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# Examining Eating Disorder Narratives through the Context of Nonsuicidal Self-Injury: A Qualitative and Correlational Internet-Based Approach

Rachel Grasfield
*Connecticut College*, rgrasfie@conncoll.edu

# Examining Eating Disorder Narratives Through the Context of Nonsuicidal Self-Injury: A Qualitative and Correlational Internet-based Approach

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Rachel Grasfield

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Abstract

The following paper is a qualitative and correlational study of narratives written by individuals with some current or past experience of an eating disorder. These narratives, which were retrieved from online communities of "eating disorder confession" sites, were collected and coded for the presence of emotions and motives of self-harm. 250 narratives were coded from two websites, used in the study for their keyword relevance. The aim of the project was threefold: the first aim was an attempt to encapsulate the eating disorder experience from the perspective of those currently suffering or in recovery from an eating disorder. This goal was addressed through the use of the emotionality codebook, developed by the researcher. The second aim of this study was to examine the way in which eating disorders could potentially be conceptualized as a form of self-harm. From a transdiagnostic approach, it could be theorized that self-harm and eating disorders are two symptoms of a larger range of psychopathologies: though they present differently, they are both ways in which individuals harm their bodies for the purpose of emotion regulation. This goal was addressed by coding the eating disorder narratives against the four foundational motives proposed to explain why individuals engage in self-harm. The third aim, which examined patterns of the emotional codes in their correlational relationship to their motive code, would lend additional support to the second aim. Creating the emotional narrative of eating disorders, as well as the successful coding for self-harm motives will be discussed in its relevance for conceptualization and treatment for the two psychopathologies.

*Keywords*: eating disorders, NSSI, Internet research, narrative research, qualitative studies

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> "My fingers reach through the screen and comb through the garbage until they find the home of the shrieking chorus, hungry girls singing endless anthems while our throats bleed and rust and fill up with loneliness. I could scroll through these songs for the rest of my life and never find the beginning." – *Wintergirls*

> "The term 'starvation diet' refers to 900 calories a day. I was on one-third of a starvation diet. What do you call that? One word that comes to my mind: 'suicide'" – *Wasted: A Memoir of Anorexia and Bulimia*

**Overview**

The following project attempts to examine the mental disorder of eating disorders in a specialized setting, in order to not only better understand the disorder itself through a certain lens, but to analyze its possible similarity to the second, distinct psychopathology of nonsuicidal self-injury. Therefore, the study presented here is multi-faceted, incorporating several areas of psychological research to achieve its aims. The introduction provided attempts to examine every aspect of the current study through its literature review. As the study here includes several areas of focus, the layout of the introduction shall be presented here, in order to guide the reader through the flow of the section. The researcher will first provide a history of eating disorder research, and how the disorders came to be in their modern understanding and interpretation. Next, the researcher will examine the way in which eating disorders are understood through the personal perspective, by looking at literature on narratives and the way in which illness is understood by the patient as well as the clinician. From this examination of narratives, online eating disorder communities are discussed, as these communities provide a narrative structure within the modern experience of eating disorders. The specific communities of pro-ana websites and the narratives they shape regarding their disorder are also discussed. From this, the researcher examines the literature concerning emotional research and eating disorders, as reported emotions within the online communities are important for the current study; this

concludes the section's review of eating disorder research. From here, the researcher then examines the second mental disorder the current study is concerned with: nonsuicidal self-injury (NSSI). The researcher will first provide the diagnostic criteria of NSSI, its recent emergence as a distinct disorder, as well as the characteristics associated with self-harm. From here, the researcher will examine the prevalence of NSSI in online communities, mirroring the work previously discussed regarding eating disorders and online communities. Finally, the researcher will tie both disorders together through looking at research concerning both eating disorders and self-harm, which most frequently regards the latter as a comorbid condition of the former. These eight areas of literature focus, while broad, are crucial to consider in understanding of the foundation of the current research.

**Eating Disorder History and Etiology**

Eating disorders are somewhat of a phenomenon, representing an incredibly loud and incredibly silent problem that an estimated 24 million people in the United States alone suffer from (Retrieved from www.anad.org). It is one that is loud in its constant address in the media and popular culture. Yet the actual struggle, the real effects and consequences of the disorder are kept silent out of fear, stigma, and apathy. Although recognition of the disorders has heightened in the last sixty years, when doctors and clinicians began to recognize the symptoms as a distinct set of illnesses, it is believed that disordered eating has a tradition spanning, potentially, the entirety of human history. The history that people – particularly women – have with extreme responses to food has been documented through history, with records of starvation as well as purging for a range of purposes spanning the possibility of continued feasting to becoming closer to god (Engel, Reiss, Dombeck, 2007). Some of the first documented cases of anorexia were recorded from the Middle Ages, where confused clergy and doctors detailed case studies of

women refusing food for spiritual direction. Interestingly, this method of piety was used to reject the female body, which was seen as disgusting and evil. Although the practice was driven overwhelmingly for religious reasons, and though such undertones are less common in the present, the idea of rejecting the female form is one very common in today's experience of eating disorders (Dias, 2003).

Such history reveals the very complicated nature surrounding eating disorders. As the time and culture surrounding the disorders change, so too do the explanations of them (Keel & Klump, 2003). When eating disorders first began to emerge as a mental illness, the explanation was largely psychodynamic. Young women from affluent backgrounds on the brink of puberty saw their imminent maturity as something to be rejected and feared. Dependent and weak women, they turned to starvation to maintain childlike figures, consequently perpetuating their state of vulnerability (Brusch 1973). Anorexia – for this was the only defined eating disorder at the time – was therefore seen as a rejection of adulthood, a disorder surrounding the desperate attempt to remain an innocent child forever. As the psychological world itself matured, the etiology of eating disorders changed as well. In the later years of the twentieth century, researchers grew interested in the familial structure of eating disorders; what families did these girls come from, and did these families have a part in the disorder? Such research sparked the belief that anorexic women came from tumultuous homes: their parents were overbearing and incredibly involved in the life of their child. Consequentially, when this child was expected to mature and make decisions on her own, she had no idea how to do this, and instead reverted to starvation in order to maintain her dependence (Chernin, 1993). Around the same time of the familial models of eating disorders, bulimia began to separate as a distinct disorder. Previously seen as uncontrolled eating, or "failed" anorexics, the perpetuated pattern of bingeing and

purging was seen as something new to research, its own illness. Bulimics also came from a tumultuous home, with over-controlling mothers and distant fathers. They wanted attention and they wanted indulgences, but they rejected this desire and the guilt they felt through wanting it through purging and ridding themselves of such impulses (Brumberg, 1989).

The early models of anorexia and bulimia show a patient who is weak-willed and fearful; her delicate physical form is a manifestation of a scared and vulnerable mind. However, newer models of etiology attempt to rectify these diminutive women by giving them a voice. Though the voice is detrimental to the body, in its message to starve or purge, the voice in its very nature is one of strength and power. Second and third-wave feminist theorists view anorexia as "a response to normative expectations of femininity and women's lack of power and control under a system of male oppression," (Boero & Pasco, 2012). In other words, eating disorders are a political statement, an attempt at activism: by rejecting the patriarchal female form for one that is child-like, these women are rejecting society's rules (Brumberg, 1989). By starving or purging, these women are making a statement against the culture we live in, the culture rampant with contradiction; from tabloids boasting of the most recent "must-try diets for the holiday season" while simultaneously splashing pictures of angular celebrities and chastising them for losing too much weight and looking unhealthy. By creating a body that is disgusting to men, who prefer heavier, curvier women, they assert their independence, their refusal to adhere to the sexual standards they are entrenched in (Ward, 2007, Brumberg, 1989).

As times changed, so did the social landscape in which individuals with eating disorders grew up. The adolescents and adults of this generation are given one very clear message: never stop moving. And it is from this message that newer conceptualizations of the eating disorders emerge. Newer models of eating disorders have begun to integrate new social phenomena seen in

everyday life taken to the extreme, namely healthy eating and exercise. The latter has been documented as a compensatory measure seen in bulimia nervosa, yet new research and new patterns of human approach to eating and weight have shifted research to examine individuals with a pathological need to exercise or "eat clean". And the population these individuals make up often do not map on to the previously described emotional teenagers; they are often adults functioning well in the real-world, holding steady jobs and even excelling, though simultaneously battling with an eating disorder. Although living with a diagnosable condition of anorexia or bulimia, the societal message to always stay active and always achieve keeps them from the helpless, immobile patients that they were previously thought to be. From this new perspective comes another view of eating disordered individuals: much like the socially-oppressed anorectic, these individuals are strong and active and stand at a near-opposite end of the spectrum of the 1970s model of the eating disordered individual (Yates, 1991).

Given the changing and multi-dimensional understanding of eating disorders, the web of characteristics that shape eating disorders have changed throughout its diagnostic history. In the current version of *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013), eating disorders fall under the classification of feeding and eating disorders. The *DSM-5* provides three eating disorders: Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder, as well as Other Specified Feeding and Eating Disorders, and Unspecified Feeding or Eating Disorders. Although the last two are clinically and diagnostically significant, for brevity's sake, the diagnostic criteria of only the first three eating disorders will be addressed here.

Anorexia nervosa is given the following diagnostic criteria:

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* (original emphasis) is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.

B. Intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.

C. Disturbance in the way in which one's boy 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.

The disorder is further broken down into two subtypes, specified below.

(i) Restricting type: During the last 3 months, the individual has not engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight los is accomplished primarily through dieting, fasting, and/or excessive exercise.

(ii) Binge-eating/purging type: During the last three months, the individual has engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Lastly, in regards to anorexia, the disorder is given a severity measure dependent on the BMI of the individual. In previous versions of the *DSM*, Anorexia Nervosa's diagnostic criteria included a percentage of body weight that the patient needed to reach in order to achieve a diagnosis. However, such measures were excluded from the *DSM-5*, and can be seen in specifying the severity of anorexia.

(1) Mild: BMI $\geq$ 17 kg/m$^2$
(2) Moderate: BMI $\geq$ 16-16.99 kg/m$^2$
(3) Severe: BMI $\geq$ 15-15.99 kg/m$^2$
(4) Extreme: BMI $<$ 15 kg/m$^2$

Bulimia Nervosa is given the following diagnostic criteria:

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
    1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.
    2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating.

B. Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.
C. The binge eating and inappropriate compensatory measures both occur, on average, at least one a week for 3 months.
D. Self-evaluation is unduly influenced by body shape and weight.
E. The disturbance does not occur exclusively during episodes of anorexia nervosa.

In addition to the diagnostic criteria, Bulimia Nervosa is also given a set of severity measures, based on the frequency of their binge/purge episodes:

i) Mild: An average of 1-3 episodes of inappropriate compensatory behaviors per week
ii) Moderate: An average of 4-7 episodes of inappropriate compensatory behaviors per week.
iii) Severe: An average of 8-13 episodes of inappropriate compensatory behaviors per week.
iv) An average of 14 or more episodes of inappropriate compensatory behaviors per week.

Binge Eating Disorder, a new disorder added to the *DSM-5*, is given the following diagnostic criteria:

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
    1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.
    2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating.
B. The binge eating episodes are associated with three (or more) of the following:
    1. Eating much more rapidly than is normal.
    2. Eating until feeling uncomfortably full.
    3. Eating large amounts of food when not feeling physically hungry.
    4. Eating alone because of feeling embarrassed by how much one is eating.
    5. Feeling disgusted with oneself, depressed, or very guilty afterward.
C. Marked distress regarding binge eating is present.
D. The binge occurs, on average, at least once a week for 3 months.

E. The binge is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

Like anorexia nervosa and bulimia nervosa, binge eating disorder is also given a set of severity measures, based on the frequency of binge episodes:

i) Mild: 1-3 binge-episodes per week.
ii) Moderate: 4-7 binge-episodes per week.
iii) Severe: 8-13 binge-episodes per week.
iv) Extreme: 14 or more binge-episodes per week.

In their many manifestations, the prevalence and presence of eating disorders presents a very real concern for society today, both for the individual and the population at large. Eating disorders leave a permanent mark on the individual that greatly changes her quality of life. The damage to the body resulting from the disorder causes lasting and chronic medical concerns, as well as a greater vulnerability and likelihood of a further mental or physical medical diagnosis in early adulthood, after the eating disorder itself has been treated (Johnson, Cohen, Kasen, & Brook, 2002). Additionally, cost of treatment puts a financial burden not only on the family of the patient, but of the health care system as well. Inpatient stays rarely lasts more than thirty days, the standard insurance cut-off, despite the fact that research unfailingly shows that such a short period of time is not enough to create a stable state of recovery. However, even with a short period of time, cost of treatment can still be exorbitant, reaching over $30,000 for a course of inpatient treatment, not including future relapses and additional help once the patient is released from the hospital (Striegel-Moore, Leslie, Petrill, Garvin, & Rosenheck, 1999). In the documentary “Thin” which follows the lives of several women currently patients at Renfrew, a well-known eating disorder clinic, the problem of discharging patients who are not ready to leave the facility leads to a struggle felt both by the patient and her clinicians.

**Narrative Research**

The use of narratives, both online, in print, and in storytelling, is a huge part of the human experience. The stories we tell and the way we shape our lives through narratives plays a massive part in the way we construct the self (Singer, 2004). How one person interprets a life event is unique to another with the exact same experience. How we view the events in our life, how we conceptualize and internalize experiences determines the type of people that we are. For example, the way in which individuals with a mental illness tell their story and construct life narratives plays a large role in their prognosis. The narrative of mental illness, and in a narrower scope, eating disorders, is important to acknowledge before it is applied to the current study.

Stigma is a social construct that defines people in terms of a distinguishing characteristic or mark and devalues them as a consequence; to do this to oneself is incredibly detrimental (Jones et al, 1984). Individuals who self-stigmatize their own mental illness, in other words, hold the same devaluing view that the public shares about their illness, are shown to have diminished self-esteem, fewer social relationships, higher ratings of loneliness, and more therapeutic roadblocks (Yanos, Roe, & Lysaker, 2011). Not only does self-stigma affect the way in which one measures the self, it may also interact with ways in which individuals respond to their illness, and consequently fail to seek help. Individuals who self stigmatize may be vulnerable to chronic illnesses, as their stigmatization of their illness is more likely to make them feel angry, depressed, fearful, anxious, isolated, guilty, embarrassed, and prevent them from recovery as well as avoid help-seeking, such as hospitals or clinicians (Dinos, Stevens, Serfaty, Weich, King, 2004). By changing their self-stigmatization, by altering the narrative in which they tell their life story to include a more accepting view of mental illness, individuals become less angry, report greater agency in their lives, and higher self-esteem (Yanos, Roe, Lysaker, 2011).

One way to change narratives in individuals who self-stigmatize is to focus on shaping narratives around aspects of life that are not focused on mental illness. By introducing other ways in which the individual can define him or herself, they are open to being less critical, and focus less on the parts of themselves – namely the mental illness – that causes distress. In Carless and Douglas (2007) men with mental illness were encouraged to use positive stories of sports or exercise to "re-story aspects of their lives through creating and sharing personal stories through which they rebuilt or maintained a positive sense of self and identity" (Carless & Douglas, 2007). The researchers found three different ways in which their participants constructed positive narratives, away from self-deprecating constructs of their illness: action narratives, which detailed "going places and doing stuff;" achievement narratives, which spoke of accomplishments through effort, skills, and courage; and relationship narratives, which told of shared experiences or potential for future shared experiences. By focusing on these types of narratives, many benefits were possible for both the clinician and the client. The clinician is able to more accurately understand what makes a client feel better, and can utilize these aspects in recovery, which wouldn't ordinarily be disclosed freely by an individual who is entrenched in self-stigmatization. The researchers also found that these particular narratives had strength in facilitating at least four of the nine common elements of recovery: redefining self, being involved in meaningful activities, being supported by others, and renewing hope and commitment. The last finding was the suggestion that these positive narratives may potentially help within the understanding of the general context of enduring mental illnesses (Carless & Douglas, 2007).

In a thesis conducted on the personal narratives individuals with eating disorders shared, the author emphasized the need to treat each case, each story, as a wholly individual entity. In

her paper, the author conducted interviews with four individuals who had in the past or were currently suffering from an eating disorder. Of the four individuals who participated, three were female and one was male; two suffered from anorexia, one from bulimia, and one from both disorders at some point. Though their diagnosis could have put them all in the same treatment center, their individual stories about getting there were incredibly different. Their noted reasons for the onset of the disorder ranged from religious conflict, parental discord, and confusion about sexual orientation. After their disorder had begun, they additionally experienced differences in how long they were able to maintain the disorder before treatment was imperative. Interestingly, they also had very different experiences with weight loss, with one individual recalling a dramatic weight loss in the first three months of the disorder's onset, while another purged countless times a day to maintain a weight that was still considered medically normal. From this small sample of stories, it is clear that the messages of narratives of eating disorders are extremely varied. Though they recounted many of the same experiences, such as problems with perfectionism, the addiction to the disorder, and the fear of recovery, they are very different stories. A respect for these individual differences is especially important when one takes into account the type of treatment individuals with eating disorders receive, and whether a broad treatment is adequate for such varying experiences (Przybyl 2010). This idea will be pursued further in the current paper.

In another qualitative study examining the life-history narratives of individuals who had recovered from an eating disorder, the focus of the experience and storytelling was again stressed, rather than a more quantitative diagnostic approach. From the twenty women interviewed, their unique stories themes appeared, namely ones of control, connectedness, and conflict; these themes emerged throughout the disease's entire timeline: from development,

experience, and recovery. The first phase, development, was closely linked to the theme of control, a feeling of being not connected, or distant from family and friends, and conflict with those around them. By looking at the three phases as three points on one life-history, the life-history was weighted as more important, with the events on the timeline merging into a continuous experience. By looking at the experience as one event, and the themes that present during the event, it was theorized that narrative plays an important role in the disease, as the disorder is shaped by the individual's struggle to discover and develop the self. As this struggle ensues, the disorder slowly moves to the stage of recovery. By looking at eating disorders through the narrative themes of finding the self, the view of eating disorders changes as well, from a condition that is not only medical, but one of deeper personal issues, where recovery can be achieved when the individual is ready to make the choice to recover by identifying and strengthening the self (Patching & Lawler, 2008).

From the incredibly large body of research available in the field of eating disorders, there is relatively little information concerning the qualitative analysis and narrative research of the eating disorder experience. The focus of eating disorder research has been largely quantitative, with the experience of the disorder being cast aside; such a focus could shift research for the benefit the population, as the personal stories given through qualitative and narrative studies provide a unique and intimate insight into the conditions.

**Online ED Communities and Group Research**

From a purely psychological perspective, there are both pros and cons of using the Internet to form communities and support systems. From the research provided above, narrative is an extremely important aspect of the human condition and the way in which we construct the self. As the Internet and online activity has become more widespread, our narratives are

increasingly built and developed virtually. Particularly, the way in which the individual narrate and experience eating disorders is applied to online groups holds interesting benefits and consequences.

Group psychology applies to Internet groups in the same fashion as it would in a real-world environment, with some heightened phenomena appearing due to its unique format. In an online setting, individuals have been shown to act differently than they would if they were sitting around in a circle disclosing the same information; that is, individuals are more likely to self-disclose more frequently and more intensely online than in person (Suler, 2004).

This phenomenon has been shown to be caused by the eight factors contributing to online communication: *dissociative anonymity*, individuals feel safe in knowing that what they say or do cannot be directly linked to their real-world lives; *invisibility*, individuals feel that because they cannot see or hear others and they themselves cannot be seen or heard, their social cues and ways in which they view themselves being expressed are compromised and communication is safer; *asynchronicity*, individuals are not communicating in real time, therefore their conversations can be delayed in order to provide the correct feedback and think carefully about responses, rather than holding a real world conversation with possible social errors; *solipsistic introjection*, in that due to no real social cues, the individual is free to assign voices and characteristics to the written words of those online, and are therefore more likely to assign personal traits, or traits they particularly associate with; *dissociative imagination*, where individuals feel as though the online world they are participating in is separate and distinct from the real world, and therefore cannot have any carrying over consequences, responsibilities, or implications; *minimization of status and authority*, individuals come together online in an intrinsically un-hierarchical way, in that no one status or position is inherently obvious, nor do

positions of status need to be created; *individual differences and predispositions*, based on personality differences, individuals may share or participate to a varying degree; and *shifts among intrapsychic constellations*, individuals believe that by being more free to share their beliefs and opinions due to the aforementioned qualities, they are in fact being their "true self," which would be impossible to portray in a real world of judgment, social cues, and identification (Suler, 2004).

So, to make the experience of entering an online world more concise: individuals, for a variety of reasons relating to the self, to communication, and to the very nature of the Internet, are more likely to speak freely and personally. Additionally, it has been found that participating in online interactions brings the phenomenon of deindividuation, where individuals are more self-centered and less socially regulated (Bargh & McKenna, 2004). This can be seen in the real world in a mob-like effect, where the view of the group takes over the individuals in the group. Literature is unclear as to whether such phenomena are beneficial or detrimental to those it affects; some studies reveal increased time online leads to isolation and feelings of separation from those in the real world, as well as distinctly less time spent with individuals in the real world (Kraut et. al., 1998, Nie & Erbring, 2000, Nie 2001). However, follow-up larger studies from the same researchers revealed that spending time online actually increased positive feelings and closeness with individuals in the real world, as well as increased individual psychological well being, and no change in how long individuals spent with familiars in the real world (Kraut et al 2000). This finding can be conceptualized if one views Internet time and life as a means of getting support and feedback when it is not apparent in the real world; by finding what they lack in real life on the Internet, these individuals are happier and able to form better relationships.

However, such idealistic views for why individuals search for Internet support structures are not always confirmed by actual experience; it has been noted in the media as well as the literature that the same structures that cause individuals to have a positive experience online can also lead to negative experiences. While anonymity and lack of censorship and responsibility lead to individuals finding a "home" or a community online, it can also be alienating and dangerous, and lead to bullying and isolation (Anderson, Bresnahan, Musantics, 2014). Additionally, while deindividuation is an experience shared by anyone who has ever been in a group, deindividuation in an online community poses further dangers: deindividuation is created through anonymity and group consensus: in online communities these are heightened, so the potential for deindividuation is more extreme. This may lead, for example, to individuals concerned about their eating problems finding a group where eating problems are commended and further lead to unsure individuals adopting such beliefs. This characteristic in the pro-ana communities will be discussed later.

Whether the experience of joining an online community is positive or negative for the individual, or has positive or negative implications for said individual, it is resolutely a different experience than anything one would have in the real world (Joinson, 1999). In studies comparing responses of individuals brought into a real world lab, and responses of those answering online surveys, the responses of the latter tend to be more detailed, more personal, and more self-disclosing. This is unsurprising given the phenomena surrounding online interactions; however, this has implications for what is taken from cyberspace. When the Internet was first coming into vogue in the last years of the twentieth century, scientists were wary of its possible uses: could it be harmful, or the next frontier of psychological research? Could one rely on the responses they were given, and was the Internet possibly the newest laboratory for psychologists? Though

studies revealed that the Internet might provide more personal answers, real world studies continue to be used, as the results obtained from online sources have not been determined to be more truthful than the ones received in real world labs (Kiesler, Siegal, & McGuire, 1984). Despite the many benefits of using online research, the positive effects of engaging with someone face-to-face, or in an environment compatible to real-world events certainly hold important and necessary forums for psychological research.

**Pro-Ana And EDs Online**

Given this information from the literature, one may now more accurately view these communities of young women, alone and together both in their struggle and in their telling of their experience. These sites are not immune to the literature's findings of the online experience; in fact, they may embody it. Individuals seeking help, acceptance, acquaintance, or recovery from these sites have been driven to them because they feel voiceless in the real world (Ward, 2006). The sites they create and participate in serve many functions, chiefly to exchange the support of the group's resources, which are inherently present as each member can offer support through their own experiences and knowledge. Additionally, these sites provide a network of safety for girls through the detailed and personal communications they engage in (Walstrom, 2000). They are looking for a community of individuals with a shared experience to theirs, and upon finding it, are introduced to a vast world that encompasses more than 500 websites, though such an estimation is rough at best (Bardone-Cone & Cass, 2006). Through anonymity, they are able to share the gritty details of their everyday life, and they do not hold back. Vivid details of a binge episode, of a purging routine, or, three-day long fast are detailed by those who experience, and supported by those who understand. As a deindividuated group, their struggle sometimes grows into a wave of religion, harkening back to the religious ties from which their disorder may

have been born. Young women pray to the illness, to "Ana" and "Mia," to their laxatives and their liters of water a day to stave off hunger (Boero & Pascoe, 2012).

A confusing and hypocritical culture drives women to safer places, where they can speak and act as they want, without the mixed messages of "you're too thin," but "don't get too fat." Since the Internet became accessible to the general public, pro-eating disorder websites and sites devoted to narratives of the disorder have grown into an extensively developed subculture (Norris, Boydell, Pinhas, & Katzman, 2002). They attract individuals who are currently suffering, are in recovery, or seeking more information. Feminist theorists view this movement towards the digital world as one of empowerment, "a space in which women who are struggling with anorexia [and bulimia] can potentially find sanctuary from the surveillance and regulatory mechanisms of control of the public sphere," (Dias, 2003). Rejected by a society that they also reject, women with eating disorders feel silenced and isolated in their experience: with the media reprimanding and applauding their behaviors and their shape, this only heightens their negative feelings towards the culture they live in. So these women, in further acts of empowerment, reject society and create their own online one.

However, such a glowing view of these websites, which contain a variety of sources from "thinspiration," the phrase coined to include anything and everything to deter women from eating, including images of emaciated bodies to quotes of encouragement or ridicule; to helplines and recovery sources, is not shared by everyone (Dias, 2003). As diverse as the culture is itself, the reactions to their formation have also been varied. They can be viewed as safe places for struggling individuals who feel as though they have no one to whom they can disclose their disorder. And, they can also be triggering and tantalizing for individuals attempting to recover, or attempting to gain admittance into its tight culture (Boero & Pascoe, 2012). The Internet,

though a potential space for support, is also one where bullying and harassment is common and intense (Anderson, Bresnahan, & Musatics, 2014). In 2008, France attempted to make such websites illegal, believing that the young, often eating disordered women, running these site were little more than murderers. Their websites, with their harmful messages and explicit content, were though to lure unsuspecting young girls into the trap of eating disorders, threatening their life. The UK, with a similar conception of these women, considered the same action (Knapton, 2013). Though both attempts did not pass, it did raise the very legitimate question about the nature of eating disorder websites, and where the cost or benefit of having such sources remain freely on the Internet lay.

These studies speak to the "pro-ana" and "pro-mia" – the nickname for the sites and they philosophy they embody, pro-anorexia and pro-bulimia, respectively – websites' strength. A deindividuated, ill group of young women may find that their primary point of connection is they view their eating disorder as a lifestyle, rather than an illness. Even within this extreme mindset comes a glimpse of meta-awareness: many of them come with warnings visible on homepages, alerting the viewers what information they are about to receive (Dias, 2003). In the earlier days of these sites, many were blocked from individuals who were not members, making their groups exclusive and difficult to gain entry (Dias, 2003). This function served to protect the group from outsiders attempting to abuse or criticize, though it also excluded individuals seeking help, and those "not sick enough" to be part of the community (Boero & Pascoe, 2012). Although their views may be deemed "wrong" or twisted by their ill mind, and though their forums of communication have been vilified from the media and even the literature, they are at their core simply means of communication. Like the other sites studied to understand the virtual world,

these sites have been formed mainly for social support, and often lack eating disorder specific content (Juarascio, Shoaib, & Timko, 2010).

Though not every pro-ana website is the same, there are many similarities outlining this side of the eating disorder spectrum. Content analyses of the most popular of these sites reveals that a large portion of the sites, and the individual sites themselves, devote time, words, and space to "thinspiration." This is not a unique idea attributed to the pro-ana community: every time you turn on a television or flip through a magazine you are exposed to "thinspiration." However, the pro-ana thinspiration goes even further. Rather than a perfectly slim and pore-free model, the pro-ana thinspiration has her ribs in sharp relief, her hipbones protruding, and her arms extended, elbows the largest part of her arm. Though it has recently been ridiculed in the media itself, the "thigh gap" (Ward, 2007) or the space where the thighs do not touch when standing with the knees together, has become a paradigm of thinness. Along with the photographs of these skeletal women are occasionally quotes, most notably Kate Moss's "nothing tastes as good as skinny feels," (Dias, 2003). Less familiar mantras are present as well, such as "skinny is good, skinny is strong," "every skipped meal is one step closer to skinny," "skip dinner end up thinner," and "good girls don't swallow." These thinspiration images and messages serve as a reprimand, a warning to all who enter what is to be gained when you lose (Dias 2003). Additionally, sites can contain "tips and tricks" sections, where vetted pro-ana members share their skills on concealing and perpetuating their illness. Tips posted to this area of the site might include how to cut up your food to conceal how little you've eaten, or what the best ways to get through a fast. Additional information such as workout routines and diet plans are also swapped among these anonymous members. Many contain BMI calculators in order for the girls visiting to find a numerical to attach to their body. Most infamously are the sites that

include spaces for the religious practices that some with an eating disorder conceptualize. These women see “Ana” and “Mia” – anorexia and bulimia respectively – as their friends and their guidance. They see their experience as somewhat of a religious one, and they pray to those who have led them to this point: the disorder itself. In these sites, the disorder is personified, often as a young woman, screaming in the ears of the minds she controls. Sites contain haunting poems of girls sacrificing their weight, friendships, and sanity for a taste of Ana. The most commonly noted instance of Ana as a religion in the literature is the “Ana Creed” which includes statements such as:

> I believe in control, the only force mighty enough to bring order in the chaos that is my world.
> I believe that I am the most vile, worthless and useless person ever have to existed on this planet, and that I am totally unworthy of anyone's time and attention.
> I believe in oughts, musts and shoulds, as unbreakable laws to determine my daily behavior.
> I believe in perfection and strive to attain it.
> I believe in salvation through starvation.
> I believe in calorie counters as the inspired word of god, and memorize them accordingly.
> I believe in bathroom scales as an indicator of my daily successes and failures.
> I believe in hell, cause sometimes I think I live in it.
> I believe in a wholly black and white world, the losing of weight, recrimination for sins, the elongation of the body and a life ever fasting.
> (Retrieved from http://anastart.weebly.com/ )

These statements, along with the “Thin Commandments” are sets of new rules that girls who believe are expected to accept, practice, and continue. Other religious statements are poems or stories that girls have written to Ana or about her. They are works of art detailing their emotion and passion, while maintaining their pain. As followers of the religion, they do not maintain that they have a good or happy lifestyle; they openly admit their pain, unhappiness, and lack of health. Embedded in the creed itself is the admission that sometimes they live in a “hell”. Perhaps for this reason, for this meta-awareness of the pain the disorder causes, they warn others

that these sites are devoted strictly to their radical beliefs, and not to continue on if you yourself do not fully believe in the Ana and Mia religion (Knapton, 2013).

The content of these sites ranges from supportive and an attempt at body-positivity, to demeaning and demanding. Although the content of these sites largely overlaps with their purpose, there are some patterns in what a site will offer its viewers, and what underlying content a person browsing these sites might expect. And to a certain extent, the pro-ana sites will have different information than the recovery sites, if these recovery sites are not masked pro-ana sites, which is often the case. One way in which the two Internet eating disorder sources differ is the way in which individuals describe the body. Again, this references the importance of narrative in how one builds one's story. On the pro-ana sites, individuals are likely to confine their body to a set of numbers: the body is quantified by weight and BMI. Often, such language is banned on recovery sites for the potentially triggering nature of revealing current weights, so the recovery sites describe the body differently. However, the recovery site members do not go on to celebrate the healthy female form: they still talk about the body in degrees of thinness, and the desire to remain thin. Although the goal of health is indicated as a motive, it was not celebrated purely for its goodness, but rather seen as a mode of continuing life. As well as defining the body, either by numbers or how far away they are from thin, both sites have a tendency to focus and define what they do with their body, namely, eating disorder activities. Both pro-ana and recovery sites highlight the same activities: purging, eating, cooking, exercising, and tasting. On both sites, eating is still a central issue in the minds of those sharing their experience. Along the same lines as the activities their bodies engaged in, both sites also tend to heavily reference their bodily experiences. These experiences can be seen as symptoms of the eating disorder, such as feeling faint or exhausted. In recovery sites, the lack of these experiences are largely met happily,

detailing a feeling of success in no longer feeling faint. On the pro-ana sites, members heavily detail the various bodily experiences they encounter that are symptomatic of the disorder, such as hair loss, lanugo, and stretch marks. Though serious, they are often met with overbearing humor, such as the remark: "I can't believe so much of my hair fell out when I brushed it this morning!!! How gross is that?!?!" These "humorous" remarks are often met with support that such physical responses are indicators that the eating disordered individual is "doing something right." (Riley, Rodham, & Gavin, 2009).

The pro-ana or pro-mia websites do not represent the majority opinion shared by individuals with an eating disorder. Although they encompass a minority opinion, their voice as a community itself is one that has led to countless medical, political, and academic debates about the "pro-eating disorder" websites. Additionally, the "pro-ana" sites are hard to differentiate from the disease-based sites; individuals who believe their eating disorder is a lifestyle do noticeably differ from individuals who take a medical approach to their disorder, understanding that while they still not be willing to recover, their daily life is driven by a mental illness, rather than a higher calling. However, the sites disease-based individuals use and the advice they post may not be discernable. They may still search for thinspiration and tips for purging. This makes the eating disorder-themed sites extremely hard to categorize: they are a confused web of different themes and beliefs. This confusion may be partially due to the fact that individuals who post to these sites are confused about their identity within the disorder: "None of the sites [...] claimed anorexia or bulimia were glamorous and desirable lifestyle choices, and the mood of the pro-ana forums is overwhelmingly supportive of the choices of everyone there. However the prevailing mood of these sites seems to be '…yes these are diseases which are dangerous to your

physical and mental health, but bearing that in mind here is the inspiration to carry on…' (Lipczynska, 2007).

In most research on pro-ana websites, the data have been strictly observational: analyses are discussed from the perspective of what the researcher believed he or she witnessed by monitoring the sites. The patterns of relationships between users are strictly what the researcher has viewed second-hand; the researcher posits the experiences garnered from the women they observe online. However, there may be a discrepancy between what the researcher thinks they are witnessing, and what the pro-ana site members actually experience. Although observational research is well documented, some studies where the researchers have become immersed in the pro-ana world have been conducted. In one of these designs, a researcher posed as a pro-ana member to see what type of reception she would receive. She created the persona of an individual who might use a pro-ana site: she gave herself the profile of a 20-year-old female with anorexia. She also gave herself the "stats" typically recorded and traded between users: at 5'6' her avatar was currently 104 pounds, with the long-term goal weight of 90 pounds. She engaged in 23 groups on 12 websites; these groups included forums, chatrooms, and diary sites, all formats where she would have one-on-one experiences with other pro-ana members. The extensive themes of support that she recorded during the experience were narrowed to establishing connections with the community, establishing norms, the need for disclosure, and encouragement towards recovery. In other words, she largely experienced what many researchers observed second-hand: the community of like-minded and similarly experienced individuals reaching out to one another with an in-this-together philosophy. However, the researcher also experienced hostility, which has also been documented by observational research. Some of this hostility came from ideas of community; individuals felt threatened by the researcher if her

views did not match their own: their hostility came from a feeling of protection towards the community the researcher conceivably threatened. Other forms of hostility came from feeling like the researcher was an unwelcome outsider; where relationships and trust between users is built over time, and the researcher did not yet earn this privilege (Brotsky & Giles, 2007).

