City Research Online

City, University of London Institutional Repository

Citation: Foye, U. ORCID: 0000-0002-3414-2854, Hazlett, D. E. and Irving, P. (2018). 'The body is a battleground for unwanted and unexpressed emotions': exploring eating disorders and the role of emotional intelligence.. Eating Disorders, doi: 10.1080/10640266.2018.1517520

This is the accepted version of the paper.

This version of the publication may differ from the final published version.

Permanent repository link: http://openaccess.city.ac.uk/id/eprint/20707/

Link to published version: http://dx.doi.org/10.1080/10640266.2018.1517520

Copyright and reuse: City Research Online aims to make research outputs of City, University of London available to a wider audience. Copyright and Moral Rights remain with the author(s) and/or copyright holders. URLs from City Research Online may be freely distributed and linked to.

City Research Online:	http://openaccess.city.ac.uk/	publications@city.ac.uk

‘The body is a battleground for unwanted and unexpressed emotions’: Eating disorders and the role of emotional intelligence.

Introduction

There is currently a trend towards biochemical and medically focussed work in the field. While such evidence is necessary to help build the understanding of the biological and genetic aetiology of these disorders, there is a danger of focusing on these means that we limit our understanding in the awareness of other causal determinants. In addition, this has the potential to detach counsellors and non-medical practitioners from engaging with these illnesses by focusing on a single dimension rather than the holistic and complex nature of these disorders. It is necessary to address these wider determinants and learnings from the range of biological, sociological and psychological models of these illnesses that are present across the literature, to understand and approach treatment of such complex illnesses. Within this movement from the medical modelling of such disorders, it has been acknowledged that there is a need for emphasis to be placed on additional theories and understanding of these disorders. The biopsychosocial model does this through embracing a more holistic approach and allows to the complexity to be addressing this, including placing focus back towards multifactorial elements of these disorders.

Considering this multifactorial perspective, there has been increased movement towards understanding the emotional complexity of eating disorders. Building on the early work of Bruch (1988; 1973), studies have shown that eating disorders may act as having a functional purpose related to emotional regulation and coping (McNamara, Chur-Hannsen & Hay, 2008;

Reid, Burr, Williams, & Hammersley, 2008; Schmidt, & Treasure, 2006). Theories have suggested that emotional dysfunction may be considered one of the main predisposing elements in the aetiology of anorexia (Oldershaw, DeJong, Hambrook, Broadbent, Tchanturia, Treasure, & Schmidt, 2012; Treasure, Corfield, & Cardi, 2012).

Work has suggested that this relationship may emerge as a result of deeper emotional difficulties with interoceptive awareness, connectedness of bodily sensation, confusion of emotional states and language observed within patients with disordered eating patterns (Harrison, Sullivan, Tchanturia, & Treasure, 2010). Furthermore, individuals with high levels of disordered eating attitudes and behaviours have been found to be highly avoidant of emotions, reporting higher levels of sensitivity and intensity to emotional arousal (Merwin, Moskovich, Wagner, Ritschelm, Craighead, & Zucker, 2013; Wildes, & Marcus, 2011).

It can be theorised that eating disorder behaviours such as restriction, binging, and purging may be understood as means to drown out states of overstimulation or fragmentation, thus reducing emotional arousal (Serpell, Treasure, Teasdale, & Sullivan, 1999). Such findings remain significant when factors such as age, depression, and anxiety are controlled for (Hambrook, Oldershaw, Rimes, Schmidt, Tchanturia, Treasure, Richards, & Chalder, 2011). Literature has also found these results remain consistent for male samples (Goddard, Carral-Fernández, Denneny, Campbell, & Treasure, 2014).

Based on the wealth of literature connecting eating disorder behaviours to emotional dysfunction, there have been a range of studies that have applied these theories in line with the conceptualisation of Emotional Intelligence (EI), "…*non-cognitive abilities, competencies,*

and skills that influence one's ability to succeed in coping with environmental demands and pressures" (Bar-On, 1997; p14). Results have shown that those with high disordered eating have significantly lower EI than control populations (Zysberg, & Tell, 2013; Hambrook, Brown, & Tchanturia, 2012; Filaire, Larue, & Rouveix, 2011; Zysberg, & Rubanov, 2010; Pettit, Jacobs, Page, & Porros, 2010; Swami, Begum, & Petrides, 2010; Costarelli, Demerzi, & Stamou, 2009; Costarelli, & Stamou, 2009; Markey & Vander Wal, 2007). This provides evidence to suggest that disordered eating behaviours may occur as a result of a range of emotional dysfunction rather than focused on a singular aspect.

This evidence has added to the concept that poor emotional and interpersonal functioning has a role in predisposing and perpetuating eating disorder onset within models of these illnesses. Such evidence has provided additional support to the cognitive-interpersonal maintenance model of anorexia nervosa (Treasure, & Schmidt, 2013) and has influenced the development of treatment approaches such as MANTRA (Wade, Treasure, & Schmidt, 2011) and The New Maudsley Model for carers of individuals with eating disorders (Treasure, Smith, & Crane, 2016). This is significant when considering the impact that poor emotional and interpersonal functioning has clinically within the treatment. The importance of the emotional aspects of life have been long explored within psychotherapeutic approaches. Early work by Bruch (1988; 1974) and Horney (1952) are among a number of theorists who have added to knowledge linking somatic and emotional experience of distress and eating disorders (Novack, 2016). Furthermore, work within this area of the literature, including findings from Petrucelli (2016), Zerbe (1995), Bromberg (2008), Barth (2001) and Kuriloff (2004), has explored the influence that emotional difficulties have on the body and within the clinical therapeutic setting as a means to understand how these complex illnesses can be understood and approached

within treatment.

