

The experience of feeling fat for women with an anorexia nervosa diagnosis: An interpretative phenomenological analysis

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1. ABSTRACT

Aim: The experience of feeling fat has been implicated as a maintenance factor in Anorexia Nervosa (AN); however, little research has been conducted into the experience. The present study aimed to explore the experience of feeling fat for women with an AN diagnosis. It was hoped that this would provide an insight into the experience of feeling fat and the ways it could be addressed within therapeutic interventions for AN.

Methodology: Semi-structured interviews were conducted with seven women with an AN diagnosis. All participants were receiving therapy at the time of their interview. The verbatim transcripts from these interviews were analysed using Interpretative Phenomenological Analysis (IPA) in order to explore the lived experience of feeling fat for women with an AN diagnosis.

Results: Four superordinate themes emerged from the analysis, these were: negative sense of self; feeling out of control; coping with feeling fat and the complex notion of feeling fat. These superordinate themes and corresponding subordinate themes are discussed.

Implications: Feeling fat was found to be a significant experience for the adult women who participated within this study. This research highlights the importance of addressing the experience of feeling fat within therapeutic interventions for adult women with an AN diagnosis. The clinical relevance of these findings are explored.

2. INTRODUCTION

2.1. Overview

This introduction focuses upon the experience of feeling fat and its relationship with behaviours and experiences associated with eating disorders. The experience of feeling fat has not been widely researched and therefore all studies relating to feeling fat for people who are average weight or underweight have been discussed, regardless of their publication date and nature of their sample (e.g. studies with both non-clinical and clinical populations are discussed) (see appendix 1 for literature search strategy). I conclude with the rationale, clinical relevance and aims of the present study.

2.2. Anorexia nervosa

2.2.1. Current clinical definitions of anorexia nervosa

Anorexia Nervosa (AN) is currently categorised by the American Psychiatric Association (APA, 2013) as a 'Feeding and Eating Disorder', which has three diagnostic criteria (see Table 1). Regardless of this dominant model of classification, it has been proposed that the Diagnostic Statistical Manual's (DSM) method of classifying eating disorders poorly reflect clinical reality. This is because up to sixty percent of eating disorder referrals are labelled as Eating Disorder Not Otherwise Specified (Fairburn & Cooper, 2011). Consequently, Fairburn and Cooper (2011) propose that a comprehensive transdiagnostic approach needs to be considered for the DSM-VI. Nevertheless, for the purpose of this research the dominant model of classifying AN was used to provide an homogenous sample (see section 4.6.2 for further information).

Table 1: DSM-5 Diagnostic criteria for AN

Criterion	Description
A	“Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal, or, for children and adolescents, less than minimally expected
B	Intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain, even though at a significantly low weight
C	Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight” (APA, 2013, p. 338).

2.2.2. Incidence and prevalence

The annual incidence of diagnosed eating disorders for individuals aged between 10-49-years-old increased from 32.3 to 37.2 per 100,000 between 2000-2009 (Price Waterhouse Coopers (PWC); 2015). However, the incidence of AN and Bulimia Nervosa diagnoses has remained stable and therefore this increase appears to be due to a rise in the diagnosis of unspecified eating disorders (PWC, 2015). The female adolescent population (15- to 19-years-old) has the highest incidence rate for eating disorders (2 per 1000), making it the second most common mental health disorder in this cohort (Micali et al., 2013). The prevalence of eating disorders in the UK is estimated to be between 600-724,850, with AN being the least prevalent diagnosis at 6,819 (PWC, 2015).

2.2.3. Current treatment recommendations

According to NICE guidelines, people with a diagnosis of AN “should be managed on an outpatient basis with psychological treatment” (NICE, 2004). When individuals require inpatient care they should be admitted to settings that can provide careful physical monitoring during re-feeding in conjunction with psychological interventions (NICE, 2004). Interventions should aim to “reduce risk, to encourage weight gain and healthy eating, to reduce other symptoms related to an eating disorder, and to

facilitate psychological and physical recovery” (NICE, 2004). The psychological interventions recommended by NICE include:

- Cognitive analytic therapy (CAT);
- Cognitive behaviour therapy (CBT);
- Interpersonal psychotherapy (IPT);
- Focal psychodynamic therapy;
- Family interventions focused upon eating disorders.

See Section 2.7 for further exploration about the treatment of feeling fat in AN.

2.3. Feeling fat

2.3.1. Definition

Very few studies that investigate feeling fat define this experience; however, it has been suggested feeling fat is related to body image perception (Giordano, 2012). Touyz et al. (1995) suggest that feeling relates to ‘affective body image’¹, which refers to the feelings that an individual holds towards their own body (Touyz et al., 1995). Moreover, Bowden (2012) proposes that feeling fat is the result of a “pathological experience of objectification of the body” (p. 228). Consequently, it seems that feeling fat is a distinct component of body image, but more specifically a distinct component of body image dissatisfaction (Simlett, 2004).

2.3.2. Measures of feeling fat

There are very few measures that directly investigate the affective body experience in the form of feeling fat (Roth & Armstrong, 1993). Instead, feeling fat has typically been measured using an informal feeling fat question to which respondents answer on a Likert scale² (e.g. Striegel-Moore et al., 1986; Roth & Armstrong, 1993; Simlett, 2004). However, it is not possible to measure an internal consistency of these single item measures and therefore it is difficult to assess the reliability and validity of these measures.

¹ Touyz et al. (1995) suggest that ‘affective body image’ differs to ‘cognitive body image’, which refers to the thoughts that an individual has regarding their body.

² e.g. “how frequently do you experience feeling fat in an average day/week? ... on average, how intensely do you feel fat” (Simlett, 2004, p. 55).

One formal measure that specifically investigates feeling fat is the Body Shape Questionnaire (BSQ; Cooper et al., 1987). The BSQ uses 34-items to examine body shape concerns and their role within the development, maintenance and treatment of AN. Throughout this questionnaire participants rate their feelings on a 6-point Likert scale when 1=never and 6=always, thus higher scores indicate greater feelings of fatness (Cooper et al., 1987).

Roth and Armstrong (1993) developed the Feeling of Fatness Questionnaire (FOFQ) to assess “the cross-situational variability of...affective body image” (i.e. the subjective experience of fatness) (p. 350). Although their study appears to have demonstrated that the FOFQ has construct validity, this appears to have been the only time that this questionnaire has been used in research.

2.3.3. Cultural and feminist ideas and feeling fat

Within Western societies, fatness is often viewed as ugly, abhorrent and despised, whereas thinness is viewed as beautiful (Malson & Ussher, 1995). These dominant societal discourses have led to thinness being equated with ‘health’ and fatness with ‘disease’ and being morally bad (Tischner & Malson, 2011). These constructions dominate Western beliefs to such an extent that they are unquestioned (Malson, 2003). It has been proposed that these Western cultural beliefs are responsible for women using the term ‘fat’ to describe a variety of experiences (Simlett, 2004; Bowden, 2012b). Indeed, the socially constructed ideal for female attractiveness in Western culture is thinness, which consequently results in women feeling unhappy with their bodies if they perceive themselves as not conforming to this ideal (Thompson et al., 1999). Thus whenever a woman states “I feel fat” she is saying that there is something wrong with her or her feelings (Hirschmann & Munter, 1995). Evidence for the role of sociocultural influence on feelings of fatness is evident through the finding that eating disorders are rare in those cultures where thinness is not valued (Thompson et al., 1999).

It has also been proposed that eating disorders, and feelings of fatness, should be understood within the context of the gender inequalities within western/ised patriarchal cultures (Malson & Burns, 2009). Indeed, it has been argued that the gendered identity and female thin ideal that is promoted within patriarchal cultures

acts as a form of female oppression (Tischner, 2013). Indeed, Thompson et al. (1999) argue that the thin ideal leads women to become preoccupied with their body rather than within other arenas used to gain status and power within society.

Another hypothesis proposed by Friedman (1993) is that women use a “language of fat” and experience feeling fat in order to fit into the male dominant society. According to this model, women hold a ‘self in relation’ position in which their identities are formed within the context of relationships (Friedman, 1993). In line with this, Friedman (1993) states that women use language to make connections with others thus making women inter-dependant. Friedman (1993) argues that this way of interacting is less valued and respected than the independent approach associated with men. Consequently, women sacrifice their way of interacting to fit in with “Adam’s world” and thus silence themselves in relationships (Friedman, 1993, p. 26). Friedman proposed two hypotheses for why this silencing of the self leads to feelings of fatness: (1) women lose their sense of self and they consequently become vulnerable to the thin ideal and less able to distinguish between emotions. Thus increasing the likelihood of displacing their emotions onto their body; (2) a process of “systematic devaluation” (p. 291) reinforces women’s sense of powerlessness and as a result they criticize themselves because they are unable to criticize the society that oppresses them. Friedman (1993) proposes that it is a combination of this self-directed anger and loss of self that reinforces body dissatisfaction and feelings of fatness.

2.4. Body image and body image dissatisfaction

The definition of ‘body image’ has developed from a static mental image of our body (Schilder, 1938) to a “multifaceted psychological experience...[that] encompasses one’s body-related self-perceptions and self-attitudes, including thoughts, beliefs, feelings, and behaviors” (Cash, 2004, p. 1). Moreover, Cash and Puzinsky (1990) also define body image as the way individuals perceive themselves as well as the way they think other people see them. This multifaceted and interlinked attitude develops and changes throughout the lifespan and can be influenced by a variety of factors including trauma, biological growth, other people and affect (Benninghoven et al., 2006).

Consequently, body image dissatisfaction is the negative subjective appraisal of one's body (Stice & Shaw, 2002). According to Mountford (2010), there are three types of body dissatisfaction: (1) a disturbance of body percept where people see a distorted view of their body; (2) a disturbance of body concept, where people are dissatisfied with what they see, whether this is a distorted view or not; (3) a fear of fatness where the person fears becoming overweight and views the body as being out of control.

2.4.1. Body image dissatisfaction, feeling fat and eating disorders

It has frequently been proposed that body image dissatisfaction can manifest as the experience of feeling fat (Simlett, 2004), which is expressed through 'fat talk' such as 'I feel fat' (Nichter & Nichter, 2009). Body image has become a significant aspect on which many women evaluate their self-worth (Eldredge et al., 1990; Benninghoven et al., 2006). Indeed, adolescent women with low self-confidence often attribute any perceived failures to their looks (Benninghoven et al., 2006).

Using a quantitative design, Lam and colleagues (2002) investigated the sex differences in body satisfaction, feeling fat, and pressure to diet among Chinese adolescents (12 to 18 years) in Hong Kong (N= 356). Participants were asked to complete an adapted and translated version of the Body Attitudes Questionnaire (BAQ; Ben-Tovim & Walker, 1991). Feelings of fatness were assessed through the BAQ's 'Feeling Fat' and 'Lower Body Fatness' scales. Local data was used to define participants weight status as underweight, normal and overweight³. Lam et al. (2002) found that female participants were more likely to be unsatisfied with their bodies, to feel fat and to experience the pressure to diet than male participants. Moreover, BMI and body satisfaction were found to be associated with feeling fat and this in turn was associated with pressure to diet, especially in female participants. Lam et al. (2002) consequently proposed that feeling fat is a mediator in the relationship between BMI/body satisfaction and the pressure to diet. They concluded that body size and

³ Caucasian guidelines for BMI were not used to assess weight status within this study because the smaller size of the Chinese frame makes it an inappropriate tool for the Asia Pacific population (Lam et al., 2002). However, this classification was still referred to as BMI throughout Lam et al.'s study.

dissatisfaction contributes to feeling fat and feeling fat produces the pressure to lose weight. Indeed, actual size only had an indirect effect on pressure to diet in female participants and this was mediated through feeling fat. Although this study provides a good insight into the impact of and sex differences regarding feeling fat, the findings need to be interpreted within the context of the study's limitations. More specifically, the BAQ was developed in English and there was no evidence presented that its psychometric properties remained when translated into Chinese. Furthermore, the western method of assessing BMI was not used in this study, thus reducing the external validity and generalizability of the findings to a UK population.

Although the experience of feeling fat is common amongst both genders regardless of weight and/or shape (Lam et al., 2002), its intensity and frequency appear to be exacerbated for people with an eating disorder diagnosis (Wardle & Foley, 1989; Fairburn, 2008). Indeed, Andersen (2000) states that "virtually every eating disorder patient has voiced the repeated persistent complaint 'I feel fat'" (p. 167). In line with this, body dissatisfaction has been identified as a prominent risk, maintenance and relapse factor for eating disorders (Polivy & Herman, 2002; Stice & Shaw, 2002). This could be due to the fact that people diagnosed with eating disorders tend to equate feeling fat with being fat, regardless of their weight (Fairburn, 2008; Murphy et al., 2010); thus leading to extreme dieting, purging and excessive exercising (Roth & Armstrong, 1993). Body dissatisfaction in the form of feeling fat could influence each eating disorder diagnosis differently as levels of body dissatisfaction improved during treatment in patients with a bulimia nervosa diagnosis but it remained stable in participants with an AN diagnosis (Benninghoven et al., 2006).

2.5. Variables of feeling fat

Research has indicated that the experience of feeling fat varies across time and situations (Haimovitz, Lansky & O'Reilly, 1993; Wardle & Foley, 1989; Roth & Armstrong, 1993). For instance, individuals can feel fat for a matter of hours or even days yet not experience the feeling at other times (Simlett, 2004). It is unlikely that one's body shape or size could change in such short time periods, which therefore suggests that feeling fat is not only about one's body size, shape or levels of body satisfaction (Simlett, 2004). The following section will outline the available literature

regarding the variables potentially involved in feelings of fatness including cognitive, affective, behavioural and situational components.

2.5.1. Cognitive components of feeling fat

In accordance with the Schema Theory (Markus, 1977; Bem, 1981), Markus, Hamill and Sentis (1977) proposed that “women who feel fat hold a self-schema in which body weight is central” (as cited in Striegel-Moore et al., 1986, p. 936). These cognitive generalizations are hypothesised to influence an individual’s self-related information processing through biases such as selective attention, encoding and recall (Markus, 1977). Moreover, the level of influence of self-schemata upon an individual’s self-perception and behaviour is dependent upon the significance of that specific trait for the individual, the greater the significance the bigger its influence (Markus, 1977). As a result, Striegel-Moore et al. (1986) hypothesised that women who feel fat hold their weight in mind when processing self-relevant information. Consequently, any self-evaluation experience unrelated to their body will also cause them to evaluate their body and weight (Striegel-Moore et al., 1986). In order to test this hypothesis they asked 46 female undergraduate students to complete a questionnaire booklet comprised of rating scales measuring “Feeling Fat”, “Parental Aspirations”, “Weight-related Remarks”, “Pressure Toward Thinness”, “Perceived Lack of Control over Eating”, “Perfectionism”, “Positive Self Image”, “tendency to compare self to others” and “response to failure”. Participants were also asked about the frequency with which they dieted and binged. A multiple regression showed significant correlations between feeling fat and perfectionism, and feeling fat and perceived social pressure towards thinness. Feeling fat was also associated with participants’ tendency to compare their own bodyweight to others. Striegel-Moore et al. (1986) consequently hypothesised that those women who strive for perfection in many areas of their lives also strive to be thinner than other women. Striegel-Moore et al. (1986) also speculated that this perceived social pressure towards thinness is interpreted by individuals as evidence that the ideal level of thinness has not yet been achieved. Striegel-Moore et al. (1986) conclude that women, for whom perceived failure leads to feeling of fatness, hold strong weight relevant self-schemas that are activated by any self-evaluative experience. Moreover, they found that the relationship between feeling fat and psychological variables equalled and surpassed the relationship between feeling fat and objective body weight. This led them to

propose that both actual body weight and psychological variables need to be considered when trying to understand the experience of feeling fat. Whilst this study helped provide an insight into the correlates of feeling fat, participants were all recruited from a subclinical undergraduate female population and therefore this finding cannot be reliably generalized to an eating disorder population.

It is unclear whether the experience of failure caused participants within Striegel-Moore et al.'s (1986) study to feel worse about their bodies because only one self-report measure was used to assess the impact of failure on feelings of fatness (Eldredge et al., 1990). Indeed, Eldredge et al. (1990) suggest "an equally plausible hypothesis...that the experience of failure among such women does not intensify feelings about their bodies but causes them to focus and reflect upon their already negative self-perceptions of fatness (p. 39). Eldredge et al. (1990) subsequently investigated this hypothesis within a sample of female university students (N= 48) without an eating disorder diagnosis. Participants completed a number of questionnaires including: the Multiple Affect Adjective Checklist (MAACL; Zuckerman & Lubin, 1965) was used to assess participants' current affective state; depressive affect was further measured with the Beck Depression Inventory (BDI; Beck et al., 1961); participants attitudes towards self, body image and eating were assessed with the Eating Disorders Inventory (EDI; Garner, Olmsted, & Polivy, 1983); finally, a general personality inventory comprising the Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1979) and the Self-Consciousness Scale (SCS; Fenigstein, Scheier, & Buss, 1975) was conducted to monitor the study's face validity. Participants were then categorised as either holding weight self-schema due to being restrained eaters who reported a preoccupation with weight and diet or not holding a significant weight self-schema due to being an unrestrained eater. Subjects were randomly assigned to a success or failure condition and were required to complete a 'verbal intelligence test' and a 'social intelligence test' (Bordini et al., 1986). All participants were provided with false feedback designed to invoke feelings of success or failure after both tests. Finally, participants completed another battery of questionnaires that included: the MAACL; the Semantic Differential measure (SD; Leon, Eckert, Teed, & Buchwald, 1979); the Body Shape Questionnaire (BSQ; Cooper et al., 1987), and the Body Image Self-Evaluation (BISE; Eldredge et al., 1990). Data was analysed using ANOVAs and results showed that restrained dieters had significantly lower self-

esteem and were significantly more depressed than unrestrained participants. Contrary to their hypothesis Eldredge et al. (1990) found that failure did not lead to restrained eaters to feel more dissatisfied with their bodies than usual. Furthermore, restrained eaters who experienced success reported equivalent levels of body dissatisfaction to those restrained eaters who experienced failure. However, an individual scaling analysis on the SD Measure (Leon et al., 1979) showed that restrained women described their bodies in a more evaluative way after experiencing success or failure. Eldredge et al. (1990) attributed this finding to mood changes related to the experience of success or failure. Consequently, Eldredge et al. (1990) concluded that women with negative beliefs about their body do feel worse about their bodies during situations requiring self-focus and/or evaluation, which subsequently impacts upon their feelings of fatness.

2.5.1.1. *Thought-shape fusion*: Cognitive approaches posit that cognitive errors are a primary component in the development of difficulties such as AN (Burton, 2011). With frequent repetition these cognitive distortions develop into thinking errors that impact upon the person and how they experience situations and events (Burton, 2011). Furthermore, cognitive-behavioural models emphasise the importance of such cognitive distortions in the development and maintenance of eating disorders (Polivy & Herman, 2002; Fairburn, Cooper & Shafran, 2003). One specific cognitive distortion that has been linked to the pathology of eating disorders and to the experience of feeling fat is that of Thought-Shape Fusion (TSF; Shafran et al., 1999). TSF is comprised of three beliefs regarding the consequences of thinking about eating forbidden foods: (1) Likelihood TSF: thinking about a forbidden food increases the likelihood that the person has gained weight or changed shape; (2) Moral TSF: thinking about a forbidden food is equally as immoral as eating the food; and (3) Feeling TSF: having such thoughts makes the individual feel fat (Shafran et al., 1999). Research has demonstrated that TSF is a measurable construct, which has a strong association to eating disturbance for individuals with and without an eating disorder diagnosis (Shafran et al., 1999). Shafran et al.'s (1999) study with an undergraduate population (N= 119) found that all participants reported feeling fatter, perceived it likely that they had gained weight and had feelings of moral wrongdoings after thinking and writing a sentence about eating forbidden food. Participants' levels of anxiety and guilt also increased after this task (Shafran et al., 1999).

Radomsky et al. (2002) extended Shafran et al.'s (1999) study further by investigating TSF in a sample of 20 women being treated for AN on an inpatient ward. Using a similar methodology as Shafran and colleagues, participants completed a battery of questionnaires before being asked to vividly imagine food that they considered fattening and to write "I am eating ____". Participants were then asked to rate the intensity of their emotional state on a 0-100 scale. Participants were provided with the opportunity to neutralise their statement and then re-rate their feelings of anxiety, guilty and beliefs about their weight. Radomsky et al. (2002) found that TSF was evident within their clinical sample as after the experiment participants felt highly anxious and guilt and their "feeling[s] of becoming fatter" increased by up to a third (p. 1172). The mean estimate given for the probability of weight gain having occurred was 24% and participants experienced a "high sense of moral unacceptability" regarding this perceived weight gain (Radomsky et al., 2002, p. 1172). Neutralising the thought significantly reduced participants' levels of anxiety, guilt, the likelihood of gaining weight and feelings of fatness thus supporting TSF as a cognitive bias within this clinical population (Radomsky et al., 2002). Radomsky et al. (2002) proposed that their findings confirm the tendency of people with an AN diagnosis to fuse thoughts and perceived shape. They subsequently propose that this cognitive bias could be reduced through psycho-education and Cognitive Behavioural Therapy (Radomsky et al., 2002). Furthermore, they suggest that cognitive interventions to address beliefs about moral unacceptability and perceived control could also reduce individual's TSF and perhaps the guilt and anxiety regarding eating.

Although these aforementioned studies provide evidence for the role of cognitive distortions within the experience of feeling fat, they also indicate that emotions, situational and behavioural factors also influence this experience. Indeed, research has found a discrepancy between affective (feel) and cognitive (think) ratings of body image dissatisfaction (Altabe & Thompson, 1992). Moreover, it has been found that feeling fat is different to being overweight and to "perceiving oneself to be overweight" (Tiggemann, 1996, p. 24). Tiggemann (1996) assessed the construct validity of the cognitive and affective indices of body image dissatisfaction using the figure preference ratings developed by Stunkard, Sorenson and Schulsinger (1983).

178 female undergraduate students were asked to choose their ideal figure, the figure that most accurately represented how they think they looked, the figure that reflected how they feel most of the time and the figure they thought was preferred by men and women (Tiggemann, 1996). Participants were also asked to complete a variety of measures to assess their levels of body dissatisfaction, dieting, body consciousness and psychological wellbeing. Tiggemann's (1996) analysis found that the cognitive and affective aspects of feeling fat are separate constructs and therefore feeling fat is different to thinking fat or perceiving self as overweight. Moreover, they report that the feel-ideal discrepancy (i.e. feeling fat) was the best predictor of self-esteem, depressed affect and dietary restraint; furthermore, depressed affect was found to be the major predictor of feeling fat (Tiggemann, 1996). Tiggemann (1996) subsequently proposed that thinking oneself is fat leads to repeated dieting, and it is this unsuccessful dieting which causes people to feel fat ("maybe through depression"; p. 24). They conclude by stating that feeling fat is considerably more significant than just being overweight or thinking one is overweight. Unfortunately, the causality of this finding could not be established with the correlational design used by Tiggemann (1996), who suggests that a longitudinal study is needed to unravel the causal relationships involved within these findings.

2.5.2. Affective components of feeling fat

The research findings previously discussed suggest that affective state also plays a role within the experience of feeling fat. In line with this, it has been suggested that feeling fat has instead become a 'catch all' phrase to express the thoughts, needs and emotions that a person is unable to acknowledge or verbalise (Simlett, 2004). This is particularly plausible because individuals with an eating disorder diagnosis often find it difficult to identify and accurately label their affective experiences (Bydlowski et al., 2005). Consequently, it has been proposed that eating disorders function as a method of controlling emotions (Vitousek, Watson, & Wilson, 1998). The following section will outline the research that has examined this proposal before discussing the Body Displacement Hypothesis (Bruch, 1978), which provides a theoretical understanding of this phenomenon.

Simlett (2004) examined the relationship between inhibited emotional expression and the experience of feeling fat for Canadian women aged between 20-59 years (N=

143). Inhibited emotional expression was measured using the Silencing the Self Scale (STSS; Jack & Dill, 1992), the State-Trait Anger Expression Inventory-2 (STAXI-2; Spielberger, Reheiser & Sydeman, 1995) and the Trait Meta Mood Scale (TMMS; Salovey et al., 1995). Feeling fat was measured using the Body Shape Questionnaire (BSQ; Cooper et al., 1987) and three single-item measures: the frequency of the experience per day and week and its intensity. A significant bivariate relationship was found between inhibited emotional expression and feeling fat (Simlett, 2004). Women who experienced feeling fat with greater intensity, frequency and degree were more likely to inhibit their emotional expression, especially in terms of their 'Externalized Self Perception' and 'Divided Self' variables. They proposed that this suggests that women who feel fat intensely tend to judge themselves by external standards and subsequently present a compliant self. Simlett's (2004) 'Silencing the Self' results demonstrated that women were likely to:

“present a compliant self while inwardly they felt angry. Relationships were also found between both the frequency of feeling fat per day and degree of feeling fat and the tendency to silence one's self expression in order to avoid conflict” (Simlett, 2004, p. 79).