The hostility that researchers and other newcomers are met with when first joining these sites is not an uncommon experience. The community is hyper-alert and constant policing their communities for "wannabes" or individuals that they feel are "posing" with an eating disorder, or who are not yet sick enough to join their ranks. Wannabes can also be individuals who are not currently battling an eating disorder, but romanticize the thinness and lifestyle characteristic of the illness. They are greatly disliked in the community, as their eagerness lacks the true struggle that individuals with an eating disorder often feel and share: their desire to be a group member means that they are without the angst and pain of the actual experience. Additionally, because of their overeager nature, they are scapegoated as the individuals who cause pro-ana to have a bad name in the press; their unwavering support makes the lifestyle choice seem more extreme to outsiders. It is also hypothesized that a lot of the hate directed at the "wannabes" is from the need to protect the community: the threat of outsiders who are not fully compatible with the site's philosophy and member experience is viewed as a breach of their safe space. Although the eating disordered individuals seem to team up as a united front against the wannabes, there is discord amongst their ranks, split between diagnosis and identification. The pro-ana and pro-mia community is different not only in how their disorder is carried out, but also in the way in which they conceptualize the disorder. Interestingly, it leads to a near-moral debate. Anorectics, who view food as a weakness and therefore absolve from eating almost entirely, see themselves as superior to their bulimic peers. There is something "pure" about their disorder that bingeing and

purging lacks, and they feel a sense of moral superiority from their status. Such feelings of morality lead them also to cast bulimia in a negative light: since bulimics are not able to maintain their fast, they see the disorder as "cheating" or even a failed anorectic. Bulimics tend to fight back against this conceptualization, rather than agree with the pro-ana groups; they sometimes split to create their own pro-mia communities. Even those that remain on pro-ana sites feel the need to defend their behaviors and make the claim that both are disorders; starving is no different than purging, as both are use for the same ultimate goal: weight loss (Giles, 2006).

In another study where the researcher made contact with the individuals posting to pro-ana sites, participants were recruited from the sites themselves. Study participation was advertised on their forums, so a unique look into the responders to pro-ana sites was achieved. It was found that, of the individuals who chose to participate, they reported high levels of eating disorder symptomatology. This is an important finding, as membership to pro-ana sites is strictly self-diagnostic in nature; being active on a site does not necessitate actual diagnosis. The study also found that the motive for these highly symptomatic individuals was in keeping with strictly observational research: the community provided an impetus and encouragement for extreme weight loss, as well as proving a sense of identity and acceptance (Rodgers, Skowron, & Chabrol, 2011).

Just viewing these sites for a few minutes negatively influences even women who do not reach criteria for psychopathological eating; they rate their self-esteem and body image much lower than control counterparts (Bardone-Cone & Cass, 2007). Although young girls who view these sites do not automatically develop eating disorders, they show a higher drive for thinness and a higher level of perfectionism than their counterparts that do not feel compelled to visit such sites (Custers & Van den Bulck, 2009). However, this relationship is purely correlational, and it

cannot be determined if these girls seeking pro-ana sites already have a vulnerability for the disorder, or if these sites are happened upon by chance, and visitation increases vulnerability. It is also unclear as to how individuals come across such sites: if they are looking for them, or if they happen upon them.

In terms of browsing the Internet, either for deliberate or accidental exposure to pro-ana sites, a study of Google searches revealed a wide net of 26 keyword searches that yielded content to pro-ana or pro-mia websites. Of these 26 searches, the most common were: pro ana, thinspiration, thinspo, pro anorexia, pro ana mia, pro ana tips, tips on anorexia, and many variations of the sort. These 26 keywords together made a total of 1,000 monthly hits, and of the 26 common keyword searches, 12 of them explicitly detail thinspiration, while 11 concerns anorexia and 3 mention bulimia. These patterns of search items also fall into global patterns, with Australia, Canada, and the United Kingdom producing the most searches for both anorexia and thinspiration. Finland, Germany, and Sweden showed more interest in searches for thinspiration alone. The Netherlands had a response pattern of high search rates for anorexia but not for thinspiration. Mexico was the only country whose keyword searches regarding bulimia yielded significant interest. The United States was an interesting case, as all of the searches yielded high regional interest; additionally, the United States was the only country that yielded searches for pro eating disorders. This keyword search is particularly of interest, as it does not explicitly relate to thinspiration, anorexia, or bulimia (Lewis & Arbuthnott, 2012). The keyword search does not prove the link between viewership and developing an eating disorder. In fact, from a patient perspective, this link is incorrectly directed. In a case study of an already-diagnosed and recovering eating disordered individual, the sites are not likely to make young girls develop an eating disorder simply by curiously Googling hit words or browsing through the

pages of thinspiration pictures, “a website will not give you anorexia, it is already there and that is what makes you look at the website in the first place,” (Lewis & Arbuthnott, 2012).

Although it seems less relevant in the minds of the public due to the lack of infamy in comparison to the pro-ana sites, a different type of Internet eating disorder sub-culture has taken root online, and its purposes are less unhealthy and hold less potential danger. Confession sites are being born in a new age of growing social media, where locked-to-public-access sites and members-only message boards are giving way to open access. Although this is in itself dangerous, as pro-ana sites are less hard to find, and even less hard to join, it also makes communication and support even easier. These confession sites read almost like group therapy sessions, with individuals sharing their stories, typing snapshots of their day. Many of them still suffer, and it is important to note that such graphic stories could be just as influential as the pro-anorexia sites. It is to this researcher’s knowledge that no studies of these confessions sites have been conducted as of yet, and all potential influences, both positive and negative, are purely speculative. But it is undeniable, by pure content alone, that the philosophies of these communities are different, in that they exist to perpetuate discussion and health, rather than to perpetuate a religion or a dangerous lifestyle. These confession sites do not exist solely for the purpose of eating disordered individuals seeking shelter from the judgmental media and masses for a place online to share secrets and stories. Virtually any and all confessions have a resource to be shared, if one visits the right site. Due to its pure presence on the Internet, many sites are devoted to eating disorder confessions.

By simply typing in “eating disorder confessions,” a web of communities of responders reveal their struggles. Any mental illness has a confession group: from depression to suicide to bipolar to general sites where people choose to share stories; on the less severe side are even

confessions about fictional characters or favorite celebrities. Within these confession sites, we are given a wealth of knowledge that may not be possible from the perspective of the therapist's couch. These are the pure, unadulterated words of the individuals suffering themselves. They are not shaped by the clinician's interviews, nor the researcher's questionnaires; they are also special in that they are the stories the young women freely share, without any prompt to evoke a certain memory or emotional experience. Of the countless experiences that every human experiences every day, these confession posters have chosen this single moment to post. Unsolicited, this information may mean something special to them. This perspective, this focus on the words we chose to share – and the ones we choose not to – comes from the well-versed sourced literature of narratives, described previously.

**Emotion Research**

The way in which individuals react and regard food emotionally, how they tell the story of the self and their relationship to food is not a unique trait of eating disorders. Food is such a prevalent and important part of our lives that even in a non-clinical sample, one's relationship to food can be studied and measured for the way in which one regards eating. This is heightened by the fact that in our Westernized culture, food is not simply a source of sustenance, but holds a wide range of values. Especially for women, high-calorie and high-fat foods are "sinful" and "bad" while healthier options are held to an almost moral superiority (Brumburg, 1989). Such valued messages about food, and the way in which we feel about them, are experienced not only by the eating disordered population, but also to the larger public to a lesser extent. It was found that the simple act of eating a meal will alter mood, depending on what that meal entails. When the meal is viewed negatively, when it contains unusual foods, is not enough food, or is unhealthy, the experience is linked to a negatively affected mood. In contrast, when offered

sweet and fatty foods, which offer high energy through calories, the food is shown to increase mood. Such foods are also shown to reduce stress through opioidergic and dopaminergic neurotransmission. Unfortunately, sensitivity to these foods and the emotional relief they provide may be an inheritable trait, leading to individuals seeking these food options more frequently. Though they improve mood, sugary and fatty foods can also be very unhealthy when overindulged or matched with a sedentary lifestyle and has been linked to the growing trend of obesity. This cycle of seeking stress-reducing food has been shown in rats to lead to weight gain and obesity. When applied to humans, a larger array of complex decisions may lead individuals to seek stress-reducing foods, such as emotional overeating, depression, and PMS (Gibson, 2006).

In a similar study examining the emotions surrounding eating, women were asked to rate their emotional state and hunger levels at six points throughout the day. From the various assessments, over six hundred emotional states were recorded, which were grouped into four emotional clusters: anger-dominance, tension/fear, relaxation/joy, and unemotional. It was additionally found that self-motivation to eat was increased when negative emotions were reported. During negative emotional states, it was theorized that the need to cope with such emotions were met through eating, as well as a heightened sense of hunger. Such findings indicate that emotional eating, and eating in order to quiet negative emotions is present even in a non-clinical sample (Macht & Simons, 2000).

The studies presented thus far group all emotional eating under one simple category of negative emotion. However, it was further theorized that under the scope of emotional eating came several unique motives, or emotion-induced eating changes. Looking at a wide range of the factors that play into emotional eating, five individual differences were found: emotions aroused

by food stimuli affect food choice, such as comfort foods; emotions high in arousal or intensity suppress eating due to incompatible emotional responses, such as intense fear or sadness driving away the urge to eat; emotions moderate in arousal or intensity affecting eating depending on motivations to eat, which was further broken into three sub-categories. In restricted or restrained eating, both negative and positive emotions enhance food intake due to deficits on cognitive control; this is best exemplified by breaking a diet, or being unable to keep up with its strict measures. In emotional eating, negative emotions elicit the tendency to be regulated and soothed by eating, and such a state leads to the choice to consume high-fat foods, which was similar to the finding in Gibson's study. Lastly, in "normal" eating, emotions affect eating in congruence with their cognitive and motivational features, that is, although individuals may restrict or indulge occasionally, their emotional patterns largely do not map directly onto their eating behaviors (Macht, 2007).

The discussed studies in this section focused mainly, so far, on the way in which our eating habits are affected by emotion, and *vice versa*. However, the relationship is also present in a non-clinical sample when abnormal eating habits – that is, dieting – are examined for their emotional impact. Work on eating and emotion in a non-clinical sample is usually skewed towards the obese population, as it is believed that such individuals achieved their weight through the aforementioned feedback loop of eating high-sugar and high-fat foods to reduce anxiety. It is also believed that obesity may have a biological foundation, with obese individuals additionally unable to adequately measure satiety; inability to measure hunger and satiety, however, is also possibly a learned behavior. From the standpoint of registering fullness, it is theorized that, when presented with a stressor, individuals of a normal weight will alter their intake – either increasing or decreasing their eating behaviors – while their obese counterparts

will eat regardless of their emotional state or stressors present. The restricting or indulging hypothesis within the normally-weighted individuals leads to a further theory regarding the former: those who restrict their food intake, but remain in a non-clinical population. For individuals who chronically restrict food, or diet, they are also likely to overeat when presented with disinhibitors, such as the belief that they have overeaten, alcohol, and stress. Such findings of restricting habits leading to overeating flows from a non-clinical population to the behavioral habits of those diagnosed with bulimia. The research on emotional cues and eating in a non-clinical population can therefore easily tie into the emotional cues and experiences within a clinical population (Canetti, Bachar, & Berry, 2001).

By looking at non-clinical samples regarding food and emotion, it can be seen that in healthy women, in particular, there are undeniable ties between food, and how we feel before and after we consume it. Such patterns are therefore unsurprisingly found within the eating disordered population. As clinical sample, the emotional ties to food, as well as the specific emotions they are likely to report or exhibit is more heightened and intense than that seen in the non-clinical population. However, it is important to note that eating disorders and the feelings experienced by individuals in relation to food does not exist in a vacuum: in a food-obsessed culture, no one is immune to the emotions "good" and "bad" food evoke, or the "eating too much" and "not eating enough" experience. Some of this emotional experience is fed or driven by personality traits; the presence of perfectionistic tendencies and a perfectionist personality is highly correlated with individuals who have an eating disorder (Hewitt, Flett, & Ediger, 1995). Individuals with an eating disorder, especially anorexia nervosa, are more likely to score high on perfectionism scales, and hold perfectionistic standards against themselves in other facets of their life, such as school, interpersonal relationships, and success in sports. Such high standards leads

to emotional distress particularly within the eating disorder, as they are unable to fully achieve the "perfect anorectic."

The tendency to self-objectify the body, or "the psychological process in which individuals internalize observers' objectifying perspectives on their own bodies and become chronic self-monitors," is also a trait that is seen in individuals with vulnerability for eating disorders (Calogero, Davis, & Thompson, 2005). Although virtually every human existing in society will, at some point in their day, be confronted with some sort of media agenda, these individuals are more strongly affected due to their tendency to self-objectify. Self-objectification is linked to lower levels of self-confidence, which strengthens body dissatisfaction and may lead to dieting behavior and the drive for thinness. Body dissatisfaction is a trait that often precedes the eating disorder and aids in the disorder's onset. However, no amount of weight loss will quell the dissatisfaction of the eating disordered individual, and body dissatisfaction will drive the need for more and more weight loss to achieve a thinner and thinner ideal. Body dissatisfaction is a focus of therapy that is very important for individuals receiving treatment for an eating disorder, and with extensive work and therapy, the degree to which individuals feel dissatisfied with their shape can diminish, and they can improve their internalized relationship with their body (Probst, Vandereycken, Coppenolle, & Pieters, 1999). Vulnerability to self-objectification and body dissatisfaction may be further fed by vulnerabilities to difficulties in emotional regulation. It has been documented that individuals with an eating disorder are more likely to display negative affect and the inability to properly regulate emotions more than their healthy counterparts. Further postulation suggest that these vulnerabilities aid in the formation of an eating disorder, the disorder being used as an unhealthy coping mechanism for the struggling

individual (Cooper, O'Shea, Atkinson, & Wade, 2014). This is a recurring theme within the current project and will be discussed in further depth.

Another unique aspect of anorexia, and the other eating disorders to a lesser degree, is the way in which individuals view their disorder as a part of their identity, as an ally or a true self. The distress individuals feel characterizes many mental illnesses; they see the disorder as something inherently wrong and separate from who they are, they seek treatment because they do not like this new aspect of their life. Their depression, or anxiety, or phobias are a part of them that they dislike and want to get rid of. This phenomenon is less common in anorexia, and in fact the opposite is frequently seen. Many individuals with anorexia take an egosyntonic view of their disorder, in that they believe their symptoms fit with their lives and who they want to be. They feel as though the disorder is natural, a part of them, and a part they are hesitant to part from. This benevolent view towards the disorder can make it very hard to treat, among other factors. In an exercise where anorectic young women were asked to write a letter to their disorder, with the prompt: "Write a letter to your anorexia nervosa as a friend and then a letter [...] as your enemy," patients reported on six of the ten positive themes, indicating that their eating disorder made them feel safe, made them feel looked after, made them feel protected, made them feel attractive, increased their confidence, allowed them to avoid uncomfortable emotions, and gave them a positive feeling of being different, or being superior. Of the ten negative themes, three were responded to frequently: feeling upset by constant thoughts of food, losing friends and relationships to the disorder, and the sense of being controlled by the disorder (Serpell, Treasure, Teasdale, & Sullivan, 1998). Viewing the disorder positively, or as a friend to the patient can have dangerous implications. Interestingly, motivation for change, or recovery, proves to be the best predictor of treatment outcome in clinical populations; proving to be better

indicators of change than psychopathological measures (Fitzpatrick & Weltzin, 2014). Egosyntonic beliefs and motivation for change are likely to be related, as believing the disease is part of one's identity is unlikely to produce the desire or motivation to change the disorder, which would lead to altering a comfortable and known identity.

It has been theorized that the eating disordered brain is fundamentally structured differently. Although such discoveries fall prey to the unknown directionality of correlations: does brain structure influence anorexia or *vice versa*; such findings are still important to the understanding of the disorder. Altered brain structures cause a difference in the way eating disordered individuals experience emotions. In the area of the brain where response to reward is processed, it has been shown that individuals with anorexia are more sensitive to punishment. Alteration to these primary processes can result in anxiety, the tendency to internalize, and threat sensitivity. In secondary processing, environmental and experiential events or cues can act on the vulnerabilities of weakened primary processes and combine to form negative emotional reactions to food and body shape. It has also been observed that the existing brain pathways involved function differently in the anorexic individual than her healthy counterpart, and that these brain changes are permanent; functional differences in the dorsal cognitive system are seen in both currently diagnosed anorectics, and their recovered peers (Treasure 2012).

In addition to the belief that the eating disordered brain is fundamentally different than its healthy counterpart, it has additionally been proposed that the emotional functioning of those with an eating disorder is equally different than those who eat normally. That is – perhaps prior to the onset of the eating disorder – individuals are unable to process emotions in a healthy way; in fact, such deficits are believed to influence the development of the disorder. As such, individuals are unable to adequately process their emotions, they seek unhealthy means to gauge

their internal states. This pattern is found strongly in those diagnosed with anorexia nervosa. In this population, it has been found that both adolescent and adult anorexia sufferers display alexithymia, or the inability to recognize emotions, as well as deficits in emotional functioning. Emotional numbness and deficits in functioning was measured through presenting an emotive face and asking patients to generate matching emotional words to the face; individuals with anorexia, both adolescents and adults, struggle with this task, as they are unable to correctly identify emotional states in others, as well as themselves (Zonnevijlle-Bendeck, van Goozen, Cohen-Kettenis, van Elburg, & van Engeland, 2002).

The inability to process and identify emotions in the self and others creates other problems with emotional processing in anorectics. It has been additionally found that individuals with anorexia nervosa are more likely to suppress negative feelings and minimize their own needs in order to preserve close relationships or care for others. In the Silencing the Self measure, the two schemas of Care: Self Sacrifice and Silenced Self were significantly higher in anorectic individuals than their healthy control counterparts, even when adjusted for depression, self-esteem, and global assessment of functioning. Controlling for these additional and often comorbid conditions lead to the firm finding that anorexic individuals are highly likely to avoid expressing their thoughts or feelings when this may pose a conflict in their relationships, leading to a prioritization of others and neglecting self-care. Their aforementioned alexithymia may therefore be a result of downplaying their emotions for the benefits of others (Geller, Cockell, & Goldner, 1999).

Although eating disorders share many diagnostic characteristics and beliefs about food and weight, to the extent that the three disorders – anorexia nervosa, bulimia nervosa, and binge eating disorder – are actually transdiagnostically identical, the degree and severity to which these

characteristics are exemplified and believed may differ by diagnosis. On the EPQ-scale, it has been reported that individuals with anorexia tend to score higher on neuroticism and psychoticism than bulimic individuals (De Silva & Eysenck, 1987). Individuals with binge eating disorder are more likely to express feelings of guilt, and experiential anxiety is attributed to lack of strategies to cope with stress, rather than the expected anxiety of gaining weight seen in anorexia. Individuals with bulimia are more likely to express their "thorny" relationship with food, which leads to feelings of anger, guilt, ambivalence, and incompetence for food. Interestingly, bulimic patients showed highest level of concern regarding calories; this pattern was attributed to the fact that anorectic patients felt more competent, detailing a higher ability to respond to caloric losses and eating restrictions. However, in their views towards food in general, bulimic and anorectic patients reported similar feelings of displeasure in eating than individuals with BED (Alvarenga, Koritar, Pisciola, Mancini, Cordás, & Scagliusi, 2014). The takeaway message of these patterns of findings reveals that, although some negative relation to food defines all three eating disorders, their emotional reaction to food and eating behaviors is very specific to the disorder itself.

**NSSI**

To some extent, the stories of women with eating disorders have been heard. Certainly they have not all been heard, for such a feat would be impossible; and even for those that have been listened to, it has not always been with a non-judgmental or positive ear. However, the struggle of an eating disorder that is known by nearly 13 percent of all women (retrieved from anad.org), is at least given the privilege of being well documented, well researched, and well sourced in treatment options. Other disorders or disorders under consideration by the American Psychological Association, such as self-harm, are not given this benefit. In fact, for the majority

of people who struggle with nonsuicidal self-injury (NSSI), or self-harm, the illness they are struggling with was not even mentioned in the *DSM-IV-TR*. They suffer silently, with no answers as to why they feel compelled to harm their bodies in response to distress. They have no diagnosis to feel connected to, and only a vague, unconnected medical community in which to gain support. They are a community of shared sufferers, without the benefit of any answers as to why they are a community in the first place.

Within the population of non-self-harming individuals, views of NSSI mirror this feeling of being undefined. In a study of non-harming individuals' views of NSSI, they tended to view NSSI's severity by how noticeable it is to others; cutting was seen as something severe, as cutters have visible wounds on their flesh, which may turn into permanent scars. Severity was gauged not by the degree of harm the individual themselves attain, but the degree to which an observer is made aware of the harming behavior. In these criteria of noticeability, participants were interestingly conflicted as to whether eating disorders qualified as a form of self-harm, as their body noticeably changes, but the overall belief was that eating disorders were in some way inherently different. Additionally, non-harming individuals believed NSSI to be something to be sympathetic towards, rather than disgusted by or rejected. This finding was in stark contrast to previous studies of medical and healthcare professionals, who were rated to be negative and unsympathetic to self-harming clients. Interestingly, this negative view of NSSI led medical professionals to see self-harm as a form of mental illness, and therefore something individuals were not responsible for; in contrast, the sympathetic public were less likely to see NSSI as a form of mental illness, and rather something that individuals should be able to control or stop (Newton & Bale, 2012).

Until the *DSM-5*, NSSI was conceptualized as a symptom of Borderline Personality Disorder (Oumaya, Friedman, Pham, Abou Abdallah, Guelfi, & Rouillion, 2008). In BPD, individuals have extremely volatile emotions and unstable relations, leading to mounting distress and an unformed strategy on how to dispel this distress. Of the BPD population, it is estimated that approximately 80% of them engage in NSSI or suicidal behaviors (Retrieved from nimh.nih.gov). However, it was noted within the medical and clinical community that outside of the large population of self-harming BPD patients, there was also a substantial group of individuals who engaged in NSSI without meeting criteria for BPD, sparking the discussion that NSSI should be viewed as its own disorder.

In the 2013 version of the *DSM-5*, Nonsuicidal Self-Injury Disorder is defined under disorders for further research as:

A. In the last year, the individual has, on 5 or more days, engaged in intentional self-inflicted damage to the surface of his or her body a sort of likely to induce bleeding, bruising, or pain (e.g., cutting burning, stabbing, hitting, excess rubbing), with the expectation that the injury will lead to only minor or moderate physical harm (i.e., there is no suicidal intent).
B. The individual engages in the self-injurious behavior with one or more of the following expectations:
    1. To obtain relief from a negative feeling of cognitive state
    2. To resolve interpersonal difficulty
    3. To induce a positive feeling state

It is noted that the relief one expects and desires from the injury occurs during and immediately after the event, and such patterns may lead to feelings of dependency and addiction, with the self-harming individual feeling as though they are addicted to the feeling that inflicting pain gives them. In addition to a proposed set of diagnostic criteria, the *DSM-5* offers a risk and prognostic factors, stating that NSSI follows a female-to-male ratio of about 3:1 or 4:1, a closer prevalence rate than an aforementioned suicidal behavior disorder, the diagnostic criteria of which, though similar to NSSI, will not be discussed here. Furthermore, the *DSM-5* provides

several differential diagnoses, including BPD, suicidal behavior disorder, trichotillomania, stereotypic self-injury, and excoriation disorder. Relevant to the current study, the DSM-5 makes no mention to eating disorders in its description of the proposed NSSI disorder. Additionally, the *DSM-5* does not mention NSSI as an issue of comorbidity at any time within the feeding and eating disorders section, though the pattern of comorbidity has been heavily established and will be discussed further within the present study.

Though the *DSM-5* proposed classification started to give shape to the disorder, allowing for potential research and study, the research itself is a confused body of literature, due largely in part to the lack of a clear operationalization of the term "nonsuicidal self-injury." Two articles using the same term may be referencing two slightly different definitions of the same disorder. And even between articles, the terminology changes. The disorder is largely defined as one or more of the following names: self-injurious behavior, injurious behavior, nonsuicidal self-injury, self-harm, and more creative variations aiming to detail the same set of behaviors. But the set of behaviors are not agreed on either: self-harm research does not clearly define what actions qualify as self-harm; some research includes suicidal behaviors, thoughts, attempts, and plans, while others view the two as separate. Within the group where self-harm is independent from suicidality, a number of actions are debated as to whether they are included in the scope of self-harm, including body modification, risky sexual behavior, and drug use. It is a messy field lacking the clear classification necessary.

In the research following the separation of NSSI from BPD, researchers began to study what caused individuals to self-harm. It still remained unanswered as to why individuals lacked the ability to calm themselves in healthy ways. One possible explanation is that individuals who engage in NSSI operate on two dichotomous dimensions: automatic contingencies versus social

contingencies, and positive reinforcement versus negative reinforcement (Nock & Prinstein 2004). *Automatic-negative reinforcement* depicts an individual who self-harms to aid in the reduction of tension or other negative affective states. The best depiction of this would be an individual who self harms to "stop feeling bad." Individuals who self-harm from the *automatic-positive reinforcement* pathway engage in the behaviors to create some sort of noticeable physiological state; these individuals report feeling numb, and the pain from self-injurious behaviors will temporarily disrupt their state of unfeeling. In acting from a *social-negative reinforcement* pattern, individuals self-harm as a form of escape: from activities, duties, interpersonal relationships, or any other aspect of life that the individual is trying to avoid. The physical mark of self-harm may keep them from engaging in an activity that they formerly had no excuse not to attend. At the other end of the social reinforcement spectrum is *social-positive reinforcement*, or the heavily used and often scathed "trying to get attention" explanation for NSSI. However, social-positive reinforcement acts as a deeper pathway for the individual, desperately attempting to communicate their internal pain through those marked on the skin.

Within the adolescent population, were frequency of NSSI is especially high, reaching an estimated 14-39% of the population (Nock & Prinstein, 2005), studies show that the most commonly reported reason for engaging in self-harm followed the automatic reinforcement pathways (Nock & Prinstein, 2004). Within the population of individuals who self-harm, a focus of research has been directed towards the younger population of adolescents engaging in NSSI. While the *DSM-5* postulates that the ratio of men to women engaging in NSSI is relatively equal, such a statistic does not apply to adolescents, where it has been found that teen girls are more likely to self-harm (Madge et al., 2008). In a similar study conducted in Canada on self-harming teenagers, researchers found similar results to the European report, but developed the project

further: rather than defining self-harm for the adolescents, they allowed the participants to include what they believed to encompass self-harm. As expected, a large portion of the participants answered in keeping with the medical parameters of cutting, burning, punching. However, they also included behaviors researchers are not inclined to include, such as nonsuicidal pill taking, and – most interestingly for the present study – eating disorders, (Laye-Gindhu & Schonert-Reichl, 2005).

In a follow-up study, the above researchers aimed to detail their dimensions of NSSI further, as well as to assign specific patterns of relations to each dimension. Additionally, working from the belief that individuals who self harm tend to show more impulsive personality traits, the setting in which one self-harmed was also examined, looking for individuals who engaged in NSSI when they were also under the influence of alcohol and drugs, or if the antecedent from the act came from social modeling. In this area, the researchers found that participants were unlikely to self-harm while under the influence of drugs or alcohol. This finding suggests that the impulsiveness attributed to self-harming individuals comes from their unplanned decision to self-harm, as well as other internal or external contingencies (Nock & Prinstein, 2005). In their attempt to assign certain emotional experiences to the dimensions of their NSSI dichotomy, it was reported that individuals who reported self-harming from the automatic negative reinforcement also reported higher levels of hopelessness, as well as a history of suicide attempts. This followed from the theory that automatic-negative reinforcement drives NSSI through the need to relieve pain, suicide being the most ultimate relief of pain for hopeless individuals. It was also discovered that individuals who followed an automatic positive reinforcement pathway were more likely to meet criteria for MDD and PTSD. This association follows from the fact that both disorders suffer from feelings of emptiness, detachment,

anhedonia, and shortened affective range; the automatic-positive reinforcement pattern would address by temporarily interrupting the feelings of numbness (Nock & Prinstein, 2005). Interestingly, both sides of the automatic dichotomy also reported high levels of perfectionism; this indicates not only a factor driving their behavior, but a clear connection to the experience of eating disorders.

Reasons for self-harming are, in the general sense, distributed across gender in individuals who self-harm; as stated earlier, Nock's four essential drives for self-harm have been documented in several NSSI populations. However, individual differences between men and women have been documented as well. Although it has been documented that women are more likely to engage in NSSI, men are more likely to report more severe measures: they were more likely to use burning as the method of self-harm, they reported more pain experience from the act, and they were less likely to monitor their wounds post-NSSI as well as attempt to cover them up. In contrast, women who self-harm reported cutting as their main form of self-harming behavior, and additionally cited agoraphobic and interpersonal problems as cited reasons for engaging in NSSI, (Claes, Vandereycken, & Vertommen, 2007).

Another theoretical approach to understanding NSSI is the belief that the specific population experiences hyper-physiological arousal in response to a stressful event, a decreased ability to tolerate the arousal and remain in the environment, resulting in the use of NSSI as a means of relieving this tension due to deficits in social problem-solving skills (Nock & Mendes, 2008). The phenomenon of hyperarousal in individuals who self-harm was not reported in individuals who attempted suicide or parasuicidal behaviors; this may be due to the fact that hyperarousal is unique to NSSI. However, the similar pathways between suicide and NSSI suggest that hyperarousal has only recently been accurately measured in this specific population.

In combination with a heightened physiological reaction, individuals who self harm are also shown to have a weaker distress tolerance; they experience more arousal, and they experience less ability to tolerate this arousal (Nock & Mendes, 2008). In this study, the social-problem solving deficit that has been repeatedly reported in the literature was once again replicated, though the problem itself was developed further. Responses indicated that individuals who self-harm are able to reach adaptive responses to a problem, if given the time. However, they are more likely to automatically produce maladaptive responses, as well as report lower scores of self-efficacy. From this finding it can be determined that their pattern of maladaptive choices may be fed by low self-efficacy, even when more adaptive responses would be available to the individual (Nock & Mendes, 2008).

An interesting diagnostic phenomenon that has been documented as occurring with NSSI is the tendency for self-harming individuals to have significantly lower self-concepts, as well as low-concepts in relation to their peers. Individuals who self-harm are more likely to rate themselves lower on academic intelligence, social intelligence and competence, physical attractiveness, and emotional stability than their non-NSSI counterparts. Additionally, individuals who self-harm, notably adolescents, are known to find strength in numbers: self-harming individuals are more likely to have other friends that self-harm. This pattern could have formed for a variety of reasons. Like the online confession and support sites, which were discussed previously, it may be that students who self-harm are drawn to other students who engage in NSSI. The idea of low self-concept may also play a role: individuals with low self-concept may be vulnerable to peer suggestion: they may drawn to other individuals with low self-concepts, and these views might further aid a vulnerability to copy NSSI behaviors.

Therefore, an interesting group characteristic of NSSI is both defined and perpetuated by the feature of low self-concept (Claes, Houben, Vandereycken, Bijttebier, & Muehlenkamp, 2010).

Much of the research regarding NSSI has been conducted within a clinical population, examining individuals who have already been hospitalized, either for self-harm or a comorbid or preexisting condition. However, there is a population of self-harming adolescents who, for all intents and purposes, are otherwise medically and mentally healthy. These individuals are not currently under inpatient hospital care, and they are relatively functioning individuals. Like their peer adolescent populations, their NSSI is something that happens in the background of their lives. This phenomenon seems to be an unlikely finding: individuals who, for all intents and purposes are healthy, are harming their body for unknown reasons. And yet, in a nonclinical sample, one in twenty five individuals have a history of self-harm (Klonsky, Oltmanns, & Turkheimer, 2003). Although this percentage is much lower than the clinical population who self-harms, it does speak to the prevalence of NSSI in all populations. It also begs the question of motives to engage in self-harm, and how strong and profound they may be, if their drive can affect psychologically healthy individuals.

The pathway of emotional distress and the inability to healthily quiet the distress that leads to engaging in NSSI is seen in several disorders, besides BDP. Individuals diagnosed with depression are at a higher likelihood to self-harm. Individuals who self-harm are at a greater vulnerability for future suicidal attempts; this works in the reverse as well, with individuals who attempt suicide are also likely to engage in self-harm. The comorbidity of anxiety and self-harm is also strong; as depression and anxiety are also closely linked, this pattern is unsurprising.

**NSSI and Online Communities**

As more and more attention is given to self-harm, confession, support, and information sites devoted to individuals who engage in NSSI, or who know someone who is self-harming have become more and more available. These sites, in a similar fashion to the growing body of confession and positive community sites, or the confession sites, provide a new and growing community of individuals to garner support, share their stories, and get medical facts about the disorder (Whitlock, Lader, & Conterio, 2007). These sites function in the same manner that well-intentioned pro-ana sites do: they provide contact for isolated and lonely individuals battling a condition they feel others around them do not understand. Additionally, these sites may also provide therapeutic help by beginning to socialize self-harming individuals, and help them cope in alternative ways; such functions should be examined as a therapeutic asset, though it is rarely used in this manner. Unfortunately, the sites that offer support and medical information are less likely to be visited or viewed by self-harming or vulnerable individuals. Instead, they are more likely to visit social networking sites that often have triggering images or information (Duggan, Heath, Lewis, & Baxter, 2011).

Most of the literature on these NSSI communities online has been conducted through the specific search engine of YouTube, where individuals can search for videos and then comment on them, either anonymously or through a free membership log-in. Within the NSSI community, a number of YouTube videos have cropped up; their content ranges from information about self-harm, to graphic images, to actually performing the act on camera. The most popular of these videos have been viewed more than 2 million times as of 2011, and the viewers, unfortunately, might seek out these videos not for a sense of community, but for education on how to self-harm (Lewis, Heath, Denis, & Nobel, 2011). Such videos, and the newly available information they

entail may actually be detrimental to the population of vulnerable viewers who want to learn how to cut, like the "wannabes" on the pro-ana sites.

In a look at the comments section for such videos, it was found that after watching the video, viewers were most likely to comment with their own story of self-harm (38.39%), followed by feedback or compliment about the video's quality (21.95%), and the video's message (17.01%), admiration for the creator him or herself (15.40%), and encouraging words to the uploader (11.15%). Of the nearly 40% who commented with their own story of self-harm, the majority did not mention recovery at all in their post, and were additionally likely to mention that they were currently self-harming. Such findings indicate that the channel of YouTube might act as a way for current self-harming individuals to use these videos to maintain their behaviors, and use the "triggering" videos to motivate their self-harm, as well as to distance themselves from recovery (Lewis, Heath, Sornberger, & Arbuthnott, 2012). Because the content of these sites are so triggering to individuals who self-harm, as well as act as an impetus for vulnerable individuals to begin self-harming, researchers have called to begin monitoring and measuring the Internet use of this population. The use of the Internet in the onset and maintenance of NSSI has been largely misunderstood, and by assessing the time spent on such detrimental sites, as well as what function they have for the individual, clinicians may gain clearer insight as to the working mind of those self-harming. Such understanding may aid researchers and clinicians in proposing a course of treatment in which recovery from NSSI may possibly be achieved (Lewis, Heath, Michal, & Duggan, 2012).

The use of such vivid and graphic imagery may have a negative affect to those who view such material. Similar to studies conducted on individuals viewing "pro-ana" images of emaciated women, studies looking at the reaction and affective responses of individuals who

have been exposed to images of self-harming have also found trends in how people respond to such stimuli. In individuals with positive perceptions of NSSI, viewing such images led to reductions in loneliness and increased NSSI enactment. In individuals with negative perceptions of NSSI, these images still seemed to reinforce and encourage NSSI; in both mindsets, the images had some positive effect that supported the act of self-harm. In both positive and negative perceptions, the images were reported as "triggering" for some of the participants (Baker, 2013). Such findings support the very important power imagery has, and what widespread access to particularly graphic images of self-harm may have to those who purposely or inadvertently seek it.

