Original Paper

The Social Construction of Defect Personal Stories of Emotions in Eating Disorders

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Abstract

This article explores episodes characterized by overwhelming emotions in Eating Disorders (ED). In ED, emotions and symptoms are connected. The mentalizing perspective understands eating disordered symptoms as a form of regulation of painful emotions and as indicative of a reduced ability to attend to mental states in oneself and others (impaired mentalizing). However, the interpersonal and emotional processes associated with impaired mentalizing are insufficiently attended to in research. Based on interviews with eating disordered patients, this article analyses stories of everyday episodes portrayed as emotionally overwhelming. The results of this analysis establish that a wide array of emotions or emotional experiences are activated, the most prominent being inadequacy, anger, discomfort, fear, and sadness. Episodes are typically "multi-emotional", characterized by a variety of emotional constellations. The findings do not indicate that eating disordered patients generally have difficulty identifying emotions. Eating disordered symptoms are therefore discussed as a form of defense. The episodes described typically instigate the activation of eating disordered symptoms. Furthermore, the episodes are predominantly social, with other people present, whether physically or in mind. In conclusion, the article discusses the implications of the findings to the understanding of eating disorders and treatment.

Keywords

eating disorders, mentalization, emotions, illness narratives, qualitative study

1. Introduction

In spite of extensive research in various disciplines to establish a "single paradigm of the 'real' origin of the disease" (Brumberg, 2000, p. 26), there is still a lack of consensus concerning the etiology of eating disorders (Tozzi et al., 2003). Accordingly, Eating Disorders (ED) are described as

"incompletely understood," but are "generally agreed to be multi-factorial" (Serpell & Troop 2003, p. 151). Bruch's pivotal work on Anorexia Nervosa (AN), and her hypothesis that AN was a condition that grew out of the inability to experience or express one's own emotions (Bruch, 1962, 1982; Fox 2009; Skarderud, 2013) has been central to the field of eating disorders and emotions. In recent years, considerably more attention has beenpaid to the significant role emotions play in eating disorders (Fox & Froom, 2009; Fox & Harrison, 2008; Geller et al., 2000; Waller et al., 2003). Consequently, having proved productive in analyzing emotions in eating disorders, the metallization model has achieved a recognized position in the eating disorder field (Skarderud & Fonagy, 2012). This study explores *episodes* in which patients are overwhelmed by emotions, i.e., experiencing impaired mentalizing. In this context, an "episode" means an incident (individual occurrence) in the course of a series of events in a person's life or everyday experiences.

The concept of metallization is relatively new, but is used with increasing frequency in the literature (Brown, 2008, Skarderud et al., 2011). According to Allen (2003), mentalizing relates to the concept of intentionality, as it involves the acknowledgment of "intentional mental states such as desires, feelings, beliefs and the like" (2003, p. 94). Mentalization is further connected to mental representation, which concerns the ability to hold an idea about something in our mind even if it is not congruent with our reality, such as being able to imagine diverse ways in which others may think or feel, "wondering why they do what they do, striving to understand their actions" (Brown, 2008, p. 31). Similarly, Bateman and Fonagy describe mentalization as "our ability to attend to mental states in ourselves and in others as we attempt to understand our own actions and those of others on the basis of intentional mental states" (2012, p. xv). For the purpose of this study, mentalization refers to the *ability to identify and express one's own thoughts and feelings and those of others*.

In discussing verbal expression of emotions in anorexia and Bulimia Nervosa (BN), Davies et al., (2011) refer to Bruch's (1973) famous explanation that an inhibition of emotion is a key feature of AN. In other words, Bruch considered this reduced mentalizing capacity to contribute to the maintenance of the disorder. Self-report studies have shown that individuals with an eating disorder fear the consequences of expressing positive and negative emotions (Geller et al., 2000; Lawson et al., 2008; Iannou & Fox, 2009, Davies, 2011).

Reduced affect regulation has long been considered a quality in ED patients (Espeset et al., 2012), and numerous theoretical models suggest that eating disordered symptoms are a means of affect regulation (Cooper et al., 2004; Harrison et al., 2009, Fox & Fromm, 2009, Fox & Power, 2009; Schmidt & Treasure, 2006; Skarderud & Fonagy, 2011; Waller et al., 2007). Despite the recognized relationship between affect regulation and eating disordered symptoms, there is limited knowledge about these processes and the context in which this correlation occurs (Espeset et al., 2012). While treatment is beginning to focus on emotional and interpersonal processes, "*the precise nature of these processes, and their contribution to the maintenance of the ED still requires empirical exploration in order to refine these treatments*" (Davies, 2011, p. 476, my emphasis). The article describes these social end

emotional processes by exploring the qualities of episodes where strong emotions arise, contributing to eating disordered behavior.

1.1 Eating Disordered Symptoms as Representations of Impaired Mentalizing

In early psychological and psychoanalytic models of eating disorders, symptoms were seen as representative of an internal state of mind that had specific *meanings* (Skarderud & Fonagy, 2012). The mentalizing model, however, understands symptoms as representations: starvation, purging, and other symptoms *represent a need to drown out or reduce painful, distressing self-states*. This is a shift in perspective for eating disorders, from a focus on the *meaning* of symptoms (*what* they mean), to an interest in "the *how* of representation" (ibid, p. 352), or in other words an awareness of impaired symbolic or mentalizing capacities. The concept of "embodied mentalizing" suggests that for patients with an eating disorder, the body has anexpressive (communicative) function, as mentalizing-or *identifying and expressing the emotions*-fails: the thin body, the empty body, the numb body, "talks" about painful emotions. However, with the exception of Skarderud (2007, 2007a, 2007b), few studies have explored overwhelming emotions asexperienced by eating disordered patients.