Inwardly expressed anger positively correlated with the frequency and degree of fatness; moreover, women who reported an increased frequency and degree of feelings of fatness were less able to identify and distinguish between their emotions. These findings are in line with Friedman's (1993, 1997) hypothesis that women silence themselves as a result of society's socially constructed norms of female behaviour. Although this study cannot imply causality, Simlett (2004) suggested that feeling fat is the result of the following thought process: “I don't know what I am feeling, but it doesn't feel good. I know that fat is not good, and that my body is not good enough the way it is, so I must feel fat” (p. 87). Simlett (2004) concluded that therapy to reduce feelings of fatness should focus upon increasing a woman's ability to express her feelings as well as improving her sense of self. Unfortunately however, all correlations were below 0.75, which suggests that each of the inhibited emotional expression measures showed considerable variation (Simlett, 2004). In other words, although the measures “appear to be measuring something in common, they also appear to be measuring something quite distinct from one another as well” (Simlett, 2004, p. 59), thus impairing the internal validity of the study.

In line with this, Forbush and Watson (2006) found that participants with an eating disorder diagnosis displayed higher levels of emotional inhibition than non-clinical controls. They subsequently argued that emotional inhibition results in distress being directed inwards causing women with eating disorders to “blend ‘real affect’ with ‘body affect’” (Forbush & Watson, 2006, p. 119).

Espeset et al. (2012) explored how individuals with an AN diagnosis managed their negative emotions and how they perceived the relationship between their emotions and eating disorder behaviours. They aimed to obtain an in-depth description of these experiences using principles from Grounded Theory (Corbin & Strauss, 2008). In order to increase the variation of participant experiences, Espeset et al. (2012) used a heterogeneous sample in terms of AN subtype, duration, treatment history, stage of recovery and participant age. Their sample was comprised of 14 women aged between 20-39 years all of whom had a diagnosis of AN. Espeset et al. (2010) found that women with an AN diagnosis avoided dealing with negative emotions (e.g. irritation, anger and sadness) by concentrating on food, their body and weight. Participants also described fear and anxiety as overwhelming and invading emotions, which they frequently linked to disgust, body dissatisfaction and feeling fat. Furthermore, “when participants felt disgust [e.g. after eating, being reminded of their own body experience by looking in a mirror or vulnerable to criticism from others], they also felt fat and big” (p. 457). Overall, the study found that participants used different strategies to cope with the different affective states. Participants reported using suppression to manage their fear; whereas, they avoided any disgust triggering situations and consequently avoided eating and situations requiring bodily awareness. Furthermore, participants tended to suppress feelings of sadness and anger when in social situations, yet they reported high levels of anger and disgust directed towards their own bodies. Finally, sadness and fear were connected to body dissatisfaction and body disgust, thus providing support for Fox and Power’s (2009) proposal that self-disgust could be a maintenance factor in eating disorders. Espeset et al. (2012) suggest that their findings demonstrate an association between body dissatisfaction and disgust for women with an AN diagnosis as a result of “complex phenomena”. They subsequently conclude that body-dissatisfaction “is too non-specific a concept to apply to the severity and complexity of AN patients’ emotions towards their body” (p. 459); however, they do not provide alternative explanations

for this term. As noted by Espeset et al. (2012), although this provides an insight into the experience of emotions for women with AN, the participants were all Norwegian and therefore this might limit the generalizability of findings.

2.5.2.1. Body displacement hypothesis: According to the Body Displacement Hypothesis (BDH), people diagnosed with eating disorders 'displace' negative feelings onto their bodies, which results in the experience of feeling fat (Bruch, 1978; McFarlane, Urbszat & Olmstead, 2011). As a result they experience an increase in their feelings of fatness when emotionally distressed (McFarlane et al., 2011). Bruch (1978) suggested that this displacement of negative affect onto the body is a coping mechanism as it localises distress, thus making it less threatening and more controllable e.g. by changing their body through exercise or weight loss. Consequently, body displacement "may play an important role in the development and maintenance of eating disorder pathology" (McFarlane et al., 2011, p. 189).

McFarlane et al. (2011) tested the BDH by randomly assigning unrestrained eaters (N= 61), restrained eaters (N= 33) and individuals with an eating disorder diagnosis⁴ (N= 26) to a control condition or an ineffectiveness induction condition. During the ineffectiveness induction condition participants were asked to think about an occasion in which they felt inadequate or useless (e.g. when "you failed...or a time when someone ended a relationship with you") (McFarlane et al., 2011, p. 291). Conversely, participants in the control condition were asked to think about an occasion "when they felt good or content with themselves" (e.g. when you received a positive comment "or a time you enjoyed spending time with another person") (McFarlane et al., 2011, p. 291). Participants were given ten minutes to reflect upon and complete a written worksheet, which asked them to imagine the situation in as much detail as possible including their thoughts and feelings at the time. Participants were subsequently asked to complete a list of word-stems with the first word that they thought about. Finally, all participants were given the State Self-Esteem Scale (SSES; Heatherton & Polivy, 1991) and Body Image States Scale (BISS; Cash, Fleming, Alindogan, Steadman, & Whitehead, 2002) and non-clinical participants also completed the Restraint Scale (Polivy, Herman & Howard, 1988). Manipulation

⁴ Anorexia nervosa (n = 8), bulimia nervosa (n = 12), eating disorder not otherwise specified (n = 6).

checks showed that the ineffective induction successfully induced a state of ineffectiveness and lower self-esteem (McFarlane et al., 2011). Findings showed that participants with an eating disorder diagnosis reported significantly lower state self-esteem than restrained eaters; furthermore, restrained eaters also reported significantly lower state self-esteem than unrestrained eaters. In line with the BDH, participants with eating disorder diagnoses used more appearance-related words in the ineffectiveness condition than both restrained and unrestrained eaters; moreover, individuals in the ineffectiveness condition used more appearance-related words than those in the control condition (McFarlane et al., 2011). Participants with an eating disorder diagnosis responded in accordance with the BDH as their body satisfaction reduced with feeling ineffective (McFarlane et al., 2011). However, the results of this study did not support the behavioural consequences of the BDH (e.g. body displacement of negative emotions will lead to an increase in eating disorder behaviours). McFarlane et al. (2011) concluded that their findings “partially support the existence of body displacement in individuals with eating disorders [because] feeling ineffective led to increased body concern in these individuals” (p. 292).

McFarlane et al. (2011) also found that the implicit measure of body concern (Word-Stem Completion Task; WSCT; Tiggemann, Hargreaves, Polivy, & McFarlane, 2004) detected body displacement effects, whereas the direct measure (Body Image States Scale; BISS; Cash et al., 2002) did not, thus providing support for Bruch’s (1978) hypothesis that people may be unaware of displacing affect onto their bodies. They also propose that body displacement is “a more pathological process unique to those with eating disorders” (p. 292). This was because contrary to the BDH restrained eaters in the ineffectiveness condition were more satisfied with their body image than those in the control group and no significant difference was found between restrained and unrestrained eaters in each condition. Although this study provides some evidence for the existence of the body displacement hypothesis, the mean BMI for the clinical sample was 21.3, which is located within the ‘normal’ range and BMI scores were not collected for the non-clinical participants. It is therefore unclear whether the same effect would occur when individuals have a lower BMI. Furthermore, the clinical sample was comprised of individuals with a variety of eating disorder diagnoses, which could have impacted upon the findings should the BDH differ between clinical presentations. Finally, the small clinical sample size reduced

the power of the study and therefore reduced the effect size and statistical power. Although these studies provide partial support for the body displacement theory, their inconclusive results suggest that other factors might be involved.

2.5.3. Behavioural components of feeling fat

The previous discussion has indicated that feeling fat is influenced by cognitive and affective factors; however, it has also suggested that other variables might also be involved in the experience of feeling fat. The following section will discuss the research that has expanded upon Tiggemann's (1996) and Lam et al.'s (2002) findings that behavioural factors might also be associated with feeling fat.

Within their aforementioned study, Striegel-Moore et al. (1986) also found a significant correlation between feeling fat and dieting, and feeling fat and binge eating. They investigated this relationship further within a second study during which 61 female undergraduate students completed the Eating Inventory (Stunkard & Messick, 1985) and a purposefully constructed Feeling Fat scale (Striegel-Moore et al., 1986). A hierarchical regression analysis showed that cognitive restraint was not significantly related to feeling fat. However, there was a highly significant relationship between feeling fat and "perceived tendency towards inhibition" and feeling fat and perceived hunger (Striegel-Moore et al., 1986, p. 942). Indeed, feeling fat was associated with repeated dieting, an inclination to eat in response to external stimuli and negative emotions, and a high frequency of eating urges (Striegel-Moore et al., 1986). Feeling fat was also found to be associated with binge eating. They consequently hypothesised that feeling fat sensitizes women to her appetite and feelings of hunger, which increases the likelihood that she will notice these sensations and will be more attentive to potential weight fluctuations (Striegel-Moore et al., 1986). Although correlational studies cannot imply causality, Striegel-Moore and colleagues (1986) speculate that feeling fat is a causal factor in the development of eating disorders.

Wardle and Foley (1989) investigated body size estimation, body satisfaction and feelings of fatness before and after eating in order to test the hypothesis that negative body self-esteem is correlated with body size overestimation. These body image variables were measured before and after the female undergraduate

participants (N= 20) ate a meal perceived to be 'slimming' or 'fattening' despite being matched for nutritional content. Feeling fat was measured using a visual analogue scale ranging from 'very thin' to 'very fat'. The mean response on this scale fell within the 'slightly fat' range, thus suggesting that most participants felt fat to some degree despite being within normal weight limits. Moreover, the more dissatisfied women were about their bodies and appearance, the fatter they felt, which suggests that feelings of fatness play a role within women's self-image (Wardle & Foley, 1989). In line with Striegel-Moore et al. (1986), they found that participants who felt fatter were more likely to restrict their food intake in order to alter their weight. Participant post-meal measures were found to be more negative than pre-meal assessments; however, this was not significantly more negative after eating a meal perceived as more fattening. Interestingly, all participants reported feeling fatter after eating regardless of their level of restraint; however, Wardle and Foley (1989) did not discuss possible explanations for this finding. Simlett (2004) hypothesised that this occurred either because women associated feelings of fullness to feeling fat, or because of feelings of guilt and/or shame about the type of food eaten. Simlett (2004) proposed that the findings supported the latter hypothesis as Wardle and Foley's (1989) participants felt fatter after the more 'fattening' meal although not to a significant level.

2.5.4. Situational components of feeling fat

Roth and Armstrong (1993) developed The Feeling of Fatness Questionnaire (FOFQ) due to the lack of a systematic measurement tool for measuring the multiple contexts of body experience (e.g. psychological and interpersonal contexts). Moreover, they hoped to fill the gap in research literature for directly assessing "cross-situational variability of affective body experience" (p. 350). Consequently, the FOFQ included statements about affective (e.g. feeling angry), achievement (e.g. exceeding standards), social (e.g. people trying to control me), somatically hyper-vigilant (e.g. feeling constipated), and self-focused situations (e.g. looking at my nude body). In testing the questionnaire's validity with a sample of 132 undergraduate women, they found that participants' experience of fatness varied considerably across the aforementioned situations. Feelings of fatness were particularly influenced by "affective state, performance evaluation, public scrutiny, self-consciousness, and the nature of one's interpersonal field" (p. 355). A varimax rotation highlighted that both

positive and negative emotions affect women's bodily experiences with happiness being linked with thinness and unhappiness and/or failure linked to fatness. Roth and Armstrong (1993) proposed that feelings of fatness "can be construed as the outcome of a complex and interrelated series of psychological operations that are initiated by an internal or external stimulus situation" (p. 355). They suggested that situations that direct a women's attention to her body (e.g. looking at her nude body) initiate feelings of fatness based upon faulty preconceptions and/or distorted social comparisons. They also postulated that affective triggers for feeling fat (e.g. interpersonal relationships) are the result of "an associative schematic network regarding self and weight [that has]...developed through repeated exposure to culturally normative messages that link weight with relationships, mood states, and achievement" (p. 356). Consequently, these findings support Striegel-Moore et al. (1986) and Wardle and Foley's (1989) theories.

2.6. Meaning of feeling fat in eating disorders

Many of the aforementioned studies have related their findings to eating disorders even though the majority were conducted with sub-clinical populations. Only one study has investigated the *meaning* of feeling fat in participants diagnosed with an eating disorder. In this study Cooper et al. (2007) explored the experience in three groups of females- those diagnosed with AN (N= 16), dieting women (N= 15) and women who were not dieting (N= 17). Each participant completed an individual semi-structured interview regarding their last experience of feeling fat and their earliest memory of feeling fat. Participants were also asked to rate their core beliefs about whether they believed them to be rational beliefs and emotional beliefs ("what the person feels to be true, despite what they know to be logically true"; p. 367). Results were analysed using non-parametric statistics on account of the small sample sizes.

Cooper et al. (2007) found that feeling fat was common within all three groups and was associated with "distress, negative emotions, internal and external body sensations, images in a range of modalities, negative self-beliefs and a first memory that was similar in emotional and cognitive content to the current experience of feeling fat" (Cooper et al., 2007, p. 367). However, women with a diagnosis of AN "had felt fatter, were more distressed by the experience, had more negative emotions

associated with feeling fat and believed the thought more 'emotionally' although not rationally to be true", than those without a diagnosis of AN (p. 371). They also noted a link between feeling fat and more frequent food restriction within the AN group. Moreover, women within the AN group felt fatter from an earlier age, which was associated with negative self-beliefs at the time of onset than other participants. Indeed, feeling fat for participants within the AN group was also associated with "negative self-beliefs which are strongly held emotionally" (Cooper et al., 2007, p. 371), a finding that might account for the disorder's resistance to change and treatment. The researchers suggested that these differences are the result of people without a diagnosis of AN developing good coping strategies or alternatively not developing an unknown mechanism associated with feeling fat in AN. One proposed suggestion for this mechanism is that dieting only requires preoccupation with weight and shape features, whereas AN requires this *and* negative self-beliefs (Cooper et al., 2007).

Cooper et al. (2007) propose that negative emotions alone cannot account for the experience of feeling fat as a significant relationship was found between eating disorder symptoms, intensity of feeling fat, and level of distress even when depression was controlled. Instead they suggest that feeling fat is "at least partially specific to eating disorder symptoms" (Cooper et al., 2007, p. 371) and recommended that treatments focus upon eating disorder specific experience as well as negative affect. In line with this, they suggest that experiential strategies (i.e. imagery-based interventions) or schema-focussed strategies should be incorporated into cognitive therapy in order to address the negative self-beliefs that they found to be associated with the experience of feeling fat (Cooper et al., 2007).

Although these findings provide support for the experience of feeling fat being different in those with and without a diagnosis of AN, there are a few limitations. These include a small sample size (N= 48) and lack of established psychometric properties (e.g. inter-rater and test re-test reliability) of the interview schedule (Cooper et al., 2007). Moreover, the retrospective recall of early feeling fat memories might have been overestimated if current levels of feeling fat were elevated. In addition, it is unclear what qualitative methodology was used to analyse the semi-structured interview data. However, even with these limitations Cooper et al.'s (2007)

study “suggest[s] that the experience of feeling fat in those with AN is worthy of further research, and may have implications for treatment of those with the disorder” (p. 372).

2.7. The subjective experience of feeling fat

The only qualitative study to specifically examine the subjective experience of feeling fat supported some of these previously discussed quantitative findings. In her preliminary study, Simlett (2004) asked 45 of her non-clinical participants to define their experience of feeling fat by asking the question: “What do you mean when you think or say ‘I feel fat?’” Her thematic analysis revealed that feeling fat was primarily a “physical experience”, which varied from “having extra weight” or “being out of shape” to more abstract and vague concepts such as feeling “bloated”, “heavy”, “not feeling right in my own skin” or being more aware of one’s body (p. 74). For 9% of participants, feeling fat meant “I am unattractive” and for 7% it was a “just a feeling” that was difficult to describe (p. 75).

Simlett (2004) stated that some participant responses did not define the experience but “reflected issues and experiences that were related” to feeling fat (p. 75). These included feeling “very negative about myself”, “disappointed in myself”, “self-conscious” and feeling “not happy with how I am” (Simlett, 2004, p. 75). Indeed, 16% of participants reflected upon how their feelings about themselves (e.g. low self-esteem, lacking in confidence, negative self-concept and stress) and their emotions impacted upon their experiences of feeling fat (Simlett, 2004). This finding suggests that feeling fat can be influenced by internal factors and/or is related to transposing emotions onto the body. Feelings of fatness were also triggered by external stimuli, including clothing feeling too tight or not fitting correctly; social comparison to other people/images, the size they thought they should be and what they used to look like; visual cues (e.g. being naked) and lifestyle habits (e.g. not exercising or eating a large meal). Several women stated that feeling fat could lead to a desire to lose weight or change their clothing. These findings clearly demonstrate that the experience of feeling fat differs in emphasis for each woman. Unfortunately, as this qualitative portion of Simlett’s (2004) research was comprised of only one question, only a limited amount of interpretation and meaning can be made.

2.8. Treatment of feeling fat within eating disorders

As highlighted within the literature search, feeling fat can motivate dieting behaviour in individuals with and without an ED diagnosis; however, the experience of feeling fat seems to be far greater for individuals with an ED diagnosis (Murphy et al., 2010). Feeling fat could also be seen as a core maintenance factor for EDs as individuals with these diagnoses appear to equate this experience with being fat regardless of their weight or shape (Forbush & Watson, 2006; Murphy et al., 2010). Consequently, feeling fat should be a target for treatment as this could reduce dieting behaviour and the likelihood of relapse; however, few treatments for AN specifically address the experience of feeling fat (Cooper et al., 2007). Indeed, out of the eating disorder treatments endorsed by NICE guidelines (2004) only one model of CBT specifically focuses upon the treatment of feeling fat (Murphy et al., 2010; Fairburn, 2008). The following section will subsequently outline how feeling fat is addressed by existing treatment protocols regardless of whether they are endorsed by NICE guidelines; this includes the Transdiagnostic Model of Eating Disorders (Fairburn, 2008) and Emotion-focused therapy (Dolhanty & Greenberg, 2007).

2.8.1. Cognitive behavioural therapy

The Transdiagnostic Model of Eating Disorders (Fairburn, 2008) proposes that feeling fat is the consequence of mislabelling emotions (affective states) and bodily experiences (physical states) or the result of particular cognitions. Although he is unsure as to why this occurs, he suggests that it could be the result of the individual's "longstanding and profound preoccupation with weight and shape" (Fairburn, 2008, p. 144). In line with this, the intervention proposed by Fairburn starts with psycho-education regarding the feeling fat and clients are subsequently asked to record the details and context of the times they feel fat over a week. This record is used to help individuals identify both triggers for the feeling (e.g. negative mood or bodily sensations) and their negative interpretations of these experiences. The treatment then aims to provide individuals with more 'appropriate' coping strategies for these triggers. As a result, individuals are encouraged to view feeling fat as "a cue to ask themselves what else they are feeling at the time and once recognized to address it directly" (Murphy et al., 2010, p. 621). Fairburn (2008) suggests that this needs to be practiced over a number of weeks as over time an individual's relationship to feeling

fat will improve and lose its significance so as to no longer maintain their shape concerns. These techniques are just one aspect of the CBT model of treatment proposed by Fairburn, however it is the only technique to specifically address this experience.

2.8.2. Emotion-focused therapy

Emotion-Focused Therapy (EFT; Dolhanty & Greenberg, 2007) involves the processing of emotions in order to improve difficulties in affect regulation (Dolhanty & Greenberg, 2007). Indeed, Dolhanty and Greenberg (2009) propose that EFT helps to break the vicious cycle of “body image disparagement and displacement, by which negative feelings are displaced onto the body and converted to ‘feeling fat’”(p. 366). This is achieved through techniques that promote re-owning and expression of emotional experience as well as focusing upon the individual’s critical internal voice (Dolhanty & Greenberg, 2009). Within their paper, Dolhanty and Greenberg (2009) conclude that at the end of an 18-month outpatient work their client’s ability to manage and tolerate emotions led to the development of mastery, agency and efficacy in “navigating her world, and facilitate a relinquishing of the eating disorder as a means of managing affective experience” (Dolhanty & Greenberg, 2009, p. 382); however, they do not report upon her experience of feeling fat. EFT has a recognised evidence-base in the treatment of depression and trauma (Robinson et al., 2013); however the literature for its treatment of EDs is sparse except for individual case studies, which show that this approach has promise (Dolhanty, 2006).

2.9. **Conclusion**

Feeling fat is a common experience that is often used by women as a measure of their self-worth (Eldredge et al., 1990) and as a statement about body dissatisfaction (Simlett, 2004; Nichter & Nichter, 2009). The intensity and frequency of feeling fat is exacerbated for women with an eating disorder diagnosis (Wardle & Foley, 1989; Andersen, 2000; Fairburn, 2008; Cooper et al., 2007). Consequently, feeling fat can act as a maintenance factor for eating disorders. Regardless of this role in eating disorder pathology the research literature specifically investigating the experience of feeling fat for women is sparse. However, it has been demonstrated that feeling fat is a distinct construct (Tiggemann, 1996) that is “the outcome of a complex and

interrelated series of psychological operations that are initiated by an internal or external stimulus situation” (Roth & Armstrong, 1993, p. 355). Indeed, low self-esteem and strongly held weight-related schemata influence self-evaluative situations (e.g. viewing body, social comparison, perceived failure), which initiates feelings of fatness (Striegel-Moore et al., 1986; Eldredge et al., 1990; Roth & Armstrong, 1993). Findings have also demonstrated a tendency for women who feel fat to fuse thoughts with perceived shape (Radomsky et al., 2002). Finally, research has also found a correlation between negative emotions and feelings of fatness (Striegel-Moore et al., 1986; Eldredge et al., 1990; Wardle & Foley, 1989; Roth & Armstrong, 1993; Simlett, 2004, McFarlane et al., 2011) and dieting and feeling fat (Striegel-Moore et al., 1986; Tiggemann, 1996; Lam et al., 2002). Consequently, feeling fat seems to be “a complex interaction between the mind and body” (Simlett, 2004, p. 45) as well as behavioural and situational circumstances.

2.10. Rationale for the current study

Although some studies have been conducted to investigate the experience of feeling fat, there are a number of gaps within this literature base. Roth & Armstrong (1993, p. 351) state that a “major weaknesses of research to date is the failure to assess subjective experiences of fatness across a sufficiently diverse and clinically meaningful range of situations”. Indeed, the existing literature into the experience of feeling fat is dominated by quantitative methodologies. Although this positivist stance provides an insight into the experience of feeling fat, it does not allow participants’ voices to be heard. Indeed, Vitousek (1997; as cited in Serpell & Treasure, 2002) argued that researchers should listen more to the voices of women when sharing their lived experience of the phenomenon being investigated. Consequently, a qualitative methodology would address Vitousek’s proposal to provide an in-depth and subjective account of the experience of feeling fat. Moreover, a qualitative study investigating feeling fat would add to the literature base whilst providing participants with the opportunity to explore their experience of feeling fat without being constrained by a questionnaire (Dovey-Pearce, Doherty & May, 2007). Furthermore, the majority of existing research has been conducted with sub-clinical undergraduate populations. This is probably due to practical reasons such as ease of recruitment. Unfortunately, this means that the “experience of feeling fat is not well understood in

those with AN” (Cooper et al., 2007, p. 366) or other eating disorders. As previous research has found that feeling fat can play a different role within the various eating disorder pathologies (Benninghoven et al., 2006) the current study will explore the experience of feeling fat specifically for women with an AN diagnosis.

2.11. Clinical relevance

Based upon their clinical practice, clinicians have proposed numerous hypotheses for the meaning of feeling fat; for instance, Andersen (2000) argued that it is a “statement of personal distress [and] is the final common denominator for many kinds of unnamed dysphoria” (p. 167). He posits that helping a person identify the emotion underlying feeling fat and empowering them to cope with this emotional distress reduces feeling fat experiences. Fairburn (2008) suggested that bodily experiences (e.g. feeling full, bloated or hot) increase bodily awareness and feelings of fatness. He proposed that this occurs due to the individual’s “longstanding and profound preoccupation with shape” (p. 114).

In line with these hypotheses, the literature previously discussed suggests that feeling fat acts as a maintenance factor for eating disorders as well as being a statement about body dissatisfaction; however, no research has been conducted into the lived experience of feeling fat for women with an eating disorder diagnosis. The proposed research would not only fill the gap within existing literature, but would also provide an understanding of the experience of feeling fat in women with an AN diagnosis.