Outside of the social media realm of YouTube, where communication is limited to viewership and video comments, a wide range of websites, as mentioned previously, can be found on the Internet. However, in addition to the helpful medical sources, there are equally detrimental sites, whose messages are just as negative as the YouTube videos. In a content analysis of these NSSI-related websites, it was found that the pages list NSSI as "an effective coping mechanism" in 92% of the cases. In addition, these sites list the addictive quality that NSSI can be experienced as, noting that self-harm was difficult to stop in 87% of the sources. Equally detrimental was the slightly positive tone, which proposed the claim that NSSI is not always painful 24% of the time. Not surprisingly, most of these sites had a "melancholic" tone, with 83% of the sites taking these negative and unhealthy views. In addition to the information on these sites claiming NSSI to be a helpful, painless, and an addictive way to relieve tension, almost 30% of them additionally contained graphic photography. From these findings, the message is clear that the Internet, more often than not, provides a social community for self-

harming individuals that only perpetuate the behavior, and clinicians should monitor such usage (Lewis & Baker, 2011).

From this body of research, it is quite clear that the Internet is a source of information for self-harming individuals, or vulnerable individuals who have not yet engaged in self-harm, and quite often, these sources perpetuate the continued maladaptive behavior of NSSI. However, it has not yet been established how one finds these sources, or indeed what leads people to these sites. What does a self-harming individual, or one wishing to gain information, initially search that may lead him or her to the YouTube videos of websites? In a content analysis of over one hundred questions searched through Yahoo! Answers, it was found that the most frequently asked question regarding self-harm concerned seeking validation for the NSSI experience or act. It was found, however, that when seeking validation, the stigma of self-harm reached the Internet, and seekers of reassurance were often met with search results invalidating and scorning their behavior. Another commonly searched question was basic NSSI information; though this may be an encouraging result, it is also important to take into account that simply looking up information – as the research shows – can be all too easily met with websites praising self-harm. A third commonly searched question was how to conceal scars, which would indicate that the individual has already engaged in NSSI, and is looking for tips on how to hide the act, or at least plans on engaging in NSSI so seriously that he or she is already taking precautionary measures (Lewis, Rosenrot, & Messner, 2012).

From this focused look at Internet-based searches and communities from the keyword searches most commonly used, the flashy concept of “NSSI 2.0” has been proposed. This unique look at self-harm encompasses the large use of Internet searches and websites within the population. NSSI 2.0 looks at self-harming individuals not through their actions, but from their

Internet histories. It is the online activities conducted by the majority of those who self harm, and their actions range from looking at NSSI-related sources for medical information, to running a website devoted to the posting of triggering, graphic images, to communicating to other self-harming individuals for a variety of reasons that is examined here. NSSI 2.0 looks at the organic flow of the searches for and material obtained by NSSI users. Using "infodemiology" and "infoveillance" to study and track how people who self-harm use the Internet, as well as demographic information about this population, such as onset of the disorder. This preliminary study found that such methods provided a successful means in which to monitor NSSI Internet use (Bragazzi, 2014).

**ED and NSSI Research**

The comorbidity of eating disorders and self-harming behaviors has given rise to a possible psychopathological pathway between the two. Eating disorders remain linked to one of the highest mortality rates for mental disorders. While 5-10% of individuals with anorexia will eventually die due to medical complications of the disorder, the emotional dysregulation spoken of above often leads to severe depression and suicide. In a population of hospitalized suicidal anorectic patients, 45% died of suicide (Soukas, Suvisaari, Grainger, Raevuori, Gissler, & Haukka, 2014). In a population of bulimic individuals, suicidal behaviors were most common in purging-type bulimia, and individuals were even more at risk if they also had a comorbid personality disorder (Favaro, Santonastaso, Monteleone, Bellodi, Mauri, Rotondo, Erzegovesi, & Maj, 2008). As NSSI is often a predictor of suicide attempts, the connection between eating disorders and NSSI can be a matter of life or death.

One potential theory is that both disorders work from a similar impulsive-compulsive spectrum. In the *DSM-5*, compulsions are defined as repetitive behaviors or mental acts that a

person feels compelled to perform in order to prevent or reduce stress; impulsivity is defined as a predisposition toward rapid, unplanned reactions to internal or external stimuli without regard to the negative consequences of these reactions, and which are usually performed them to experience pleasure (American Psychiatric Association, 2013). Individuals with an eating disorder showed varied signs of compulsive behaviors, such as calorie counting and body-checking, as well as impulsive behaviors, particularly seen in bingeing. Eating disorders and OCD, in which compulsions and impulsivity are often experienced share a high rate of comorbidity at 29.5%, and childhood OC disorders present a vulnerability for developing an eating disorder later in life (Carlson 2007). High comorbidity in the two disorders may stem from the shared psychopathological pathway of impulsion and compulsion detailed above; individuals with either or both disorders are more likely to experience inflexibility, rigidity, stubbornness, and perfectionism. This shared psychopathological pathway also extends to self-harm; the etiology of self-harm can also be mapped onto the impulsive-compulsive theory. Self-harm itself is seen as an impulsive act: the growing need to relieve pain or to relieve numbness is quickly and unthinkingly answered by the act of self-harm; research has shown that individuals who self-harm do not ruminate on the act before engaging in it. Self-harm can also be seen as a compulsive behavior, as individuals often engage in NSSI in more than one isolated event, and feel the need to self-harm in order to relieve stress. It can therefore be seen that eating disorders and self-harm may function in the impulsive-compulsive pathway; the same internal drives and needs are acted out in two externalized ways: NSSI or an eating disorder (Carlson 2007). From this shared pathway, it could be conceptualized that this deeper, ingrained pathway is what broadly defines a larger disorder, with eating disorders and NSSI falling into the roles of

symptoms in such a conceptualization, an idea that is furthered in this paper's hypothesis and study.

In an interesting diagnostic proposal, Favazza and Rosenthal (1990) attempted to define what is referred to as Deliberate Self-Harm Syndrome, or Repetitive Self-Mutilation. Within the parameters of this disorder are individuals who habitually harm their flesh in a manner that is not psychotic or indicative of mental illness. The interesting theory surrounding this disorder is its inclusion of "harm" to encompass eating disorders. Favazza proposes that individuals with Deliberate Self-Harm Syndrome desire to reduce intense negative feelings through dysregulative actions, such as cutting or bingeing. The "or" in this definition is of paramount importance; Favazza hypothesized that individuals with bulimia who were unable to binge due to external constraints would substitute this behavior for self-harm through cutting or burning. Therefore, the individual disorder's characteristics of food patterns or self-harming are encompassed in a single phenomenon, where the symptoms are engaged in systematically by its diagnosed individuals, based on the behaviors they are able to perform when needed. Additionally, Favazza believed that individuals with Deliberate Self-Harm Syndrome may also move transdiagnostically in our sense of the diagnosis, yet still be resolutely diagnosed with DSH; for example, an individual may begin as a bulimic and then no longer binge and purge, but still engage in NSSI. Though her diagnosis may change in the present sense, under the diagnostic terms of DSH, her diagnosis would remain stable, as her symptoms had merely changed (Favazza & Rosenthal, 1990).

**Research Aims**

The goals of the current project were threefold. The first goal was to set up a broad study in which to capture several emotional patterns within the experience of an eating disorder, with

possible specific patterns of emotions also pointing towards some future basis of study. Through looking at the emotions expressed by the eating disorder sufferers themselves, the researcher hoped to gain a clearer picture of the disease as well as the experience. From a self-report measure like voluntarily submitting narratives, it was expected that the emotional experiences documented in these pieces would hold a very intimate and explicit snapshot of the eating disorder experience. Furthermore, such findings would reveal an aspect of the illness that is missed through questionnaires, BMIs, and quantitative research: that is, what the experience is like for the sufferer herself. By examining a variety of emotions as well as subcategories that fall under the broad feelings, it was hoped that frequencies of responses would shed additional light into the eating disorder experience as reported by first-person narratives. These stories, and the emotions they present, will allow for an analysis of meaning, of ecological findings, and what, from a personal perspective, an eating disorder is.

The second goal of the current study was to establish a preliminary link between eating disorders and self-harm (NSSI). The estimated comorbidity of eating disorders and self-harm of 61% is especially high (Paul, Schroeter, Dahme, Nutzinger, 2002) when one considers it to the general population average of 4% that engage in NSSI (Nock & Prinstein, 2005). It was due to this close link that the current research paper was developed. If individuals with an eating disorder additionally engaged in self-harm, then it was possible that their reasons for self-harm were linked to their eating disorder, namely their desire to harm their bodies as a way of releasing distress. From this theory, it was conceptualized that the link between eating disorders and NSSI could possibly merge into a larger theory of self-harming. As it has been proposed in the literature, it may be possible to conceptualize eating disorders as a means of self-harm. Rather than, or in addition to, the goal of weight loss or thinness, individuals with an eating

disorder use food restriction or purging in the same fashion that in individual with NSSI might use a razor or a lighter. In other words, eating disorders could be conceptualized as a form of self-harm, by using the body's food intake as the means of pain. Additionally, eating disorders could serve the same function of NSSI by the utilization of the behaviors (such as fasting or bingeing) in moments of emotional distress (Carlson, 2007). The researcher wondered if such a phenomenon was experienced by individuals with an eating disorder; if, through their narratives of the disorder, they vocalized their desire to cause the body pain in order to relieve distress. From this paradigm, the several areas of literature were converged to form this final area of inquiry. Through the medium of online confession sites, where responses may be more truthful and accurate, individuals with an eating disorder may, among their emotional depictions of the disorder, also depict their eating disorder as a means of harming the body. A qualitative analysis of their responses would reveal whether or not, through the Internet-based sources, the link between eating disorders and NSSI were experienced by individuals with an eating disorder in the proposed sense that eating disordered individuals used their disorder to harm their body with the same motives that individuals who engage in NSSI harm their body, just with a different behavioral output.

The third goal of the current study was to incorporate the two codebooks by examining the patterns of emotionality in relation to patterns of NSSI motives to further support the link connecting eating disorders and self-harm as two symptoms of a larger psychopathology. The researcher was interested in whether or not certain emotions were particularly prevalent when accompanied by one or more of the four NSSI motives. A quantitative analysis of the relationship between the main emotional codes (fear, disgust, shame, sadness, hate, anger, pride, envy, guilt, loneliness, comfort, denial, control, misunderstood, and suicidality) and NSSI motive

codes was conducted. If a large enough set of responses to the sub-codes were collected, these measures would additionally be tested against the NSSI motives. It was theorized that emerging patterns between specific emotional experiences of eating disorders and specific NSSI motives might further support the researcher's aim to examine eating disorders within the context of self harm.

## Methods

### Participants

The design of this study was unique in nature: in keeping with similar Internet-based literature, no participants were directly recruited or aware of their participation in the study. Rather, all of the material analyzed in this study came from individuals who had posted to anonymous confession websites, unaware that the site's content was being monitored by the researcher, and would be used within this study. To maintain the integrity and truthful nature of the narratives, the individuals posting were not made aware of, at any time during their post or during their study, that their words were being analyzed. Furthermore, site facilitators were not contacted as to the nature of the study.

Such a procedure regarding participant involvement and awareness was followed for several reasons. First, these sites offer safe spaces for individuals to share experiences in a way that feels open and unjudged. This was the perfect place to "recruit" and collect data, as it will give rich narratives where individuals do not feel that they need to hold back, fearing identification. Additionally, because these narratives were unsolicited, the researcher avoided any expectancy bias that may have been seen if the researcher had asked for narratives. With no knowledge that the researcher was collecting their words, they were therefore unable to elicit demand characteristics, skewing the data. Such collection measures also allowed the researcher to gain many responses from a particular subset of the population – those dealing with an eating

disorder – which may not be available in a small university population. In a source as large as the Internet, it would be nearly impossible to identify an individual by a single story; however, identity in any form – if names or places are given – were obscured in the discussion for purposes of anonymity, which has been detailed extensively below.

As this study was not able to ask consent from its participants, anonymity and participant respect was of the utmost importance. In regards to the nature of the material being collected for the present study, the researcher was fully aware of the delicate and potentially exposing information such data contain. These narratives, the object of analysis, are snapshots of the participants' lives; they are the clear moments that can be defined from the painful existence of living with an eating disorder. They are inherently important in that they have been chosen by the responder as a discrete, memorable instance; one that is not only remembered, but is needed to be shared. By remaining anonymous, the researcher was unable to ask for narratives, which would have led to certain stories being reported. The fact that these stories were freely shared by the participant is important in that they gave them without prompt, and chose them entirely based in their own, personal beliefs or interests.

Such individuals are not being recruited or asked to share their stories; the data are coming from the information they have added freely on the Internet for their personal and unknown reasons. Because these participants had not being informed of the study, their rights were crucially important. They had not consented to study, and they do not know that their stories will be analyzed; as divulging this information would jeopardize altering narratives or shifting perspectives for the benefit of the researcher. Although such individuals cannot technically be called participants, the researcher is incredibly invested in their rights and maintaining their anonymity.

To address these concerns, the researcher took special note to omit any indicators of names, places, numbers, or identifiable factors. Such omissions were marked with an "X," or similar alphabetic placeholder, which signified that potentially identifying information had been removed. Site facilitators in which this information is being collected from are also invested in anonymity, and often such information is censored before it is even published to the site. This is for the additional factor of removing potentially triggering information; many sites do not publish caloric intake, weights, or mention of a particular food, in case of causing suffering readers comparing themselves to their narrative familiars. Although the sites already have had their information filtered, the researcher will add additional omissions if she sees fit, or if there is the possibility of having any identifying information available to the coders. Additionally, IP addresses and all other information which may potentially track the place in which the narrative has been posted were not collected. The websites themselves were not visited except for the purpose of removing the narratives to a Word Document; from this format, it would be impossible to find where the narrative had been posted from, and when (see Appendix F).

Although observing readily available information on the Internet provided the researcher with a wealth of data from a large population of freely expressing individuals, there were some drawbacks in using this methodology. The primary drawback of observational research online in an anonymous format is that no demographic information could be discerned. With such a heightened concern for anonymity, it became clear than almost no background data on the individuals posting to this site could be made known to the researcher. Therefore, the participants of this study are largely unknown; their age, gender, race, and ethnicity were unable to be compiled. Age could add a further ethical concern; based on the general knowledge of eating disorders, many sufferers experience the disorder in early adolescence, making them below the

age of consent for research. However, the researcher believed that such extensive checks to the anonymity of the participants did not infringe on the rights of minors. Additionally, as these minors had already accessed and posted to the sites used for the study, they had already, knowingly or not, consented to having their personal information on the Internet. As their participation in the study occurred even before the study began, it was believed that despite the fact that writers of these narratives could be below the age of eighteen, their rights were not infringed on. Furthermore, their disease onset, severity, and diagnosis could not be known. In an added complication, it could not even be resolutely determined that every narrative analyzed in this study came from an individual participant; it is possible that a single participant posted to the site regularly, and therefore would result in a single individual counting as more than one data response.

**Research Design**

The research design utilized in this study is a qualitative content analysis. The aim of this study was to examine the nature of eating disorder from the perspectives of individuals currently battling an eating disorder, or with a history of an eating disorder. From this interest, the study was focused further on the emotionality of these perspectives, and whether any of them contained motives of self-harm within their perspectives. Given this research goal, the quality of the data was the main interest, and the appearance of their nature was studied through coding. At the end of the three-month data collection period, the narratives underwent a coding process using a manual developed by the researcher. Patterns and frequencies within coding and the analysis process will be considered in the results and discussion section of this paper. Additionally, the appearance of NSSI themes within the eating disorder narrative was an interest for this project, and the narratives containing these themes were additionally analyzed.

The second research design utilized in this study is a correlational analysis. Pearson's correlations were run after the coding data from the emotional codebook and NSSI codebook had been collected and recorded. The main emotional codes within the former codebook were analyzed for significant correlations in relation to their matching NSSI codes. The aim of this analysis was to examine the larger research goal of providing preliminary support to the theory that eating disorders and NSSI are two symptoms of a larger psychopathology. Achieving significant correlational relationships would add weight to the fact that individuals with an eating disorder can fall into certain patterns when emotions and motives are examined. Furthermore, the aim of this study was to combine the two previous research aims in a novel and meaningful way.

**Measures**

For the purposes of this study, the researcher designed two codebooks specifically for the narratives collected. The first codebook was a 15-category codebook designed for measuring emotionality in the collected narratives (see Appendix A). The codebook included straightforward emotions, such as fear, anger, and sadness. In addition, the codebook included experiences that had intense emotional experiences surrounding it, such as control, suicidality, and denial. Although these are not strictly emotions in a traditional sense, feelings of being in control or out of control, or feeling in denial about an eating disorder had some underlying emotional state, and could be important in outlining the eating disorder narrative; therefore they were additionally included in the emotional codebook. The emotions and subcategories of this measure were selected for a number of reasons. First, they were emotional experiences that have been detailed in the literature; fear, control, sadness, and isolation are all well documented experiences when understanding eating disorders. The researcher included some of these emotions found in the literature to see if such emotions would be present when looking at the

new population found in online confession sites. Second, some of the main emotions and subcategories were included if they were interests of the researcher. From her research of the literature, as well as several autobiographies and documentaries of women who have recovered from an eating disorder, the researcher had many emotional codes that could be of interest to examine further. Some of the emotions in the codebook, such as the many subcategories of fear, the anger code, the envy code and various sub-codes were areas that the researcher was particularly interested in examining within these narratives.

Of these 15 categories, 13 contained subcategories, for a total of 47 additional subcategories. Coding was based on the narrative containing any of the 15 categories. In order to code positively, the coder must recognize the presence of the emotion; the frequency of the emotion in the narrative was not collected in the current study. The narrative could contain as many mentioned emotions as the coder deemed relevant. Additionally, narratives could code for a main category but not achieve a positive coding for a subcategory. The emotional codebook also contained an area for the coders to note any additional emotions contained in the narrative that were not included within the codebook; such documentation could be important for future studies. Coding involved reading the narrative and then checking all of the categories and subcategories that applied to the specific narrative.

The second codebook that was developed concerned motives of NSSI within the eating disorder confession narratives (see Appendix B). The coding criteria used were based off of Nock's four-anchor model of NSSI motives (Nock & Prinstein, 2004). All of the eating disorder narratives were coded using this scale, which had four measures. Narratives could code for one or more of the four anchors described by Nock, or could be left with no code, if a motive was not easily discernable. This codebook was created as it provided a clear and brief measure of NSSI;

as the literature into the psychopathology is new, comprehensive measures that would apply to a larger body of research were hard to obtain. The measure used in this current study provided a concise and clear way in which to measure an important aspect of nonsuicidal self-injury, that is, the motives that lead them to engage in the behavior.

The emotion codebook was designed by the researcher, its development was influenced by the previous literary research, diagnostic questionnaires, peer research group input, researcher interest, and prior study of the narratives from similar sources. The NSSI codebook was taken from previous, established literature, but its use is novel in that it looks not at self-harm motives, but eating disorder motives. The outcome of this process is a wholly new codebook, as well as a new way in which to use an established criteria method. However, the inter-rater reliability between the two coders was very high, with agreement on both the emotion and motive codebooks resolved completely internally; further data into this aspect of the codebook will be introduced in the Results section below. Although a third party was available to decide on any unresolvable coding issues, such a process was not necessary during the entirely of the coding process.

**Procedure**

As this study was conducted by collecting information already present on the Internet, the study had no participant experience, as they were unaware that their information was being studied. Therefore, the procedure for this study was solely focused to data collection. The participants in this study were given no directions in the way in which to structure or compose the data they were submitting, or the way in which they should respond on the assigned websites.

Data were collected entirely from websites already present on the Internet. The researcher focused on websites designed to post “confessions” from individuals who anonymously share

their stories. Confession stories were only taken from websites that are designed to be unbiased; these websites often include disclaimers that they do not endorse eating disordered behaviors or support the content of the confessions. Such websites were recruited as randomly and fairly as possible. Previous studies have used popular search engines, and the most popular items searched under a relevant keyword (Norris, Boydell, Pinhas, Katzman, 2006). The websites chosen to be included in the data are chosen as randomly and unfairly as possible, by simply taking the first result when a relevant keyword search is used. Additionally, Internet-based research also faces the complication of having their data sources drop out, in a sense. Particularly within eating disorder websites, their sites are commonly shut down, either by the moderator or an outside source; when this occurs within the project, another keyword search is performed, or the researcher moves down the relevant searched results (Dias, 2003). Similar methodology was upheld here, though fortunately at no time during the study did either of the two sites shut down.

For the current project, "eating disorder confessions" was typed into the keyword search for the popular blog site, Tumblr. Tumblr was use because it is a relatively new social media site, and it has been largely unstudied within psychological research, to this researcher's knowledge. Additionally, the wide accessibility of the site allows anyone with Internet access to create a page. Within Tumblr, one can "tag" photos, posts, quotes, or other sources of media in terms of the relevant content they include. With the ability to tag, the "ana", "mia", "thinspo", and NSSI tags became incredible popular and well-used, allowing individuals to look up pages and pages of relevant searches. The staff who monitor Tumblr recognized this potentially dangerous use of their website, and as of February 2013, searching for any of these tags will immediate evoke a "PSA-like message" at the top of the screen:

"Everything Okay?

> If you or someone you know is suffering from an eating disorder, self-harm, or suicidal thoughts, please visit our Counseling and Prevention Resources Page for a list of services that may be able to help." (Retrieved from tumblr.com)

The proactive and health-oriented message of the Tumblr community was another drawing factor for the researcher to conduct data analysis on this specific form of social media websites.

The most popular blogs that appeared in the keyword search were recruited for possible use. Blogs were discounted from the data if they showed any sort of bias for or against eating disorders; if eating disorder confessions were not the primary interest of the site (i.e. the site also posted confessions of individuals suffering from other disorders; while still important, such narratives could confuse the data and were not relevant to the current study aims); and if pictures or other forms of media were included on the site. All of these exclusionary principles are in keeping with current Internet research practices.

For example, when one types "eating disorder confessions" into the Tumblr search engine, the first related link is the blog: http://eatingdisorderconfession.tumblr.com. From this site, narratives were collected as the site administrators post them. The second most related link from the same keyword search on Tumblr was http://your--ed--confessions.tumblr.com/ and from these two sites, the narratives for the study were collected. The two sites combined had a very frequent posting schedule provided by the site monitor, and it was therefore unnecessary to look further at additional sites in order to collect data. Sites were only used in data collection if the researcher has no affiliation or relationship with them.

As is standard practice in reviews of online material, it is important to note its rapidly changing and impermanent nature. The researcher could not guarantee that all sites used during the collection of data would still be working when the project was complete. It is very common

in this area of research for sites to get shut down, especially for their provocative nature (Dias, 2003). Therefore, all blogs used were the most relevant websites when searched for *during* the project; their continued use as a source cannot be guaranteed in the future, nor can their relevance in relation to keyword search be maintained definitely.

To keep the data as fairly recorded as possible, the sites were be monitored for three months. All of the posts that were uploaded between October 1, 2014 and January 1, 2015 were eligible to be entered as data to be coded. The large span of time allows the researcher to gather as much data as possible; posting schedules on individual blogs could not be known to the researcher, and it was hoped that the three months led to sufficient information collection. In this area, the researcher was fortunate in that all sites that were monitored at the beginning of the study maintained their eligibility, and none of the sites whose data were used needed to be dropped from the final data collection. Furthermore, posting schedules were much more frequent and regular than the researcher anticipated, and the number of sites used was reduced from what was originally planned; the researcher used the top two relevant sites from the keyword search: www.your--ed--confessions.tumblr.com and eatingdisorderconfession.tumblr.com (See Appendix D and E).

Data collected from the blogs were in the form of narratives. These narratives are the "confessions" and also fell under certain exclusionary principles. Similar to website choices, these principles are in keeping with the literature. Narratives were excluded if they do not fall between the measures of 25-300 words (Knapton, 2013). Again, such practices were taken from literature. Narratives that were longer than the maximum given are likely to be coded incorrectly, as too much information could cause confusion, confounding, and ultimately a greater chance of discrepancy between raters; such long narratives were also more likely to be off-topic, repetitive,

or too vague. Additionally, narratives that were too short may not be able to portray enough information for the current project, and coding may be too difficult with so few words. Giving this word anchor allowed for more succinct measurements, and a coding process that led to cleaner data.

Each narrative was coded for emotion by the researcher and a volunteer. This project aimed to code the narratives by recording the emotional cues and motives that each narrative projected, with the expectation that narratives may contain more than one emotion. Additionally, emotions were broken down further as to what their emotion is directed towards (for example, fear may be further categorized as fear of gaining weight, fear of being discovered, fear of death, fear of recovery, etc.) This breakdown of subcategories within emotions was reflected in the detailed coding manual. The coding for emotional themes in the narratives was be performed by the researcher and a peer in the psychology department. The peer coder was familiarized with the coding manual through the researcher, undergoing extensive training on practice narratives, as well as receiving a codebook manual, designed by the researcher (see Appendix C). Before coding the final collected narratives, the researcher and the volunteer spent approximately three hours familiarizing themselves with the codebook and coding pilot data to practice the codebook's application. When the codebook was adequately learned, the two coders met to discuss their coding of the final narratives used in this study on a weekly basis. When discrepancies occurred between the coders, the narrative and the concerns with coding were brought to a third coder from a peer group in the psychology department. However, all discrepancies within the current project were able to be reconciled through discussion between the two coders

The same coding process was followed for the NSSI codebook. The same coders were used for both sets of codebooks, the researcher and a volunteer. Approximately one hour of training using the NSSI codebook was given to the researcher and the volunteer, including familiarization with the codebook material through practice coding with pilot data before being given the final narratives. This process, as well as the NSSI coding process as a whole was much shorter than the emotional coding period, as the codebook itself was much shorter and lacked the intense detail that the emotional codebook contained. All of the eating disorder narratives, regardless of the emotional codes they had achieved, where then coded against the motives of NSSI. Again, the coders met to discuss their coding as well as any difficulties they had with the narratives.

## Results

In the present study, 250 narratives were coded for emotionality and motives of self-harm. 229 coded positively for at least one emotion on the codebook, and 192 coded positively for one of the four motives of self-harm. The narratives erred on the shorter side, in terms of word count, of the allowed range of collected data ($m = 46.792$). Interrater reliability was very high within the emotional codebook. Of the 250 narratives, one or more of 63 codes and sub-codes could be applied, creating 15,750 potential coding events. Of these, 300 of the coding responses differed between the researcher and her volunteer. An interrater reliability analysis using the Kappa statistic was performed to determine consistency between the two raters. The interrater reliability for the raters was found to be very high, with Kappa = 0.98.

The following section will examine each of the codes and sub-codes within the emotional codebook. The way in which each item received a positive code will be discussed, in addition to providing examples of the collected narratives when they coded positively for the discussed

code. Additionally, the rationale behind coding the narratives will also be reported. As well as the emotions present on the codebook, the researcher will also discuss the narratives that failed to code, as well as a popular emotion that was not contained in the codebook. Then, the section will examine the NSSI coding process, providing similar examples, rationale, and detailed explanation. Lastly, the section will also contain the significant results obtained from the Pearson's correlation between the major codes and the motives of NSSI codes.

**Fear**

Table 1

*Frequency and Percentages of Fear Code and Sub-code Items*

| Item | Raw Number Reported | Percentage of sample |
|---|---|---|
| Fear | 53 | 21.20% |
| Fear related to the disorder | 26 | 10.40% |
| Fear of gaining weight | 9 | 3.60% |
| Fear of permanent harm | 0 | 0.00% |
| Fear of disorder itself | 15 | 6.00% |
| Fear of dying | 3 | 1.20% |
| Fear related to detection/intervention | 15 | 6.00% |
| Fear of being "found out" | 5 | 2.00% |
| Fear of being told/forced to stop | 1 | 0.40% |
| Fear of having behavior changed | 5 | 2.00% |

Of the sixteen emotional coding scales, fear was one of the most frequently reported emotion, with 53 of the 250 narratives achieving a positive code for fear. Fear was also the largest coding scale, with two subscales and eight potential further coding measures for the two subscales. General narratives of fear did not have a direction as to what the reporting individual was afraid of: they disclosed fear in some sense, but it was unclear as to what they feared. Additionally, a general code of fear could be given if fear was present within the narrative, but it was not specifically related to one of the subcategory coding items.

> "As a long distance runner I LOVE my running group and friends… until we all go out to brunch after our runs on the weekend. Then, I fear them and hate myself. Most of them happen to work in medicine and they always laugh when I order because we just ran but I

> always eat the least (and only my "safe" foods) but I know one day soon they will see the pattern and then I am afraid they'll hate me, judge me or just plain pity me. The last one scares me the most."
>
> "I think my mom has an eating disorder (anorexia) and that I am her biggest trigger … And this scares me so much I just don't know what to do. It also gets me mad."
>
> "I will never be able to go to the doctor for help, because my deepest fear is that they say I don't have an eating disorder and I'm just making it all up."

In the first narrative, the emotion of fear was very evident. However, it was mainly pertaining to the feeling of being judged or rejected by her friends, as well as her friends themselves. Therefore, narratives of this fashion would achieve a code for fear but no subcategories. The other two narratives show fear as well, though again the direction of their anger does not quite fit the coding manual for the present study. In the second narrative, what "it" is that is making the narrative writer mad would require some assumptions on the part of the coder, so it was left as a general code of fear. For the third narrative, like the first, what she was afraid of was not specifically on the codebook, as she indicates her fear is marked by the possibility that she does not really have an eating disorder. This is an interesting reaction, as well as a unique means of being afraid: she is afraid that she has incorrectly identified the cause of her suffering, that the comfort she presumably has from giving a name to her problems will be taken away by a doctor.

**Fear related to the disorder**

Fear was divided into two types: fear relating to the disorder and fear of detection or intervention. Of the former, narratives could be additionally coded for fear of gaining weight, fear of what is happening to their bodies, fear of inflicting permanent harm, fear of the disorder itself, and fear of dying from the disorder. Of the latter subscale, narratives could be coded for the three additional measures of fear of being "found out", fear of being told or forced to stop, and fear of having behavior changed.

Fear of gaining weight was coded positively when the narrative directly mentioned a fear of weight gain; of these, there was not a broad spectrum of interpretation. Fear of gaining weight could be seen in the narrative's fear of their body shape changing, as well as a mention of gaining pounds specifically, of getting fat.

> "I woke up this morning terrified because I had a dream that I went up X sizes. Now I'm terrified that I'm going to relapse because the last thing I want is for 2015 to be as horrible as 2014. To add onto that my depression has been getting bad again and I'm so scared that I'm going to relapse. I know relapse is a part of recovery but I'm afraid I won't have the strength to pull myself back together."

> "I knew this was bad the night I weighed myself and nearly killed myself because I had gained the slightest bit. I threw away the scale that night but now I have a fear of being weighed on top of all the eating issues. One keeps fuelling the other and it's the cycle that never ends."

> "I am starving but the idea of calories scares me, where do they go when I consume them? Realistically becomes energy. In my mind, fat. I'm so tired."

In the first narrative, the fear is directed at the possibility of weight gain, or its hypothetical implications from a dream. She is so terrified of gaining weight that her unconscious mind constructs the fear in the form of nightmares. The second narrative, which is much more negatively charged, shows the extreme distress when faced with the actual experience of gaining weight. Not only has her fear of gaining weight been realized, which is met so negatively that she considers suicide, but she also fears the event happening again, as mentioned in the newly developed fear of being weighed at all. The third narrative shows a more direct fear with how weight is gained. She is scared not only of gaining weight, but of what may – even unrealistically – cause her to gain weight. The third narrative is a very good outline of the intense fear of gaining weight leading to the intense restriction of food intake seen in the diagnostic measures of anorexia.

The fear of their bodies code was dictated for narratives where the individual expressed fear in the physical toll their disorder was having. This could have been a direct cause, such as vomiting blood after a large binge/purge episode, or could have a more indirect cause, such as heart palpitations or damaged immune systems from repeated starvation; the latter type of narrative can be seen in the exemplified narratives below.

> "I've had my ED for X and I have never had any serious side effects. now my period is Y late and I'm freaking out. I don't know what to do."

> "Lately, when I eat, it comes straight out after a short amount of time. I don't use laxatives and I never have. I don't understand why this happens, and I would be lying if I said I wasn't worried."

In the first narrative, the indirect cause of restriction leading to an interruption on her menstrual cycle is the cause of her fear. Infertility is a documented long-term effect of continued starvation, and in the first narrative, the individual is afraid that her eating disorder may have other effects on her body, besides the intended weight loss. Her fear is also heightened by the fact that, as she says, this is the first time she has been made aware of "serious side effects." In the second narrative, the fear from the body is more direct, in that her digestive system has been disrupted by the eating disorder. Though slightly less emotive than the first narrative, she too is also alarmed by the additional, unplanned symptom her body is now exhibiting.

Fear of the disorder itself was coded when individuals volunteered narratives detailing their fear of the disorder. The fear was not directed at some specific part of the disorder, or what they were doing to their bodies, but rather as if the disorder was a foreign entity. In these narratives, the disorder almost became a thing outside of the individual, and participants felt frightened of it. Fear of the disorder itself was an interesting phenomenon, as it captured an aspect of the eating disorder experience where individuals feel as though the disorder is something dissonant with their person. Not only do they dislike the disorder, but they

acknowledge the power the disorder has over them, and this leads to the fear of the disorder itself.

> "I know that ana and mia is not good, healthy, pretty, comfortable or many other adjectives that magazines tires to see you the only one that fits them is sickness, terrifying, creepy, ugly but that's just what I decided, my choice, my life, my body. All I ever wanted was to be SKINNY not fit, do not get confused only you can choose to be here or not but just one last thing I'm gonna sat once you get into this there's no escape."

Among the many emotions this narrative details, the undercurrent of the fear of the disorder - even in one unwilling to give it up, who has accepted it as a lifestyle - is very prevalent. In the narrative above, she specifically refers to the disorder as "terrifying," though perhaps even more frightening is her insistence that is a choice without any hope or chance of recovery.

Fear of dying was coded when individuals indicated the fear that the disorder and the many health complications that accompany anorexia or bulimia would prematurely end their life. In these narratives, individuals feared that the damage they had caused their bodies through their eating disorder would be so severe that they would lose their life. They noted the effect the disorder had had on their overall health and functioning, and directly linked the fact that they might die to the eating disorder.

> "I never realized how much weight I've lost until just now. I'm laying in bed with my robe on, and everytime I sniffle (I've got a cold) the tie that ties around your stomach/rib cage actually is hurting my rib cage because the bones are sticking out so far. This ED will be the death of me."

In the narrative above, not only does the individual believe that her severe weight loss - which she is just recognizing by the prominence of her bones - will be the cause of the end of her life. It is also interesting to note that, while she herself does not make the connection, the

narrative writer also mentions a cold, which could be an implication of an immune system weakened by the disorder, which is common in prolonged cases of eating disorders.

Fear of permanent harm failed to achieve any positive coding for the current study. Reasons as to why none of the narratives coded for this items can be found in the discussion section of the paper.

**Fear of detection or intervention**

Prevalent in many of the narratives was the fear that people in the sufferer's outside life would try and infringe, either noticing the changed behaviors, attempt to fix them, or intervene in some ritual or plan. All three of these potential sources of fear were subcategories under the other fear category, fear related to detection or intervention.

Fear of being "found out" was the fear that other individuals would notice the disorder. Unlike the above two codes, this fear was not directly tied to the fear of being forced to recover or change, but merely the fear that people around them would find out about the disorder. This speaks to the very secretive nature of the disorder, and the extreme need to keep things hidden.

> "One of my biggest fears is someone finding out about my disorder, but at the same time it's something I wish for. I want people to know I'm struggling but at the same time the thought of anyone knowing about my secret makes me sick."

> "My mum phoned me this morning asking me if I throw up after every meal, apparently my dad thinks I am. I'm so scared about them finding out."

