is that the diversity of OSFED subtypes might make it difficult for people to co-construct their experiences. Further, I wondered if it might instigate individuals to categorise each other's eating difficulties hierarchically, as often seen in biomedical discourse (Ison & Kent, 2010). While this might open up an additional scope for analysis, I wondered how that might leave the participants feeling about their struggle. Lastly, conducting it over Microsoft Teams would have impeded the "less artificial" co-construction of eating difficulties in OSFED/UFED. Hence, an interview schedule was created with open-ended questions to hold a pilot interview for feedback and changes.

2.6.3.2 Pilot Interview.

Given that both OSFED and UFED are newly formed medical terms and lack qualitative studies, it was essential to conduct a pilot interview to ensure that the study is authentic to my intention of aligning with CoP's humanistic values. This means paying special attention to underlying connotations and discourses around eating disorders and the DSM. As a novice qualitative researcher, this posed a great learning opportunity.

Given the medicalised nature of OSFED/UFED, an overarching lesson from the pilot was re-formulating a schedule not from the 'clinician's' perspective but using the participants' language to better understand and collaborate with them. The decision was made to start with a question about the participants' awareness of diagnostic categories for mental health to set the interview scene without assuming their knowledge of psychiatric terms. Reflecting on my

experience of interviewing, I was inspired not to begin the interview labelling the participant's experience as 'OSFED/UFED' by asking questions like: "How long have you been identifying as OSFED/UFED?". I realised this approach pathologised them at the start, perpetuated the medical model and set the dominant tone of the medical discourse for the rest of the interview. Taking a step back from this process made me realise the challenges of working with a medicalised term in a non-medicalised way. I recall reflecting on my CoP values of working more humanistically and bridging the gap between clinicians and individuals using language. At this point, I was reminded of how my 'trainee counselling psychologist' position places me with my participants and clients in terms of access to power and control. Thus, the step forward was to refocus on co-construction and be mindful of the power of dominant medical discourses to be communicated and reinforced in my process of interviewing and relationship with the participants.

Further changes included asking open-ended questions about their eating difficulties and using their specific descriptive words throughout the interview to co-construct OSFED/UFED differently.

On a similar note, I decided to change the question, "How has the diagnostic label of OSFED/UFED helped you make sense of your eating behaviour?". This question highlights the underlying assumption that the label helps, which is directive and also incongruent with my critical stance towards the medical model. This was changed to "Does OSFED/UFED impact how you make sense of your eating difficulty? ". I was pleased to make further changes by allowing participants to describe and define their experience using their own words and asking non-direct, open-ended questions about their understanding of their eating difficulties. Staying true to my epistemological stance and allowing co-construction was the biggest takeaway from this experience. Further, considering my values as a reflective yet

scientist-practitioner, I see the importance of acknowledging my agendas, experiences and motivations for this study (Chinn, 2007).

Lastly, the decision was made to include the pilot interview data in the analysis, as even though the schedules varied, I felt obliged ethically and as an exploratory researcher to acknowledge the depth and value of information that the participant granted. It is their contribution of time and involvement with the feedback that ultimately shaped the study to be what it is today.

2.6.3.3 Transcription.

All interviews were transcribed verbatim three weeks after the completion of their interview. This allowed participants to withdraw their data if they wished, but none made this request.

While the Microsoft Teams function did transcription, understandably, the automated task was inaccurate but it provided a base to save time. After this, I manually transcribed each interview to protect confidentiality and to process the data myself.

. = standard pause (of less than one second)

[pause] = longer pause (of between one and three seconds)

[long pause] = long pause (of more than three seconds)

Non-verbal communication was described using boxed brackets, such as [laughter]. Additionally, identifying information was omitted [...] or anonymised to preserve confidentiality.

2.6.4 Data Analysis

Many studies and researchers have formulated and inspired different ways of conducting an FDA, pointing to a lack of a manualised approach for this analysis (Arribas-

Ayllon & Walkerdine, 2008; Coyle, 2007; Willig, 2008a). Foucault himself was opposed to defining a way of how things should be done (Foucault, 1994). Traditionally, researchers approached FDA as a set of ideas and techniques that could be applied in unison with the research aims. Having said that, I have paid considerable attention to my novice position as a researcher and chosen to use Willig's (2013) six stages of analysis as a guide for this study. The nature of discourse analysis is often described as a "craft-like-process" (Harper et al., 2008, p.194), encouraging researchers to record their experience executing an FDA. Therefore, I rely on my reflective journal to embed reflexivity in this thesis, which has been an integral part of my reading and methodological process (Willig, 2008b). These have been included throughout this section.

The analysis began with transcription, where I started to note specific themes or ideas that occurred the most. The initial readings were done alongside this process to have a coherent understanding of all interviews as they happened at different points in time from September 2023 to April 2024. After having compiled all transcripts, they were uploaded to NVivo (version 20). The decision to use a computer-based programme was based on their efficiency in managing qualitative written data for coding purposes (Evans & O'Connor, 2017). In order to analyse the information systematically, each transcript was individually coded by labelling all extracts in the entire interview. The labels were discrete and descriptive. The process of going through the transcript and developing codes was done twice for each interview to make sure I reached saturation with my data. Using NVivo for the initial coding process allowed for a seamless yet meticulous process for neatly organising the data. While coding, I was able to reflect on my experience of interviewing, my position as a researcher and how that impacted the data that was collected. Once the transcripts had been exhausted, the process of a Foucauldian analysis began.

2.6.4.1 Discursive Constructions.

The first stage of the analysis is concerned with identifying and categorising the various ways in which 'eating difficulties' in relation to OSFED/UFED were constructed in the transcripts. It is essential to look beyond the literal reference to the word 'OSFED/UFED' or 'eating difficulties' but include both implicit and explicit references to it. In this case, I specifically include mentions of any OSFED subtypes (for example, low-frequency binge eating or night eating) or similarly described ways of eating difficulties. Given that OSFED is not used in everyday language, participants labelled their eating using 'symptomatic' references such as restrictive eating, binging or overeating. It is crucial to work with the shared meaning of this term rather than make a literal comparison. The focus here is on constructing a public and collective reality (Coyle, 2007; Walton, 2007).

Using NVivo, all codes that were similarly constructed were categorised. This process was more inferential and made me realise how the position of the researcher can affect the analysis. This was managed by categorising data once all the transcripts were coded to make sure my interpretation of one transcript did not influence the other. All categories were then written down on paper for each participant, and this enabled me to colour code and identify the discursive constructions being formed (Appendix H). This way, each extract from the interview was coded, categorised and identified as part of a discursive construction. This created a helpful visual guide to identify the five main discursive constructions and the various ways they were constructed by the participants.

2.6.4.2 Discourses.

Since a discursive object can be constructed in many ways, this stage aims to identify the differences between the constructions of 'eating difficulties'. This process entails identifying the discourses most used by the participants and locating them within the wider discourse, as prevalent in current literature and the socio-cultural context of the study.

It was evident after placing the discursive constructions together on paper which discourses had been relied on through the language of the constructions and the codes. Seeing different participants with such different eating experiences create similar ways of talking made me realise how power structures and language create our public reality (Burman & Parker, 1993; Coyle, 2007). To consider it a "craft-like-process" (Harper et al., 2008, p.194), these discursive constructions were drawn out on a whiteboard with the identified wider dominant discourse, and the next steps of analysis were conducted based on these discourses (Appendices I-M).

2.6.4.3 Action Orientation.

At this stage, there is a need to pay closer attention to the discursive contexts within which the various constructions of 'eating difficulties' were deployed to understand the function and motivation of the constructions. The issues of power are relevant to this stage as there is more clarity on what the various constructions can achieve within the text.

This stage made me more aware of my critical view and disdain for pathologising medical structures because of how I perceived the participant's resistance and ambivalence towards the OSFED/UFED label. In my attempt to be mindful of this impacting the analysis, I continued to focus on the extracts and specific words to interpret the action orientation for the constructions. I recall feeling very connected with the participant's voices and my ability to empathise with their experiences. Action orientation was clearly marked on the whiteboard and colour-coded to identify the interlinked process with the other stages.

2.6.4.4 Positionings.

This stage involves identifying the possible subject positions that participants place themselves or others in within the discourse. 'Positioning' for Foucault has the potential to impact how individuals view themselves and, subsequently, their feelings and behaviour

(Dick, 2004; Willig, 2013). Subject positions symbolise the productive nature of disciplinary power to be able to classify people into hierarchies (Foucault, 2002).

This stage was conducted in a similar way as the previous one. Subject positions were inferred from the knowledge I had already grasped from the data and the process colour-coded on the whiteboard. Seeing the visual representation was imperative to witness the process of deconstructing and reconstructing 'eating difficulties.' I was reminded of not losing my reflexivity in this study by omitting my positioning in the analysis (Harper, 2003). Acknowledging that I was also occupying a particular space or position as both a researcher and clinician with a lived experience of disordered eating was something I had to continue to reflect on.

2.6.4.5 Practice.

This stage is closely linked to subject positions as it seeks to explore the relationship between discourse and practice. That is the ways in which these subject positions provide or take away opportunities for action. Hence, discourse can limit or determine the possibilities of action based on the subject's positioning in the wider discourse. This understanding is essential in answering one of my sub-questions concerned with the impact of these constructions on treatment access and early intervention. Intertwined with the previous steps, this stage brought forward examples in my current clinical practice in an eating disorder service that made me reflect on the potential of this study for helping build a new narrative of eating and bodies.

2.6.4.6 Subjectivity.

Analysing the relationship between discourse and subjectivity is the final stage of the analysis. The attempt here is to determine the consequences of taking up various subject positions on the participants' subjective experience. I faced mild discomfort in assigning my interpretation of it as 'absolute'; perhaps the strong presence of the biomedical discourse in

the data made me aware of the 'absolute-ness' of their research and clinical claims. This awareness made me very conscious of my claim over the interpretation of the participant's subjectivities. Given my research question, I have aimed to expand on subjectivity and positioning together; however, I am conscious of how interpretive this stage can be. For this reason, subjectivity has been a less concrete part of the analysis but simply relied on to construct a more vibrant understanding of 'eating difficulties'. My interpretation, contrary to the positivist way of analysis, is simply 'my' interpretation based on my values and experience as the primary researcher of this study.

2.7 Reflexivity

Reflexivity is a crucial component of any qualitative research to account for the impact of subjectivity on inquiry (Rees et al., 2020). I acknowledge that as the primary researcher, my subjective perspective will be fundamentally interwoven with the research process of this qualitative study. Failure to attend to reflexivity can adversely affect the knowledge gained and the quality of data (Francisco et al., 2023). Willig (2013) defined a distinction between personal and epistemological reflexivity. Both require consideration of the researcher's axiology (Ponterotto, 2005). The former is focused on the researchers' own experiences, agendas and motivations, while the latter examines our assumptions about knowledge and what can be known.

I strive to be immersed in this study and embrace my role while staying in a paradigm that resonates with my practice (Morrow, 2007). A crucial part of embodying reflexivity is being aware of my individuality and its implications on the research process, as well as the influence of this study on me. Thus, as encouraged by Coffey and Atkinson (1996), I intend to show my ingrained reflexivity in this project, which was aided by having discussions with my supervisors, peers, and colleagues and maintaining a research journal has facilitated my awareness of myself in interaction with this study.

3 Chapter Three: Analysis and Discussion

This section presents the analysis of the discursive constructions identified as people talked about their eating difficulties. During the analysis process, numerous ways of constructing eating difficulties were identified, and these were then organised within five main discursive constructions that sought to answer the research questions together. These discursive constructions are set within a wider discourse and are used as headings to guide the presentation of this section. These constructions are not independent of each other but instead should be considered as an interconnected network of discursive practices producing the concept of eating difficulties and different subjectivities. The broader dominant and counter-discourses that were relied on to create each discursive construction are considered under each heading. Finally, the structure of this section is organised by the four discursive constructions that draw from wider dominant discourse:

- Eating difficulties as a binary or rigid concept
- Eating difficulties intertwined with fatphobia
- Eating difficulties in relation to the OSFED diagnostic label
- Eating difficulties as transdiagnostic

And one discursive construction inferred as the counter to the dominant discourse as:

- Eating difficulties as a spectrum

This analysis was devised from my selected epistemological and methodological position, keeping in mind Foucauldian concepts in the context of eating realities. I acknowledge, within this position, that this analytical process has evolved from my personal, cultural and historical context (van Dijk, 2011). Despite the methodological rigorousness of FDA, a Foucauldian perspective suggests that discursive practices comprise all modes of knowledge, which also consists of this piece of analysis. This thesis itself is considered a discursive construction which, through my positioning, composes knowledge (Willig, 2008a).

Throughout the analytical process, I was aware of and reflected on my own claims of knowledge and the discourses used to construct them. Having said that, it is essential to state that this chapter is one of the various possible ways the data presented would have been interpreted. Additionally, the discourses employed by the study participants in this chapter are not being considered as consciously or intentionally chosen to construct their 'eating difficulties' nor as a deliberate social action. The focus of the analysis instead is on how they talk about the discursive object, which helps identify the various accessible ways of talking about 'eating difficulties'.

3.1. Eating Difficulties as a Binary or Rigid Concept

Eating difficulties as a binary or rigid concept as a discursive construction draws from the wider dominant biomedical discourse, heavily influenced and situated within the pathologisation of certain types of eating and diagnosis. The discursive constructions and extracts below show the plethora of ways in which participants have constructed their eating difficulties, especially in relation to eating being a binary concept. There was a notable and unintended inclination towards constructing eating in a rigid way. However, awareness of this way of talking about eating was also present, and resistance was met to this rigid conception of eating. The selected extracts will explore the discursive constructions while holding action orientation and subject positions in mind.

3.1.1 Eating as a Normal-Abnormal Binary

Extract 1:

Riley: I'll be in the deep depths, either, restricting or binging and then I'll manage to find the strength to stop doing that one thing. But then I can't just stop and then be normal. It's just a switch on to the other one and it's quite sudden. It can just be a random day and suddenly I'll.. I'd have gone from eating very minimal to eating loads.

Extract 2:

Ira: ... there's kind of the perception that people are just like "just, just eat normally, just kind of exercise normally". And the idea that it needs to be a certain… you need to be having a certain level of difficulty to be able to discuss it with other people and for them to take you seriously.

Drawing from the wider biomedical discourse around eating previously discussed in the existing literature, the language that is available to Riley and Ira is dichotomous. The concept of 'normalcy' and the idea of their eating being 'abnormal' positions the participants in an exclusionary and stigmatised way. Their eating is abnormal from what is perceived as the 'norm', but as Ira mentioned "*you need to be having a certain level of difficulty to be able to discuss it with other people and for them to take you seriously",* suggesting a threshold within 'abnormality' even to be seen or their struggles considered legitimate. OSFED diagnosis is less researched and not well known when compared to threshold disorders (Krug et al., 2024). For a model that functions on operationalising and categorising 'abnormal' behaviours, the term 'Otherwise Specified' showcases how ill-defined this category is as compared to the others. Individuals struggling with OSFED symptoms and not having a defining 'popular' label, such as anorexia or bulimia nervosa, can experience their subthreshold symptoms to position them as an outgroup within the 'normal' community and the 'eating disordered' one.

Extract 3:

Riley: …there's a lot on the NHS website that describes it [anorexia and bulimia] and discusses it and it helps you understand what's happening and feel less like a complete "Nutter" [chuckle] But… there isn't as much information on the different ones [OSFED/UFED]. So, it feels more like you're the outcast within the eating disorder world or the strange one, it's just not valued.

Riley's talk of OSFED focuses on the 'unspecified' nature of the label, regarding it as less significant than the threshold eating disorders. As discussed above, this suggests the idea of normativity within 'abnormality', perhaps suggesting even a 'correct' way of being abnormal. These norms around eating are not just perpetuated by society and others but also internalised and sustained by individuals in the way they talk to themselves. This is noticed explicitly in Riley's self-talk around chasing what they thought was 'normal' in extract 1, "*But then I can't just stop and then be normal".* The technology of power or the technique in which power is dispersed within dominant discourses can create 'rules' such as around eating, weight and bodies that can become internalised and form technology of the self, leading people to engage in self-surveillance (Foucault, 1991).

The two functions of disciplinary power highlighted by Foucault can be seen in many ways in this discoursive construction of *Eating Difficulties as a Binary or Rigid Concept*. This is the binary division and branding (normal/abnormal) and assignment of self-surveillance (Foucault, 1991). This seems to manifest in participants' attempts to construct their eating and the value that is placed on it. This perpetuates the 'social norms' or becomes the standard way of life (Mills, 2003). Norms are created and maintained by circulating discourses that define ideal ways of being for people, even creating an invisible set of social rules that claim the legitimacy of specific ways of being (Guilfoyle, 2009).

The beginning of the pathologisation process of eating by the involvement of medical frameworks and the rise in public awareness of 'abnormal' eating (Bruch, 1978) is continued by the various editions of the DSM. There has been a surge in the medicalisation of the body and continued evolution of what an 'eating disorder' entails with every new edition of diagnostic manuals (as seen in section 1.5.3). This increases not just public awareness of this topic but also creates a language for talking about eating difficulties. A language which takes for granted its implied sense of 'legitimacy'. As Foucault (2003) argued, those in power set

the agenda. In our contemporary era, the medical dominant institutions have become the arbiters of truth, "a moral exercise used to define normality, punish deviance and maintain social order" (Lupton, 2013: p. 9).

Extract 4:

Kai: So it sort of helped that I was looking at it as like, oh, this [binging] is something unhealthy and maladaptive that I do. But there's always a journey that I can go on to make it healthier and more, you know, well adjusted.

Extract 5:

Rowan: I would say that of course it's not considered normal, that's why people call it a disorder.

In the above extracts, Kai and Rowan both use dichotomous language when talking about eating. Within this construction of *eating as a normal-abnormal binary,* there is an inherent subject position of compliance to the dominant biomedical discourse by using the binary and pathologising language associated with it. Exclusion from one domain in society, in this case of 'normal' eating, leads to the generation of other spaces and positions in which 'abnormality' can belong (Guilfoyle, 2009). This is often a more devalued space, but the power arrangements such as between clinicians with the power to define 'health' and the disordered eating individual will remain in place as long as this position is accepted. Kai and Rowan's way of constructing eating and complying with this popular construction continues to place them within the hegemonic system of inclusions and exclusions. During the majority of the interviews, the idea of 'normalcy' in eating was often an implied reality and an assumed way of the world. The extracts suggest the reason for deploying this binary construction of eating is that this may be the only social reality and language they know or is popularly accepted by others. In such a manner, compliance is achieved by using language that characterises their eating in this way and generates this idea of 'acceptability' within the

dominant discourse. The prevailing pathologising way of talking about eating also reduces the subject positions offered to people to construct their eating difficulties differently, such that the resistance towards the force to comply with the dominant discourse becomes difficult.

Extract 6:

Ira: … when you're there [GP clinic] for something else they…. like weigh you or they work out your BMI and they just generally say like, "It would be good if you lost weight" or something like that. Like "this is the ideal BMI", but I think… because I know that BMI isn't a good measure of like health and it varies based on like stature and muscle and all of that and…I tried and like hold it loosely but it's still kind of… it's something I've thought about since I was a teenager, so it's still kind of there in my mind, that idea that I need to be between these two numbers.

Here, Ira shows awareness of the limitations of a medical model by contesting the idea of an 'ideal' way to be by trying to critique the binary of eating and weight. Although they struggle to uphold this resistance, Ira showcases the possibilities of questioning this strict dichotomous vision within the current laid-out subject positions in this discursive construction. Increasing awareness and education about the way systems of weight function as well as their limitations show potential towards making available different subject positions. Perhaps an increased awareness in clinicians about the perpetuation of 'ideals' and 'normalcy' in our day-to-day practice might help reduce the shame and stigma on this topic. My interpretation of the subjectivity within these positions incites a feeling of disempowerment, fear of exclusion and even pressure to conform.

3.1.2 Eating as a Rigid Concept or Label

This discursive construction is complimentary to the previous one, where eating difficulties were seen in a normal/abnormal dichotomous way and how that intertwines with a rigid view of eating disorder labels.