This deeper understanding could help to inform treatments, which to date rarely focus upon the experience of feeling fat and its relationship with AN. This is particularly important as AN is still poorly understood in comparison to other mental health difficulties (Schmidt & Treasure, 2006) and as a result it is one of the most difficult diagnoses to treat (Vitousek, Watson & Wilson, 1998). The in-depth understanding of feeling fat provided by this study may give an insight into which treatment strategies will be helpful in supporting patients with this experience (Cooper et al., 2007). This deeper understanding of feeling fat would also enhance the therapeutic relationship, as individuals will feel better understood by their

therapists who would be better able to “meet their clients more effectively in the inter-subjective space” (Doyle, 2013, p. 30). With this support, clients might also be able to verbalise what it is like to experience feeling fat. Overall, this could have a positive impact upon the statistics that less than half of individuals receiving treatment for AN recover and for one fifth the AN remains chronic (Steinhausen, 2002).

3. AIMS AND RESEARCH QUESTIONS

This study aims to explore the lived experience of feeling fat for adult females with a diagnosis of AN. A rich descriptive and interpretative account of feeling fat will be obtained through the qualitative approach of Interpretative Phenomenological Analysis (IPA) (Smith & Osborn, 2008; Smith, Flowers & Larkin, 2009). I hope that the semi-structured interviews used will enable participants to discuss the aspects of the experience that are most prominent for them; however, the areas to be explored are:

- How participants experience feeling fat;
- What feeling fat means to participants;
- The consequences of feeling fat for participants.

With this in mind, the main research question was:

What is the experience feeling fat for adult females with a diagnosis of Anorexia Nervosa?

4. METHODOLOGY

4.1. A qualitative approach

The subjective experience and meaning of feeling fat for women with an Anorexia Nervosa (AN) diagnosis is currently an under-researched phenomenon. In line with the positivism of the medical model (Cosgrove, 2000) the majority of research conducted into the experience of feeling fat has taken a quantitative stance. Consequently, the present study aims to obtain a more in-depth account of feeling fat for women with an AN diagnosis. A qualitative approach was selected as these methods provide rich descriptive accounts of an experience and are therefore well suited for exploratory research (Barker, Pistrang & Elliott, 2002). Such approaches can also be used to inform the “conceptual and definitional clarification” of the phenomena being investigated (Harper, 2011, p.84; Smith, 2003). Moreover, qualitative approaches are “exploratory [and] discovery-orientated” and can be guided by the participant thus increasing the potential to reveal unexpected findings that had not previously been considered by researchers (Barker, Pistrang & Elliott, 2002, p. 74).

4.2. Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) (Smith, 1996; Smith et al., 2009) is a postmodern qualitative approach (Smith & Osborn, 2008) concerned with the in-depth investigation of personal lived experiences; both in terms of the meaning of the experience and how participants understand their experience (Smith, 2011). IPA has a theoretical stance based in phenomenology, hermeneutics and idiography (Smith, 2011); brief descriptions of these and their relation to IPA will be now be described.

Phenomenology “is the philosophical movement concerned with lived experience” (Smith, 2011, p. 9). IPA is phenomenological in that it aims to explore “an individual’s personal perception” of the phenomenon being investigated, rather than attempting to “produce an objective statement of the object or event itself” (Smith & Osborn, 2008, p. 53).

Hermeneutics is the “theory of interpretation” (Smith et al., 2009, p. 21). According to the hermeneutic cycle “to understand any given part, you look to the whole; to understand the whole, you look to the parts” (Smith et al., 2009, p. 28). This circular process of interpretation is evident within IPA as researchers can move back and forth between numerous ways of thinking about the data (Smith et al., 2009). Furthermore, IPA uses a “double hermeneutic” as participants first have to reflect upon and interpret their experiences so that they are meaningful to them (Brocki & Wearden, 2010), and in turn the researcher tries to make sense of the participant’s interpretation of their experience (Smith & Osborn, 2008, p. 53).

Idiography is “concerned with the particular” (Smith et al., 2009, p. 29). IPA takes an idiographic stance as its case-by-case analysis enables the voices of individual participants and their subjective experiences to be heard, whilst concurrently exploring similarities and differences between participants’ experiences (Smith et al., 2009). This idiographic stance consequently provides a universal understanding through the detailed exploration of the particular detail (Smith et al., 2009). Idiography therefore makes generalisations cautiously and locates them within the particular (Smith et al., 2009).

4.2.1. Reasons for choosing IPA

IPA was the method of analysis chosen for a number of reasons. First and foremost, IPA aims to “capture the quality and texture of individual experience” (Willig, 2008, p. 57) and is therefore in keeping with the current research objective of exploring the lived experience of feeling fat for adult females with a diagnosis of AN.

IPA is theoretically underpinned by a phenomenological, interpretative and idiographic stance (Smith & Osborn, 2008; Smith, Flowers & Larkin, 2009), which matches closely with the study’s aim. The phenomenological nature of IPA is relevant for the current study as the experience of feeling fat is under-researched even though it can be a significant experience for people with a diagnosis of AN. It has also been argued that a phenomenological and social constructionist approach should be used to study how women experience distress (Cosgrove, 2000). This is because

phenomenological approaches can emphasize “the richness and complexity of an individual’s lived experience and privileges agency” (p. 247).

Furthermore, the idiographic nature of IPA allows for both individual and group level experiences to be revealed (Smith et al., 2009). Consequently, the participant-led and inductive nature of IPA (Gee, 2011) fits with my belief that individuals should be empowered to have their voices heard and should be regarded as the experts in their life experiences.

Finally, the structured nature of IPA has been described extensively within literature (e.g. Smith & Osborn, 2008; Smith et al., 2009); which was appealing to me as a novice IPA researcher.

4.3. Why not a different qualitative method?

Other qualitative approaches were considered including Grounded Theory (Glaser & Strauss, 1967), Narrative Analysis (Crossley, 2000) and Discourse Analysis (Kendall & Wickham, 1999); however, I decided that these methods were not appropriate for the reasons outlined below.

Grounded Theory (GT) aims to develop theoretical explanations for the phenomena being investigated (Starks & Brown Trinidad, 2007). This approach would not capture the detailed descriptions of personal experience required by the present research; for example, Willig (2008) argues that IPA is more suitable for understanding personal experiences whereas GT looks into the social processes. Moreover, GT requires a large sample and thus the time required to recruit participants and analyse the data would exceed my resources as a professional doctoral student (Smith et al., 2009).

Narrative Analysis focuses upon the stories told by individuals and/or communities (Harper, 2011) and in particular how these narratives alter over time and in accordance with the individual’s context (Riessman, 2008). Consequently, this approach focuses upon how narratives inform understanding of an experience, rather than the in-depth analysis of the subjective experience as required by the current study (Smith et al., 2009).

In line with this, Discourse Analysis (DA) did not feel appropriate because it focuses upon how language is used “to accomplish personal, social, and political projects” (Starks & Brown Trinidad, 2007, p. 3174). Consequently, DA examines how participants construct accounts of their experiences based upon what they say. In contrast, IPA researchers analyse what participants say in order to learn how participants makes sense of their experience (Smith, 2011, p. 10), which is more in line with the current study’s aims.

4.4. Researcher’s relationship to the research and epistemological position

4.4.1. Reflexivity

Reflexivity is the awareness of how the researcher’s beliefs and assumptions influence the collection, analysis and interpretation of qualitative data (Willig, 2008). Indeed, Salmon (2003) stated that “results of psychological research reflect the researcher as much as the researched” (p. 26; as cited in Brocki & Wearden, 2010). Consequently, it is important that researchers “own their perspective” through transparent self-reflexivity (Elliott et al., 1999, p. 221) and by clearly acknowledging their perspectives throughout their research (Brocki & Wearden, 2010). I hope to achieve this by providing an account of my journey and influences in the development of this research and by describing my theoretical and epistemological positions below.

4.4.1.1. *Personal position:* I am a 29-year-old white British female. I was born and raised in Hong Kong where I attended an International School with children from a wide variety of countries and cultures. My family moved to a small town in South West England when I was 10-years-old, and they still remain there to date.

I have studied and/or worked within psychology for the last 10 years; however, I have never worked within an eating disorder setting. Throughout my psychology career I have taken a critical stance to mental health difficulties. I believe that anybody can and will experience mental health difficulties at some point within their life. I view mental health difficulties as the result of an interaction between psychological, environmental, social and biological factors and I believe that mental health

diagnoses are socially constructed and therefore should be viewed from a critical stance. Within my clinical practice I endeavour to take an integrative approach influenced specifically by systemic, narrative, feminist and cognitive behavioural paradigms.

4.4.1.2. *How I came to this study:* My awareness of eating disorders began when I was 10-years-old and one of my friends was admitted to an inpatient eating disorders unit. At this time I found it difficult to understand why someone would choose not to eat; it was a thought that had never crossed my mind. Upon her return to school I remember feeling worried that I might somehow exacerbate her difficulties due to this lack of understanding. During my secondary education at an all-girls' school a number of my peers and close friends also experienced eating difficulties. Confusion still remained for me as to why they would starve themselves and I felt helpless about how I could support them. I have realised that this intrigue and confusion still remains within both my personal and professional lives. Personally, I often wonder what it meant for my friends to "feel fat" and curious about how their experiences were similar and different to other people with or without an eating disorder diagnosis. Professionally, I have never worked within an eating disorder service and in hindsight I wonder whether this is the result of my previous feelings of hopelessness when supporting my friends during our school years.

Although I have never been diagnosed with an eating disorder, I do experience times when I feel fat. Upon reflection this has occurred most frequently when I have been lacking in confidence (e.g. not being able to find something to wear because my outfit just doesn't look right or because I think my friends look better than me). I can also feel fat when I catch a glimpse of my body from an unflattering angle. I realise with further reflection that at these times I am often feeling low in mood and/or anxious. Interestingly, the frequency of these feelings of fatness have reduced since I embarked on this research. Due to my experiences of feeling fat it is important that I 'bracket' my assumptions throughout the research process (see section 4.10.1).

4.4.1.3. *My position as a researcher:* In line with my personal epistemological position, I took a social constructionist stance throughout this research process. This

stance posits that there are multiple realities, which are co-constructed through social interactions and language (Burr, 2003).

I am also influenced by the feminist perspective that a woman's relationship with her body is influenced by the patriarchal society in which we live (e.g., Striegel-Moore, 1995; Fairburn et al., 1998). Indeed, before embarking on the current research I was aware and angered by the 'thin ideal' for women promoted by Western society; for example, size 8 dresses being pinned to store mannequins; underweight models in the fashion industry; airbrushing photos and the media's preoccupation with shaming celebrities who look 'fat'.

4.5. Context of the study

Participants were recruited from an eating disorders (ED) service, which provides assessment and treatment to adults (aged 18+) with moderate to severe eating disorders. The large multi-disciplinary team is comprised of Psychologists, Psychiatrists, Psychotherapists, a Dietician and a Support Worker. Referrals to the service can be made by General Practitioners and other mental health professionals.

4.6. Participants

4.6.1. Recruitment

A criterion based purposive sampling approach was used in order to obtain the homogeneous sample required for IPA studies. Participants were all recruited from the same community eating disorders service. I attended two team meetings at this service during which I told care co-ordinators about the research and gave them copies of the Clinician Information Sheet (see Appendix 2) and Participant Information Sheet (see Appendix 3). Care co-ordinators were asked to identify and inform any service user on their caseload who met the study's inclusion criteria (see section 1.5.2) about the research by giving each of them a Participant Information Sheet. This information sheet provided a brief description of the main aims of the research, what participation would involve and stated that potential participants could contact me directly or inform their care coordinator if they were interested in participating. Although service users could decide whether or not to take part in their

own time, I asked the care co-ordinators to remind them about the study two weeks after providing them with the information. I also sent three emails to the ED service team to remind them about the study and giving them electronic copies of the information sheets. My field supervisor helped me to recruit three participants and the final participants were recruited by other members of the ED team.

As IPA studies aim to provide an in-depth interpretative account of an experience, only a small number of participants are required (Smith et al., 2009). This is because larger data sets tend to inhibit the time, reflection and dialogue required for successful analysis, especially among less experienced researchers (Smith et al., 2009). Indeed, Smith et al. (2009) proposed that professional doctorate projects using IPA should typically include between four and 10 participants with interviews lasting one hour. Consequently, the present study aimed to recruit between six and eight participants.

4.6.2. Inclusion criteria

In order to obtain the homogenous sample required by the IPA approach, all participants had to meet the inclusion criteria outlined in Table 2.

Table 2: Inclusion criteria

Criterion	Explanation
Female	This would provide an homogenous sample as required by the method of analysis, Interpretative Phenomenological Analysis (IPA).
Diagnosis of AN as defined by the DSM-5	
18-years-old or older	As adults can provide informed consent and also because recruitment took place within an adult eating disorder service.
Experience feeling fat	Not all patients with a diagnosis of AN experience feeling fat.
Currently receiving treatment from the ED service	To ensure that participants could easily access support should they find participating within the research distressing.
Fluent English speaking	IPA relies upon meaning of language, therefore non-English speaking participants were excluded in order to ensure that information and richness of data was not lost in translation (Smith et al., 2009).
Could provide informed consent	Participants needed to have the cognitive capacity to understand what the research would involve and the reasons for it being conducted so that they could make an informed voluntary decision to participate.

4.6.3. Exclusion criteria

Individuals who did not meet all of the inclusion criteria were excluded from the study (see appendix 4 for further details).

4.6.4. Participant characteristics

Seven women aged between 18 and 49-years-old participated within the study (see Table 3). All of the women were receiving therapy from the ED service at the time of their interview. Participants disclosed their age, BMI, diagnosis, treatment history and ED duration after consenting to participate in the research (see Table 3). On the occasions when participants were unsure of their BMI, consent was obtained to obtain this information from their care co-ordinator. Participants varied in the amount

of detail provided regarding treatment history, and not all participants were aware of the therapeutic models they had undertaken. Two participants (Sarah and Lisa) reported feeling as though they were starting to overcome their eating disorder and were experiencing feeling fat less than they had previously.

Table 3. Participant Characteristics and demographics

Alias	Age	Current Diagnosis	BMI	Previous ED Diagnoses	Previous Treatment	ED Duration
Jody	28	Anorexia Nervosa, restricting type	16	None	Outpatient	3 years
Ava	34	Anorexia Nervosa, restricting type	14.1	None	Inpatient and outpatient.	23 years
Mandi	49	Anorexia Nervosa, restricting type	18.2	None	Inpatient and outpatient.	34 years
Rachel	32	Anorexia Nervosa, binge-purge type	12.5	None	Inpatient, outpatient, day centre.	18 years
Lisa	19	Anorexia Nervosa, binge-purge type	17.1	Bulimia Nervosa	Outpatient	2 years
Sarah	18	Anorexia Nervosa, restricting type	17	None	Outpatient treatment.	1.5 years
Savannah	24	Anorexia Nervosa, binge-purge type	18.2	None	Inpatient and outpatient.	10 years

4.7. Ethical considerations

Ethical approval for the study was granted by London – Riverside NRES Committee (see Appendix 5 for supporting documentation).

4.7.1. Informed consent

All potential participants were provided with Participant Information Sheets outlining the purpose of the research and what participation will involve (Appendix 3). They were able to consider whether to participate within the study in their own time and were offered the opportunity to meet with the interviewer prior to agreeing to take

part. The information outlined within the Participation Information Sheet was verbally repeated to participants and they were given the opportunity to ask questions prior to providing informed consent and starting the interview. Participants were also reminded that they could withdraw from the study at any time without providing a reason.

Written consent was obtained from all participants and was countersigned by the researcher (Appendix 6).

4.7.2. Confidentiality

Confidentiality and its parameters were explained within the Participant Information Sheet and was reiterated verbally to participants prior to the interview. Participants were informed that information discussed during the interview would not be shared with the ED service unless I was concerned about risk to the participant or others.

Participants were informed that only myself, my supervisors and a professional transcribing service would have access to the data. Moreover, they were made aware that all data would be kept securely and confidentially at my home. They were told that all identifying information would be removed or changed within written transcripts and that anonymised quotes would be used within the write-up.

4.7.3. Affiliation of the study

Participation Information Sheets stated that the research is being conducted independently from the ED service from which recruitment was taking place. It was also made explicit that not participating within the study or withdrawing from the study would not impact upon the treatment or standard of care they received from the ED service. This was important because my field supervisor is a therapist within the ED service and he was informing the women on his caseload about the study.

4.7.4. Managing potential distress

The in-depth discussion about feeling fat required of the study could have potentially been distressing for participants. Consequently, I provided participants with information about what the study would involve and the topic to be discussed before they consented to participating. I also made it clear to participants that they could

take a break at any time during their interview, and could choose not to answer any questions that they did not want to answer. They were informed that they could stop the interview at any time without having to provide a reason.

I aimed to conduct the interviews as sensitively as possible by drawing upon my clinical experience and person centred approach to empathise, listen and contain participant distress.

Time was allocated at the end of every interview to debrief with the participants and give them the opportunity to reflect upon their experience of participating. I also gave them a 'Debrief Sheet' (Appendix 7), which outlined where they could seek further support if required.

4.8. Data collection

4.8.1. Semi-structured interviews

As suggested by Smith and colleagues (2008 & 2009), data was collected using semi-structured interviews. This method facilitated an informal and flexible dialogue in which initial questions could be adapted according to participant responses, thus enabling me to probe interesting areas that arose (Smith & Osborn, 2008). This also allowed participants to alter the direction of the interview to an issue that I had not considered when devising the interview-schedule (Smith & Osborn, 2008). Furthermore, using this flexible approach helped me to build a rapport with participants and allowed me "*to enter as far as possible, the psychological and social world of the respondent*" (Smith & Osborn, 2008, p. 59).

4.8.2. Interview design

The semi-structured interview schedule was developed in consultation with my supervisors and in line with relevant literature and Smith and Osborn's (2008) guidelines (see Appendix 8).

4.8.3. Service-user involvement

During the design of this research I consulted with a service-user from the ED service regarding the research documents (see Table 4 for an outline of the feedback and

how I incorporated it into the research). This was because service-user involvement can improve research and lead to clearer outcomes (National Institute for Health Research, 2013). For instance, involving service-users in the development of research questions can ensure that the questions are meaningful and relevant to potential participants (Allam et al., 2004). The woman who was consulted about the research did not participate within the study.

Table 4: Service-user feedback

Document	Feedback Given	How I used the feedback
Participant Information Sheet (PIS)	<ul style="list-style-type: none"> • Clear description of the study and why the research is being conducted. • It is very long so participants might skim read it. 	I decided to verbally reiterate the information within the PIS before obtaining consent to ensure that participants had understood the study and what participation would involve.
Consent Form	<ul style="list-style-type: none"> • Very clear and easy to understand. • Suggested including a space for participants to initial that they have been made aware of where to find further support if required. 	I did not feel this amendment was necessary as participants would be provided with a debrief sheet outlining where further support could be obtained at the end of their interview. Moreover, participants' care co-ordinators would be aware of their participation within the study.
Interview Schedule	<ul style="list-style-type: none"> • Questions are simple, precise and to the point. • "I would be able to answer them after some consideration". • Suggested that participants might find it hard to put their experiences into words and recommended that I give participants time to think about their response before prompting. 	I held this suggestion in mind throughout each interview, and tried to provide enough time for participants to think about their answers.

Debrief Sheet	• “Easy to read” with a good selection of support options.	N/A
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4.8.4. Pilot interview

I did not conduct a pilot interview as I had already received service-user feedback regarding the interview schedule; however, I did check the quality of data obtained after the first interview and concluded that no further amendments were required.

4.8.5. Formal interviews

Once an individual expressed an interest in taking part in the study, a face-to-face meeting was arranged. Participants decided the location of this meeting (either at their home or the NHS building where they normally receive treatment). During this meeting, I ensured that all participants were fully aware of the aims, purpose and nature of the study through verbally reiterating the information outlined within the participant information sheet. Participants were also provided with the opportunity to ask any questions that they had about the research. Participants were subsequently asked whether they would still like to participate within the study. Following verbal informed consent, written informed consent was obtained using a Participant Consent form (see Appendix 6). Following informed consent the interviews were conducted. Demographic details were then collected from participants before starting the interview.

All interviews lasted between 40 and 63 minutes. I audio-recorded and later transcribed all seven interviews verbatim. All personal and identifying information was changed or removed from the transcriptions in order to maintain participant confidentiality.

4.9. Data analysis

The interview data was analysed using Smith and Osborn’s (2003) IPA approach. This method was chosen due to the reasons outlined within section 4.2.1. As suggested by Smith and Osborn (2003), transcripts were entered into a table with columns for ‘Exploratory Comments’ and ‘Emergent Themes’; however, I altered the

sequence of these columns due to my personal preference and to facilitate my analysis.

4.9.1. Individual case analysis

Each interview was analysed separately using the following procedure. Following the transcription process I listened to the interview again whilst reading the corresponding transcript in order to get a sense of the participant's emotions. I subsequently re-read the transcript a number of times in order to become more familiar with the content. Throughout this process I recorded any significant observations in the 'Exploratory Comments' column. This included summarising or paraphrasing sections of the interview; identifying similarities, differences and contradictions; making connections and preliminary interpretations. The next stage of analysis required a "higher level of abstraction" in order to identify 'Emerging Themes' based upon my exploratory comments (Smith & Osborn, 2003, p. 68). In line with the phenomenological underpinning of IPA I used the participant's own words and phrases as the emerging theme where possible, whilst ensuring that theoretical connections could be made within and across cases (Smith & Osborn, 2003). This process was repeated and refined until I had roughly 30 'Emergent Themes' for the interview (see appendix 9 for an audit trail). I subsequently listed all emergent themes in order of appearance and started to look for connections between them to form clusters of themes (see appendix 9). Each cluster was given a title, thus creating a superordinate theme (see appendix 9); these were crosschecked with the original transcript to verify that they still reflected the interview content. Finally, I created a table listing the superordinate themes, associated subordinate themes and supporting quotes from the text (see appendix 9). This process was repeated for every interview and care was taken to bracket the previous interviews so that new themes could emerge from each new transcript. This helped me to identify where participant experiences were both similar and different.

4.9.2. Cross case analysis

Once I had analysed each interview on an individual basis, I examined the theme tables for interrelationships and differences between cases. I consequently combined and reviewed the superordinate themes from each interview and created a master list of superordinate and subordinate themes for all participants (see appendix 10).

4.9.3. Write-up

The master list of themes provided the structure for the write-up of the findings. Verbatim extracts were included within the write-up in order to illustrate the theme being discussed. In line with Smith (2011), I endeavoured to include an extract from at least three participants for each theme to show a “density of evidence for each theme” (p. 17).

4.10. Data validity and quality

Adhering to validity criteria for qualitative research can improve the standard of the qualitative research being conducted, whilst also demonstrating that the findings “are as valuable as those from quantitative research” (Yardley, 2008, p. 238). As recommended by Smith et al. (2009) I used Yardley’s (2000, 2008) framework to assess the validity and quality of the study. Yardley (2008) proposes four core principles for evaluating the validity of qualitative research, these are: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance.

4.10.1. Sensitivity to context

I was sensitive to the context by being aware of existing literature regarding feeling fat. This is demonstrated within the thorough literature search conducted into AN and the experience of feeling fat. This not only provided me with an insight into the gaps within the existing literature base but also helped to shape my interview schedule. Furthermore, the findings of my research were considered within the context of the existing literature (see section 6). I was also aware of the theoretical literature surrounding the research topic by reading about the underpinnings of IPA.

The women who participated within the study were also given the choice of where they would like to be interviewed – either at the clinic where they receive therapy or within their home. This would have helped them to feel at ease with the location and may have made them feel able to “express themselves freely” (Yardley, 2008, p. 245).

The interview schedule was comprised of numerous open-ended questions, which enabled participants to dictate the direction and nature of the interview (see Section 3.8.1 for further details). Furthermore, a service-user was consulted to provide feedback on the information sheets and interview schedule prior to meeting with the first participant (see section 4.8.3).

I was sensitive to the data by being reflexive and ‘bracketing’ my assumptions (Smith et al., 2009) prior to and during the analysis process (see section 4.9.1). This was aided by discussions with my primary supervisor and my peer researchers. Consequently, I did not impose my beliefs and interpretation about the experience and meaning of feeling fat onto the data, which allowed me to be open to alternative viewpoints (Yardley, 2008).