There is considerable evidence to exemplify a baseline for understanding that emotional functioning is a leading concept within the area of eating disorders, however this is often overlooked within clinical research (Rice, 2016; Woolridge, 2016). As a result, there is a need for ongoing and more in-depth emphasis on the emotional aspects and complexity of eating disorders in a field which is becoming more physiologically focused and manually based. While we have a strong understanding that the emotional functioning and abilities of patients with eating disorders is salient for the onset and maintenance of these disorders, this work is often quantitative with limited qualitative work having probed this association.

Aim

The aim of this paper is to explore the role that EI has in the experience of eating disorders both from the practitioner and personal perspective, to understand which aspects of the emotional life have an impact on onset and treatment of these disorder. While quantitative literature has outlined overall EI is lower in eating disorder populations, we aim to address which aspects of EI are important within this study. By using a qualitative lens to explore this relationship, research will be able to understand how emotional aspects contribute to the development of disordered eating as well as understanding the wider impact this has on the maintenance of such illnesses. As a result, this paper hopes to add to the discourse of EI in eating disorders as a mean to help inform how interventions can be developed to target specific emotional dysfunction throughout the illness cycle.

Methods

The findings reported within this paper are part of a larger UK based study which explored the variables and barriers impacting the onset and maintenance of eating disorders. The overall study used a sequential, mixed methods design that was analysed in two phases. This included an initial exploratory qualitative phase consisting of 32 participants with personal and professional experiences of eating disorder followed by an evaluative quantitative analysis to test the emerging hypotheses with a general population sample of 435 participants. The current paper reports the first phase of this wider study.

Design

The study used an in-depth qualitative design, using an underpinning critical realist ontological perspective. While there are objective and measureable understandings to human behaviour, the design of this study acknowledged that there must be an incorporate of the subjective interpretations of how individual meaning shaped by independent experience and subjective perception (Snape & Spencer, 2003). As a result, a qualitative design as used to give the study a real world view that explored the experiential knowledge and learning shared by participants in the sample. This design provides insight into the practitioner and personal experiences that lead to unique interpretation and understanding of how emotion interacts with the disorder, something that may have been lost during pure quantitative inquiry (Snape & Spencer, 2003).

Participants

While evidence to date has considered the relationships that exist between EI and eating

disorders, little is known in relation to the lived experience of this relationship and how such dysfunction may impact on recovery and treatment for these illnesses. As a result, this study was designed to recruit participants with personal and/or professional experience of eating disorders to help establish the nature of this relationship and the mechanisms associated that may support how EI can inform interventions as well as the factors that may interact as barriers within real-life practice. Based on this aim, the study recruited two participant groups; practitioners working in the treatment or prevention of eating disorders (n=27) and those with personal lived experience (n=5). A total of 32 participants took part in the study.

Professional participants from multi-disciplinary roles were selected due to their involvement in the detection, recognition, and treatment or support for eating disorders, including roles working as therapists in NHS settings, private practitioners and counsellors, support group facilitators, and staff inclusive of third sector workers and teachers who delivered support roles to students and young people. Practitioners were included due to their proactive role in the area and were recruited if they had a minimum of one year in their role to ensure direct experience with the role had been completed. A number of the participants (n=13; 48%) openly identified as having dual roles, e.g. a counsellor who had personal experience of living with an eating disorder.

The second group was recruited due to their personal experience of living with an eating disorder. Participants with personal experience were screened prior to inclusion to ensure that those included in the study were considered to be in self-reported recovery, e.g. at least two years out of treatment and not currently engaging in disordered eating behaviours to ensure that participants were safe to discuss their experience. There was no exclusion based on diagnosis, meaning that participants had a range of diagnosis including anorexia, bulimia, OSFED and

multiple diagnoses across their life. Of those with personal experiences, the diagnosis was inclusive of anorexia, bulimia, and OFSED, with a number of individuals describing the experience of more than one diagnosis across their lives.

Sampling

Due to the small numbers of individuals with professional or personal experience with eating disorders, and the specialism related to this topic, the sampling method used for this study was a non-probability approach. As a widely used sampling framework in social sciences this method is considered most appropriate for qualitative designs, particularly those that focus on a complex or specialised area (Bryman, 2004).

Method

To ensure that the methods used during data collection were appropriate and suitable for the participant groups the study employed three qualitative data collection methods.

Interviews

Face-to-face interviews for practitioners and counsellors who had in depth experience with eating disorders (n=12). This approach allowed for the development of the general questions within the semi-structured interview schedule as directed by the participant' experiences and understanding of the context. This flexibility allowed participants the opportunity to extend their answers and pursue a particular area of interest, however kept participants focused on exploring the specific mechanisms of EI on the maintenance of the

disorder and this impact on their practice. As many participants had dual roles and personal experiences that influenced their involvement in eating disorders this method provided a confidential and safe environment for participants to explore these areas.

Focus Groups

Focus groups were conducted in person for those working in the third sector and educational settings (a total of 10 participants across three focus groups). This method was used as it was viewed this group context would be more conductive for these participant groups. Due to the nature of the topic and the direct professional role these participant groups have with prevention and treatment of eating disorders focus groups were considered a better method to facilitate discussions and disclosures as all participants are "*…in the same boat"* (Finch & Lewis, 2003; p.190). This was particularly salient for both the education and pastoral care staff and the Binge Eating Disorder support group workers. These groups felt that, while they wanted to take part in the study and felt they had important views.

Furthermore, the use of focus groups was a beneficial method of data collection for these participant groups due to the time constraints that such staff have. Due to time constraints and ethical procedures in place for research within NHS settings a focus group was used as opposed to individual interviews for this participant group (n=5).

All participants within these professional groups were however provided with the option to take part in a one-to-one interview if they felt more comfortable, or requested.

The focus group interview schedule represented the same semi-structure approach as

the interviews with the same questions used in both methods.