The 'rigidness' of eating disorders categories and the idea of meeting the 'threshold' for the carefully laid out criteria for each different diagnosis made me often reflect on its impact on how I viewed the participants and their words. The rigidity of eating disorder labels is not just something that I identified as a discursive construction in the interview, but I felt challenged by it during the entire research process. I sometimes found myself mentally applying the OSFED or UFED label criteria to the participants during the interviews and analysis. While I was cognisant of not medicalising people's talk and kept the inclusion criteria flexible, I noticed an inherent 'medical gaze' when analysing the data. Foucault described this type of gaze as the clinician's tendency to fit a person's story into a biomedical framework by focusing only on the relevant medical elements of the problem (Misselbrook, 2013). Having my reflective journal, identifying and separating this notion from the analysis process, was helpful in being able to see and build a story out of the participant's talk. This made me realise the prevalence of the biomedical undertone of this entire thesis, which is contrary to my position on this topic. This demonstrates the pervasiveness of the biomedical discourse in shaping our experiences and understanding of a phenomenon (Johnstone & Andrus, 2024). Perhaps this is to be expected when working with any 'psychiatric label' when positioned as a psychologist or clinical researcher.

Extract 7:

Rowan: Umm, I would say they [eating disorders] are quite specific with the criteria. So sometimes some things might go out to be missing because everybody has a

different pattern and there are not all the things that people do in terms of their eating habits that are included.

Extract 8:

Ira:…there are definitely issues with them [eating disorders] and that sometimes the criteria are quite specific and a lot of people might need help that aren't quite within a certain diagnosis.

While Rowan and Ira construct eating disorder labels as rigid, they also take a critical role towards them by naming their inability to capture a true picture of the variety of eating experiences and struggles. This way of construction seems to allow the participants to hold a sense of criticality while also making space for those who are 'missed' from the medical view of diagnosis.

Extract 9:

Ira…I guess it's like the idea that… You have to do certain specific things to meet a label and, and, in my head it means that, like maybe not forever, but like for a long while I will still like, meet these criteria. If I have a diagnosis then it means it's like a long-term condition.

Continuing from the previous extract, Ira describes the stigmatising impact of the medicalised construction and use of language. The rigidity of labels seen throughout the extracts is met with a sense of resistance. The strict or rigid construction of eating disorder labels, while it feels exclusionary and stigmatising, also gives space to 'subthreshold' participants to navigate if they would want 'membership' in this exclusive space of diagnosed eating disorders. For example, Ira's hesitance to adopt a certain diagnosis for themself is evident because their eating symptoms have not been conceptualised within a rigid threshold eating disorder category, causing them to float between the 'eating disordered' and the 'healthy individual'.

Additionally, this way of talking about eating also further maintains the normal/abnormal binary around eating. This raises the question of what happens to those who struggle to fit themselves in the rigid labels but don't also find their eating within the 'norm'. Diagnostic classifications have been built on such a categorical model that functions on the assumption that 'mental disorders' can be conceptualised into valid and discrete entities (First et al., 2004). However, rigid categories seldom allow for a thorough examination of the full spectrum of eating behaviours. With many 'disorders' merging into one another and also into 'normality' (Kupfer et al., 2002), there is little meaningful use of rigid categorisation in clinical practice. Still, it perpetuates legitimising power and constructs of normality for people to function under.

Extract 10:

Ira: I think it would also make me feel like I need to tell other people more, and because if there's a kind of neat way of describing what I'm experiencing, then it makes sense to tell other people about it. But I don't really want to, so I just kind of avoid that as well.

Within this construction of *Eating as a Rigid Concept or Label*, participants often find themselves as perpetuating, stuck and powerless against the label and are seen creating some room for its critique. The above extract also sheds light on the pressure created by this specific "*neat way of describing"* eating difficulties. Here, Ira speaks with a sense of fear about the implied pressure to make a diagnosis public for others to know. This outlook highlights the ability of diagnostic categories to echo disciplinary power, involving the sense of self and public surveillance of one's eating (Foucault, 1991). There is also an internal pressure to conform to the psychiatric label within this discursive construction. The idea of feeling obligated to make a diagnosis public further places Ira in a powerless position against the labelling power of medical and psychiatric institutions.

Within this construction and subject position, the participants have mapped out ways of resistance to the rigidity of eating disorder constructs, which are unique to those who find themselves falling between the cracks of 'normality' and 'threshold' eating disorder categories.

Extract 11:

Kai: So I think now where we're at a stage or like we have been for like a decade, I believe where we're looking at eating behaviours beyond the few that we know of in terms of disordered or unhealthy or maladjusted or whatever.

To conclude this section, I want to point out the impact of exploring this topic from the 'unspecified' subject position, especially when drawing from a rigid medical discourse. This seems to have led Kai to experience a broader way of looking at eating behaviours. While their words still align with the medical discourse of pathology and health, they have the capacity to position themselves to look beyond the specified threshold labels.

3.1.3 Eating Difficulties *as Challenging to Label*

This construction emerged due to the impact of the complementary relationship between the above two constructions of *eating as a normal/abnormal binary* and *eating as a rigid concept or label.* Together they form the discursive construction of *Eating Difficulties as a Binary or Rigid Concept*. Here, we will see how the participants negotiated eating disorder labels in the context of their eating difficulties against the rigid and binary constructions prevalent within the biomedical discourse. This construction also highlights the impact of the participants' changing subject positions. Negotiation of labels is a key theme under this discursive construction and can be seen as an attempt to step out from the dominant medical discourse.

Extract 12:

Riley:… I think I'd be more comfortable with them just saying it's an eating disorder instead of it some 'other unspecified'. I just don't see how that little bit of unspecified..

just feels a bit off to me for some reason, but to other people they probably really appreciate it.

Extract 13:

Kai:…but having a label for it, having that label, even if it's… and I do appreciate that it's 'unspecified', but having a label for it does help you.

In their own unique yet different ways, both Riley and Kai negotiated the label of OSFED/UFED and assigned different meanings to it. It seems the function behind Riley's way of constructing this negotiation is to challenge the current dominant discourse. This way of talking about their eating makes available subject positions that allow them to reject and be critical of the predominantly medical and exclusive constructions. Foucault has consistently stated that it is always possible to build resistance against prevailing power arrangements (Foucault, 1980b). Riley showcases micro-resistance by rejecting the vague terminology of the label for themself, which seem to help them forge a space of autonomy and contest the dominant diagnostic power structures. "Where there is power, there is resistance" (Foucault, 1978, p. 95). While power operates through discursive practice that produces knowledge, this study attempts to carve alternative discourses and create space for resistance. This way of analysis not only offers a platform for resistance and showcases counter knowledge being produced by the participant's use of language but also my dissemination of this research, which also has the potential to challenge dominant power structures. A position of resistance while negotiating labels allows space for further exploration of alternative ways of looking at eating difficulties that might be deemed more redeemable.

Kai takes up a different position to Riley. The idea of their eating difficulties being labelled as 'unspecified' seems to somehow make it a more appealing category to fit into. Perhaps their understanding of the word 'unspecified' could have been probed and explored

further during the interview. Kai's positioning with this way of negotiating labels is better understood below.

Extract 14:

Kai:… recognising it [binge eating] in the first place and sort of demystifying it rather than seeing it as an individual failure, you see it as like a clinical thing and which is just something I always use, like the example that if someone broke a foot, you wouldn't be like, "I can't believe you broke a foot. You cannot go to a doctor and you cannot have a plaster or something. Just stew in misery with that broken foot", it's like you don't do that for physical ailments, so it's stupid to do that for anything psychological as well.

It seems the function of this construction for Kai is empowerment by utilising the legitimising power of the medical discourse. It suggests that aligning with the power structures gave them more autonomy and agency over their eating difficulty as well as finding a more confident position within the social disciplinary power governing the norms of eating and bodies. Within this subject position, Kai is able to utilise the biomedical framework and language to shift the 'responsibility' of the 'abnormality' away from them and onto the *"clinical thing".* This position has the potential to be experienced as empowering rather than stigmatising. Indeed, there are various ways within the medical discourse that labels are negotiated by resisting or adapting to certain aspects of it.

Another way of negotiating as a resistance is seen through Ira's talk of their experiences with diagnosis.

Extract 15:

Ira:… I find it difficult to associate myself with it [OSFED label] because I don't think of my symptoms as like bad enough to warrant a diagnosis, so maybe it's not the

fact that there isn't a diagnosis that fits me, but it's my lack of willingness to apply a diagnosis to myself.

Extract 16:

Ira: I think if I apply a diagnosis to it [eating difficulties] then it makes it more of like a real thing. And I don't want to, like, obsess over it more if you know what I mean…

Resistance and negotiation of labels also seem to allow the participants to dodge the 'legitimising' power of the medical discourse, which is seen consistently in this study to be associated with shame and stigma of 'abnormality'. Ira showcases the process of resistance from disciplinary power that relies on norms and definitions of normality and abnormality to regulate behaviour (Foucault, 1991). In this construction, Ira is able to position themselves as autonomous by practising awareness and choice over their unwillingness to fit into a diagnostic label.

The construction of resistance and negotiation within this section has also brought to the surface the gap between the so-called 'helping professionals' and people. During the research and interview process, as well as in my clinical practice, I have always witnessed a gap in understanding between the 'knowledge disseminators' such as clinicians, researchers and the people—especially those less exposed to westernised medicalisation of our lives. I am aware of my own view on this having an impact on the perception and presentation of data in this thesis. Having said that, there are two overarching subject positions available to people in the binary and rigid world of eating disorder labels. It seems it is either through rejection and resistance or aligning and adapting to find a sense of empowerment, which suggests to me an inherent disempowering element in the current system. It is also important to acknowledge my counselling psychology identity, which seeks to present this gap and use this thesis as a medium of constructing a rebellion as well as carving a new way forward.

3.2. Eating Difficulties Intertwined with Fatphobia

This discursive construction draws from the wider dominant biomedical discourse that is heavily influenced by the weight stigma or fatphobia embedded in the medical structures that started the segregation of fatness away from the 'norm' (Anderson, 2024). While this discursive construction relies on the biomedical discourse for sowing the seeds of fatphobia, it also suggests the current social discourse and views on slimness and bodies maintain it. This discursive construction will explore how fatphobia functions in different presentations of eating difficulties and how it impacts those of a higher weight, especially when experiencing binge eating. While the participants do not actively use a feminist discourse, I will be relying on it to inform my understanding and even challenge the inherent medical underpinnings of this study and participants' talk.

3.2.1 Controlled and Restrictive Eating Valued

Extract 17:

Riley: …I think because of the mindset you're in, when you're restricting… hearing someone say "ohh she's lost a lot of weight, I'm concerned…" it's actually quite gratifying… you're then proud that your efforts are being shown.

Extract 18:

Riley: It's still ingrained in our culture to appreciate a smaller body, or, to value a smaller body as better.

Here, Riley constructs restrictive eating and associated weight loss in a way that these behaviours come with a certain sense of pride and hard work. The discourse around smaller bodies, while medically and historically rooted, is still influencing the language and construction of people with eating difficulties. In contemporary Western societies, powerful signifiers of a person's physical and emotional health, morality and beauty are based on their body weight, shape, size, and its management (Lupton, 1996; Markula et al., 2008). The

idealisation in the current Western capitalist environment of a healthy body with virtues of self-control, discipline, or denial (Peterson & Lupton, 1996) is also produced by some of the participants in the study. The demonisation of fatter bodies in the biomedical discourse (Nash & Warin, 2017) and the further construction of 'abnormality' in eating impact how certain bodies are viewed in society. Earlier, the way participants highlighted the normal and abnormal binary construction of eating imposed a moral value on eating behaviours. This subsequently leads to pathologisation and the creation of a discursive construction of weight stigma or fatphobia.

In the current world, being 'overweight' is considered morally weak or lacking in self-discipline (Markula et al., 2008). It leads to various public health interventions to adopt a 'health' focused approach to lifestyle and diet (Aphramor & Gingras, 2008). This approach to health further sidelines and demonises fatter bodies. Slenderness or thinness and restraint over eating still hold a valuable place, signifying greater morality, control, beauty and consequently 'good health' (Burns, 2004; Lupton, 1996; Malson, 1998). In the above extracts, Riley's talk makes available subject positions of compliance to the slimness ideal while also maintaining a position of insight and criticality about the origins of such discourse. Compliance with the slimness ideal is also met by internal validation of achievement and success. It is also important to point out the feeling of being 'seen' and visible when restricting and losing weight. This is further explored in this discursive construction of *Controlled and Restrictive Eating Valued* to understand the visibility of different types of eating difficulties.

At this point, I am also aware of the deconstructive process of this study, which is to externalise conversations with the participants and separate them from the issues highlighted here (Cowan & McLeod, 2004). The essential idea is to analyse the language and dominant discourses available to them to construct their realities and that issues highlighted here are not

core embedded personal characteristics. I am aware of the discomfort of holding these invaluable experiences shared by my participants and putting focus away from their individual subjective experiences to visualise the discursive context and subsequent impact of the space 'outside' of themselves. This creates an inner tension of not wanting to undermine their individual stories, narratives and experiences but also highlighting the fatphobic constructions in their talk of eating difficulties. I understand now that this section of the thesis triggers the feeling of social injustice the most within me, leading me to take a more critical perspective on this issue.

Extract 19:

Ira: There's a lot of like pressure in the media, in society, like societal expectations of what people should look like and, and, and... kind of what they should be doing in terms of exercise and eating. And so I think… I think that was where it kind of started and I was… like in terms of BMI, like overweight, so… I kind of at that point just thought I was trying to lose weight so that I could become healthy, but in not eating or like sometimes for like a day then. And it wasn't… It didn't really improve my life.

Extract 20:

Ira: I would just kind of go as long as I could without eating and [pause] and yeah, just kind of really fixated on the idea that I was, that I didn't want to put on weight.

These extracts sit within the 'health' focused biomedical discourse where a slimmer body is idealised. This discourse also upholds power relationships in the way in which the participant's sense of self is constructed in the context of fatness and bodies. Striving for thinness and also being seen in this way leads to the further establishment of norms and normalcy in the social and medical discourse surrounding bodies. The subject position available in this construction is one where health disguised as thinness is valued and put on a pedestal, perhaps a gold standard to be achieved. This further fuels the fear and stigma around

weight gain. The person is positioned to long for fitting in and disciplining oneself to accomplish the set norms. Taking from Foucault (1991), disciplinary power and self-surveillance are enacted within this discourse. This construction also functions to put the responsibility of eating and health on the self. Healthism inspired people to strive for perfectionism and 'fix' their imperfect bodies through an everchanging trend of diet and exercise regimes. In this, self-surveillance of health behaviours is perpetuated, and self-discipline is encouraged. Any illness then is considered the fault of the person (Cheek, 2008).

For the participants struggling with restrictive eating and a presentation similar to atypical anorexia of OSFED, this position can be incredibly distressing and perhaps even feel pressured when there is already a stigma around their eating difficulties not being "*bad enough*" (see extract 15)—all of this set within the exclusionary and rigid world of eating disorders.

The societal views and standards of eating and bodies also play a role in perpetuating the fatphobic discourse around bodies. While the medical discourse has perpetuated the claim of treating and diagnosing female bodies, it also put forward a view of the female body as something to be controlled (Carey, 2009). It creates an environment in society where female bodies are seen as 'other' to the self. These are seen in media representations through which diet and exercise standards are communicated and become a source of perpetuating and disseminating fatphobic ideas. Here we can rely on Foucault's (1991) theory of the adoption of the dominant discourse and disciplining oneself to fit into these norms. This makes it easy to understand the media as a significant proponent of a damaging 'beauty' myth (Wolf, 1991) instigating eating difficulties. While the biomedical model positions fatness as a matter of health, the social and media influences position it as a matter of appearance. This discourse while making available subject positions of compliance and subordination, makes it further detrimental and exclusionary for those struggling with eating difficulties or disorders of a

higher weight, such as OSFED or UFED. The fear of exclusion and the 'threat' of fatness interpreted from these extracts suggest a punishing and disciplining power relationship with the perpetrators or creators of this discourse and the subjects.

Extract 21:

Riley: … I'm not sure whether the concerns of like the obesity epidemic that's happening and the push within healthcare to encourage people to not be that size, whether that's just perpetuating the ideal to be smaller because then science is telling you that it's… it's telling me to appear a certain way, it's telling you to physically be healthy which… Yeah, it's… It's mainly just external things. Telling you what to do and how to be. And as humans, we want to fit in, so we want to appease what we're told.

This extract adds to the development of the discursive construction of *Controlled and Restricted Eating Valued* by further elaborating on the stigmatisation of larger bodies followed from the 'obesity epidemic' where fatness has been equated with lack of restraint, ill health, ugliness or willpower (Rice, 2007). These medicalised health constructions also continue to put the responsibility of controlled eating on the self (Crawford, 2006; Dodds & Chamberlain, 2017; Mackenzie & Murray, 2021). Technologies of power, which is the way power functions and is exercised by people in society (Foucault, 1978) does not coerce people to make particular food and eating choices. It rather problematises specific ways of eating as less socially desirable and risky to health, which is aimed at shaping the responsibility of health onto the person (Coveney, 2006).

Here, Riley highlights the focus of healthcare being on body size or shape as well as the legitimising power of science in creating notions of health that are limited to physicality. Following Foucault's concept of biopower, which is a form of power exerted more subtly, often internalised, it forms a sense of self and self-surveillance (Foucault, 1979). In this case,

biopower operates to enhance conformity to norms surrounding bodies, where slimmer bodies are idealised and even adopting normative behaviours around food and weight by desiring thin bodies, 'controlled' eating and exercise to be seen as healthy citizens taking responsibility for themselves. Biopedagogies operating around fatter bodies are theorised based on the concept of body mass index (BMI) and transmitted through various informational sites telling people what they must do and how they must be (Halse, 2009). Riley's talk points to the legitimising power of these institutions instigating conformity, "*as humans, we want to fit in, so we want to appease what we're told".* While these bio-pedagogical messages signal people about ways of maximising health and producing productive bodies, they also have detrimental effects on those who are unable to showcase the idealised results for their bodies (i.e. thin, fit and healthy bodies). LaMarre and Rice (2016) have also alluded to these messages around fit bodies producing disordered eating in a culture where it is difficult to decipher the process of achieving the 'healthy' body. Adding to this, Aphramor and Gingras (2009) point towards the contradictory instructions dispersed in our society about managing our bodies through restraining or indulging. This may have some role in instigating disordered eating behaviours in a person attempting to tread the fine line between these two behaviours that are favoured in our society. Biopower plays a role in how bodies, especially larger and eating-disordered bodies, are understood (Lupton, 2013). This perpetuates norms and normativity and continued self-monitoring in an attempt to enact the types of bodies marked as preferred.

While thinness or fitness becomes a norm, controlled and restricted eating becomes more valued by society and oneself. This type of being and eating is more likely also to be seen and less stigmatised. This also plays a role in how larger bodies and 'uncontrolled' or 'indulgent' or binge eating are perceived.

Extract 22:

Riley: I find it more challenging emotionally to be in the binging and it… I know this, but my brain is silly in doing this, but there's been moments where I've tried to make myself in the somewhat anorexic state again when I am binging because it's like I'd rather be doing that [restricting] than this [binging]. That... seemed like other people didn't really value the pain of binging, but they value the pain of restricting.

During Riley's interview, they spoke about their experiences of both restricting and losing weight, as well as binge eating. Their talk identified how restriction and weight loss were much more rapidly identified, seen and acknowledged by others. The value of restriction also lay in how care and concern were provided. When this way of eating and body shape is less stigmatised than its counter, i.e. binging and larger bodies, get unseen and stigmatised. In this discursive construction of restrictive eating holding some intrinsic or extrinsic value also highlights the ways in which the available subject positions further perpetuate fatphobia, disordered eating and stigma regarding less popular, higher weight eating disorders such as OSFED.

3.2.2 Binge Eating and Fatter Bodies Shamed, Stigmatised or Unseen

Fluent in the biomedical discourse, the participants have used the weight and disordered eating stigma talk to describe their experiences. Fatphobia, while entrenched in both restricting and binge eating, plays a different role in terms of positioning and action. This will be explored in this section in more detail.

Extract 23:

Rowan: I'll just keep feeding myself until I feel tired. I just don't feel full, so I'll just keep eating and eating… And that leads me to feel even more stressful sometimes,

like or why am I doing this? I can see myself doing it but it's like I don't have any control over it.