4.10.2. Commitment and rigour

Commitment and rigour refers to the need of ensuring that the analysis “has sufficient breadth and/or depth to deliver additional insight into the topic researched” (Yardley, 2008, p. 248). The nature and structure required of IPA helped me to analyse the data to a detailed level and I obtained feedback regarding the analysis from fellow trainee psychologists and my supervisors. Moreover, an audit trail of my analysis has been included within appendix 9.

4.10.3. Coherence and transparency

According to Yardley (2008) “the coherence of a study means the extent to which it makes sense as a consistent whole” (p. 248). I was able to achieve this within the present study by attending training lectures and workshops related to the theoretical background of IPA and its analytic process. Furthermore, one of my supervisors was an expert in IPA and he provided guidance for the duration of this project.

Transparency of a study “refers to how well the reader can see exactly what was done, and why” (Yardley, 2008, p. 250). I have consequently been transparent in terms of the research process within this method section, and made sure that an audit trail is available within Appendix 9.

Moreover, being reflexive is an important feature of the transparency of a study (Yardley, 2008) and I therefore kept a reflective diary throughout the research process, within which I reflected upon my reactions to clients and their stories during their interview and whilst analysing the data. Personal reflections from my reflective diary were also included within the discussion of the study.

4.10.4. Impact and importance

The current research was conducted in order to fill a gap within the existing AN literature. Consequently, the study's findings have the potential to make a significant impact upon the literature base and the understanding of the experience and meaning of feeling fat for women with AN. This could potentially influence the interventions used to support women with an AN diagnosis (e.g. it could highlight where adaptations to therapeutic interventions could be beneficial).

5. RESULTS

The findings of an Interpretative Phenomenological Analysis (IPA) of the experience of feeling fat for women with a diagnosis of Anorexia Nervosa (AN) are presented within the following section.

5.1. Summary of themes

Four superordinate themes and eight subordinate themes emerged from my analysis of the seven interviews (see Table 5 for an overview). An exploration of these themes will provide the basis of the following section.

Table 5: Superordinate and corresponding subordinate themes

Superordinate Theme	Subordinate Theme
Negative sense of self	Negative hyperawareness of their bodies
	A perceived sense of inadequacy
	Fearing judgement
Feeling out of control	
Coping with feeling fat	Eating disorder behaviours
	Distraction
	Finding self-worth outside of weight and shape
The complex notion of 'feeling fat'	Difficulty in verbalising the experience
	Feeling misunderstood by others

Due to the double hermeneutic involved within the IPA process (see section 4.2) this account should be thought of as one possible construction of the experience of feeling fat for women with an AN diagnosis. However, rigour was ensured using Yardley's (2000, 2008) data quality principles outlined within section 4.10. Subsequently, the analysis will be supported through the use of verbatim extracts⁵ from participants' transcripts in order to demonstrate "sensitivity to context" (Yardley, 2000, 2008). This will ensure that participants' voices are heard, whilst also allowing readers to conduct their own credibility checks (Elliot et al., 1999). Each quote will be presented alongside my personal reflections in order to highlight my influence within the analysis process.

All seven participants within the study provided a detailed account of their experiences of feeling fat. Consequently, it is unfeasible to represent all aspects of these experiences within the current word limit and I therefore acknowledge that the themes do not encompass all facets of the participants' experiences. Instead, the themes were chosen due to their reoccurrence across participants' accounts (as recommended by Smith et al., 2009) and their relevance to the research questions. The similarities and differences between participant experiences are also discussed throughout the following section (see Appendix 10 – Table showing the recurrence of themes across participants).

⁵ To maintain confidentiality all participants have been given pseudonyms and any identifying information has been removed or changed. Quotes have been edited to enhance readability: repeated words, minor hesitations and utterances such as "um" have been removed. Square brackets '[']' contain additional material to aid the reader's understanding and [...] indicates where text has been deleted. Three dots at the start or end of a quote indicate that the person was talking prior or after the extract.

5.2. Superordinate theme: Negative sense of self

This superordinate theme aims to encapsulate how feeling fat was experienced in a context where participants were experiencing and viewing themselves very negatively. Indeed, the experience of feeling fat was intensified by participants' hyperawareness of their bodies. This experience became so overwhelming that many of the participants wanted to escape from within their own skin. This is evident within the subordinate theme '*hyperawareness of their bodies*'.

The experience of feeling fat and how participants evaluated themselves, both in terms of their weight and as people generally seemed to negatively influence each other in a reciprocal way. This is demonstrated within the subordinate theme of '*a perceived sense of inadequacy*'.

As a result of participants' feelings of fatness and negative sense of self, they frequently worried that others would evaluate them in the same way as they evaluated themselves. This is discussed within the subordinate theme '*fearing judgement*'.

5.2.1. Subordinate theme: Negative hyperawareness of their bodies

This subordinate theme related to the hyperawareness to internal and external physical sensations that all participants experienced. It is described as negative hyperawareness because the women found it to be a particularly distressing experience, which often led to rumination about their body, negative emotions and feeling fat. Indeed, feeling fat seemed to describe the women's experiences of being hyper-vigilant to feeling "uncomfortable" within their bodies:

I'll just feel wrong, just something doesn't feel right (Ava)

I've felt sometimes [moved shoulders in a wriggle with pained facial expression], like uncomfortable and [...] as someone who wants to get out from their body (Lisa)

I [pause] sort of feel it's like similar to anxiety and it feels almost like my skin is crawling, like I can't physically be in my body (Savannah)

This experience is so distressing for Lisa (who has a diagnosis of AN, binge-purging type) and Savannah (who has a diagnosis of AN, binge-purging type) that they want to escape from their bodies, thus giving the impression that they feel trapped by their physical self. Indeed, Savannah's description of feeling fat as "making my skin crawl" conjures up images of feeling very unpleasant or even frightened of the sensation. This could be linked to the anxiety of being trapped within her body.

Participants' hyperawareness of their bodies and the sense of anguish and being trapped were exacerbated before, during and after eating. This was particularly prominent for Rachel who has a diagnosis of AN, binge-purging type:

...it's particularly stressful and distressing when I eat something and [...] of course when anyone eats the food goes down and you get a slight sensation in your tummy and to me that is so hard. I really struggle with any type of eating any amount and [the] process between eating it and it going to my tummy. Even if it's just digesting in that moment it's a really painful procedure for me and I find I get very irritable and scratchy. I kind of get very impatient and I can't sit comfortably and I get irritable and moody and aggressive. I just want to sleep, I want to hide away because this mere sensation of me eating anything and it having a slight sensation in my tummy is horrible (Rachel).

Rachel's description of the sensation of fullness as being "slight" seems to belie the intensity of the distress she experiences at these times on account of wanting to "hide away from this mere sensation". Perhaps she is trying to accentuate just how distressing the sensation of fullness is for her by comparing her experiences to others. This account conjures up an image for me of someone eating a large jagged rock, which painfully moves down the oesophagus to rest uncomfortably within the stomach. I also wonder from whom she wants to hide away: her parents for fear of being aggressive towards them or herself for feeling or being horrible?

Sarah's attention was drawn to her body by the pain of her stomach being bloated:

...when I feel fat [it] is often because I'm bloated and my stomach obviously hurts, so I can see that my stomach is distended and then I can just feel it, feel really uncomfortable and then I feel fat consequently there (Sarah).

This quote suggests that feeling fat is the result of feeling bloated which draws her attention to her distended stomach and it is seeing this that makes her feel fat. Sarah (who has a diagnosis of AN, restricting type) develops her description further by discussing the role that her thoughts play in this process:

...all I thought was about that [feeling fat]. I'd just focus on that, it was like a cat pouncing on a mouse and I wouldn't let it go. It would just develop, it would escalate and I'd think negative things and stuff like that... (Sarah).

At first Sarah talks as if she was the cat overpowering the mouse, but perhaps also identifies as the trapped mouse as she struggles to overcome her thoughts about feeling fat thus causing the feelings to “escalate”. Identifying as the mouse also highlights the feelings of threat induced by feeling fat. It is an interesting metaphor for her to have used considering that cats prey on mice to eat yet she talks about food as threatening throughout her interview. Furthermore, the phrase ‘to play cat and mouse’ refers to keeping the subject “in a state of uncertain expectation, treating him alternately cruelly and kindly” (Cowie, 1990, p. 176) and could therefore be an accurate description for the battle between feeling out of control and feeling in control, which are explored further in sections 5.3 (superordinate theme: ‘feeling out of control’) and 5.4 (superordinate theme: ‘coping with feeling fat’).

For Rachel these intrusive thoughts about feeling fat dominated her thought processes and didn't allow her space for thoughts about anything else. This was more prevalent when she was on her own:

I'm so aware of my body structure, so I feel like [long pause] in a way I feel like I take up so much space especially in my head, my head feels very big and my thoughts and this area of my body [signalling to stomach and thigh area] so when I'm on my own and with my own thoughts [...] my whole being seems to not be expanding, I don't think I'm growing as I'm talking but I'm just very aware of my body (Rachel).

Although Rachel denies that her body feels as though it is “expanding” or “growing”, her repetition of this statement implies that ruminating upon her body structure influences her feelings of fatness. Her thoughts are so powerful that they make her feel fat, which in turn makes her body feel alien. Perhaps, for her, to feel thin is to be human?

...part of that is to do with the thoughts in my head and not being able to get out of the thoughts in my head but also just not feeling like I'm human (Rachel).

Participants also spoke about feeling fat when their attention was drawn to their body by external sensations. Sarah’s account summarises the distress felt by the majority of participants at wearing clothes that felt too tight. She also highlights the fact that this sensation does not remain localised at the site of the clothing but affects the whole body and sense of self:

I feel like I'm too big and ungainly and just like I'm splurging out my clothes and I feel it all over my body. I just feel really, really crap (Sarah).

This idea developed further by Mandi (who received a diagnosis of AN, restricting type), who feels too big for her boots:

Sounds really crazy and you'll laugh and I can laugh now – my boots were too small because I had different socks on and I said to my husband ‘oh my boots feel really small today’ [...] it didn't make me think about my toes being any fatter, I wasn't stupid enough to think that [...] All because I'd been for dinner and I'd had two weeks' notice of that meal (Mandi).

Mandi denies thinking that she had put on weight on her toes; this could be a way of positioning herself so as not to appear “crazy”.

The women described feeling fat when they looked at their bodies:

I just look at myself in the mirror in the morning and I don't look right and I just see fat for some reason (Ava).

I'm a shocker for baths and showers [...] anything like that that shows my nakedness. Sitting on the toilet even with the fat hanging over the side of the toilet seat. Sitting here now even with the fat on my legs. It's just shocking (Mandi).

These accounts give me the sense that Ava (who has a diagnosis of AN, restrictive type) and Mandi experience tunnel vision towards the aspects of their bodies that they find “repulsive” (Mandi). As a result the “fat” becomes central to their view of themselves and all other aspects of their self fade into their peripheral vision. It seems that Ava does not know why she “just sees fat” and her use of “for some reason” could be an attempt to justify an experience that I might judge her about. Mandi's use of the adjective “shocking” could be a description of the surprise that she feels when perceiving her body, perhaps it does not look how she envisaged; this experience is echoed by Ava “not look[ing] right”. Alternatively, “shocking” could imply that Mandi feels a sense of disgust when looking at her body as a result of this tunnel vision.

5.2.2. Subordinate theme: A perceived sense of inadequacy

This subordinate theme addresses how feeling fat was a statement used by participants in part to express a sense of inadequacy, as summed up by the following quote from Jody:

I'm not good enough, I'm not good enough, I feel fat, I feel fat (Jody).

Jody (who received a diagnosis of AN, restricting type) suggests that feeling fat means that she has let her standards slip and is therefore not achieving her perfectionist goals. This appears to be an accidental and gradual process ending with the sudden realisation that “you've become sloppy”:

I have got high expectations and you lose your standards you know, you kind of go from having very high standards to kind of feeling fat means your

standards slip and you've become sloppy, which equals jogging bottoms which equals greasy hair which equals you know general sloppiness (Jody).

Interestingly, Jody describes the experience of feeling fat as feeling "sloppy" which equals jogging bottoms and greasy hair both of which would perhaps be assumed by others not to be associated with the experience of fatness. Perhaps, she is conveying her worry that feeling fat is the start of a downward spiral, which will end with her being unkempt possibly due to feeling unworthy of caring for her appearance.

Savannah's account develops this idea further as she explains that feeling fat means she is inadequate in numerous aspects of herself:

It means a lot of really very negative things. It means I feel physically fat, and I feel too big, I feel like I take up more space than I should or that I deserve to, that I'm incompetent, I'm lazy and I don't have self-control or self-discipline, that I'm physically unattractive, that I'm a bad person, that I've failed, generally that I've failed [laughs] not even just in a weight wise, just as a person in my life generally (Savannah).

Savannah's perceived "incompetence" is not only related to her physical experience (e.g. "I feel too big") and appearance (e.g. "I'm physically unattractive") but also her behaviour ("I'm lazy and I don't have self-control...") and her sense of self (e.g. "I'm a bad person", "I've failed [...] as a person in my life generally"). From this quote it seems that Savannah judges her level of achievement solely upon how fat she feels physically, an interpretation that is supported later in her account:

I think the biggest impact it probably has is that I judge [feeling fat] as being one of the, if not the most important factors on judging myself. So sort of when I feel fat it overshadows any other things that would be more positive that I might judge myself on so [pause] whereas other people might do good things and judge themselves on being a good person or judge themselves on 15 or so different variables of how they are as a human being when I feel fat that overshadows everything else so even if there is some evidence that I've done something that might be good or that I might be a good person, that other people might value me outside of my weight it sort of gets drowned out

by the fact that I'm fat. I don't know if that makes sense? But certainly when I feel fat I judge myself very negatively (Savannah).

However, Savannah acknowledged that she does not clearly define what it would mean for her to be a "good person" and therefore she appears stuck in a cycle of perceived inadequacy:

I don't clearly define being a good person [pause] I don't know that I don't fit in with other people is a big part of how I view being a good person. If I don't do good things, if I don't behave in a good way, if I'm not kind enough to other people, that I haven't achieved enough [pause] I don't know and it is a problem because it's very vague in my mind because inherently I'm not a good person (Savannah).

I found it powerful to hear that Savannah views herself as "inherently" bad, a phrase which suggests that she views it impossible for her to become a good person because of feeling fat. Savannah's experience of feeling fat at times when she perceives herself as not behaving "in a good way" or "not being kind" was echoed by many of the other participants. Indeed, many of them referred to feeling fat as a form of punishment for a moral digression such as being "mean" or not adhering to their self-imposed rules. Feeling fat therefore appears to be a statement about their feelings of guilt for past behaviours:

...I've got it wrong and maybe I've eaten the wrong thing or too much, or drunk too much (Rachel).

I suppose whenever I've shouted at somebody or whenever I've been frustrated and you know, kind of said something that I shouldn't have said or I have done something mean, or if I've been mean or you know I said something out of turn or something like that, I suppose then that's why I feel fat because in a way it's a punishment I suppose. Being fat is like a punishment (Jody).

...the feeling fat will obviously link back to me eating something or doing something and then to punish myself by feeling fat I'd just think even more negative thoughts (Sarah).

Jody does not refer to a perpetrator of this punishment, which gives me the impression that she feels punished by an external entity; conversely, Sarah states that she punishes herself or "beats [herself] up" for her behaviours with her negative thoughts. These feelings of inadequacy and guilt left many of the participants feeling undeserving and unworthy of nice things or enjoyment:

...[feeling fat] sort of prevents me from doing things that I want to do because I feel like I don't deserve to do them (Savannah).

...I don't ever treat myself to anything nice as in clothes, I always buy second hand. I would give my last penny to the man on the street [...] I will spend any amount of money that I've got making someone else look nice, feel nice. I will say nice things to other people about how they look (Mandi).

Like food isn't a necessity it's a, it's a reward, it's a privilege, it's something that has to be earned (Jody).

Mandi and Jody make frequent references to money and feeling unworthy, which could imply that they perceive themselves as individuals lacking in value, especially in comparison to other people who "earned" their value by being thin. Indeed, this perceived lack of self-worth appeared to be maintained by participants' tendency to negatively compare themselves to others:

I never look at someone and think they're fat. I think everybody else looks perfect (Ava).

[I feel fat] having been out seeing skinny people, having seen a picture in a book, having seen a magazine, having seen someone on tele. Having seen my husband watching strictly come dancing on the tele. You can see I can roll it off, I feel threatened by every other woman that I see because I think that they're better than me (Mandi).

Mandi's declaration that she feels "threatened by every other women" provides an indication of the fragility of her sense of worth and adequacy; especially given the high number of scenarios that she lists in which she feels inadequate. Furthermore, her reference to seeing her husband watching professional dancers on TV highlights her fear of being judged or rejected if others viewed her as inferior as she perceives herself; this will be discussed further in section 5.2.3. In line with this, Jody stated that feeling fat means that she is "average [...as] nothing separates [her] from anybody else" meaning that "there is nothing special about [her]". This implies that for Jody feeling skinny provided her with a sense of achievement and improved her self-worth.

Participants' experience of feeling inadequate when they feel fat was also exacerbated by their tendency to compare themselves to their previous "anorexic self":

...when I was really, really skinny I don't remember having this kind of stomach (Jody).

It's disappointing to feel that way. It saddens me that I don't look good enough. Like I don't look like I used to look when I was very anorexic. It feels like I'm letting myself down because I'm feeling like this. Just feeling fat is such a disgusting attitude to have about yourself (Mandi).

...if I got an outfit that I know I wore ages ago and it didn't fit that would [make me feel fat] (Ava).

Sometimes I feel myself fat and I don't want to go and buy new clothes because I'm like should I buy a size bigger now (Lisa).

These extracts suggest that the female participants with an AN diagnosis who feel fat, preferred and perhaps idolise their previous self, who was in some cases more underweight than their current self or in others just perceived to be thinner. This comparison to their previous self emphasizes why recovery can be difficult for individuals with an AN diagnosis.

Given the previous descriptions regarding the impact of feeling fat, it is perhaps unsurprising that feeling fat negatively effects participants' confidence levels, as summed up by Lisa:

...I hate myself, I don't like myself...you're not good enough, you have to be improved.

...if I feel fat I probably will have like less confidence in myself so if I go out then I won't be striding along happily, it will probably be more scuttling and things like that. I won't feel very confident in myself and will consequently have lower self-esteem.

In the first account, Lisa starts talking about hating herself in the first person but ends by talking from the second person standpoint. This could just be a more powerful perspective from which to chastise herself or alternatively it could be construed that she is judging herself from the perspective of others. Indeed, in the second quote it seems that Lisa wants to walk quickly to potentially hide from other people she encounters perhaps due to fear of being judged as outlined by the next subordinate theme, 'fearing judgement.

Although for Mandi feeling fat meant that she was inadequate to the extent that she perceived herself as "disgusting", she also identified positive aspects of herself:

You just feel physically like you're just nothing, I say that and emphasise physically because personality wise I know that I'm a good person (Mandi).

These accounts suggest that feeling fat plays a crucial role in how these women judge their self-worth; for them, feeling thin equates to being good or special and feeling fat means they are inadequate. The accounts also hint at how feeling fat and a lack of self-worth can affect each other and maintain eating disorder behaviours.

5.2.3. Subordinate theme: Fearing judgement

Participants within the current study seemed to equate feeling fat as evidence that they were overweight. This subordinate theme aims to capture participants' subsequent fear of being judged negatively by others due to their perceived fatness.

As such, the participants appeared to project their own self-judgements and subsequent rejection of self onto others. This was most apparent throughout Mandi's account as she used the same adjectives to describe her experience of feeling fat and for how she believed other people viewed her:

I think they're looking at me, how fat I am and are judging my appearance, how wobbly I am, how much cellulite I've got, how un-toned I am, how yuck I look [...] I know they don't know me but it matters to me what people think [pause] and that's another big problem. That's why I emailed you so when I walked through the door you weren't going to see an emaciated skeleton, you'd be aware of the fact that I look normal, in my eyes anyway (Mandi).

I'm a pleaser [...] I'm too keen to please other people, for other people to like me and to accept me. Which is why I suppose all this appearance thing comes in. I want to look a certain size so people think I'm part of normal everyday life, but that's a bit extreme because not everybody is slim (Mandi).

For Mandi, this concern was related to both strangers and potentially to professionals, as she was concerned about how I would view her. It is also evident that feeling fat prompted Mandi to try and present a more socially acceptable self in order to please others. However, she contradicts herself in the two accounts presented above as in the first she implies that looking normal is a bad thing and in the second she explains that she wants to look part of "normal everyday life".

Rachel also held the belief that only slim people are accepted within society and Jody expressed concern that other people would literally move away from her because of her physical appearance:

...when you say fat I want to challenge [pause] what ideas society, when someone says fat what society thinks about fat. I want to distance myself from that word (Rachel).

[Feeling fat] negatively impacts on the way I see myself because I suppose I see myself as ugly, as being like not worthy, you know no one will find me attractive, no one will like me, people will distance themselves from me. If I

was standing in a queue people would kind of move away from me or move to the other side of the street (Jody).

Moreover, being in a public place increased Savannah's levels of anxiety, hyperawareness of her body and subsequently made her aware of her feelings of fatness. Consequently, it seems that feeling fat and the fear of judgement are part of a vicious cycle of anxiety and hyperawareness of her body as illustrated in the following excerpts:

I have a lot of problems with sort of social anxiety and when I get anxious I become sort of hyper-aware of things, especially physically how I look, what I'm physically doing with myself so I think that just makes me more aware of it [feeling fat] (Savannah).

...that people will judge me negatively, that people won't like me [...] [the fact] that other people might value me outside of my weight sort of gets drowned out by the fact that I'm fat (Savannah).

Sarah made very few explicit references to a having a fear of being judged; however, on one occasion she alluded to feeling judged and rejected by a man to whom she had been attracted and this was one of the catalysts to the first time she felt fat:

...it sounds really stupid but there was a guy who was really hot and [laughs] nothing really happened and I think I blamed it on my weight for some reason even though I had never even spoken to him (Sarah).

I wonder what made her blame this perceived judgement and rejection on her weight considering she had not spoken to him; perhaps it was easier than blaming it on another aspect of herself as weight can be addressed through dieting. Alternatively, perhaps it was because she was already dissatisfied with the way she looked and felt and this experience made her more aware of it. Furthermore, her clarification at the start of this explanation that "it sounds really stupid" could be evidence of a desire to show me that she is able to think rationally and therefore demonstrates a fear that I am judging her. Throughout the majority of her subsequent interview, Sarah discusses how she has managed to overcome the feeling fat and appeared to have

developed a more positive sense of self (see section 5.4.3) and potentially this reduces the tendency to transpose her own negative perceptions onto others.

5.3. Superordinate theme: Feeling out of control

This superordinate theme describes how all seven participants used the term feeling fat to describe experiences in which they felt out of control. This included times when they felt out of control through factors such as puberty, their bodies not responding to strategies to lose weight, negative emotions, being ‘attacked by fat cells’ and feeling ‘possessed by the devil’ and aspects of treatment.

Many of the participants described circumstances in which their bodies’ felt out of control. Indeed, Rachel first experienced feelings of fatness as her body started to change during puberty:

...it was around this time that I started developing and I really remember feeling uncomfortable in my body, just feeling like it [was] a bit alien (Rachel).

...but also my breasts developing [pause] and I think that I perhaps had one period around that time... (Rachel).

Rachel’s recollection of this time implies that these bodily changes were unwanted and confusing. Ava also described feeling powerless and as a result felt fat when she was unable to lose weight:

...I feel like I have lost control, say I’m doing exercise or I am standing on the scales and for some reason the weight is not going down. I’ve stopped eating, standing on the scales and it’s still not going down (Ava).

Ava’s use of “for some reason” suggests that she feels confused about why she is unable to lose weight even though she has “done everything right”. These accounts from both Ava and Rachel suggest that they feel as though their bodies are doing their own thing, which leaves them both feeling helpless. This is further supported by Ava’s visualisation of being attacked by fat, which is so vivid that it makes her feelings of fatness seem fatal:

I feel like I'm being attacked by fat cells, I don't know why I feel that way but say I ate a little bit more than what I normally eat or say I ate something that is out of my comfort zone, I will start feeling fat attacking me, I can feel it crawling on my body and sort of getting a hold of me, and it is very, very scary [...] this thing's going to take over me and it's going to kill me (Ava).

Ava's description of "being attacked by fat cells" implies that she feels as though her body is attacking her from within. Although she states that she is unsure why she feels this, she goes on to explain that it occurs when she has eaten something out of her comfort zone. This gives me the impression of a battlefield where she can be within the safety of her "comfort zone" but if she ventures over the parapet she will be attacked. Consequently, it seems that Ava views her body as a separate entity over which she has limited or no control during the times that she feels fat. I also wonder whether this feeling out of control of her body was impacted upon by the feelings of anxiety, worry and fear that are evident throughout Ava's account.