Although the experience of "feeling fat", according to Bruch, is directly connected to the inability to distinguish or express one's own emotional states (Bruch, 1962, 1982), psychological therapies were late in taking the emotional difficulties in eating disorders into account. However, the idea that eating disordered behaviors seek to moderate or suppress emotions has started to gain influence within the literature (Fox, 2009, Cooper et al., 2004, Waller et al., 2007, Skarderud & Fonagy 2012).

While Espeset et al. (2012) explore how patients view the relationship between *negative* affect and *anorexic* behavior, this study includes both Anorexia Nervosa (AN) and Bulimia Nervosa (BN). Additionally, and based on the assumption that weakened mentalizing may occur in relation to any kind of emotion, this study aims to identify any emotionor emotional experience that is experienced as overwhelming, whether these are "negative" (e.g., sadness) or "positive (e.g., happiness) in character. Models that understand eating disorder symptoms to suppress emotions ask questions about the role of emotions in ED, about which emotions are important, and about whether some emotions occur more frequently than others do. The level and duration of emotional arousal are also interesting topics in this respect. Fox (2009, p. 238) raises the question of whether persons with eating disorders have difficulties with everyday levels of emotion. This study responds to these questions.

Thus, we know little about both the behavioral and social features, and the communication that characterize these processes. To address this knowledge gap, this article identifies the *location* where the episodes occur and the people depicted as *characters* in the episodes. Further, it uncovers the *emotions* activated in the situations, and exposes the *crisis or incident* that provides tension and emotion arousal. According to Bochner and Riggs (2014), stories also always have a point or *moral* that gives meaning to the experiences depicted.

This article starts with a presentation of the "mentalization" concept in ED, followed by a presentation of the research design. Thereafter, the presentation of the results pays special attention to the emotions

identified in the interviews and the context in which these emotions arise. The article concludes with a discussion of the findings, underlining the defense aspect of episodes and its implications. Recommendations for further research is suggested.

2. Method

The study goals and choice of methodology address the point that the role of subjective experiences of basic emotional processes in the development and maintenance of ED has not been sufficiently considered. This has contributed to the neglect of "emotional inhibition" as an important concept in studies of emotions in ED (Fox, 2009), and limited discussion in the literature on the subjective experience of emotions in ED, and how people account for the difficulties they experience when their emotions are hindered. This study therefore employs a phenomenological approach in which understanding the phenomenon from the perspective of the patient is emphasized. The research design thus understands the patient as the expert of his or her own illness experience, and asks the participants to describe episodes or situations in which they have experienced being overwhelmed by (strong) emotions. These are situations in which the ability to identify both own and other peoples thoughts and feelings may be affected. Such narratives about illness told by ill persons themselves also contain "the culturally patterned social and personal elements of sickness," elements often excluded from the technically constrained discourse of disease (Kleinman & Seeman, 2000, p. 231). The illness narratives are thus "narratives *about* illness" (Hydén, 1997, p. 54); stories that convey knowledge and ideas about the ED. However, they are also "narratives*as* illness" (ibid.), indicating that the storyteller, illness and narrative are combined, and that the ED experience is told through a personal narrative about occurrences that have been problematic for the person.

The participants were asked to describe episodes in which they were overwhelmed by emotions. Therefore, they told *stories*. Storytelling is not an easy endeavor in general. First, stories are told *in situ*, as a response to a request, "assembled to meet situated interpretive demands" (Gubrium & Holstein, 1998, p. 166). Stories are thus not readymade to tell, they actually are "unfinished" (author, 2010), and have to be construed in the exact moment of telling. This incomplete aspect of the illness narratives means that the storytellers appreciated an "assistant voice" (Hydén, 2000), to guide them through the recounting of their experiences of illness. In this case, the assistance was a semi-structured interview guide that helps the interviewee in starting and structuring the telling. Another aspect of storytelling about ED that is likely to be challenging is the description of experiences of an illness that to date has an unanswered etiology not yet put into words (author, 2010, 2012).

2.1 Participants

Participants were recruited from a specialized service for eating disorders and were inpatients at the time of the interview. Twenty persons were invited to participate, of whom14 accepted. This number is presumed to be large enough to cover different episode characteristics. Furthermore, data collection, transcription, and analysis had to be manageable within the time available. The sample consists of 12

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women and 2 men aged 18 to 44 (mean 26.4). Nine participants had no previous history of hospital treatment for their eating disorder, while five had a previous history of hospitalization, two for only very short periods (days). Participants thus had limited familiarity with the understandings of and terminology for ED used in treatment.

The inclusion criteria consisted of inpatient hospitalization for a regular period of three months of treatment in the eating disorder unit. Illness severity was an exclusion criterion, as some acutely ill patients were considered unsuited to participate in the study for health reasons and it was also considered ethically inappropriate to ask these patients to participate. Decisions about which patients were too ill to be asked to participate were made in consultation with the therapists in the unit.