In the first narrative, it is interesting to note that while the individual explicitly says she is afraid of someone finding out about her disorder, she says – in the same sentence – the competing desire of wanting someone to find out about the disorder. This seems to speak to a sort of need for validation. Although unwilling to give up the disorder, driving the fear of being found out, she also wants some sort of confirmation of her struggle. In the second narrative, the

writers seems to have the validation the first one desires, yet this validation, this understanding of the eating disorder's presence, makes the individual afraid, as knowing about the disorder leads to her secret being let out.

Within the fear of detection subscale, fear of being forced to stop and fear of having behavior changed could be read similarly, but there was a distinction between the two narratives coded for each subscale. Within the fear of being forced to stop, individuals feared that someone would attempt to force them into recovery. Stopping, in this sense, meant the disorder as a whole; it meant a complete cessation of the eating disorder through some sort of recovery or treatment forced on the individual. Within the fear of having their behavior changed, individuals were fearful of a smaller domain of interruption; this fear was attributed to an event of time when they would be unable to uphold rituals or dieting practices, such as a holiday meal or going to a restaurant. They did not directly fear being forced into recovery and forced to stop their eating disorder, but rather that some small daily responsibility would temporarily stop the needs of their disorder in a way they had no control over.

> "My parents finally accepted that I have bulimia. I really don't know how to feel about it because it means recovery. I am scared of recovery."
>
> "I am literally scared of food. And I don't think anyone I know would understand it. I am terrified when someone asks me to go out for food, wants to cook for me, if someone brings X to class or when I get a lot of X for my birthday. Terrified."
>
> "When I'm at college, I can completely control everything I eat and don't eat, and I've been able to starve myself easily. When I'm home, between seeing friends from home and my parents cooking all the time, I have zero control. I'm absolutely terrified of the month I'm going to spend home for winter break and I can't stop thinking about it."

The first narrative pertains to the specific fear of detection and fear of having the behavior stopped. Very clearly, she states that her parents have found out about her disorder, and this understanding will lead to her being forced into some sort of recovery program. This impending ending of her disorder frightens her. The second and third narratives pertain to fear of

having the behavior changed, where events or times during which the individual's plans regarding the eating disorder may be interrupted by other's plans, or an unplanned event, like going out to dinner. In the second narrative, she lists several life events that might interrupt the disorder, including going out to meals, having a meal cooked for her, and a birthday of a peer. All of these things will temporarily infringe on her ability to maintain the disorder's need for rules and food consumption, and she is scared of this. The third narrative shows the fear of having the behavior stopped when in an environment where others are around: when she is at home. She notes that in this environment she will have her behaviors stopped by those around her, and this infringement terrifies her.

**Disgust**

Table 2

*Frequency and Percentages of Disgust Code and Sub-code Items*

| Item | Raw Number Reported | Percentage of sample |
|---|---|---|
| Disgust | 25 | 10.00% |
| Disgust in the body | 15 | 6.00% |
| Disgust in weight | 13 | 5.20% |
| Motivating disgust | 1 | 0.40% |
| Towards physical symptoms | 3 | 1.20% |
| Towards actions | 3 | 1.20% |
| Towards eating disorder | 2 | 0.80% |

Disgust was coded for feelings of revulsion; they could be general feelings of disgust, or were broke up further into six subcategories. The measure of disgust was a relatively well-reported measure with 25 of the 250 narratives coding positively for disgust.

Disgust could be coded for general feelings of aversion, or in instances when the subject of the disgust was unclear or undefined; this coding practice is similar to the one used to code for general feelings of fear. In the narrative below, both feelings of disgust do not fit within the coding scheme provided in this study. However, as the general disgust was generally directed

towards the self, as in the narratives below, potential future work could be dedicated to looking at self-disgust within eating disorders.

> "I can't stop eating and throwing up and eating more. I feel so disgusting, I hate it. I feel like nothing I do will ever be enough and that I will always be fat."

> "Each week is the same: "I'll do better this time, I'll eat clean and I won't worry about calories or anything else." Then, a binge occurs, on junky and fatty foods. You feel horrible, you can't stand how disgusting you are. "I promise to starve myself tomorrow and for as long as I can, I deserve it for the constant binging." One, maybe X of Y. Then, the cycle begins again. It is never-ending."

In both of these narratives, the individual reveals that she feels a sense of revulsion in herself. She feels "disgusting." This was coded as general feelings of disgust, as attributing the whole emotion to herself implies a deeper set of several emotions and feelings that may be at play, resulting in the individual concluding that she herself is a disgusting individual. In the first narrative, she herself feels disgusting; this self-directed disgust was not an available code within the current codebook, and therefore achieved a code of general disgust. In the second narrative, again the disgust is directed towards the self. It is interesting to note that in both narratives, the feeling of disgust is indicated when the person has finished eating. In the first narrative, the writer mentions a pattern of eating and bingeing, so it is impossible to tell which aspect, or perhaps both combined, of the disorder have caused her feelings of disgust. The second narrative implies a cycle of restriction plans resulting in bingeing, which is a common eating pattern when one has deprived oneself of food (Canetti, Bachar, & Berry, 2001). This failure to continue the "clean" eating plan results in a binge, of which the individual feels guilty, as well as disgusting for the food she has consumed. The disgust, it seems, is not only from the food itself and the calories she may worry about, but an additional emotional disgust of being disgusted in herself for failing to have the willpower to eat healthily.

The coding scale of disgust in body was coded positively when individuals showed a feeling of disgust at the shape of their body. This code was further broken into disgust in weight, as the two were not necessarily synonymous. For example, an individual might report specifically that she was unhappy with her body, but made no mention of her unhappiness in the body being directly linked to her weight, or perceived weight. The two codes were left separate, as it was thought that the disgust at being to thin could possibly be seen in the disorder. In late-stage anorexia, women may have moments of lucidity or clarity, where they are able to truly see their bodies: in a case such as this, disgust in the body would be applicable. This specific experience was not seen in the narratives, though the separated codes of disgust were not always seen together. Although all of the disgust in weight narratives was directed at feeling disgusted in gaining more than they should, the other side of this emotion is one to keep in mind.

> "Sometimes I get so worked up about my body, I punch myself. The voices never ever stop telling me how fat and disgusting I am."
>
> "I'm scared of taking a bath. I feel disgusting, but I can't see myself naked. I haven't looked myself in the mirror in days, I can't handle the fact that I'm a lot fatter."
>
> "The fact that if I ever feel full I feel disgusting and fat and like a failure shows that something's wrong but I can't stop."
>
> "My finger nails, the skin around fingers are ruined … My hair is falling and my teeth are getting bad .. It's all because of purging and I'm still the same disgusting fat failure."

The first of these narratives coded only for disgust in body, as weight was not mentioned. Though she does mention being fat, the link could be more direct. Additionally, the coders were hesitant in coding this specific item as "the voices" was not only an ambiguous term, but potentially indicative of other mental disorders. It was unclear whether she actually heard voices, or if she was referring to the Ana voice that so many experience as the small voice in their ear telling them not to eat when they waver. The other three narratives all show disgust in the body directly related to weight, and the belief that she weighs too much. In the second narrative, she

goes into detail in how she actually avoids looking at her body because she finds it disgusting through the imagery of taking a bath, where her whole body would be exposed to her. In the third narrative, her feeling of fullness is evoked, which may be indicative of an experience of feeling as though she eats too much. Any direct caloric intake could not be noted, but the feeling of overeating and fatness was interestingly placed in this narrative, as she feels both of these things, yet also feels stuck in the disorder. In the fourth narrative, the individual is distraught that she perceives herself as fat, even though she has taken the precautionary measures to remain thin by purging her food. This is an interesting narrative as she also discloses the other – potentially serious – health concerns she has experienced due to her purging; she herself makes the direct link. There is no mistake in that she knows her purging behaviors have ruined her health and aspects of her appearance. Yet the thing that she feels disgusted about, the thing that has made her feel awful is not the fact that her teeth are rotting or her hair is falling out, but that despite all of this, she still sees herself as fat. This narrative very clearly speaks to the measures young women will take, even cognizant of the health risks, to achieve thinness.

Motivating disgust was a challenging measure to code, as it defined a specific emotion that could be quite easy to miss. Motivating disgust was coded as the feeling of disgust that drove individuals to keep starving or binge/purge cycle. Motivating disgust was seen in individuals who felt their body to be disgusting, and used this disgust as a reason to further engage in the disorder. This was a coding measure not often seen within the collected narratives. Below is an example of motivating disgust.

> "Each week is the same: "I'll do better this time, I'll eat clean and I won't worry about calories or anything else." Then, a binge occurs, on junky and fatty foods. You feel horrible, you can't stand how disgusting you are. "I promise to starve myself tomorrow and for as long as I can, I deserve it for the constant binging." One, maybe X of Y. Then, the cycle begins again. It is never-ending."

This narrative achieved a positive code for motivating disgust, as the disgust she felt was directly linked to the way in which she would engage in the eating disorder behavior in the future. The disgust she felt when she binged informed her future behaviors of starving. This is a perfect example of motivating disgust: the disgust she felt in herself, in her body, in her actions was a driving force in how she continued and progressed the eating disordered pattern of behaviors. Interestingly, she used the eating disorder behaviors that made her feel disgust to continue to engage in eating disorder behaviors; she used two different sets of eating disorder behaviors in an attempt to make herself feel better. That is, the disgust she felt from one set of behaviors she thought would be answered by engaging in another set of eating disorder behaviors.

Disgust in physical symptoms was another code that was not seen very often within the narratives. This code detailed the emotion of disgust directed at the physical symptoms of the disorder, both direct or indirect. For example, individuals may report feeling disgusted by the purging aspect of the disorder (direct) or the fact that their hair is falling out from starvation (indirect).

> "This is so gross. I haven't had a bowel movement in X because I have consumed literally nothing. I binged a few days ago and purged most of it but the rest came out today and I feel gross. It hurt so bad and it makes me feel like a failure."

The narrative above is an example of an individual feeling disgusted by an indirect aspect of the disorder: the disorder has indirectly caused the internal functions of her body to change in ways that she is now aware of. Her ability to properly digest food has been interrupted by the disorder, which makes her feel disgusting. This is a good example of an indirect feeling of disgust, as the disgust she feels is not at something the disorder is immediately concerned with,

such as being disgusted with vomit, but with a secondary nature of the disorder; in this case, the damage it has done to her digestive system.

Disgust in actions was the feeling of disgust individuals felt by the actions they took to maintain their disorder. They felt disgusted by themselves engaging in laxative use or extreme fasting, yet the disgust did not lessen their desire for recovery, which is an interesting phenomenon within the eating disorders.

> "I used to love X. My mum made me a whole pan of it for lunch and I couldn't stop eating. I purged afterwards and felt so miserable, with vomit and saliva smeared all over my face. My hands smell and I can still taste the vomit in my tongue."

In the above narrative, the individual feels disgust in her actions after she has purged. She very vividly describes her disgust by the way in which the affects of purging leave visceral reminders on her body: she can smell and taste it. The disgust in her actions at the end of this narrative is very clear: purging through vomiting disgusts her, as she shares explicitly. However, there is also a secondary potential reading of the narrative in that the actions that disgust her are bingeing on the food in the first place. The site's administrator has censored what exactly the food is originally, but the narrative writer connects the food to good memories, to childhood perhaps, as it is her mother who makes it. It could be seen that the actions she feels disgusted in is the act of purging on the food itself. She has good memories of the food, but the disorder has warped her ability to enjoy it like she used to, and she instead binges on it.

Disgust in the disorder itself was very similar to fear of the disorder itself. Different from disgust in general, disgust in the disorder showed a seeming split between the individual and the disorder, with the individual detesting the disorder. This split between the disorder and the individual, and such a negative reaction, is another interesting relationship to consider when

exploring the personal experience of eating disorders; these individuals may feel disgusted by what feels like a foreign part of them, but they also feel tied to it.

> "Of course I hate the sore throats, the shakiness, and the weakness. Of course I hate when I accidentally throw up on my hand and the watery eyes and runny nose. Of course I hate hiding all this, I've even resorted to puking in plastic bags in my room. But for some reason, I think it's better than having anything in my stomach."

The narrative above very clearly displays a disgust of the disorder; in fact, she sites several aspects of the disorder that are extremely unpleasant and things that she dislikes. She cites the medical side effects that the disorder has given her, the ruined health, as well as the actions she has taken in order to maintain her disorder: hiding her purging activities. However, it is interesting to note that at the end of this narrative, all of the hatred she feels for the disorder ultimately fails to compete with what she does not hate about the disorder: the feeling of being empty. She states several unpleasant aspects of the disorder, things that she hates engaging in and experiencing. However, these things together do not lead her to desiring recovery, but rather are pushed aside for what she wants, what she is willing to experience in order to feel as though she has nothing in her stomach.

**Shame**

Table 3

*Frequency and Percentages of Shame Code and Sub-code Items*

| Item | Raw Number Reported | Percentage of sample |
|---|---|---|
| Shame | 30 | 12.00% |
| Shame towards self | 24 | 9.60% |
| Shame towards disorder | 3 | 1.20% |

The feeling of shame was defined as feeling humiliated or distressed by ones actions. As this was a narrative with a considerable number of positive codes, 30 of the 250 narratives detailed shame, this emotion could be expounded further in future studies. General feelings of

shame were coded when the narrative fell outside of the two subcategories of shame: self-shame and shame in the body.

> "I almost started screaming and crying because my mom wouldn't let me go to work unless I ate something, and she watched me to make sure I was actually eating it…. I'm always so embarrassed when someone makes a big deal about it…"

Again, this narrative seemed to touch upon an emotion not specifically outlined in the codebook, which would be shame towards how they are perceived by others, or shame in what others think of them. Her shame, or embarrassment, seemed to apply broadly to any individual who "made a big deal" about her disorder. It is interesting that she passes this feeling off as being unwarranted or exploded as a bigger issue than she believes it to be.

Shame in self was a coding measure where some interpretation was used. Shame in the self was specifically used when the narrative directly mentioned it. Shame could be felt in relation to their actions, or how they believed to fail in comparison to others. Another common source of shame was the self-aware nature in how their disorder warped how they viewed others.

Self-shame was seen in feeling ashamed of how they judged others weight unfairly. Additionally, feeling like a failure was also coded as self-shame, as failure was often reported as a sense of shame in the self for not losing weight, or not being disciplined and following eating disorder rules. As failure was not a feeling included on the codebook the coders agreed that self-shame was an adequate code for detailing failure.

> "The fact that if I ever feel full I feel disgusting and fat and like a failure shows that something's wrong but I can't stop."

> "I don't know what to do. I don't know who to tell. I tried telling my parents about my eating disorder but when they freaked, I lied and said I was fine so they wouldn't be more ashamed than me. I feel like I never will be able to eat normally. Gosh I feel so alone and ashamed. I feel like people watch me when I eat, even when it's healthy."

> "One of my biggest triggers is my morbidly obese sister. Explain to me how I am supposed to get over that, she is my sister. I am a terrible person for even letting that be a trigger but I don't know how it started to be one, or why, and I don't know how to make

> it stop. And I can't possibly tell because then they'd know how awful I am. To my sister: If you ever find out, I am sooo sorry. It has nothing to do with you, I'm the messed up one."

The first narrative details shame coming from feeling like a failure, reporting her feelings of being full as abnormal and indicative of something wrong. She is aware that she should not feel this sense of shame, that her feeling this way is something that she should stop, though she feels too entrenched in the disorder to do so. The second narrative shows shame in the self for how they have affected others. She is reluctant to tell her parents about the disorder because she doesn't want them to "freak." She also mentions feeling watched whenever she eats, which is another possible indicator of being ashamed in the self. She felt embarrassed by eating, and therefore felt that others must be watching her partake in the activity. The third narrative exemplifies shame in warped thinking, and the way in which their disordered thinking colors their views of others. She feels ashamed in herself not for eating or not eating, but rather in how her disorder has affected her thinking and appraisal of others, specifically someone presumably close to her: her sister.

Shame in the disorder was used to show humiliation in the disorder itself. Distinct from shame towards self, the individual did not feel ashamed of her thoughts, feelings, or the way in which she thought she had failed; rather, shame towards the disorder was reported as a sense of humiliation when the disorder became apparent in social settings or in family dynamics. This shame in the disorder also speaks to the nature of secret-keeping within eating disorders, and the interesting dichotomy of being proud of one's separate status and simultaneously finding the disorder - in some way - wrong,

> "Last year, during National Eating Disorder Awareness Week, I tried to help raise awareness and made bracelets. My friend asked why I was so into this. I lied and told her I knew someone with an eating disorder. I wish I could tell my best friend of X that it was me with the eating disorder but I don't want her to look down upon me in pity. I wonder if I will own up to it this year."

> "I saw this girl in my grade in PE class. And i noticed how skinny she got over the past few weeks. I think she looks disgusting and amazing at the same time. I remember when I judged her (in my thoughts) according to the fact that she looked healthy and not sickly. How she's getting way thinner than me. All of her bones stick out and I am really jealous. I feel terrible for her, because of the dirty looks I gave her and I feel terrible for myself, because I trigger other people around me with my ED. Sorry."

The first narrative speaks to the shame that leads to secretiveness within eating disorders; the shame comes from the fear of what disclosing an eating disorder might to do a friendship, and therefore leads to shame of the disorder itself. The second narrative also strongly speaks to shame of the disorder, with the shame of the power of the disorder to affect others being the chief concern within the individual. She is afraid that her own thoughts, fueled by her eating disorder, may have caused the disordered eating of another. She feels ashamed that her disorder may have caused her to potentially harm the health of another.

**Sadness**

Table 4

*Frequency and Percentages of Sadness Code and Sub-code Items*

| Item | Raw Number Reported | Percentage of sample |
|---|---|---|
| Sadness | 20 | 8.00% |
| Sadness towards self | 9 | 3.60% |
| Sadness towards disorder | 7 | 2.80% |

Sadness was coded as any general indication of unhappiness or misery. 20 of the 250 narratives achieved a positive code of sadness. Sadness was one of the more challenging code items, as frequent references within the narratives of crying had to be interpreted by the codes as an indication of sadness, or another emotion. Additionally, sadness was one of the motives that were not often literally reported, such as fear or disgust. Sadness was further broken down into two additional codes of sadness towards self or sadness towards body, depending on what in particular the narrative writer was feeling sad about. Additionally, a code of general sadness could be achieved if the direction was unknown or too vague to definitely code positively for one

of the additional measures. The following is an example of a narrative that achieved a positive code for sadness, but not for any further sadness code.

> "I let myself go for a really long time because of holidays, and I just weighed myself for the first time since before Christmas and now I can't stop crying. here we go again."

As defined above, the mention of crying was decidedly indicative of sadness; although the narrative does mention weight, the sadness was not directly related to the body or the self sufficiently for a further code, and the narrative is therefore an example of coding for general sadness. It is implied, within this narrative, that there was a relationship between weighing herself and crying. Though she did not say explicitly that she was sad about her weight, it was agreed by the coders that crying after such an activity was most likely an indication of sadness.

Coding for sadness towards self was coded when the individual felt sad about her own life, her thoughts, or how the disorder had impacted such things. The sadness was portrayed as an unhappiness towards the individual as a person, or the way in which she felt herself to be changed negatively, namely due to the disorder.

> "Whenever people that care about me ask how I feel, I can only say that I'm okay because I feel like I'm sad and bad way too much that I'm annoying everyone."

> "Everybody thinks I'm better now but I'm dying on the inside. I need help but I can't say it."

The first narrative was coded as sadness towards self because she feels unhappy with herself as a result of the disorder. The sadness, which is explicitly stated, is an emotion resulting in the way in which her disorder has affected her. Additionally, she notes that she feels "bad" too much of the time to disclose these feelings to others. This seems to mirror the theory that individuals with eating disorders will minimize their own struggles or pain in order to benefit those around them (Geller, Cockell, & Goldner, 1999). In this narrative, she is unwilling to disclose her true emotional state because she does not want to annoy people, or to trouble them.

This is an important distinction to recognize, as sadness towards self is not a naturally intuitive emotion, and could be confused for other measures in the present codebook. The second narrative also seems to indicate an unwillingness to disclose how she is truly feeling. Although she does not explicitly state why she feels as though she cannot ask for help, she does very explicitly state the dissonance between how people perceive her and what is going on inside of her mind. She very vividly feels as though "she is dying on the inside," indicating extreme sadness, yet she feels as though she cannot express such distress.

Sadness towards body was unhappiness towards the narrative writer's weight or shape. Again, the code of this was difficult to obtain and had to be given considerable thought, as sadness towards body or shape could be mistaken for disgust in weight or fear of gaining weight. As in sadness towards body, crying was an indicator, as well as an element of depressive and unhappy cues when discussing the body, rather than feelings of repulsion, seen in disgust.

> "I'm often okay with the number. That I wear, on the scale, that I eat. The numbers don't get to me that much. But I'm almost never okay with what I see. I'm never happy with how I look."

> "I can't look through magazines anymore. I see the models in them, and cry. No matter how hard I try…I'll never look like them."

Both narratives indicate a feeling of sadness driven by the way in which they perceive their body or their weight. In the first narrative, this feeling is more explicitly stated, with the writer reporting that she is unhappy with the way she looks. Interestingly, she has no negative relationship to her body in regards to the size she is or the number on the scale, but rather the person she sees. Her sadness in her body is expressly in her reflection, and feeling as though she can never be good enough in terms of her shape. Such feelings can be interpreted identically with the second narrative, with the feelings of unhappiness being catalyzed by looking at pictures of

models. Again, she fails to match to someone or some shape that she could feel good about. The sadness was seen in this narrative in the disclosure of crying while looking at the magazines, indicating extreme distress at the exposure to a body she felt she could not match. She also feels like the bodies she would like to match herself to are ones of which she could never achieve, this sense of absolute failure could also contribute to the sadness she expresses.

**Hate**

Table 5

*Frequency and Percentages of Hate Code and Sub-code Items*

| Item | Raw Number Reported | Percentage of sample |
|---|---|---|
| Hate | 41 | 16.40% |
| Hate towards self | 28 | 11.20% |
| Towards body | 7 | 2.80% |
| Driving/maintaining disorder | 4 | 1.60% |

Hate was a surprisingly frequent code, with 41 of the narratives achieving a positive code for the measure. Hate was coded when the individual felt a very strong abhorrence or detestation towards one of the many directions hate was detailed with. The frequency of the code for hate may say something about the nature of the disorder, particularly the way in which individuals suffering feel a powerful dispassion for their disorder, themselves, or others around them; such strong emotions are important to take into account when considering the individual eating disorder experience. Additionally, the prevalence of hate may additionally add to the questioning of egosyntonic versus egodystonic outlook with an eating disorder, as hate would suggest a profound tension between the individual and her disorder.

Hate was broken into four additional measures, but general hate could also be measured when the hateful emotions were too vague to discern their direction, or when individuals did not feel hatred towards something in particular.

> "I can't stop eating and throwing up and eating more. I feel so disgusting, I hate it. I feel like nothing I do will ever be enough and that I will always be fat."

> "I have relapsed so many times I can't even count them anymore. Eating disorders can be fun if you like passing out, thin hair, extreme exhaustion, hearing your parents cry, and always having everyone treat you differently. I mean if you're into that kind of stuff. But I am not."

The first narrative was coded as general hate, because although she mentioned hating something in particular, the "it" was too vague to interpret correctly, and the narrative was too short to provide any additional clues as to what she it was that she hated. The second narrative was coded as general hate, for although the individual did not specifically say that she hated the disorder, her last few words in the narrative did give weight to a very strong opposition to it, and it was believed that the overall message of the narrative was her hatred towards the disorder and its effects.

Hatred towards self was seen as loathing the self; this was hard to discern between sadness towards self, and anger towards self. However, anger towards self, which will be discussed in the following section, did not portray the intensity that hate did, and sadness towards self was slightly different in the amount of blame individuals placed on themselves. Self-hating narratives were coded when the individual felt a very strong aversion to herself or the way in which her disorder had affected her and those around her. They were directed towards the individual herself, making the code specific and detailing a unique set of experiences. Additionally, hating the self was commonly something that the individual was aware of experiencing, and the emotion was often explicitly stated within the narrative.

> "I just binged and I don't know if I should purge. I just hate myself so much. Why can't I be normal?"

> "I have such a bizarre relationship with food. I love to eat and try new things, but as soon as I put that first bite in my mouth, I start to hate myself. I hate myself, so I eat more. It's a never-ending, vicious cycle."

> "As a long distance runner I LOVE my running group and friends… until we all go out to brunch after our runs on the weekend. Then, I fear them and hate myself. Most of them

> happen to work in medicine and they always laugh when I order because we just ran but I always eat the least (and only my "safe" foods) but I know one day soon they will see the pattern and then I am afraid they'll hate me, judge me or just plain pity me. The last one scares me the most."
>
> "It's been at least X with this disorder, I can't handle it anymore. I've gone through times of losing and gaining, eating nothing to eating everything. I've told friends and they still don't care, even my best friend hasn't said a word since I admitted to it all. I try so hard to reach my goals and it never works, I'm so upset with myself. I hate that I'm never satisfied with myself, it's ruined my life."

The first two narratives indicate that hating the self is tied to eating; the hate is present in the first and second as an impetus to purge, or complete the eating disorder cycle. The hatred begins immediately after they decide to eat, and they hate not only that they have eaten, but that they themselves could not stop from giving in to food. The third narrative shows a more general feeling of self-hate, with the individual hating herself for the way in which her disorder has affected the way she interacts with individuals. The fourth narrative is directed at the self, and not at the feelings surrounding binge episodes, but rather the lingering hate that continues the disorder and delays her satisfaction in herself.

Hate towards the body was seen as loathing the body, particularly one's perceived weight or shape. Again, such an emotion was distinct from sadness towards the body or disgust as the very oppositional nature of the way in which individuals hated their own body. Interestingly, hatred toward the body was almost always coded for hatred toward the self as well, which may have an interesting implication for the way in which individuals with an eating disorder have trouble separating the body from the self, seeing an overweight life as one that makes them "bad." It is possible that hating the body was commonly seen with hating the self, because hating the body was just an extension of the deeper feelings of self-hatred that they experienced. It could be seen that hating the body was the same as hating the self for these individuals, as the two could be seen as one in the same for this population.

> "It's summer and I feel like I'm getting fatter because I'm actually eating breakfast now and I hate it. I feel like my clothes are getting tighter but then I get paranoid that I'm just imagining things. People have stopped commenting on how skinny I am and it's so triggering to think I might have gained weight I don't know what to do."

In the above narrative, the hatred in the body was seen as the narrative writer experienced changes in her body as a result of different eating patterns. She felt that the introduction of eating breakfast was causing her to gain weight, a feeling that she hated. She also felt hatred towards her body because she felt it was having a noticeable reaction in the clothes she wore, though interestingly she was not sure if her judgment in this was accurate. Additionally, she felt as though the reaction she had from others supported her belief that she had gained weight, in that she no longer received comments on her "skinniness." The narrative showed great discomfort, though most of it was concentrated on the hatred she felt for her potentially changing body.

Hate driving/maintaining the disorder was the final code for the larger emotional scale of hate. Originally, the two forms of anger were in separate codes. However, in the final version of the codebook it was decided that the two emotions were so similar, and so hard to discern, that they should be put together as a single coded item. For the current study, it was understood that driving anger was the feelings of anger that encouraged individuals to pursue the eating disorder; the anger was seen as a motivator for engaging in eating disorder behaviors such as purging or fasting. Maintaining anger, in contrast, was seen as a component within the disorder, not driving it. Maintaining anger was seen as a factor that caused the continuation, cyclical nature of the disorder. Although these two types of anger detail different anger sources, it is possible that they inform one another: that driving anger will lead to maintaining anger, or *vice versa*. Because the relationship is so closely related, and so difficult to discern within a single narrative, it was ultimately defined as a single coding item. If, in the future, a more clear and broad distinction can be made between the two items, then they could be coded separately.

> "I thought I was okay for awhile until my really thin friend told me how she looked like a cow and how she needed to lose weight and here I am clearly bigger than her and hating myself for it."
>
> "I've lost X and I crave more. It's like a drug. You get that feeling of pure joy every time the scale the drops. But then you get that feeling of pure failure and hatred every time it stays the same or goes up. It shouldn't be so black and white. It shouldn't matter what the scale says at all…"

The first narrative is an example of hate driving the disorder, as the feelings of hate are what are continuing the disorder, or influencing the onset of eating disorder behaviors. It is the hate - specifically in the body - that is driving the disorder. She hated being bigger than her friend, and even though "she was okay for awhile" the comment and acknowledgement of being larger spurred her eating disorder behaviors. The second narrative is an example of hate maintaining the disorder. Although it is also implied that again there is hate toward the body, the overwhelming emotion here is that it is the hatred that is maintaining the disorder. Its continuance is due to the fact that the individual feels hatred. In the second example, hate maintaining the disorder can be seen as the emotion informing the disorder's sustained nature. It is interesting that she uses the comparison to substance abuse, to the disorder acting like a drug. If taken in this sense, it could be seen that hatred maintains the disorder, because it is part of the web of addictive qualities within the disorder that make her want to continue her behaviors. Experiencing eating disorders as an addiction, as the second narrative clearly does, is another area of research with eating disorder literature, though not focused on in this study.

**Anger**

Table 6

*Frequency and Percentages of Anger Code and Sub-code Items*

| Item | Raw Number Reported | Percentage of sample |
|---|---|---|
| Anger | 14 | 5.60% |
| Anger towards self (perfectionism) | 5 | 2.00% |
| Anger towards others | 0 | 0.00% |
| Anger at not stopping | 2 | 0.80% |

Anger was seen as the strong feeling of displeasure or irritation, directed either generally or towards one of three subcategories. Anger had less of the severe emotional distress that was seen in hate, and it was only coded 14 times within the narratives. Anger achieved a positive code if individuals portrayed a deep irritability; general anger was coded if this feeling was not directly directed at one thing, or if it was too vague to determine what the individual was angry about. Coding for anger was not achieved if there were additional feelings of anger, but they were not directed at anything related to the eating disorder, such as being angry at one's grades.

> "I have an ED. That it get me really mad. I'm sorry but I can't control it, I can't control my mind. I'm the biggest mess."

The above narrative was coded as general anger. It could be read that the individual was angry at the disorder itself, and her anger was directed at the eating disorder. However, this code did not exist in the current manual, and as an additional coding item could help in future work; this will be explored in the discussion further.

Anger could be further coded as anger towards the self. This code was specifically detailed to code narratives for perfection. Narratives that coded for anger towards the self were narratives where individuals were angry with themselves for failing. This failure was defined as an inability to maintain perfectionism. As perfectionism is an aspect of eating disorder that is very prevalent, it was believed that narrowing the scope of anger towards self to mean perfectionism would show a very important aspect of the eating disorder experience. Five of the 14 narratives for anger were coded as anger towards self, which may give weight to the way in which anger is experienced within the eating disorder narrative.

> "Good at school, but not good enough. Talented in some ways, but not talented enough. Skinny, but not skinny enough. Underweight, but not underweight enough. Sick, but not sick enough. When will I ever be enough? When will I be perfect?"

> "I'm constantly in between restricting and binging. At one moment I'm obsessing about every single calorie, and than the next I'm saying screw it and eating so much, and then I'm mad at myself for it later. I'm a living contradiction and its so confusing."

The first narrative is a paramount example for anger towards the self as an idea of failed perfectionism. Although the narrative does not actually contain the word anger, nor does the speaker denote the feeling of anger, the sense of comparing oneself to a standard that is usually unachievable, and then failing is a common occurrence in eating disordered individuals. In the first narrative, this feeling of never being "enough" or "perfect" outlines the feelings of anger at never achieving unattainable perfection. The second narrative is more literal in its anger at the self, clearly stating that "screwing it and eating so much" makes the individual angry. Such anger can be seen as failed perfectionism, as the anger is driven by the individual eating, which is seen as the ultimate failure in an eating disorder when some sort of fasting behaviors are upheld.

Anger at others was seen as the feeling of displeasure towards those trying to intervene with the disorder. Anger towards others was positively coded when the narrative writer expressed being mad at parents, friends, teachers, or doctors that were trying to get them into recovery and away from the disorder. They would find themselves on the offensive of individuals trying to infringe on their behaviors. Interestingly, no narratives achieved a positive code for this measure. Further discussion of its lack of coding can be found in the discussion, but it is possible that anger is not the emotion typically present in individuals who face an intervention, and something closer to fear or sadness would be more commonly seen.

Anger at not being able to stop was coded as the frustration towards the cyclical nature of the disorder. Positive codes for this measure were achieved when the individual wanted to recover or stop their behaviors, but found herself "stuck." Again, this may be seen as another area of anger towards the self. However, the perfectionistic nature was not seen in this code;

rather, the individuals felt angry for not being able to get *healthier*; they were trying to let go of such severe perfectionism that guided the disorder.

> "My brother moved in with me shortly after his Xth birthday. He tried really hard and made me dinner, he even made it vegetarian and everything when he is a big meat eater. I had to eat some because I didn't want to hurt his feelings. I couldn't finish it and ended up throwing it all up. What is wrong with me? Why can't I just keep food down like a normal person?"

The narrative is an example where anger was directed at the self, concerning the inability to give up the eating disorder. The last two questions, "What is wrong with me?" and "Why can't I just keep food down like a normal person?" portray a desire to shed the eating disorder and live a healthier lifestyle. The anger is very clearly directed at the individual, but rather in the individual's failed perfectionism, the anger is felt by the individual's inability to recover. The frustration she clearly feels from purging after the party shows anger at not being able to quit or stop the disorder, despite her best efforts. This measure provides interesting insight into the nature of eating disorders; in that the feelings of the desire to recover may not be indicative of their actions; although the individual wants to recover, the desire is not strong enough to conquer embedded sets of patterns and beliefs. So, even though an individual may attempt recovery and give her very best efforts, she may be unable to recover; a common occurrence in eating disorders. And this pattern can be accompanied by anger, in the feeling of irritation at not successfully recovering or making a step towards recovery.

**Pride**

Table 7

*Frequency and Percentages of Pride Code and Sub-code Items*

| Item | Raw Number Reported | Percentage of sample |
|---|---|---|
| Pride | 7 | 2.80% |
| Pride in "strength" | 2 | 0.80% |
| Pride in thinness/attractiveness | 6 | 2.40% |

Pride was a relatively underreported emotional scale, with only 7 of the 250 narratives achieving a positive code. Pride was the only positively skewed emotion in the codebook; although areas of control and anger could be seen as individuals upholding positive feelings about the disorder due to perfectionism and rigidity, pride was the only clearly positive code in the manual; and it was also the least reported. This says something very interesting about this particular population, namely that they do not view their disorder positively. This may be because these sites are not clearly defined as a pro-ana source, and such individual seeking this philosophy may be wary to stray outside the online borders where their beliefs are shared. However, confession sites are purposefully unbiased, and pro-ana or positive views of eating disorders are not outwardly discouraged. Despite this, such beliefs were very rare in the current set of data.

Additionally, there was a narrative that directly contradicted the pride of having an eating disorder: the pride in recovering. This is an important aspect to mention, as it is often forgotten or ignored in the focus on individuals currently suffering, that there can be pride and happiness in life after recovery, and in achieving recovery itself. The narrative below is an example of pride not in the disorder, but in recovering from it. This constructive form of pride is additionally accompanied by the fact that she is afraid of relapse, but the very real pride in attempting to recover is an important emotion to note, as well as one that should rightfully be felt when recovering from such a destructive and difficult disorder.

> "I started eating again slowly and have started working out to try and get a nicer body instead of starving or binging and purging. I'm so happy and proud of myself, but I'm scared going back to school will trigger me again."