While restrictive eating has been described as having more control over eating, experiences of binge eating have primarily been associated with feeling out of control and with little understanding of the eating behaviour. This was noticed repeatedly by the participants' talk of their binging experiences, which was quite contrary to the ones who struggled with restrictive eating. For Rowan, positioning themselves as helpless to binge eating and desiring to gain control places them as responsible and accountable for their eating difficulty. Inherently implying control over one's eating and body is a virtuous and normative value (Peterson & Lupton, 1996).

Extract 24:

Kit: I've just started talking about it [binge eating] because this is something that is very, very personal and I don't like addressing it because this is something that I'm really shameful of…

Extract 25:

Riley: And I guess the difference emotionally is with the binging you have the guilt and the shame attached to it. But of course, if you then mess up with undereating and you actually eat normally or over eat, then you do have the guilt and the shame. But there's never any pride within the binging.

A significant component of the talk around binge eating was the association of shame and stigma attached to the eating behaviour. This was felt by almost all of the participants who experienced binge eating. The distinction between pride with restricting and shame with binging was notable in Riley's experiences of both of these eating difficulties. Here, shame is also experienced as a painful self-awareness of one's difficulty in meeting the expected ideal around eating, which is perpetuated by societal norms (Manion, 2003).

The participant's experiences of shame and their attempts to control binge eating portray shame as a disciplinary power in the sense that it compels people into normative subjectivity. Kit and Riley's talk of shame sits alongside Foucauldian disciplinary power in how shame around eating is experienced in society by the creation of 'health morality' (Crossley, 2002), as well as its internalisation on how we shame ourselves. Such constructions of shame continue to perpetuate the marginalisation of those who do not fit into the norm and ideals of a health-focused medical discourse. The loss of pride, feelings of shame and the difficulty in seeing this within oneself or the world positions the individual in a further isolated state.

Extract 26:

Riley: You feel isolated and lost in both restricting and overeating but this [binge eating] feels a bit more isolating.

Shame can isolate and make one feel separated from the social group. Shame and stigma surround pathology and abnormality. However, listening to people talk about their experiences of binge eating also highlighted how the normal-abnormal binary of eating constructed such rigid ways of being in the 'in group' or within a normative position. The focus on health and controlled eating and bodies continued to sideline bigger bodies and 'out of control' eating. OSFED and binge eating disorder being the most common eating disorders (American Psychiatric association, 1980) of those with higher weight has implications on how weight stigma impacts people's ability to overcome shame, recognise their difficulty as 'legitimate' and seek help that is also not perpetuating the normative ideals around food and bodies. Individuals with OSFED and those with higher weight eating difficulties can often find themselves being under-recognised and unnoticed (Ralph et al., 2022).

Extract 27:

Riley: I feel like people are more concerned about undereating than overeating. Cause when I've brought it up to a couple people close to me saying "I'm struggling with binging and overeating now" and saying like the challenges that faces, it was almost like a "at least you're not restricting" sort of shrug off the shoulder.

Extract 28:

Kit:…when I was in school, I realised that this [binge eating] might become a problem eventually, but I never paid attention to it till the time I started therapy.

Binge eating, here, is something that is neglected by others, like in the case of Riley or unseen by oneself, as Kit described. Riley's comparison of binging with restricting showcases the way in which importance and care are given to symptoms aligning with anorexia. Restrictive eating was noticed as a concern and a responsibility of the collective. In this construction, binge eating is positioned not to be seen as 'serious' enough or worthy of attention when compared to restricting. In such positioning, larger bodies or bodies of a higher weight can continue to be marginalised in an obesity-focused biomedical discourse nuanced by healthism that contributes to the culture of a thin ideal in our society (Gotovac et al., 2020). It can also be argued that the ideal perpetuated is of a healthy, controlled, productive person, often seen as morally superior. This is seen in the moral panic around obesity in eating disorder literature (Gotovac et al., 2020). This, in turn, further stigmatises larger bodies and the eating difficulties associated with them. With this, losing weight becomes the standard for treatment for those with binge eating and larger bodies (Brown-Bowers et al., 2017).

In line with the tenets of healthism, the influence of weight loss in overweight type 2 diabetic adults to decrease their long-term morbidity and mortality was investigated to reveal no association between the two variables (Køster-Rasmussen et al., 2016). On the contrary, HAES-based interventions in obesity management improved physical and psychological

outcomes and promoted changes in eating habits and behaviour in overweight and obese adults (Ulian et al., 2018). This juxtaposition in the outcomes of the two bases of interventions makes a compelling case for the exploration of HAES as a way of conceptualising health in people of all types of bodies.

The function of this construction also puts the responsibility of binge eating on the self. In the healthism biomedical discourse, self-regulation and personal responsibility regarding food consumption and exercise often overlook the limitations of control many individuals have over their eating (Marmot, 2015). Targeting the individual rather than the system continues to portray individuals who binge eat as those refusing to conform to the disciplinary power. Not recognising systemic inequalities in health and further ignoring binge eating as a 'legitimate' difficulty is likely to make more people develop obesity and continue to struggle with their eating in the shadows. This position makes available limited choices for accessing help and support. It holds the capacity to worsen feelings of isolation by putting the responsibility of eating on self and, thereby, the fear of having to cope with it alone. The neglect of care by others and self was noticed in the talk of many who experienced binge eating. This further creates isolation around this topic as their eating difficulties go unseen.

Extract 29:

Kai:…I've experienced this when people who are bigger and they admit that they have binge eating problems. It's never taken in the same way as when people who are of a smaller body type are. So it's it's always associated with "Of course you eat more, Look at yourself".

Kai is able to shed light on how binge eating often gets intertwined with larger bodies. Here, difficulties with binge eating are constructed as inherent for those with fatter bodies. Kai has also opened a discursive space to challenge the hypocrisy of relevance and significance of eating difficulties in people with different body types. This construction

renders fat bodies as unseen in the eating disorder world, where their eating difficulties become linked as a result of their fatness. Research ingrained in biomedical discourse has correlated binge eating disorder diagnosis with fatness (e.g. Grucza et al., 2007) with popularly used treatment manuals (*Overcoming Eating Disorders: A Cognitive-Behavioral Therapy Approach for Bulimia Nervosa and Binge-Eating Disorder Therapist; Agras and Apple, 2007*) reporting an increased likelihood of binge eating disorder as body size increases (Agras & Apple, 2007). The longstanding medical literature and 'repositories of truth' have the unintended consequences of perpetuating fatter bodies and their eating difficulties as abnormal and even giving less space to be understood as uniquely as eating disorders of a lower weight. This perpetuates the cycle of stigma and shame and upholds the power dynamics between medical structures, clinicians and people.

This becomes especially significant to consider when working with people not stereotypically associated with the 'eating disordered' body. In the following extract, Kai positions themselves as "*a fat kid*" who never conceptualised their binge eating as a legitimate concern due to the misconception of eating disorders or disordered eating being only associated with skinny bodies.

Extract 30:

Kai: … growing up in the 2000s and the sort of like the skinny ideal, the Paris Hilton, Britney Spears sort of thing, but all of that was associated and the models, all of that was associated with, like, anorexia. So you automatically associated any eating disorder or disordered eating with a very skinny person.

Positioned as an anomaly in the eating-disordered world, those who find themselves aligning more with symptoms of OSFED/UFED are seldom 'skinny' enough to be considered for more 'legitimate' labels like anorexia nervosa, and their eating difficulties often go neglected. While binge eating and fatter bodies go unseen due to the stigma, the

popularisation of "*skinny ideals*" (see extract 30) as the bodies linked with eating disorders continues to perpetuate a "norm" of what we often perceive or think of when understanding eating disorders.

3.2.3 Eating Difficulties Unnoticed by Health Care Professionals (HCPs)

This discursive construction focuses on the ways in which treatment and seeking support from HCPs have been constructed in light of people's eating difficulties, severity, weight and BMI. In the below extract, Riley talks about their experience of accessing GP care for weight loss and restrictive eating.

Extract 31:

Riley:…it was just like, "yeah, you've lost weight. You can gain it again" and it stops there and then we went another time because I ended up losing my period and I can't remember whether it was in one of the other two visits but another time, just because I was feeling sick and thought I was allergic to something. Because every time I ate, I felt icky…or just uncomfortable and it was just never picked upon that the issue was psychological instead of the physical elements that were happening…

Here, help-seeking for eating difficulties has been constructed as ignorant of psychological perspectives and limited to a biological weight-focused framework of eating difficulties. This way of talking also highlights issues of awareness among healthcare professionals regarding the complexity of eating disorders. Riley makes space for the visibility of psychological factors affecting their weight loss, which now positions them in a space of more visibility and empathy for their struggles with food. The focus on weight and subsequent weight restoration in Riley's case or weight loss in other cases has been the centre of practice in conceptualising eating disorders. Reliance on BMI or other weight-based terminology as a measure of individual health perpetuates weight stigma yet is ingrained in the language of health care providers and even public health messaging such as 'the obesity

epidemic' (McEntee, Philip & Phelan, 2023). Our weight seldom reflects problematic behaviour used to attain the current weight and neglects a real understanding of the problem. Basing severity solely on the BMI ratings in the DSM-V also falls short in determining biological marks of medical concern (Dang et al., 2023). Focusing on weight gain as 'healthy' and important in cases of eating disorders of lower weight and then reversing the expectation and labelling 'excessive' weight as 'unhealthy' can create a confusing loop of messaging through language as people try to reset and redefine their relationships with their bodies and eating.

Extract 32:

Ira: …I'll be worried if I approached someone say like GP about it… and they wouldn't take me seriously because umm I don't feel like my symptoms are bad enough for them to take me seriously and provide me with help and umm... I think it was only really when I started, weighing myself like four times a day that I felt like I could talk to my therapist, even about it, and because that felt like it was bordering on bad enough that I kind of deserve to get help for it, if that makes sense.

Here, Ira highlights another common way eating difficulties in people of higher weight and help-seeking have been constructed within this extract as well as by other participants who deemed their eating difficulties not severe enough to seek help. This construction also has an underlying implication that care and attention are reserved for those meeting the perceived rigid and severe threshold of eating disorders, such that the notion of threshold categories as exclusive labels indicates severity as worthy of receiving help. Clinical severity in diagnostic manuals is often based on the BMI level (American Psychiatric Association, 2013). This can pass on a message that establishes the worthiness of care based on body weight and size. This way of construction continues to propagate health care

professionals and institutions as rejecting and unwelcoming to those that don't have overt difficulties, such as being underweight and fitting into a clear-cut descriptive category. Discerning the function of power, medical systems and fatphobia in creating people's realities of their bodies and eating is essential for questioning and positioning our practice as psychologists and researchers in the wider discourse. Taking a critical stance towards healthism, weight stigma, and even the role of gendered experiences while working with all types of eating difficulties holistically is a vital approach longing to be realised. Doing so can allow various empowering subjectivities and deviation from the dominant discourse.

3.3. Eating Difficulties in Relation to the OSFED Diagnostic Label

This discursive construction is focused on the construction of the OSFED label by the participants who themselves have self-identified with symptoms of this diagnosis. Situated within the biomedical discourse, the discursive constructions created look at how OSFED as a diagnosis, which was initially aimed to provide a more meaningful categorisation to people under the eating disorder diagnosis categories in the DSM-V, is spoken about by the participants. This covers both acceptance and rejection of the label, along with how the negotiation with the diagnosis persists.

3.3.1 Rejection of the OSFED label

One of the ways in which this discursive construction of *Rejection of the OSFED label* came about was with participants' lack of awareness and interest in the label. Phoenix, Kit and Rowan took an ambivalent position, suggesting their disinterest in this specific diagnostic label. During the interview, Kit talked about their awareness of eating disorders, mainly limited to the three threshold eating disorders. This was followed by exploring how they spoke about their binge eating in relation to the OSFED diagnostic label. Since Kit was exposed to this specific label through this study, they expressed an apathetic response towards the label's capacity to give meaning to their eating difficulties. Given that OSFED is a recent

and less used diagnostic label, it was not well known to some of the participants, definitely not as much as they might know about anorexia nervosa or bulimia nervosa. Understandably, due to this, OSFED was absent from the common language of the people and only available to be viewed within and from a biomedical discourse lens.

Extract 33:

Researcher: does this [OSFED/UFED label] impact in any way how you make sense of your binge eating?

Kit: Not really, [chuckle] because it [binge eating] is still something that I need to work on. So like, maybe the effort might be less now, but like nothing more than that.

Researcher: So it doesn't have much of an impact on how you understand your eating difficulties?

Kit: No, because I'm quite well aware of it [binge eating].

Kit constructs the OSFED label as something separate and indifferent from their binge eating experience. The binge eating being something "*that I need to work on",* relying on their awareness of it rather than the OSFED label. Here, they suggest not wanting to associate with the diagnostic label "*No, because I'm quite well aware of it [binge eating]"* while they work on managing their eating difficulties in their own way. Kit positions themselves as resisting the biomedical discourse by gatekeeping their binge eating from being labelled as OSFED and instead prefers to rely on their own subjective understanding. This position and way of construction also allow them the flexibility of exploring their eating without the rigidity or exclusivity of diagnostic labels. Indeed, an alternative approach to understanding and talking about eating difficulties is lacking within this context, which, in turn, limits the possibility of action.

Extract 34:

Riley: I don't particularly like it [OSFED] because it feels a bit flippant and…

Researcher: Hmm what do you mean?

Riley: 'Oh it's just one of the other things' whereas the others [TEDs] have a term attached to it. So often just feels like it's not important enough to be properly researched or thought on or treated.

In the above extract, OSFED is constructed in comparison to the threshold eating disorders as something not valuable enough. The understanding of OSFED continues to be through the pre-existing knowledge of the threshold eating disorders. During the interview, Riley constructed OSFED as demoralising, even labelling it "*careless*", very similar to her disdain of OSFED not being seen as separate, distinct and holding similar clinical value and importance. While OSFED is often labelled as 'subthreshold' (Todisco, 2018), studies rooted in positivism have shown equal levels of impairment and distress between TEDs and OSFED (Fairweather-Schmidt & Wade, 2014; Withnell at al., 2022). The literature review conducted highlighted the limited clinical utility and difficulty of studying the various subtypes of OSFED from a positivist lens (e.g. Fairweather-Schmidt and Wade, 2014; Mustelin et al., 2016; Withnell et al., 2022;).

Further, Mustelin et al. (2016) also concluded that OSFED failed to present itself as a meaningful diagnosis that reflected 'eating pathology' in the community. I would also take a step forward and suggest that quantitative positivist research, which reflects the rigidity of diagnostic structures, has a limited vision and scope of understanding eating difficulties, such as OSFED, that present in a variety of ways. Socio-cultural factors also impact how disordered eating behaviours are expressed across cultures, which sway from the Eurocentric vision of eating disorders (Levinson & Brosof, 2016)—further diluting the ability of diagnostic manuals to encompass its 'legitimate' knowledge across cultures. Additionally, as

discussed above, a lot of eating difficulties, such as binge eating, can go unseen or rejected, forming a barrier for people to come forward in clinical practice or research studies with strict diagnostic criteria. Even those struggling with restriction can find difficulty associating with the concept of 'abnormality' and the stigma carried by a diagnosis. Even comparing their bodies with the 'skinny' image of anorexia popularised in the media carries with it a challenge to recognise restriction in those of a higher weight as equally deserving of attention.

With this understanding, the participant's position of avoidance, ambiguity or rejection of the OSFED label can be seen as their way of challenging the biomedical discourse due to the shame, stigma and exclusivity attached to it. Even while rejecting the dominant discourse, their constructions still suggest compliance as they continue to operate under the parameters of diagnosis and treatment laid out in the medical discourse. In current clinical practice, there is evidence of disapproval of CBT-E treatment experience for OSFED (Mahon, 2000), suggesting a need for improved care for service users being identified under this diagnostic label.

According to Foucault, "power is exercised only over free subjects" (Foucault, 1982, p.221), meaning that for power to be operated, the subjects must have available a realm of possibilities with diverse ways to behave, act and feel. This way, freedom becomes a condition for the exercise of power. This is echoed in this discursive construction of *Rejection of the OSFED Label,* as participants challenge the power structure, which in turn highlights the existing power relation between the subjects and medicalised structures. Foucauldian concept of power and freedom also elucidates how power brings with it rules and constraints, which require 'practising' freedom instead of setting it as a goal to be achieved to challenge dominant power structures in society (Carrette, 2007). Simply put, it's about a positive resistance that gives people the ability to choose one action over another, allowing for alternate subject positions.

The discursive construction of *Eating Difficulties in Relation to the OSFED Diagnostic Label* is constructed based on the participant's negotiation of their positioning in the OSFED biomedical discourse, which has led to conflicting constructions of the label. This is explored in the following section, which examines interesting ways of negotiating compliance while functioning under the medical discourse.

3.3.2 OSFED as Comforting and Legitimising

Contradictions in how participants constructed OSFED were evident in some of the interviews. As seen above, Riley and Kit were averse to associating their eating difficulties with OSFED. However, they were open to the idea of OSFED helping other people who did not fall under the rigid diagnostic criteria for threshold eating disorders. This negotiation with the OSFED label becomes more evident with Kai's description of OSFED and the contradictory subject positions that are available in this construction.

Extract 35:

Kai: …as I familiarised myself more with it [OSFED diagnosis], it did help in the sense that it provides clarity to you, to me at least, it provided clarity and you almost felt like… you almost feel vindicated in a way that you feel like, oh, yeah, all of these things that I was struggling with, they were real things. And they weren't just something in my head, and it wasn't just, "you're just fat".

In this extract, Kai aligns their talk with the biomedical discourse and constructs OSFED as having the clinical ability to provide meaning to their eating experiences. Meaning is provided in a way where Kai experiences the OSFED label as having the power to legitimise their binge eating behaviour as if it were a "*real thing*". It's almost as if their binge eating was 'seen' as a 'clinical' thing separate from their 'fatness'. The burden of fatphobia that Kai carried, which led to them neglecting their binge eating, seems to have been lifted away by the OSFED diagnostic label. Almost shifting fatness away from the responsibility of

binging and being perceived more as a 'clinical' thing. This way of constructing separates their body shape from their eating. Here, Kai positions themselves as having more freedom from the stigma of fatphobia. During the interview, Kai expressed how identifying with the OSFED diagnostic label helped them talk about their eating in therapy, which enabled them to truly notice and recognise their binge eating as something that can be managed instead of a *"by-product of being a fat person*". This phrasing of their fatness can also be interpreted as a feeling of punishment for straying away from the body size norms.

Responses to psychiatric diagnosis vary among individuals, with some even expressing relief and validation (Dinos et al., 2004; Lafrance, 2007). Having a diagnosis and a sense of validation also comes with a provision of language for talking about distress (Proudfoot et al., 2009). Kai's account suggests the power of the diagnosis to normalise and legitimise their eating difficulty while providing an offer of hope of a 'cure'. A diagnosis has the potential to convert individual distress to a shared experience which is labelled as treatable and credible. In the Western context, this understanding plays a vital role as this is a culture that celebrates stern individualism and prefers the agentic and responsible individual (Kitzinger, 1992; McKendy, 2006). For individuals facing adversity or psychological distress, this framing of success can pose a real challenge. Those perceived as not exerting the required personal control are quickly shamed as weak or lazy (LaFrance, 2007). Kai's grief of binge eating as a by-product of their fatness found them in a position of neglect and shame where responsibility for their 'weaknesses' lay on them. The biomedical model for those in distress and experiencing challenges offers a helpful and advantageous alternative to the dominant set of assumptions. It provides an exemption from blame by understanding distress and dysfunction as an aspect of the illness and not as a personal failing.

Extract 36:

Kai: I was taking it [binge eating] more seriously and thinking of it more as a problem that has an underlying cause and then also something that has a resolution, something that can be healed.

Kai's talk reveals the reliance on the biomedical model to make meaning of their eating experiences. Kai's construction of OSFED as a comforting label that allowed them to operationalise their eating difficulties showcases an acceptance of the medical dominant discourse. This positioning allows them to experience more agency and a sense of control over their previously described "*uncontrolled*" eating. It's almost as if by aligning with the medical discourse, some power is being reclaimed back from feeling sidelined and marginalised as a fat person experiencing binge eating. Their background in psychology can also be a factor in understanding Kai's use of language and comfort in adapting the biomedical discourse. Having experienced binge eating in the past and gotten help may have also played a role in the language readily accessible to them that echoes the legitimising power of psychiatric diagnosis.