Table 1. Overview of Participants

Participants	Age	Gender	ED diagnosis at admittance	BMIat interview	Relationship status	Children
1	21	M	AN	18.0	Single	
2	27	F	BN	26.7	Single	
3	32	F	BN	21.9	Single	
4	33	F	BN	20.2	boyfriend	2
5	20	F	BN	19.7	Single	
6	40	F	AN	15.9	Single	
7	18	F	AN	16.0	Single	
8	22	F	AN	15.5	Single	
9	28	F	AN	15.0	single	1
10	20	F	AN	17.6	Single	
11	25	F	BN	22.8	co-habiting	
12	22	F	AN	18.4	Single	
13	18	F	AN	16.7	Single	
14	44	M	AN	15.8	Single	
In total	Mean: 26.4 AN: 25.9 BN: 27.4	Male:2 Female:12	AN: 9 BN: 5	Mean: 19.4 AN: 16.5 BN: 22.3	Single: 12 In relationship: 2	Having children: 2participants

As the ED-unit accepted AN and BN patients only, these are the diagnoses represented among the participants in the study. Nine participants had an AN diagnosis, while five were diagnosed with BN. The majority had an additional diagnosis, the most common being depression. Twelve participants

were single at the time of the interview. Only two of the participants had children. Both relationship status and parent status are similar to those found in previous studies (Moen, 2010), in that participants are mainly single with no children. At the time of the interview, the current Body Mass Index (BMI) averaged 16.5 (range 15.0 to 18.4) for the AN group, and 22.3 (range 19.7 to 26.7) for the BN participants.

2.2 Data Collection and Analysis

The semi-structured interview guide developed by Skarderud and Karterud (2011) to explore impaired mentalizing in ED has been further developed by the author to correspond to the purpose of this study: to explore *episodes* characterized by overwhelming emotions in eating disorders. The interviews took place in a suitable room in the hospital. The interviewees were thus familiar with the site, and they were also familiar with the interviewer, as I worked part-time at the hospital ward at the time. All interviews were conducted and transcribed by the author. The interviews lasted from 30 minutes to two hours, resulting in approximately 300pages of interview transcripts. In contrast to other studies of ED in which interviewees withdrew (i.e., Fox, 2009), all participants appeared for the interviews.

The interviewer opened the interviews by repeating the purpose of the study, which had also been explained in the consent form. Then the interviewee was asked whether in the past week or so they had experienced one or more episodes where they have felt overwhelmed, for instance felt like "losing control", felt "unable to think clearly", felt like "shutting down", or like the situation is unbearable. Often the interviewees were able to remember one or several episodes that were either recent or took place sometime earlier. The participants were then encouraged to talk about the episode they found to be the most emotional and then to talk about one or more such episodes, if able to. In these stories, the identification and exploration of emotions or emotional experiences were of particular interest. The framing, such as the location of and potential participants in episodes, was also a significant focus area for the research. The interviews also focused on information that could help illuminate thoughts, ED symptoms, level and length of emotional arousal, and the episode rate in recent months.

The interviews were analyzed using first cycle and second cycle codes and coding (Miles et al., 2014). The first cycle coding represent the codes initially assigned to the data. By descriptive coding, I assigned labels to data to summarize the basic topics in the participants' descriptions of the episodes, i.e., where the episode took place, persons present, incident and thoughts and emotions that occurred. Some codes were made prior to fieldwork, as I wanted descriptions of the specific episodes in which participants had felt emotionally overwhelmed. In the second cycle coding, segments of data from first cycle coding were grouped into categories, identifying emergent themes and explanations. The final discussion on defect and defense is a result of this condensation.

2.3 Ethical aspects

The study is approved by the Norwegian Regional Committee for Medical Research Ethics. The topic of this research is sensitive, as it concerns behaviors that are "intimate, discreditable or incriminating" (Renzetti & Lee, 1993; in Liamputtong, 2009, p. 227), and occurs in back regions (Goffman, 1992), the

"private spaces" where personal activities take place and only insiders participate (De Laine, 2000, in Liamputtong, 2009, p. 227). The researcher must be attentive to these intimacies.

About two weeks after potential participants arrived in the hospital ward, they were handed an invitation to participate in the study by the staff at the hospital ward. The invitation consisted of a description of the study and a consent form. The patients were asked to sign the consent form and return it to the staff if they wanted to participate in the study. As the participants were considered vulnerable (Liamputtong, 2009), the staff was made aware that patients might feel pressured to participate given the context of their hospitalization, and staff was therefore instructed to highlight the voluntary nature of their participation.

3. Results

In total 38 multifaceted episodes characterized by overwhelming emotions are portrayed in the data and analyzed. Table 2 below illustrates the key components in the episodes: they take place at a *location*. At the location, there are typically one or more *characters* present (social interaction). The location and the characters form the context for *the occurrence* itself. The fourth component included is *the emotions* activated.

Table 2. Episode (n=38) Components and Characteristics

Episode components			
Locations	Interaction	Occurrence	Overwhelming emotions
Specific or non-specific locations	Social or non-social episodes	Critical event/ happening	Types of emotions

The *locations* where the episodes occur are categorized as specific and non-specific locations or places. Different *characters* also appear in the episodes, and these largely depend on the location in question (for instance, in the parents' home, the characters are usually parents, step-parents or siblings). Characters are thus significant others or general others (Mead, 1934), such as family members or random people at the scene. Further, characters are either physically present at the scene or present in the storytellers mind only. The location *and* the characters constitute the context for the occurrence. This problematic event or happening underpins the overwhelming *emotions*. The stories describe several emotions as interrelated in the episodes. However, some emotions are identified as occurring more frequently than others occur. The emotions have in common that they are perceived as overwhelming in nature. A representation of the identified components in the episodes is provided below. Based on the findings, the article also argues that the episode components form a temporal order, in which they start out at a social or not-social location where something happens. This context generates emotions.

3.1 Episode Locations

The episodes are categorized as taking place at *specific* or *non-specific* locations. The specific locations are a) the parents' home, during visits, b) the hospital ward, where the person is an inpatient, or c) in the storyteller's own home. However, about half of the episodes (16) take place at non-specific locations, and are categorized as "could be occurring anywhere," in the words of one participant. In these latter stories, the physical location is understood as not having a significant impact on the episode. This contrasts with the former case, where the location influences both participants and events in the episodes.