Written Narratives

Five personal written narratives were used within this study to provide autobiographical accounts of individual's personal experiences of living with an eating disorder. The aim of using personal experiences through the stories of those who have lived with an eating disorder allows the research to address areas that are beyond the scope of professionals throughout the spectrum of participants included. Based on the reflective process of participants telling their story, these written narratives provide the unique insight through their own voice as a means to create truth through the participant's way of constructing meanings (Riessman, 1993).

As the subject matter of such narratives was potentially distressing and difficult to disclose, depending on experience, it was considered that a written approach was most suited to this study. According to Freeman (2007) a written approach is stronger where a topic is distressing and in turn creates a deeper understanding as the participant has time to reflect and develop with voice within their life story. While participants were provided with guidance and research questions, following the same framework of interviews and focus groups, this approach allowed for flexibility through the open nature in which the participants carried and created the direction of written piece (Riessman, 1993).

Procedure

Ethics

Institutional ethical approval was granted prior to the study commencing. Participants were provided with the context, and study aims were explained in a Participant Information Sheet

prior to data collection. Participants received information including an overview of the study and description of the research team, as well as ensuring they were offered the opportunity to any questions or seek clarification.

Interview Schedule

As the key aim of this phase of study was to explore areas based on individual and professional experience the interview schedule followed a staged approach. This approach allowed the interview process to begin with an open-ended approach and funnel down to focus on key issues to address more purposeful research aims and queries. By using three key areas to address in the interviews this semi structured framework provided flexibility and freedom for participants to digress and explore issues they felt important as opposed to sticking closely to set questions (Bryman, 2004). This was of key importance for the exploratory nature of this study.

Experience of eating disorders

This initial phase of the interview used an open ended approach with the aim to discuss the participant's experience of working with eating disorders as a means to provide insight into their role, how they work and the other roles that are included in, or needed for, provision of support of eating disorders.

Causal or risk factors, areas of need and their implications

To narrow down the focus of the interview, more refined questions regarding causation, risk factors and challenges were addressed as a means to explore the current gaps within services

as well as addressing areas and factors that need attention within research involving interventions for eating disorders. With the research aim to highlight the need to explore potential barriers to treatment engagement and effective early intervention /recognition the focus of this phase of questions was narrowed to investigate these areas using different expert and specialist experience to guide the hypothesis as to what barriers currently exist for those living with an eating disorder.

Emotional Intelligence

As the final stage of questioning focus was narrowed down to address the role of EI. Using a focused and closed ended questioning style, the intention of this section was to address the specific aims of the study by exploring if these variables are valid when working with eating disorders and the impact these may have in practice. This method of questioning was used as a means to control the discussion towards addressing the narrow research questions of the study (Bryman, 2012) and provide insights into the role of these variables within a real life setting through the experience of professionals. Probing allowed the interview to focus through the cascading of questions (Dickson & Hargie, 2006) towards the exploration of impact and practice perspectives.

Procedure for interviews and focus groups

Participants were then invited to take part in a semi-structured interview at a time and date that was convenient to them. Interviews and focus groups were scheduled to take one hour with an additional fifteen minutes allocated before and after the data collection to gather consent and allow participants to ask questions regarding the study and how the data would be used by

the research team. All interviews and focus groups were audio-recorded and fully transcribed for analysis. Participation was voluntary and participants were free to withdraw at any time during or after the data collection. One researcher conducted all of the interviews and focus groups to ensure consistency across data collection.

Written Narratives procedure

Participants met with the lead researcher who introduced the study and screen individuals to ensure they met the inclusion criteria and were safe to participate in the data collection. Once informed consent was given, participants were talked through the less structured process and were provided with a sheet of prompts set in the staged format of the interview schedule to guide participants through the nature of the content that the study was asking. These were highlighted as prompts and that participants were free to follow any narrative style that they felt best suited how they wished to tell their story. Narratives were returned in person in a word processed format that was either uploaded or typed from hand-written submissions by the lead researcher. During this meeting, the lead researcher who was able to debrief participants and ensure that participants were safe and not triggered by the content. All participants were provided with support information including a local service that had been informed about the study and were able to provide one-to-one support if any participants felt they needed to avail of this.

Data analysis

Thematic content analysis was used to analyse the qualitative data collected from this

phase of the study, following the thematic analysis phases outlined by Braun and Clarke (*2006; p35*). The aim of this data analysis was to develop an understanding of participant's experiences, barriers to help seeking and challenges faced through the emergence of key themes. Analysis used an inductive approach to the data coding in which themes were selected based on the data collected rather than to fit pre-existing codes (Fereday, & Muir-Cochrane, 2006). This method enabled deep exploration of the data due to its flexibility, which allowed themes to highlight the similarities and differences between differing participant groups' involved in the research.

To aid in potential errors, subjective interpretation and personal biases, members of the supervision team for the project acted as secondary raters to cross check emerging themes and elements that transpired from the data. Secondary raters independently coded and organised themes from 10% of transcripts at random as a method of cross-checking of the emerging codes to check validity and reliability. While inter-rater reliability is used within the qualitative analysis, it is a debated topic in which the positivist nature of validation has been critiqued. Literature argues that quantitative technique detracts from the nature of qualitative enquiry and the primary raters decision making, particularly in areas where it is necessary to have an in-depth knowledge and experience within the data (Morse, 1997). While the primary researchers' decision making was trusted throughout the process, this method of 'peer checking' was used as a means to provide rigour to the qualitative interpretation and coding, to reduce the impact of subjective bias (Armstrong, Gosling, Weinman, & Marteau, 1997).

Findings

Four key themes were extracted from the data where participants discussed emotional factors, related to EI, that were seen as salient to the disordered eating experience.

Emotional Regulation

A central theme emerging from the data was the role that coping had in relation to eating disorder onset. All eighteen participants with a personal experience (inclusive professionals with lived experience) spoke of the role of the eating disorder as a coping mechanism.