Given the contradictory positioning and constructions of OSFED by the participants, it is essential to reflect on how the discourse being created by this study is being impacted. The other participants did not explicitly uphold this diagnosis onto themselves, and Ira and Riley even openly criticised it. Having said that, they still showcased compliance with the 'idea' of this label as long as it was not associated with their eating difficulties. This made me wonder about my presence as a 'trainee psychologist' or 'researcher' during the interview. Riley, Phoenix and Kai, when talking about their interview experience, positioned me as the 'expert'. This has made me aware of how I might be perceived as a member of the medical realm, interviewing individuals about technical diagnostic categories. One of them is OSFED—a diagnosis which is likely known more by professionals than other people. The

concept of this study was to not collude with medicalism. Hence, the interview schedule was developed with the idea of using the participant's language and creating more inclusive inclusion criteria. However, given the dominance of medical discourse in this thesis, it is important to note that my position as a 'researcher' or 'psychologist' will bring in a dominant element of medicalism. With this comes the power of the medical structures and DSM to exert compliance on language and co-construction of meaning. The world and meaning are created when people talk to each other (Burr, 1995), which makes us "simultaneously the products and the producers of discourse. We are both constrained and enabled by language" (Edley and Wetherell, 1997, p. 206). This understanding is further reflected in the next chapter, where I discuss the future scope and limitations of the study. Perhaps a study that integrates and adapts feminist research methods could pose a boon for building on this project and clinical interventions.

This discursive construction of *Eating Difficulties in Relation to the OSFED Diagnostic Label* also portrays the limited availability of discourses to talk about OSFED and its related symptoms. Evidently, in the participants' talk, even while challenging the medical discourse, they still complied with its framework. Aligning with the dominant discourse added to perpetuating its normalising and legitimising power. The limited subject positions available to the participants due to the domineering medical discourse suggests a gap in the topic of eating difficulties. Perhaps this research and method of exploration can provide scope for occupying alternative subject positions for participants to operate under and understand its implications for practice.

3.4. Eating Difficulties as Transdiagnostic

This discursive construction is set within the dominant biomedical discourse and goes slightly beyond traditional diagnosis and looks at psychological mechanisms that underlie 'eating disorder psychopathology'. With the medical model at its core, this discursive

construction is based on a more nuanced framework of understanding eating, which is perhaps an attempt to make up for the shortcomings of the diagnostic system. This section discusses some transdiagnostic constructions identified in the data.

3.4.1 Transdiagnostic Conceptualisations of Eating Difficulties

Extract 37:

Riley: …and for me, with my brain, having something explained is to like "and this is what's happening. This is often why it's happening, and this is the treatments that's for it." And seeing my behaviours, and my thoughts written down and explained, I found that really useful.

Riley relies on the biomedical discourse when constructing eating difficulties in a way where the focus is on creating an individualised formulation of understanding behaviours, cognitions and an underlying cause. In this way of construction, the speaker opens the discourse to go slightly beyond the rigid diagnosis-limited understanding of eating disorders that seldom communicate meaningful information apart from engaging us in stereotypes. Riley's talk elicit a Cognitive Behaviour Therapy (CBT; Beck, 1976) formulation, which is rooted epistemologically in positivism (Grant, 2009). There is an inherent position of compliance to the reductionist biomedical discourse, which locates the 'problem' of Riley's difficulties within themself. In this extract, the clinician is positioned as holding the role of the 'explainer', which suggests a power imbalance within this way of talking; however, Riley subjectively experiences it as "*useful*". This way of constructing eating difficulties is very widely available, given the prevalence of positivism in research and practice (Ponterotto, 2005).

The reliance on labels and diagnosis, while it certainly comes with a sense of security for clinicians about communicating a singular idea, unfortunately, often ignores the actual distress. The transdiagnostic CBT-E model for eating disorders by Fairburn et al. (2003)

places the focus on cognitions and dysfunctional self-worth beliefs while labelling it as the 'core psychopathology'. This approach potentially takes away the categorical lens by focusing on mechanisms that maintain the eating disorder, such as the fundamental beliefs surrounding weight and shape concerns and difficulty with control. The factors maintaining the eating disorder might differ at an individual level but are considered to be prevalent and relevant at a diagnostic level (Fairburn, 2008; Fairburn et al., 2009). Again, diagnosis is the focal point. In a cognitive-behavioural transdiagnostic model, dysfunctional self-evaluation remains at the core of the maintenance of the 'eating disorder'. This approach and way of constructing eating difficulties can open up a more flexible space by focusing on various maintenance mechanisms of an 'eating disorder' that Riley found useful. However, it still limits the discourse and the available language around eating to focus on body, shape, and control. This is not very different from the ongoing distress presented on the surface, as well as how eating-disordered individuals are constructed in the dominant discourse. This continues to centre the eating within the individual and their 'dysfunctional' cognitions without a more comprehensive understanding of socio-cultural, especially a feminist-inspired model of understanding eating behaviours that expands the discourse to include gender roles and fatphobia.

It can be said with confidence that the ongoing, dominant diagnostic manual way of categorising eating disorders is not best suited if we wish to improve clinical outcomes as well as also look out for the majority of people who do not fit the stereotypes of threshold diagnosis like EDNOS or OSFED (Fairburn & Harrison, 2003; Turner & Brynt-Waugh, 2004). While OSFED/UFED created another 'box' for atypical cases, it didn't really serve much purpose for the participants, except for what we have discussed in the previous discursive constructions. An alternative and more radical transdiagnostic conceptualisation of eating was put forward by Waller (2008) in his conceptualisation of eating disorders as a sub-

set of anxiety disorder. This way of speaking about eating difficulties was also echoed in Rowan and Kai's talk during the interview.

Extract 38:

Rowan: …it could be work, it could be something else that's happening around my life. A lot of, uh, disordered eating and I tend to binge quite a bit, especially at night… When I'm feeling stressed or if I'm anxious about something, so that tends to happen quite a bit.

Extract 39:

Kai: ... recognising that a lot of my binge eating was associated with my anxiety because I had anxiety all my life and how a lot of it was related to that, where I would feel anxious, or I would feel I would have a depressive episode and my binge eating would then increase. But recognising that this thing [binge eating] was related to that thing [anxiety], helped me take this thing [binge eating] more seriously.

Both Rowan and Kai have a similar construction of their binge eating, where it's regarded as interlinked and a manifestation of their anxiety. Again, drawing from a biomedical discourse and staying within the realm of pathology. Here, eating difficulties have been constructed in this way by the participants to have a broader view of their OSFED symptoms that is not limited to their eating, body, shape and control and accounts for their concurrent experiences of anxiety. With this, they have created some flexibility within the biomedical discourse to harvest a deeper understanding of their eating behaviour while still operating under the subject position of compliance. This way of constructing maps out possibilities of action that allow the participants to "*take this thing more seriously*" (see extract 39), pointing to the legitimising power of the biomedical discourse and how it shapes our experiences and understanding towards an 'objective' pathology-based view of eating.

Eating disorders as a diagnostic category have a very high comorbidity with anxiety disorders (Swinbourne & Touyz, 2007) as well as carry core beliefs about vulnerability (e.g. Waller et al., 2000). Behaviours such as restricting, binging, purging or body checking that are usually associated with the eating disorder label can also be seen as safety behaviours that reduce immediate anxiety by reducing awareness of the current emotional state (e.g. Pallister & Waller, 2008). Rowan and Kai have constructed their eating similarly as a way to manage their anxiety. Instead of getting wrapped up in dual diagnosis and having people carry the burden of multiple 'labels', a more personable understanding of distress can be propagated by researchers and clinicians so that our work not only serves us but also those with a variety of presentations of eating difficulties.

Waller (2008) had a radical take on a transdiagnostic approach to eating disorders by dismantling the label entirely and incorporating it under anxiety disorders. His proposal is based on a solid foundation of the shortcomings of the current diagnostic framework. However, re-categorisation is still a categorisation. It can be argued that it might be more helpful. However, it will still be working under the current framework of eating disorder categories where anorexia, bulimia, binge eating, and OSFED are all separate entities but are reframed under anxiety disorders. Although, this is an interesting proposition and not a researched model. It does enrich our understanding of how anxiety and eating difficulties are interlinked but only has the capacity to present this in terms of diagnostic categories. It is difficult to say if such an approach will not neglect subthreshold disorders like OSFED, but it also opens up space to consider how these thresholds might be created. On what basis is severity classified, and how are interventions tailored to that? Furthermore, the idea of a threshold or differentiating line between healthy eating and disordered eating is still left for exploration.

3.5. Eating Difficulties as a Spectrum

Given how dominant the biomedical discourse has been in the extracts presented so far, it has made it very challenging to confront the power structures in this pervasive dominant ideology about eating. *Eating difficulties as a spectrum* emerged as a discursive construction drawing from the spectrum counter-discourse, bringing in the possibility of challenging the power structures of how eating difficulties are talked about and defined.

3.5.1 A Spectrum Approach to Eating

Extract 40:

Ira: So there's a lot of like barriers in my mind too about actually talking about it [eating difficulty] with people. And umm, if we thought about it as more of a spectrum of disordered eating behaviours to healthy eating behaviours, and then I think that would make it easier for me to kind of apply my experiences and then discuss them with others.

Here, Ira relies on a spectrum approach to understand eating that incorporates both 'healthy' and 'disordered' eating in the same continuum while suggesting the ability to move within it. This construction allows the individual to have more flexibility and agency in the process of making sense of their eating behaviours. This suggests that a label is not fixed or rigid, and as people move along in their lives, they can find themselves in different positions in the eating continuum. Ira counters rigid eating disorder categories by adopting a less stigmatising and more inclusive approach to eating that lowers the pressure of a diagnosis. This extract also suggests a choice to communicate eating behaviours in a more acceptable way for both themselves and others.

A spectrum or a continuum model of many human and psychological phenomena has been increasingly developed, such as gender, sexual identity or autism, suggesting a scope in exploring this pathway for eating.

Extract 41:

Ira: …I wouldn't like them [HCP] to think of it as like a specific disorder and but more like… like you say, 'difficulties' that I'm having… So think of it as more of like a scale.

While constructing the idea of a spectrum for their eating behaviour, Ira relies on my continuous use of the word 'difficulties' during the interview. It was an intentional decision to use the word 'difficulty' instead of 'disorder' to destigmatise the study as well as manage the barriers of bias and power relations that are triggered by using pathologising language. It seems Ira's quote, "*like you say, 'difficulties' that I'm having",* points to a co-construction process during the interview where a discourse countering the medical model was made available. As mentioned before, this study in itself is a creation of a discursive construction, negotiated and constructed with all parties involved in the development of this piece of work (Willig, 2008a). This extract exhibits the process involved in Ira's reliance on a spectrum formulation of eating that may have developed from the interaction with a less stigmatising word 'difficulties' rather than 'disorder'.

The spectrum approach to eating versus a categorical one has been debated and presented in different ways in research (e.g. Brooks et al., 2012; Curzio et al., 2018; Foerde et al., 2022; Shisslak et al., 1995; Treasure & Collier, 2001;). The clinical conceptualisations of 'eating' change over time, although there appears to be an innate tendency for humans to think in terms of categories. This can be counterproductive as many syndromes like autism and even components of identity and personhood, such as sexuality and gender, are more adequately thought about as a spectrum. The spectrum approach to eating behaviours has

been conceptualised in diverse ways by different researchers, all involving innate flexibility, reduced stigma, and thus offering individuals a language with varied subject positions. Proponents of the spectrum approach indicate that 'disease' or 'disorder' is distributed continuously in the general population, which raises the question of how much of it an individual has rather than whether an individual has the disorder or not (Striegel-Moore et al., 1992; Szmukler, 1985).

The categorical approach is better operationalised statistically and fits the biomedical model well (Szmukler, 1985). However, the concepts of normality or 'healthy' eating and abnormality or 'disordered' eating are less pervasive in spectrum approaches due to their less rigid framework. Building on Brooks et al. (2012), the majority of eating disorder cases, such as OSFED, go without a specific threshold label and fall behind in the hierarchy implicit with these categories. The spectrum discourse of eating opposes the dominant discourse, where the current diagnosis system often captures a 'snapshot' of a single eating disorder (Fairburn & Cooper, 2011). Still, in reality, eating is more fluid and has the potential for fluctuations across the lifetime. In extract 9, Ira constructs diagnosis as "*If I have a diagnosis then it means it's like a long term condition",* which takes away from seeing the whole course of an individual's journey with eating difficulties as well as how it changes over time in severity. Diagnosis often migrates over time from anorexia to bulimia to OSFED (Fairburn, 2008).

Prior to the popularly used CBT-E transdiagnostic approach for OSFED/UFED (Fairburn et al., 2003), individuals initially with EDNOS (now known as OSFED) were not covered in research testing the efficacy of eating disorder treatment. This resulted in no specific considerations of intervention recommendations for people with atypical or subthreshold eating difficulties (Fairburn, 2008). Spectrum approaches such as Brooks et al. (2012) also enable subthreshold cases to be identified and give more consideration to a spectrum where 'normalcy' also consists of some 'abnormality'. Thus, it shuts down the purist

idea of 'healthy' or 'normal' eating. Such as the model suggests the notion that healthy individuals, on occasion, also deviate and have 'unhealthy' eating behaviours without it being considered a 'pathology' (Brooks et al., 2011). When the dividers of labels and threshold diagnosis are removed, it also opens up more space for people's difficulties to be recognised a lot sooner, help-seeking to be less stigmatising and a more efficient application for early interventions to combat the prolonged impact of disordered eating.

The spectrum discourse for eating difficulties is sparse compared to the biomedical discourse but continues to build momentum. This was also evident in the data as the 'spectrum approach' to eating difficulties was primarily derived from Ira's talk, making it a minority approach. Given the dominance of the biomedical constructions in the data, I believed it was necessary to represent counter discourses irrespective of their infrequency in the data. This is an attempt to disrupt dominant constructions and showcase the limited availability of language and subsequent ability for action within the biomedical discourse. In line with my counselling psychology values, the purpose of research for me is empowerment and inclusive progress for people, especially in an area like eating disorders, which is of great importance to me. This analysis has been an attempt to build on a discourse that challenges current rigid power structures while highlighting its implications in daily practice as we come across the impact of healthism, fatphobia, stigma and shame. This chapter presents the abundance of the biomedical discourse and a counter-discourse that is more rooted in and aligned with counselling psychology values. However, I would like to use the last section of this discussion to briefly highlight the scarcity of any explicit talk derived from a feminist discourse around eating. Even in eating disorder journals, writings from explicitly feminist scholars are few (LaMarre et al., 2022), especially when, historically, eating disorders were commonly perceived as primarily affecting women. Yet the low prevalence of feminist approaches in interventions as well as during the interviews is worth reflecting on.

3.6 Reflecting on the Absence of a Feminist Discourse

Extract 42:

Riley: I'd be very surprised to find any female who isn't struggling with eating, this is just eating. And which I find really concerning and yeah, it's just a lot more common than I think we know about. Even the people who I deem as being quite healthy with food, once I get to know them, I realise actually, no you still struggle. It's just a very basic human necessity to eat, and it should be easy and normal. But for some reason the females in the Western world find it really, really difficult.

Towards the end of Riley's interview, they added essential elements of socio-cultural and gendered factors constructing and impacting eating behaviours. With their phrasing "t*his is just eating"*, food and bodies are stripped of any socio-political connotations. However, women's bodies and their eating habits have always been representative of more than a body or food. The association of certain kinds of female bodies as representing an ideal in a patriarchal structure (Popenoe, 2005) or the pathologisation of anorexia in female bodies (Bruch, 1978) impacts the construction of eating difficulties today in the Western world. Building on the cultural influence on bodies, Bordo (1994) argues that female bodies are profoundly gendered, and in contemporary culture, this gendered nature of mind/body dualism is that of embodiment. While Riley also relies on a binary view of eating as 'normal', it also showcases the pathologising medical discourse surrounding eating and the limitations of such a construct to account for socio-cultural factors as well as to reduce eating experiences to just external behaviours. The stigma and shame are bound to be associated with this. Furthermore, Bordo (1994) rejects the idea of bodies being purely physiological, but women's bodies are always in the grip of cultural practices. The fear of fatness, the obsession with thinness, defining femininity by body image are all composites of Western culture (Orbach, 1978). Additionally, common eating difficulties like binging, restriction or

purging can be considered psychological responses to the prevailing cultural beliefs about body and body image (Orbach, 1982).

While a feminist discourse and gendered experiences of body and eating may not have been explicitly relied on during the interviews, this does not reflect on how this discourse continues to shape people's realities outside of the context of this study. During the analysis process, the heavy prevalence of a biomedically inclined language was surprisingly high. Even with my attempts to move away from the medical model in my study design, it seems there is an inherent undertone of medicalism in this study. My position as a 'psychologist' automatically creates power dynamics between the participants who are struggling with eating difficulties. The structure of the interview placed me as the 'leader' asking questions, and my title as a psychologist possibly activates biases about clinicians. I wonder if the 'medical gaze' (Foucault, 2003) prevailed among participants who filtered their experiences to fit the biomedical paradigm generally associated with clinicians. Foucault (2003) builds that doctors are more doctor-oriented and do not cater towards the patients. However, this power structure also forces the recipient of this gaze to fulfil and perpetuate this role. As a female novice researcher, I fully endorse and cannot deny the reality of gender and power in the way constructs around eating have been developed. While not thoroughly explored in this study, it is essential to shed light on feminism and its vital role in forwarding the dialogue about eating and bodies beyond just medicalism.

Additionally, there is a need to study eating difficulties differently and more exploratively. A feminist dialogue also has the potential to collaborate with therapeutic approaches to further empower people struggling with eating and their bodies. Ultimately highlighting pathologising forces within our system so that we can uplift the individual as more than just a disease but to be seen as an amalgamation of many facets of the world we live in.

4 Chapter Four: Summary and Critical Evaluation

Heading towards the end of this thesis, this last chapter starts by revisiting the research questions to summarise and conceptualise the main findings of this study. This is followed by discussing the original contribution made by this research, especially in the context of counselling psychology. This chapter continues to a critical review and evaluation of the study and ends with a summary.

4.1. Research Questions and Analysis Summary

This research aimed to explore how 'eating difficulties' are constructed by those who have self-identified with symptoms of OSFED/UFED. This was to gain an understanding of how individuals who don't fit into a threshold eating disorder category rely on language to conceptualise their eating as well as its implications for treatment access and early intervention. To disseminate the research findings clearly, they will be summarised according to the research questions (as stated below) that together answer the primary question: *How do people identifying with OSFED/UFED talk about their eating difficulties?* It is important to reiterate that this study does not aim to assert an objective truth from its findings, as my subjectivity has been central to collecting, analysing, interpreting and presenting this phenomenon.

4.1.1 What discourses are available to talk about the experience of OSFED/UFED?

The Foucauldian Discourse Analysis identified five discursive constructions: *(1) Eating difficulties as a rigid or binary concept, (2) Eating difficulties intertwined with fatphobia, (3) Eating difficulties in relation to the OSFED diagnostic label, (4) Eating difficulties as transdiagnostic (5) Eating difficulties as a spectrum.*

The first four discursive constructions, drawing from the wider biomedical discourse, were considered dominant as that is the current understanding of eating difficulties, with roots in the powerful medical model. The biomedical discourse constructs eating difficulties from the lens of a 'disorder', often understood as rigid categories that define abnormality and

pathologise certain eating behaviours. Accordingly, diagnostic labels are constructed as defining 'bad enough' by creating thresholds amongst eating disorders that legitimise certain experiences of distress. With this, the 'abnormalities' that do not meet the threshold categories get vaguely labelled as 'other or unspecified', and their subthreshold symptoms get stuck within the categorical frictions of the medical model.

Eating difficulties as a rigid or binary concept highlighted this dichotomous view of eating and led to constructions that upheld the idea of 'normative' eating and viewed eating as defined by rigid labels. Within this discursive construction, 'eating difficulties' were placed within a rigid normal-abnormal binary, restricting individuals and their diverse and dynamic eating experiences to pre-existing fixed categories. This resulted in a negotiation of labels as they relate to the participants' eating difficulties in an attempt to challenge the limitations of this binary perspective.