Episodes taking place in parents' homes occur during visits to participants' parents. Visits often include meals; having coffee and cakes or dinner. However, the situations described do not relate to food *per se*; rather, the interaction between the participants in the episodes and the topics discussed seem to be the most important elements. One exception is Anna's childhood memories of being denied another slice of pizza. To be served pizza at her parents now, hands her the overwhelming sad emotions on a plate, so to speak. Filling her up. The binging and purging that follows, lasts for days. In this way, food, relations, present and past is intertwined.

Episodes taking place in the hospital ward either concern a specific event (weighing) that normally takes place on a specific day of the week as inpatients have to step on the scales, or episodes relate to meals or food. One episode also involves participation at a weekly staff meeting, during which the treatment for the specific patient is discussed.

Episodes taking place at home are situations characterized by the person being home alone, either because they live alone, or because the person they live with (partner, mother) is away. Even though these are all situations where the storyteller is alone, they are social in character. This is because the stories of the episodes include other persons, their actions, and/or their presumed thoughts and feelings.

Episodes taking place "anywhere" (non-specific)are also characterized by being social. Such situations include being "in the exercise room and the person next to you is a faster runner" or at the supermarket and the salesperson does not smile at you and you think, "no one is nice to me". Another example involved being at the library borrowing a book, reading in it, and finding that "this is in fact too advanced for me", or just "starting to think about something you have said" (that brings up feelings of shame). These situations include interaction with other persons, with other minds, or comparison with other persons. A frequent subject in these stories is the feeling of inadequacy: of not being satisfactory or good enough when it comes to physical appearance, academic/intellectual achievements, athletic skills or intellectual or social capital (Bourdieu, 1995).

3.2 Episode Interaction

A majority of the episodes describe other persons *physically* present. Six of the episodes have people present *in the storytellers/participants mind*. Thus, in total 32episodes include other persons, physically present or present in mind. These are therefore defined as social episodes. Six episodes are defined as non-social, meaning that they contain no apparent interaction with other persons. Most of the episodes

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are social in character. When the narrator, on the other hand, is alone both physically and in mind, the episode is characterized as *non-social*. In these episodes, the overwhelming emotions are described as generated by, for instance, the weighing in the hospital ward activating anger and fear: the fear that arises while being home alone and bored, or the uneasiness and insecurity evoked by thinking that maybe one will never recover. In addition, one person described the ED and the daily binging and purging as a habit.

Six episodes where the interviewee is physically alone are social in character, as the stories include other persons appearing in the interviewee's mind. These other persons are often significant others (Mead, 1934) such as parents and siblings, but may also be generalized others (ibid), such as when interviewees think about "what other people might think."

Most episodes are characterized by social interaction with other persons physically present at the same location as the interviewee. As table 3 illustrates, half of these episodes are described as occurring "anywhere" (at random locations) and consequently, the persons interviewees interact with in the episodes are also random and dependent on the location or activity. Furthermore, seven of the episodes take place in relation to significant others, like parents, siblings or the interviewee's own children. Six episodes are described as happening in interaction with staff and other patients in the hospital ward, while another seven episodes happen in interaction with people in the course of everyday activities: pupils at school, members at the gym, or customers in the cafeteria.

3.3 Episode Emotions/Emotional Experiences

Each episode describes the activation of a range of emotional experiences. An episode is never described as activating one or two emotional experiences only. However, some types of emotions are described as occurring more often than others, and this is especially true for the emotions of inadequacy and anger, which, as Table 4 shows, are portrayed as prominent in half of the episodes.

Table 3. Emotions/Emotional Experiences Activated in Episodes-Frequency (Episodes: n=38)

Emotion/emotional experience	Frequency (n=38)	Percentage of total
Inadequacy	19	50
Anger	18	47
Discomfort	13	34
Fear	11	29
Sadness	10	26
Resignation	9	24
Shame	6	16
Uncertainty	5	13
Stress	3	8
Exhaustion	3	8

As illustrated in Table 3, the most frequently occurring emotional experience is inadequacy, described in half of the episodes, closely followed by anger (experienced in 18 of 38 episodes). These two are distinguished from the rest by their relative dominance in the stories. The third most common emotional experience is discomfort (13), followed by fear (11), sadness (10) and resignation (9) – all occurring relatively often in the stories (in about one-third of the episodes). Below, the emotions and emotional experiences that are most common in the stories are presented. Due to their relative low incident rate, the emotional experiences of uncertainty, stress, and exhaustion are not included.

3.3.1 Inadequacy

Nineteen out of thirty-eight reported episodes of weakened mentalizing describe emotions of inadequacy. This emotional experience is also portrayed as inefficiency, shortcoming, incapacity, lack of independence, and feelings of failure. Further, interviewees describe feeling incompetent, not being "good enough," feeling "like a loser," as if they are "not doing things right," or as if they will "never be able to succeed at anything". Cindy's story takes place at her parent's house, sitting "around the dinner table... everybody talking about the fantastic life my sister lives":

You know; living abroad, now she is going to New York, funding her education through a grant, and you know..."lalala". And here I am; in and out of hospitals, struggling to finish my studies, not knowing what I'd like to do... and... and... so... that meal was quite... difficult.

