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Battles over ‘unruly bodies’: Practitioners’ interpretations of eating disorders and the utility of psychiatric labelling

Authors

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Abstract

Our article offers a critical appraisal of psychiatric medical constructions of eating disorders (EDs) by highlighting the complexity of professional discourses, power plays, claims and counterclaims in ongoing struggles over ‘unruly bodies.’ Inductive thematic analysis of data from five studies was undertaken, covering thirty semi-structured interviews with UK healthcare professionals working in the ED field. Professionals engaged in various struggles over eating disorders, which were compounded by the labelling process itself. Although person-centredness was valued, encounters with ED patients were frequently framed as outstandingly problematic in terms of treatment resistance, with clients’ unruliness spurred on by ED competitiveness on social media and in-hospital rivalries. Paradoxically, the labelling of eating disorders created further expectations in terms of achieving specific weight levels and diagnostic labels, resulting in lay competition over who was sickest, that was mirrored by treatment priorities within an over-stretched public health system. Narratives also highlighted interesting tensions between professionals rationalising their work with patients and acknowledging themselves as potentially vulnerable to societal pressures promoting EDs. Arguably, while lay narratives around EDs continue to be framed by authorities as unruly behaviours in deviant individuals, the gap between officially sanctioned and illicit ED discourses will only grow.

Introduction

Eating disorders (EDs) are a group of mental health diagnoses that involve unusual food, weight, and shape control. These psychiatric diagnostic categories have power (Plummer 2020) in terms of ongoing struggles over ‘unruly bodies,’¹ especially with respect to disciplinary action (Foucault 1978). Here, the battles are largely over such issues as patient interpretations of their condition, the needs for professionalisation, treatment resistance and the funding of ED treatments (House et al. 2012; NICE 2021). The diagnostic authority (or ‘labelling’) of eating disorders – which traditionally resided within the psychiatric profession – is especially contested. EDs do not represent clearly formulated or universally accepted categories, instead groups claiming investment, experience, and expertise in disordered eating. Also present are evolving and shifting delineations of meaning and varying modes of treatment. While control over the defining and treatment of EDs is hotly debated, at the same time, professionals in the helping professions are increasingly expected to engage with psychiatric diagnoses (Cohen 2016; Harbusch 2022; Jutel 2014). Until recently, the competing demands on professionals working in the expanding ED field have been treated as a side issue. Our paper contributes to this cultural debate by offering a critical appraisal of how psychiatric medical constructions of EDs are employed in practice, highlighting the complexity of professional discourses, the power plays, and claims and counter claims within the field. A secondary analysis of data from five qualitative studies was undertaken, covering thirty semi-structured interviews with healthcare professionals (clinical and assistant psychologists, mental health nurses, psychotherapists, dieticians, general practitioners, psychiatrist, and allied health professionals) who work in the ED field. We focus on how, why, and when these professionals use or choose to contest psychiatric labelling in their

¹ We use this term to mean bodies that transgress the boundaries and norms constructed by society.

clinical practice, covering the everyday power struggles that take place in professional arenas with and over patients classed as having eating-related ‘unruly bodies.’

Eating disorder diagnosis and biopower

Labelling theory asserts that for a behaviour to be seen as a problem and to exist outside of the parameters of what is considered as normal or acceptable, it must be defined or labelled by those authorised (by themselves or others) to do so (Becker 1963). Traditionally, diagnostic authority (which we view as a form of effective labelling) of eating disorders (EDs) has resided with psychiatry. However, non-psychiatric professionals and lay groups also claim investments in, as well as knowledge and experiences, of eating disorders. Two volumes, the *Diagnostic and Statistical Manual for Mental Disorders (DSM)* (American Psychiatric Association 2013, 2022) and the *International Classification of Diseases (ICD)* (World Health Organization 2019) — which largely converge in their perspectives on eating disorders — are regarded as key diagnostic documents, influencing pharmaceutical use, psychiatric drug regulation agencies, health insurance, lawyers, policymakers, health practitioners and researchers throughout the western world (Cook and Décary 2020). Representing the efforts and concerns of numerous experts and groups appointed to the DSM revision process, and connected with pharmaceutical and judicial bodies, the DSM has been dubbed a veritable “industry of and for itself” (Bredstrom 2019: 347).