Eating difficulties intertwined with fatphobia draws from a position in the biomedical discourse that is 'health' focused, making larger bodies undesirable, and places the responsibility of surveillance and control of eating and bodies on the individual (Crawford, 2006; Dodds & Chamberlain, 2017; Mackenzie & Murray, 2021). Within this discursive construction, ways of eating were seen as having varied value, with controlled and restrictive eating deemed valuable due to a sense of morality attached to body size and fatness considered morally weak (Markula et al., 2008). This led to the construction of binge eating and bigger bodies as shameful and unseen. These 'health' focused perspectives also bring to light the biases towards fat bodies and the shortcomings of HCPs in the recognition and understanding of eating difficulties.

Eating difficulties in relation to the OSFED diagnostic label is situated within the biomedical discourse and debates about the clinical utility or meaningfulness of this label (Mustelin et al., 2016; Todisco, 2018). Within this discourse, constructions emerged rejecting

the OSFED label due to its limited, negligent and stigmatising nature. However, the legitimising power of the medical model, which was perceived as comforting, was also highlighted within this discourse. Overall, the limited capacity of diagnostic labels to conceptualise such varied eating presentations was noticed.

Eating difficulties as transdiagnostic continues to align with the dominant ideology and power structures. Within this discursive construction, the focus has been placed on the underlying cognitive mechanisms that better explain the maintaining factors of eating disorders. These mechanisms continue to locate the 'pathology' within the individual and yet again align with positivist values. This includes the participants utilising aspects of CBT to understand and explain their eating difficulties as well as recognising that these eating difficulties manifest in tandem with their experiences of anxiety.

Eating difficulties as a spectrum emerged as a counter-discourse, and its sparse availability in the data highlighted the dominant power structures embedded in our society that influence the understanding of eating and limit the availability of alternate ways of subjectivity and action. Within this discourse, eating was constructed as a spectrum of behaviours to account for a range of eating habits that cannot fit into the binary views of eating, such as OSFED/UFED. The spectrum approach allows for flexibility in defining lived experiences, which is otherwise absent in the current dominant discourse, and reduces stigma around recognising eating difficulties and subsequent help-seeking (Brooks et al., 2012).

4.1.3 What subject positions are justified by these constructions?

Where *eating difficulties as a binary or rigid concept* was deployed, the medical framework of diagnosis was constructed as 'legitimising', 'pathologising' and even 'neglecting' of subthreshold symptoms of OSFED/UFED. The participants occupied a subject position of 'compliance' towards the dominant discourse by using the language associated with this framework. Compliance with the power structures of the dominant biomedical discourse left

the participants with a dissonance and disconnect between their subthreshold experiences and the rigid eating disorder labels. The outcome was resistance within the participants, as evidenced by their negotiation with labels. Even within the power dynamic, there was an ability to occupy positions of more agency through these attempts at resistance.

Within *Eating difficulties intertwined with fatphobia,* participants positioned restricting as 'complying with the slimness and controlled eating' ideals. The subject position of complying and holding a 'valuable' position when restricting continues to uphold the societal norms around morality, beauty and health (Burns, 2004). On the other hand, larger bodies and binge eating are seen to be lacking control, going against the normative virtue of gaining mastery over one's body and eating (Peterson & Lupton, 1996). This positions the individuals struggling with binge eating and fatness as 'helpless' to their eating difficulties as well as their concerns 'neglected' or 'unseen' as legitimate difficulties separate from their body shape and size.

When *Eating difficulties in relation to the OSFED diagnostic label* was used, this label was constructed as something 'separate', 'limiting' and even 'careless' when attempting to define people's eating experiences. This stance of rejecting this diagnostic label allowed the individuals to position themselves more flexibly and with more agency while still complying with the biomedical discourse. As agentic individuals, they could create space for their non-normative experiences of eating difficulties and move away from the shame and stigma associated with the OSFED/UFED diagnostic label. This continued negotiation and critique made space for a more 'critical' positioning of the self. Additionally, the legitimacy of labels and medical structures impacted the positioning of OSFED as 'comforting', 'normalising' and 'legitimising' as it provided a sense of validation and converted the individual eating distress to a more 'treatable' thing. This took the responsibility of managing a distressing eating experience in isolation away from the individual.

Eating difficulties as transdiagnostic made available subject positions that allowed for more flexibility to talk about eating difficulties but ultimately showed compliance to the biomedical discourse. Using the transdiagnostic approach aided the meaning-making process undertaken by the participants and allowed them to make sense of their eating difficulties through explanations that were more accessible. However, the 'problem' continued to be located within the person and positioned them as 'objects to be fixed'.

Where the discursive construction *Eating difficulties as a spectrum* was used, help or care was positioned as more 'personalised', 'flexible' and 'accessible'. This discursive construction was interpreted as offering subject positions motivated by a wish for more visibility for symptoms like OSFED/UFED that struggle to receive adequate care (Mahoon, 2000). These positions for practice expand beyond the categorical understanding of varied eating difficulties and adopt a more approachable and less stigmatising method. Within this construction, individuals can be more 'active participants' in the meaning-making process rather than passive recipients of 'taken-for-granted' medical knowledge.

4.1.4 What is the impact of these constructions on treatment access and early intervention?

Biomedical constructions of 'eating difficulties' were most often linked with a sense of rejection from being unable to fit into a 'rigid' category of 'eating disorder'. The constructions of abnormality and fatphobia perpetuated the stigma associated with a diagnosis. Within this discourse, treatment access was set within a 'reality' of receiving a diagnosis or label, perhaps influenced by the context of the study focused on OSFED/UFED – a diagnostic category. The stigma and label avoidance generated by the DSM can prevent individuals from pursuing any form of treatment and avoiding mental health services (Ben-Zeev et al., 2010). The impact of fatphobia constructed a reality where binge eating and larger bodies were not legitimate stakeholders within the 'eating disorder' discourse, thus affecting help-seeking. Out of all

'eating disorders', binge eating takes the longest, i.e. up to 6 years, to receive any specialist care from the time the difficulty first started (Austin et al., 2021). Clearly, this under-served group of people face their own unique barriers to accessing care, let alone early intervention.

Some barriers to early intervention constructed within the dominant discourse, especially pertaining to understanding the OSFED/UFED label, were the lack of problem recognition and motivation to seek help for 'subthreshold' symptoms (Mills et al., 2023). OSFED/UFED is not a widely known label, which instigates doubt regarding the 'legitimacy' of eating difficulties, especially in individuals of a higher weight. This is especially important since individuals with OSFED/UFED are less likely to receive treatment when compared to other threshold disorders (Field et al., 2014). Additionally, lack of expertise in this phenomenon in primary care and fear of continued stigmatisation (Mills, 2023) are 'real' barriers within the biomedical constructions of the participants.

The spectrum discourse offered positions that made interacting with and addressing the 'eating difficulty' more accessible and flexible. While this discourse is not yet widely used by services or clinicians, it does offer a use of language that has the potential to reduce stigma around diagnosis and make recognition of eating difficulties a less pathologising and more encapsulating of diverse experiences of eating that are not rigid and allow for fluctuations over time. Within the ‘reality’ of the spectrum discourse, individuals can access treatment and care that is tailored to their atypical eating experiences and doesn’t undermine those with higher weights who get otherwise overlooked or sidelined in the current milieu of help-seeking within the NHS. Moreover, psychoeducation involving the spectrum approach to disordered eating directed towards the general population as well as HCPs has the potential to promote help-seeking. Such intervention programmes can enable individuals to expand their understanding of the impact of eating difficulties beyond BMI and tackle the internalised ‘healthism’ biases.

4.2. Original Contribution and Significance to Counselling Psychology

The current body of knowledge has shown a need to better understand eating difficulties as a spectrum in order to better represent OSFED/UFED, the largest eating disorder category in the DSM-V and a presentation that is most prevalent in our community yet misunderstood and under-represented in literature (Byrom et al., 2022). There is a need to take a critical stance towards the medical model and positivist roots of our profession that tends to study 'eating difficulties' as a 'disorder' without questioning the frameworks that have created this system. It is essential to explore eating difficulties as a spectrum so as to enable services to consider the psychosocial impact of individuals' lives on their 'residual symptoms' and accordingly offer treatment within these services. Embodying counselling psychology's reflexive, curious and critical attitude (BPS, 2020), I channelled my ambition to conduct an inductive research enquiry about how language constructs our reality of 'eating difficulties'. This thesis provides practitioners of all kinds who encounter individuals struggling with their eating a reflexive gaze to consider how they use discourse and its implications on creating a 'legitimate' truth about this phenomenon by highlighting the power relations contributing to the legitimisation of the existing dominant biomedical discourse. This study also attempts to provide the readers with a counselling psychology-inspired lens of understanding eating distress and criticality towards the medical model. Disseminating this research is also a starting point in raising awareness about the variety of eating difficulty presentations as well the oppressive powers of current medical structures that sideline subthreshold presentations. Attempts to broaden the lens and raise awareness are all in hopes of empowering people (both practitioners and clients) to unpack how we understand our primal survival function of eating while being attuned to our subjective experiences.

There are many stories to be told, and like any research, this study also carries limitations of applicability, especially those unique to a discourse analytic method (Harper,

1995). Having said that, this thesis is my endeavour as a trainee counselling psychologist to impact our traditional ways of working with the 'disorders' of eating.

4.2.1 Studying an Understudied Phenomenon

First, this thesis directly contributes to the gap in the current body of research on studying experiences of OSFED/UFED. While there is a mountain of research for threshold eating disorders like anorexia nervosa, there is evidence to suggest that certain eating disorders like OSFED are often overlooked in both research and clinical practice (NICE, 2017). While there is a limited amount of research done on eating disorders, it is vital to highlight the inequalities within this field. Specific populations, such as those with OSFED/UFED, have been historically overlooked and underserved by researchers on this topic. This thesis has attempted to contribute to correcting this impartiality and give voice to people struggling with 'subthreshold' eating difficulties in the margins of the eating disorder medical discourse.

The current literature available to understand this phenomenon is mainly from a positivist epistemological perspective that focuses on clinical utility and is only able to see the variety of eating difficulties through a diagnostic lens. The ongoing sense of authority and privilege exuded by the biomedical discourse as a way of understanding eating behaviour limits the scope for conceptualising eating difficulties that fall outside of the rigid threshold categories. The current diagnostic criteria have been arbitrary, less research-driven and full of inconsistencies (Krug et al., 2024). This leads to a lack of clarity among the stakeholders, practitioners, researchers, and clients regarding the understanding of and intervention for these unique and distressing eating behaviours. There is a need to see beyond the medical model and evaluate the impact of this discourse on the realities of people with OSFED/UFED. In this thesis, there are noticeable narratives that guide our understanding of factors that construct realities of eating difficulties. As this thesis has highlighted various subjective and interpersonal experiences, it has gone much beyond the medicalised diagnostic conceptualisation and

provided a new lens, i.e. the spectrum approach to study this phenomenon. At the same time, the aim was not just to fill a gap but also to give a direction away from the dominant way of studying OSFED/UFED that also incorporates the understanding of power in our current system.

4.2.2 Methodological Diversity and a Counselling Psychology Perspective

My research has contributed to the epistemological and methodological diversity, which is still greatly needed in a field submerged in positivism. A social constructionist and discourse analytic lens have been useful in building a non-traditional research strategy for the marginalised OSFED/UFED presentation of eating difficulties. Taking a critical lens and focusing on the current use of diagnostic categories has allowed the examination of the positions available in a biomedical discourse for practitioners and clients. Further, this thesis is an attempt to undermine dominant discourse and medical structures by empowering and transforming the resistance present in them, for example, between the 'normal' and 'abnormal' eating individual and the fatphobia inherent in the medical and social world. Parker et al. (1995) suggested that unless these oppositions are carried forward to new practices, we run the risk of perpetuating 'old' practices of division and exclusion.

Additionally, this thesis not only brings an inclusive lens to eating disorder research by studying the understudied, but it has also created a unique framework for working with a diagnostic label in a non-pathologising way that accounts for the variability of presentations in OSFED/UFED. This is seen in the use of specific terminology like 'eating difficulties' and the creation of a flexible inclusion criterion that is driven by people's willingness to self-identify with 'subthreshold' symptoms. A positivist study seldom comprises such practices and thus struggles to study the phenomenon of OSFED/UFED in its entirety (Fairweather-Schmidt & Wade, 2014; Riesco et al., 2018).

As a Counselling Psychology trainee, my endeavour in this field is to actualise our commitment to deepening and holding on to our understanding of people beyond any diagnostic label or category (Cooper, 2009). While the issue of diagnosis is debated in the field (see Sequeira & Van Scoyoc, 2011), the contribution of this study is bringing the humanistic CoP values that compete against the 'thingification' (Levinas, 2003) or the reduction of human experiences into labels. My position in this research has been vital in presenting the subjective realities produced by biomedical discourse, its 'real world' impact on people's actions and building a more collaborative counter-discourse to look at eating difficulties. Eating or feeding ourselves is a profoundly primal and personal experience embedded diversly in cultures, yet it is heavily medicalised. Indeed, a humanistic CoP lens brings value by challenging the ongoing reductionist and pathologising practices- "Somewhere in the realm of the psychological professions, there need to be practitioners who can welcome – and work with – the richness and vastness of clients beyond their diagnoses." (Cooper, 2019).

4.2.3 Clinical Practice

At present, I would argue that most practitioners and services involved with eating disorders continue to be constrained by the biomedical discourse and the associated reductionist ways of working and labelling eating. This system is worse for individuals with OSFED/UFED, who are likely to miss out on early intervention as they are less likely to get readily picked up by primary care practitioners. Consequently, their suffering is prolonged (Mills, 2023). This thesis aims to bring a more flexible way of talking about eating, such as a spectrum approach and intends to bridge the gap between services, practitioners and people. The spectrum approach of eating introduced here is not presented as a model but merely the creation of a flexible vision of language that can be incorporated, built on, or further explored by researchers and clinicians alike. I would like this thesis to inspire all practitioners to be

aware of discourses that challenge the medical model in an attempt to free ourselves from its legitimising power and develop a critical stance. Certainly, the power structures that exist have been made more visible through this discourse analytic method and can be more easily considered in our therapeutic work. This thesis encourages practitioners to heighten their awareness about the conceptualisation of eating in our current world, regardless of the service or client group they work in. Eating is a common human experience and is often attached to social, political and medical connotations.

It is pertinent to note the importance of early intervention and detection of these 'subthreshold' symptoms and their tendency to be neglected in the current medical model. The vision here is to make interventions more accessible by deconstructing the current rigid structures and supporting early access to care. Developing outreach programs providing psychoeducation can highlight ‘residual’ symptoms and OSFED subtypes as legitimate difficulties and normalise their concerns to reduce stigma. Further, information can be disseminated about misconceptions about body shapes, size, and eating disorders. Myths about ‘losing weight’ for health can be dispelled by encouraging dialogue. Peer groups can be promoted to encourage social support for individuals with OSFED. Given the variety of OSFED symptoms, services and clinicians can work towards personalising therapeutic interventions based on the subtype. This might impact the involvement of services with individuals with OSFED/UFED to encourage monitoring of symptoms to potentially prevent progression of distress. It is also essential to acknowledge how the current view of gender as a spectrum influences individuals seeking care for eating difficulties. Clinicians and researchers may benefit from adapting their work to be more inclusive of the variety of eating and gender presentations by developing gender-informed interventions (Thapliyal et al., 2018).

Dissemination of this thesis furthers the dialogue on the issues with the NHS relating to eating disorders, such as biases and internalised fatphobia within HCPs and clients themselves, the structural limitations of help-seeking for non-normative eating difficulties, and concerns around early detection of subthreshold symptoms. The main barriers highlighted in this study were self-stigma, fatphobia, denial and ambivalence towards help. As responsive and reflexive clinicians, we must recognise the pervasive presence of the biomedical discourse in our everyday therapeutic practice. This ranges from labelling clients as anorexic, bulimic or even 'unspecified' to 'mindless' application of rigid transdiagnostic models (Fairburn et al., 2003) and the presence of fatphobia in our systems and within our clients. This way, we may be able to build spaces of resistance and perhaps even pilot a spectrum understanding of eating. For now, this thesis has introduced a counter-discourse and encouraged micro resistance. Finally, the conversation about building alternate ways of working with the variety of eating difficulties is now being continued by this study.

4.3. Evaluation and Critical Review

This section presents a critical review of the study in line with Yardley's (2015) criteria for evaluating qualitative research, which attends to sensitivity to context, commitment and rigour, and transparency and coherence. The impact and importance of this study have been discussed in the previous section (see 4.2).

4.3.1 Sensitivity to Context

Throughout this research, I have endeavoured to explore and demonstrate how 'eating difficulties' have been constructed by participants by being aware of the stigma, fatphobia and power dynamics involved in this area of research. For this reason, the decision to consistently use a non-pathologising word like 'eating difficulties' instead of 'disordered eating' or 'eating disorder' was used. The first chapter showcases awareness of the historical emergence of the pathologisation of eating and fatphobia. The methodology section has demonstrated the

ability to account for the sociocultural perspective when designing the data collection method, interview schedule and inclusion criteria. My position as a researcher and practitioner was continuously reflected in each chapter, where I contested the issues of labelling the participants eating based on the understanding embedded in the dominant discourse. The findings presented have been constructed through the process of doing this research and have not been an imposition of any pre-conceived categories. This can be seen in a detailed account of carrying out FDA in section 2.6.4.

4.3.2 Commitment and Rigour

Undertaking an FDA as a research methodology without any prior experience in conducting qualitative research shows my immense commitment to this topic and my epistemological position. My criticality towards my quantitative research background played a role in motivating me to engage with the topic by continuing to take up extensive reading about FDA and social constructionism, as well as engaging with my supervisor and colleagues regarding the process of the analysis.

4.3.3. Transparency and Coherence

To ensure transparency and coherence, I have explicitly described and reflected on my rationale, methodological and analytical decisions, as well as consider the impact of my subjectivity and position in influencing the research. The analytical process was documented in detail and has also been presented in the appendices (see H-M).

4.3.5 Limitations and Suggestions for Future Research

It can be argued that the methodological choices made in the study had limitations even though the carefully thought-out rationale informed them. FDA is limited in its exploration of participants' lived experiences and can 'direct the power' to the researcher interpreting the data (Coyle, 2000; Harper, 2003). Future research using interpretative

phenomenological analysis (IPA) may be helpful in exploring the lived experience of individuals with OSFED/UFED (Larkin & Thompson, 2012).

I was aware of this imbalance in power throughout the study, where the participants often positioned me as an 'expert' who also had control over leading the interview and setting the schedule. This sense of power was felt while analysing and interpreting data, which made it important for me to continue to assert that this thesis is one of the many interpretations of the data. Moreover, the dominant prevalence of the biomedical discourse in guiding this study also positioned me, the researcher, in a position of power. For future research, a feminist method-inspired focus group could be a more naturalistic method of data collection, which can offer more insight into the social context for the meaning-making process (Wilkinson, 1999). This method can also shift the balance of power away from the researcher and direct it to the participants. The focus group methodology can also be expanded to include HCPs within the sample, both as exclusive groups and in mixed groups with individuals experiencing eating difficulties. This can be an opportunity to include another stakeholder in the conversation and involve the yielders of power to engage in dialogue meaningfully with the ones most impacted by these power dynamics. Further additions of writing, drawing or other creative methods can relinquish the control from the researcher, making them less likely to be positioned as questioners or experts (Harris et al., 2015). These suggestions might help address the hierarchical relationships in a research setting.

Another limitation is the study's small sample size, which may have contributed to the limited discursive diversity in the data. Even using the current interview setup, which entails a power dynamic, more deliberate data can be sought for future research that incorporates more diversity in this participant group. This can be in the form of researching a particular age group, gender, ethnicity or OSFED subtype (e.g. low-frequency binge eating). Lastly,

interview questions have the potential to be made more purposeful for making space for alternative discourses to arise.