It was thus not the food aspect of the meal that Cindy experienced difficult, but the topic of the conversation and how this made her feel. When I asked how the episode made her feel, she responded: "Mmm, a feeling of inadequacy and as if... one had the impression that positive attention requires an effort." Cindy got the feeling that she had to accomplish something, had to be *effective*. Bruch describes the feeling of ineffectiveness as a symptomatic feature in ED, explaining anorexia as "a struggle for control, for a sense of identity, competence and effectiveness" (Bruch, 1973, p. 24). According to Bruch (1962, 1973) the paralyzing sense of ineffectiveness is caused by the "lack of awareness of inner experiences and failure to rely on feelings, thoughts and bodily sensations to guide behavior" (Skarderud, 2013, p. 176), or in other words, impaired metallization. However, it could be argued that the social interaction Cindy describes communicates the valuation of achievements and successful constructions of identity that is characteristic of contemporary society (Giddens, 1990, 1991; Beck, 1992). Cindy also describes feeling "some kind of envy, but also deep <u>fury</u> (underlining indicates that the word is stressed), because... my sister has not gone through the same things that I have"; this refers to her parents' divorce, which she believes had a harsher effect on her as the oldest child. The episode made her think that "I have to pull myself <u>together</u>, rather... in my life" and she noticed that self-examining thoughts about stagnation emerged. Her story illustrates how feelings of inadequacy, but also anger, arise during the interaction: the experienced lack of social valuation produces the emotional experience of inadequacy. She handled the emotional turmoil later that afternoon by binging. Sarah also describes the emotional experience of inadequacy. She states that eating makes her feel "like a big loser," but if she does not eat, she feels like "I am light, and as if I am winged, and I am good at

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something." "*Why is 'not eating' to be good at something?*" I asked. She explained: "Because… I am really not good at anything, but if I can do that, then it is something." It is hard, not eating, and this makes it an achievement. "There is nothing that I am good at," she stated loudly, "You know, that is something to <u>mention</u>." She continues:

I wish there was something that could define me, that…for instance if you are really good at soccer, then... "Oh, Linda, she's the good soccer player." Or, if I for instance played the violin, but I… I gave it up, but if I had continued and been… you know, if I had been good at it, and practiced more, and continued, then I could have been "Sarah who is such an accomplished violin player," right? Or… when somebody is, like my sister, she is very, you know, <u>sociable</u> and charms people, she is good at storytelling or... entertaining, or… very... so that is sort of something that she is good at. Whereas me… I wish I were good at… puhh (small laughter), I don't know...

The feeling of inadequacy, that she will "never accomplish anything in her life" and that she "will be in this same spot for the rest of my life," is evident in Sarah's despairing voice. She is angry with herself, and sad that emotions and thoughts make her miserable all the time, "but it is really hard turning a complete way of thinking around," she explains. Both Cindy and Sarah have emotional experiences of inadequacy, stagnation, and a challenged identity. Both also express inadequacy related to their introverted personality, perceiving their extrovert siblings as more interesting. Both also express anger in relation to the experiences their stories portray. The emotional experience of inadequacy is not a basic emotion. Anger, however, is. According to Fox (2009), there is a growing consensus of a minimum set of basic emotions, which includes anger, disgust, anxiety, happiness, and sadness (Fox, 2009, p. 329). Emotions that are more complex are derived from these. Among the four negative emotions, anger (and also sadness) has been found to be a significant contributor to disordered eating (Fox & Fromm, 2009).

3.3.2 Anger

The second most identified emotion in interviewees" stories is anger. The terms aggression, rage, frustration, irritation, annoyance, or feeling "really cranky" or "pissed off" are also used. In line with Fox (2009), these labels represent complex emotions deriving from the basic emotion of anger. In Cindy and Sarah's stories above, anger and the emotional experience of inadequacy are the more prominent and appear together. The multidimensional specter of emotions isa general characteristic of the episodes described. The situation recounted by Peter below predominantly portrays anger. The event narrated takes place in the hospital ward:

We were having a meal, I think. And it was… first of all, we had… it was just before Christmas, so we were served rice porridge. And, we were served three pieces of ham to go with it. The portion of porridge was fairly large, and we had to add quite a lot... of butter or almonds, in addition to being required to have the ham, next to it. That alone, both that the dish was new, that is, it was not what we expected to have. But, also, because it (the portion) was quite huge, and it was... I associated... There were these strips of fat in the meat. In addition to all this, there was the porridge. In other words, quite

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an overwhelming meal. I then felt, my immediate response (...) The first thing I feel as I observe this meal, is… that it starts to flame up inside. A violent... I just have a feeling of getting burning hot inside. I feel a fierce rage inside of me. That is, I feel a fierce rage, and then aggression. (...) Thus, everything indicated that I had a crisis. And that I was simply really pissed off.

Peter describes how the meal catches him off guard, and how he cannot control the rage that arises inside him. Along with anger, both disgust and anxiety (for food) are prominent in his story. Davey and Chapman (2009) maintain that disgust is significantly correlated with measures of ED symptomatology, but that disgust may be linked to other relevant emotions, such as anxiety, rather than being an independent risk factor for symptoms. Fox and Harrison (2008, p. 94) also argue that the emotions of anger and disgust may be related in people with eating pathology, describing disgust as representing a way to manage "the toxic" and egodystonic (in conflict with one's ideal self-image) or distressing emotion of anger. The authors suggest that persons with eating pathology experience much higher levels of anger compared to people without such pathology (ibid.). The anger felt by Peter could thus trigger the emotion of disgust, and importantly in relation to ED, the specific disgust for food.