Savannah also described feeling out of control when she experiences negative emotions:

I'm not very good at being aware of my emotions or describing my emotions or probably responding to negative emotions and I think sometimes complicated difficult emotions get condensed in my mind into 'I feel fat' (Savannah).

It is perhaps unsurprising that Savannah experiences her body as being out of her control due to her lack of emotional awareness or ability to respond to negative emotions. Indeed, the physiological changes associated with emotions would feel incredibly threatening if you were unsure of their cause. Furthermore, Savannah's reflection about condensing complicated difficult emotions into feeling fat suggests that she finds these emotions unbearable. As a result she attempts to control these emotional experiences by transposing them onto her body.

Many of the participants personified their experience of feeling fat as a devil or demon:

...it's my devil above my shoulder that says the things to [me] (Lisa).

...you kind of realise that you are actually a person, you're not having your life ruled by a demon [... which] made me do silly things, really crazy things which shouldn't happen (Sarah).

...it makes you something that you're not [...] some people might say it feels like you're a devil possessed (Mandi).

These descriptions make me think of marionettes, the jointed puppets that are hung from and controlled by strings, as these women imply that the devil that possesses them is their puppet master who makes them behave in certain ways. Interestingly, Lisa describes the devil as “*my devil*” as if it is something that she possesses and could even be fond of; however, this is contradicted by her explanation that feeling fat felt like being “bullied” at other points within her account. Sarah who had devised positive coping strategies for feeling fat at the time of her interview (see section 5.4.3) describes having an epiphany at realising that she is actually a person, perhaps instead of being someone who is possessed. Furthermore, externalising feeling fat as a demon also enabled Sarah to separate the “crazy” behaviour from herself, thus protecting her sense of identity. Finally, it seems that Mandi feels possessed by an external force but her statement “you’re a devil possessed” infers that she also identifies as the devil and reinforces the superordinate theme of ‘negative sense of self’ (see section 5.2).

Another trigger for feeling out of control was caused by stressful life events or perceiving life as being out of control:

...this [AN behaviour] is probably the only part of my life that I've got control in [pause] yeah that's true, it's spot on actually (Mandi).

...sort of complicated life situations get condensed down into ‘I feel fat’ and there's a practical response that you can do to counteract that (Savannah).

These extracts demonstrate how participants used the AN behaviours to regain a sense of control when life seemed uncontrollable. This experience was also exacerbated by aspects of their treatment, it particularly prominent for Jody who explained that she had been “completely oblivious” to feeling fat prior to receiving her diagnosis:

...I think the only time when I've actually [felt fat...] and it has beaten me up has been quite recently, probably only in the past kind of two years [...] so it's since I have had the diagnosis really that I have kind of felt fat (Jody).

...because [pause] I didn't decide that I wanted to get help because I didn't recognise I had a problem. Everything was basically thrown at me and I didn't have control of it (Jody).

These extracts suggest that feeling fat became more prominent for Jody when she was no longer in sole control of her behaviours and began to receive help through treatment. Indeed, Jody experiences both the treatment and feeling fat as an attack and she subsequently feels “beaten up” and as though things are being “thrown at [her]”. This is perhaps unsurprising if it is interpreted within the context of Jody's identity being intertwined with feeling slim (see section 5.2), as treatment is designed to overcome the eating disorder behaviours that maintains her ideal sense of self and stops her feelings of fatness (see section 5.3.1).

Different aspects of treatment triggered this sense of feeling out of control and loss of personal agency for each participant. It seems that the trigger for this loss depended upon the significance of the behaviour to individuals. For Ava this was related to being made to eat, whereas Rachel found having to remain seated after a meal particularly anxiety provoking and not being able to exercise was most stressful for Mandi:

It [feeling fat] was sort of happening quite frequently because [...] my dietician and [...] therapist [...] were trying to increase my calorific intake so I kept trying all these various foods and that kind of started feeling like it was making me fat (Ava).

...having to sit and stay with food inside me, so having to retain food after a meal or a snack and having to sit, or lie after eating (Rachel).

I have not been able to exercise properly and that has really affected my mental health, especially now this questioning you're doing about research feeling fat, you've got me at a really good time because it's absolutely 200% paramount currently (Mandi).

This reinforces how important it is for practitioners to enquire about the experience of feeling fat for their clients, especially in light of their therapeutic intervention as a potential trigger for clients to feel out of control.

5.4. Superordinate theme: Coping with feeling fat

All of the women developed strategies to cope with their feelings of fatness; indeed they all discussed using the maladaptive coping of eating disorder behaviours (as they all had a diagnosis of AN and felt fat) (subordinate theme *'Eating disorder behaviours'*). However, a number of participants described using more positive coping strategies of *'Distraction'* as well as *'Finding self-worth outside of weight'*.

5.4.1. Subordinate theme: Eating disorder behaviours

Participants overcame feeling fat through eating disorder behaviours such as starvation and exercise:

I feel like I need to fight it with exercise, but it's like a war, it feels like I'm waging, I'm waging a war with fatness (Ava).

This account highlights how powerful and traumatic the experience of feeling fat is for Ava. It conjures up images of an urgent and violent "matter of life and death" battle to protect herself from feelings of fatness. Furthermore, it highlights the struggle to maintain the power and control in a 'tug of war' that Ava discusses throughout her interview. Ava could also be suggesting that the experience of feeling fat makes her feel like she has "been through the wars". The comparison of feeling fat to a battle was evident within Sarah's account:

I'd combat [feeling fat] by starving myself [...] and the only goal I seemed to have was to not eat and be thin and so when I looked in the mirror I was [...] triumphant [...] because I'd think oh yeah look at all you've achieved (Sarah).

It seems therefore that Sarah was fighting to improve her sense of self through starvation and reaching her ideal thin body. The "triumph" she experienced at 'winning' the battle served as a motivating factor for her to continue with this maladaptive coping strategy. Indeed as seen from the quote below, starving herself could be interpreted as providing Sarah with a 'guiding light' away from feeling fat and perhaps made her feel light in weight; however, this is an arduous and unrewarding process:

...[feeling fat] made life [...] black and white almost [...] now I can see colour but back then it was literally like the darkness of the negative thoughts and then the white, the light of [pause] not eating [pause] and the feeling fat would stem from the black and lead me towards the white and then I'd just fall back. It was like climbing ladders and falling off all the time (Sarah).

This unrewarding battle between feeling fat and eating disorder behaviours was experienced by many of the participants who found that the feelings of fatness remained even when they had lost weight. Savannah's description captures the despair and confusion felt by many of the participants about how they never felt good enough as a result of this 'readjustment':

...I've lost weight, my brain sort of registers that but then I feel like the standards of measuring it sort of just readjust like I didn't feel dramatically less fat at a very low weight compared to when I was significantly overweight so I feel like as my weight has changed over time there have been some times where I've felt less fat [pause] but certainly on a physical aspect it sort of just readjusts to whatever the current situation is really (Savannah).

Consequently, this implies that feeling fat is not just related to physical weight, but is dependent upon a range of variables. In light of this readjustment of the standards measuring feeling fat, it is unsurprising that participants often reported that feeling fat made them despondent and miserable:

Laura: How does feeling fat affect your everyday life [Mandi]?

Mandi: [pause] How doesn't it is more the answer. How does it affect... [sigh and pause] how do you describe that feeling? Miserable existence, although I'm not a miserable person generally. It creates a miserable mindset if you allow it to, if you don't wear a mask. It's just, it's a burden, nuisance isn't quite strong enough, burden is better. It's grievance, it's aggro.

Although I asked how feeling fat affected her life, Mandi rephrased the question and described “that feeling” as a miserable existence. This emphasises the overwhelming distress and impact that feeling fat has on her - feeling fat is not just miserable, it is a “miserable existence”.

5.4.2. Subordinate theme: Distraction

Savannah and Mandi both spoke about reducing their feelings of fatness through distraction from their self-focus:

...but in a more constructive way with trying to distract myself with different things like [pause] being busy and keeping myself occupied with other things that are not related to physical appearance or feeling fat or food (Savannah).

When I'm working I'm focused on the people that I support, it doesn't mean it's not there it's just in a little box behind my right earlobe, not at the front you know [chuckle] [...] it's always there [pause] it's how much you allow yourself to be aware of it (Mandi).

Distraction by focusing on external tasks reduces the experience of feeling fat for both women thus providing support for the subordinate theme of ‘negative hyperawareness of their bodies’ and the impact of self-focus upon the experience. Indeed, Ava also spoke about how focusing upon her job had previously helped to reduce her feelings of fatness; however, unfortunately at the time of her interview she had been forced to stop working due to her low weight, thus indicating how fleeting this coping strategy can be:

[When I was working] I didn't feel the fat crawling up me, I didn't feel any of that, as long as the next day I was able to be up, at work early and perform (Ava).

I think about it that's the one time that I actually did not care about if I put on weight. I actually felt I needed the extra sort of body weight and everything to cope with the kind of job that I was doing (Ava).

In fact, many of the participants reported a reduction in their experience of feeling fat when they were focusing upon their jobs and interestingly the majority of their careers involved caring for others.

5.4.3. Subordinate theme: Finding self-worth outside of weight and shape

Combating feeling fat was an all-consuming drive for the participants interviewed. Whereas Jody, Ava, Mandi and Rachel primarily used eating disorder behaviours to overcome this experience, Lisa, Sarah and Savannah had developed a more positive coping strategy of changing how they evaluate their self-worth.

Although Savannah described feeling fat as “the most important factors [for] judging [herself]” (see section 5.2.2), she later explained that over time and through therapy she has learnt to expand the criteria on which she evaluates herself:

A lot of the work I have been doing in therapy recently is to look at evaluating myself in a different way rather than just on that one aspect of my weight and my physical appearance. To look for evidence of times when I'm a good person or when I've been productive or just to sort of broaden my interpretation of how I evaluate myself and to focus on other things that balance out feeling fat because the train of thought in my mind would very much 'I'm fat, I'm a bad person, I'm useless' so the feeling fat is a hard one to change but to change the other things that I directly associate with that, that sort of has a domino effect on them. I've done all these other things that are good or there are all these other aspects of me that are good aspects. It sort of drowns out the noise of sort of feeling fat in my head [pause] if that makes any sense? (Savannah).

This account suggests that changing her self-focus and focus of her self-evaluation improves her self-worth and perhaps increases her feelings of happiness. Indeed, as Savannah talked about this change in her focus during her interview I was struck by the improvement in her demeanour as highlighted in the following extract from my reflective diary:

There was a definite change in [Savannah] as she started talking about the positive aspects of herself. It was almost as if a weight was lifted from her shoulders, even her tone of voice seemed lighter/brighter (Laura).

In hindsight, my use of the word “lighter” to describe Savannah’s disposition is interesting; is it possible that feeling fat makes her feel oppressed and heavier in character?

Sarah described feeling fat as like “being in a bubble” that made her forget who she was; however, focusing upon “the bigger picture i.e. exams, uni, life [...made her] realise how insignificant [feeling fat] is”. In turn this helped Sarah to focus upon her life goals rather than feeling fat, a coping strategy that Lisa also strives to use:

I can see the outside [of the bubble]; I can see the surroundings, like why I am alive. It’s like well you have a life plan, you may as well follow it rather than being stuck at this one point (Sarah).

I know what my goal is – to be happy and healthy and successful and when I see the numbers going up on the scale, sometimes I’m not happy but I know that’s what I need for my goal (Lisa).

I start to write all the positive things up what happened me, and then I realise what is important is not what I see, it’s what I do and I can be improved if I am doing it, if I’m not doing it I can’t be improved (Lisa).

Sarah’s excerpt suggests that prior to focusing on her life plan, feeling fat made her feel stuck and as though life was miserable and pointless and therefore couldn’t think about the future. Lisa’s quote indicates that learning to focus upon her goals has not been straightforward as she implies that she still struggles with feelings of fatness at times.

5.5. Superordinate theme: The complex notion of feeling fat

This final superordinate theme attempts to illustrate how all seven of the women with an AN diagnosis and who experience feeling fat found it difficult to make sense of feeling fat to differing degrees. The two subthemes explore how participants had

'Difficulty in verbalising the experience' and were left with a sense of *'Feeling misunderstood by others'*.

5.5.1. Subordinate theme: Difficulty in verbalising the experience

Six out of the seven participants (women with a diagnosis of AN who felt fat) either commented on finding it difficult to find the words to describe their experience of feeling fat or it was demonstrated by their hesitation and difficulty in answering questions:

It's really difficult because it's hard to put into words [...] to feel fat is just something I have never really thought about, I suppose in a way I say it like I say it every day, every time I eat I say 'I think I'm going to get fat, I feel fat, I'm going to get fat' but I have never actually thought about it (Jody).

...when you're having it [feeling fat] you're not thinking about it, you just have it (Rachel).

Consequently, it seems that the experience was difficult for Jody and Rachel to verbalise because it is an automatic and unconsidered response, perhaps in Jody's case to express her anxiety about becoming fat. Whereas, Mandi found it difficult to think about feeling fat because it seems as though it is not just an experience for her but defines her sense of self:

...It's just [pause] it's difficult to put into words 'cause to think about it also, isn't painful but it's like hey ho, this is me really (Mandi).

I wonder if this is the reason that Rachel struggles to be honest about her experience or alternatively perhaps she does not want to be honest and therefore look unfavourable in my eyes. Rachel and Mandi also both explain that it is hard to find the words that accurately describe their experiences and perhaps this is because they tend to avoid thinking about it:

...it's really hard to be honest about it and talk about it in a way that makes sense to me (Rachel).

...I don't know what words to use that are powerful enough to express it without blaspheming, which I wouldn't do on a recording (Mandi).

Alternatively, Savannah explained that feeling fat was hard for her to “pin down”:

...it is something for me that is quite vague that I tend to [pause] it kind of bleeds into a lot of other things [...] I think I sort of attach it to a lot of different things [long pause] so it's difficult to pin down exactly what it is...

Her use of the qualifier “I think” and the pauses within this quote suggest that she is uncertain about what she “attaches” to feeling fat. It appears that feeling fat is a catch-all phrase for her negative experiences.

5.5.2. Subordinate theme: Feeling misunderstood by others

Mandi, Lisa and Savannah expressed a sense that other people did not understand what it was like to feel fat:

I thought nobody else knows what I'm saying; even if I said to my dad he doesn't understand (Lisa).

...have you got any idea with it's like to be like this every day, 24/7? Have you got any idea?” That's just what I want to say to them. Take a walk in my shoes, step into my world because they've got no idea (Mandi).

Lisa's account suggests that a variety of people, including family members who she is close to, fail to understand her experience of feeling fat. Mandi's words, such as “everyday”, “walk in my shoes” and “step into my world” highlight the all-consuming nature of feeling fat and how it overwhelms her whole life and world. For such a significant life experience to be continuously misunderstood by others would lead to intense feelings of loneliness and isolation, which would perhaps feed back into the feelings of judgement described in section 5.2.3. Furthermore, this is the second time that Mandi has spoken about her footwear; perhaps she is suggesting that walking in her shoes would give others an understanding of how it feels to be “too big for her boots”.

During her interview, Savannah frequently sought reassurance that I had understood what she was saying (e.g. "...if that makes any sense? [giggles] I don't know?"). She also paints a picture of being upset about feeling fat and being dismissed by others who do not comprehend her experience:

I suppose just from general life experience or from a therapy point of view I found it really unhelpful in the past when I've been quite upset or tried to speak to somebody about feeling fat and the response is just "yeah but you're not fat" or being dismissive (Savannah).

It is possible that being dismissed in this way has reduced the amount of reflection that Savannah has done about the experience, which could be the reason why the experience is too difficult to verbalise. This highlights the importance of professionals understanding the experience of feeling fat so as to make their clients feel understood and help them to verbalise their experiences.

6. DISCUSSION

This study aimed to obtain an in-depth understanding of the experience of feeling fat for women with a diagnosis of Anorexia Nervosa (AN). Semi-structured interviews were conducted and a rich descriptive and interpretative account of feeling fat was obtained using Interpretative Phenomenological Analysis (IPA) (Smith & Osborn, 2008; Smith, Flowers & Larkin, 2009). This study helped to fill the gap within the existing literature base as to date few studies have explored the experience of feeling fat. Moreover, the studies that have been conducted have predominantly used quantitative methodologies and participants from non-clinical populations. The main research question was:

What is the experience of feeling fat for adult females with a
diagnosis of Anorexia Nervosa?

In line with this research question, the following areas were also explored:

- What is the experience of feeling fat for women with an AN diagnosis?
- What does feeling fat mean to women with an AN diagnosis?
- What are the consequences of feeling fat for women with an AN diagnosis?

Throughout the following chapter, the study's findings will be discussed within the context of these research aims, existing literature and psychological theory. Discussions within IPA research are viewed as a dialogue between the research findings and the existing literature (Smith et al., 2009). IPA is designed to take researchers into "new and unanticipated territory" and therefore new research material not previously discussed within the introduction will be introduced throughout this section where necessary (Smith et al., 2009, p. 113). This will help to place the findings within the wider context thereby enhancing the understanding of the findings (Smith et al., 2009). In this discussion a critique of the research methodology will be provided, and the implications of these findings to clinical practice will be examined and recommendations for the direction of future research will be made. Finally, a conclusion is drawn and reflections about the study are presented.

6.1. Responding to research questions

Throughout the next section, I will conceptualise the findings within the context of existing literature and psychological theories. This will be broken down into the following sections:

- The experience of feeling fat for women with an AN diagnosis;
- The meaning of feeling fat for women with an AN diagnosis;
- Consequences of feeling fat for with women an AN diagnosis.

6.1.1. The experience of feeling fat for women with an AN diagnosis

This section addresses the first research question regarding the experience of feeling fat for adult women with an AN diagnosis. Overall, feeling fat was a significant experience for all of the women who participated within the study and three prominent themes regarding this experience emerged from the data: “Negative bodily hyperawareness”, “Feeling out of control” and “The complex notion of feeling fat”.

6.1.1.1. *Negative bodily hyperawareness*: The experience of feeling fat was characterised by participants’ ‘negative hyperawareness of their bodies’ (section 5.2.1). Given that an “intense fear of gaining weight or becoming fat” is one of the diagnostic criteria for AN within the DSM-V (APA, 2013), it is understandable that individuals with this diagnosis would monitor their bodies for fatness. However, it seems this monitoring exacerbated participants’ bodily experiences so that they felt “wrong” (Ava) and “uncomfortable” (Lisa) to such an extent that they want to escape from their physical self during these times (section 5.2.1). This could be the result of an information processing bias similar to that described in the Cognitive Models of Panic Disorder (Clark, 1997). Indeed, Fairburn et al. (1998) hypothesised that individuals selectively attend to information that is congruent to their concerns (i.e. feelings of fatness) and this frequent body checking magnifies the imperfections perceived by the individual. As such, the physical hyperawareness described by participants within the current study could amplify their normal bodily sensations, which they consequently interpret as evidence of being fat (Fairburn et al., 1998). This could develop into a vicious cycle where hyper-vigilant checking increases

arousal, anxiety and self-focused attention, which in turn will exacerbate the perceived need to continually monitor their body for change and perceived fatness (Fairburn et al., 1998). This theory is supported by Rachel's experience of her body expanding at the times when she thinks about her body and feelings of fatness; moreover, Sarah explained that her feelings of fatness escalated when she ruminated about them (section 5.2.1). Alternatively, the selective attention displayed by Mandi and Ava through their tunnel vision could be an information processing bias resulting from holding body weight and shape self-schemata (Markus, 1977).

According to Fairburn et al. (1998) this selective attention is exacerbated at times of increased arousal, which would explain why participants within the current study often spoke about feeling fatter around mealtimes, when seeing their body or if their clothes felt too tight. Furthermore, individuals' with an AN diagnosis often struggle to identify and label or inhibit their emotions (Bydlowski et al., 2005; Simlett, 2004; Forbush & Watson, 2006) and it is therefore possible that the participants within this study attributed the physiological changes associated with emotions to feelings of fatness. Indeed, Savannah explained that she is "not very good at being aware of emotions [...and] complicated difficult emotions get condensed in my mind into 'I feel fat'" (section 5.3.1). This finding therefore provides further support for Simlett's (2004) findings and Forbush and Watson's (2006) proposal that women with eating disorders "blend 'real affect' with 'body affect'" (p. 119) as well as for the Body Displacement Hypothesis (Bruch, 1978; McFarlane et al., 2011) and in partial support for Friedman's (1993) proposal that women silence themselves by directing emotions inwards. No other participants within the current study spoke about the relationship between their emotions and feeling fat, perhaps because individuals are often unaware of displacing emotions onto their bodies (Bruch, 1978).

For most participants, the experience feeling fat was exacerbated by hyperawareness of their bodies at times when they were on their own. Conversely, Savannah described feeling more aware of her body during social situations (section 5.2.3). This could be explained by the Objectification Theory (Fredrickson & Roberts, 1997), which posits that women view themselves as objects "whose value is based on physical appearance". This occurs through the process of 'self objectification' during which individuals monitor their body and this results in self-consciousness,

body shame and social anxiety (Fredrickson & Roberts, 1997). Indeed, women with eating disorders demonstrate higher levels of social anxiety and fear of negative evaluation in social situations than women without an ED diagnosis (Swinbourne et al., 2012). In accordance with this participants within the current study frequently spoke about their fear at being judged and rejected on account of their appearance (this will be discussed further in section 6.1.3.1. below).

6.1.1.2. *Feeling out of control*: Although control is often related to eating disorders none of the literature investigating feeling fat outlined within the introduction considered the role of control (apart from the control related to food restriction). Yet a significant finding of the current study was that feeling fat was characterised by the experience of 'feeling out of control' (see superordinate theme 5.3). Some of these triggers of feeling out of control (e.g. puberty, body not responding to weight loss strategies, negative emotions etc.) develop the aforementioned theme of 'negative bodily hyperawareness'. In line with Espeset et al.'s (2012) findings, participants' accounts implied that losing control felt very threatening ("I feel like I'm being attacked by fat cells"; Ava) and increased their feelings of fatness, which consequently encouraged the use of ED behaviours (see section 6.1.3.2). This is congruent to Slade's (1982) proposal that a reduction in control amplifies body image distortions and subsequently increases an individual's motivation to engage in ED behaviours (Slade, 1982). According to this model, if these ED behaviours are not maintained then individuals will experience a feeling of terror (and in line with Espeset et al. (2012) I hypothesise feelings of fatness), that reinforces the continued use of restriction, binge-purging and/or exercising (Slade, 1982). This creates a vicious cycle that maintains ED behaviours and can therefore account for why people diagnosed with AN are difficult to treat (Slade, 1982; Fairburn, 1998). Indeed, many of the participants within the current study explained that aspects of treatment reduced their sense of control and therefore increased their feelings of fatness.

Participants within the current study appear to derive their self-worth from feeling in control and thin; consequently, Savannah, Mandi and Jody indicated that feeling fat meant that they were unworthy (see section 6.2.2). This is in accordance with findings that there is a correlation between feeling fat and negative self-beliefs and low self-esteem (Eldredge et al., 1990; Simlett, 2004; Cooper et al., 2007).

Developing Slade's (1982) model further, Fairburn et al. (1998) posit that over time control over eating becomes a symbol for self-control in general as well as a symbol for self-worth (Fairburn et al., 1998). The increase in self-worth associated with a sense of control makes dieting highly rewarding and therefore difficult to change. Indeed, over time individuals have been found to define themselves by the AN (Garner et al., 1997).

Rachel described feeling particularly fat and distressed during and after a meal because of the "slight sensation" of food in her tummy. According to Fairburn et al.'s (1998) model, this distress is the result of viewing eating as failing to be controlled. Furthermore, the reduction of interests evident throughout participant accounts could increase their inclination to derive control and self-worth from dieting (Fairburn et al., 1998). This supports Fairburn et al.'s (1998) theory that "aspects of starvation encourage further dietary restriction" (p. 5) and can undermine an individual's perceived sense of control.

The sense of feeling out of control of their bodies could be entwined with the negative bodily hyperawareness discussed in sections 5.2.1 and 6.1.1.1. This is because individuals with an AN diagnosis monitor their weight closely as weight loss is used to measure self-control and self-worth. Consequently, the repeated checking and feelings of fatness associated with bodily hypervigilance can make the individual believe that they are failing to control their weight and shape (Fairburn et al., 1998). Fairburn et al. (1998) propose that this mechanism of people judging their self-worth in terms of their shape and weight is culturally specific to Western societies where thinness is celebrated and fatness avoided.