Pride was divided into two categories, the first being pride in the strength of their maintained behaviors. The pride in maintaining behaviors has been commonly reported on the

pro-ana sources as an eating disorder experience. Individuals with an eating disorder, namely anorexia, see their refusal of food to have some moral goodness: the fact that they abstain from the very human need to eat shows their strength and willpower, two incredibly important philosophies. Therefore, they take pride in their ability to maintain willpower by maintaining their strictly regulated behaviors. This may be seen in comparing what they eat - or do not eat - with what other, less strong-willed individuals eat. Pride in strength did not achieve any positive codes. As a known aspect of eating disorders, this was a surprising finding within the data. However, because of the nature of data collection, from a confession site, it is possible that individuals did not want to brag openly about their superior status of being able to forgo food, Again, the lack of positive codes for this measure can be found in further detail within the discussion section.

Pride was also subcategorized into pride in thinness or attractiveness. Presumably, this is a very common theme in the eating disorder experience, and has been reported in the literature. The feeling of superiority experienced by individuals with an eating disorder is partially due to the shape that they achieve from their severe actions. Seen mostly in anorexia, the pride in thinness is tied to the pride of maintaining the behaviors, as the two are very obviously tied; extreme thinness is hard to accomplish without extreme dieting measures. It should be noted that this pride is very culturally tied, and such feelings are not exclusive to eating disorders. Feelings of pride at achieving weight-loss or having the desired slim form is commonly seen in the nonclinical population, as our current society praises those - especially women - who are very thin. Pride in thinness in an eating disorder is taken further; as early compliments at weight loss trigger further need to lose weight. Additionally, a morbid pride in extreme weight loss can be

seen in later stages, with individuals exhibiting pride in their continued ability to eschew food in favor of a skeletal form.

> "I saw my best friend from kindergarten the other day. We used to be the same size, but now she's chubbier and taller. I felt so happy to be petite and little. I shouldn't have been so excited about that. I am disgusting."
>
> "I'm a working college student, a legal adult, and I just reached the weight I was when I was prepubescent and going into middle school. I felt really proud of myself until I wrote that down and realized that it just sounded sick."
>
> "Homecoming was a couple weeks ago and when i went to my cousin's house to take pictures. One of my friend's younger siblings told me I looked like a bag of bones in my dress. It's sad how I took that as a complement [sic]. It's sad how happy that made me."
>
> "X years after being diagnosed with anorexia, Y treatment centres, and Z years of being 'recovered,' and I still compete to see who has the lowest weight. I watch shows with underweight people and say, 'I was worse than that, ha.' I still eat fine and exercise moderately, but Goddamn, that last step is just so damn hard."

The four narratives all detail a pride in one's shape, specifically in their thinness. Interestingly, these feelings of pride also come with the awareness that this pride is unhealthy, that they should not feel positively about how thin they are. In the first narrative, the individual is proud that she is thinner than an old friend, but feels guilty that this difference in weight makes her feel good about herself. In the second narrative, the realization that she is proud of her extreme thinness itself is what causes her to understand how unhealthy the feeling is. And in the third narrative, comments about weight – which are assumingly not compliments – are taken positively, though she realizes that these are not in fact their intended message. The last narrative is different than the other three, as there is no acceptance of the unhealthiness of feeling proud in thinness. Instead, the individual is almost bitter, still using the weight loss as a way to compare herself to others, and to come out on top. Her last statement indicates that this tendency to compare her shape to others in order to achieve some sense of moral better-ness seems to be a lingering behavior despite apparent recovery.

**Envy**

Table 8

*Frequency and Percentages of Envy Code and Sub-code Items*

| Item | Raw Number Reported | Percentage of sample |
|---|---|---|
| Envy | 21 | 8.40% |
| In relation to friends | 10 | 4.00% |
| In relation to siblings | 2 | 0.80% |
| In relation to mother | 0 | 0.00% |
| In relation to media | 3 | 1.20% |

Envy, and the comparison between other eating disordered individuals as well as healthy people surrounding the eating disordered individual, is another strongly reported experience within an eating disorder. Although there are many sources within envy, the direction of it this study was most interested in was of course focused with body and weight; specifically feelings of jealousy towards perceived thinner friends, or their body shape. Within this study, envy was reported relatively frequently, with a total of 21 positive codes. In order to delve deeper to find where the source of this envy was most common, envy was divided into four different objects of envy: friends, siblings, mother, and media. Of these four categories, envy was relatively easy to detect as to where and to whom such emotions were directed. Narratives frequently named their sources of envy specifically. However, many narratives cited classmates, rather than friends as a specific source of envy, and this missing code should be noted as a future research direction, as such narratives were coded as general envy. Additionally, general envy was also seen in narratives, where the object or direction of envy was not given. Although these were less common, the presence of such an emotional state is important in mapping the emotional experience of an eating disorder.

> "I'm always worried other people in my life have an ED when I see them skipping meals, dieting, food-shaming, body-checking or body-shaming, binging & purging…just participating in any of these destructive behaviours. However an ugly side to this ED (mine) is i'm not only worried because I care about them but because I'm worried they're

> going to lose more weight than me. This ED has made me see people as competition, by which to measure (literally) myself against."

The above narrative was coded for general feelings of envy, as the object of envy she was comparing herself to was not exactly clear. She mentioned "other people," and though this may be implied as peers or classmates, the coders were reluctant to categorize these feelings of envy into a direct source. It is interesting that her envy came from the behaviors she saw in others that she perceived to be eating disorder related. She felt envious not in the shape of those who might participate in such activities, but the competition of losing more weight than she. Her envy was not directly related at any one person for any one reason, but for a constructed competition she engaged in with those around her to lose the most weight. This sense of competition and "one-upping" each other within the eating disorder population is very common, and encapsulated in this narrative of general envy.

Giving support to the modern theorists belief that anorexia and bulimia move beyond the cultural vanity and drive for thinness, media was less reported than friends and siblings. Interestingly, the feeling of envy towards mothers was not reported; this finding will be discussed further in the following section of this paper. Envy towards friends was seen when individuals were envious of the bodies or shapes of their friends. In future work, this may be defined to include peers, or separated for a separate group of peer envy.

> "So this cute and sweet guy just asked me out and I said yes for two reasons. 1) Because he is skinnier than me and I plan to use that as inspiration. 2) Because I can use dates with him as deadlines for reaching my goals … What has this disease done to me I don't even know who I am anymore it's completely mutated my brain."

> "I resent my best friend because she'll always be the gorgeous blonde, blue eyed skinny girl that gets hit on. I'll always be her disgusting fat friend that looks like a bloated cow. I just want to be the pretty one for once…."

> "I don't starve myself to be skinny. I just love the control It gives me. I told myself I would stop once my bmi reached X which it has… But last night I found out my friends bmi is Y which makes me feel horrible about even considering myself starving/skinny."

The first narrative showed envy towards the body of a significant other. It is possible that the speaker of this narrative is a male, and he views the body of his same sex to be a smaller version of his own and therefore more desirable. It is also possible that the speaker of this narrative is a female, and would like to achieve the pre-pubescent, boyish figure of the romantic interest. Although there is no way to indicate the truth of this narrative, both pose interesting scenarios to consider within eating disorders: the prevalence of eating disorders in males and its presence in romantic relationships, or the prevalence of the female form being cast aside for the thinner male one. The second narrative shows a direct comparison between two friends, with the speaker believing herself to be the uglier, fatter friend who is therefore ignored by the opposite sex. It is interesting to note that, while weight does play a huge factor in the speaker's envy, she believes it will fix all of the things she is envious of her friend: her coloring, her physical attractiveness, and her popularity in the dating world. Central to some beliefs early on in dieting before the eating disorder's onset, she believes that a change in her weight will also address all of her perceived flaws. The third narrative claims that starvation for her was the key to control, rather than thinness. Although it is undoubtedly true in the mind of the speaker, it is also interesting to note that the individual also feels envious of her friend's lower BMI, indicating thinness.

Envy related to siblings included the narratives where the object of the narrative writer's envy was a sibling, usually a sister. It was believed that in close proximity to family, especially another young woman of similar age, individuals with eating disorders may be more likely to compare themselves - and come up short - to their sisters (Nichter, 2001). Additionally, the added affect of sharing genes might strengthen feelings of envy when one sister was naturally

thinner. It was also possible that both sisters developed an eating disorder, or some sort of unhealthy eating or competition, and such an environment could further breed envy.

> "My sister is such a huge trigger for me, her "diets" consist of eating whatever and exercising sometimes and losing weight so easily and here I am restricing my already healthy diet and over exercising and not losing any weight and what sucks more is we have the same body type so it's like looking at mirror of what I could look like."

> "I developed my ED around the time my twin sister moved in with her boyfriend. Around the same time she was getting healthier from hers. Now that she moved back home I've noticed she lost weight. I got so upset and jealous that she looks smaller than me. I feel like a terrible sister and I don't want us to compete."

In the first narrative, the speaker is envious of her sister, who naturally seems to be able to lose weight easily without engaging in any rigid dietary methods. She feels discouraged that – with the same goal in mind – she works harder than her sister, yet sees less of a result. There is also the additional harm within envy of siblings of sharing genetic traits that make comparing oneself to another easier; that is, when sisters look alike, it is easier to see what one could look like at a different weight than when comparing oneself to peers. In the first narrative, seeing her thinner sister makes the comparison of her own weight even harsher. The second narrative also indicates the envy in relation to a sibling who may share similar physical traits. Again in this narrative, the speaker feels as though her sister is thinner than her and is envious of this fact. Additionally, it is interesting to note that the narrative speaks to the fact that both the writer and her sister have experienced an eating disorder. Possibly because of this shared experience, the writer also feels "terrible" for being envious of her sister, as the competition between two eating disordered individuals is not something she desires.

Envy towards the media was an attempt to capture the role that celebrity culture and influence have on the way in which one views the female body, including her own. In recent years, the media has been called out for photoshopping their actresses or only putting the thinnest

girls in runway shows. Although small steps in the right direction are being taken to becoming informed about this misleading and unhealthy practices, there is still the overwhelming tendency many have, especially young girls, to compare themselves to the women they see on television. And, as these women do not even look like themselves in real life this comparison is not only unfair, but also perpetually disheartening to women. As model Cindy Crawford said of her flawless photographs and magazine covers: "Even I don't wake up looking like Cindy Crawford," noting the intensive work with makeup, lighting, and computer editing that it takes to make a perfect picture. The code of envy towards the media wished to capture the way in which young women relate to the women they see on television, and the way such comparisons shape their views about the female body and what it should look like.

> "Even though I know it's unrealistic, I want to look just like X from Y without the tail. That movie is my biggest trigger and one of the reasons I've stopped eating."

> "I can't look through magazines anymore. I see the models in them, and cry. No matter how hard I try…I'll never look like them."

In the first narrative, there is a direct relationship shown between the media's portrayal of what women ought to look like, and someone's internalization of such messages leading to extreme dieting habits. According to the speaker, exposure to some character – the name of whom was removed for anonymity and triggering purposes by the site's director – directly led to her use of fasting to lose weight. Interestingly, she begins the narrative by acknowledging how unnatural X's body is; though she knows that such a female ideal cannot be achieved, it does not stop her from trying to reach it. And this is an incredibly important message: that even the self-awareness of the futility of reaching media standards will not stop some from trying to come close, at least. The second narrative does not imply that the disorder's onset was a result of media comparison; however, the relationship might have a maintaining factor, as the pictures in magazines she refers to are a reminder of her failed thinness. Although it cannot be said if this

has any direct relationship on her eating disorder, it certainly speaks to the power the media has to make her feel negatively about herself, and create a vulnerability for drastic weight loss methods.

**Guilt**

Table 9

*Frequency and Percentages of Guilt Code and Sub-code Items*

| Item | Raw Number Reported | Percentage of sample |
|---|---|---|
| Guilt | 24 | 9.60% |
| Guilt directed at self | 6 | 2.40% |
| In how they affect others | 10 | 4.00% |

Of the 250 narratives, guilt achieved a positive code in 24 of them, making it a relatively frequently reported measure. Guilt was coded when the narrative indicated some sense of wrongdoing or culpability relating to the eating disorder. Although this was not a specific code, guilt could also be felt for the feelings one had from the eating disorder, namely judging people they loved to be fat. Although guilt had two additional sub-codes, the guilt towards one's thoughts was not one of them, and therefore such instances were coded as general guilt, as well as any codes where feelings of guilt were vague or undirected. Usually, these general codes of guilt were accompanied with the narrative writer confessing to be a "terrible" person.

> "My sister is morbidly obese. Seeing her is a huge trigger for me. I pray that she never finds out and I'm sorry I am such a terrible person. I'm so sorry."

> "With loads of encouragement from my boyfriend I deleted my calorie counting app and promised I'd be honest with him from now on. But I couldn't do it and I redownloaded the app and didn't tell him yet. I'm such a failure and a terrible girlfriend."

In the first narrative, the speaker feels guilty for negatively viewing her overweight sister as a trigger for her. She feels badly for judging her sister on the sole construct of weight, and apologizes for her disordered mind causing her to view her sister in this way. In the second narrative, the speaker feels guilty for the way in which she fails her boyfriend by being unable to

be honest about her eating disorder. She sees downloading a calorie counting app as a way of being dishonest to her significant other, and she feels guilty that she could not maintain healthier habits for someone close to her.

Of the two additional measures within the scale of guilt, one was directed at the self, and one was directed at the external world and those around them. The former was guilt directed at the self, which coded positively when the individual admitted to failure. This specifically meant failure by eating or purging, failure by not reaching a goal weight, as well as seeing a perceived weight to be an indication of failure. Anger towards self was somewhat similar, as both describe a sort of emotion resulting from failure. However, guilt rather than anger had a sense of blame, and most cases were quite explicit in their use of self-condemnation.

> "My family constantly points out my eating. For example they will go "woah slow down you're eating so much and too quickly." when I've barely started my meal… It's the most triggering thing ever and it makes me feel guilty for eating that meal."

> "Binged last night because it was halloween, and I just could not quit eating! I tried purging in my friend's bathroom because I was in pain from how much I ate and I felt so guilty. I feel so horrible"

> "I know I am thin. But whenever I eat, guilt takes over and I feel disgusting. So I starve myself…I'm so disgusted and ashamed of myself"

> "All I see when I look in the mirror is fat. I've gained weight and I'm not further from my goal weight. I've never felt more ashamed in my whole life. I'm such a failure.."

In the first narrative, the guilt directed at the self was heightened by the fact that her family drew attention to it. When it was brought to attention that she was eating, her guilt for eating – for presumably going against some rule within her eating disorder – was felt. In the second narrative, the guilt is explicitly from the binge she had on Halloween; the excess of food made her feel guilty and she therefore tried to rid herself of it. Additionally, it is possible to interpret that further guilt may be felt within the narrative as she fails to fully engage in a purging episode, or if she is unable to purge; however, such information is only a projected response, and

has no direct support in the given narrative. The third narrative is an interesting case, for while the speaker does admit to thinness, this thinness does not stop her from having an unhealthy relationship with food. Again, the very act of eating – not even bingeing is clearly stated – makes her feel guilty, perhaps due to a perceived lack of willpower. So, the narrative writer absolves this guilt by starving, by removing the food that causes her to feel guilt. It is unclear if whether such precautions make her feel additionally guilty, as "I'm so disgusting and ashamed of myself," has no direct object of guilt or direction, but the guilt of the eating disorder itself may be cause of the feeling. In the fourth narrative, the weight gain and furtherance from the goal has made the individual feel guilty. Again, it may be perceived that the guilt is directed not only at the person's weight, but additionally at the measures that allowed the weight gain: failed eating disorder behaviors.

Guilt in how the disorder affect others was coded positively to capture the self-reproach individuals felt when they saw how their eating disorders were affecting others, namely the emotional toll their disorder was having on those who had to stand by and watch it. Interestingly, economic guilt was also highly expressing, with individuals feeling guilty for spending money on food and then purging it, throwing away perfectly good food, or the cost of a treatment program. The relatively high frequency of this additional measure, with 10 of the 24 guilty codes representing the guilt towards others shows a very important and often forgotten aspect of the disorder. That is, these individuals know what they are doing. It is not, as the media and scathing critics may suggest, a vain and self-centered disorder. These narratives in particular detail the anguish these individuals feel by hurting others. Not only is it not their intention to cause harm to those they love, but also they are keenly aware that it is a result of the disorder they cannot give

up. This awareness shows another dichotomy within the eating disorder narrative, where the individual feels guilty about the burden of her supposedly egocentric disorder.

> "I know I have anorexia. I have literally no one except my dad right now and I feel like a burden because of how stressed he already is. He doesn't know anything about what to do to help me recover and I really can't do it alone."
>
> "My grandpa was got diagnosed with cancer over the summer. His health has been going way down since. He hasn't been home since summer. I feel like I need to get better before he passes so he doesn't have to see me like this. But I'm afraid it'll be too soon for me and I just can't recover that fast. I don't even want to recover to begin with."
>
> "My family is struggling for money and yet they always give me money for lunches in college. I'm so undeserving of money or food or kindness so I've been putting all the money back into my mums bag so they can afford to give my brothers and sisters a good Christmas. I don't want them to find out ever and I just wish they'd stop giving the money to me so I'd feel less guilty for not eating."

The first narrative details the guilt in the emotional burden her eating disorder would cause her father, and the emotional toll recovery would be for him. Although she claims him to be her only source of support, she refuses to use him because she feels badly about how her disorder might affect him. One might see this sacrifice of health to be a sort of selflessness, as such guilt would be unlikely to be felt if she needed a doctor to treat the common cold, but feared the reaction her father would have to the visit. Again, this evokes the tendency for anorectic women to push down their own emotional troubles in order to support others. The second narrative shows guilt more towards the body, though the importance of the relationship and the way in which the relationship has been altered because of the eating disorder is very important. In the second narrative, the individual feels guilty that her dying grandfather will last see her as a sickly individual. Although she wants to get better for him, to make him feel better before he passes, she is unable to give up the disorder. The guilt is not only directed at the disorder itself, but also details her guilt that her disorder is visibly affecting others in a way she cannot fix. The last narrative is an example of economic guilt: the individual feels bad that she is wasting her parents' money they give her for food she won't eat. Not only is there guilt in the fact that her

struggling family finds it important enough for her to eat that they make her part of the budget, but she feels as though her disorder somehow makes her unworthy of the kindness. Interestingly, not only is she guilty that she is taking money that she thinks could be used elsewhere, but she also feels guilty for being given money at all, for feeling as though it is necessary for her to eat at all.

**Loneliness**

Table 10

*Frequency and Percentages of Loneliness Code and Sub-code Items*

| Item | Raw Number Reported | Percentage of sample |
|---|---|---|
| Loneliness | 8 | 3.20% |
| Attributed to the disorder | 5 | 2.00% |
| Driving the disorder | 2 | 0.80% |

Loneliness was positively coded when one detailed the absence of friends or companionship. Isolated was another measure on this codebook and the two coders did have some trouble with discernibility, which will be discussed further in the discussion. However, for present purposes, whether it should be its own code or not, loneliness achieved a positive code when individuals commented on their lack of friends or social life, when they felt like an outcast or solitary. Loneliness evoked some desire to go back to the way things were before, some longing for social connectedness again. Possibly because of its uncertain nature, loneliness was a rather underreported emotion, with only 8 of the 250 narratives achieving a positive code.

Loneliness was additionally coded into two measures: attributed to the disorder and driving the disorder. Loneliness attributed to the disorder was coded when individuals felt rejected because of their disorder. They felt as though the disorder put some sort of distance between themselves and their friends, and they therefore were left alone. Such loneliness could be caused because the disorder turned away friends, or because the disorder took up so much of

the individual's time that she neglected her social activities. Social activities as well constituted loneliness, with quitting sports or extracurriculars as a result of the disorder leading to feelings of loneliness.

> "I was certain I had recovered, but in the last few X my eating disorder has gotten way out of control. I can't talk to my best friend about it because I don't want to upset her. I have no one"

> "I don't know what to do. I don't know who to tell. I tried telling my parents about my eating disorder but when they freaked, I lied and said I was fine so they wouldn't be more ashamed than me. I feel like I never will be able to eat normally. Gosh I feel so alone and ashamed. I feel like people watch me when I eat, even when it's healthy."

In the first narrative, the individual felt lonely due to the fact that she could not tell her best friend, her presumed confidant, that her disorder had relapsed. This sense of not being able to tell her friend about her condition made her feel alone, because her friend was not there for her. The same idea is presented in the second narrative, where the individual feels lonely from the secret of the disorder separating her from fully interacting with her family.

Loneliness driving the disorder detailed an emotion that actually predated the onset of the disorder. The positive code for this measure was achieved when the individual thought that their weight or shape was the cause of their loneliness, and that by losing weight they would therefore be under the correct conditions to make friends. This idea ties in with the previously described tie between the body and the self. Individuals felt themselves to be friendless and unworthy as one in the same with being fat; and by fixing one the other would be remedied.

> "I dont just feel fat. I AM fat. My thighs are huge. I have "handlebars" as people say. I have major stomach fat. When I don't eat, I feel so strong and in control. But when I do eat I feel weak and so fat. My mom is a nurse so she makes me eat. When she calls me to dinner it's a dread. I hate myself and where I am. If I was alone no one could notice that I starve myself."

In the above narrative, the individual feels as if she is not desirable and would be more so if she was thinner; she feels lonely in her own body. Interestingly, she additionally wants this

loneliness. She thinks that without the concern of her mothers or anyone else who might make her eat, then she would achieve this thinness better when left to her own devices.

**Comfort, Familiarity, and Routine**

Table 11

*Frequency and Percentages of Comfort/Familiarity/Routine Code*

| Item | Raw Number Reported | Percentage of sample |
|---|---|---|
| Comfort/familiarity/routine | 42 | 16.80% |

Of the sixteen emotional coding scales, comfort was one of the most frequently reported emotions, with 42 of the 250 narratives achieving a positive code for comfort. Although there were no subscales for this emotion, it became a relatively broad category, with several types of narratives falling under the scale of comfort. The name itself: comfort, familiarity, routine does provide that the code itself is searching for more than one emotional cue. For a narrative to achieve a positive code for comfort, the individual had to view the disorder as a form of comfort or routine, giving the coders a sense that the narrative detailed an individual who felt "stuck" in the disorder. They felt as though the disorder provided them some sort of emotional stability that they lacked in the real world. The constant nature of the disorder, as well as the comforting option that it was always a set of behaviors they could return to if they felt themselves being distressed, provided a sense of comfort and ease. The routine of the disorder, the daily thoughts and activities, additionally could provide this mentioned emotional stability. Although the category was relatively broad, this should not diminish anything about its code: the fact that it was seen so frequently speaks to the largely felt nature of the disorder, in that individuals feel it to be a sense of comfort, or a routine they cannot get rid of.

As the category was relatively broad, both positive and negative reactions to this feeling of routine were included in the scale, accounting for a larger number of positive responses. The

individual could feel as though the disorder was some sort of security blanket or safety mechanism, with returning to is certainties a source of comfort for the individual; this would be seen as a positive interpretation of comfort. The more commonly seen was a more negative view on comfort, where they felt the routine of the disorder was something they could not break free of. The felt trapped in the cyclical routine of the disorder, and desired to break free from it. In this sense, the code was not comfort at all.

> "I have such a bizarre relationship with food. I love to eat and try new things, but as soon as I put that first bite in my mouth, I start to hate myself. I hate myself, so I eat more. It's a never-ending, vicious cycle."
>
> "Every time I feel like I've overcomes my disorder, it slowly creeps back into my life worse than before."
>
> "It's been X since I've even though[t] about binging or purging and lately it's all I can think about. In the most twisted and sick way I miss it."
>
> "Each week is the same: "I'll do better this time, I'll eat clean and I won't worry about calories or anything else." Then, a binge occurs, on junky and fatty foods. You feel horrible, you can't stand how disgusting you are. "I promise to starve myself tomorrow and for as long as I can, I deserve it for the constant binging." One, maybe X of Y. Then, the cycle begins again. It is never-ending."

In the first and fourth narrative, the speaker directly mentions the cyclical nature of the disorder that makes one unable to break free of the routine. They feel as though the pattern of eating, hatred, and repentance through fasting or purging is one that they feel stuck in, that they cannot seem to leave. It is familiar to them; it is something they can predict. In the second narrative, the individual has actually attempted recovery, but the routine and familiarity of the disorder make it impossible for her to fully and finally shake. The same experience is similarly shared in the third narrative. Although the individual has seemed to achieve recovery, the patterns and routines of the disorder are not easily forgotten, and she mentions that she's spent time considering going back to them. The last part of her narrative is fascinating, as she allows that "In the most twisted and sick way I miss it". In this, she acknowledges that the life she is

living is healthier than the one she had with an eating disorder; however, she still misses the presumed comfort or additional benefits it gave her. This "missing" may also play a role with her preoccupation of past behaviors, and potentially set back her recovery if she relapses.

**Isolation**

Table 12

*Frequency and Percentages of Isolation Code and Sub-code Items*

| Item | Raw Number Reported | Percentage of sample |
|---|---|---|
| Isolation | 25 | 10.00% |
| Isolation from others | 10 | 4.00% |
| Isolation from family | 4 | 1.60% |
| Isolation from self | 15 | 6.00% |

Isolation was another rather frequently presented emotion within the narratives, with 25 of the 250 emotional codes achieving a positive code. As explained above, the code for loneliness and isolation held some similarities. However, the main difference in differentiating the two was: 1) severity, and 2) the perceived desire for social contact. Narratives that coded for isolation seemed to present slightly more severe cases, where the individual not only felt distanced from social peers, but completely separated from them with no source of connection between the two. This led to the second criteria, which was that in many of the isolation cases, the desired social contact was not present.

Isolation was split into three categories. The first of these was isolation from others. Again, this coding mechanism did not discern between friends and peers, and further projects should do so. Isolation from others was coded positively when the individual felt segregated or detached from their peers.

> "I wonder if my friend's family has noticed that ever since I moved in, they run out of certain foods and toilet paper really quickly."

> "I recently moved to America as a college exchange student. I have nobody to watch what I eat and it's been X and I'm already spiralling out of control. My family are

> suspicious, and I wish somebody had of told me not to go. It worries me how much damage I will do in a year."
>
> "This has ruined my life. I pushed my friends away. I'm pushing my family away. My grades are dropping along with what little self esteem I had. The worst part is I don't even want to get better."

In the first narrative, it is important to point out that while the speaker does entertain the notion that her friend has noticed a difference in their living situation since the speaker moved in, the speaker lacks the desire for her family to know. Her detachment from the connection she has to other people dictates isolation. In the second narrative, although the individual does include the wish that she had been told not to leave home, she also feels isolation from those who she is currently living with. Isolation was also importantly coded when there was a deep misunderstanding between the speaker and those around her. Again, this code could be confused with the misunderstood code, which will be addressed in the misunderstood section below. In the third narrative, the individual admits to isolating herself; again, her lack of desire to get better or reconnect with those she pushed away indicate a sense of isolation,

Isolation from family concerned the same exact emotion seen in isolation from peers, with the only difference being that the reclusiveness was felt in relation to family members.

> "My mom always reminds me that I'm fat, that I eat "too much" but she doesn't see how hurt I'm about that. I see myself as shit and I hate that NOBODY SEEMS TO CARE. Also, I have an eating disorder since last year and NOBODY SEES THAT. I'm so angry and no one is gonna believe me because I'm not skinny. I'm a fat bulimic and I need to confess this."

Although this narrative was very emotionally charged and very angry in nature, there is also an underlying sense of isolation. Her mother not only does not recognize her disorder, but is actively commenting in a way that upsets her daughter's already warped thoughts. Although she does state that no one is going to believe her, there is no yearning for her mother to understand,

for a closeness that would make such support possible. Rather, she is resolutely isolated from her family; not only because of her eating disorder, but of their inability to identify it.

Isolation from self was an interesting concept that the researcher explored within the narratives. Isolation from self detailed the feeling of being outside the self, or of one's actions being in dissonance with whom the narrative writer believed himself or herself to be (i.e., ego-dystonic). This dissonance was caused by the eating disorder, or the actions they took to maintain the disorder. They felt, in some way, that the disorder had changed who they integrally were as humans, that because of the disorder they were at odds with the young women they had been before the onset. This feeling was seen in many different cue words, namely feelings of being shocked or surprised by the way in which they thought or viewed the world, seeing it as a sharp contrast to whom they were before the disorder. Comments such as "I don't know who I am anymore" or "I'm losing who I used to be" were indicative of this.

Another interesting and very relevant point that the code of isolation from self might have is to support the egosyntonic nature of eating disorders, which has previously been challenged in the current paper. At first glance, the isolation from self and the acknowledgement that these women's selves had changed, usually for the worst, seems to contradict the idea that eating disorders are incorporated to the self of the one suffering. However, isolation from the self could be reconciled by this very idea. It is possible that some sort of insight or self-awareness caused isolation from the self, when the individual saw that the disorder have been incorporated into her identity, and remembered who she had been before hand. Individuals felt isolated from who they were because who they had become – while still their identity – was ultimately a foreign and unnatural identity.

> "I've been ill for X so that I've just completely given up. This started so early and I feel like my whole personality has developed around my disorder."

> "I hate myself for saying this but I honestly can't wait for school to start back so I can restrict without my mother knowing.. what have I become?"
>
> "No matter how hard people fight to help me, my eating disorder still overpowers them. It's sad I can't even control my own thoughts."
>
> "I just ate X, I hate myself so much I can't breathe I never eat more than Y at the most. I can't do this any longer I'm losing my mind."

In the above narratives, the isolation from the self is very clearly seen in the nature of their thoughts and beliefs that they call into question. The existential nature of their narratives evokes a sense that these individuals are questioning their identity, when concerning the eating disorder. They feel as who they are is inherently different now, and it can be seen that this difference is not always welcomed or enjoyed. The first narrative explicitly says that her personality has become her eating disorder, that who she is as a person has been warped by the disease. The second narrative challenges her own priorities; her desire to start school in order to maintain secrecy makes her wonder "what have I become?" The third narrative calls into question the nature of her thoughts, which she sees as being warped by the disease; even though she acknowledges the fierce support system that she has, the disorder is still stronger, and she evokes the feeling that she is powerless to it, that it has taken over her. The last narrative shows a resignation at the dissonance she sees in herself and the self that she has become with her eating disorder. The idea of "losing her mind" but that she "can't do this any longer" may describe the fear of losing who she is, but being helpless to the process, and ultimately give in to it.

**Denial**

Table 13

*Frequency and Percentages of Denial Code and Sub-code Items*

| Item | Raw Number Reported | Percentage of sample |
|---|---|---|
| Denial | 9 | 3.60% |
| Driven by other's emotion/belief | 4 | 1.60% |
| Driven by self | 5 | 2.00% |

Denial, though present within the collected narratives, was a relatively difficult emotion to code for, with only 9 of the 250 achieving a positive code, as denial itself suggests that the reporting individual is not aware of the severity of an issue, or the issue itself. Coding for denial therefore required close reading of the narrative, and from such focus narratives detailing denial were evident. Denial-positive narratives indicated a lack of concern – or an outright rejection – of an eating disorder. Often, this denial was fueled by the persistence of not being thin enough to have a disorder or belief that food is not necessary. Although both narratives do not outright state their denial, as such admittance would negate the feeling of denial, the emotion was coded based on the coder's perception of what the narrative writer believed, and whether such beliefs were healthy.

Denial was split into two further subscales: denial driven by other's emotion or belief, and denial driven by the self. Denial driven by others emotion was coded when the narrative indicated some mode of concern toward the narrative speaker, usually vocalized by a parent or clinician. Denial driven by others was coded positively when such concerns were brought to the speaker, but the speaker did not believe they were necessary or that the disorder was severe enough to warrant concern. In the narrative, the narrator expressed how the concern was unfounded, and often cast the concerned individual in a negative and over-reacting light.

> "My mom and therapist want to put me in treatment this winter break but 1) I'm not even skinny enough and 2) I'm so scared about having to explain what's going on with me to friends and family. I feel like they'd judge me."

> "I've been told to gain weight because I'm "underweight" but I'm still fat, they just judge me off scales. They're wrong."

> "My significant other refuses to see that I have a disorder because they think I'm just getting fitter by losing weight. It may only be a slight disorder but their denial is helping fuel my denial."

In the first narrative, the speaker is directly referring to a parent and a clinician as the source of her denial. She denies their belief that she needs help for two outlined reasons, being thin enough and fear of judgment. Interesting, even though she denies being thin enough for treatment, she does imply that there is something wrong that she would like to seek help for. However, on some level the denial is keeping her from heeding the advice of a parent or clinician. In this case, a slightly paternalizing view was taken, assuming that the parent and the clinician were right in bringing up the issue of treatment, and were not simply overreacting or being overly sensitive to the speaker's eating habits. In the second narrative, it is unclear at to who "they" are, though it is certainly some external opinion. In this narrative, the source of denial is more clear-cut, with the individual believing that she is not thin enough for treatment, and denies that her condition is severe enough to medical attention. The third narrative is an interesting case, as it shows denial not driven by other's concern, but by the denial of others. This narrative encapsulates an incredibly unhealthy relationship where the speaker's significant other denies her illness, causing her to downplay it as well. Her denial is driven not due to the concern of others, but rather by the lack of concern. This is a pattern that may also be seen in other cases, despite its solitary appearance within this data set.

Although it is important to note that the denial driven by others reaction is most often motivated by the need to lose more weight in order to be taken seriously, it is important to note that such a belief is not exclusive to those with an eating disorder. In fact, until the *DSM-5*, anorexia's diagnostic criteria included a BMI that needed to be reached in order to achieve a diagnosis. Additionally, hospitals and insurance companies refuse to treat or cover treatment courses respectively if the patient does not have a critical BMI, and will subsequently discharge or stop covering treatment when a "healthy" BMI has been reached, despite whether or not a

healthy mindset has also been achieved. The denial in individuals to consider themselves sick is seen just as prevalently in those institutions that should be assisting these women.

Denial driven by the self provided a denial of the eating disorder, but with the focus on weight or body shape, rather than the concerns of others. The speaker made no note of the concerns of parents, peers, spouses, or clinicians in their refusal to accept the severity of their condition, but seemed to simply deny it outright. It should be noted that it is possible that some sort of concern was made known to these individuals, and the conversation was left out of the narrative.

> The thing is, my body image isn't distorted. I see what is real because I also see it in the shower or just looking down at myself. So when I look in the mirror and see fat, even if I'm just bloated, I am fat.
>
> I didn't think it was a problem, I still don't because I don't hate food, I don't care about it period. The only reason I eat is so I don't faint and can function but I'm still losing and I don't know whats going to happen, how am I going to fix this?
>
> I know I may have an ED, but I feel like I'm just too fat for that. It's so frustrating because I have such caring friends who always ask me what I would like when I go out with them or if I'd like to even go out with them. I always feel so guilty because I always say "no, thanks" because I know there'll be food included and I don't want to eat.

In the first narrative, there is no way of knowing if the speaker is giving a correct assessment of her shape, nor even if she has an eating disorder. However, given the fact that such a confession has been posted on a specifically themed eating disorder confession website, there is a very good likelihood that she has some sort of concerns with eating and weight. In this narrative, she denies what may be perceived comments about her weight, insisting that she can see the truth. This is a very good case of close reading to determine denial, as the denial itself is not present, but it is implied in the way in which the narrative is written and the beliefs of the speaker. In the second narrative, the speaker considers having a "problem" due to her perceived relationship with food; she believes that having an eating disorder entails hating food, whereas

she simply doesn't care about it. The denial in this narrative is seen in the dramatic toll this empathy towards food is causing her body (fainting and barely functioning) that she does not seem to have a problem with. The very fact that she thinks food is necessary only to keep one's heart pumping implies a dangerous denial towards her health and what is considered healthy. In the third narrative, the speaker even entertains the idea of having an eating disorder, and then denies it because of her perceived weight. Her denial also causes her to separate herself from her friends, as her denial of the disorder perpetuates it, and the disorder is causing isolation from friends. In the denial driven by the self narratives, the denial – like in denial driven by other's beliefs – is largely driven by the belief that the speaker weighs too much to qualify as having an eating disorder. This begs the question: at what magic weight does the eating disorder justify itself? This question will be answered in the discussion section of the paper.