Cindy's emotional experience of inadequacy also comprises anger related to how her sister has "gotten away with" things easily, and Sarah feels angry with the ED and the way it diminishes her thoughts, feelings, and life in general. Within the eating disorder literature, the relative contribution of each basic emotion has not been studied extensively (Fox & Froom, 2009). However, as already mentioned, there havebeen several attempts to understand the role of anger in ED, and these reveal both higher levels of anger and higher levels of anger suppression in people with eating disorders (Fox & Froom, 2009; Fox & Power, 2009; Geller et al., 2000; Waller et al., 2003). When it comes to disgust, which interestingly is not obviously prominent in the episodes (apart from in Peters story), the majority of studies find self-disgust to be important in eating disorders (Fox, 2009). Yet, it could be argued that Sarah's experience of a lack of identity typically signals self-disgust. It is, however, foremost in relation to food and body shape that disgust has been found to be important in ED (Fox & Froom, 2009; Troop et al., 2002).

3.3.3 Discomfort

The emotional experience of discomfort is also labelled uneasiness or unpleasantness. Hanna feels uneasy thinking that "I will never recover, it is no use trying." She is also uncomfortable gaining weight, afraid that the number on the scales will increase endlessly. Catherine describes the uneasiness of days with binges:

It is as though it is decided from early on that day; I feel such an...an inner uneasiness, that I (she pauses), yes, that I just have to...have to get it over with.

Interviewer: *How does that feel? How do you know?*

I just feel it… such an inner uneasiness, as if I... (she pauses)... Yes, that I just have to... That it just <u>has</u> to be done.

Some days Catherine just feels the urge to binge. One of the triggers for these binges "has a lot to do with not being good enough, it begins there, and then it escalates to everything being wrong," she states. As such, the experience of inadequacy is part of her discomfort. In addition, along with the uneasiness, a strong sense of sadness emerges, experienced as difficulties finding happiness in life. The only thing that can make her happy is the pleasures of food: "it can be the most positive thing happening to me during a whole day, that big meal as I...yes." Food thus represents both sadness and joy in Catherine's life, representing the dichotomy of ED as both friend and foe (Serpell et al., 1999), both usefuland problematic. This is described as one of ED's distinct features and what distinguishes it from other illnesses, namely "the friend," or "the highly valued nature of anorexic symptoms" (ibid, 177). The friend is exemplified here by Catherine's bulimic symptoms giving her the pleasure of enjoying food, and the release following compensation (vomiting) afterwards.

Discomfort or uneasiness is a state of mind described in a significant number of episodes. The emotions or emotional experiences described are categories emerging from participants" use of words. Discomfort is not considered a basic emotion, and is thus labelled as an emotional experience. Adam depicts feeling uncomfortable among people, for instance in a line by the register in the cafeteria, knowing his skinny body is observed, or getting glances at the local store. He describes these episodes by the term "social," fearing "that people can <u>see</u> what I have been doing." "*What have you been doing?*" I ask. Adam explains:

Right...that I have been so …that I am not <u>eating</u> ... That I am <u>workingout</u> so much... that I …That people can <u>see</u> it, and that people <u>talk</u> about it.

Interviewer: Mm...

And I feel uncomfortable that ... that.. sort of, yes ... that people care at all ...

Interviewer: Mm ...

...because I don't think it is any of their ... problem, and they should not be involved inmy problems.

Adam states that he knows that people notice because he has received comments: "I have had episodes where people have confronted me face-to-face, telling me that "you have to eat!" and that is hard." Such episodes scare Adam: "You get very anxious when somebody comes and states that "you are way too thin," and "you have to eat" and "this is not good".'The fact that people notice makes him anxious. He has started to fear "the glances" people send. Additionally, he feels angry because "I think that it is none of their business." There is no care in such an attention, it is only exhausting, he states. Summing up Adam's story, the emotional experience has multiple aspects, encompassing discomfort, anger, exhaustion, and anxiety, all predominantly activated by the glances and comments experienced in social interaction.

3.3.4 Fear

Nearly one out of four episodes encompasses fear. The interviewees also use the terms anxiety, panic, distress, feeling upset or scared to define this emotional experience. Gina recalled two specific episodes, both containing discomfort and uneasiness. Interestingly, fear is prominent in only one of the

episodes. The "fear-episode" took place in the high school cafeteria. Gina sits down by a table alone. After a while, she feels immensely uncomfortable, leaves the cafeteria, and walks home. I ask her to describe the emotions that emerged:

Mmm... I don't know... maybe... I feel ashamed, sort of, by... my own awful appearance... in a way, and I feel some discomfort inside... feel a bit uneasy, and that (pauses), I am not sure... (pauses). Yes, I almost feel a bit scared, or in a way, that it is an unpleasant situation, in a way.

Gina searches for words best suited to describe the experience. As she arrives at the emotion of fear, she seems content to have pinpointed the central, maybe most prominent emotion to describe the situation; fear; "fear that everybody will... see me, in a way... that they, yes, don't know, just that they see all the things that I myself can see about me that are flawed, somehow." She could not stop thinking about what everybody else in the cafeteria was thinking as they observed her, and she was "feeling what they were thinking," which was that she was fat and ugly.   Uncomfortable and upset, she left school. These are typical thoughts and feelings she has been having lately. I ask her if these feelings typically occur in social settings:

It is... ehm... (she pauses), I don't know, like, both in social settings when I am with people, but that is in a way since many of these thoughts in a way are my thoughts... eeh...or that is, my beliefs. Uh... but, they also appear in non-social settings, except when the settings are social I am thinking that everybody else... think... the same thoughts. Thus, it has also happened when I have been alone that I have... that it could be... for instance that I have been looking in the mirror or… perhaps fear has not been part of it, but... in any case, I have felt shame and uneasiness.