Feeling fat for the participants within the current study consequently appears to encompass the three different types of body dissatisfaction proposed by Mountford (2010); for instance, Mandi and Ava had distorted views of their bodies by only seeing "fat" when looking in the mirror; moreover, all participants were dissatisfied with what they see and feeling fat made participants feel as though their bodies were out of their control (section 5.3). Moreover, the current findings suggest that feeling fat might not just be a statement about body dissatisfaction, but could also be a

6.1.1.3. *The complex notion of feeling fat:* In line with Simlett's (2004) findings, all participants within the current study expressed having difficulty verbalising their experience of feeling fat. Jody stated that it was "hard to find the words [...because] to feel fat is just something I have never really thought about", a sentiment also echoed by Rachel (section 5.5.1). It is possible that feeling fat is an automatic and unconsidered response that Jody and Rachel use to express their feelings of dissatisfaction regarding their body of self and/or negative emotions. Mandi and Rachel expand upon this statement by explaining that they are unable to verbalise their experiences of feeling fat as doing so highlights their perceived inadequacies, which Rachel found difficult to be honest about. This suggests that these participants avoided thinking about feeling fat, as a protective strategy against the difficulties that it masks (see section 6.1.3.2). Moreover, Savannah explained that her experience of feeling fat as its "quite vague" because it "bleeds into a lot of other things" thus making it hard to describe. These accounts suggest that feeling fat is more than just a statement about body dissatisfaction but also includes negative sense of self and negative emotions.

Participants within the current study appeared more able to verbalise the meaning of feeling fat than the experience of feeling fat. This finding is in contrast to Simlett's (2004) study in which participants struggled to provide "definitional information, instead giving answers that reflected a more general picture of how this experience affected them" (p. 91). Perhaps this difference is due to our different study designs and epistemologies. Moreover, Simlett's (2004) participants were only asked this one question, whereas participants in the current study had already answered at least four other questions in relation to their experiences of feeling fat. Reflection upon the experience and meaning of feeling fat might have made it easier to verbalise especially as many of the participants stated that it is an experience that they do not consider.

6.1.2. The meaning of feeling fat for women with an AN diagnosis

This section addresses the second research question regarding the meaning of feeling fat for women with an AN diagnosis. Two prominent meanings for feeling fat emerged from the data: "I am inadequate" and "I am bad".

6.1.2.1. *“I am inadequate”*: The subordinate theme “a perceived sense of inadequacy” (section 5.2.2) most immediately answered the research question regarding the meaning of feeling fat for participants with an AN diagnosis. Indeed, in line with Hirschmann and Munter’s (1995) feminist theory “I feel fat” appeared to be an expression of participants’ feelings of inadequacy. For instance, Savannah explained that feeling fat meant that she had failed “not even just weight wise, just as a person in my life generally” and Jody repeatedly said that for her feeling fat meant “I’m not good enough”. It was apparent that six of the seven participants struggled to view themselves in a positive light, which could be the result of the cognitive bias of disqualifying the positive (Burns, 1989). This is supported by the emergent theme of “FF most believable/trustworthy feedback” present within Mandi and Rachel’s transcripts. Alternatively, within the Self-Regulatory Executive Function Model (S-REF; Wells & Matthews, 1996) negative self-perceptions are hypothesised to dominate ‘processing resources’ due to their threatening nature. Consequently, this reduces an individual’s resources and ability to be aware of and integrate positive views of themselves into their sense of self (Wells & Matthews, 1996). In line with this model, participants within the current study often spoke about feelings of fatness “overshadowing any other things that would be more positive” (Savannah) and Ava explained that it stopped her engaging in her hobbies.

In line with Striegel-Moore et al.’s (1986) correlation, five participants within the current study frequently compared their physical appearance to others and/or to their previous self, which consequently led to feelings of fatness. This was particularly prominent throughout Mandi’s account due to the fact that she described feeling “threatened by every other woman”. I interpreted this statement as an indication of the fragility of Mandi’s self-worth and perceived inadequacy at not achieving her ideal self. This was similar to Jody’s experience of feeling fat providing confirmation that she has failed to meet the high perfectionist standards that she set for herself, even when she was severely underweight. This suggests that she was never able to meet her ideal standards, thus resulting in feelings of inadequacy and fatness. Savannah also explained that her standards for measuring her feelings of fatness readjusted when she lost weight resulting in feelings of despair and confusion. This unrelenting experience of feeling fat can be explained by Fairburn et al.’s (1998) theory, which proposes that over time individuals have to resort to additional weight control

behaviours (e.g. exercise, purging etc) in order to meet their perfectionist standards for weight loss. This proposal could also provide support for my interpretation that Jody perceives feeling fat as the start of a downward spiral that will end with her being unkempt if she does not control her feelings of fatness. Indeed, Fairburn et al. (1998) also suggest that failing to meet their perfectionist standards is perceived by individuals with AN as another failure within their dietary control. This is in line with many studies that have found an association between perfectionism and the development and maintenance of eating disorders (Striegel-Moore et al., 1986; Stice, 2002; Bastiani et al., 1995; Srinivasagam et al., 1995). Indeed, increased levels of perfectionism were associated with a greater prominence of eating preoccupations and rituals, lower body weight and diminished motivation to change in subjects with an AN diagnosis compared to “healthy controls” (Halmi et al., 2000, p. 1804).

These results indicate that the participants within the current study evaluated their self-worth on their feelings of fatness. The self-evaluative experiences described within this section appear to have resulted in feelings of fatness for each participant. This is congruent with Striegel-Moore et al.’s (1986) findings and consequently indicates that participants might hold strong weight-relevant self-schemas that are activated at times of self-evaluation. Alternatively, these findings could be in line with Eldredge et al.’s (1990) proposal that self-evaluative experiences and perceived failure caused participants to reflect and focus upon their negative self-perceptions. In light of the theme of negative bodily hyperawareness (sections 5.2.1 and 6.1.1.1.) I propose that the current findings are more in line with Eldredge et al.’s hypothesis. However, it is unclear which of these experiences caused the other but it seems that the relationship was reciprocal with ‘perceived sense of inadequacy’ and the experience of feeling fat impacting upon each other.

6.1.2.2. *“I am bad”*: Jody, Ava and Savannah explicitly stated that feeling fat also meant “I am a bad person”. This meaning can also be interpreted within Rachel and Sarah’s interviews as they discuss feeling fat after engaging in behaviours they deem unacceptable (e.g. eating the wrong thing or being mean to someone). It is therefore possible that feeling fat is also a statement about feelings of guilt. This is in line with Radomsky’s et al.’s (2002) finding discussed within the introduction that participants experienced a “high sense of moral unacceptability” regarding perceived

weight gain (p. 1172). Moreover, Jody stated that every time she eats she thinks 'I'm going to get fat, I feel fat, I'm going to get fat' and this increases her feelings of fatness. Consequently, these findings provide some support for the Thought Shape Fusion (TSF) cognitive distortion (Shafran et al., 1999); however, this theory relates specifically to guilt regarding eating, whereas the current findings related to eating and other behaviours perceived to be bad. Perhaps this indicates that the TSF cognitive distortion is not just triggered by thoughts related to eating food.

In line with this, three of the participants also explained that feeling fat was a punishment for the moral digression, which again could be related to Shafran et al.'s (1999) TSF. Moreover, studies have demonstrated that individuals diagnosed with AN are highly sensitive to punishment, a finding that was correlated with a drive for thinness (Jappe et al., 2011). This could account for the lack of motivation to change evident with individuals with an AN diagnosis. Consequently, it could be argued that participants interpret feeling fat as a punishment for not adhering to their values, a belief that could motivate eating disorder behaviours further.

6.1.3. Consequences of feeling fat for women with an AN diagnosis

This subsection will address the final research question: what are the consequences of feeling fat for women with an AN diagnosis? The findings regarding this research question are answered by two of the subthemes, '*Fearing judgement*' and '*Coping*'.

6.1.3.1. Fearing judgement: Participants expressed concern that others would judge and reject them based upon their weight and/or shape (section 5.2.3). As the women (except Sarah) did not describe any actual instances of being judged or rejected, it seems that they project their own self-judgements and self-rejection onto other people. For instance, Mandi talks about how important it is for her to know "what people think" because she assumes they will be "judging her appearance" and Savannah believes that people will not like her. These experiences are consistent with the theories and findings that women with an ED diagnosis have elevated levels of social anxiety as a result of feeling insecure (see section 6.1.1.1).

When viewed in the context of cognitive models of social anxiety (e.g. Wells, 1997) and low self-esteem (e.g. Fennell, 1998), these responses could be understood as

negative core beliefs. Indeed, it seems as though these fears of being judged are negative automatic thoughts (NATs) that participants experience when in specific triggering situations. These NATs would elicit physiological changes associated with fear and anxiety, which could have influenced participants' feelings of fatness through negative bodily hyperawareness. Indeed, Savannah stated that she felt more aware of her body when in the company of other people (see section 7.2.11).

Rachel's fear of being judged was influenced by the thin ideal promoted by Western society as she described wanting to challenge society's ideas about fatness and to distance herself "from that word". This could provide support for Thompson et al.'s proposal (1999) that women feel unhappy with their bodies if they perceive themselves as not conforming to the socially constructed ideal of female attractiveness – being thin. It also reinforced notion that feeling fat was interpreted by participants as evidence that they are fat, as Rachel used ED behaviours to achieve this distance.

Thus whenever a woman states "I feel fat" she is saying that there is something wrong with her or her feelings (Hirschmann & Munter, 1995).

Fearing judgement as a result of the experience of feeling fat led Mandi to present a false self (Winnicott, 1965) that she perceived as more socially acceptable than her real self; for example, she described trying to please people so that they think she is "part of normal everyday life". This is in line with Simlett's (2004) finding that women who feel fat judge themselves on external standards and consequently present a compliant self. This compliant self when viewed within the context of Friedman's (1993) feminist theory could be perceived as Mandi sacrificing herself in order to fit in with Adam's world. Although this safety behaviour potentially reduces Mandi's anxiety in the short term, it could maintain her negative sense of self by inhibiting the possible development of an authentic self (Striegel-Moore et al., 1993).

6.1.3.2. Coping: Participants described an all-consuming drive to overcome their experiences of feeling fat and three process were employed to try and achieve this as outlined by the subthemes of '*eating disorder behaviours*', '*distraction*' and '*finding self-worth outside of weight and shape*' (section 5.4).

In line with Slade (1982) and Fairburn et al.'s (1998) models and with the studies discussed within the Introduction (Roth & Armstrong, 1993; Polivy & Herman, 2002; Stice & Shaw, 2002; Lam et al., 2002; Cooper et al., 2007; Fairburn, 2008; Murphy et al., 2010), participants within the current study stated that eating disorder behaviours helped them to overcome feelings of fatness. This suggests that participants equate their feelings of fatness with being fat regardless of their weight (Fairburn, 2008; Murphy et al., 2010) and they consequently believe that dieting, purging and excessive exercising will reduce these feelings of fatness. This finding also provides further support for the suggestion that feeling fat acts as a maintenance factor in AN. Unfortunately however, this dieting behaviour could have exacerbated participants' feelings of fatness as Striegel-Moore et al. (1986), Tiggemann (1996), Wardle and Foley (1989) found a correlation between repeated dieting and feeling fat.

Cooper et al. (2007) hypothesised that for dieting behaviour to develop into AN, individuals need to have a preoccupation with weight and shape *and* negative self-beliefs. This proposal was supported the current study's finding as participants were preoccupied with feeling fat and all displayed negative sense of self. Moreover, participant accounts implied that ED behaviours were used to obtain a feeling of control during stressful life events and circumstances, which influenced feelings of fatness. For instance, Savannah spoke about "complicated life situations" and these could be interpreted from Sarah's account during which she frequently mentioned restricting her diet during her exams and Lisa talked about stressful situations at home. Furthermore, Mandi stated that "this is probably the only part of my life that I've got control in". This fits with Slade's (1982) theory that individuals who have low self-efficacy but high levels of perfectionism need to feel in control of at least one aspect of life. Furthermore, Sarah described feeling "triumphant" at losing weight and Mandi stated that this gave her a "buzz". It therefore seems that eating disorder behaviours and weight loss helped to improve their self-esteem, which is in line with Bruch's (1973) portrayal of AN as "a desperate struggle for a self-respecting identity". However, as discussed in section 5.4.1. participants' relief from feelings of fatness were short lived after weight loss, thus suggesting that the experience of feeling fat is not solely dissatisfaction with their weight or shape and providing further support for Bruch's (1973) proposal.

Participants described using distraction in order to reduce their feelings of fatness; for example, Savannah was able to distract herself by keeping herself occupied with activities unrelated to feeling fat and/or food, and Mandi explained that focusing “on the people [she] supports” reduces the prominence of feeling fat. This distraction could be used in order to reduce negative emotions (e.g., feelings of anxiety) and thus it could serve as an emotional function of avoidance which is likely to become reinforcing (Kleifield, Wagner & Halmi, 1996). Alternatively, it could be viewed more positively as a technique that reduces the likelihood that they will engage with negative eating disorder behaviours (Murphy et al., 2010). I believe this also provides further support for the superordinate theme ‘negative hyperawareness of their bodies’ (section 7.2.1.1).

Mandi’s job could also be interpreted as a method of finding value outside of weight and shape. In line with this, Savannah explained that finding dimensions on which to evaluate her self-worth other than feelings of fatness helped to reduce her experience of feeling fat (section 5.4.3). Moreover, Sarah stated that being able to focus on life and the “bigger picture” made her realise how “insignificant [feeling fat] is”. These accounts add further support to the finding that the women who participated within the study judged their self-worth solely upon their feelings of fatness. Consequently, it would be important for interventions to support individuals in developing their sense of self, perhaps using schema-focused strategies.

6.2. Methodological considerations

A major strength of the IPA methodology used was that it enabled an in-depth exploration of participants’ lived experiences. This detailed analysis of each interview ensured rigour and facilitated the interpretation of the text, whilst allowing individual experiences to be encapsulated. Indeed, the small sample size meant that the idiographic nature of IPA was met (Smith et al., 2009). Furthermore, women with a diagnosis of AN made up the current research sample, which filled a gap within the existing literature base, which has primarily used samples from sub-clinical populations.

It is important to adhere to guiding principles to ensure the quality of qualitative research (Yardley, 2000; Smith et al., 2009). Yardley's (2000) guidelines were followed throughout the development and implementation of this research, as discussed within the methodology section (see section 4.10). To further enhance the standard of the present study, Smith's (2011) IPA quality evaluation guide was also adhered to throughout the write up process. As required by Smith (2011), the present study subscribes to the theoretical principals of IPA (see section 4.2); it has included a detailed audit trail and quotes from at least three participants have been used to evidence each theme to provide transparency for the reader; and it is well focused on the area of feeling fat for adult women with an AN diagnosis. Furthermore, my primary supervisor (an experienced IPA researcher) and a peer IPA researcher audited the analytic process and by checking and providing feedback regarding sections of analysed transcripts and the generation of themes. This helped to develop the credibility of my analysis, thus ensuring the "strong data and interpretation" and a "coherent, plausible and interesting analysis" (Smith, 2011, p. 17). Due to the double hermeneutic involved within IPA, the findings of this study are comprised of participants' experiences and my interpretations of their descriptions (Smith et al., 2009). Consequently, the findings should be viewed as one of numerous ways for understanding the experience of feeling fat for women with a diagnosis of AN (Smith et al., 2009). Due to the double hermeneutic involved within IPA studies, feedback and validation regarding the themes was not sought from participants (Smith et al., 2009).

A significant criticism of the IPA methodology is that it requires and even recommends that student researchers use a small sample size (Smith et al., 2009). This reduces the external validity of the current study and therefore limits the generalizability of its findings. Moreover, although the sample used was homogenous in terms of diagnosis and gender, the participants came from different backgrounds and cultures. Indeed, one limitation to the study was that English was not the first language for one participant. This meant that there were some words and phrases that did not translate easily into English, even though her spoken English could be deemed fluent. This negatively impacted upon the analysis process in which language is key. Furthermore, some participants reported feeling fat less at the time of their interview and their interviews tended to focus more upon overcoming feeling

fat than the experience itself. However, in retrospect there were several consistent themes amongst the other women interviewed as they too sought to reduce this experience (see section 5.4.). Moreover, in line with Espeset et al.'s (2012) experience, these participants were "able to reflect upon their experiences in a way that give very rich data" (p. 452).

The methodology could have been improved further had I conducted a pilot interview; this is because answers to the first question ("could you give me a brief history of your eating difficulties?") did not elicit any information about the experience of feeling fat. However, this in itself provided information that the experience of feeling fat is not often the trigger for eating difficulties. I also acknowledge that the interview schedule will have affected the course of the interviews. Nevertheless, I made a conscious effort to use the interview schedule flexibly and as a result I endeavoured to ask questions based upon participants' answers. Moreover, at the end of their interview participants were given the opportunity to speak about any aspects of their experience that they had not yet discussed; therefore allowing for unexpected areas to be examined.

Research demonstrates that individuals diagnosed with eating disorders can struggle to identify and verbalise their emotions often displacing these onto their bodies instead (Bruch, 1978; McFarlane et al., 2011; Espeset et al., 2012). It is therefore possible that participants within the current study were unable to explain this side of their experience due to a lack of awareness. Consequently, the IPA methodology will not have captured this aspect of their experience, thus impacting upon the validity of the current study. Furthermore, it should be acknowledged that all participants were receiving psychotherapy for the eating disorder at the time of their interviews. This will have further impacted upon the validity of the study, as it will have effected how participants interpreted their experiences and perceived themselves. For example, if participants had engaged within a form of Narrative Therapy they might have been encouraged to externalise the eating disorder from themselves (White & Epson, 1990), which could account for the finding that some participants referred to the AN as a "devil". However, it was decided that it would be unethical to recruit participants who were not receiving psychological therapy at the time of their interview due to the distress that participation could cause.

Researcher self-reflexivity is crucial to qualitative research (Elliot et al., 1999; Yardley, 2000, 2008; Smith et al., 2009). Consequently, throughout this study I have considered the impact of my perspectives, values and experiences upon the analysis and interpretation (as explained in sections 4.4 and 6.5). In particular, it was important to consider my experiences of supporting friends who had eating disorder diagnoses with their feelings of fatness, as well as my own experiences of feeling fat. Indeed, it was these experiences, which sparked my interest within this topic. I subsequently endeavoured to bracket my experiences (see section 4.10.1), whilst adopting a curious stance.

6.3. Clinical implications and recommendations

The DSM-V diagnostic criteria for AN (see section 2.2.1) does not include reference to the experience of feeling fat; this was removed during the revisions for the DSM-IV. Instead feeling fat is perhaps encompassed by criteria B⁶ and C⁷ of the current criteria although this is not explicit. Consequently, clinicians might be inclined to focus upon the “intense fear of gaining weight or becoming fat” rather than the experience of feeling fat. This hypothesis is further supported by the lack of interventions that specifically address the experience of feeling fat (see section 2.7). As the current research findings show that feeling fat was a significant experience for participants, I believe that more focus needs to be paid to this experience during AN interventions.

I propose that exploring the experience and meaning of feeling fat during therapy would provide clinicians and the individuals they support with a deeper understanding of the significance of feeling fat for that person. This increased understanding will also provide clinicians with an insight into the possible maintaining factors for both feeling fat and the eating disorder. This will consequently provide valuable information regarding which therapeutic intervention would be most suitable for

⁶ “Either an intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain” (APA, 2013, p. 338).

⁷ “Disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation” (APA, 2013, p. 338).

supporting the individual. Furthermore, this could improve the therapeutic relationship and will perhaps help clients feel better understood by their therapist.

Existing treatment protocols that address the experience of feeling fat primarily focus upon supporting individuals to identify and process their emotions (e.g. Fairburn, 2008; Greenberg & Johnson, 1988). The findings from the current study support the use of this method for addressing some aspects of feeling fat; however, feeling fat was also found to be related to other factors. Indeed, in line with the dominant theme 'negative sense of self' (section 5.2) feeling fat also seemed to be an expression about participants' dissatisfaction with themselves as people. This suggests the need for interventions aimed at improving an individuals' self-worth, identity and developing a positive sense of self unrelated to the individuals' weight and shape (e.g., CBT-E, Fairburn, 2008; Schema Therapy, Young, Klosko & Weishaar, 2003). Moreover, this dissatisfaction with self appeared to be related to participants' high levels of perfectionism as they repeatedly felt like a failure for not achieving their goals, which resulted in feelings of fatness. One protocol that could be useful in addressing the links between feeling fat, low self-esteem and perfectionism is the 'broad form of CBT-E' (Fairburn, 2008). Fairburn (2008) recommends that this broad form of CBT-E should only be used with individuals for whom low self-esteem and clinical perfectionism appear to maintain the AN behaviours. This implies that Fairburn (2008) does not perceive low self-esteem to be a common experience for adult women with a diagnosis of AN; however, I wonder whether the current finding that feeling fat appears to be a statement about negative sense of self makes this a more prominent trait than Fairburn (2008) suggests. Further research needs to be conducted into this proposal however, as IPA studies should be generalized with caution due to their small sample size.

Cognitive biases also played a role within the experience of feeling fat e.g. feelings of moral unacceptability, perceived control and fear of being judged. Consequently, cognitive strategies and psycho-education aimed at addressing these could also help to reduce the experience of feeling fat for adult women with an AN diagnosis. As the experience and meaning of feeling fat varied between the participants, clinicians will need to explore their client's experience in detail in order to decide which of the aforementioned strategies will be the most beneficial. These cognitive strategies

could also help address the sense of feeling out of control that also characterised feeling fat for participants in the current study. Alternatively, interventions focused upon reducing over-control such as Radically Open-Dialectical Behaviour Therapy (RO-DBT; Lynch et al., 2013) might also be beneficial.

Feeling fat appeared to be an all-encompassing experience for participants, which resulted in a lack of engagement in activities other than those aimed at reducing the experience of feeling fat. This however seems to have exacerbated their experiences because of the associated increase in bodily hyperawareness. Individuals should therefore be encouraged to find value outside of their weight and shape, a coping strategy employed by some of the study's participants. Fairburn (2008) provides a protocol for "enhancing the importance of other domains for self-evaluation" (p. 102); alternatively Acceptance and Commitment Therapy (ACT; Hayes, 2004) might also be a useful tool in encouraging individuals to focus on values unrelated to their weight/shape.

There are several important practices within the frame of Narrative Therapy (NT; White & Epton, 1990) which could help to reduce feelings of fatness for individuals with an AN diagnosis. Firstly, helping individual's to alter their dominant narrative to include 'unique outcomes' thus creating an "anti-anorexia" story (White & Epton, 1990; Goldner & Madigan, 1997). This process includes individuals as active members of their therapy and could help clients feel more in control of their treatment (White & Epton, 1990). Together these aspects of NT could reduce the client's feelings of fatness associated with feeling out of control. Another technique central to NT is 'Externalization' in which individuals are supported to view the problem a separate entity to themselves (White & Epton, 1990). This could be helpful for individuals who experience feeling fat as they can personify the fatness so it becomes unrelated to their identity; however, this should be done with care as some participants described the feelings of fatness as a demon separate to themselves, which appeared to make them feel out of control and exacerbate their experience. One method of overcoming this possible limitation is to encourage clients to join the 'Anti-Anorexia League' (Epton, 1999). This group of individuals document their experiences of AN using anti-language and share these with others experiencing similar difficulties (Epton, 1999). This could helpful to individuals who experience

feeling fat to feel more understood as one of the themes within the current study was 'feeling misunderstood by others'. Collective narrative approaches such as The Tree of Life (Denborough, 2008) and Narrative song writing (Denborough, 2002) could also reduce this feeling of isolation and help to develop alternative anti-anorexia and anti-feeling fat narratives. They might also help individuals to focus on aspects of their life other than their weight and shape.

6.4. Future research directions

The findings of this study support the suggestion made by Cooper et al. (2007) that "the experience of feeling fat in those with AN is worthy of further research, and may have implications for treatment of those with the disorder" (p. 372). However, it also highlights the need for further research into the experience of feeling fat. Indeed, the current study provided an insight into the lived experience of feeling fat for women with a diagnosis of AN. Consequently, repeating the current study with a sample of individuals with an alternative eating disorder diagnosis would be particularly useful to discover whether the experience of feeling fat is similar across eating disorder diagnoses and its impact upon the transdiagnostic model of eating disorders (Fairburn, Cooper & Shafran, 2003).

A number of participants within the current study stated that they had not considered the experience of feeling fat and most expressed having difficulty finding the right words to describe the experience sufficiently. Conducting a longitudinal study might provide participants with the opportunity to reflect further upon their experience of feeling fat during the time between interviews, thus potentially increasing the richness of data. Moreover, longitudinal studies can help to reduce the retrospective nature of interviews, although this was perhaps a limitation of the current study as participants frequently alluded to feeling fat during the interview.

Participants within the current study were all receiving therapy at the time of their interview, however it became clear that Sarah and Lisa both reported a reduction in the frequency that they felt fat, partly due to developing strategies to overcome this. It is possible that this was the result of the therapy that they had received.