4.4. Summary and Final Thoughts

This research aimed to explore how 'eating difficulties' are constructed by individuals who have self-identified with symptoms of OSFED/UFED. This was to better represent and gain an understanding of this 'diagnostic' category, which is often marginalised and labelled as 'subthreshold' in the current medical discourse. Additionally, uncovering its implications for treatment access and intervention was also part of the study. The findings suggest that the biomedical discourse remains widely available to speak about 'eating difficulties' for individuals identifying with OSFED/UFED. This continues to maintain the legitimising and exclusionary form of psychiatric control and power. The various ways in which the biomedical discourse operates and is relied on were also evident in the participant's constructions. Despite the dominant discourse felt throughout this study, participants also relied on a rather radical and more empowering spectrum discourse. This was interpreted as resistance and an attempt towards gaining more agency when talking about their 'eating difficulties'. The spectrum approach is understood as an alternative and humanistic way of constructing eating that can accommodate the various unique presentations and fluctuations that an individual may experience. Although its prominence is far from the biomedical discourse, this is all in an attempt to de-stigmatise and challenge the power imbalance in our current lens.

Finally, this thesis has been my sincerest endeavour and one of my hardest undertakings in creating knowledge that can have a meaningful yet modest impact on how we see struggles with eating. Having said that, my presence and motivation have been central to the construction of this study. This is something I was continuously reminded of at every stage of this research. Throughout this journey, I have held the utmost regard and empathy for

my participants for their experiences, contribution and courage to open up and share a part of their lives for this study. The exploration of various discourses and subject positions merely offers other ways for practitioners, researchers and even individuals to question their presumed understanding of eating. Perhaps this can enlighten others to critically reflect on the origins and consequences of language used around bodies and eating. This research has enabled me to embody a reflexive, inclusive and perhaps even a bit rebellious practitioner attempting to challenge the medical model. As I continue my practice in an eating disorder service in the NHS, I am reminded that, again, it comes down to micro-resistance in my attempt to create a more welcoming environment for every individual struggling with eating.

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Appendices

APPENDIX A: Notice of Ethics Review Decision

University of East London

School of Psychology Ethics Committee

NOTICE OF ETHICS REVIEW DECISION LETTER

For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

Reviewer: Please complete sections in blue | **Student:** Please complete/read sections in orange

Details	
Reviewer:	**David Harper**
Supervisor:	**Harriet Walker**
Student:	**Gurbaani Bhalla**
Course:	**Prof Doc in Clinical Psychology**
Title of proposed study:	A Foucauldian Discourse Analysis of 'Residual Eating Disorders': Other Specified and Unspecified Feeding and Eating Disorders (OSFED/UFED).

Checklist (Optional)	YES	NO	N/A
Concerns regarding study aims (e.g., ethically/morally questionable, unsuitable topic area for level of study, etc.)	☐	☐	☐
Detailed account of participants, including inclusion and exclusion criteria	☐	☐	☐
Concerns regarding participants/target sample	☐	☐	☐
Detailed account of recruitment strategy	☐	☐	☐
Concerns regarding recruitment strategy	☐	☐	☐
All relevant study materials attached (e.g., freely available questionnaires, interview schedules, tests, etc.)	☐	☐	☐
Study materials (e.g., questionnaires, tests, etc.) are appropriate for target sample	☐	☐	☐
Clear and detailed outline of data collection	☐	☐	☐

Data collection appropriate for target sample	☐	☐	☐
If deception being used, rationale provided, and appropriate steps followed to communicate study aims at a later point	☐	☐	☐
If data collection is not anonymous, appropriate steps taken at later stages to ensure participant anonymity (e.g., data analysis, dissemination, etc.) – anonymisation, pseudonymisation	☐	☐	☐
Concerns regarding data storage (e.g., location, type of data, etc.)	☐	☐	☐
Concerns regarding data sharing (e.g., who will have access and how)	☐	☐	☐
Concerns regarding data retention (e.g., unspecified length of time, unclear why data will be retained/who will have access/where stored)	☐	☐	☐
If required, General Risk Assessment form attached	☐	☐	☐
Any physical/psychological risks/burdens to participants have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐
Any physical/psychological risks to the researcher have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐
If required, Country-Specific Risk Assessment form attached	☐	☐	☐
If required, a DBS or equivalent certificate number/information provided	☐	☐	☐
If required, permissions from recruiting organisations attached (e.g., school, charity organisation, etc.)	☐	☐	☐
All relevant information included in the participant information sheet (PIS)	☐	☐	☐
Information in the PIS is study specific	☐	☐	☐
Language used in the PIS is appropriate for the target audience	☐	☐	☐
All issues specific to the study are covered in the consent form	☐	☐	☐
Language used in the consent form is appropriate for the target audience	☐	☐	☐
All necessary information included in the participant debrief sheet	☐	☐	☐
Language used in the debrief sheet is appropriate for the target audience	☐	☐	☐
Study advertisement included	☐	☐	☐
Content of study advertisement is appropriate (e.g., researcher's personal contact details are not shared, appropriate language/visual material used, etc.)	☐	☐	☐

Decision options	
APPROVED	Ethics approval for the above-named research study has been granted from the date of approval (see end of this notice), to the date it is submitted for assessment.
APPROVED - BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES	In this circumstance, the student must confirm with their supervisor that all minor amendments have been made **before** the research commences. Students are to do this by filling in the confirmation box at the end of this form once all amendments have been attended to and emailing a copy of this decision notice to the supervisor. The supervisor will then forward the student's confirmation to the School for its records.

	Minor amendments guidance: typically involve clarifying/amending information presented to participants (e.g., in the PIS, instructions), further detailing of how data will be securely handled/stored, and/or ensuring consistency in information presented across materials.
NOT APPROVED - MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED	In this circumstance, a revised ethics application **must** be submitted and approved **before** any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application. **Major amendments guidance:** typically insufficient information has been provided, insufficient consideration given to several key aspects, there are serious concerns regarding any aspect of the project, and/or serious concerns in the candidate's ability to ethically, safely and sensitively execute the study.

Decision on the above-named proposed research study	
Please indicate the decision:	**APPROVED - MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES**

Minor amendments

Please clearly detail the amendments the student is required to make

Section 4.3: This should include participant contact details
Section 4.4: Since external examiners could potentially raise issues with the transcription it might be wiser to delay erasing the audio recordings until after the viva. If this is changed, note this throughout (e.g. Section 4.7)
Section 6.1: The 'yes' box should be ticked as the participant sample fits the definition

Participant Information Sheet:

a) **It might be worth considering having a second, shorter and more accessible project title for use with participants.**
b) **I suggest you refer to 'serious risk' rather than just risk (para 4, p.13)**
c) **Move the explanation of not identifying participants by changing names from the bottom of p.14 to the first time you mention this issue (e.g. p.13)**
d) **Ensure the time periods for which data will be stored are consistent – here it is three years, whereas it was five years in Section 4.7. Incidentally, once you hav e finished your course you will need to pass access to the OneDrive containing this data to your supervisor.**
e) **In the consent form you say the interview will be audio-recorded but you don't make reference to that here. Did you mean audio rather than video? If so, how will this be managed (e.g. by asking participants to turn their camera off)?**

Consent Form

a) **How will you be gathering a signed form if you only meet via Teams etc? Will you ask them to sign and scan/take photo or take them emailing the form back as sufficient?**

Debrief sheet

a) **P.18 You say here you will keep the data for five years. As noted above, please be consistent about the duration.**

Major amendments
Please clearly detail the amendments the student is required to make

Assessment of risk to researcher		
Has an adequate risk assessment been offered in the application form?	**YES** ☒	**NO** ☐
	If no, please request resubmission with an **adequate risk assessment.**	
If the proposed research could expose the researcher to any kind of emotional, physical or health and safety hazard, please rate the degree of risk:		
HIGH	Please **do not approve a high-risk** application. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not be approved on this basis. If unsure, please refer to the Chair of Ethics.	☐
MEDIUM	Approve but include appropriate recommendations in the below box.	☐

LOW	Approve and if necessary, include any recommendations in the below box.	☒
Reviewer recommendations in relation to risk (if any):	Please insert any recommendations	

Reviewer's signature	
Reviewer: (Typed name to act as signature)	David Harper
Date:	**29/08/2023**
This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Ethics Committee	
RESEARCHER PLEASE NOTE For the researcher and participants involved in the above-named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place. For a copy of UEL's Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard.	

Confirmation of minor amendments (Student to complete)	
I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data	
Student name: (Typed name to act as signature)	**GURBAANI BHALLA**
Student number:	**2160419**
Date:	**06/09/2023**
Please submit a copy of this decision letter to your supervisor with this box completed if minor amendments to your ethics application are required	

APPENDIX B: Amendment to Ethics Application: Change of Title

ETHICS APPLICATION AMENDMENT FORM

University of East London

School of Psychology Ethics Committee

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology

Note that approval must be given for significant change to research procedure that impact on ethical protocol. If you are not sure as to whether your proposed amendment warrants approval, consult your supervisor or contact Dr Trishna Patel (Chair of the School Research Ethics Committee).

How to complete and submit the request	
1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	When submitting this request form, ensure that all necessary documents are attached (see below).
4	Using your UEL email address, email the completed request form along with associated documents to Dr Trishna Patel: t.patel@uel.ac.uk
5	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.
6	Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

Required documents	
A copy of your previously approved ethics application with proposed amendment(s) added with track changes.	**YES** ☒
Copies of updated documents that may relate to your proposed amendment(s). For example, an updated recruitment notice, updated participant information sheet, updated consent form, etc.	**YES** ☐
A copy of the approval of your initial ethics application.	**YES** ☒

Details	
Name of applicant:	**GURBAANI BHALLA**
Programme of study:	**PROFESSIONAL DOCTORATE IN COUNSELLING PSYCHOLOGY**
Title of research:	A Foucauldian Discourse Analysis of 'Residual Eating Disorders': Other Specified and Unspecified Feeding and Eating Disorders (OSFED/UFED).
Name of supervisor:	**Dr Harriet Walker, Dr Rachel Tribe**

Proposed amendment(s)	
Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below	
Proposed amendment	**Rationale**
Change of title to: A Foucauldian Discourse Analysis of 'Eating Difficulties' in Other Specified and Unspecified Feeding and Eating Disorders (OSFED/UFED)	The proposed title change is done to make the thesis aim clearer, and accessible to readers as 'eating difficulties' as a term is less pathologising and easier to understand for most people. This also makes the study more approachable and less restricted to those with an interest in eating disorders. This amendment matches the aim of the study to explore eating difficulties in a more humanistic way in those with residual eating disorder symptoms like OSFED/UFED.
Proposed amendment	Rationale for proposed amendment
Proposed amendment	Rationale for proposed amendment
Proposed amendment	Rationale for proposed amendment

Confirmation		
Is your supervisor aware of your proposed amendment(s) and have they agreed to these changes?	**YES** ☒	**NO** ☐

Student's signature	
Student: (Typed name to act as signature)	**GURBAANI BHALLA**

Date:	**01/08/2024**

Reviewer's decision		
Amendment(s) approved:	**YES** ☒	**NO** ☐
Comments:	Please enter any further comments here	
Reviewer: (Typed name to act as signature)	**Trishna Patel**	
Date:	**01/08/2024**	

APPENDIX C: Participant Information Sheet

Participant Information Sheet (PIS)

Version: 2
Date: 06/09/2023

PARTICIPANT INFORMATION SHEET

Exploring Discourses Around 'Residual or Subthreshold' Eating Disorders

Contact person: Gurbaani Bhalla
Email: u2160419@uel.ac.uk

You are being invited to participate in a research study. Before you decide whether to take part or not, please carefully read through the following information, which outlines what your participation would involve. Feel free to talk with others about the study (e.g., friends, family, etc.) before making your decision. If anything is unclear or you have any questions, please do not hesitate to contact me on the above email.

Who am I?

My name is Gurbaani Bhalla. I am a doctoral student in the School of Psychology at the University of East London (UEL) and am studying for a Professional Doctorate in Counselling Psychology. As part of my studies, I am conducting the research that you are being invited to participate in.

What is the research?

I am interested in how 'other specified and unspecified feeding and eating disorders' are currently being talked about by individuals experiencing these eating difficulties. This is in the hope to explore challenges in accessing care as well as its implications for the types of psychological services offered.

Why have you been invited to take part?

You have been invited to participate in my research as I am looking to involve individuals experiencing symptoms of Other Specified and Unspecified Feeding And Eating Disorders (OSFED/UFED). I emphasise that individuals are not required to have a formal diagnosis from a clinician but identify their eating difficulties to be ANY ONE of the following:

- Binging or purging behaviours at a low frequency and/or for a limited period.
- Binging behaviour at a low frequency and/or for a limited period.
- Food-restrictive behaviours or other symptoms of anorexia, however, are of "normal" weight.
- Recurrent episodes of purging without binge eating.
- Recurrent episodes of night eating.
- Other eating behaviours causing significant distress that do not meet the above or any other eating criteria.

I am looking for participants who do not have a prior history of other eating disorders like Anorexia nervosa, Bulimia nervosa, Binge eating disorder or Avoidant Restrictive Feeding and Eating Disorder.
You will not be judged or personally analysed in any way, and you will be treated with respect. You are free to decide whether to participate and should not feel coerced. It is entirely up to you whether you take part or not, participation is voluntary.

What will I be asked to do if I agree to take part?
If you agree to participate, you will be asked to discuss the topic during a conversational online interview with myself which will be recorded. However, only the audio recording will be retained and subsequently transcribed. Interviews will last approximately 60 minutes and will be conducted via video conferencing platform Microsoft Teams.
I will not be able to pay you for participating in my research, but your participation would be very valuable in helping to develop knowledge and understanding of my research topic.
Your taking part will be safe and confidential. Your privacy and safety will be respected at all times. The standard limits to confidentiality apply, where disclosure of serious risk to self and/or others may need to be escalated further. Participants will not be identified by the data collected, on any written material resulting from the data collected, or in any write-up of the research. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally as all personally identifying information will either be removed or replaced by using pseudonyms.
Participants do not have to answer all questions asked of them and can pause or stop the interview at any time.

Can I change my mind?
Yes, you can change your mind at any time and withdraw without explanation, disadvantage or consequence. If you would like to withdraw from the interview, you can do so by letting the interviewer know and exiting the video call. If you withdraw, your data will not be used as part of the research.

Separately, you can also request to withdraw your data from being used even after you have taken part in the study, provided that this request is made within 3 weeks of the interview data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Are there any disadvantages to taking part?

You will need to spend approximately 60-90 minutes talking about your experiences during the interview. We don't think there are any other disadvantages, although some people feel emotional when they talk about their eating difficulties. If you are affected in this way, the researcher will handle the discussion sensitively and give you an opportunity to have a break or to end the interview if you wish. If you need further support after the interview, you can contact the counselling services identified below. These will also be made available to you in a debriefing letter at the end of your interview.

- Mind (National): Provides advice and support to empower anyone experiencing a mental health problem. Infoline: 0300 123 3393 Website https://www.mind.ord.uk/
- BPS Directory of Chartered Psychologists: An online source to locate professional psychologists https://www.bps.org.uk/public/find-psychologist
- BACP (British Association for Counselling and Psychotherapy): A membership organisation that sets standards for therapeutic practice. Phone: 01455 883 300 (to locate professional counsellor).

How will the information I provide be kept secure and confidential?

For the purposes of data protection, the University of East London is the Data Controller for the personal information processed as part of this research project. The University processes this information under the 'public task' condition contained in the General Data Protection Regulation (GDPR). Where the University processes particularly sensitive data (known as 'special category data' in the GDPR), it does so because the processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. For more information about how the University processes personal data please see www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository (Registry of Open Access Repositories, ROAR). Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles and conference presentations.

Anonymised research data will be securely stored by researcher Miss Gurbaani Bhalla for a maximum of 5 years, following which all data will be deleted.

Who has reviewed the research?

My research has been approved by the School of Psychology Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Gurbaani Bhalla Email: u2160419@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Harriet Walker. School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: h.walker2@uel.ac.uk

or

Chair of School Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

Thank you for taking the time to read this information sheet

APPENDIX D: Participant Consent Form

CONSENT FORM

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Exploring Discourses Around 'Residual or Subthreshold Eating Disorders': Other Specified and Unspecified Feeding And Eating Disorders (OSFED/UFED)

Contact person: Gurbaani Bhalla

Email: u2160419@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet dated 06/09/2023 (version 2) for the above study and that I have been given a copy to keep.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation in the study is voluntary and that I may withdraw at any time, without explanation or disadvantage.	
I understand that if I withdraw during the study, my data will not be used.	
I understand that I have 3 weeks from the date of the interview to withdraw my data from the study.	
I understand that the interview will be audio recorded using Microsoft Teams.	
I understand that my personal information and data, including audio recordings from the research will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission.	
It has been explained to me what will happen to the data once the research has been completed.	

I understand that short, anonymised quotes from my interview data may be used in material such as conference presentations, reports, articles in academic journals resulting from the study and that these will not personally identify me.	
I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to.	
I understand that emailing the completed form back to the researcher will imply consent and my agreement to take part in the above study.	

Participant's Name (BLOCK CAPITALS)

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Participant's Signature

.....

Researcher's Name (BLOCK CAPITALS)

GURBAANI BHALLA

.....

Researcher's Signature

.....

Date

.....

APPENDIX E: Participant Debrief Letter

Participant Debrief Sheet

PARTICIPANT DEBRIEF SHEET

Exploring Discourses Around 'Residual or Subthreshold Eating Disorders': Other Specified and Unspecified Feeding And Eating Disorders (OSFED/UFED)

Thank you for participating in my research study on how OSFED/UFED is being currently talked about by individuals experiencing these eating difficulties. This document offers information that may be relevant in light of you having now taken part.

How will my data be managed?
The University of East London is the Data Controller for the personal information processed as part of this research project. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. More detailed information is available in the Participant Information Sheet, which you received when you agreed to take part in the research.

What will happen to the results of the research?
The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference presentations and talks. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally as all personally identifying information will either be removed or replaced by using pseudonyms.

Anonymised research data will be securely stored by the researcher, Miss Gurbaani Bhalla for a maximum of 5 years, following which all data will be deleted.

What if I been adversely affected by taking part?
It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise distress or harm of any kind. Nevertheless, it is possible that your participation – or its after-effects – may have been

challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways, you may find the following resources/services helpful in relation to obtaining information and support:

- Mind (National): Provides advice and support to empower anyone experiencing a mental health problem. Infoline: 0300 123 3393 Website https://www.mind.ord.uk/
- BPS Directory of Chartered Psychologists: An online source to locate professional psychologists https://www.bps.org.uk/public/find-psychologist
- BACP (British Association for Counselling and Psychotherapy): A membership organisation that sets standards for therapeutic practice. Phone: 01455 883 300 (to locate professional counsellor).

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Gurbaani Bhalla Email: u2160419@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Harriet Walker. School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: h.walker2@uel.ac.uk

or

Chair of School Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

Thank you for taking part in my study

APPENDIX F: Research Poster

APPENDIX G: Interview Schedule

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1. Are you aware of diagnostic categories for Mental Health difficulties (*Awareness of "eating disorder" diagnostic category?*)

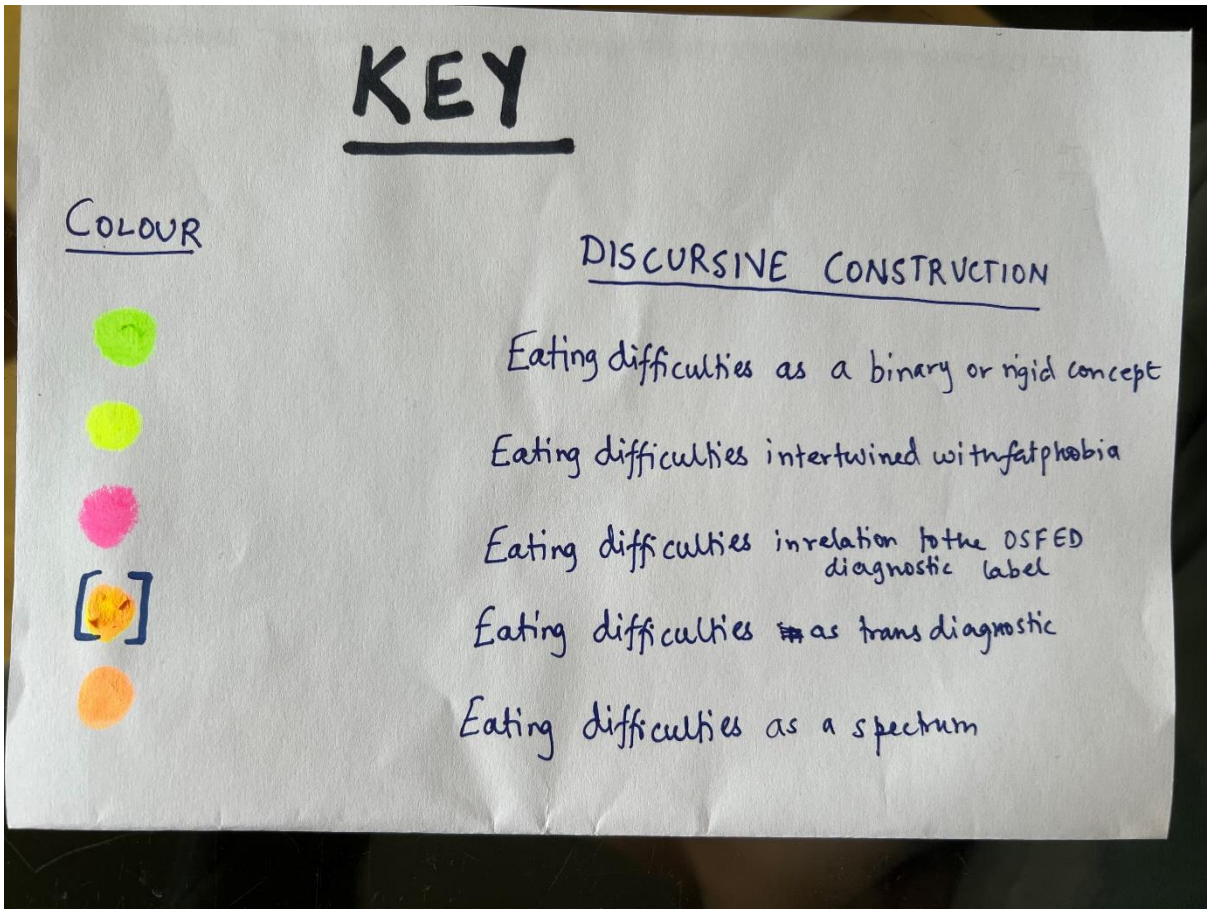
   How do you feel towards it?