Both social and non-social settings thus activate overwhelming feelings of shame and uneasiness in Gina. However, the feeling of fear is activated in social settings only. Social settings give her the sensation that everybody present has similar thoughts about her as she has herself. The *social noise* from people present is thus the factor that for Gina creates fear in social settings, as opposed to non-social settings. According to Cooley (1902), a person's self grows out of their interactions with others, and thus our concepts of self are based on our understanding of how others perceive us. Thus, we see ourselves through others, but not for who we really are, but for how we believe others see us. Gina sees herself through the eyes of the others, and this look--what she believes other people think of her--escalates the uneasiness and fear inside of her. This is similar to how "the glances" Adam gets escalate the uneasiness inside of him.

3.3.5 Sadness

The interviewees refer to sadness and despair in six and four episodes respectively. Jenny's story contains both. The location of the episode is a meeting at the hospital ward. Her treatment is on the agenda, and she attends the meeting. The others present are members of the staff: therapists, doctors, nurses, social workers, nutritionists, physiotherapists, and managers of the ward. There are generally about 10-12 participants in the meetings. A primary issue at this particular meeting was Jenny not gaining enough weight, and ultimately losing weight. Underweight patients at an eating disorder unit

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are commonly expected to gain weight during treatment. She explains that she had "no idea why it happened (losing weight), and did not understand myself why it happened, because I did not do anything to make it happen." Prior to the meeting, she had been given an extra meal to compensate for the weight loss. Jenny underlined that she had not "been messing with food at all" to lose weight. She describes arriving at the meeting:

And then they said that we were to find a solution together as to how to... what to do, for them to make sure that I did not lose weight, and then I informed them that I now had an entire extra meal, and I know that it might be what is needed, because… But then they had, in fact without me having a say in it, they had decided that I had to be monitored more strictly (after meals) …and that I could not make my own sandwiches... and they had to be stricter when it came to… for instance what I had to drink… they thought I drank too much water... Everything seemed kind of to be wrong, which I truly disagreed with, and then… I in fact really despaired, because they expressed pretty strong distrust in me—"that strong!" I thought… and then, then I fell a bit apart…

First, Jenny identifies that she felt "a little sad" because she felt blamed of dishonesty: "when I tell them truthfully: "no, I did not do anything," and they do not believe me, then I feel really sad that they don't believe what I am telling them."She was also distressed by the fact that she was supposed to participate in the decision-making, yet she felt decisions were made without her. She did not feel that the decision was mutual, and thus "genuinely felt that it was completely sad." She states that only she could know the truth, and she was "awfully sad to be mistrusted by everybody or that they are suspicious of you." Jenny also describes anger in relation to the incident: "it just made me pissed ... off, or I was ... yeah, I don't know what I was."After leaving the meeting, she went back to her room and cried for the rest of the day, "It didn't stop; I think I cried all day, and the next day, too."To assure weight gain, the staff decided that it was in Jenny's best interest that restrictions were introduced. The dishonoring of the situation, however, discredits her (Goffman, 1990).

Fox and Fromm (2009) conclude that anger and sadness are the basic emotions that are significant contributors to disordered eating. Jenny's description of both anger and sadness in connection with the same episode illustrates an interesting combination of the two, indicating a relationship between anger and sadness (contributing to or enforcing each other), which were both prominent in Jenny" story.

3.3.6 Resignation

The emotional experience of resignation is also referred to as hopelessness, impotence, disappointment, powerlessness, or helplessness. Resignation and sadness occur frequently and often interrelated in the episodes. According to Bulic (2000), clinical observations of women with AN commonly reveal feelings of hopelessness and also depressed or flat affect, guilt, a sense of worthlessness, low self-esteem, and irritability. In this study, resignation represents a general, overall feeling towards one's life or situation as a whole, while sadness and despair (presented above) are predominantly connected to distinct episodes or situations. The emotional experience of resignation brings the presentation of emotional experiences back to its starting point, namely inadequacy, such as in the manifestation of resignation in

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Cindy's "family dinner experience." The situation produces self-examining thoughts about stagnation and hopelessness. Meredith describes several episodes and numerous emotions, but hopelessness is at the core. I ask:

Interviewer: You describe quite a number of emotions...Are there any emotions that are recurring, which you think occur... more <u>often</u> than others ... in these situations?

It is, I would say, hopelessness, that you have not achieved ... yeah, you have sort of not accomplished anything ... so you feel a bit powerless and sad, really—sad a lot.

For a long time Meredith had not been able to go to school, which she described as having not "gotten anywhere," and this had been "a vicious circle for years."Sarah had already identified the emotional experiences of discomfort, loneliness, and frustration in her story when I asked her if she considered these emotions typically to be the most challenging for her. She paused, before answering in one word: "<u>Hopelessness.</u>"*Hopelessness,* I repeat*, what is it about?*

The fact that I am not able to... change ... And how it is going to be ... I think, like, a lot about the future, things like that, you know ... I want to <u>move on</u>, and ... but I keep ruining for myself all the time ...

Sarah pauses, her voice sad and despairing. I pointed out that her whole life is ahead of her. She continues, arguing: "But hopelessness that I will not be able to <u>achieve</u> anything, that I will be at a <u>standstill</u> for the rest of my life. And then ... yeah ..." Sarah maintaines in a tearful voice, describing hopelessness as an omnipresent and dominant emotional experience in her life.

4. Discussion

This study examines episodes where persons with eating disorders experience being emotionally overwhelmed. Four main episode components are explored: episode location, episode interaction, critical events, and emotions in episodes.