Consequently, repeating the study with participants who are not receiving therapy or who have just commenced therapy could improve the homogeneity of the sample.

Throughout the clinical implications and recommendations section I discussed numerous different interventions that might help to alleviate feelings of fatness. Studies should be conducted investigating whether these techniques do in fact help to reduce the experience of feeling fat for individuals as hypothesised.

6.5. Self reflections

This was the first time I have conducted a qualitative research project and therefore research interviews. I was mindful of this new role in light of my experience of therapeutic interviews and had to make a conscious effort to remove my 'therapist hat' to ensure my questions took a research focus. This was difficult on the occasions where participants mentioned risk issues and at these times I took time to ensure their safety and obtained consent to speak with their therapist about my concerns. Furthermore, throughout the data collection process I often found myself reflecting upon how participants might have perceived me in light of my slim frame (my weight is in the healthy range). I wondered how this might have influenced their responses to my questions and their engagement with the interview process. Lisa was the only participant who enquired about my personal reasons for conducting the research, including whether I have had an eating disorder. Interestingly, Lisa was very focused on how she overcomes the experience of feeling fat and I wonder whether this was in part due to our conversation about my experience of supporting my friends.

Conducting this study has improved my understanding of AN and in particular the experience of feeling fat. I now appreciate how confusing feeling fat can be for individuals, especially as the experience is difficult to verbalise. In hindsight I wonder whether my feelings of frustration and confusion about how best to support my friends was in part a reflection of their feelings.

This research has reinforced my belief that the client is the expert in their life and my role as a clinician is to support them to discuss and make sense of the aspects of their life that they perceive as distressing. Indeed, this study has demonstrated how

significant the experience of feeling fat can be for women with an AN diagnosis yet it is not included within the diagnostic criteria nor addressed within dominant AN interventions. Finally, I have learnt how powerful and rich language can be if attention is paid to the words, phrases and metaphors used. I will endeavour to take the skills of interpretation into my role as a clinician in the future.

6.6. Conclusion

This study provides an understanding of the experience of feeling fat for women with a diagnosis of AN. This appears to be the first qualitative study to focus solely upon the experience of feeling fat and it therefore provides a new perspective and understanding to the existing literature.

The current research found that the experience of feeling fat was characterised by a negative hyperawareness of their bodies and feelings of being out of control. However, participants often found it difficult to verbalise their experiences of feeling fat, a finding that was attributed to some participants using the phrase 'I feel fat' to manage emotions but for others it appeared to be difficult to reflect upon the experience and difficult to find the words. The current research also highlighted that feeling fat in part represents a negative sense of self for women with an AN diagnosis. This is in contrast to the previous research conducted, which found that FF is a combination of cognitive, affective and behavioural responses. This difference could be accounted for by the qualitative stance taken by the current study, which has allowed for a more in-depth account of feeling fat than quantitative studies can provide. Finally, participants tended to equate their feelings of fatness with being fat and consequently used eating disorders to try to overcome this experience. This provides support for the suggestion that feeling fat acts as a maintenance factor for AN (Striegel-Moore et al., 1986; Polivy & Herman, 2002; Stice & Shaw, 2002; Roth & Armstong, 1993). Some participants had also developed more positive coping strategies of distraction and finding value outside of their weight. In conclusion, feeling fat was a significant experience for the women who participated within this study, and it played a role in maintaining the anorexia nervosa. It is therefore important that clinicians explore the experience and meaning of feeling fat for women with an AN diagnosis, in order to effectively address the experience.

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9. APPENDICES

APPENDIX 1 – Literature search strategy

A systematic literature search was conducted to identify articles relevant to the current study. The following psychology and medical databases were searched: Web of Science, PsychINFO, Pubmed, the Campbell Library, the Cochrane Library, Ovid MEDLINE, Scopus and Google scholar.

To ensure that relevant articles were identified I amalgamated a number of different search terms, including: “feel* fat*” AND “eating disorder”; “feel* fat*” AND “anorexia nervosa”; “feel* fat” in all text; feel* AND fat* in all text; feel* AND fat* AND anorexia nervosa; body dissatisfaction; “body experience”; Thought-Shape Fusion; Body displacement hypothesis.

I read the abstracts of each article in order to determine their relevance to the current study. If an article appeared relevant I read the remainder of the text to identify any relevant findings.

APPENDIX 2 – Clinician information sheet

University of
Hertfordshire



Clinician Information Sheet v5.0
Date: 7th May 2014
IRAS Project ID: 151415

CLINICIAN INFORMATION SHEET

Project Title: What is the Experience and Meaning of 'Feeling Fat' for Women with a Diagnosis of Anorexia Nervosa?

Introduction

I am inviting a group of women with a diagnosis of Anorexia Nervosa (AN) to take part in a research study exploring the experience and meaning of feeling fat. I would be most grateful if you would take the time to read the following information, as I hope that you might be able to help me with participant recruitment. This will simply involve passing on Participant Information Sheets to your clients who meet the study's inclusion criteria.

The researchers

This study is being carried out by Laura Major, Trainee Clinical Psychologist. It is part of my Doctoral qualification in Clinical Psychology (DClinPsy).

The study is being supervised by David Viljoen, Chartered Clinical Psychologist & Family and Systemic Psychotherapist, [REDACTED] and Pieter Nel, Deputy Programme Director, University of Hertfordshire DClinPsy.

What is the purpose of this study?

Although a common feeling for all women, feeling fat also acts as both a statement about body dissatisfaction and as a maintenance factor for eating disorders. However, very little research has been conducted into the meaning of feeling fat, and where research has been conducted it has involved adult participants without an eating disorder diagnosis. The proposed research would provide an understanding of the experience of feeling fat in women with a diagnosis of AN. It is hoped that this information might help us to better understand the relationship between feeling fat and AN. In the long term, it is hoped that this information will help us have a better understanding of clients' needs and therefore help us to provide a better service for young people with AN.

What is involved?

If a client decides that they would like to take part, I will arrange to meet with them so that they can ask any questions that they have. If they still want to participate I will ask them to sign a consent form. I will then interview your client about their experiences and the meaning of feeling fat for about 1 to 1 ½ hours.



A charity exempt from registration

Participants will be able to take a break at any point during the interview. They can skip questions that they do not wish to answer and can stop the interview at any point without giving a reason.

All interviews will be audio recorded, and then written up afterwards.

Who is taking part?

Female clients from the adult Community Eating Disorders Service in [REDACTED] who fulfil the inclusion criteria below:

- Experience feeling fat or complain that they feel fat
- Aged 18-years-old or older
- Have a diagnosis of AN according to the DSM-5
- Fluent English speakers
- Able to give informed consent.

I hope that between 6-8 participants will take part within the study.

Do clients have to take part?

No. Participation is entirely voluntary and participants can withdraw their consent at anytime during the study without giving a reason.

Will taking part be confidential?

Yes, participation within the study will remain confidential. However, if I am concerned about harm to the participant or the safety of others, I will have to inform their lead clinician because of my duty of care.

Any personal information, interview recordings and interview transcripts will be stored in a safe locked location, which will only be accessible by the researchers.

The research will be written-up and submitted as part of my Doctorate in Clinical Psychology. The overall findings of the study may also be published in a research paper. I may use interview quotes within these write-ups, but these will be completely anonymised. Participants will all be informed about this.

What are the benefits of taking part?

Many women enjoy the opportunity to give their personal opinions and they can find it helpful to talk about particular experiences. Taking part in this study will give your client(s) an opportunity to speak openly and honestly about what it is like to live with AN.

What are the potential difficulties that taking part may cause?

There are no known risks to taking part in this study. However, in the interview I will ask questions about how participants experience feeling fat and what the

experiences means to them, which might be upsetting. If a participant becomes upset during the interview, she will be able to talk about these issues with myself in confidence. She will be asked if she would like to take a break and will be able to stop the interview if she wishes. She will not have to answer any questions that she is not happy answering.

Following the interview I will give participants a 'Debrief Sheet' containing information about where to seek further support if they require.

What if I have questions or concerns?

If you are worried about the study or the way you or your client has been treated, you can speak to me, Laura Major, and I will try to address your concerns. Alternatively, you could speak to my supervisor, David Viljoen, using the contact details below. If you want to make a complaint then you can do this through the NHS Complaints Procedure.

Who is organising and funding the research?

The University of Hertfordshire is funding the research. It is being undertaken by Laura Major, Trainee Clinical Psychologist, as part of my doctoral qualification in Clinical Psychology.

Who has reviewed the study?

This study was reviewed by the Riverside Research Ethics Committee and was given ethical approval (Ref: 14/LO/1292).

What do I have to do?

If, after reading this information sheet, you think that any of your clients meet the study inclusion criteria, please give them a Participation Information Sheet.

Clients can decide whether or not to take part in their own time. I would however appreciate your help in reminding them about the study two weeks after your first discussion about it.

If a client decides to participate then they can either contact me directly or ask you to forward their contact details to me so that I can arrange a time and date for an initial meeting.

If you or any of your clients have any questions about the research, please do not hesitate to contact me using the details below.

Thank you for taking the time to read this.

Laura Major
Trainee Clinical Psychologist
Address: Doctor of Clinical Psychology Training Course,
University of Hertfordshire,
Hatfield,
AL10 9AB.

Email: [REDACTED]

Tel: [REDACTED] (please leave a message for me with the DCLinPsy Course
Administrator, [REDACTED], and I can call you back).

David Viljoen
Chartered Clinical Psychologist & Family and Systemic Psychotherapist

Address: [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Tel: [REDACTED]

Email: [REDACTED]

APPENDIX 3 – Participant information sheet

University of
Hertfordshire



Participant Information Sheet v6.0
Date: 18th August 2014
IRAS Project ID: 151415

PARTICIPANT INFORMATION SHEET

Project Title: What is the Experience and Meaning of 'Feeling Fat' for Women with a Diagnosis of Anorexia Nervosa?

Introduction

You have been invited to participate in a research study that will explore the experience and meaning of feeling fat for women with Anorexia Nervosa. The following information should help you to understand why the research project is being conducted and what it will involve. Please feel free to contact me if you would like clarification or more information.

The researchers

My name is Laura Major, I am a Trainee Clinical Psychologist and I am conducting this research as part of my Doctorate in Clinical Psychology. The research is being supervised by David Viljoen, Chartered Clinical Psychologist & Family and Systemic Psychotherapist, [REDACTED] and Dr Pieter Nel, Deputy Programme Director, University of Hertfordshire DClinPsy.

What is the purpose of the research?

Although a common feeling for all women, feeling fat also acts as both a statement about body dissatisfaction and as a maintenance factor for eating disorders. However, very little research has been conducted into the meaning of feeling fat, and where research has been conducted it has mainly involved adult participants without an eating disorder diagnosis. The proposed research would provide an in-depth understanding of the experience of feeling fat for women with Anorexia Nervosa (AN). In the long term, it is hoped that this information will help Clinical Psychologists and service providers to better understand the experience of feeling fat and its possible relationship to AN. It is hoped that this information will provide a better understanding of service users' needs, which can help inform treatment and thus improve services for women with AN.

Why have I been invited to take part?

Female service users with a diagnosis of Anorexia Nervosa from the Community Eating Disorders Service [REDACTED] have been invited to participate. I hope that 6 to 8 women will take part.



A charity exempt from registration

Do I have to take part?

You are not obliged to take part; it is your choice and you can change your mind at any time, without giving a reason. Participation is entirely voluntary and your decision will not affect any aspect of the care and treatment that you are receiving [REDACTED].

What will happen if I take part?

If you would like to take part, or would like more information about the study then please contact me using the details below. We can discuss this on the phone and/or we can arrange a time and place to meet. This can either be at the [REDACTED] or at your home, wherever you prefer.

During this meeting I will answer any questions that you may have. If you still want to participate then I will ask you to sign a consent form to say you are happy to take part.

I will then ask you some questions about what it is like for you to feel fat. This interview will probably last between 1 to 1 1/2 hours. I will audio record our conversation. After the interview you will be able to ask any questions that you have or tell me if anything from our conversation is worrying you.

In addition to your interview, I will also ask you the following:

- How old you are
- Your current diagnosis
- Your current BMI
- Previous eating disorders that you have experienced
- Any treatment that you have received.

What will happen to this information?

The audio recording of our conversation will be typed out word for word (transcribed) so that it can be looked at in more detail. The method of analysis aims to explore any common themes that will help to understand your experiences. A professional Transcription Service (a company who type out interviews) may be employed, however they will sign a confidentiality agreement to say that they will keep the information private. The audio recordings and written transcripts will be anonymised and kept in a locked cabinet.

Will my answers be kept private?

Your care coordinator [REDACTED] will be told if you agree to take part in the study. Details from your interview will not be shared with your care co-ordinator unless I am concerned about your safety or the safety of others.

My supervisors will look at anonymised sections of your transcript in order to check the quality of this doctoral research. If you give additional consent, I will also discuss sections of your anonymised transcript within a peer review group (a group of Trainee Clinical Psychologists) who are bound by the same duty of confidentiality towards all participants.

The results of the research will be written up in a report. Anonymous extracts from your interview might be included within the report to illustrate themes that were identified. These quotes will not include any information that might identify participants. A shorter article containing these anonymised quotes will also be written for an academic journal. The research findings may also be presented at conferences in the future, but again this would not include any identifying information of participants.

Your information, audio recordings and interview transcripts will be stored in a locked cabinet that my supervisors and I can open. They will be kept for five years and will then be destroyed.

I will ask you if you would like a summary of the research when it is finished.

What are the possible benefits of taking part?

Some people enjoy talking about their own views and experiences. Taking part in this study will give you a chance to speak openly and honestly about what it is like to have Anorexia Nervosa and to feel fat.

Your participation will help to increase knowledge within the field and provide a better understanding of the meaning of feeling fat. It is hoped that this information will provide a better understanding of service users' needs, which can help inform treatment and thus improve services for women with AN.

What are risks of taking part?

There are no known risks to taking part in this study. However, I will ask you some questions about what it is like when you feel fat, which you might find distressing. Every measure will be taken to minimise the risk of distress. If you are asked a question that you do not want to answer then you can skip it. If you do feel upset we can take a break or even stop the interview if you do not want to continue.

Following the interview, you will have the opportunity to discuss with me any worries or concerns raised by the interview. I will also provide you with a debrief sheet containing the details of support sources.

What will happen if I change my mind and no longer want to take part?

If you decide to withdraw from the study please contact me on using the details provided at the end of this sheet. You can stop taking part at any time (including

during the interview) without giving a reason for stopping. You can choose whether your interview is included in the research or deleted, both of these options are OK.

If you change your mind and decide not to take part in the research, then this will not affect your current or future care or treatment [REDACTED] in any way.

What if there is a problem or something goes wrong?

If you are concerned about any aspect of the study, you can contact me directly and I will try to answer your questions. You could also speak to my research supervisor, David Viljoen, using the contact details below. If you want to make a complaint then you can do this through the NHS Complaints Procedure.

Who has reviewed the study?

This project has been checked by the Riverside Research Ethics Committee and they said it was ethical and could be done (Ref: 14/LO/1292).

What should I do if I want to take part or want to ask some questions?

You can contact me (Laura Major) directly or ask your care co-ordinator to get me to call you.

You can email your questions to me on [REDACTED] or you can leave a message for me with my Course Administrator, [REDACTED], on [REDACTED].

If you have any queries or concerns you can also contact my supervisor:

David Viljoen
Chartered Clinical Psychologist & Family and Systemic Psychotherapist

Address: [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Tel: [REDACTED]
Email: [REDACTED]

**This information sheet is for you to keep.
Thank you for reading this – please ask any questions if you need to.**

APPENDIX 4 – Exclusion criteria

Exclusion Criterion	Explanation
Male	Past literature has found that body dissatisfaction is greater for women than men (Tiggeman, 1996).
Younger than 18-years-old	As adults can provide informed consent and also because recruitment took place within an adult eating disorder service.
Diagnosis other than AN as defined by the DSM-5	Interpretative Phenomenological Analysis (IPA) requires an homogenous sample; furthermore, Benninghoven et al. (2006) found that feeling fat played a different role with Bulimia Nervosa than AN.
Do not experience feeling fat	Not all patients with a diagnosis of anorexia nervosa experience feeling fat.
Not currently receiving treatment from the eating disorder service	This could reduce their ability access further support should they find participating within the research distressing.
Non-fluent English speaking	IPA relies upon meaning of language, therefore non-English speaking participants were excluded in order to ensure that information and richness of data was not lost in translation.
Unable to provide informed consent	Participants needed to have the cognitive capacity to understand what the research would involve and the reasons for it being conducted so that they could make a voluntary decision to participate.

APPENDIX 5 – Ethical approval documentation



Telephone: 0117 342 1385

18 August 2014

Miss Laura Major
Doctorate of Clinical Psychology Training Course
University of Hertfordshire
Hatfield
AL10 9AB

Dear Miss Major

Study title: What is the experience and meaning of 'feeling fat' for women with a diagnosis of anorexia nervosa?
REC reference: 14/LO/1292
Protocol number: LMS/PG/NHS/00226
IRAS project ID: 151415

Thank you for your email of 18th August 2014. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 14 August 2014

Documents received

The documents received were as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Participant information sheet (PIS) [Participant Information Sheet]	6	18 August 2014

Approved documents

The final list of approved documentation for the study is therefore as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
GP/consultant information sheets or letters [Clinician Information Sheet]	5	07 May 2014
Interview schedules or topic guides for participants [Interview Schedule]	2	07 May 2014
IRAS Checklist XML [Checklist_04072014]		04 July 2014

Letter from sponsor [Letter of Sponsorship]	1	02 June 2014
Other [Participant Debrief Information Sheet]	4	07 May 2014
Other [Academic Supervisor CV]	1	04 April 2014
Participant consent form [Participant Consent Form]	5	07 May 2014
Participant information sheet (PIS) [Participant Information Sheet]	6	18 August 2014
REC Application Form [REC_Form_04072014]		04 July 2014
Research protocol or project proposal [Research Protocol]	2	07 May 2014
Summary CV for Chief Investigator (CI) [Laura Major CV]	2	07 May 2014
Summary CV for supervisor (student research) [Field Supervisor CV]	1	31 March 2014

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

14/LO/1292	Please quote this number on all correspondence
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Yours sincerely



Miss Maeve Groot Bluemink
REC Assistant

E-mail: nrescommittee.london-riverside@nhs.net

Copy to: *Professor John Senior*
Professor Tim M Gale, Hertfordshire Partnership NHS Foundation Trust

NRES Committee London - Riverside

Level 3 Block B
Whitefriars
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BS1 2NT

Tel: 0117 342 1385
Fax: 0117 342 0445

30 September 2014

Miss Laura Major
Doctorate of Clinical Psychology Training Course
University of Hertfordshire
Hatfield
Hatfield

Dear Miss Major

Study title: What is the experience and meaning of 'feeling fat' for women with a diagnosis of anorexia nervosa?
REC reference: 14/LO/1292
Protocol number: LMS/PG/NHS/00226
Amendment number: Minor Amendment 1 29/9/14 - Updated PIS V6
Amendment date: 29th September 2014
IRAS project ID: 151415

Thank you for your email notifying the Committee of the above amendment.

The Committee does not consider this to be a "substantial amendment" as defined in the Standard Operating Procedures for Research Ethics Committees. The amendment does not therefore require an ethical opinion from the Committee and may be implemented immediately, provided that it does not affect the approval for the research given by the R&D office for the relevant NHS care organisation.

Documents received

The documents received were as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Notice of Minor Amendment		
Participant information sheet (PIS) [Clinician Info sheet_v6 (tracked)]	5.0	07 May 2014
Participant information sheet (PIS) [Clinician Info sheet_v6 (clean)]	6.0	19 September 2014

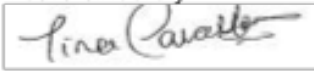
Statement of compliance

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

14/LO/1292:

Please quote this number on all correspondence

Yours sincerely



Miss Tina Cavaliere
REC Manager

E-mail: nrescommittee.london-riverside@nhs.net

Copy to: *Professor Tim M Gale, Hertfordshire Partnership NHS Foundation
Trust
Miss Laura Major
Professor John Senior*

Ms Laura Major (Dr Pieter Nel)
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22 August 2014

Dear Laura,

Re: UNIVERSITY OF HERTFORDSHIRE SPONSORSHIP IN FULL for the following:
RESEARCH STUDY TITLE: What is the experience and meaning of feeling fat for women with a diagnosis of anorexia nervosa?
NAME OF CHIEF INVESTIGATOR: Ms Laura Major
IF STUDENT, NAME OF SUPERVISOR: Dr Pieter Nel
UNIVERSITY OF HERTFORDSHIRE ETHICS PROTOCOL NUMBER: LMS/PG/NHS/00226

This letter is to confirm your research study detailed above has been reviewed and accepted and I agree to give full University of Hertfordshire sponsorship, so you may now commence your research.

As a condition of receiving full sponsorship, please note that it is the responsibility of the Chief Investigator to inform the Sponsor at any time of any changes to the duration or funding of the project, changes of investigators, changes to the protocol and any future amendments, or deviations from the protocol, which may require re-evaluation of the sponsorship arrangements. It is also essential that evidence of NHS Trust Management Permissions (formerly known as R&D Approval) are sent as soon as they are received.

Permission to seek changes as outlined above should be requested from myself before submission to an NRES (NHS) Research Ethics Committee (REC) and notification to the relevant University of Hertfordshire Ethics Committee with Delegated Authority (ECDA), and I must also be notified of the outcome. It is also essential that evidence of any further relevant NHS management permissions (formerly known as R&D approval) is provided as it is received. Please do this via email to research-sponsorship@herts.ac.uk

Please note that University Sponsorship of your study is invalidated if this process is not followed.

In the meantime, I wish you well in pursuing this interesting research study.

Yours sincerely



Professor J M Senior
Pro Vice-Chancellor (Research and International)



A Charity Exempt from Regulation under the
Senior Schools of the Church Act 1963

Thank you for your help!

If you have any queries or concerns please do not hesitate in contacting myself or my supervisor, David Vijoen.

Laura Major
Trainee Clinical Psychologist
Address: Doctor of Clinical Psychology Training Course,
University of Hertfordshire,
Hatfield,
AL10 9AB.

Email: [REDACTED]

Tel: [REDACTED] (please leave a message for me with the DClinPsy Course Administrator, [REDACTED], and I will call you back).

David Vijoen
Chartered Clinical Psychologist & Family and Systemic Psychotherapist
Address: [REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Tel: [REDACTED]

Email: [REDACTED]

APPENDIX 7 – Participant debrief sheet

University of
Hertfordshire



Debrief Information Sheet v4.0
Date: 7th May 2014
IRAS Project ID: 151415

PARTICIPANT DEBRIEF INFORMATION SHEET

THE EXPERIENCE OF FEELING FAT AND ANOREXIA NERVOSA

Thank you very much for taking part in this research.

I wanted to better understand how women with an Anorexia Nervosa diagnosis experience feeling fat. I was interested in:

- How you experience feeling fat (e.g. as a thought or physical feeling)
- What feeling fat means to you
- What happens as a result of feeling fat (e.g. does it make you do things or think different things).

Sources of comfort and help

Talking about your experiences may have left you feeling upset. This is quite normal and should pass in a few days. If you feel upset for more than three days there are local sources of support and comfort, which may already be familiar to you.

1. You could try and speak to your family and friends about your feelings.
2. You can talk to your care co-ordinator at the [REDACTED].
3. If you need advice from a mental health professional outside normal working hours then you can contact the Mental Health Helpline on [REDACTED].
4. There are also a number of national organisations who can also offer you support, for example:

beat (the working name of the Eating Disorders Association; www.b-eat.co.uk) is the leading UK charity for people with eating disorders and their families. They provide information, help and support. The **Beat Adult Helpline** (tel: **0845 634 1414**) is a telephone support service for anyone over 18-years-old. It is open Monday to Thursday 1.30pm – 4.30pm. You can also email them on help@b-eat.co.uk.

The Samaritans (tel. 08457 909090; www.samaritans.org). The Samaritans is a helpline, which is open **24 hours a day** for anyone in need. Their staff are trained volunteers who will listen sympathetically.

5. You are welcome to contact me again to discuss your experiences and feelings caused by taking part in this study, to share any worries you might have or to ask questions.

(Please turn over for contact details)



A charity exempt from registration

Name: Laura Major
Email: [REDACTED]
Telephone number: [REDACTED] (please leave a message for me with the
DClinPsy Course Administrator, [REDACTED], and I will call you back.
Address: Doctorate of Clinical Psychology Training Course,
University of Hertfordshire,
Hatfield,
AL10 9AB.