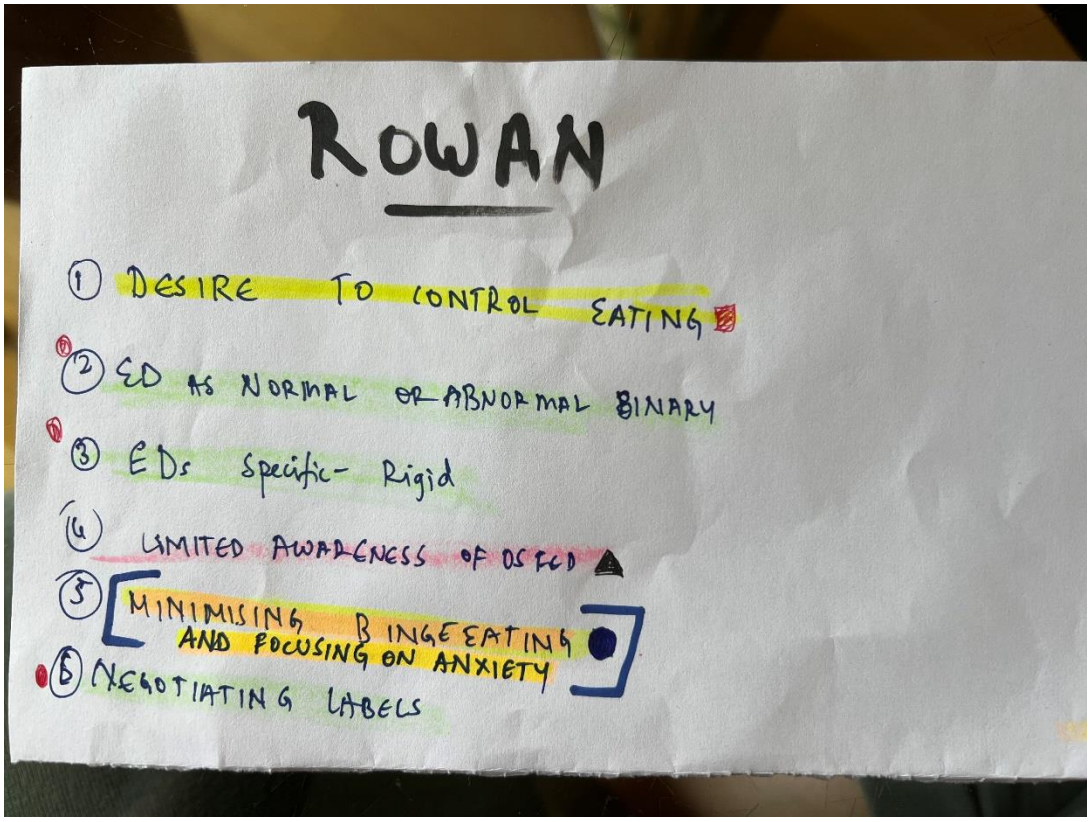
2. Could you describe your eating difficulties? *(Were you ever formally diagnosed? how did you come about identifying this?)*
3. How long have you struggled with your specified eating difficulty?
4. What does your specified eating difficulty mean to you? (*What impact has it had?)*
5. When you think about your experience with the specified eating difficulty, is there a word you would use for it? Or define it?
6. Are you aware of this other way of defining it called Other or Unspecified Feeding and Eating Disorder (OSFED/UFED)? (If no, Provide the participant with a description of OSFED/UFED).
7. What comes to your mind when we talk about OSFED/UFED? (*Any thoughts or its relation to your eating difficulty?).*
8. Does OSFED/UFED impact how you make sense of your eating difficulty?

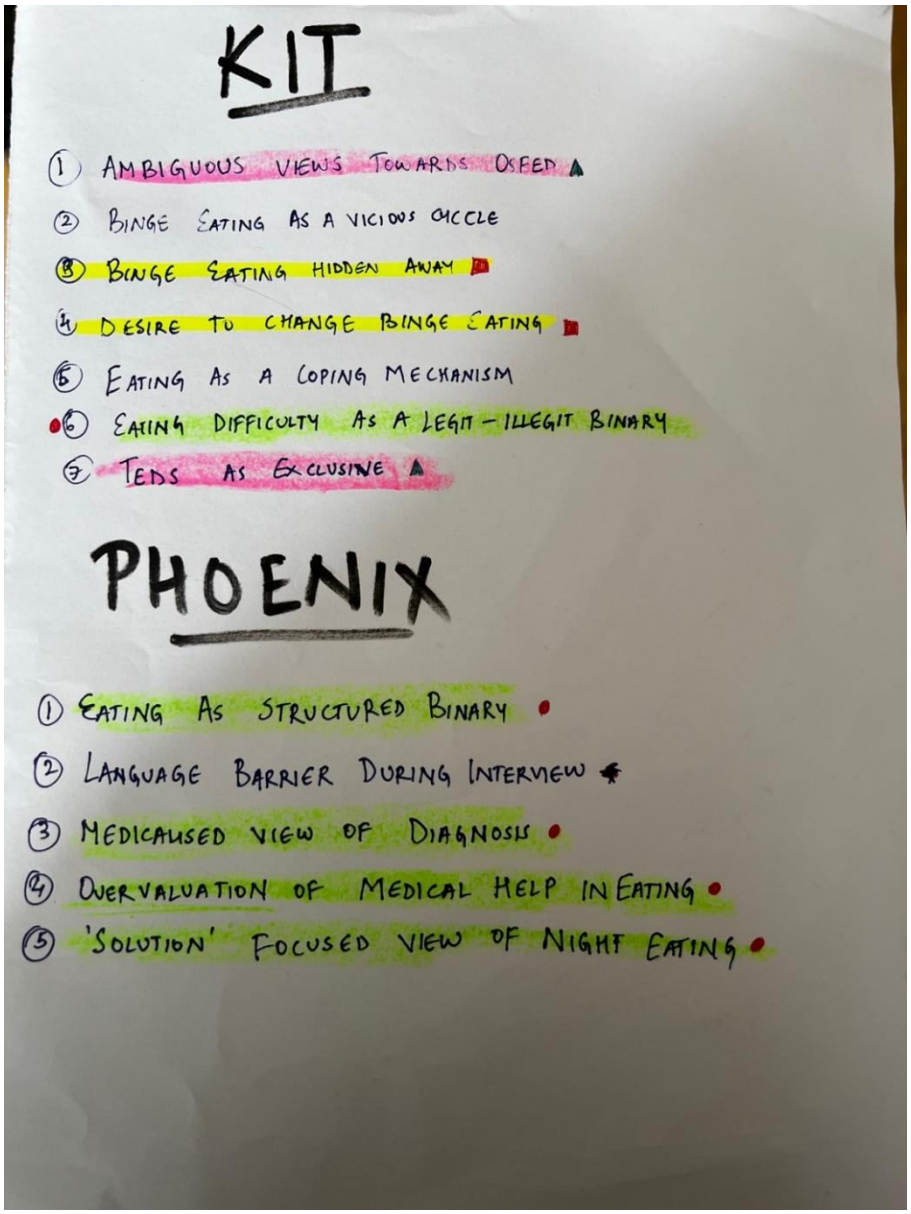
   (If so, could you elaborate and provide examples?)

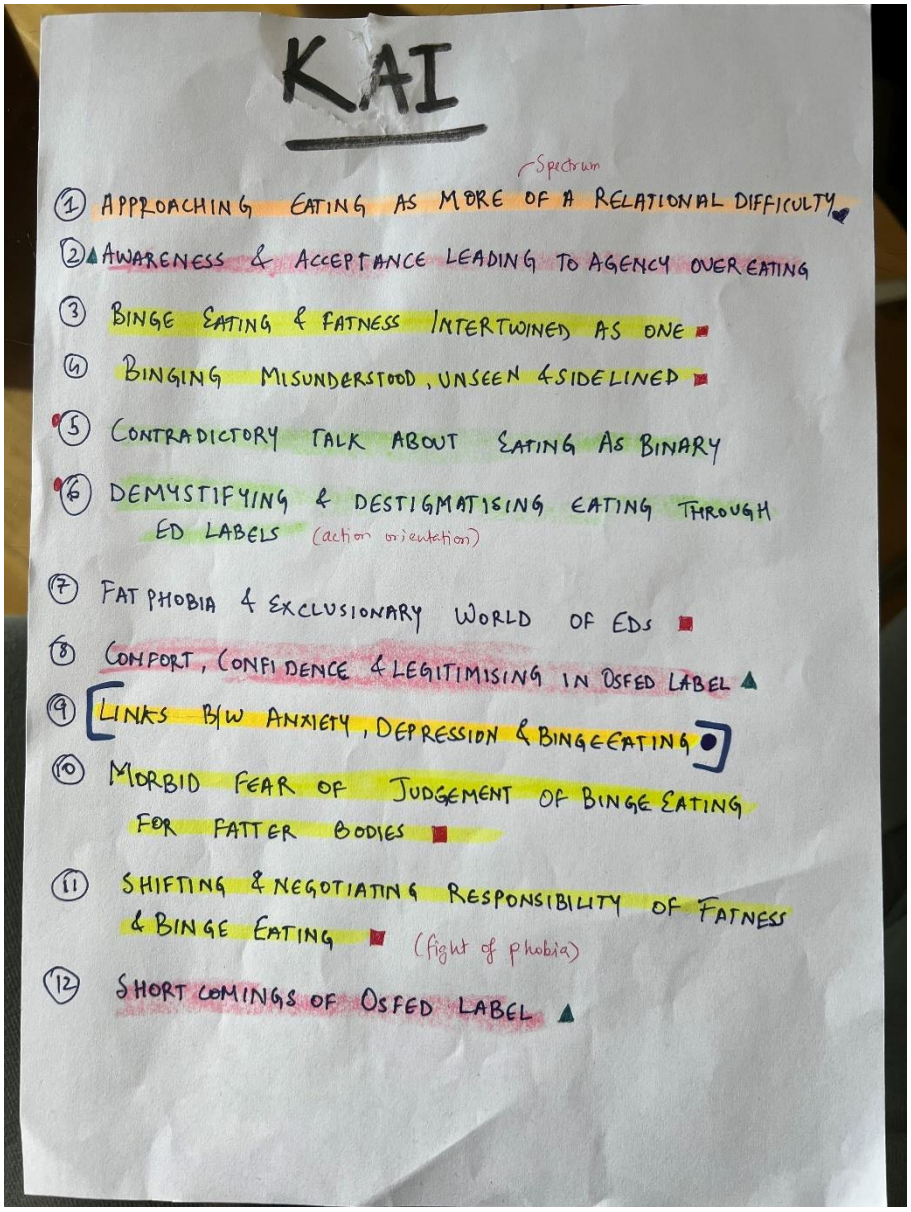
9. Have you tried accessing help for your eating difficulties? If so, could you tell me more about it?
10. How would you want your eating difficulties to be understood by HCPs? *(Is this different from the OSFED/UFED diagnostic label? Why do you think that is?)*
11. Is there anything else you would like to add?

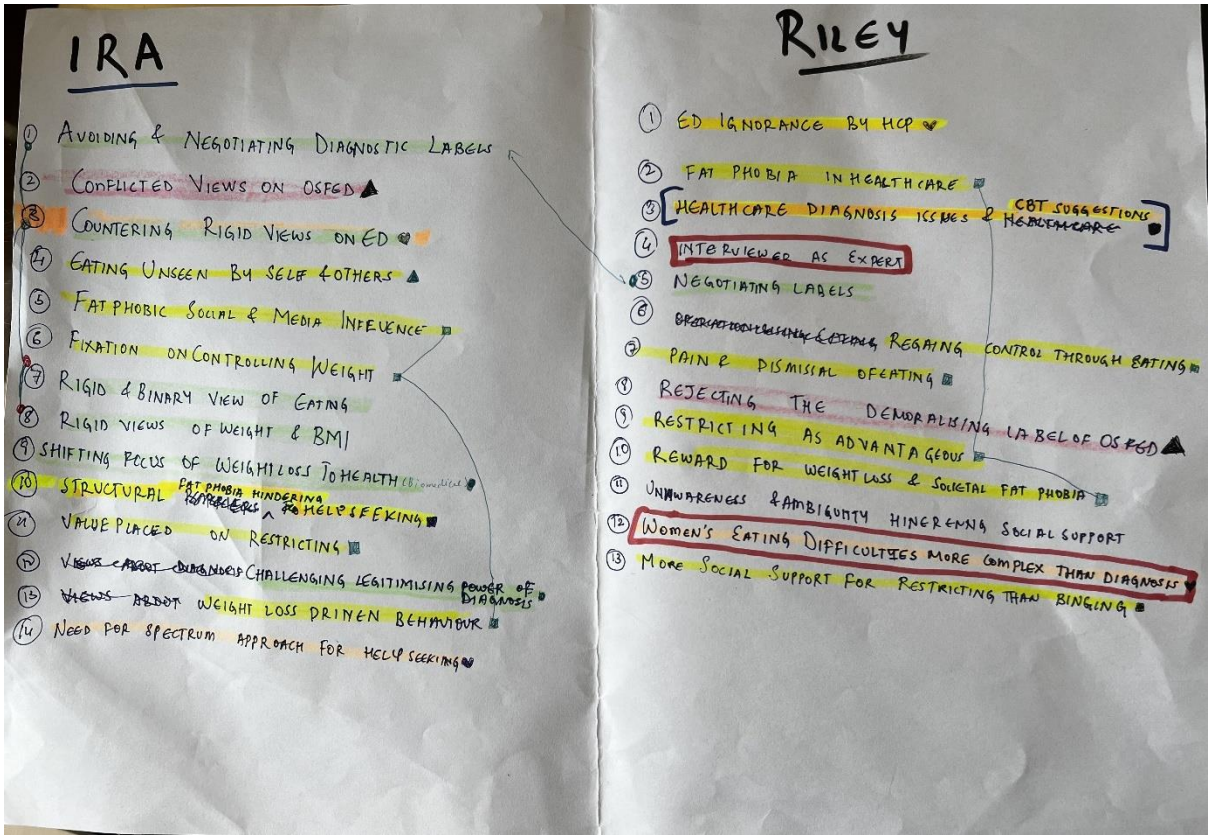
APPENDIX H: Sample of initial discursive constructions (paper)



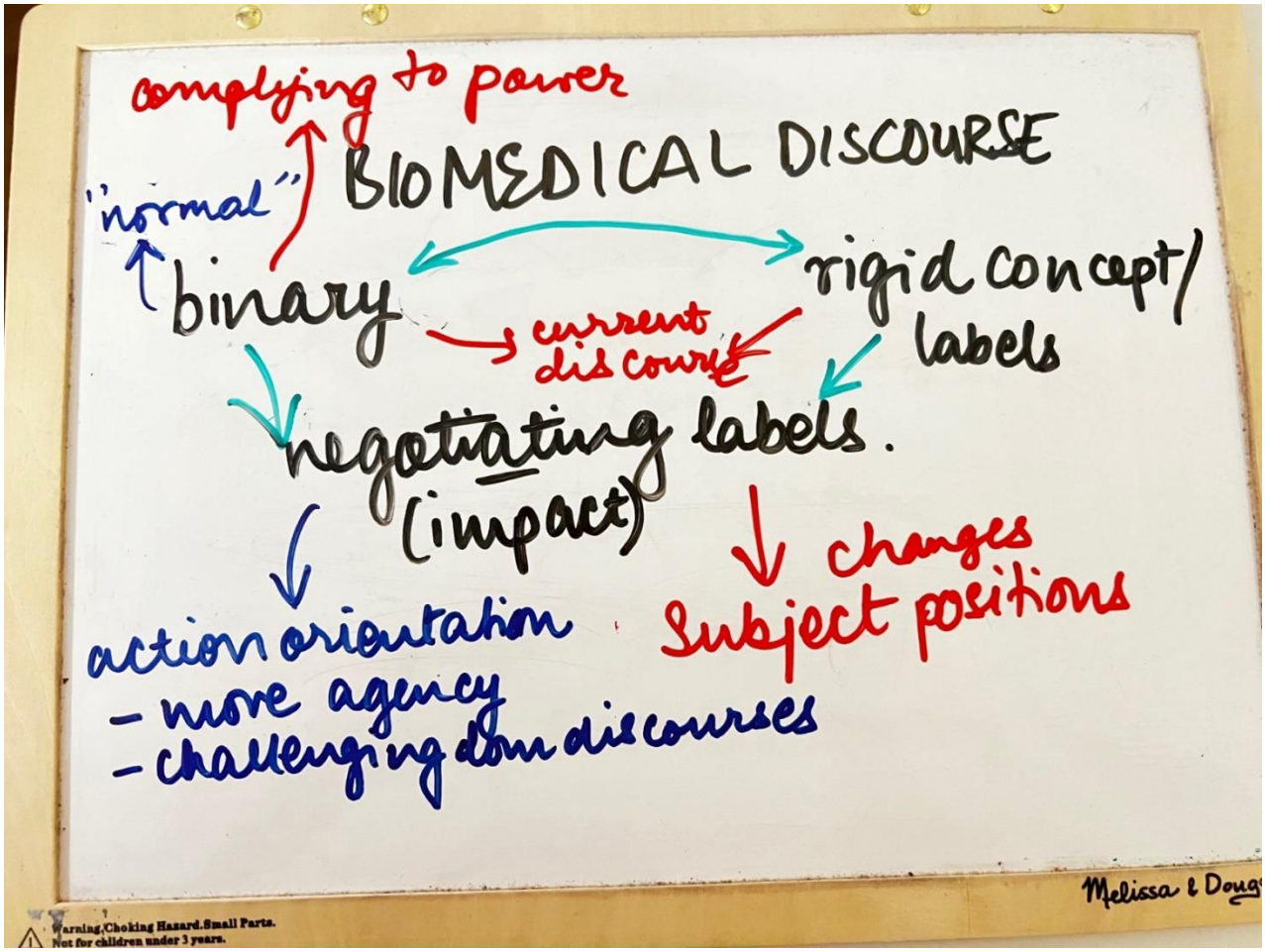



KIT
1 AMBIGUOUS VIEWS TOWARDS OSFED
2 BINGE EATING AS A VICIOUS CYCLE
3 BINGE EATING HIDDEN AWAY
4 DESIRE TO CHANGE BINGE EATING
5 EATING AS A COPING MECHANISM
6 EATING DIFFICULTY AS A LEGIT - ILLEGIT BINARY
7 TEDS AS EXCLUSIVE
PHOENIX
1 EATING AS STRUCTURED BINARY
2 LANGUAGE BARRIER DURING INTERVIEW
3 MEDICALISED VIEW OF DIAGNOSIS
4 OVERVALUATION OF MEDICAL HELP IN EATING
5 'SOLUTION' FOCUSED VIEW OF NIGHT EATING