Episode locations are specific or non-specific. "Specific locations" are at parents' house, at home, at the hospital ward or at places like the school, cafe, or cinema. "Non-specific location" refers to episodes that could take place anywhere. The different locations also entail different participants in the episodes. The most commonly present participants are family members, staff, and patients in the hospital ward. However, pupils, teachers, and friends are also present in everyday life. In non-specific locations, the interviewees interact with general others: people happening to be at the same place at the same time as the interviewee. Thirty-two out of 38 episodes are social in character, meaning that other people are present, either physically or in the interviewee's mind. Only six episodes are described as non-relational, indicating that no other persons influence the situation.

The results further demonstrate that episodes are "multi-emotional", encompassing various emotions and/or emotional experiences. No episode are described to encompass only one or two emotional experiences. However, some emotions occur significantly more often than others do. The most regularly occurring emotions/emotional experiences are (ranked by frequency): inadequacy, anger,

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discomfort, fear, sadness, resignation, shame, uncertainty, stress, and exhaustion. Inadequacy and anger are apparent in half of the episodes, while discomfort is present in one third, and fear, sadness and resignation appear in approximately a quarter of the episodes.

Findings illustrate that the emotional experience of inadequacy typically emerges in social interactions. This is primarily due to the value others communicate that they give to achievements and successful constructions of self and identity. Secondly, interviewees find that others prefer extroverted personalities, which is also a trait validated by contemporary society's emphasis on personal constructions of identity (Giddens, 1990, 1991; Beck, 1992) in general and in social media specifically. This might give rise to experiences of inadequacy. These feelings of inadequacy in eating disorders are somewhat different from the "lack of awareness of inner experiences and failure to rely on feelings, thoughts and bodily sensations to guide behavior" that Bruch (1962, 1973) describes as causing the specific sense of ineffectiveness in ED. This article therefore argues that the personal experience of *ineffectiveness and inadequacy emerge in social interaction due to the social value ascribed to specific personality traits and personal achievements*. In the individualized society (Beck, 1992), it could be argued that "positive attention requires an effort," as one participant notes.

This study confirms the presence of anger in eating disorders (Fox & Fromm, 2009). Participants describe anger to occur in relation to various emotional experiences, such as inadequacy, disgust, and discomfort. The social context in which anger emerges is prominent in interviewees" stories, with anger arising because of expectations and "glances" from others present. As such, this study demonstrates the former limitedly studied social location of the emergence of anger in ED.

Likewise, the emotions of fear is described as arising within social context. Thinking that everyone else present shares your negative thoughts about yourself creates an overwhelming *social noise*. This unasked for social influence, or unwarranted positioning, is prominent in the story of sadness told by Jenny. The importance of sadness in eating disorders, as established by Fox and Fromm (2009), is hence confirmed by this study.

The relatively low rate at which shame is mentioned in interviewees' stories is noteworthy, especially given that shame is considered a central emotion in eating disorders (Skarderud, 2007c). However, as the categorization of emotions is based on how interviewees name their experiences, some of the described emotional experiences could be derivatives of shame. For instance, it can be argued that the emotional experiences of inadequacy and ineffectiveness derive from shame (Scheff, 1988, 2000, 2003). Knowing the social shame (and other emotions) derivatives will contribute to the understanding of the role the emotions of shame plays in ED. Further research is needed on emotions and their derivatives in ED.

In describing the emotions and emotional experiences in the episodes, the storyteller's ability to identify their own and others' thoughts and emotions is notable. Given the metalizing perspective and the recognition that people with ED tend to display alexithymia, the rich descriptions of emotions were not anticipated. However, Fox's (2009) qualitative study also includes findings that broadens the

understanding of alexithymia in ED as a trait not prominent in ED in general. This contributes to the understanding of ED, emphasizing the social feature of this phenomenon. Nevertheless, the episodes and the emotions that emerge from them typically lead to ED symptoms such as binging, purging, and starving, even though the participants demonstrated ability to put feelings into words in retrospect. This could indicate, as argued by Pedersen et al. (2014), that the ability to mentalize may not necessarily entail a capacity to regulate affects.

To summarize, episodes characterized by overwhelming emotions and emotional experiences in eating disorders are characterized by being social: The experience of overwhelming emotions mainly emerges from social interaction. Illuminating the social context in which these emotions occur allows for an additional understanding of impaired mentalizing, namely as *defense* rather than defect (impairment); a defense or protection against social ideals and judgments. The social construction of defect or impaired metalizing is firmly anchored in the medical discourse. It is however, only by scrutinizing the context of the episodes that the defense aspect–this social shield-becomes visible. Not uncommon is the social interaction that takes place in the episodes experienced as degrading. Due to the devaluation of the narrator's or participants self in the social interaction, the social interactions that give rise to ED episodes are experienced as unpleasantly interfering.

Results indicate that ED treatment could benefit from considering the overwhelming emotions in ED as indicative of *defense, as a shield against social interference*. The experienced emotions could be argued to be natural and comprehensible, rather than pathological and unreasonable. Thus, defense or defect in this respect indicate different understandings of ED in general and symptoms in particular, and might require different treatment approaches. Efforts should be made to consider and apply knowledge of society, social interaction and how it affects individuals in treatment of ED. As Brown (2008) explains, seeing a lack of mentalization as defensive means that the treatment goal is not remediation, but rather insight or understanding. Therapeutic empathic understanding of personal emotional reactions to social contexts as defenses will likely strengthen therapeutic alliances, as the illumination of context makes visible participants" need to defend themselves, as their selves are not acknowledged. Under these social conditions and requirements, defense emerge as a shield.

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