5. If you have concerns that you would like to raise with [REDACTED], you can contact my
Field Supervisor:

Name: David Viljoen
Email: [REDACTED]
Tel: [REDACTED]
Address: [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

6. If you have further concerns that you would like to raise with the University of
Hertfordshire, you can contact my Academic Supervisor:

Name: Pieter Nel
Email: [REDACTED]
Tel: [REDACTED]
Address: Doctorate of Clinical Psychology Training Course,
University of Hertfordshire,
Hatfield,
AL10 9AB.

Thank you again for taking part!

APPENDIX 8 – Interview schedule

Interview Schedule v2.0
Date: 7th May 2014
IRAS Project ID: 151415

Project Title: What is the Experience and Meaning of 'Feeling Fat' for Women with a Diagnosis of Anorexia Nervosa?

INTERVIEW SCHEDULE

Onset of Feeling Fat

- 1) Could you give me a brief history of your eating difficulties?
- 2) Can you tell me about the first time that you felt fat?
Prompt: When did you first feel fat?

Experience of feeling fat (i.e. what it is like to feel fat)

- 3) Could you describe what the experience of feeling fat is like in your own words?
Prompt: How does it feel physically, emotionally, and cognitively?
- 4) Does your experience of feeling fat change over time or situations?
Prompt: Is there a time/place/situation/emotion in which you feel fat the most/least? Does anything increase/reduce the experience of feeling fat?

Meaning of Feeling Fat (i.e. what it means to feel fat)

- 5) Could you tell me what feeling fat means to you?
Prompt: What does it mean to feel fat? Why is that a good or bad thing? What emotions do you feel when you feel fat? How does it impact on how you see yourself? Does it impact upon your self-esteem? Does feeling fat impact upon your relationship with your body?
- 6) Does the meaning of feeling fat change over time or situations?
Prompt: Is there a time/place/situation in which feeling fat means something different?

Consequences of feeling fat

- 7) What do you do and/or think when you feel fat?
Prompt: Does feeling fat relate to your anorexia behaviour e.g. restricting, fasting, bingeing, purging, over exercising?
- 8) How does feeling fat affect your everyday life?
Prompt: School, work, interests, relationships, self-esteem, identity. What does it mean for your relationship to other people?
- 9) What would life be like if you never felt fat again?

APPENDIX 9 – Audit trail

APPENDIX 9a – Analysed section of transcript, participant 3

	Original Transcript	Exploratory Comments	Emergent Themes
108	I: ...So you said that it makes you feel crap physically, psychologically,		
109	emotionally, would we be able to break that down into those different		
110	areas, would you be able to sort of describe how it is for you physically,		
111	how it is for you emotionally? Or is that a bit tricky?		
112			
113	P3: [pause] it's not tricky, it's finding the right words that suit what you're	Hard to find words...	Difficult to put into words
114	asking for. Physically, as I said you feel fat, you feel sluggish, you feel	for what <u>you're</u> asking	Needing to please others
115	wobbly, you feel untoned, you feel bloated, your clothes are tight. Ummm	Sluggish	Negative sense of self
116	lardy. It's just all negative [pause] vibes. Feelings – it's much the same I	wobbly, untoned, bloated, clothes tight	Negative sense of self
117	suppose. Yuck, its just, its difficult to put into words 'cause to think about	Lardy, negative vibes	Negative sense of self
118	it also, isn't painful but its like hey ho, this is me really. Yeah, er mentally,	Difficult to put into words	Difficult to put into words
119	it makes you feel rock bottom [I: ok] it makes you feel... your self-esteem	Isn't painful but its me	Negative sense of self
120	is lousy, your self-worth. You feel other people are looking at you, you	Feel rock bottom, lousy self-esteem	Negative sense of self
121	feel unattractive to others. You question others all of the time, you	Other people are looking at you	Negative sense of self
122	question yourself.	Unattractive to others	Negative sense of self
123		Questioning self & others constantly	Negative sense of self
124	I: what do you question others about?		
125			
126	P3: how you look. Reassurance – "why are you looking at her? I saw you	Importance of how I look to others	Negative sense of self
127	looking at her" you know its typical 24/7 buzzing in my head [I: ok]. I	Reassurance that other's aren't better	Comparing self to others
128	could be walking down the street and someone will be in front of me –	Social comparison	Comparing self to others
129	"look how skinny she is"		Comparing self to others
130			
131	I: so you think that of the person in front of you, how skinny she is?		
132			
133	P3: absolutely, I don't question other people about their appearance [I:	Want to question others about appearance?	Comparing self to others
134	ok] but I, I definitely notice it	Social comparison	
135			

136	I: mmm, and what goes through your mind then when you see somebody		
137	down the street and you think how skinny she is, what happens next?		
138			
139	P3: bitch, I want to be like that. But then it's rational to think "no hang	Social comparison & jealousy	Not accepting who I an
140	about it's not healthy like that" doesn't stop me wanting to be like it. You	Rationalising – to be viewed	Not accepting who I an
141	might see a bar of chocolate in the shop but you haven't got any money,	positively by me?	
142	it doesn't stop you wanting it does it?		
143			
144	I: no, ok. So you said rationally you can think 'actually its not healthy to		
145	be like that but its...???		
146			
147	P3: yeah it doesn't stop me wanting it	Ideal = skinny – FF tells me I'm not my	Not accepting who I an
148		ideal	
149	I: and when you see people walking down the street, does that influence		
150	the feeling fat?		
151			
152	P3: yeah all the time	Constant social comparison	Comparing self to othe
153			
154	I: how does it influence?		
155			
156	P3: because they look better than me and I wanna be like them [I: ok]	Social comparison & jealousy	Comparing self to othe
157	mmm		Not accepting who I an
158			
159	I: and so if it, does it, does it make you then feel fat seeing other people		
160	or?		
161			
162	P3: [pause] yeah, yeah. I, I, you know if someone walked by me and I	I notice & judge sizes of others	Comparing self to othe
163	judge them to be a size 14-16, I wouldn't think of them as big, but I	I wouldn't think of them as big	Wish to be viewed positive
164	wouldn't want to be that size [I: ok]. If someone slender walked by me, in	I wouldn't want to be that size	Comparing self to othe
165	front of me, next to me, whatever, and I perceive them as slender, more	People more slender than me	Comparing self to othe
166	slender than me, and I think most people are more slender than me apart	Most people are more slender	Comparing self to othe
167	from the out of the ball situation umm... it just, it just makes me go insane	It makes me go insane	Feeling possessed
168	[I: ok]. It's not a jealousy; I'm not a jealous person. [Whispers] It's just	It's not jealousy, I'm not jealous	Wish to be viewed positive
169	it's... I don't know what it is. I just wanna know how they get like that. You	I want to know how they get like that	Not accepting who I an
170	know the, the amount of people on holiday recently, I saw this really	Hyper-vigilance for slender people	Comparing self to othe

<p>171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205</p>	<p>super toned lady and I drove my husband insane because I was obsessed with looking at her. Not in a sexual way, just obsessed. And I wanted to go up to her and say to her "excuse me how do you look like that?" And my husband had to stop me [!: ok]. It's that strong, this body image thing, dymorphia thing, eating thing is that strong. And the body, as I've tried to relay to people, the body image thing, is probably stronger than the eating thing [!: ok] but it does all connect as we know.</p> <p>I: mmm and... so seeing that women on holiday just made you just want to go up to her and...</p> <p>P3: oh I dread going on holiday [!: ok] dread it. Who dreads going on holiday?</p> <p>I: and why is that, that you dread it?</p> <p>P3: because I'm faced with having to show my body, I'm faced with all of these people on the beach, I'm faced with people looking at me – although they don't know me from Adam [!: ok]. It's just being exposed.</p> <p>I: mmm this might sound like a silly question but I wouldn't want to put words in you mouth so I want to hear from your experiences, but what it is about being exposed to people that you don't like?</p> <p>P3: coz I think they're looking at me, how fat I am and are judging my appearance, how wobbly I am, how much cellulite I've got, how un-toned I am, how dis_ yuck I look.</p> <p>I: ok, and what's bad about them thinking that?</p> <p>P3: well I know they don't know me but it matters to me what people think [!: ok] [pause] and that's another big problem [unclear]. That's why I emailed you so when I walked through the door you weren't going to see an emaciated skeleton, you'd be aware of the fact that I look normal, in my eyes anyway so...</p>	<p>Looking at toned lady obsessively Not looking in sexual way, but obsessed How do you look like that? Husband had to stop me, its strong Body dysmorphia thing is that strong I've tried to relay to people Body image thing stronger than eating thing</p> <p>I dread going on holiday Who dreads going on holiday</p> <p>Faced with showing my body Face with people looking at me Feeling exposed</p> <p>People looking & judging me as fat See how wobbly I am, cellulite, untoned How yuck I look</p> <p>It matters what people think That's another big problem I'm not emaciated skeleton I look normal in my eyes</p>	<p>Comparing self to othe Comparing self to othe Not accepting who I an Feeling possessed Feeling possessed Diff for others to understan Feeling possessed</p> <p>Comparing self to othe</p> <p>Feeling not good enou Fearing judgement Feeling not good enou</p> <p>Fearing judgement Negative sense of self Negative sense of self</p> <p>Wish to be viewed positive</p> <p>Feeling not good enou Feeling not good enou</p>
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206			
207	I: so you don't want other people to judge you...		
208			
209	P3: I don't want them to but I'm sure they, I'm convinced they do [I: ok]. I,	Convinced people judge me	Fearing judgement
210	I haven't got paranoia, but I'm convinced that other people judge me.	Convinced people judge me	Fearing judgement
211			
212	I: mmm and what's bad about other people judging you?		
213			
214	P3: [pause] They're reading the books contents before knowing the real		Fearing judgement
215	cover, as simple as [I: ok]... that's a good quote that isn't it?		
216			
217	I: it is, it's a very good quote		
218			
219	P3: yeah I like that		
220			
221	I: so they're reading the contents [P3: yeah] and they're not, sort of not		
222	knowing you [P3: yeah], ok		
223			
224	P3: but also on the flip side of that, this mask is there isn't it you see	I mask the real me	Not accepting who I an
225	because your book's also got a mask on the front of it.	I mask the real me	Not accepting who I an
226			
227	I: ok, and how do you think this mask impacts on the feeling fat?		
228			
229	P3: can you run that past me that again? How does this?		
230			
231	I: does the mask that you use impact on your feeling fat? [P3: yes] In		
232	what way?		
233			
234	P3: Because I can pretend I am ok when I'm not [I: ok] and that is	Mask helps me pretend I'm ok	Need to conceal hated s
235	probably [pause] a... 90% of the time	I'm not ok 90% of time	Not realising ideal self
236			
237	I: ok [pause] so you pretend you're ok when you're not		
238			
239	P3: I've become 25 years an expert at it now to most people [I: ok mmm]	I'm an expert at pretending I'm ok	Need to conceal hated s
240	and I'm very aware of that.	I know I pretend to be ok	Need to conceal hated s

<p>241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275</p>	<p>I: and what are you pretending to be ok from?</p> <p>P3: that people don't realise that I've got a mental health issue... if they were to know it wouldn't bother me, but I've learnt in the past that over the years of experience, that sometimes you can tell people too much [I: ok] so now maybe this is why I've got more of a pretence about it... and also the other thing is, if you say to people 'oh you got atypical anorexia' "you look alright to me, yeah you look fine" and they got no idea what goes on inside your brain so you have to behave the way they expect you to behave and that's ticketyboo fine apart from my physical condition she's ticketyboo she's fine [I: ok]... [pause] and that's not the case.</p> <p>I: is there anybody you can be with without the mask in place?</p> <p>P3: my psychologist that I see on a weekly basis and also...[pause] the majority of the time [pause] my husband who I drive insane.</p> <p>I: ok. Why do you drive him insane?</p> <p>P3: because I get on his nerves [long pause] coz it's trying to explain to people without getting on their nerves 'cause there comes a point "I don't want to hear it anymore" and that's where we're at now. So I don't have a chance to express, unleash it you know?</p> <p>I: mmm what do you like to be able to unleash and express?</p> <p>P3: just how I'm feeling, I suppo_, in the work that I do I support people with mental health issues and learning disabilities [I: ok] and I give them all the time in the world that I've got, and I really get into their mind to understand them. I ask the same of other people with me but then I can't expect that of everybody.</p> <p>I: ok and what kind of things do you want to tell them that will make you feel better?</p>	<p>Don't want people to know I have MH Previous experience You can tell people too much This is why I have a pretence / mask</p> <p>You look alright to me, you look fine They don't know what goes on in brain Have to be ticketyboo, fine Have to be ticketyboo, fine but I'm not</p> <p>Can be self unmasked self with psychologist and husband most of time</p> <p>I get on his nerves trying to explain I get on their nerves "I don't want to hear it anymore" Express/unleash = ?</p> <p>Want to express how I am feeling I support people in work I get into their minds to understand Can't expect people to do the same</p>	<p>Fear of rejection Fear of rejection Fear of rejection Need to conceal hated s</p> <p>Diff for others to understand Diff for others to understand Fear of rejection Fear of rejection</p> <p>Diff for others to understand Diff for others to understand Feeling unsupported Feeling unsupported</p> <p>Feeling unsupported Feeling unsupported Feeling unsupported</p>
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<p>276 277 278 279 280 281 282 283 284 285 286 287</p>	<p>P3: "have you got any idea with its like to be like this everyday, 24/7? Have you got any idea?" that's just what I want to say to them. Take a walk in my shoes, step into my world because they've got no idea.</p> <p>I: so is it about them understanding what it's like?</p> <p>P3: yes absolutely [I: ok] especially when, I keep going back to this, especially when people perceive me as being ok. I don't want sympathy from anybody but I want them to realise 'oh there's not something quite right there'</p>	<p>Do you know what its like to be like this? Have you got any idea? You need to step into my world to understand</p> <p>Desire to be understood People perceive me to be ok Want people to realise I'm not ok</p>	<p>Feeling misunderstood Feeling misunderstood Feeling misunderstood</p> <p>Feeling misunderstood Feeling misunderstood Feeling unsupported</p>
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APPENDIX 9b – List of emergent themes, participant 3

Negative sense of self
Comparing self to others
I'm beyond help
Needing to please others
Feeling not good enough
Feeling misunderstood
Feeling unsupported
Difficult to put into words
Difficult for others to understand
Disappointed with self
Comparison to previous self
Feeling out of control
Feeling repulsed by self
Rare to not FF
Need to conceal hated self
Not accepting who I am
I'm a nice person vs I'm repulsive
It's a miserable existence
Feeling unworthy
FF most believable feedback
Striving for unattainable goal
Fearing judgement
Fearing rejection
Not realising ideal self
Wish to be viewed positively
Carrying the weight of the world
Feeling possessed
External focus reduces FF
Control feels/looks good

APPENDIX 9c – Clustering of emergent themes, participant 3

Superordinate Theme 1	Emerging Themes	Page#. line#	Quote
Negative sense of self	Not accepting who I am	3.95 15.546	<ul style="list-style-type: none"> • you hate the way you look and feel so disgusting you have to put this mask on • they just accept themselves...But I can't say that to myself, I'm probably half their weight.
	Feeling not good enough	9.302 17.619	<ul style="list-style-type: none"> • It saddens me that I don't look good enough • You just feel yee_, physically like you're just nothing
	Negative sense of self	3.94 4.115 17.619	<ul style="list-style-type: none"> • When you feel so negative about yourself and you hate the way you look and feel so disgusting • Physically, as I said you feel fat, you feel sluggish, you feel wobbly, you feel untoned, you feel bloated, your clothes are tight. Ummm lardy. It's just all negative [pause] vibes. Feelings – it's much the same I suppose. • oh rock bottom, absolutely crap, rock bottom. You just feel yee_, physically like you're just nothing
	Comparing self to others	5.165 15.536	<ul style="list-style-type: none"> • If someone slender walked by me, in front of me, next to me, whatever, and I perceive them as slender, more slender than me, and I think most people are more slender than me apart from the out of the ball situation umm... it just, it just makes me go insane • having been out seeing skinny people, having seen a picture in a book, having seen a magazine, having seen someone on tele.
	Disappointed with self	13.454 15.484	<ul style="list-style-type: none"> • because maybe I should have eaten something more nutritious • It makes me feel miserable that I'm letting myself down
	Comparison to previous self	2.57 9.303	<ul style="list-style-type: none"> • I know I would have felt fat if things were too tight. I had one pair of jeans I always kept for donkey years and they were my safety jeans. I now have safety trousers so it's no different. • Like I don't look like I used to look when I was very anorexic
	Feeling repulsed by self	3.78 11.375	<ul style="list-style-type: none"> • disgusting, unsightly, unattractive [pause], slobbish, blubbery [pause] just, just repulsed with yourself. • Erm I'm a shocker for baths and showers, getting undressed in front of my husband, anything like that that shows my nakedness. Sitting on the toilet even with the fat hanging over the side of the toilet seat. Sitting here now even with the fat on my legs. It's just shocking.
	I'm a nice person vs I'm repulsive	15.541 17.619	<ul style="list-style-type: none"> • in my heart I know I'm a nice person but its just this fat appearance business thing • You just feel yee_, physically like you're just nothing, I say that and emphasise physically because personally, personality wise I know that I'm a good person
	Not realising ideal self	2.54 10.362	<ul style="list-style-type: none"> • I remember weighing 8 stone 12 and it was 'woah my god' • kidding yourself that you can get into a smaller size when you can't
	Control feels/looks good	10.337 20.1010	<ul style="list-style-type: none"> • I had control of it [I: oh ok]. To me it's all a control thing. When I think about it, I'll swim excessively, having salad every night. And I'm just on the buzz because I can swim manically • this is probably the only part of my life that I've got control in
	Feeling unworthy	18.629	<ul style="list-style-type: none"> • I don't ever treat myself to anything nice as in clothes, I always buy second hand.
	External focus reduces FF	26.943 27.974	<ul style="list-style-type: none"> • When I'm working I'm focused on the people that I support, it doesn't mean its not there its just in a little box behind my right earlobe, not at the front you know [chuckle]. • ummm it's always there [pause] it's how much you allow yourself to be aware of it

Superordinate Theme 2	Emerging Themes	Page#. line#	Quote
Feeling possessed	Feeling possessed	3.93 15.526	<ul style="list-style-type: none"> it just makes you, it makes you something that you're not some people might say it feels like you're a devil possessed
	Feeling out of control	10.340 19.669	<ul style="list-style-type: none"> I have not been able to exercise properly and that has really affected my mental health [I: mm], especially now this questioning you're doing about research feeling fat, you've got me at a really good time [I: why?] because its absolutely 200% paramount currently Especially because I haven't been able to exercise impact bang, you know
	FF most believable feedback	21.764 25.907	<ul style="list-style-type: none"> if you said to me 'oh [REDACTED] you've got a lovely figure, you don't need to worry about loosing weight, if anything you need to put it on'. I wouldn't believe any of that He can tell me until he is blue in the face how great I look, how slim I am, I don't believe him for one minute. And I say that with a lot of passion and a lot of conviction, I don't believe it. My kids say 'oh mum you look nice' but I'll poo poo it. I won't believe it.
	I'm beyond help	16.578 24.859	<ul style="list-style-type: none"> I just have something deeply ingrained and it's a daily struggle It's so ingrained in me now I've had years of help, I've had CBT, person-centred approach therapy, this new therapy I'm doing, private counselling... odd courses here there and everywhere, I've had years of support intermittently and its never gone away

Superordinate Theme 3	Emerging Themes	Page#. line#	Quote
It's a miserable existence	Carrying weight of the world	14.489	<ul style="list-style-type: none"> It makes you feel very troubled [I: ok] like this massive boulder on your head 24-7. Yeah it probably a good way of putting it. Like the guy who carries the world around on his shoulders, it feels like that
		26.296	<ul style="list-style-type: none"> It's just, it's a burden ummm nuisance isn't quite strong enough, burden is better
	It's a miserable existence	9.309	<ul style="list-style-type: none"> if I could wake up tomorrow with no mental or physical health problems ah the world would be a different place'
		20.736 25.924	<ul style="list-style-type: none"> I'm very miserable, very downbeat Miserable existence, although I'm not a miserable person generally.
	Rare not to feel fat	13. 475	<ul style="list-style-type: none"> ummm so there's times like that when I don't feel fat but it's the majority of time that I do. Very rare, very rare occasions, very very rare.
Striving for unattainable goal		14.492 20.709	<ul style="list-style-type: none"> it feels like that [I: ok] every day every hour, every minute that you feel fat I was trying to give an example of a rare, oh my god very rare occasion it might do.
		9.330 20.706	<ul style="list-style-type: none"> When I'm on a buzz, when I've lost loads of weight but then I'll even still turn around and look at my backside and legs and think they're still a bit fat still that one situation I gave the example of when I'm pencil thin...[pause] I'll still find a reason to say I feel fat, although it will be less logical then but that feeling of feeling fat, [sigh] does it ever go away? No.

Superordinate Theme 4	Emerging Themes	Page#. line#	Quote
Feeling fat is difficult to put into words and to understand	Difficult to put into words	3.77	• It's really difficult because I'm sitting on the chair even now feeling it. Ahhh
		4.118	• Yuck, its just, its difficult to put into words 'cause to think about it also, isn't painful but its like hey ho, this is me really
	26.928	• I don't know what words to use that are powerful enough to express it without blaspheming	
	Difficult for others to understand	22.779	• I think is difficult for people to understand because as I say I come across as a normal person
		3.76	• It's like you've got to be inside my head to understand what I'm saying.
		25.885	• he just doesn't put up with any rubbish from me and that's his way of dealing with it.

Superordinate Theme 5	Emerging Themes	Page#. line#	Quote	
Wish to be viewed positively: Fearing rejection	Needing to please others	2.71	• it's hard to describe, although I will try to for the purpose of this research	
		16.564	• I'm a pleaser, I would say yes I probably have because I'm too keen to please other people	
		18.631	• I go out of my way to buy things for other people to make sure they look lovely	
	Fearing judgement	6.196	• coz I think they're looking at me, how fat I am and are judging my appearance	
		6.210	• I don't want them to but I'm sure they, I'm convinced they do [I: ok]. I, I haven't got paranoia, but I'm convinced that other people judge me.	
		11.374	• And I do wash by the way just for this record, I do wash! [I: laughs]	
			17.602	• because I worry about what you're thinking about me
	Fearing rejection	16.565	• For other people to like me and to accept me. Which is why I suppose all this appearance thing comes in. I want to look a certain size so people think I'm part of normal everyday life	
18.663		• Physically I'm not a very tactile person but I need to know that I'm loved for who I am. And that makes it very difficult when I'm questioning what he thinks I look like		
Feeling misunderstood	8.278	• "have you got any idea with its like to be like this everyday, 24/7? Have you got any idea?" that's just what I want to say to them. Take a walk in my shoes, step into my world because they've got no idea.		
	24.887	• I want people to understand me, but no its like 'no don't talk about it right now leave it out there'		
Feeling unsupported	8.262	• it's trying to explain to people without getting on their nerves 'cause there comes a point "I don't want to hear it anymore" and that's where we're at now. So I don't have a chance to express, unleash it you know?		
Need to conceal hated self	3.91	• Although I'm coming across, as I'm sure you've picked up straight away, as quite a bubbly, cheerful person but others will tell you in this field of work I am, who I work with – it's a mask		
	7.235	• Because I can pretend I am ok when I'm not [I: ok] and that is probably [pause] a... 90% of the time		
Wish to be viewed positively	5.169	• It's not a jealousy; I'm not a jealous person. [Whispers] It's just it's... I don't know what it is.		
	6.202	• well I know they don't know me but it matters to me what people think		
	12.433	• I'm not trying to you know undermine you when I say that		
		15.543	• Even if I see an obese person walking down the street, and to me obese is like 20 stone or something like that... I don't think they look fat, I just think 'good luck to them,	

APPENDIX 10 – Recurrence of themes across participants

Superordinate Theme	Subordinate Theme	Jody	Ava	Mandi	Rachel	Lisa	Sarah	Savannah
Negative sense of self	Negative hyperawareness of their bodies	✓	✓	✓	✓	✓	✓	✓
	A perceived sense of inadequacy	✓	✓	✓	✓	✓	✓	✓
	Fearing judgement	✓	✓	✓	✓	✓	X	✓
Feeling out of control		✓	✓	✓	✓	X	✓	✓
Coping with feeling fat	Eating disorder behaviours	✓	✓	✓	✓	✓	✓	✓
	Distraction	✓	X	✓	X	✓	✓	✓
	Finding self-worth outside of weight	X	✓	X	X	✓	✓	✓
The complex notion of 'feeling fat'	Difficulty verbalising the experience	✓	✓	✓	✓	✓	✓	✓
	Feeling misunderstood by others	X	X	✓	X	✓	X	✓