> *"An eating disorder is a way of coping with emotions. I'm recovered 20 years but I know for a fact that when I'm going through a bad time I could easily turn back to anorexia as a coping mechanism, because I know it works – I never would because I work hard at it and don't want to go back but it is always there as an option." (Personal Experience)*

When discussing the predisposing factors that underpin an eating disorder, participants reflected that there was an additional element that influenced their experiences. Irrespective of the predisposing factors or triggers, such as trauma, bereavement or bullying, participants described their disordered eating as a "*coping strategy"*. Four of the personal narratives discussed avoidance of emotional stimulation as their preferred way of coping. It is noteworthy that it was not always negative emotions that were considered overwhelming but also positive

emotions. One participant discussed that it didn't matter what the emotion was, positive or negative, sometimes it was just feeling it too strongly that would trigger a binge-purge cycle. As a result of the eating disorder, or disordered eating behaviours, were viewed by both those with lived experience and professionals as having a 'purpose'. Rather than being a number of behaviours related to the body, food or eating, participants recognised that the behaviours were seen to have a positive active role for the individual to cope with life events or triggers.

When discussing these issues with professionals 16 of the professionals considered this aspect of coping as highly important to the onset of an eating disorder as it was viewed that this method of coping was often exhibited that the disordered eating was a "*coping strategy against feeling feelings"*.

> *"There's a mash of emotions squashed in together… I found myself looking for a way to dull that, to numb that, to quash all of those emotions - to avoid feeling, to get to a place of not feeling. Something inside me worked out that food could bring about this numbing of feelings... it's all about numbing the feelings." (Professional & Lived Experience)*

This was a consistent theme with all five of the personal narratives discussing the usefulness of their eating disorder who opened up to say that the eating disorder essentially had a "*purpose*" at that time to cope with life events.

> *"When life becomes too hard, you can't cope for whatever reason, you're eating disorder is there and it takes away the pain and makes things manageable. I can't express in words what that feels like or what it means but*

I do know that for even a few moments the stress, the tears, the anger, the hatred – it all calms." (Personal Experience)

This was further reinforced by professional's descriptors which also recognised this aspect of the disorder as helpful "… *like a golden key",* "…*a safe place*" or "… *a comfort blanket".* By having a use, with many describing experiences with positive language, this was an explanation of why recovery and therapeutic change from the "*useful"* behaviours was difficult in practice. The illness is seen as a positive, something that works and something that effectively helps that person manage the unmanageable and intense emotions they are constantly faced with. Described by one professional, this is a difficult position for individuals in which professionals are asking them to give up this "… *wonderful thing that actually works".* The fact that these behaviours have a purpose, that seemingly works for a period of time, directly impacts of readiness to change, help seeking and treatment engagement as individuals are not ready to let that golden key go.

As the eating disorder provides a positive function it can be seen that this in itself may act as a considerable barrier to engaging with change and treatment. This was further reflected by another professional who noted that "… *for the sufferer, it's working for them at this stage, why would you give it up?"*

This draws to attention that it is vital that professionals understand such underpinning driving forces to the eating disorder as this can help pinpoint the motivation individuals have for engaging with such destructive behaviours and why change is difficult. From this perspective, it can be seen that if *this wonderful thing* does indeed help it may become the

default coping mechanism, therefore, may help understand areas of relapse for these individuals.

Emotional Expression

A key theme that was extracted from the data, particularly in relation to the barriers for individual's help-seeking and treatment engagement were the difficulties within this patient population have in regards to emotional expression and communication. For those with personal experiences three of the narratives expressly discussed this aspect of their experience. For all three, it was reported that often the disordered eating attitudes and behaviours became a means of communicating distress. One participant reflected this as a "*voicelessness*" that came from having no emotional language with the physical actions and manifestations related to disordered eating as a means to communicate this distress with the feelings that if it can't be said then if it can be seen it is communicated;

> *"I was invisible to the world; I was a ghost, voiceless. No matter how bad it got I couldn't get it out or show it... Whether it was visible ribs or scars on my skin, I just didn't know how else to express it and this was my way of showing that I was hurting..." (Personal Experience)*

This theme was particularly important for professionals, with twelve participants, particularly those professionals with counselling or healthcare backgrounds, recognising that individuals with eating disorders had difficulties communicating emotional distress, for example, many participants reporting finding difficulties saying how they were feeling or

finding an emotional language.

The skills and capabilities to communicate and interact with the social world have been attributed to the abilities to express and recognise emotional experiences and displays. This has been a key theme within the definition of EI (*Salovey & Mayer, 1990; Mayer & Salovey, 1997)* where impairments, or low levels of EI, may lead impact on individual's abilities to communicate and build relationships with others. When explored within the data these impairments were found to have a direct impact on individual's abilities to engage with help-seeking and treatment services.

"Many clients, they can't express the emotion and can't name it." (Professional)

In addition, difficulties in displaying their emotions physically was also noted in reference to an absence of emotional expression alongside the occurrence of inappropriate expressions of emotions. One professional noted how any emotion being felt for one young woman often led her to express anger and violent outbursts. For another professional, they noted that often they saw clients who failed to express any non-verbal cues when verbally expressing distress and upset.

This was discussed as particularly relevant when exploring the more extreme manifestations of disordered eating, i.e. Anorexia, in which the physical emaciation may be observed as an expression of the "*emotional starvation"* experienced or a physical call of distress. Patients were described by one participant as "… *starving, sometimes literally, to make an emotional connection"* suggesting that physical emaciation may be observed, as an expression of the emotional starvation experienced or a physical call of distress. It was

acknowledged that it was not that these individuals do not want to engage or get better but that they struggled in the room with those emotions and expressions.