KAI
Spectrum
1 APPROACHING EATING AS MORE OF A RELATIONAL DIFFICULTY
2 AWARENESS & ACCEPTANCE LEADING TO AGENCY OVER EATING
3 BINGE EATING & FATNESS INTERTWINED AS ONE
4 BINGING MISUNDERSTOOD, UNSEEN & SIDELINED
5 CONTRADICTORY TALK ABOUT EATING AS BINARY
6 DEMYSTIFYING & DESTIGMATISING EATING THROUGH ED LABELS (action orientation)
7 FAT PHOBIA & EXCLUSIONARY WORLD OF EDs
8 COMFORT, CONFIDENCE & LEGITIMISING IN OSFED LABEL
9 LINKS B/W ANXIETY, DEPRESSION & BINGEEATING
10 MORBID FEAR OF JUDGEMENT OF BINGE EATING FOR FATTER BODIES
11 SHIFTING & NEGOTIATING RESPONSIBILITY OF FATNESS & BINGE EATING (fight of phobia)
12 SHORT COMINGS OF OSFED LABEL


IRA
1 AVOIDING & NEGOTIATING DIAGNOSTIC LABELS
2 CONFLICTED VIEWS ON OSFED
3 COUNTERING RIGID VIEWS ON ED
4 EATING UNSEEN BY SELF & OTHERS
5 FAT PHOBIC SOCIAL & MEDIA INFLUENCE
6 FIXATION ON CONTROLLING WEIGHT
7 RIGID & BINARY VIEW OF EATING
8 RIGID VIEWS OF WEIGHT & BMI
9 SHIFTING FOCUS OF WEIGHT LOSS TO HEALTH
10 STRUCTURAL FAT PHOBIA HINDERING HELP SEEKING
11 VALUE PLACED ON RESTRICTING
12 CHALLENGING LEGITIMISING POWER OF DIAGNOSIS
13 WEIGHT LOSS DRIVEN BEHAVIOUR
14 NEED FOR SPECTRUM APPROACH FOR HELP SEEKING
RILEY
1 ED IGNORANCE BY HCP
2 FAT PHOBIA IN HEALTHCARE
3 HEALTHCARE DIAGNOSIS ISSUES & HEALTHCARE
CBT SUGGESTIONS
4 INTERVIEWER AS EXPERT
5 NEGOTIATING LABELS
7 REGAINING CONTROL THROUGH EATING
PAIN & DISMISSAL OF EATING
9 REJECTING THE DEMORALISING LABEL OF OSFED
10 RESTRICTING AS ADVANTAGEOUS
REWARD FOR WEIGHT LOSS & SOCIETAL FAT PHOBIA
11 UNAWARENESS & AMBIGUITY HINDERING SOCIAL SUPPORT
12 WOMEN'S EATING DIFFICULTIES MORE COMPLEX THAN DIAGNOSIS
13 MORE SOCIAL SUPPORT FOR RESTRICTING THAN BINGING

APPENDIX I: Discursive Constructions and Analysis Process I



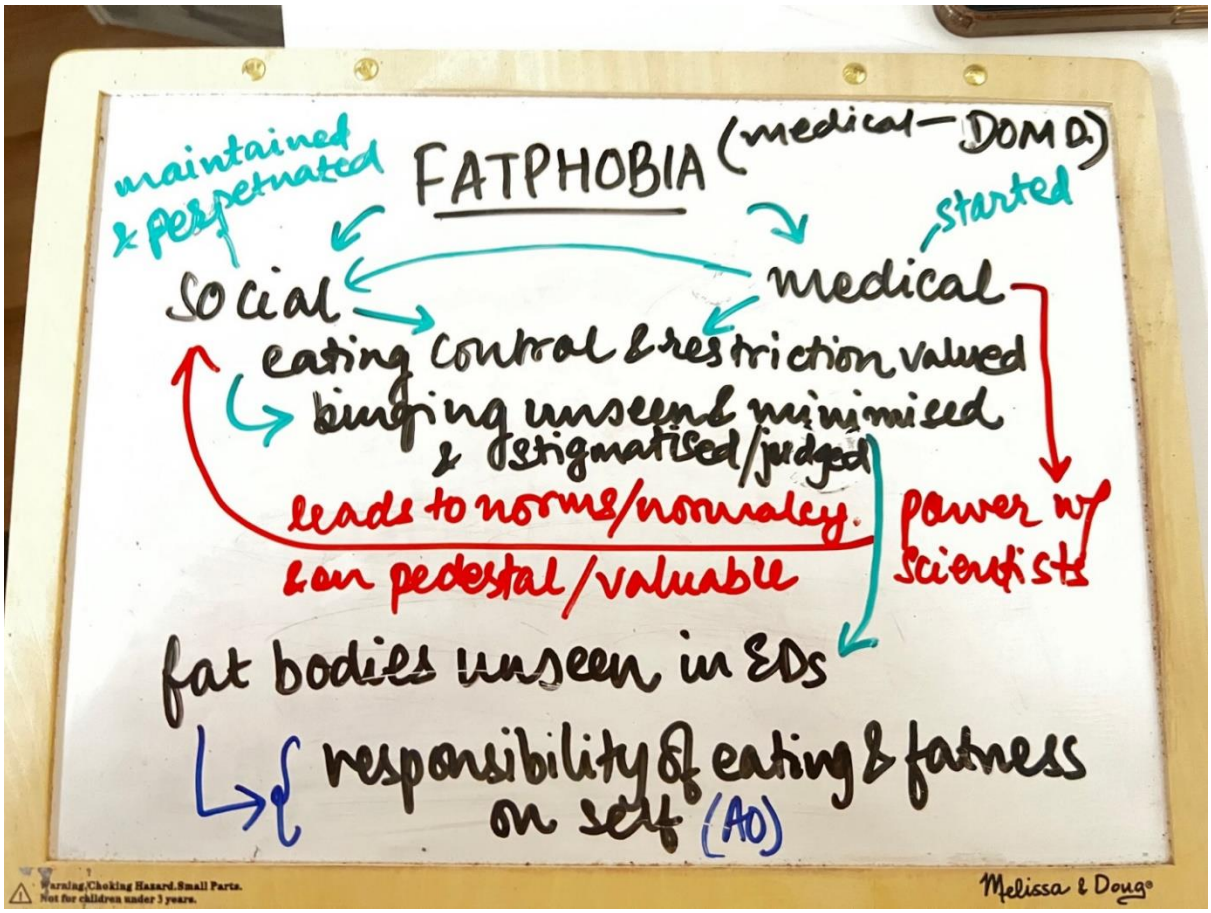
Discursive Construction: Eating as a rigid and binary concept leading to negotiating labels (impact of the current discursive construction)

Discourse: Biomedical Discourse

Action Orientation: Sense of agency fluctuates based on the construction, challenging dominant discourse

Subject positions: Complying to power when talking about eating in a binary. The subject position changes when they challenge the dominant discourse by negotiating labels which gives them more agency.

APPENDIX J: Discursive Constructions and Analysis Process II



Discursive Construction: Fatphobia

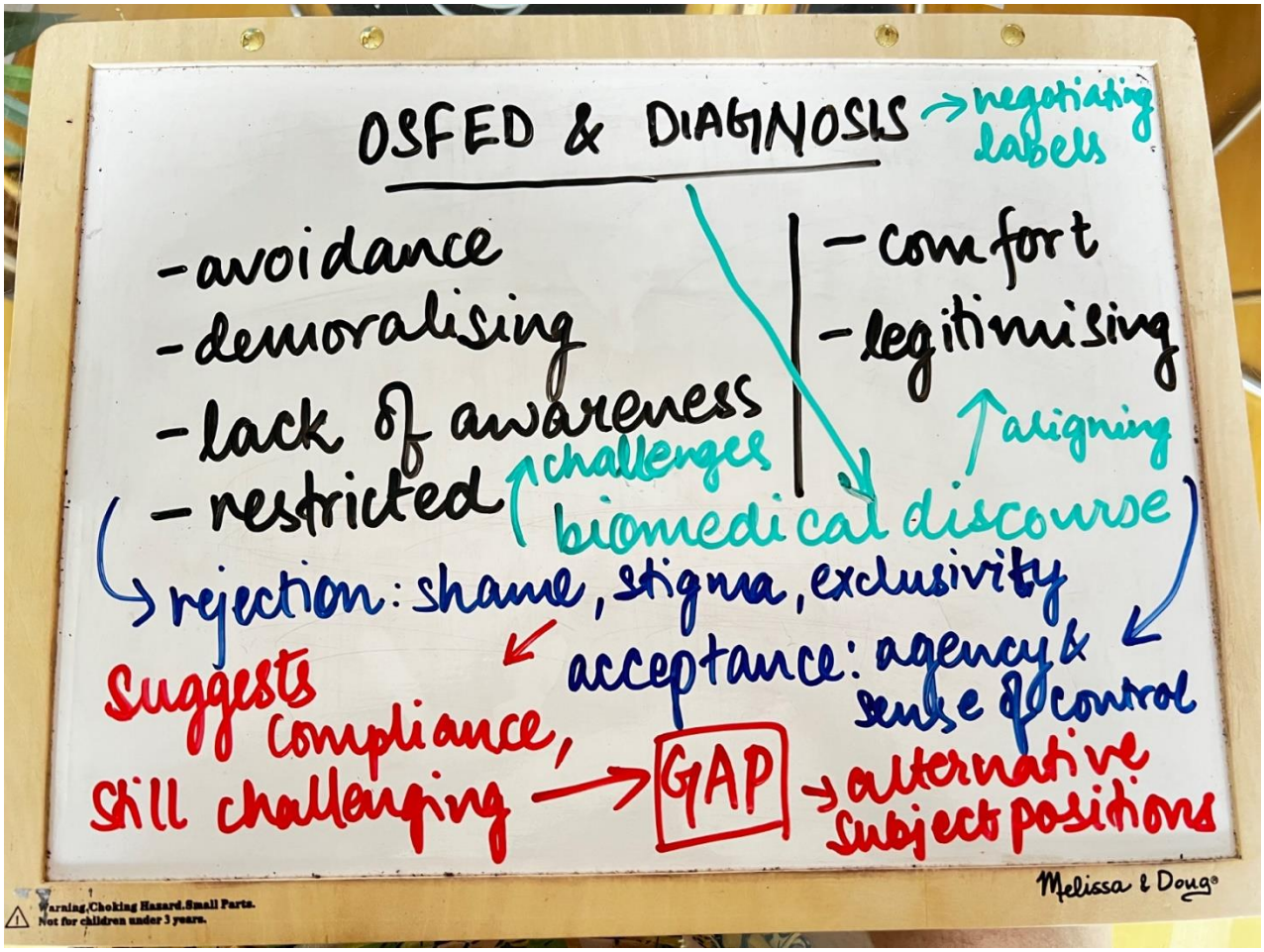
- Control on eating and restriction valued and seen as virtuous
- As a result, binging and fatter bodies go unseen, neglected, minimised, judged, and stigmatised.
- issues with HCP and help-seeking- BMI ignorance, structural issues

Discourse: Biomedical Discourse– the medical discourse has constructed fatphobia in the context of eating but is also maintained and perpetuated by social discourse around slimness, body ideals etc.

Action Orientation: Responsibility of eating and fatness on self

Subject positions: Fat bodies unseen in Eds (binging intertwined with fatness and seen as one, binging not seen as a 'serious' enough thing or a 'disorder' worth giving attention to.

APPENDIX K: Discursive Constructions and Analysis Process III



Discursive Construction: OSFED label and eating difficulties– influenced by negotiating labels

For: Comfort, legitimising (aligning with the biomedical discourse)

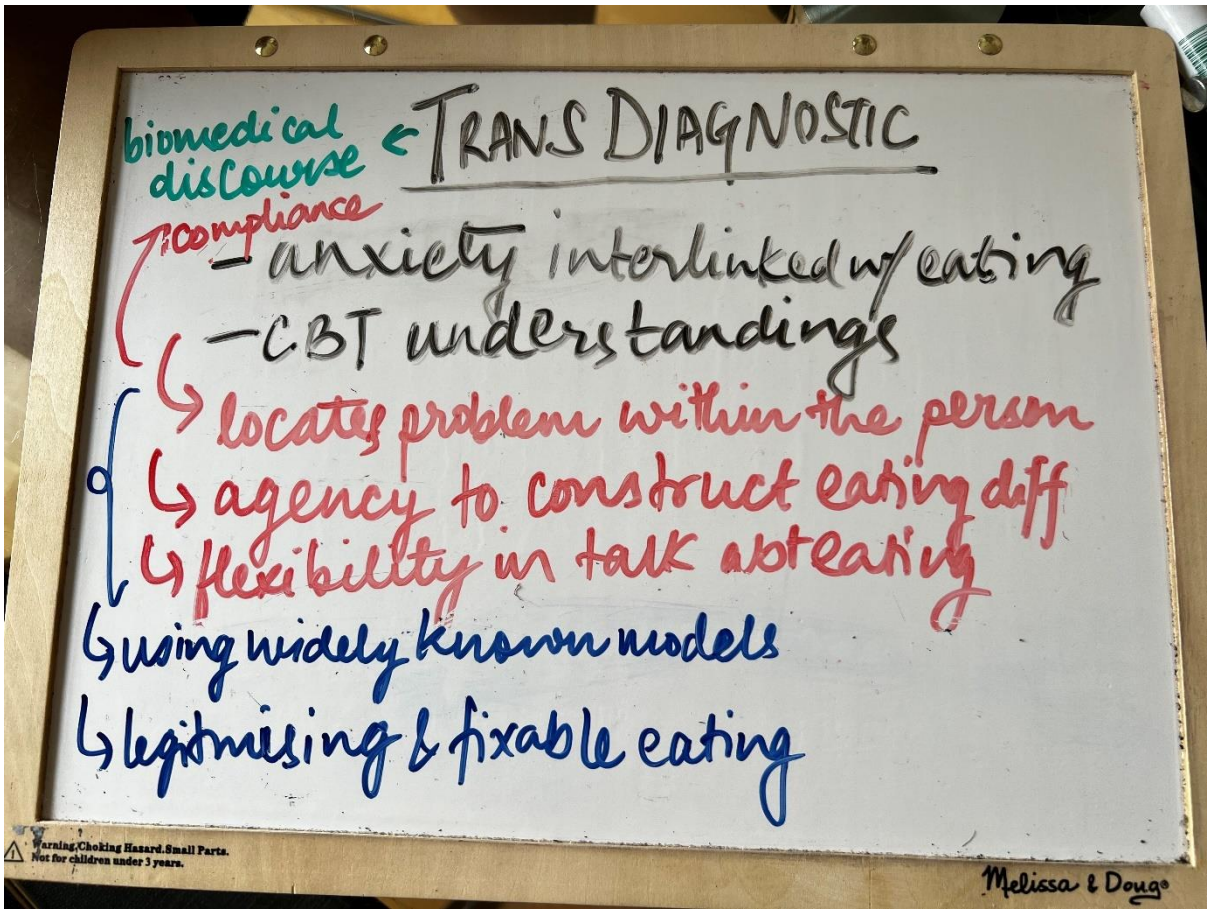
Counter: Avoidance, demoralising, lack of awareness, restricted (challenges biomedical discourse)

Discourse: Biomedical Discourse

Action Orientation: Acceptance leads to agency and a sense of control. Rejection because it leads to shame, stigma, and exclusivity.

Subject positions: Both suggest compliance, even the rejecting ones because they are still functioning on the model of OSFED classifications and diagnosis. Even though they are still challenging the biomedical discourse, this suggests a gap and need for a counter-discourse to make available alternative subject positions.

APPENDIX L: Discursive Constructions and Analysis Process IV



Discursive Construction: Transdiagnostic

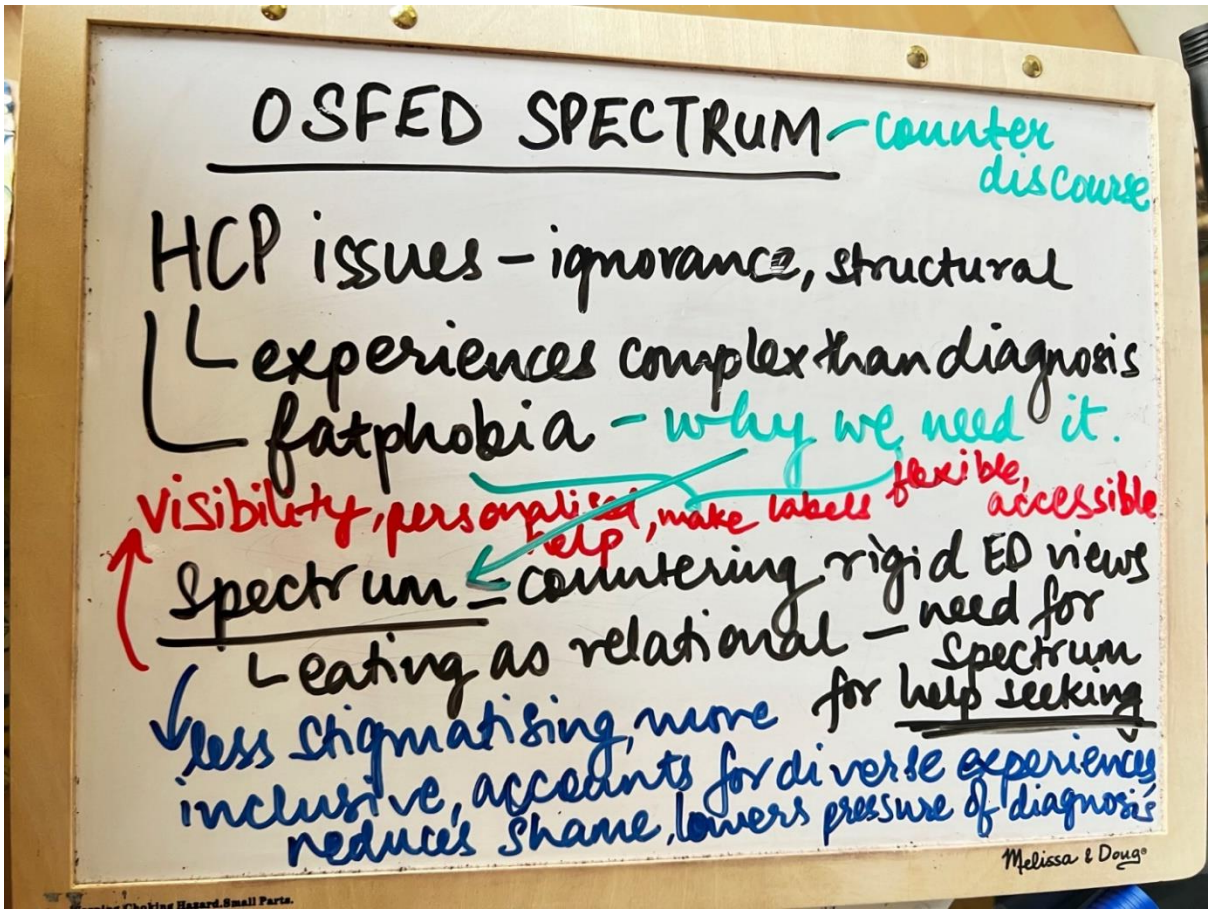
- CBT framework
- Interlinked or comorbidity with anxiety
-

Discourse: Biomedical Discourse– roots in positivism and centered around diagnosis.

Action Orientation: Transdiagnostic models are widely known, CBT popular apparoach. 'Fixable' and legitimising eating difficulty.

Subject positions: Some agency to construct eating, flexibility, problem lies with the person.

APPENDIX M: Discursive Constructions and Analysis Process V



Discursive Construction: Spectrum Approach

- Experiences more complex than diagnosis
- Fatphobia

Spectrum view: countering rigid ED views

Counter Discourse: Spectrum approach to ED

Action Orientation: less stigmatising, more inclusive, accounts for diverse experiences, reduces shame, lowers pressure of diagnosis

Subject positions: Visibility, personalised help, makes labels flexible and accessible.