**Control**

Table 14

*Frequency and Percentages of Control Code and Sub-code Items*

| Item | Raw Number Reported | Percentage of sample |
|---|---|---|
| Control | 54 | 21.60% |
| Feelings of being in control | 10 | 4.00% |
| Due to success/thinness | 2 | 0.80% |
| Due to actions in disorder | 6 | 2.40% |
| Feelings of being out of control | 44 | 17.6% |
| Due to actions in disorder | 12 | 4.80% |
| Due to failed actions in disorder | 15 | 6.00% |

Of the sixteen emotional coding scales, control was one of the most frequently reported emotions, with 54 of the 250 narratives achieving a positive code for control. As control is such a large part of the eating disorder experience, from both the perspective of the individual with the disorder and the clinicians attempting to treat it, the high reporting frequency for this measure was expected. The large category of control was further divided into feelings of being in control, and feelings of being out of control.

Interestingly, narratives coding for control could also code positively for both feelings of being in control *and* feelings of being out of control. This contradictory set of emotions present within a single narrative may provide insight into the confusing nature of an eating disorder, by feeling both in control by their behaviors, as well as controlled by the disorder itself. This finding might also show the varying experience of the disorder, with feelings of control waxing and waning, based on the environment or the individual's own actions.

> "A friend who also suffers from an ED told me I would lose control. At the time, I'd never felt so in control in my entire life. Everything was great, she was just overly worried. I was just going through a 'phase'. Now, X on, I feel more out of control than ever."

> "I dont just feel fat. I AM fat. My thighs are huge. I have "handlebars" as people say. I have major stomach fat. When I don't eat, I feel so strong and in control. But when I do eat I feel weak and so fat. My mom is a nurse so she makes me eat. When she calls me to dinner it's a dread. I hate myself and where I am. If I was alone no one could notice that I starve myself."

In the first narrative, the change in control from feeling in control to feeling out of control changed as the duration of the disorder changed; she felt in control in the beginning, and then felt her grip of the disorder spiral out of control. Interestingly, in the second narrative, feeling in control and out of control is felt simultaneously, and the feeling is dependent on the particular actions within the disorder. The feeling of being in and out of control, both throughout the disorder's duration and in the same time span is another interesting aspect to examine.

**Feeling in control**

Within the control scale, there were two additional subscales, each with two further measures. The first of these measures was feeling in control. Some narratives were coded just for feelings of being in control, without qualifying for additional emotions for feeling in control.

> "I exercise way more than I should sometimes more than X depending on what I did that day and how much I ate. Sometimes I can't sleep without exercising."

In this narrative, the speaker clearly feels in control; she uses over exercising as a measure of keeping herself in check. Overexercising is her way of controlling her body; she also reports this control is so strong that she cannot go through her other daily needs, such as going to sleep, without exercise. However, the way in which she feels in control does not code against the two additional control measures, so the narrative was simply coded for feeling in control.

Narratives that coded for being in control could also code for additional details that were included narrative. The first of these was if the speaker felt in control due to thinness or attractiveness. Feelings of being thin might make an individual feel in control, as controlled behaviors led to this weight loss. As defined in the pride section of this paper, the success of being thin would conceivably be achieved by weight loss, which dictates extreme measures of control.

> "When people say I've lost weight, I tell them it's because of the stress I'm under at University. I am stressed, but I spend all my time studying so that there's never any time for food or sleep. I just need to be perfect."

This narrative was the only positive code for feelings of control due to success in thinness, and additionally the code was not hard to achieve a positive mark. The speaker uses control – by focusing all of her time on studying rather than eating – to achieve weight loss that is noticeable enough for others to comment on. The speaker, though she hides the cause of her weight loss, does give some impression of feeling in control by closely monitoring her schedule in order to cut out meals and lose weight.

The other additional code encapsulated feeling in control due to actions in the disorder. This might be successfully completing a fast, or purging after every meal. Feeling in control due to actions in the disorder was coded positively when individuals felt like the actions within their disorder made them feel in control. It is perceived that eating disorders are often formed by an

individual's need to gain control of her situation; to reach for one aspect of her life in which she can force a specific outcome. Therefore, it was believed that feelings of being in control, especially due to the actions taken in the disorder, would be a popular code.

> After over X of eating very few calories, I have just started to eat so little that I'm constantly very dizzy. I don't mind the dizziness because it shows that I'm eating little enough to lose more weight.

> I purged today, all I ate was X. I was feeling sick from what I ate, physically and mentally, hence why I purged. I hadn't purged since XX of this year and now I'm doing it again...Worst part? I felt so much better after purging, even if it was a small amount and took X tries. I think, this is going to be a permanent thing. I feel terrible for doing it all again but I can't help it. I even have a calorie counter and whatnot.

In the first narrative, the control is seen in the possibly dangerous restriction of calories that the speaker has limited herself to. However, this limited intake – despite the physical reaction her body has had by becoming faint – has made her feel in control. Such feelings are due to her willpower in sticking with her diet. She feels in control due to the fact that she has not wavered from fasting; in fact, this feeling has encouraged her to continue her behaviors and lose even more weight. The second narrative shows some internal struggle within the writer, as she admits to the episode being the first one in a while. However, she notes that purging – the successful action within a bulimic episode to rid oneself of food – made her feel better. There was an aspect of control she felt when she purged, when her actions made her feel better after the awful feeling of eating. It should be noted that the end of her narrative does include a markedly negative feeling towards relapsing, but the positive effect from maintaining control through her actions does not sway her, and it seems as though she ultimately feels as though she has more control when she completes the actions of the disorder.

Although the code for control was an frequently reported one, the subcategory of feeling in control was considerably less so; there were only ten of the 54 control narratives that

specifically detailed feeling in control. As feeling in control is one of the main explanations of eating disorder etiology, this finding is very interesting. This may have some implications for what the emotion of control really does play within an eating disorder, and what this finding might have in what is understood about the experience. A more complete discussion of this idea can be found in the discussion section of this paper.

**Feeling out of control**

Feeling out of control was the more frequently reported emotion within the measure of control. Narratives could be coded for feeling out of control without positively coding for any of the two additional measures set under feeling out of control. These narratives were coded when the feelings of being out of control were too vague to be given any sort of indication of direction, or if the feeling of being out of control could not be attributed to any of the subcategories.

> "I want to be recovered so bad, but every time I try to take the first step I just end up breaking down. i just want to feel normal."

> "I feel powerless against my ED and I don't know what to do. It's so discouraging but I feel like it's out of my control. How ironic."

> "I used to be extremely skinny back when I had my ED, and don't get me wrong…I'm not overweight now, but I'm a 'healthy weight'. But constant thoughts about how much I'm eating and how much I weigh are literally eating all of my time. I don't know how to get back to how I was before this all started. I don't know if I can."

In the first narrative, the feeling of being out of control is more general. Though she does not specifically state that she feels out of control, the idea is present in her explanation of how she cannot recover. This details the emotion of not having control over the eating disorder itself. This feeling is replicated in the second narrative to a more literal degree. The speaker in fact states that she is "powerless" to her eating disorder and could not recover due to the fact that it has control over her. The last part of the narrative also seems to imply the idea mentioned above concerning the need for control in the disorder's onset; her claim of irony may be driven by the

fact that the disorder controlling her was once meant to be an act of control that she herself had. The second narrative directly relates her lack of control in the disorder to feeling "powerless" a very intense word concerning the control she feel she has over her body. The last narrative is also quite vague in the way the individual feels about being in control. The aspect of being out of control can be seen in the desire to "get back" which is furthered by her belief that such an action may not be possible. Additionally, her desire to be thin might be desire to reclaim some sort of control, which she is currently feeling like she does not have.

When applicable, narratives coded for feeling out of control could be further coded into one or both of two categories. The first of these was feeling out of control due to actions in the disorder. Interestingly, this detailed the exact same set of actions seen in feelings of control due to actions in the disorder, namely bingeing and purging. However, the direction was switched so that this set of narratives depicted individuals who felt like they were out of control due to the actions they were taking in the disorder. Both control codes would define the same set of actions, but the way in which the individual experienced them was wholly different.

> "I'm so scared because I have next to zero gag reflex from purging too much and I can't stop eating."
>
> "It feels like my body is taking revenge on me for putting it through starvation, restriction and purging and it is now making me crave so much food! I can't stop it and I hate it so much!"
>
> "I just can't seem to stop eating unless I throw away the food. I just can't, I feel so numb when I see food, it's like an auto-pilot feeling. One moment I'll be staring at it, then eating everything before I know it. I can't keep doing this."

In the first narrative, the individual seems to explore two areas in which she feels out of control. She feels out of control within her own body, because of her lack of gag reflex, and she cannot control the mechanism needed to purge. This would relate to feeling out of control due to actions in the disorder, as feeling as though she wants to purge cannot be regulated from her. The

additional feeling of being out of control comes from craving food, which can also be seen as related to the actions she takes, if such craving is indicative of a binge episode. It could also be seen as feeling out of control because she cannot stop herself from eating. The fact that she "can't stop eating" shows her lack of control in her ability to curb her behaviors. This idea is seen in the second narrative as well. The second narrative writer explains her frustration in herself for the way she acts around food. She correctly identifies the biological mechanism that makes the body crave food when it has been deprived it. However, she sees this need for food, this craving that she gives into and cannot stop as a feeling of being out of control. She feels out of control for eating, for giving in and bingeing. The third narrative also details a lack of control when around food, but to a slightly more serious degree. She feels out of control when it comes to food, and cannot control her actions when she begins to binge. She also interestingly mentions a feeling of numbness, or "auto-pilot" feeling, when around food, which is an aspect of binge eating within the *DSM-5* diagnostic criteria. She additionally mentions that she can only control food by not having any of it around her, which can be seen as a desperate – and failed – measure to gain control around food.

The second of these additional codes was feelings of being out of control due to failed actions in the disorder. That is, because the failed in some measure or rule constructed within their disorder, this failure led them to feeling as though they had lost control in the general terms of their life. This could be seen when individuals felt like they had lost control by breaking a fast, by eating in the first place, or by not purging. Episodes of bingeing, which were also seen as an action in the disorder could also be seen as a failed action in the disorder, as feeling out of control during a bulimic episode could be felt during a binge period, simply for the fact that the individual does not want to eat prior to the binge.

> "I'm so close to having the body I've worked the past year for. Toned, fit and muscular. I work my ass off at the gym but I've never quite controlled my eating habits. The more I try, the worse I get. Now, having just eaten X, I'm about to make myself sick for the Y. I'm terrified I'm gonna relapse, and just like last time double in size."

> "My new years resolution was to be healthier and more careful, all I have done is binge on very fatty food, eat everything and cry about it for the rest of the day, then tell myself tomorrow I will stop, but it just keeps happening. I am gaining so much."

> "Each week is the same: "I'll do better this time, I'll eat clean and I won't worry about calories or anything else." Then, a binge occurs, on junky and fatty foods. You feel horrible, you can't stand how disgusting you are. "I promise to starve myself tomorrow and for as long as I can, I deserve it for the constant binging." One, maybe X of Y. Then, the cycle begins again. It is never-ending."

In each of these narratives, the writer presumably starts off the day, week, or even year with the firm belief that they will restrict. Their beginning goal is that they will be successful in restricting. And then, in all three cases, they feel as though they have failed themselves; they give in and eat. Their experience is seen as feeling out of control due to failed actions in the disorder because they believe that they failed their restriction goals; by eating any amount of food they have failed to restrict perfectly. Failing with in the disorder – or eating, as it was mostly seen as – led to other severe emotions and internal punishment, with individuals reporting that the feeling of being out of control from failed actions led to terror, feeling disgusting and horrible, and crying.

**Misunderstood**

Table 15

*Frequency and Percentages of Misunderstood Code*

| Item | Raw Number Reported | Percentage of sample |
|---|---|---|
| Misunderstood | 38 | 15.20% |

Of the sixteen emotional coding scales, feeling misunderstood was one of the most frequently reported emotion, with 38 of the 250 narratives achieving a positive code for feeling misunderstood. As this was a one-item coding measure, high numbers of responses could also be due to the fact that the feeling of being "misunderstood" could be applied more broadly. In

general, misunderstood was coded positively when individuals felt as though people around them did not fully understand the disorder, its severity, or its presence in the narrative writer's life. Misunderstood was positively coded also when individuals wrote about parents or peers commenting on, judging, and ridiculing eating disorders in general, with the assumed lack of knowledge that the speaker suffered.

The feeling of being misunderstood by individuals in their everyday live in regard to their eating disorder speaks to the finding that online disorder communities provide a sense of support to individuals who lack such relationships in real life (Boero & Pascoe, 2012). The frequent finding of individuals feeling as though they were misunderstood by those around them (with an emphasis on parents, friends, and family members) gives weight to the theory that these sites provide the community that individuals with an eating disorder cannot find outside of the virtual world.

Feeling misunderstood was differentiated from being isolated from others by the degree to which individuals *wanted* others to understand. Isolation pertained more to the feeling of distance, or not being able to communicate with others because of the presence of the disorder. Misunderstood, while still containing the feeling of distance and lack of communication, spoke of an added desire to have others understand them. Often, coding for misunderstood was seen in narratives that mentioned family or friends, where they felt the disorder was ridiculed, not taken seriously, or ignored by the people around them. The feeling of misunderstood, while an isolating experience, specifically required the individual to feel as if they wanted to be understood, rather than being satisfied by their distance. This coding item was added later to the codebook, in order to help clarify the difference between being isolated and emotionally

separated from others, and feeling as those around the individual simply did not understand what they were going through mentally and physically.

> "It's funny how my parents tell me to eat less X but in reality I've eaten nothing. Do they not pay attention to me anymore? Do they not realize that I don't eat? I just need support through this."
>
> "I suffered with exercise bulimia and my friends and family treated it like nothing. I was consuming as small amounts of food as possible and working out for hours on end until I was in too much pain to keep going. How is that nothing?"
>
> "My dad just shared that his sister was anorexic as a teen and showed that he knew a great deal about the disorder, to the point he would easily be able to identify the patterns with me. Even though I'm not ready for intervention, I felt confused as to why he hadn't until he said that the only cure was for her to "wake up to herself"'. What does he think of me?"
>
> "I know not everyone understands eating disorders. But the way some people tease and joke about them is driving me to a state of anger and loneliness I've never experienced before."

In all four narratives, the speaker is detailing the desire to be understood, yet the people around them are not responding in the way they desire. In the first narrative, the speaker feels ignored by parents and peers respectively, feeling as though their actions should speak loud enough for some form of detection, but have not. In the second narrative, the speaker displays her frustration that those around her were not able to understand or even acknowledge her disorder. She explains the extreme actions she underwent, and describes her disbelief that others could not observe these behaviors as abnormal. Her question "How is that nothing?" indicates her frustration that her disorder was not correctly responded to by those around her, because they did not realize the disorder at all. The third narrative speaks of the lack of detection of the eating disorder from a person close in the speaker's life; she feels misunderstood as while her father can correctly identify an eating disorder in others, her own struggle has seemingly been ignored. The last narrative speaks to more general feelings of being misunderstood, due to more general public opinions and conceptions of eating disorders. She notes how "some people" take eating disorders

lightly, resorting to joking about the serious mental disorder; this use of humor and misunderstanding makes her feel alone and misunderstood. As someone who has undergone the severity of the disorder, she feels alone in that she cannot understand how someone could take the disorder so lightly, without understanding the real problems that accompany it.

**Suicidality**

Table 16

*Frequency and Percentages of Suicidality Code*

| Item | Raw Number Reported | Percentage of sample |
|---|---|---|
| Suicidality | 17 | 6.80% |

Of the 250 narratives, 17 of them coded positively for suicidality. The coding item was added for two reasons by the researcher. First, from the literature review the comorbidity between eating disorders and suicide attempts is troublingly high, and it was theorized that this shared relationship might be additionally seen within the online narratives. Second, the literature also provides the theory that NSSI is a vulnerability factor for suicidality. As this study was concerned with both eating disorders and self-harm, it was theorized that individuals who felt suicidal within their eating disorder might also hold interesting patterns in terms of the paper's second research aim, concerned with NSSI motives.

The sense of "giving up," while potentially a broad criterion for suicidality, was also used as a positive coding, as it indicated an individual's discontinued attempt to continue living. Additionally, feeling numb, or not caring about the possibility of dying was also coded as suicidality, suggesting a very real and concerning lack of desire for the preservation of one's own life. Suicidality was coded for any narrative that indicated the individual wanted to die, or that she wanted the disease to end her life.

> "My heart hurts whenever I'm walking for longer than X. I know one day my heart will stop beating because of that. I know I won't make it much longer. And the worst is, it didn't even made me thin. Please get out. It's not worth it."

> "I never realized how much weight I've lost until just now. I'm laying in bed with my robe on, and everytime I sniffle (I've got a cold) the tie that ties around your stomach/rib cage actually is hurting my rib cage because the bones are sticking out so far. This ED will be the death of me."

> "I only live because I feel like I need to starve myself to death. I have other, better ways to kill myself, but I want it to be painful and slow. I don't even know why i'm writing this, I just needed to tell someone."

In the first narrative, not only does the individual display severe medical complications that have resulted from her eating disorder, but also her apathy has led to a positive code in suicidality. Her medical concerns brought on from the eating disorder are potentially-life threatening. Although the narrative does not contain any specific suicidal plans, she does not seem particularly emotional about the possibility of her life ending. The idea of "giving up" led this narrative to be coded for suicidality. Although she seemingly does not care about her life, this apathy is strictly seen in her own mortality; she urges others not to follow her own path, which furthers the belief that she considered her life to already be over. The second narrative additionally mentions the physical harm that has come from the perpetuation of the disease. It is also possible that by mentioning her cold, she is referencing her weakened immune system, another long-term symptom of eating disorders. Similar to the first narrative, the individual takes a certain apathetic view towards her life, and seems to have come to the conclusion that her eating disorder is going to kill her. The narrative is quite numb, with no real concern or worry about her life. The beginning of the narrative might indicate that this has gotten out of her control, and the only real option she has to end the eating disorder is to die. The third narrative is unique as the individual reveals that she is going to use her eating disorder as a suicide method by starving herself to death. She sees starvation as a – correctly – punishing and painful way to die, and this is her intentional plan. This narrative shows a very real suicidal individual, with a plan and means to carry out her suicide.

**No Code**

Table 17

*Frequency and Percentages of No Code Items*

| Item | Raw Number Reported | Percentage of sample |
|---|---|---|
| No code | 21 | 8.40% |

All of the narratives collected for this study were examined for coding within the manual developed for the current study. Although many of the narratives were able to be coded for at least one of the wide arrange of emotions that were detailed in the codebook, there were some narratives that were not able to achieve a positive code in any of the measures. This was, of course, expected by the researcher to some extent, as it would be impossible for a codebook to encompass every conceivable emotion expressed within an eating disorder experience. Confession sites do not explicitly ask for emotional stories from their members, rather, individuals can share anything they want. Therefore, the researcher came across several narratives that were mere comments with no emotional values tied to them, or emotions that were undefined within the current codebook.

> "I purged for the first time today and I don't really know what to do now. I don't feel better, I feel worse."
>
> "I thought that working out would help the voices stop screaming at me that I'm fat but instead it intensified them…"
>
> "I've been skinny my entire life, and family friends and coworkers always told me this and that I should be a model. I've never wanted to be one but now I've developed an ED and I feel like the pressure from these comments contributed to it."

The first narrative could not be coded partially because the narrative writer herself did not know how she was supposed to feel. If a positive code could be given, the best suggested answer would be "confused" which was not a very common emotion seen, and was additionally not seen in many other narratives. In the second narrative, while the individual is very clearly emotionally charged, there is no measure within the codebook that could adequately capture what exactly this

individual was feeling. A close positive code for this narrative might be "distress" though even with this suggestion, it is hard to tell what exactly this speaker is feeling. The third narrative does include some feeling of pressure, but this emotion was not present within the codebook. Additionally, the vague sense of pressure was not felt within the eating disorder strictly, but rather towards those pressuring her to be thin.

Additionally, not every "confession" had an emotional component. Some narratives were just snapshots of life within the speaker, and had no real emotional component to them; of the majority of the narratives that could not be coded, this was the reason for not achieving a code. Simply put, not every narrative was emotional.

> "I always think to myself that X calories is a "full daily intake" because I always considered that my "limit". I still feel myself hesitate to cross that boundary every time I sit down to eat; counting to see how much I "have left" as if food was just a number."

> "I remember my momma telling me that I had to suck in my stomach when I was in middle school because it would make me more attractive. Well, little does she know what that did to my life."

These narratives were unable to be coded because there was no emotional component to them, they simply share a habit or snapshot of life, they were unable to be coded. The un-emotional narratives, as well as the narratives that did not contain a clear emotion or an emotion that could be found within the codebook nevertheless constitute very valid and important looks into the experience of an eating disorder. The fact that they were not coded for the present study does not make them, in any way, less important than those that were used for the analysis of this project.

**"Feeling fat"**

The researcher purposefully did not include feeling fat as a coding scale for the measure, as "feeling fat" is not technically an emotion, but rather indicative of unnamed distress personified as weight. For this reason, it was important not to perpetuate the belief that fat was a

feeling through adding it to an emotionality codebook. However, its prevalence in the narratives is still one worth mentioning, as its reference is often indicative of a very real experience within the eating disorder community

> "Lately I've fallen back into my old habits. I've lost X lbs since Y. I ate Z a few hours ago and I've felt sick and fat ever since."
>
> "I ate a small X tonight and tomorrow is a big dinner party and I can't get out of it. I feel so fat but I can't throw it up because my parents are next to the bathroom. I tried to recover but every time I do I fail almost right away."
>
> "I have been eating pretty normal for a while. But when I look back I regret it. I've lost control and I just want it back. I just want to be thin. I'm tired of this fat and this feeling of fat."

**Nonsuicidal Self-Injury**

Table 18

*Frequency and Percentages of NSSI codes*

| Item | Raw Number Reported | Percentage of sample |
|---|---|---|
| Automatic negative | 85 | 34.00% |
| Automatic positive | 25 | 10.00% |
| Social negative | 41 | 16.4% |
| Social positive | 41 | 16.4% |

All of the narratives coded for emotionality taken from the eating disorder confession website were additionally coded for self-harm. The way in which this was accomplished was to consider whether the narrative implied or directly stated one of Nock and Prinstein's (2004) four motives of self-harm as an aspect of their eating disorder. If the narrative had some sort of drive that could be identified as automatic positive, automatic negative, social positive, or social negative motives of their eating disorder, then the narrative achieved an additional positive code for self-harm. This is a novel idea, as the motives for self-harm have never been matched against eating disorder experiences.

Many of the eating disorder narratives fell under one of the four self-harm categories. Of the 250 narratives, 192 were coded for NSSI motives, which is an overwhelming majority of the

collected narratives. As so many of the narratives fit the NSSI coding scale, it could be tentatively inferred that such a close match indicates the connection between self-harm and eating disorders.

The majority of these narratives fell under the automatic negative reinforcement code, which details the desire or drive to stop feeling bad, or to rid oneself of negative thoughts or feelings. Eighty-five of the narratives indicated that self-starvation or bingeing and purging were used as a means of reducing negative thoughts and or feelings. Within the population of self-harming individuals, it has been found that automatic negative reinforcement (henceforth referred to as A-) is the most commonly reported motive driving episodes of self-harm. Eating disordered individuals may use their disorder to reduce tension due to the fact that the population is less skilled at self-regulation, leading to a more intense experience of "bad thoughts and feelings" which puts them in a vulnerable position towards using unhealthy methods to reduce stress. Indeed, such a framework has been used to understand why individuals self harm. With both populations experiencing the distress absent from a way to healthily dissuade it, it's possible that self-harming the body through injuries or eating disorder becomes the means to self-regulate. The evidence suggests that for many of the narrative writers, such a pathway has been recognized and repeated.

> "I am so frustrated. I can manage to restrict during most of the day then in the evening I think I could just eat normally and don't mind it. Then after I do it I hate myself and I feel like I can't handle it anymore and actually feel like going crazy!but I don't feel like I deserve to call it an eating disorder cuz I feel like I eat so much… I don't even know if it really is a lot anymore because I don't know how much a normal person eats…"

> "I don't take laxatives to lose weight, I know it doesn't work. I take them because I can't stand having food in my stomach, it makes me feel like a failure."

> "I know when things started, how I lost control and when I got worse. This all started at my birthday. Because one of my friends said "You look like this model! Like the face. And the body too" she was a plus size model. She was beautiful but my friend has

> basically called me fat. I went to the balcony silently and cried for hours. They asked why my eyes were so puffy and red. That night, I purged all the food I ate."
>
> "I'm literally so upset right now. I ate nothing for breakfast and lunch and I just ate X slices of pizza and I found out that there are Y calories in those slices and I just want to purge so badly. But I want to recover… but I feel like I am so fat and I just want to die and see bones at the same time."

All of the narratives presented above achieved an A- code, evidenced by their referral to the eating disorder as a means of reducing tension or to stop negative feelings. All four of the narratives show a feeling of increased tension or negativity before the eating disorder act, either restriction or bingeing. The act of the eating disorder managed to quiet some of these negative feelings, at least temporarily. Some of the A- narratives also detail a sense of growing tension after the tension-reducing act of the eating disorder. This cycle of tension building and reducing is also seen in self-harm through bodily injury. NSSI is only a situational means of reducing tension, and the relief it gives is short-lived. In the first and fourth narratives, the NSSI act itself, eating, also brings a sense of building tension, a feeling commonly shared in individuals who self-harm. In the second narrative, the individual is motivated to engage in the eating disordered behaviors for the purpose of feeling empty. It can be implied that having food in her stomach leads to an uncomfortable mental and physical state, and by purging, she can stop feeling bad. In the third narrative, the eating disorder behaviors are motivated more through the need to emotionally stop feeling bad. After receiving negative comments from peers regarding her body, the writer felt motivated to engage in eating disordered behaviors to stop feeling negatively about herself.

Automatic positive reinforcement (A+) had the lowest number of positive responses, with 25 of the narratives achieving a positive code for A+. This code detailed the use of the eating disorder as a way to interrupt a sense of feeling of numbness. The bodily pain of injury, starvation, bingeing, or purging answered the individuals need to feel something out of the

numbness they had previously experienced. The numbness and lack of affect might is answered by the pain of self-harming, as the physiological experience will temporarily interrupt the feeling of not being able to experience any sort of sensation. Even though the physical pain does not directly answer the emotional numbness, the pain can be processed by the numb brain to create some sort of experience that is resolutely felt. Traditionally, the self-harming seen to answer this numbness was bodily self-harm through cutting or burning; from the responses seen in the narratives, another way to engage in self-harm to create a physiological state as a result of experienced numbness might be through engaging in an eating disorder.

> "It no longer hurts anymore. It's been so long, living this way. I am not sure whether the pain has lessened or if I've just gotten used to the weariness of hunger. It's so familiar now, it almost feels safe."

> "Drugs and starvation have desensitized me. Nothing feels good anymore, food doesn't taste like anything. I always need a constant adrenaline rush, I can't function like a normal fucking person anymore, I've lost sleep, I've lost time. What am I?"

> "I just can't seem to stop eating unless I throw away the food. I just can't, I feel so numb when I see food, it's like an auto-pilot feeling. One moment I'll be staring at it, then eating everything before I know it. I can't keep doing this."

The above narratives achieved a positive code for A+, as they detailed a sense of numbness that they thought the eating disorder could address through the actions that would cause physical pain. In the first narrative, the individual describes her lack of feeling, stating that "It no longer hurts anymore." Her feelings of numbness are additionally related to feelings of hunger, which may indicate that the feeling of pain that the eating disorder originally gave her, either through starvation or bingeing, are no longer present. The second narrative also indicates a sense of numbness, claiming to feel "desensitized" through her starvation. She searches for some feeling through food or substances, yet, she cannot fully get the response she desires. This leads to an extreme emotional state for the writer, who feels isolated from herself and her identity, her numbness new to her. The third narrative indicates a sense of numbness through its mention of

being on "autopilot." The food makes her feel numb, and while she is in contact with food, this numbness leads her to binge eating, which is an additional feeling in which she has no emotional connection or response.

Social negative reinforcement (S-) is the mind frame that performing NSSI behaviors will prevent the individual from engaging in social activities that they would like to avoid. For example, cutting that produces scarring on the arms and legs might lead the individual to avoid situations that might involve wearing or removing clothing that would reveal the affected areas, such as swimming or other outdoor activities. In the eating disorder framework, activities that the individual might want to avoid might include birthday parties, family dinners, and holidays where food plays a substantial role. Or, it could include activities where individuals must don clothes that they feel self-conscious or overweight in, such as a trip to the beach or a formal even where a dress is worn. In this motive to self-harm, the action is used as a tool for escaping the people, responsibilities, activities, and other life events that they do not want to participate in. This method was seen relatively frequently within the eating disorder narratives, with 41 of the narratives achieving a positive code for S-. This might indicate a rather large percentage of the population using the eating disorder, or the behaviors that make-up the disorder as either an excuse or an outlet to separate themselves from the outside world. As isolation was commonly seen as an emotion experienced within the narratives, such escapist motives show a possible connection between what drives an eating disorder, and what results in such a drive.

> "I'm not eating so I'll be thin for the holidays. I thought I was recovered but I realized I wasn't and I don't want to go through this hell again. It was never enough and I guess it never will be."

> "I know I may have an ED, but I feel like I'm just too fat for that. It's so frustrating because I have such caring friends who always ask me what I would like when I go out with them or if I'd like to even go out with them. I always feel so guilty because I always say "no, thanks" because I know there'll be food included and I don't want to eat."

> "Sitting at the table not eating because you're terrified. A coworker asks "why aren't you eating?" Another chimes in, "Duh you're anorexic!" Both laugh and enjoy this obviously hilarious joke. Neither know that's my diagnosis. Or my hell. My embarrassing, dizzy, lightheaded, self hating hell."

> "I'm absolutely terrified of my birthday. I'll be forced to eat tons of unhealthy food, family members will point out my weight loss, I'll feel uncomfortable in my dress and the guilt and regret for eating it all will kill me the night after."

> "I had a huge panic attack when my dad asked me to eat with the family yesterday night. I went crazy and ballistic saying I can't eat late, I have homework and other things. He can't mess with my fast and weight loss progress."

The first narrative implies the connection the narrative writer feels from the holidays and social expectations she will need to uphold, and her regret that she is not thin enough to participate in them. This feeling of wanting to get out of a social situation, of needing the eating disorder in order to be better prepared for the real-world responsibilities and events is an example of social negative motives, in that her eating disorder is a way in which to cope with the responsibilities she cannot escape. The second narrative also shows the way in which the eating disorder is used in response to external forces that are unavoidable, such as the lunch break during work. The narrative writer, in this case, feels as though her inability to participate in "normal" activities, like eating lunch, is something that directly contradicts her eating disorder, and therefore does not participate in it. However, this leads to ridicule and cruel jokes made by her co-workers, who experience her not eating. The third narrative is a good example in a possible future use of social negative motives, in that the individual is fearful of an activity in which her eating disorder behaviors are threatened. She imagines the case where she will have to participate in the event, and additionally predicts the behaviors she will be reduced to engage in, if the event interrupts her eating disorder. The fourth narrative is a clear case of social negative motives, in that the individual avoids eating dinner with her family because of her eating disorder. The eating disorder prevents her from engaging in social responsibilities and

relationships, as she is unwilling to eat. The social situation of a family dinner, where it is presumed that her behaviors would be on display to others, is something she wants to avoid, and she uses her strict disorder-driven rules of eating too late to get out of the responsibility.

Social positive reinforcement (S+) is the motive that seems to ring alarm bells within the self-harming and other clinical populations: it is the "attention seeking" motive. Such motives are traditionally seen as selfish and self-indulgent, with the individual engaging in such behaviors for the simple need to have others notice them. This can be detrimental for the eating disordered population, who are often seen as having a sense of agency within their disorder, where it is thought that they'd get better if they "just ate." Attention-seeking behavior is a risky word, as it seems to confound on the idea that eating disorders are put on by the individual in order to evoke responses from others purely for her own benefit. However, this is a misunderstood experience within those populations who may engage in behaviors for the main reason to gain the attention of others. Such behaviors are not meant to cause waves simply for the joy of the individual to watch others squirm, but because they desperately need and want help, and have no other way of communicating this desire with others. The individuals who self-harm in areas that can be commonly seen through clothes, such as the wrists, are largely not doing so for the vain need to have others worry, but rather because they need help, and are too scared to openly ask. Such an experience is also seen in eating disorders, with individuals desiring to become thin to the point of emaciation not for the comments they receive, but because such detriment to the body is they only cry for help that they know how to give. It is very important, in understanding this population that the motive of "getting attention" is not perceived as a self-indulgent means of becoming the center of everyone's concern, but rather a last-resort sense of helplessness, the voiceless asking for help.

S+ was a relatively commonly seen motive within the eating disorders narrative, with 41 of the 250 narratives achieving a positive code. This is an interesting finding, as S+ motives are the least commonly seen motive within the traditional definition of NSSI. It might be that the two populations have some sort of fundamental difference, or possibly that getting attention for losing weight is a more socially acceptable in our current culture as a means for attention than burning oneself or cutting.

> "Homecoming was a couple weeks ago and when i went to my cousin's house to take pictures. One of my friend's younger siblings told me I looked like a bag of bones in my dress. It's sad how I took that as a complement. It's sad how happy that made me."

> "I know my friends have noticed that I never eat and they can see all the weight I've lost and they haven't said anything and I can't help but think they just don't care."

> "I loved my ex so much but he always compared me to his skinny ex girlfriend, so I need to be skinnier and perfect, because I loved him just so much."

> "It's summer and I feel like I'm getting fatter because I'm actually eating breakfast now and I hate it. I feel like my clothes are getting tighter but then I get paranoid that I'm just imagining things. People have stopped commenting on how skinny I am and it's so triggering to think I might have gained weight I don't know what to do."

> "My dad called me a disgrace to the family for beginning to gain weight so I started starving now I either purge or skip meals, whichever fits my day best."

In the first narrative, the speaker is happy that a friend has commented on her extreme weight loss, as this is an attention she has been given as a result of the eating disorder. It is interesting to note that, while she enjoyed the attention, she also recognizes that the attention she was given was not actually positive; that the mention of being so thin should not make her feel happy. In the second narrative, the individual is motivated to engage in her eating disorder through an internal competition with an ex-girlfriend of her boyfriend. She wants her boyfriend to pay attention to her disorder, to comment on her thinness, rather than focus on the weight of another. Therefore, her motivation is clear in that it is driven to be thin enough to get her significant other's attention. In the third narrative, the writer notes that she is no longer receiving

affirmation of her thinness, and believes that her new dietary measures have caused her to gain weight, leading to a shape that does not evoke comments from those around her. She is seemingly motivated to get back to a condition in which individuals will once again comment on her thinness. She is aware that the way in which others have given her attention regarding her eating disorder have changed, and she is triggered into the motivation of resuming an eating disorder in order to once again receive the comments and validation. In the fourth narrative, the individual seems to engage on an eating disorder fueled by revenge. After harmful comments made by her father, she retaliates by starving herself. It is implied that such behaviors will lead to a bodily state in which her father's words will be rescinded. It is also possible that after such damaging words, the writer wants the attention from her father in a way that is not negative (implying weight gain) and through her eating disordered behavior, she will receive the attention she desires.

**Correlations between emotional codes and NSSI motive codes**

A correlational analysis was run between all of the main emotional codes and the four motive codes of NSSI. It was originally planned that sub-codes would also be run, but lack of responses within a given sub-code made the likelihood of achieving significance a narrow possibility. The cost of learning more about each emotion in depth was in sacrificing a more broad interpretation of emotions that could be coded against NSSI narratives. However, within the 16 main codes, ten emotions reached a significant relationship with one of the NSSI codes. For a complete overview correlational analyses run, see Appendix G.