As reflected by five of the professionals, the eating disorder becomes a means of communicating the unsaid, "… *the eating disorder becomes the physical manifestation of what's going on underneath like with self-harm"*. Overall this provides insight into the impact of such emotional deficits in emotional expression has on help-seeking processes and treatment engagement. Without a means of expressing and communicating the emotional difficulties that may have prompted the onset of such maladaptive coping strategies that are disordered eating behaviours it becomes challenging for these individuals to engage with early interventions and talking therapies. Such challenges create substantial barriers for these individuals in seeking support and engaging effectively with a therapeutic modality that required engagement with emotive topics that require active communication and explorative of emotional issues.

Emotional Awareness

Emotional awareness and knowledge of emotions were found to be damped or impaired during the eating disorder journey. The experiences of all five personal narratives and three of the professionals with personal experiences expressed that there was a feeling of disconnection or ambivalence to their own emotions. Difficulties were experienced by individuals in which they reported feeling lost, frustrated and confused by their emotional experiences and arousal. It was highlighted by one participant that often the physical arousal associated with emotional arousal was rarely connected.

> "*Sometimes I would think my body isn't my own, that my thoughts aren't my own because I was so disconnected from myself." (Personal Experience)*

For another participant, they described an experience of dissociation for their body leading to them not recognising panic attacks symptoms such as having a lump in the throat and the heighten emotions surrounding this experience. This led them to misunderstand and ignore what these physical and emotional reactions was telling them, and instead developed strategies where food was used as a maladaptive coping strategy to literally stuff the feelings back down.

This disconnectedness was recognised by professionals who recognised how this left individuals feeling *helpless* in the disordered eating cycle in which the lack of awareness created confusion resulting in feeling *muddled,* which intensifying feelings of self-hatred;

> *"He didn't understand what he was feeling. That's it. It's like he had a ball of rage and anger and emotion and he didn't know where to put it, he didn't know where to go with it and he would sometimes direct it at others but mostly at himself – that's why he would try and kill himself." (Professional)*

For others the poor emotional awareness resulting in fear and confusion caused by emotional arousal lead one participant explaining they would often "*… literally run away from the emotions"*. This was seen as related to the individual's awareness of emotions and their capabilities to appraise and connect with the emotional material. This inability to pick up emotions observed by practitioners within therapy was perceived by the participants to come

from this disconnectedness from the emotional self. Poor internal awareness of emotional states of arousal can be seen to lead to a lack of insight into their illness. This can be seen as a barrier to individuals engaging in help-seeking.

One participant acknowledged she had difficulties not only within awareness of her own emotional states but also those of others, this was principally in reference to empathy. This was seen to come from a lack of insight the emotional functioning of others and was recognised by eleven of the professionals, mostly counsellors and NHS therapists, to have an impact for building relationships and engaging in a therapeutic relationship. For one professional this was described through reflection that

> "*Often they are seeing me as difficult or critical or unhelpful or able to understand them." (Professional)*

Without this mutual understanding of emotions, engaging in a talking therapy and thus understanding the empathy of the therapist that is necessary to building trust and emotional connections would be lost where a mutual understanding of each other was not present. This concern was shared by five professionals who discussed the difficulty they had with building relationships with individuals, with one noting that this lack of connection did not diminish the want to recover or connect, instead it was central that therapists don't view this as ambivalence or non-compliance but rather it is a barrier that both client and professional must address and understand;

> "*It's not that they don't want to connect with (with you as a therapist), they just*

don't know how to do it correctly… they might not want to be in the room with us but there is a drive underneath to connect, they might not know what they want or what is wrong or what to do or how to talk about it but there is an intrinsic want to connect. They are still in that room with you week after week." (Professional)

Emotional connections

Within the data, it was discussed by a three of the personal narratives that, from their experiences that there were difficulties with creating emotional connections and engaging with relationships.

"*We hold ourselves back from that (creating relationships); won't allow ourselves." (Personal Experience)*

This was seen as creating barriers to help-seeking and early recognition as many individuals expressed that they always pushed people away.

"*I know I didn't think about anyone else, how this affected them. It's not that I didn't care; I just couldn't pick up how things must affect other people. I had no concept of other people's feelings… it is hard to connect with others when you can't connect with yourself." (Personal Experience)*

For one participant she felt that it was this lack of emotional connectedness and sustained relationships that lead to her to seek solace in her eating disorder, describing anorexia as her

only and *best friend.*

This theme of relationships was recognised as significant by professionals with fifteen practitioners noting that they felt it was the difficulties with relationships often stemmed from difficulties in emotionally connecting with others. This was seen as particularly difficult for individuals with eating disorders, seen both as a result of the cognitive and psychological changes that occurred as a result of the disordered behaviours ("… *he was a different person, that was not my son sitting in front of me anymore")* but more importantly prior to the onset of the illness.

This difficulty connecting emotionally was observed across therapeutic settings where it was suggested that this was the biggest barrier to engaging with treatment. It was considered that the most important aspect of treatment and talking therapies is the therapeutic relationship or alliance that is created between the client/ patient and therapist. Where there are difficulties connecting with others emotionally these relationships are stunted, making individuals seem resistant to treatment.

> "*It's not that they don't want to connect with (with you as a therapist), they just don't know how to do it correctly… they might not want to be in the room with us but there is a drive underneath to connect, they might not know what they want or what is wrong or what to do or how to talk about it but there is an intrinsic want to connect. They are still in that room with you week after week." (Professional)*

This highlights that ambivalence to treatment can be wrongly conceived by professionals as an individual not wanting to change. Instead, though understanding the emotional dysfunction experienced by individuals, this non-compliance may be more clearly understood as the individuals difficulty engaging with the therapeutic relationship and attempting to connect emotionally.

Discussion

The findings of this study adds to the body of evidence that already exists within the field to support the idea that poor EI and emotional dysfunction may play a larger role in the development and chronicity of eating disordered behaviour than is currently emphasized within the biologically based conceptualization that is often a focus within the literature. This paper adds to the understanding that low EI plays a role by exploring the elements of EI that are salient to the lived experience as well as understanding how facets of emotional dysfunction impact on treatment and interventions. By exemplifying these mechanisms it is hoped that intervention development can utilise these aspects of emotion and provide practitioners with the insights to collaboratively work with patients to address and develop EI skills collaboratively. These themes reflect similar findings by previous papers thus further highlighting the salience of paying attention to the emotional aspects of eating disorder onset and maintenance when approaching treatment and therapeutic interventions (Kyriacou, Easter, &,,Tchanturia, 2009; Federici, & Kaplan, 2008). These findings however add to this narrative providing insight that such emotional aspects are not unique to anorexia nervosa but appear to transcend across all diagnosis.

This is evidenced by the overarching use of descriptors in which disordered eating was not described as a means of weight control but in the context of managing emotions through eating, purging or binging as a way to effectively avoiding or manage distress. This suggests that where individuals do not have the EI skills to manage their own emotions they have found alternative means to do so, using food (or restricting eating) as a means to manage, avoid regulating their emotional difficulties. The paper, however, displays that such skill development requires such development to engage beyond coping and regulation skills but to also consider building an emotional language, awareness of emotional arousal and providing ways to express emotion effectively.

Furthermore, many participants discussed they felt unable to express their distress verbally or physically through emotional expression, therefore they used the body as a means of expressing and communicating such struggles. These results support the literature in which difficulties with emotional expression have been cited amongst eating disorder populations (Hambrook et al, 2011). Where individuals lack EI skills, it can be theorised that the body, the physical representation of the self, becomes a battleground for these unexpressed and unwanted emotions. As a result, it is vital that interventions consider these difficulties and provide active resources and skills to replace the maladaptive learned behaviours. As discussed in the findings, this dysfunction has a considerable impact on professional practice within talking therapies and can result in the assumption that patients are ambivalent rather than silenced by their emotional dysfunction.

Appraisal and understanding of emotions were also considered a central theme for eating disorder development. Individuals reported difficulty understanding their emotional states with references to a lack of connection between the self and their emotions. The desire for

individuals to dampen their emotional arousal links with literature regarding sensory and emotional sensitivity that has been reported in eating disordered individuals (Merwin, Mosovich, Wagner, Ritschel, Craighead, & Zucker, 2013; Zucker, Merwin, Bulik, Moskovich, Wildes, & Groh, 2013). Therapeutic processes and relationships may be impaired and difficult to manage therefore are important to consider when designing care plans and interventions.

The findings presented in this study are consistent with previous research which has investigated the relationship between eating disorders and EI, finding difficulties with the facets of EI within disordered eating populations (Gardner, Quinton & Qualter, 2014; Zysberg & Tell, 2013). As displayed by the findings presented in this paper emotional dysfunction across the facets of EI construct appears to have a role in the development and maintenance of an eating disorder. This qualitative exploration of disordered eating adds to the understanding as to why this relationship exists and how this impacts not only on individuals but also practitioners providing services.

Limitations

Several limitations of the study have been considered. It must be considered that the sample was recruited through avenues which indicate a bias towards those with therapeutic understanding and experience. This may influence the insight and awareness that individuals have into such issues as EI factors and therefore may ask the question if the language used is influenced by these therapeutic experience or is reflective of their personal insights of their experiences. Furthermore, as focus groups were conducted the influence of social desirability should also be considered when considering the insight shared by participants within this paper.

In addition, as the sample excluded participants who were currently engaging in

disordered eating behaviours the insight explored were retrospective and may therefore be influenced by therapeutic engagement. As a result, exploring these themes with individuals currently engaging with disordered eating may reflect different experiences and have a different perspective on the function of their eating disorder that may considerably influence the findings.

Conclusion

The study suggests that low or absent EI appears to be one important piece toward understanding the manifestation of eating disordered behaviour. According to the individuals interviewed within this study, a breakdown in coping may make an individual use maladaptive eating patterns as a way to cope with difficult life situations and experiences.

From this perspective, the issues that underpin, drive and maintain the eating disorder can be seen not to lie in a need to be thin or have the perfect body but in the need to navigate an emotional life. As a result, it can be viewed that the true driving force behind the behaviours may be evoked by the individual's emotional and interpersonal processing that, where dysfunctional, "*…will result in confusion in bodily and emotional awareness and permanent patterns of maladaptation"* resulting in disordered behaviours, such as eating disorders (Bruch, 1973, p.69). Based on these findings, it may be concluded that eating disorders are not purely about losing weight or wanting to be thin, but are driven by deeper psychopathology motivations that cannot be explained by such sociocultural models (Fairburn, 2008). This study provides evidence of the role that inabilities to cope with, regulate and express the internal emotional turmoil plays to motivate and maintain the eating disorder.

Caution must be considered when interpreting the relationship between emotional dysfunction and restrictive eating disorders to disentangle if emotional dampening exists as a result of engagement in avoidance strategies that are psychologically driven or if this effect is derived from a physiological reaction to starvation (Brockmeyer, Holtforth, Bents, Kammerer, Herzogm & Friederich, 2011). With evidence that weight restoration is associated with stronger engagement within treatment and therapeutic intervention (*Fairburn, 2008*), it is clear that emotional skill management must be viewed not in isolation but within the context of what is already known about eating disorder treatment.

Implications for Practice

The findings of this study have real implications to practice as they may alter how practitioners approach and view the core driver behind eating disorders. Based on the conclusions presented, it is necessary that therapeutic models and interventions address the role that emotion holds within the development and maintenance of disordered eating, and move beyond viewing these illnesses from a weight-based centre. Without addressing these core aspects, individuals will continue to navigate their emotional lives in maladaptive and dysfunctional ways. By taking this approach, a transdiagnostic intervention needs to be considered for treatment to be effective.