A Pearson's correlation was run to determine the relationship of feelings of disgust to each of the four motives of self-harm. There was a positive correlation between disgust and automatic negative motives, which was statistically significant, ($r = .111$, $n = 250$, $p < .05$). This

finding suggests the relationship between individuals who feel disgusted either in their body, in the disorder, or in their actions may engage in their eating disorder in order to reduce negative feelings. This relationship is feasible: it could be seen that a manifestation of an eating disorder is a young woman attacking the body in which she feels disgusted with, and such an attack will lead to lessening the feelings of disgust.

A Pearson's correlation was run to determine the relationship between feelings of shame and each of the four motives of self-harm. There was a negative correlation between shame and automatic positive motives, which was statistically significant, ($r = -.120$, $n = 250$, $p < .05$). This finding suggests that when one feels shame in herself or her body, she is unlikely to engage in the eating disorder with the motive of reducing feelings of numbness. This relationship can be understood in that individuals who feel shame within the disorder are not concurrently experiencing numbness, and therefore do not use the disorder to experience a physiological state or emotion.

A Pearson's correlation was run to determine the relationship between feelings of hated and each of the four motives of self-harm. There was a negative correlation between hate and automatic positive motives, which was statistically significant, ($r = -1.08$, $n = 250$, $p < .05$). This relationship is similar to that found with shame, in that individuals who feel hatred towards themselves of their bodies are not likely to engage in the disorder in order to stop feeling numb, or to produce some emotional experience.

A Pearson's correlation was run to determine the relationship between pride and each of the four motives of self-harm. There was a positive correlation between pride and social positive motives, which was statistically significant, ($r = .153$, $n = 250$, $p < .01$). This relationship indicates that individuals who feel pride in their disorder may also use the disorder to gain a

sense of attention or to be noticed. It would imply that individuals proud of their behavior or their weight want a similar sense of recognition and appraisal from those around them.

A Pearson's correlation was run to determine the relationship between envy and each of the four motives of self-harm. There was a positive relationship between pride and social positive motives, which was statistically significant, ($r = 3.16$, $n = 250$, $p < .01$). This relationship supports a preliminary theory that individuals envious of those around them, who are either thinner, or also engaging in an eating disorder, may engage in their own in order to garner attention and recognition. It would imply that envy and social positive motives are linked in that individuals who compare themselves to others will engage in eating disordered behaviors to have those they compare themselves to to recognize the disorder as well. Additionally, there was a negative relationship between envy and automatic negative reinforcement, which was statistically significant, ($r = -.117$, $n = 250$, $p < .05$). This finding supports the additional correlation within envy and motives, in that it suggests that individuals who feel envious of others do not engage in their eating disordered behaviors in order to stop feeling numb. The externalized feeling of envy does not translate to the internalized feeling of numbness.

A Pearson's correlation was run to determine the relationship between guilt and each of the four motives of self-harm. There was a positive relationship between guilt and social positive motives, which was statistically significant, ($r = .119$, $n = 250$, $p < .05$). This is an interesting finding; in that it seems to imply that individuals who feel guilty, either due to the disorder or due to how their disorder affects others seems to additionally feel motivated to engage in the disorder in order to gain attention or acknowledgement.

A Pearson's correlation was run to determine the relationship between comfort and routine and each of the four motives of self-harm. There was a negative relationship between

comfort and social positive motives, which was statistically significant ($r = -.140$, $n = 250$, $p < .05$). This supports the relationship that individuals who feel like the eating disorder gives them a sense of comfort or routine do not engage in the behaviors for the motive of getting attention or recognition; the disorder seems to have more personal functions for the individual. Additionally, there was a positive relationship found between control and automatic positive, which was statistically significant ($r = .144$, $n = 250$, $p < .05$). This suggests a relationship between feeling in and or out of control, as well as being motivated to engage in eating disordered behaviors for the purposes of creating some physically painful state.

A Pearson's correlation was run to determine the relationship between isolation and the four motives of self-harm. There was a positive relationship between isolation and automatic positive motives, which was statistically significant, ($r = .163$, $n = 250$, $p < .01$). This gives weight to the relationship of individuals who feel isolated and alone in their disorder, additionally feel as though by engaging in the behaviors, they will stop a feeling of numbness.

A Pearson's correlation was run to determine the relationship between control and the four motives of self-harm. There was a negative relationship between control and social positive motives, which was statistically significant, ($r = -.143$, $n = 250$, $p < .01$). This supports the relationship that individuals who feel either out of control, or in control within the context of their eating disorder are not motivated by the ability of their actions to draw attention or notice. Similar to the findings within the comfort code, the reasons for engaging in the eating disorder are for more personal functions. The second significant finding when examining the relationship between control and NSSI motives supports this theory. There was a positive relationship between control and automatic negative motives, which was statistically significant, ($r = .156$, $n = 250$, $p < .01$). This supports the relationship that engaging in an eating disorder may give the

individual a sense of control in the beginning of the disorder's onset, yet the individual soon begins to feel as though the disorder takes over her life. The motive of engaging in the disorder to stop negative feelings addresses both of the directions of control: feeling in control may stop bad feelings, and feeling out of control may be the response to trying to stop bad feelings through engaging in eating disorder behaviors.

Lastly, a Pearson's correlation was conducted to determine the relationship between suicidality and the four motives of self-harm. There was a positive relationship between suicidality and automatic positive motives, which was statistically significant, ($r = .236$, $n = 250$, $p < .01$). This relationship supports the theory that individuals who are suicidal within their eating disorder experience may use the eating disorder behaviors as a way to end a sense of numbness.

## Discussion

The following section will address the way in which one may interpret the data that has been recorded in the above results section of this project. The current study involved three processes: coding for emotions within eating disorder narratives, coding for motives of NSSI within the same eating disorder narratives, and running analyses on the correlational relationships between coded emotions and coded motives within narratives. The implication from these processes, and the support they may provide in conceptualizing eating disorders as a potential disorder of self-harm, are discussed here. The other concerns addressed in this section include what has been absent or missing from this study for a variety of reasons, why such findings were missing, and what work could be done in the future to answer the many questions that have been formed from the question this study attempted to answer.

### The Eating Disorder Narrative

First I will speak to the information one may glean from the nature of the narratives collected, and the positive coding they achieved. I will first state that it would be impossible to interweave 250 of these stories – of these small windows of time afforded from the few words given – into one comprehensive and overarching eating disorder narrative. To do so would be to neglect the importance of individual storytelling, the unique experience that comes from any mental illness, and such a task would ultimately do a disservice to the field of understanding psychopathology. Instead, I speak to the richness – and the incredible differences – one can see from snapshots of experiences shared on a corner of the Internet. If there is anything that can be taken away from this project, I urge it to be the fact that Someone With an Eating Disorder cannot be stereotyped, pinned down into a few key phrases or experiences.

That being said, it is important to identify the patterns that were seen in this data, and what can be taken from such findings. This work will be purely hypothetical, as no clear claims can be made, and all that can really be taken away from the analysis is what *could* be. The top five most reported emotions were, respectively: control, fear, comfort/routine, hate, and misunderstood. From the frequency of these findings, a tentative outline of the eating disorder experience might be drawn. Though again, the researcher presses that such a conclusion is not meant to be a blanket statement encompassing every individual with an eating disorder.

From these findings, the eating disorder experience, in terms of what the individual is feeling, can be shaped as thus. She – for demographically those most affected by eating disorders are young women – is a fearful individual. The fear may be driven by her seeming inability to control herself with regard to her eating behaviors. Though it is thought that eating disorders give a struggling individual a sense of control – this belief was mirrored when individuals spoke of their control at the beginning of their disorder – it seems as though when the disorder progresses,

for a majority of young women they feel as though they cannot control their actions. This lack of control may lead to fear, as well as hatred. The hatred is potentially not only towards the disorder, but also overwhelmingly towards themselves and their bodies. This hatred may be what caused the disorder's onset, as an emotion that made the individual predisposed and vulnerable to controlling her diet. The hatred may also be strengthened by the disorder, solidifying the emotion and strengthening it, so that it drives her to continue to lose weight. This potential cycle, of hatred leading to controlling food intake leading to hatred of the body and self, although an uncomfortable experience, is one that also brings comfort. It is often believed that this population find themselves in tumultuous environments of which they have very little control or ability to exert their will. The pattern of the eating disorder, though feared and hated, is a pattern nonetheless, and this sense of consistency may bring a feeling of comfort and routine. However, such consistency is not always viewed positively: it is often the case that although these individuals experience the eating disorder's routine, it also makes them feel as though they are stuck and hopelessly caught up in it, with no hope for recovery before getting sucked back into its strength. And, lastly, the routine cycle of hatred, control, and the feelings of fear lead to another emotion: feeling misunderstood. Though eating disorders are often discussed in forums ranging from health classes to movies, the disorder still leads to a sense of being separate from others. The presence of the disorder creates a barrier between the individual and those closest to her, such as family or friends. She may discover that, though well intentioned, the sympathy of others cannot provide the comfort she needs in dealing with her disorder. She may discover negative perceptions others hold towards eating disorder, while simultaneously failing to realize that she herself has an eating disorder. She may discover that she feels separated from those without an eating disorder, because they will never understand what she deals with on a daily

basis. It is this feeling of being misunderstood, of having no support network in the real world, that may drive so many individuals with an eating disorder to seek a like-minded set of individuals online. It may be this experience that led to the narratives discussed in this current study. From these most common emotional findings, this hypothetical scenario of the eating disorder experience can be drawn, an experience highlighted by control, fear, comfort, hate, and feeling misunderstood.

From the data, there were also findings that were not highly reported, and these should also be incorporated into the eating disorder narrative. The results of this study indicated that pride, loneliness, and denial were the three emotions that were experienced the least. From these findings, the eating disorder experience, in terms of what the individual did *not* feel, can be shaped as thus. While living with her eating disorder, she was less likely to see it as a part of her of which to be proud. Even weight loss, especially relative to others, brought little pride, as such a realization also led to shame for comparing oneself to another solely on the basis of weight. Additionally, she was less likely to feel lonely. It is possible that she did not feel lonely because she was too encompassed by the needs of the disorder, and simply had no room to feel lonely. It is also possible that such loneliness was abated by online communities. In terms of research constraints, it is also likely that loneliness was simply too hard to detect in the narratives. From the stories, it was also found that the individual was unlikely to express feelings of denial. Again, this may be due to the fact that it was hard to detect, or not an emotion one often felt like reporting, or could even acknowledge clearly enough to report. However, it is also possible that individuals with an eating disorder do not often feel the sense of denial.

Finally, it is important to incorporate those emotions that fell in the middle of the spectrum, the emotions that were experienced to some extent, though not overwhelmingly. As

the aim of this study was to define – in some broad and hypothetical way – an eating disorder experience from a collection of experiences, it is important to look at those emotions that fewer individuals reported. Of these, individuals reported, respectively: shame, disgust, isolation, guilt, envy, sadness, suicidality, and anger. Of these findings, an interesting overall narrative can be drawn. From these reported emotions, one sees a girl who is at odds with her disorder largely due to her interaction with the outside world. Shame, though often felt towards the self as a sense of embarrassment or failure, suggests that such negative feelings are expressed when in relation to something or someone else. Unlike fear, shame's direction necessitates a sense of otherness: in order to feel like a failure, one needs some measure in which to fail on. The experience of shame seems to show an experience where the individual is – on some level – aware of her environment, and fails to achieve some sort of passable acceptance within this place. She also felt a sense of disgust, both towards herself as well as towards the eating disorder. This seems to mirror the pattern seen in the reported feeling of hatred. She may feel disgusted in her body, and such a feeling of sickness for her shape may lead her to pursue unhealthy eating habits that eventually emerge as an eating disorder. And then, the feeling of disgust is shifted to these behaviors: the ones in order to lessen her feelings of disgust in herself. She may feel disgusted by physically what she is doing: by the act of purging or the way in which her body reacts to severe starvation. However, like hate, the pattern of disgust in the body and the actions towards quieting this bodily disgust are seen in a cycle. She was also relatively likely to experience some sort of envy. With the media sending so many signals of what the female body should look like, the eating disorder does not exist in a vacuum. She may look at several sources as a way in which to measure her own body. Comparing one's weight and shape in relation to others may be a way to gauge success; however, the feeling of envy indicated that individuals often failed when they

measured themselves to others. The other women with whom they were likely to compare themselves are most likely to be women with whom they can easily relate to, such as peers, sisters, and young models or actresses in magazines or television. The comparison to their mothers was not seen. Additionally, she may feel isolated. This sense of isolation might be fed by the feelings that she is not like those around her. What she once had in common with her friends or family seems very far away, when the eating disorder is on the forefront of her mind. It is possible that this also informed the feeling of being isolated from oneself, in that such a feeling of being removed, of being wholly taken over by the eating disorder left her with the unsettling reaction that she was not who she had been before, giving weight to the possibility that she did not feel like herself within the eating disorder, but somehow changed. She may also feel a sense of guilt, once again by her ability to remain connected to those around her. Rather than selfishly do anything to achieve her weight goals, she may feel guilty for wasting food, for the emotional distress she is causing others when they see her sitting at the table without touching anything on her plate. This mindfulness may suggests that such individuals do understand how their behavior affects others, and such a feeling creates distress and guilt in the way their disorder has secondarily affected those they love. She may also experience sadness, either towards her body or herself. From the former, it is possible that such sadness, like hate and disgust, are what has led her to her current behaviors. In the sadness towards the self, it is possible that she feels sad not only from her eating disorder, but from the very often comorbid emotional disorders experienced, most importantly depression (Polivy & Herman, 2002). This sadness, and the other negative emotions may build up until there is the very dire emotion of wanting to die. She may feel suicidal because of the way in which the eating disorder has so thoroughly controlled her life – has so negatively controlled her emotions – that she no longer wants to continue living. Or, she

cannot envision a life that does not contain her eating disorder, and she would rather die than commit to this future. This emotional connection between suicidality and eating disorders, while important in the narrative of the disorder, will be discussed further in the following section. Lastly, the individual may lash out and feel angry. There may be a sense of frustration in herself, a sense of anger at feeling what has been previously outlined: of being stuck in the disorder without any control, of the damage caused to interpersonal relationships for the sole goal of being thin. She may feel angry with herself, for not being able to achieve recovery with all of these emotional odds stacked against her, she may feel angry at the disorder itself for changing her.

From these emotions, from piecing them together in the patterns found in the collected data, one may begin to construct an eating disorder narrative. Such a project is important in recognizing the very important role narratives play, especially within psychopathology. From identifying these emotions and weaving them into a narrative one may tell about a young woman's experience with an eating disorder, the focus shifts to the young woman, to her experience. She is not a set of symptoms or a number on a scale, but a very real set of emotions and distresses. And this – the researcher believes – is a key aim in understanding the disorder: through the individual's understanding.

There is one final aspect of the eating disorder narrative that – while not an included measure of emotion in the current study – is still one crucial to discuss when outlining the eating disorder narrative. As the result section mentioned, the idea of "feeling fat" was one that while purposely avoided in a measure of emotion, is still critical to the eating disorder experience. In this section, the idea of feeling fat will be furthered with the inclusion of another observation within the narratives, and how such a finding is relevant to the study's aims. That is, the feeling

that one could not fully identify with having an eating disorder until she reached some personal, mystical number on the scale. This leads to an unanswerable philosophical question: at what magic weight does the eating disorder justify itself? From the tone of the narratives collected, it could be argued that such a number does not exist. Within such a competitive population, there will never be a weight at which a girl will find herself the thinnest, and therefore worthy of the title of having an eating disorder. Of course, such an experience is not universal: there were many narratives in which the diagnosis was fully understood and cognizant within the individual. However, for many of the girls, despite reporting severe restrictions, health problems, and substantial weight loss, they believed themselves to be outside of the definition of an eating disorder. This brings up another interesting question, in that the aim of this study was to, in some way, create an eating disorder experience from the many collected narratives. However, even when they coded for emotions and did exhibit eating disorder symptoms, many of the young women believed themselves to be too fat to have an eating disorder, despite their actual weight. Therefore, the idea of having to reach some weight in order to qualify for an eating disorder – a ridiculous concept in that it will never conceivably achieved – is an important additional finding in the study, and one to seriously consider when looking at eating disorder narratives.

**Eating Disorders and Self-Harm**

Perhaps the most important – and newly introduced – aspect of this study was the proposed method of looking at eating disorder experiences through the motive of self-harm. That is, whether or not reasons for self-harming mapped onto an eating disorder narrative. Had this aim been achieved, then the potential for the two separate psychopathologies to be linked even closer together would be offered some support. As the results outlined, the researcher believes

that this aim has been satisfied. Therefore, the close association between eating disorder and self-harm are discussed here, as well as the potential therapeutic benefits such a finding would have.

It is important to note that the researcher is not putting forth a theory where the nature of food and eating within eating disorders should be ignored entirely in favor of viewing the entire body of behaviors as one of harm. Rather, the use of food and eating within an eating disorder should be *expanded* to include the possibility that an additional use of food is its ability to cause physical harm to the body. Certainly, the growing prevalence of eating disorders can be somewhat attributed to the thin-obsessed culture we are entrenched in. Though eating disorders have been prevalent throughout history, modern Western culture seems to be a breeding ground for body dissatisfaction (Brumberg, 1989). Therefore, it is still extremely important to consider the role of food and food restriction within the cultural context. The researcher does not deny that eating disorders, to some degree, are a response to the demands of society, and restricting food will lead to the desirable effect of losing weight. However, it is argued here that a shift should be made in seeing eating disorders as an illness primarily concerned with thinness. By integrating the theory that the physical harm of eating disorder behaviors may have some additional function for the individual, the starving or purging as a means for thinness does not necessarily need to be sacrificed. Rather, the novel approach can be added to traditional theorie and models of eating disorders, merely broadening and clarifying the overall understanding of eating disorders. By accepting the self-harm hypothesis, one does not have to reject the importance of thinness eating disorders uphold, and the researcher thinks it would in fact be detrimental to do so. The theory presented here is that the close relationship between eating disorders and NSSI evolves from the similar complex pathways they attempt to answer. That is, by restricting food, or eating until your stomach can rupture, one is deliberately causing the body

harm. And though this harm might be for the future benefit of losing weight, it could also be argued that the harm itself, in that moment, provides a benefit for the individual. That the harm caused by eating disorders, the physical pain of the activities, give those engaging in them some sort of comfort or sense or emotional regulation.

The current literature does give immense support to the close relationship between eating disorders and self-harm. Studies solidifying the comorbidity of the two behaviors are well documented. Even in non-clinical samples, the comorbidity of self-harm and eating disorders has been well established, though onset of the behaviors in such a sample is harder to obtain (Wright, Bewick, Barkham, House, & Hill, 2009). Even though the comorbidity has been established, research has shown the mere knowledge of this pattern has been inadequately applied. Although a number of eating disordered individuals additionally report engaging in self-harm, there are currently no assessments or measurements that can simultaneously diagnose the two disorders within the same set of testing (Paul, Schroeter, Dahme, & Nutzinger, 2002). This is troubling, as a notable percentage of individuals with an eating disorder will also report, at some time during their treatment, the additional existence of their self-harming behaviors. However, this is usually discovered after the initial eating disorder intake, during therapy sessions, rather than during the initial diagnostic period concerning the eating disorder (Sansone & Sandone, 2002).

Furthermore, though the comorbidity of eating disorders and self-harm has been established, it is often the case that eating disorders are treated as one diagnosis, whereas diagnostically, there are three. And these three disorders present different predictive values as well as severity measures for likelihood to engage in NSSI. Furthermore, the eating disorder may even have a further predictive value for more serious behaviors, such as suicidal ideation. In an outpatient study, it was found that in both the anorectic and bulimic samples, over half of the

young women reported NSSI or suicidal ideation. When looking at the populations separately, the bulimic sample reported both suicidal ideation and NSSI at higher levels. A predictive factor of suicidal ideation in bulimic individuals was whether or not she had also been diagnosed with depression. General psychopathological symptoms, or "psychological distress," were additionally found to be a strong predictor of NSSI, only. As the researchers concluded, this finding supported the need for a more intensive evaluation of general psychopathological symptoms in eating disordered individuals, particularly in bulimic individuals. Such a measure could potentially decrease even further harm to the self, such as suicide attempts or severe ideation (Ruuska, Kaltiala-Heino, Rantanen, & Koivisto, 2005). This, as well as routine suicide ideation assessment, is an important research endeavor, as solitary and repeated suicide attempts are common among patients with eating disorders, and risk of death within an inpatient population is 12.8%, with 45% of those deaths being from suicide (Suokas, Suvisaari, Grainger, Raevuori, Gissler, & Haukka, 2014).

Additionally, work on the mechanisms that may cause a variety of self-destructive and dangerous behaviors have been conducted, of which eating disorders and NSSI have both, as distinct disorders, been included. Negative urgency, a personality trait characterized by the tendency to act "rashly" in response to negative emotions was found to be the only impulsivity-related trait that provided a common risk factor for another of dangerous behaviors, including self-harm and "eating problems" (Dir, Karyadi, & Cyders, 2013).

In a closer look at overarching mechanisms that cause both self-harm and eating disorders, it was found that both are seen as "dissociated compensatory attempts to serve self-regulatory functions" (Farber, 2007). That is, both are ways in which individuals unhealthily learn to calm themselves. In this study, rather than the Nockian approach to self-harm, the

researcher believed the principle cause of self-harm stemmed from childhood, when young children attach themselves to a parent or other figure who inflicts harm. Such early relationships forge brain pathways, importantly providing the foundational concept in the child of harm from a traditionally positive source, which later informs him or her to use harm in order to sooth the self. In the same "traumatic attachment" case, an individual could later develop an eating disorder, rather than engage in NSSI. Through the process of psychotherapy, the individual learns healthier attachment, and from this new pathway, the desire to heal oneself is thus cured.

In addition to shared mechanisms, it has also been proposed that shared life events, rather than a shared diagnosis is what connects eating disorders – specifically bulimia – to self-harm. Namely the shared life event of physical or sexual abuse. Abuse is a known risk factor in the development of bulimia as well as self-harm. It is therefore possible that individuals with bulimia are more likely to engage in NSSI not because of their bulimia, but because of the past abuse. That is, the comorbidity may not be due to the shared diagnosis of bulimia, but rather due to the past history of the individual, and how such histories have made her vulnerable to certain psychopathologies (Dohm, Stiegel-Moore, Wilfley, Pike, Hook, & Fairburn, 2002). In this study, it was found that individuals diagnosed with bulimia or binge eating disorder did not differentiate on their tendency to self-harm or abuse substances. However, the rate of both NSSI and substance abuse was higher among women – with BN or BED – who had experienced physical or sexual abuse. In a web-based study that looked exclusively at individuals who had a history of childhood sexual abuse, it was found that these individuals reported higher on the measures of: body dissatisfaction, eating disorders, suicide ideation, physical abuse, physical neglect, emotional abuse, and emotional neglect. Such findings lend support to the theory that sexual abuse can have many long-term psychological effects on an individual, including their mental

health status later in life, especially in relation to self-harming behaviors (Murray, MacDonald, & Fox, 2008). It is therefore possible, as the above study suggested, that early life events have a greater weight in the later multiple psychopathologies – such as NSSI and an eating disorder – that develop, rather than the belief that self-harm develops out of an eating disorder.

Another common mechanism in which to view the existence of both an eating disorder and engaging in self-harm is through the scope of personality. It is possible that certain personality traits found in eating disordered individuals make the possibility of also engaging in self-harm more likely; that is, there might be a unique personality trait of someone who engages in an eating disorder *and* NSSI. Superficial self-harm, that is, self-harm that is not engaged in during a major psychotic episode and does not include the removal of limbs or serious damage to organs, can be divided into two types of harm: compulsive, including skin picking and hair pulling; and impulsive, including skin cutting or burning. The distinction between compulsive and impulsive NSSI may be driven by the difference of compulsive or impulsive personality traits (Davis & Karvinen, 2002). Individuals with bulimia are more likely to exhibit impulsivity, as it is thought that the temptation to binge, and the ability to resist such urges are a large differentiating factor between anorexia and bulimia (Polivy & Herman, 2002). When looking specifically at self-harm, individuals with anorexia are more likely to engage in the impulsive form of self-harm. In this study, it was found that on the scale of intent to self-harm, anorectic and bulimic individuals did not report differently. Within the measure of obsessive-compulsive symptoms and addictive personality characteristics, individuals in both eating disorder groups scored higher on the two measures when they additionally reported intent to self-harm. The researchers concluded that this study on impulsivity and compulsivity therefore represent unique

dimensions, of which one or both could be present in an individual; and, higher rates in either dimension are seen in eating disordered individuals who intend to engage in NSSI.

However, despite this heavy body of research, it has yet to be suggested seriously in the literature that eating disorders and NSSI are not similar behaviors, or two psychopathologies that co-exist, but rather two sides of the same coin. That is, they are not two disorders, but two symptoms of a larger, unfounded disorder. The current study attempted to pave the way for such a philosophy though the application of the NSSI codebook to the eating disorder narratives. It was believed that, if enough responses were garnered, then the finding that what drove self-harm also seemed to drive eating disorders could provide weight to the theory. The closest the theory comes to fully linking eating disorders and self-harm is through the scope of self-regulatory functions. This idea seems to drawn on the two disorders from a larger problem: the ability to self-regulate with healthy emotional techniques. Individuals who engage in eating disorders are more likely to have negative affect and trouble – sometimes stemming from childhood – with self-regulation (Polivy & Herman, 2002). This finding is similarly reported in populations that engage in self-harm (Klonsky, Oltmanns, & Turkheimer, 2003). It is therefore possible that the two disorders are merely a manifestation of the deeper issue of self-regulation.

The researcher now proposes a shift in the way in which eating disorders are conceptualized both medically and within the larger scope of the general public. As eating disorders are generally believed to be – as the name and behaviors imply – a disorder largely concerned with food and eating, it is now theorized that such a focus should be shifted somewhat. The researcher does not deny that, of course, food plays a large role in the eating disorder's formation. However, it is believed, through the current study's findings, that such a focus is limiting and unhelpful both to the patient and the clinician. Although food is important

to the individual with an eating disorder, the role of this food – it is argued – is what is of the utmost importance. That is, the use of food is the real issue behind the disorder, rather than the fact that the young woman refuses to eat, or rids herself of food. That is, food is really used to harm the self.

When conceptualized in this manner, the eating disorder does not become an issue of withholding food or purging it, but *why* such behaviors are being done. In other words, food should be looked at not as a behavior, but what purpose that behavior serves. Traditionally, the belief is that the purpose of the behavior is to lose weight by controlling the intake of the individual. The researcher argues here that in many cases, the purpose of the behavior is not only to lose weight, but more importantly to harm the self. This is the principal theoretical proposal that the current study attempts to address. Rather than starve or purge to lose weight, the individual may engage in such behaviors to harm herself. And such harm is done for the exact same reason that an individual might use a razor against her skin. The act of an eating disorder or self-harm can both be seen as ways to harm the body, to produce a physical pain – such as mouth and stomach bleeding or intense hunger pains – in order to quiet some emotional qualm. As the study showed, the motives of self-harm, of causing the body deliberate self-inflicted harm without intent to die, can be seen in the narratives of eating disorders. In both cases, the individual knowingly acts on her body in a way that will cause physical pain – through burning flesh or vomiting. And this physical pain is in response to some internal mechanism: to relieve pain, to respond to numbness, to escape responsibility, or to gain attention from others. Both eating disorders and self-harm are a way in which an individual can cause a detriment to her physical form, and such pain answers a deeper issue, an intense emotional need.

Additionally, it was found that individuals engaged in their eating disorder through reporting all of the four NSSI motives. This strengthens the relationship between the two psychopathologies, as there is not just one area of self-harm drives that are linked to eating disorders, but potentially all four of particular theorized models. Individuals with eating disorders engaged in their behaviors for similar reasons as those who engage with NSSI across the entire spectrum of possible motives: the engaged in the eating disorder for the behaviors to reduce a sense of stress or negative feelings; to produce a physiological state that would answer their sense of numbness; to avoid social situations and responsibilities, where their activities would not be compatible with normal social scripts, or where they would be required to wear clothing they felt uncomfortable in; and to gain a sense of attention or acknowledgement from those around them.

Of course, not all eating disorders are forms of self-harm; there are cases where an eating disorder is chiefly concerned with weight, where the individual is suffering from a diet that has gone badly wrong. However, from the data collected for this study, for potentially the majority of eating disordered sufferers, this is not the case. Rather, their eating disorder has emerged as a way to harm themselves as a maladaptive response to internal stressors. And such a theory has a very real application for the way in which eating disorders are treated. Currently, eating disorder treatment has one of the lowest success rates of all psychological conditions, with very few women achieving full recovery, or even partial recovery (Polivy & Hermnan, 2002). In the treatments available, a good deal of the work addresses the food behaviors the individual has engaged in, teaching her how to achieve a balanced diet and reduce the urge to purge or restrict. The treatment spends a good amount of time talking about the food behaviors, how one thinks about food, and how one perceives her weight. This pattern does have an exception of

interpersonal therapy for eating disorders, which does not address the eating aspect of the disorder at all at all. This structure of most therapy courses very naturally follows the current belief that eating disorders are chiefly a concern about food. However, if one follows the newly proposed philosophy that eating disorders are not a disorder of food and eating, but rather a disorder of harming the self, then the therapeutic focus would shift in the treatment plan. In similar fashion to interpersonal therapy, the focus of the treatment would be not on the dietary concerns of the individual, but rather on why the individual felt the need to harm herself, and what such harming behaviors accomplished. Through understanding why the individual harmed herself, and what functions the eating disorder achieved, then the maladaptive behaviors would be addressed through the work on harm, rather than on nutritional training.

The novel treatment approach proposed, through looking at eating disorders as acts of self-harm, rather than acts to lose weight, is of course not a universal treatment approach, and like any therapy, will be unlikely to work for an entire population. However, if such a focus on harm and self-harm address the deeper issue that might underlie the eating disorder for a subset of the population, then such approaches and theoretical work should be carried out.

**The Link Between ED Emotional Patterns and NSSI Motives**

The third aim of this study was to examine the relationship between certain patterns of emotions and NSSI motives. This aim was addressed through the correlational analyses that were conducted and reported in the Results section of the paper. Though correlation is a very hesitant analytic measure, in that there is no definite direction or causation that can be drawn, the very nature of the relationship lends additional support to the finding that eating disorder narratives largely code positive for motives of NSSI, and that such similarities may be indicative of the two sharing symptomatic qualities of a larger disorder.

The relationships found between ten of the sixteen major emotional codes and at least one of the self-harm motives lends support to the fact that certain emotional experiences within an eating disorder co-exist with specific motives within self-harm. The fact that such a relationship can be derived indicates that, potentially, there are certain emotional experiences of eating disorders that map onto certain self-harm motives. For example, the current research supports the theory that an individual experiencing envy within the disorder may also experience the drive to continue the disorder in order to gain attention or acknowledgement. An individual who feels proud of her disorder may similarly be motivated by the potential attention she may gain. In contrast, an individual who feels as though the disorder gives her a sense of comfort or routine is likely to not want such behaviors to attract attention, and is therefore not motivated to continue them in order to have others notice her. Rather, the feeling of numbness she experiences may motivate her, and the pain she experiences through the actions of the disorder address this lack of emotion. An individual who feels isolated within her disorder may be motivated to continue the actions in order to answer a sense of numbness; this numbness may be caused by the disorder itself, in the cyclical fashion that was seen in the emotional landscape the narratives portrayed. An individual who feels a sense of disgust within her eating disorder experience is most likely driven to engage in the behavior to reduce negative feelings. She may be motivated to engage in the eating disorder in order to answer her feelings of disgust towards herself or her body; through attacking her body with which she is disgusted. Individuals who feel ashamed of their disorder are less likely to be driven by the fact that their behaviors will terminate feelings of numbness. Rather, as they feel ashamed, they are likely not looking for a feeling that can be derived through the physical deprivation of an eating disorder. The shame they feel in their disorder, or in how the disorder affects other does not drive, or is not driven by, corresponding feelings of numbness.

Individuals who feel a sense of hate, either for their body or for themselves, are also less likely to engage in an eating disorder in order for the action to bring them a sense of pain or sensation to answer numbness. Similar to the finding in shame, both emotions are less likely to make the individual feel numb, and therefore, this is not a factor driving the behavior for the needs that they seek. Individuals who feel guilty in their disorder, either due to the disorder itself or how it affects others, interestingly show that they may also be driven by the potential for attention they may be given through their eating disorder actions. This finding is curious, in that guilt presumably means that one is receiving attention she does not want, making her feel burdensome. It is possible that individuals could potentially experience both the emotion or the motive at the same time: perhaps they feel guilty for how their disorder is affecting those they love, though at the same time want their loved ones to see the affect the disorder is having on the sufferer herself. This torn sense of wanting to recover, and yet wishing to continue unnoticed was seen within the emotional narratives. Future work into the relationship between this emotion and its motive should be examined further. Within control, the dual relationship between feeling either in or out of control was seen to accompany the motive of stopping negative feelings. Both directions of control may be answered through this relationship. It is possible that individuals who feel out of control are motivated to engage in eating disorder behaviors for the hope that such behaviors will make them feel better. It is additionally possible that individuals who feel in control of their disorder may feel as though participating in eating disorder behaviors may make the bad feelings of the eating disorder itself go away, in the cyclical nature that has been shown throughout the paper. Control also held a negative relationship with social positive motives, in that individuals both in and out of control did not seem to engage in their eating disorder for the purpose of attention. Lastly, it was found that individuals who felt suicidal held a positive

relationship with the automatic positive NSSI code, supporting the theory that they engaged in their eating disordered behaviors to stop feelings of numbness.

Like the conjectures regarding the eating disorder narrative and the conceptualization of eating disorders as a form of self-harm, these offered theories are preliminary at best. They do not provide any definite answers to the way in which certain eating disorder experiences may be motivated by certain ways to harm the body. But the very fact, supported by this data, which shows that such a finding can be met, is potentially novel research. For the current study, emotional codes were collected not only to garner a broad eating disorder narrative, but also to determine if some of these narratives, when broken down into their separate emotional components, provided additional relationships when analyzed alongside the separate NSSI motive components that they were coded for.

The use of correlation in this study allows the researcher to paint a more sophisticated picture of the proposed relationship between self-harm and eating disorders. By coding for NSSI motives within the eating disorder narratives, it could be supported that within the data, many of the eating disorder sufferers seemed motivated to behave in four areas that are additionally seen to motivate self-harm behavior. The addition of these correlative studies provides additional backing to this theory. Additionally, it may be proposed that such ties run even deeper, in that specific emotional experiences within an eating disorder lend to specific motives. The relationship between self-harm and NSSI can be furthered through these relationships by the support that certain emotions coded with certain NSSI themes. This may further the transdiagnostic study of eating disorder and self-harm, in that individual eating disorder experiences might be better examined, on a more individual level, when their motives are taken into account. From this data, it is possible that individuals are motivated to engage in their eating

disorder in order to address certain emotions. Or, as the direction of this study cannot be determined, it is equally possible that the experience of certain emotions motivates an individual to engage in an eating disorder. The unique relationship between emotion and motivation might be examined further, as a large theme of this study, when looking at eating disorder narratives and stories, is that there is no singular experience. By looking at the relationship between emotions and motives, it could be determined that some individuals self-harm through eating disordered behaviors because they are motivated in different ways, or feel differently. The specific nature of the experience, where emotion and motive intersect, gives further weight to the possibility that self-harm motives and specific emotional experiences within an eating disorder could be largely observed as two symptoms of a larger psychopathology.