References

- Armstrong, D., Gosling, A., Weinman, J. & Marteau, T. (1997). The place of inter-reliability in qualitative research: an empirical study. *Sociology, 31 (3),* 597-606.

- Bar-On, R. (1997). *The Emotional Quotient Inventory* (*EQ-i*): *A test of emotional intelligence*. Toronto, Canada: Multi-Health Systems, Inc.
- Barth, D. (2001). Thinking, talking and feeling in psychotherapy. In J. Petrucelli & C. Stuart (Eds.), *Hungers and compulsions: The psychodynamic treatment of eating disorders & addictions* (pp. 41–52). Northvale, NJ: Jason Aronson Inc.
- Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3, 77-101.
- Brockmeyr, T., Holtforth, M.G., Bents, H., Kammerer, A., Herzog, W. & Friederich, H.C. (2012). Starvation and emotion regulation in anorexia nervosa. *Compr Psychiatry, 53 (5),* 496-501.
- Bromberg, P. M. (2008). Shrinking the tsunami: Affect regulation, dissociation, and the shadow of the flood. *Contemporary Psychoanalysis, 44*, 329–350.
- Bruch, H. (1973). *Eating Disorders: Obesity, AN and the Person Within.* Basic Books: New York.
- Bruch, H. (1988). Conversations with anorexics. New York: Basic Books.
- Bryman, A. (2004). *Social Research Methods (2nd Ed.).* Oxford: Oxford University Press.
- Bryman, A. (2012). *Social Research Methods (4th Ed.).* Oxford: Oxford University Press.
- Costarelli, V., Demerzi, M. & Stamou, D. (2009). Disordered eating attitudes in relation to body image and emotional intelligence in young women. Journal of Human Nutrition and Dietetics, 22, 239-245.
- Dickson, D. & Hargie, O. (2006). Questioning. In Hargie, O. (Ed.). *The Handbook of Communication Skills (3rd Ed.).* East Sussex: Routledge.
- Fairburn, C.G. (2008). Eating Disorders: The Transdiagnostic View and the Cognitive

Behavioural Theory. In Fairburn, C.G. (Ed), Cognitive Behavioural Therapy and Eating Disorders, New York: Guilford Press, 7-22.

- Federici, A., & Kaplan, A.S. (2008). The patient's account of relapse and recovery in anorexia nervosa: A qualitative study. European Eating Disorders Review, 16 1-10.
- Fereday, J. & Muir-Cochrane, E. (2006). Demonstrating Rigor Using Thematic Analysis: A Hybrid Approach of Inductive and Deductive Coding and Theme Development. International Journal of Qualitative Methods, 5 (1), 80-92.
- Filaire, E., Larue, J. & Rouveix, M. (2010). Eating Behaviours in Relation to Emotional Intelligence. International. Journal of Sports Medicine, 32, 309-615.
- Finch, H. & Lewis, J. (2003). Generalising from Qualitative Research. In Ritchie, J. & Lewis, J. (Eds.). *Qualitative Research Practice. A Guide for Social Science Students and Researchers*. Thousand Oaks, CA: Sage Publications, 170-198.
- Freeman, M. (2007). Autobiographical understanding and narrative inquiry. In Clandinin, D. J. (Ed.) *Handbook of narrative inquiry: Mapping a methodology*. Thousand Oaks, CA: Sage Publication, 120-145.
- Gardner, K. J., Quinton, S., & Qualter, P. (2014). The role of ability and trait emotional intelligence in bulimic symptoms. Eating Behaviors, 15(2), 237-240.
- Goddard, E., Carral-Fernández, L., Denneny, E., Campbell, I.C. & Treasure, J. (2014). Cognitive flexibility, central coherence and social emotional processing in males with an eating disorder. The World Journal of Biological Psychiatry, 15, 317-326.
- Hambrook, D., Brown, G. & Tchanturia, K. (2012). Emotional intelligence in anorexia nervosa: Is anxiety a missing piece of the puzzle? Psychiatry Research, 200, 12-19.
- Hambrook, D., Oldershaw, A., Rimes, K. A., Schmidt, U., Tchanturia, K., Treasure, J.,

Richards, S. & Chalder, T. (2011). Emotional expression, self-silencing, and distress tolerance in anorexia nervosa and chronic fatigue syndrome. British Journal of Clinical Psychology, 50 (3), pp. 310-325.

- Harrison, A., Sullivan, S., Tchanturia, K. & Treasure, J. (2010). Emotional Functioning in Eating Disorders: Attentional Bias, Emotion Recognition and Emotion Regulation. Psychological Medicine, 40 (11), 1887-1897.
- Heatherton, T.F. & Baumeister, R.F. (1991). Binge Eating as Escape From Self-Awareness. Psychological Bulletin, 110 (1), 86-108.
- Horney, K. (1952). The paucity of inner experiences. *American Journal of Psychoanalysis, 12,* 3-9.
- Kuriloff, E. (2004). When words fail: Psychosomatic illness and the talking cure. *Psychoanalytic Quarterly*, *73*, 1023–1040.
- Kyriacou, O., Easter, A., Tchanturia, K. (2009). Comparing views of patients, parents and clinicans on emotions in anorexia. J Health Psychology, 147(7) 843-854.
- Markey, M.A. & Vander Wal, J.S. (2007). The role of emotional intelligence and negative affect in bulimic symptomatology. Comparative Psychiatry, 48, 458 – 64.
- Mayer, J. D. & Salovey, P. (1997). What is emotional intelligence? In Salovey, P. & Sluyter, D. (Eds.). Emotional Development and Emotional Intelligence: Implications for Educators. New York: Basic Books, 3-31.
- McNamara, C., Chur-Hansen, A. & Hay, P.J. (2008). Emotional responses to food in adults with an eating disorder: A qualitative investigation. European Eating Disorders Review, 16, 115-123.
- Merwin, R.M., Moskovich, A.A., Wagner, H.R., Ritschel, L.A., Craighead, L.W. & Zucker,

N.L. (2013). Emotion regulation difficulties in anorexia nervosa: Relationship to self-perceived sensory sensitivity. Cognition & Emotion, 27 (3), 441-452.

- Morse, J.M. (1997). "Perfectly Healthy, but Dead": The Myth of Inter-Rater Reliability. *Qualitative Health Research, 7,* 445-447.
- Novack, D. (2016). To Know Another Inside and Out: Linking Psychic and Somatic Experience in Eating Disorders. *Journal of Infant, Child, and Adolescent Psychotherapy, 15(4),* 147-179.
- Oldershaw, A., DeJong, H., Hambrook, D., Broadbent, H., Tchanturia, K., Treasure, J. & Schmidt, U. (2012). Emotional processing following recovery from anorexia nervosa. European Eating Disorders Review, 20 (6), 502-509.
- Parker, J.D.A. (2000). Emotional Intelligence: Clinical and Therapeutic Implications. In Bar-On, R. & Parkers, J.D.A. (Eds). *The Handbook of Emotional Intelligence: Theory, Development, Assessment, and Application at Home, School, and in the Workplace,* San Francisco, CA: Jossey-Bass Inc., 490-504.
- Petrucelli J. (2016). Body-States, Body Image and Dissociation: When Not-Me is 'Not Body'. *Clinical Social Work Journal, 44 (1*), 18-26.
- Pettit, M.L., Jacobs, S.C., Page, K.S. & Porras, C.V. (2010). An assessment of Perceived Emotional Intelligence and Eating Attitudes among College Students. American Journal of Health Education, 41 (1), 46-52.
- Reid, M., Burr, J., Williams, S. & Hammersley, R. (2008). Eating disorders patients' views on their disorder and on an outpatient service: a qualitative study. Journal of Health Psychology, 13 (7), 956-960.
- Rice, T. (2016). On Targeting Emotion Regulation Deficits in Eating Disorders through

Defense Analysis. *Journal of Infant, Child, and Adolescent Psychotherapy, 15(4),* 319-336.

- Riessman, C.K. (1993). *Narrative Analysis. Qualitative Research Methods Series, No. 30.* Newbury Park, CA: Sage.
- Salovey, P. & Mayer, J.D. (1990). Emotional intelligence. Imagination, Cognition & Personality, 9 (3), 185-211.
- Schmidt, U. & Treasure, J. (2006). Anorexia Nervosa: Valued and Visible. A Cognitive-Interpersonal Maintenance Model and its Implications for Research and Practice. British Journal of Clinical Psychology, 45, 343-366.
- Serpell, L., Treasure, J., Teasdale, J., & Sullivan, V. (1999) Anorexia nervosa: friend or foe? International Journal of Eating Disorders, 25, 177-186.
- Snape, D. & Spencer, L. (2003). The Foundation of Qualitative Research. In: Ritchie, J. & Lewis, J. (Eds.). Qualitative Research Practice. A Guide for Social Science Students and Researchers, Thousand Oaks, CA: Sage Publications, 1-23.
- Swami, V., Begum, S. & Petrides, K. V. (2010). Associations between trait emotional intelligence, actual-ideal weight discrepancy, and positive body image. Personality and Individual Differences, 49, 485-489.
- Treasure, J. & Schmidt, U. (2013). The cognitive-interpersonal maintenance model of anorexia nervosa revised: A summary of the evidence for cognitive, socio-emotional and interpersonal predisposing and perpetuating factors. *Journal of Eating Disorders,* doi: 10.1186/2050-2974-1-13.
- Treasure, J., Corfield, F. & Cardi, V. (2012). A Three-phase Model of the Social Emotional Functioning in Eating Disorders. *European Eating Disorders Review, 20 (6),* 431-438.
- Treasure, J., Smith, G., & Crane, A. (2016).Skills-based learning for caring for a loved one

with an eating disorder: The new Maudsley method.(Second Edition) London: Routledge.

- Wade, T.D., Treasure, J. & Schmidt, U. (2011). A case series evaluation of the Maudsley Model for treatment of adults with anorexia nervosa. Eur Eat Disord Rev. 19 (5), 382-389.
- Wildes, J.E. & Marcus, M.D. (2011). Development of emotion acceptance behavior therapy for anorexia nervosa: A case series. International Journal of Eating Disorders, 44 (5), 421-427.
- Wildes, J.E., Ringham, R.M. & Marcus, M.D. (2010). Emotion avoidance in patients with anorexia nervosa: initial test of a functional model. International Journal of Eating Disorders, 43 (5), 398-404.
- Woolridge, T. (2016). Introduction. *Journal of Infant, Child, and Adolescent Psychotherapy, 15(4),* 255-258.
- Zaitsoff, S.L., Geller, J. & Srikameswaran, S. (2002). Silencing the self and suppressed anger: Relationship to eating disorder symptoms in adolescent females. European Eating Disorders Review, 10 (1), 51-60.
- Zerbe, K. (1995). *The body betrayed*. Carlbad, CA: Gurze Books.
- Zucker, N.L., Merwin, R.M., Bulik, C.M., Moskovich, A., Wilder, J.E. & Groh, J. (2013). Subjective experience of sensation in anorexia nervosa. Behaviour Research and Therapy, 51, 256-265.
- Zysberg, L. & Rubanov, A. (2010). Emotional Intelligence and Emotional Eating Patterns: A New Insight into the Antecedents of Eating Disorders? Journal of Nutritional Education and Behavior 42 (5), 345-348.
- Zysberg, L. & Tell, E. (2013). Emotional Intelligence, Perceived Control, and Eating Disorders. SAGE Open, 1-7.