It is important to note that this finding is very new, and therefore simplified. The emotional patterns in relation to the NSSI motives they additionally coded for was watered down to the relationship concerning only one emotion and one motive. As was seen in the emotional coding of the narratives, it was often found that a single narrative could contain several different emotions. The experience of an eating disorder cannot be broken down into one easily defined emotion. Therefore, future research should look at advancing the analysis of emotional patterns of eating disorder experiences and their motives. For example, perhaps the pattern of exhibiting both disgust and anger share a relationship with a specific NSSI motive. Although such detailed relationships could not be analyzed at this time, further work into these complex relationships may portray a more accurate picture of the emotional narrative of an eating disordered individual in relation to the motives that could drive her behaviors.

**Limitations**

**Missing coding items**

The coding scale used in this study to determine the emotional experience within the narrative was completely new: it had been developed by a pilot study of narratives on similar sites, and from a combination of the research on emotionality in eating disorders as well as experience with the data the codebook was created to score. Although this meant that it was not only tailored to measure the exact interest of the researcher, as she was the creator of the manual, it also meant that – even with intensive research – there were some flaws with the measure. One of these flaws is the finding that some of the subcategory coding items were unable to achieve a positive code from the population of data collected. There were six items that failed to achieve a code: envy at mother, pride in maintaining disorder, disgust in eating disorder, anger at not being able to stop, and fear of inflicting permanent harm. In this discussion section, the researcher will take each item and discuss why it is possible that the sizeable amount of collected data did not contain any indication of these emotional experiences. While all have been indicated in the literature, they were missing from the set of experiences discussed here.

First, the inclusion of specifying envy towards the mother was used for the historical pattern and understanding eating disorders have maintained for centuries. When eating disorders were first identified and studied, they were largely seen as psychodynamic family problems. As the mother is the female role model for her daughter, it was thought that a relationship concerning mother and daughter and their body shape could develop (Brusch, 1793). This finding has been replicated in the present; it is not simply a Freudian idea of gender roles and jealousy. The more modern introduction of “fat talk” or discussing one’s perceived need to lose weight with other women has a profound effect when such talk is shared between a mother and a daughter. It has been found that the way in which a young girl interprets her own body is largely colored by the way in which her mother sees her own. That is, the relationship a mother has with

her own body, and her desire to diet or lose weight has a significant effect on how her daughter will see her body and weight. In fact, it has been found that many girls experience their first diet in a joint mother-daughter effort to lose weight. Therefore, the unhealthy body negativity of our mother's generation has been unknowingly passed down to us, and has the potential to continue (Nichter, 2001). This prevalent finding led to the inclusion of "envy towards mother" in this study.

There are several reasons why such findings – despite their presence in other sources – have not been found in the current study. It is possible that there was the presence of maternal envy in the items that were coded for general envy; these girls were thinking of their mother in their envy, but were not implicit in the direction of their envy. It is also possible that while on an Internet-based site, surrounded by their virtual peers, their mindset was more skewed towards those in their lives closest in age to them. By being a member of an Internet site that was probably mainly adolescent girls, it is possible that feelings of envy were directed more at other peers.

Secondly, the item of pride in maintaining the disorder was not coded in this study. This item was made to encapsulate the experience of superiority that has been noted in individuals who believe that by starvation or neglecting food, they see themselves as strong, and those who eat are weak and less morally good (Brumberg, 1989). However, this experience was not seen in the data. It is possible that this is an emotion that did not fit with the general environment of the website. It was specifically not a pro-ana site, and it is possible that girls thought that by posting their pride in the eating disorder, their experience could be construed as a pro-anorexia lifestyle. That is, it is possible that girls did not feel comfortable revealing how positively the eating disorder made them feel, in fear of social rejection on a confession site.

The third item that did not receive a positive code was disgust towards the eating disorder. This was meant to encapsulate the late-stage feeling that has been noted in anorectic and bulimic individuals that even though they are aware of the harm their body has undergone, they are too entrenched in the disorder to let it go. The power that it has over them disgusts them, though they are too entrenched in it to seek help. This can be seen in the moments of clarity when an anorectic individual realizes how thin she is. This feeling was not expressed in the narratives. It is possible that it was too complex of an emotion to be accurately identified, or too complex for an individual to formulate in a short confessional narrative. It is also positive that disgust in the eating disorder was too convoluted, and confused with other disgust measures.

The fourth item that failed to achieve a coding was anger at not being able to stop. This is similar to the above emotion, where individuals want to seek help or begin recovery, but they continue going back to the disorder and its patterns. This feeling of wanting to get better, but not being able to pull oneself out of the disorder was described in anger at not being able to stop. However, such an emotion was not seen in the narratives. There are a few possible reasons as to why this may be. First, it is possible that anger towards not being able to stop was in fact coded for the comfort/familiarity/routine code, as both indicate a feeling of being “stuck” in the disorder. Although comfort does not include the aspect of wanting to “unstick” oneself from the disorder, it could be seen as two very similar emotions. Another explanation might be that anger was the incorrect emotion to encapsulate this feeling. Being unable to fully recover may not be met with anger, but a variety of other emotions, such as shame and sadness, or helplessness. It is possible that, while anger at not being able to stop does attempt to answer a noted experience of eating disorders and recovery, using “anger” as the emotional heading was inaccurate.

The last item that failed to achieve any positive codes within the 250 collected narratives was fear of inflicting permanent harm. Narratives would have coded positively if they indicated the worry that their disorder would lead to continued and chronic health issues, such as a esophageal tears, arrhythmia, or osteoporosis. None of the narratives mentioned the fear of what would happen if they continued engaging in the eating disorder, which is an interesting finding considering that there were three positive coded narratives for fear of dying, indicating that some of the individuals did indeed realize the seriousness of their medical situation. Additionally, several narratives had negative views of the disorder and its effect, so the realization that the disorder could be dangerous was definitely present in the narratives. The fact that such an understanding of the direness of their condition did not code for fear of permanent harm could be for several reasons. It might be the case that individuals simply do not know the health risks that are directly at play if their eating disorder is maintained. It is also possible that within the midst of their disorder, their main concern is for the disorder itself, and they cannot see other harm they might be causing. It is also possible that within these very short snapshots of life captured on confession websites, the writers simply neglected to add this aspect of their life with the disorder, in favor of sharing more pressing emotions. The fear of permanent harm may still be present and underlying the experience, but was simply not recorded within this population.

**Missing coding scales**

The following section will address almost the opposite concern of the previous section. While the items that were on the manual that did not achieve a code have just been discussed, now the items that were not on the manual but could have achieved a positive code will be discussed. These emotions were noted when coding the narratives, as the manual allowed for space to include additional emotions. Although the codebook was broad and most emotional

narratives could achieve a code, as it has been stated, this is the first use of the codebook, and it is far from perfect. Just as items were included that failed to code, so too were items that were excluded but could code positively. There were five emotions that were seen in a number of the narratives that could be examined in future study: hatred towards eating disorder, feeling like a failure, embarrassment, anger at disorder, and anger at others. It is important to note that all of these additional emotional codes are profoundly negative.

The first emotion that was seen in the narratives was a strong hatred towards the eating disorder. Individuals often stated that they "hated it" with it referring to the disorder itself. In the current codebook, the individual could code for hating the self or the body, but hating the eating disorder was an entirely new experience. These narratives expressed how much they loathed the eating disorder and what it made them do. They hated the actions they underwent to maintain the disorder as well as the social effects that were secondarily caused, such as isolation. Although these narratives would code for general hate, there is an aspect of the experience that is missing by neglecting to include that the direction of their hate was actually towards their eating disorder. This would seem to imply a very strong aversion to their condition, as well as the fact that, though they are continuing with the actions, they cannot stop performing them, and such a failure leads them to resent the disorder itself. This is an interesting finding that should be explored further.

The second emotion that was seen was feeling like a failure. For the purposes of this study, the individuals who reported feeling like a failure were positively coded for shame in the self. However, it is important to note that while this code was seen as an accurate representation of the emotion given the current constraints of the codebook, the additional code of feeling like a failure should be added for all of the narratives that included the experience. The feeling of

failure came to focus several different objects or directions. Individuals felt like a failure when they were unable to maintain a fasting period, as well as before and after bingeing and purging. Individuals also felt like a failure compared to their friends, who they perceived as being thinner and better people. Independent from weight and the eating disorder, individuals felt like a failure when they let their loved ones down, such as when they were unable to eat a meal at an anniversary, or when they binged on their mother's cooking. Feeling like a failure, both within the confines of the eating disorder as well as separate from it may be an indication of the noted lack of self-esteem seen in the eating disorder population (Polivy & Herman, 2002). It is very possible that feelings of low self-esteem and worthlessness increase the feeling that one is a failure in several aspects of life, including being a "successful anorectic" or "successful bulimic."

Another emotion that transcended the eating disorder experience to general life experience was the feeling of embarrassment. Again, these narratives often coded as shame, and such a code was accurate, but the actual emotion on a future codebook could help in outlining the eating disorder experience. Individuals often felt embarrassment when their eating disorder was brought to the attention of others. When in social eating situations, such as the cafeteria or the break room at work, the individual felt embarrassed when others commented on the fact that she was not eating. Jokes about the individual having an eating disorder or being "weird" added to the sense of embarrassment. The narrative writer felt embarrassed when her eating habits were directly called into question and addressed to her. It is interesting that this negative emotion was felt, rather than the feeling of pride at being different than others and not eating. Embarrassment was also felt internally when individuals – not confronted by others – still managed to let others down or act in a way that was driven by the eating disorder that made them uncomfortable. For

example, an individual could note embarrassment when she was unable to finish eating a meal cooked for her.

Two directions of anger were seen in some of the narratives that were not included in the original codebook. The first of these is anger at the disorder itself. In the missing codes, it was noted that there was no reported anger at not being able to stop the disorder. However, this does not imply that anger was not felt. In fact, there were some narratives that included a feeling of being angry at the disorder. They were angry at the consequences and the power it had over them. This is an interesting emotion to note, as it was an almost a distancing and personifying experience. The disorder was an illness the girl was felt and experienced; yet she saw it as something separate and something to be angry at. The other source of anger was again directed externally, though in this experience it was directed at a very real source. Individuals reported feeling angry towards others. This anger at others was actually a coding measure, though it specified being angry with others for forcing them into recovery. The sort of anger described here was not in response to being forced into recovery, but at being ignored. Their anger was towards others who did *not* pressure them to recover. They were angry that individuals were not responding in the way they needed: to support the start to getting better. This potentially says something very powerful about the way in which an eating disordered individual interacts with the people in her external world, as well as the desire for recovery, and what would make recovery successful.

**Broad Codes: Comfort and Misunderstood**

The following section will address coding measures that received a substantial number of positive codes. Both of these coding measures were added later in the process of developing the coding manual, to address codes that were difficult to encompass in the more traditional coding

measures, such as fear and shame. Although the high reporting rates indicate that the feeling was experienced by a large part of the population examined, it is also important to note that such well-reported measures were also the two broadest measures, and that in future research, it may be beneficial to split these categories into subcategories with specific valences.

The first of these categories was comfort/familiarity/routine. As the name implies itself, it encompasses more than one emotion, or three separate paths to a similar emotion. Narratives that achieved this code spoke of a variety of experiences, but the chief, unifying factor was that the disorder brought a sense of comfort to the individual, be that comfort derive from the consistency of the pattern of behaviors, or the emotional regulation benefits one receives after completing such behaviors. Although there are many ways in which one could conceivably break down this category, the section present will provide one possibility: dividing the direction of comfort into positive and negative experientially. That is, does the comfort from the disorder bring positive feelings to the individual: does the routine calm her and make her feel better, or does the comfort from the disorder bring negative feelings to the individual: does the routine of it make her feel distressed and distraught that she is hopeless to the cycle. This is a good foundation in which to further examine the experience of comfort and routine within an eating disorder.

The other broad category that should be considered in this section is the code of being misunderstood. This code was formed in order to answer to discrepancies within the code of isolation, and whether or not feeling like someone did not understand the disorder necessitated isolation or, potentially, loneliness. Therefore, the category of misunderstood was created to encapsulate the feeling of lacking the knowledge, both personal and regarding eating disorders, that narrative writers thought those surrounding them exhibited. Again, this feeling of being misunderstood encompassed a wide range of potential experiences from an even wider range of

sources: from being misunderstood by parents, teachers, doctors, and peers. The feeling of being misunderstood could further trigger negative emotions: such as anger and hopelessness as to the fact that no one understood them. In further research, it would be beneficial to additionally note whom the narrative writer felt misunderstood by, as well as what secondary emotion – when present – the individual felt when they experienced being misunderstood.

**Vague Codes: isolation versus loneliness**

In the last critique of the codebook and its effects on the study, this section will examine the areas of the codebook where further clarity could give way to a more accurate assessment of certain emotions. The interrater agreement rate for this coding study was very high: in every case where original coding answers differed, a collaborative conclusion could be met agreeably without the need of a third party. However, there were areas where the coders sometimes realized the difficulty in positively coding a narrative for a specific coding item, or another similar one,

The most profound instance of this vagueness was seen in the two codes isolation and loneliness. Although they contained different sub-codes, there was initial confusion between the two emotions, and the possibility that such confusion led to coding errors. Isolation and loneliness are quite similar experiences: both speak to a separation an individual experiences from others, such as peers or family members. Being isolated from others may cause an individual to feel lonely, and vice versa, feeling lonely may lead to an individual isolating herself. Not only were they similar, but they also could conceivably act on one another, so that the dominant emotion was difficult to identify. However, in this study, the two emotions were separated in this way: loneliness spoke to a less severe reaction to being separated from others. Loneliness seemed to imply that the individual felt the strain from deteriorating relationships,

and such strain caused the distressing emotion. Isolation was a more dire response. The isolated individual lacked, somewhat, the distress of these weakening relationships. In other words, she cared less that she was not as close to her peers or families. In this study, isolation implied that the individual was – at the very least – content with her status of being solitary.

**Lack of Positive Emotions**

The reasoning behind utilizing a confession site, rather than a pro-ana site to garner a set of data to detail the eating disorder experience was done purposefully: those in the pro-ana and lifestyle belief are the minority of the population. Although they are overrepresented in the media and the news, as well as in the literature, those who believe that their eating disorder is a blessed life are very few: most believe that the disorder is hard, and that they would not wish such an experience on their worst enemy (Serpell, Treasure, Teasdale, & Sullivan, 1998). Therefore, the confessional sites were used in order to attempt to receive responses in a population where the experiences provided might be more generalizable. And, as seen in the wide range of responses and types of narratives, it is believed by the researcher that such a goal has been successfully accomplished.

However, it is important to note that by making this decision, the minority was potentially left out from the data pool. Although it is impossible to know the philosophies of these young girls, it is possible that those who maintain the pro-ana belief do not feel comfortable posting on sites that do not explicitly state that their intent is to provide pro-ana support. It is very possible that these individuals, small though they might be, were left out of the data; and their experiences as important as well.

The belief that such a pattern occurred within the study based on the sites used is due to the lack of positive emotions reported from the sample of narratives taken. It is also important to

note that the codebook was scaled for such findings: of the main codes, the only potentially positively skewed emotion was pride. However, even in the space for additional codes, there were no narratives where their unaddressed emotions were positive. For example, there were no narratives where the individuals were happy about their disorder; there were no narratives where any individual showed explicitly that she was content with her life containing an eating disorder, and frequently displayed the exact opposite. Even within the positively skewed code of pride the narratives were decidedly negative: they rejected their pride, they were disgusted by its presence.

The lack of positive emotions within these narratives could be explained for two reasons. It has been established that such findings are due not to the codebook or the study itself, but purely due to the eating disorder experiences shared. It is either possible that by choosing a confession site, the complete presence of the pro-ana experience was eliminated. Or, both sets of individuals were responders in this study, and then a tentative conclusion regarding the emotionality of eating disorder experience could be drawn: simply put, no matter how one regards her eating disorder, as a disease or a religion, it is not a positive experience.

Along the same line as lacking positive emotions surrounding their eating disorder, there was also a lack of reports of feeling in control, a measure included on the current codebook. Although feeling in control is not necessarily a positively interpreted emotion as soundly as pride may be viewed, it unquestionably has positive implications. Feeling in control makes on feel as though they are able to cope with their life and their surroundings. Feeling in control seems like one has a grip on their rational and emotional needs. Feeling in control is also an emotion commonly cited with eating disorders; in fact, the feeling of needing to be in control is often reported as a factor in the disorder's development. However, this emotion was not seen in the current study. This may be due to the fact that, while individuals believe the disorder will give

them control, it very often does the opposite, and they find themselves at the mercy of the disorder (Brumburg, 1989). It may also be that the population submitting narratives to a confession site view the disorder particularly negatively, and do not feel as though their disorder is giving them control. Whatever the cause of such findings may be, it is important to note that feeling in control – a traditional emotion tied to eating disorders – was not seen frequently within the narratives.

**Recommendations for Further Research**

From this study, the potential for future research is very strong. Throughout the paper, several mentions of areas of further work in relation to the current study have been addressed. In this section, such recommendations will be addressed. This study used two codebooks, one entirely new and one in a novel approach. As this was the first study to use such a methodology, several further studies could use the foundation of the current one to engage in further work.

First, the emotional codebook in its new state could be honed and adjusted for future work to account for replication and validity. Vague or redundant codes could be removed; or, codes that were seen but not included on the codebook could be added for future investigation. Additionally, the NSSI codebook used is only one measure in the growing body of self-harm research. It only codes for the motivations behind engaging in self-harm. If one wanted to theorize a link between eating disorders and NSSI as a larger psychopathology, the connection would be made stronger if additional NSSI measures were applied to eating disorder narratives or participants. This current study utilized a single NSSI measure to achieve its research aims: future work could continue applying different and varying NSSI measures in order to examine the same relationship. It might also be beneficial to use the codebooks in the current, or any additional or altered version of the present measures, within a population meeting in the real

world. Although the virtual population gave the researcher access to a much larger source of data than recruitment at a small college, a good deal of interpretation was needed in order to code the narratives. If a similar study was conducted with eating disordered individuals in a lab it is possible that different results could be yielded. Additionally, when there was an issue of vagueness of confusion over a code's meaning, such problems could be addressed through a more interview-based study. Another area of future work could be to reverse the way in which this study suggested the correlation between eating disorders and self-harm. If eating disorders can be seen as a form of self-harm, with similar underlying mechanisms, then a reverse process should, in theory, yield support. That is, if the emotional codebook and an eating disorder motive scale were given to a population of self-harming individuals, similarities in the transdiagnostic measures should also be reported. A future work may be to focus on administering eating disorder measures or the current emotional codebook to an NSSI population, and examining if similarities in results could be replicated. Additionally, it was supported that specific eating disorder experiences, qualified by the emotions they contain, have a specific link to the motives that drive the behaviors, or it such motivations lead to specific emotional states. However, this finding was simplified to include only one emotion in relation to motivation. As the study shows, the eating disorder experience can encompass a wide array of emotions, and such findings should be utilized in the future. With the preliminary link provided here, future work may be of use when looking at multiple emotions in an eating disorder and their relations to NSSI motives.

## Conclusion

This qualitative and correlational study examining the narratives of individuals either currently suffering or recovering from an eating disorder, taken from the anonymous confession sites on the popular social media site Tumblr has given a wide-encompassing look into the

emotional experience and drives surrounding an eating disordered individual from her own perspective. By taking a qualitative approach to narrative studies, a broad narrative pattern was assessed through the use of a codebook assessing emotions and directed emotional experiences. Through the collection and analysis of these emotions, it was found that within the eating disorder experience, many of the stories included the emotions of control, fear, comfort and routine, hate, and feeling misunderstood. The frequency of these emotions, though not indicative of every eating disorder experience, allowed the researcher to outline a broad narrative for an individual with an eating disorder as one centered around the feeling of being out of control and hating the body feeding the need to diet in order to quiet the distress one feels both internally and in regards to her external environment. This leads to a cycle of maladaptive eating patterns that the individual grows to hate, as well as strengthening the hatred and negative feelings she has towards herself. Such a consuming pattern, which the individual feels she cannot – and sometimes, does not want to – get out of leads to a feeling of being misunderstood by her family and peers, and she is therefore possibly led to the Internet to seek comfort from like-minded individuals. It is not a glamorous portrait to paint, and it likely does not end with a happy ending. With the lack of responses for pride and feeling in control, it is doubtful that the initial emotional stability and positive affect that the individual intended to answer through losing weight is never really achieved.

Additionally, the novel proposal to look at eating disorders as a disorder primarily concerned with harming the body, rather than slimming it, was applied through the use of a NSSI motive codebook. From these findings, support can be given that individuals with an eating disorder may use the disorder and the detriment it has to the body as a way of causing physical harm in order to quiet some emotional pain or distress. Within the eating disorder narrative, a

majority of the narratives additionally coded for one of the four motives of self-harm: they were starving themselves or bingeing and purging in order to stop feeling bad, to end a sense of numbness, to avoid social situations, or to gain attention and a response from unknowing peers or family. Like the self-harmer will cut their wrists or burn their skin, the eating disordered individual will starve and binge in order to achieve some sort of unaddressed emotional pain. The pain of starvation or purging acts in the same function, it seems, that NSSI does, in that it will provide some larger emotional goal for the individual. Taking this theory into account, the way in which eating disorder treatment is implemented may benefit from a shift in focus to the eating behaviors themselves, to what these behaviors, on a deeper level, satisfy for the individual engaging in them.

To examine the novel proposal further, and provide additional and quantitative support for the findings, correlational analyses were run on the major coded emotions and the NSSI motives that they additionally had been positively coded for. It was found that within ten of the sixteen emotions, there was a significant relationship between the emotion and the motive. From these findings, it can be supported that individuals who feel a certain way within their disorder might be motivated to carry out eating disordered actions; or, individuals who feel motivated to engage in their eating disorder might report specific emotional experiences. Though the direction of the relationship cannot be supported, both findings are interesting, in that there is a clear relationship between certain eating disorder emotional narratives and NSSI motives. These patterns may imply, through future work, that some eating disorder experiences are driven by specific motives. Such a deep understanding may provide additional resources when looking to clinically assess and treat eating disorders: if individuals harm their body through their eating disorder while being driven by motivations, a specialized treatment may be possible.

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Appendix A

Eating Disorder Codebook

**ED CODEBOOK:** To code positively in this section, narratives must reveal one or more of the following emotions and/or sub-categories of emotions:

**Fear** ____
- Relating to the disorder ____
  - Fear of gaining weight ____
  - Fear of what is happening to their bodies ____
  - Fear of inflicting permanent harm ____
  - Fear of the disorder itself _____
  - Fear of dying from disorder ____
- Relating to detection/intervention ____
  - Fear of being "found out" ____
  - Fear of being told/forced to stop ____
  - Fear of having behavior changed ____

**Disgust** ____
- Disgust in their body ____
  - Disgust in their weight ____
- Motivating disgust ____
- Towards their physical symptoms ____
- Towards their actions in maintaining the disorder ____
- Towards the eating disorder ____

**Shame** ____
- Towards self ____
- Towards disorder ____

**Sadness** ____
- Towards Self ____
- Towards body ____

**Hate** ____
- Towards Self ____
- Towards body ____
- Driving disorder/maintaining disorder ____

**Anger** ____
- Toward self (perfectionism) ____
- Towards those trying to stop them (parents, teachers, doctors, etc.) ____
- Anger at not being able to stop ____

**Pride** ____
- In "strength" of maintaining behaviors ____
- In thinness/attractiveness ____

**Envy** ____
- In relation to friends ____
- In relation to siblings ____
- In relation to mother ____

In relation to media ____
**Guilt** ____
Directed at self (failure) ____
In how they affect others ____
**Loneliness** ____
Attributed to disorder ____
Driving disorder ____
**Comfort/familiarity/routine** ____
**Isolation** ____
From others ____
From family ____
From self ____
**Denial** ____
Driven by other's emotion/belief ____
Driven by self ____
**Control** ____
Feelings of being in control ____
Due to the success of thinness/attractiveness ____
Due to actions in disorder ____
Feelings of being out of control ____
Due to actions in disorder ____
Due to failed actions in disorder ____
**Feeling misunderstood** _____
**Suicidality** ____

Any additional items:

Appendix B
NSSI Codebook

**NSSI CODEBOOK:**

NSSI = deliberately injuring oneself without suicidal intent

To code positively in this section, narrative must reveal behaviors as an effort to purposefully inflict bodily pain for the reason(s) of:

Automatic-negative (A_) = to reduce tension/ stop feeling bad
_____

Automatic-positive (A+) = to stop feeling numb/ to feel something
_____

Social-negative (S-) = to escape social situation/ people/ activities/ responsibility/ life
_____

Social-positive (S+) = to get attention/ reaction
_____

Appendix C
ED Codebook Training Manual

# Training Manual for Honors Thesis Codebook

## ED CODEBOOK:

- **Fear** = General feelings of being afraid, being scared, etc.
- Relating to the disorder = General feelings of fear in a direct relationship to the ED
    - Fear of gaining weight = Feelings of being afraid of weight gain
    - Fear of what is happening to their bodies = Feelings of being afraid of the physical changes that have happened due to their ED (both caused and incidental)
    - Fear of inflicting permanent harm = Feelings of being afraid of the long-term changes (could be caused or incidental, could be directly related to ED, or more indirect)
    - Fear of the disorder itself = Feelings of being afraid of the disorder, afraid of its power over the individual
    - Fear of dying from disorder = Feelings of fear towards possible lethality (both caused and incidental, also directly or indirectly related)
- Relating to detection/intervention = General feelings of fear that their disorder will be interrupted by others
    - Fear of being "found out" = Feelings of fear that someone is going to notice the change in behavior/eating
    - Fear of being told/forced to stop = Feelings of fear surrounding doctors and any form of treatment forced by another
    - Fear of having behavior changed = Feelings of fear surrounding the possibility of some schedule change/interruption; not related to forced treatment (ie. forced to go out to dinner and eat with family, forced to stop a binge/fast episode)

- **Disgust** = General feelings of aversion
    - Disgust in the body = Feelings of being disgusted by their shape
        - Disgust in weight (high) = Feelings of being disgusting that motivate weight loss
        - Disgust in weight (low) = Feelings of being disgusting as a result of weight lost
    - Towards their actions = Feelings of being disgusted by that they are doing/will do in order to maintain disorder (could be caused or incidental)
    - Towards the eating disorder = Feelings of being disgusted of the disorder, afraid of its power over the individual

- **Shame** = General feelings of humiliation, distress
    - Shame towards self = Feelings of being ashamed of one's body, one's actions, one's weight etc.
    - Shame towards disorder = Feelings of being ashamed by what the disorder is doing to others/how it is affecting them

- **Sadness** = General feelings of unhappy, depressed

    - Sadness towards self = May seem like depression, large feelings of being unhappy with life
    - Sadness towards body = Feelings of sadness in relation to size or weight (could be in comparison to others)

- **Hate** = General feelings of intense dislike
    - Hate towards self = Feelings of dislike of oneself, can be general
    - Hate towards body = Feelings of dislike of the body,
    - Hate driving/maintaining disorder = Indicating some event/belief that perpetuates the disorder

- **Anger** = General feelings of annoyance, displeasure
    - Anger toward self (perfectionism) = Feelings of anger related to the desire to be perfect and failing; of not meeting a set goal/ideal
    - Towards those trying to stop them = Feelings of anger towards people (parents, teachers, peers, etc.) who are trying to get them into treatment/stopping
    - Anger at not being able to stop = Feelings of anger towards self at being stuck: wanting to stop/recover, but falling back into pattern

- **Pride** = General feelings of satisfaction, fulfillment, etc.
    - In "strength of maintaining behaviors" = Feelings of being proud of oneself for not giving in to food/others, of staying "strong" in reaching one's goals (for weight loss)
    - In thinness/attractiveness = Feelings of being proud of weight loss, of feeling thin/attractive/accepted by others; can be in relation to others' reactions

- **Envy** = General feelings of resenting others
    - In relation to friends = Feelings of resenting the shape, weight, eating habits of their friends; measuring (and failing) in comparison to friends
    - In relation to siblings = Feelings of resenting the shape, weight, eating habits of their siblings; measuring (and failing) in comparison to siblings
    - In relation to mother = Feelings of resenting the shape, weight, eating habits of their mother; measuring (and failing) in comparison to mother
    - In relation to media = Feelings of resenting the shape, weight, eating habits exemplified by the media; measuring (and failing) in comparison to media figures

- **Guilt** = General feelings of culpability, blameworthiness
    - Directed at self (failure) = Feelings of guilt following some failed behavior or un-met goal, blaming the self for not succeeding
    - In how they affect others = Feelings of guilt in relation to how their behaviors are affecting others

- **Loneliness** = General feelings of solitude
    - Attributed to the disorder = Feeling lonely in virtue of the need to hide their behaviors, feeling alone because they cannot function outside with ED
    - Driving disorder = Feelings of loneliness predating ED, with the ED as an attempt to normalize/fit into peer groups/culture

- **Comfort/familiarity/routine** = Feelings of being stuck in disorder, of feeling like the disorder is a comfortable pattern that one can try and get out of, but will always return to; could be seen as coping strategy, lifestyle, etc.

- **Isolation** = General feelings of withdrawal, seclusion
    - From friends = Feelings of being withdrawn from friends, from peer activities they used to enjoy, or unable to communicate with friends
    - From family = Feelings of being being isolated from friends, from activities they used to enjoy, or unable to communicate with family
    - From self = Feelings of being isolated from self, feeling like a different or fundamentally changed person as a result of ED

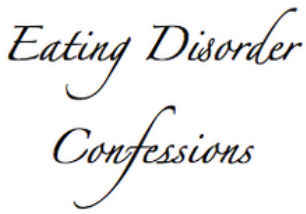
- **Denial** = General feelings of rejection, dismission
    - Driven by other's emotion/belief = Being confronted by a friend and denying the existence or seriousness of the ED
    - Driven by self = Refusing to confront the self through denying the existence of seriousness of the ED

- **Control** = General feelings of power, authority
    - Feelings of being in control = Feelings of being strong, having power
        - Due to success of thinness/attractiveness = Feelings of being in control due to ED - facilitated by compliments, or perceived attractiveness/thinness
        - Due to actions in disorder = Feelings of being in control due to followed measures/rules of the disorder
    - Feelings of being out of control = Feelings of being a weak, being powerless
        - Due to actions in disorder = Pre or post binge episode, eating when "rules" didn't permit it
        - Due to failed actions in disorder = Feelings of losing control due to failed actions; ie. breaking a fast, not purging, promises not to binge, etc.

- **Feeling misunderstood** = General feelings that the people surrounding the narrative writer do not understand what the individual is going through, fail to take it seriously, or misinterpret it. This can be accompanied by feelings of anger, loneliness, isolation, sadness, etc.

- **Suicidality** = Thoughts associated with suicide/dying, or the desire to end one's life; causing oneself great bodily harm

Appendix D
Sample Confession Website One




HOME

**DISCLAIMER:** We do *not* support or encourage eating disordered behaviour. We are pro recovery and wish the best for our followers. **If you are easily triggered, please do not follow.** Although we do our best to make this blog as trigger free as possible, not everyone has the same triggers. Please do not forget that recovery is always an option and it is something that everyone deserves.

The confession box is currently **OPEN.**

**Click HERE to submit a confession.**

Click HERE to see just confessions.

DIRECTORY
INFO AND FAQS
RULES/GUIDELINES
ANSWERED QUESTIONS
NOTEWORTHY BLOG POSTS
MEET THE MODS

next

**9236) Okay so I tend to restrict/binge but idk if it is an actual Ed or just disordered eating. I have anxiety and depression and I get extreme anxiety about going places because I feel like I am too fat. Idk what is wrong with me. I feel like I cant live .**

Regardless of whether it's an ED or just disordered eating, you deserve to not have something effect your life in such a negative manner. Disordered eating isn't something that you have to wait to see if it becomes an ED before you get help. Disordered eating can have many harmful effects as well.

SHARED 13 MINUTES AGO ♥ 1 NOTE

tw ed eating disorder confession

**9235) I've been suffering from anorexia for almost X and recently I'm glad to say that I'm finally getting much better from it! Now I can eat food normally again, now I eat Y, Z, XX, without feeling the urge to vomit or binge all the time!! And guess what? I'm feeling comfortable with my body! And I want to say to all those [people] who are struggling with the recovery: do not ever give up! :)**

SHARED 1 HOUR AGO ♥ 9 NOTES

tw ed eating disorder confession edited for content

**9234) My body repels all my food.**

SHARED 1 HOUR AGO ♥ 14 NOTES

tw ed eating disorder confession

**9133) How come when I binge and purge I lose X but when I dont eat at all for a day i lose hardly any?**

SHARED 2 HOURS AGO ♥ 17 NOTES

tw eating disorder ed confession

**9132) I think I might be developing an eating disorder.. I've only eaten X for the past Y. I'm so scared, but I can't tell anyone. They wouldn't believe me..**

SHARED 3 HOURS AGO ♥ 12 NOTES

Retrieved from: http://eatingdisorderconfession.tumblr.com/tagged/confession

Appendix E
Sample Confessions Website Two


Retrieved from: http://your--ed--confessions.tumblr.com/

# Appendix F
## Format of Retrieved Narratives for Coding

202. I purge after every meal and my disorder has gotten so bad that while I'm eating I feel the need to throw up. I have been trying so hard to quit, but everyday it just gets worse and worse. Also, I am too ashamed to tell anybody, including my family, about my eating disorder because I know they will judge me and only make me feel even worse about myself.

203. I have no idea of how to tell my mom I have an ED before Thanksgiving. I'm so scared she'll be as ashamed of me as she was when I self-harmed as a teenager and I honestly can't take that. If only I could just get out of going home for the holiday altogether.

204. I'm scared of taking a bath. I feel disgusting, but I can't see myself naked. I haven't looked myself in the mirror in days, I can't handle the fact that I'm a lot fatter.

205. I developed my ED around the time my twin sister moved in with her boyfriend. Around the same time she was getting healthier from hers. Now that she moved back home I've noticed she lost weight. I got so upset and jealous that she looks smaller than me. I feel like a terrible sister and I don't want us to compete.

206. I can't look through magazines anymore. I see the models in them, and cry. No matter how hard I try…I'll never look like them.

207. I thought that being more in control of my eating would improve my grades. I can't focus and I've wrecked my memory because of this. The thing that was supposed to make me perfect and in control is killing me and I can't stop.

208. Of course I hate the sore throats, the shakiness, and the weakness. Of course I hate when I accidentally throw up on my hand and the watery eyes and runny nose. Of course I hate hiding all this, I've even resorted to puking in plastic bags in my room. But for some reason, I think it's better than having anything in my stomach.

209. I feel like I am slowly falling apart, and the only way to keep myself going is to keep losing weight and to keep my ED close to me. I really don't know what is going to happen. I am afraid.

Appendix G
Correlations of Emotions and NSSI Motives

Table 19

Correlations between Main Emotional Codes and NSSI Motives

| Emotion | Automatic negative | Automatic Positive | Social Negative | Social Positive |
|---|---|---|---|---|
| Disgust | .111* | -.063 | -.064 | -.008 |
| Shame | .060 | -.120* | .054 | -.031 |
| Hate | .086 | -.108* | .089 | -.108 |
| Anger | .017 | .098 | -.102 | .063 |
| Pride | -.066 | -.055 | -.071 | .153** |
| Envy | -.117* | -.099 | -.086 | .316** |
| Guilt | -.052 | -.060 | .055 | .119* |
| Loneliness | -.077 | .018 | -.102 | .066 |
| Comfort/routine | .100 | .144* | -.037 | -.140 |
| Isolation | -.060 | .163 ** | -.026 | .032 |
| Denial | -.088 | .083 | .101 | .055 |
| Control | .156** | .027 | -.027 | -.143* |
| Misunderstood | -1.03 | -.100 | .043 | .071 |
| Suicidality | -.017 | .236** | -.023 | -.056 |