Epistemologically, the many revisions made to the DSM and ICD have called into question the nature of their diagnostic criteria, and their ability to accommodate the natural course of mental illnesses and their (lack of) cultural and ethnic sensitivity (Sweet and Decoteau 2018). In practice, many patients presenting with psychopathology relating to EDs still fail to satisfy the criteria for a discreet disorder and are therefore consigned to a non-

specific ED category such as OFSED.² Some scholars have also challenged the dominance of the traditional biomedical approaches to mental illness, arguing that mentally illnesses are socially constructed concepts (Horwitz 2012), and that reductionist labels fail to capture the social contingency which underlie labels in practice, nor to distinguish between medical issues and the ordinary troubles with which human service professionals contend (Weinberg 2013). Nevertheless, for those working in medical and human service professions, knowledge of psychiatric labels constitutes ‘cultural capital’ (Bourdieu 1986) in the sense that these classifications are endowed with institutional authority and bestow upon clinicians leverage over non-compliant patients (Jutel 2009), which in certain circumstances covers forced removal of patient autonomy imposed by legislation.³ As Zola (1972) noted psychiatric labels of health and illness, such labels ‘depoliticize’ issues, and effectively close off other types of intervention (Busfield 2017).

Psychiatric categories can be understood as instruments of ‘biopower’ in that they are part of the techniques modern nation states use to regulate subjects and control bodies in various ways (Foucault 1978). As a form of governmentality over the administration of bodies, biopower is intimately tied in with population regulation, economic power, knowledge production and ‘*alèthurgie*,’ a term Foucault used to include various truth manifestations that serve the authorities that legitimise them (1978: 20). Examples of the exercise of biopower in modern medicine include struggles over pandemic public health approaches, contests over mental health strategies as well as new struggles over abortion rights (Nash 2019), demonstrating that it is not possible for contemporary citizens to escape the net of these forces. It is through the constant refreshment of the empirical ‘evidence’ concerning EDs that professionals can maintain both patronage and clinical power over

² ‘Other Specified Feeding or Eating Disorders’ is non-specific category which includes ‘atypical anorexia.’

³ Compulsory in-patient treatment is enforceable in the UK under the Mental Health Act 2007 and the Children’s Act 1989 (see NICE 2021)

bodies (Foucault 1978). Once established as ‘facts,’ psychiatric discourses permeate through society and are taken up first by institutions and then individuals who are expected to engage in acts of self-care that is, techniques that ‘permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves’ (Foucault 1989: 18).

ED treatment issues

Since 1980's, the role of medical and other professionals in diagnosing and treating eating disorders has evolved considerably (Pirie 2016). Yet psychiatry continues to struggle to discipline ‘unruly’ bodies and minds, despite its considerable reach. EDs are marked by both internalised and manifest social deviance, including aberrant behaviours in response to socially available thinness norms, considerable treatment resistance (Mc Lorg and Taub 1986) and poor long-term outcomes (Nagl et al. 2016). Anorexia nervosa (AN)⁴ and bulimia nervosa (BN)⁵ — illnesses that can severely impair physical and mental health, and carry high rates of mortality — predominantly afflict younger persons (Arcelus et al. 2011; Nagl et al. 2016). EDs can be hard to detect, yet studies suggest that general practitioners (GPs) receive minimal training on EDs (BEAT 2022). Studies depict EDs as notoriously difficult to treat and suggest that care provider reactions to their ED patients span a whole range of emotions such as frustration, fear, helplessness and apathy (Geller et al. 2012; Halmi 2013). Even when on the brink of death patients with anorexia nervosa may continue to refuse treatment and clinicians may resort to legal sanctions that allow for highly coercive

⁴ Self-induced malnutrition with weight loss. Danger is seen when the body mass index (BMI) drops below 17.5kg/m.

⁵ Uncontrollable urge for frequent high-calorie food, alternating with fasting and vomiting, and use of purgatives.

treatments such as re-feeding. Tied in with this is the issue of professional reputation. Health professionals perform in teams which, as Goffman explains, ‘cooperate together in order to maintain a particular definition of the situation’ and seek to give the impression of a well-performing team (Goffman 1959: 96). For professionals operating in the public health care sector, problems are compounded by the underfunded, patchwork nature of ED services, at a time when cases are reported to be growing globally (Galmiche et al. 2019). The situation has worsened since the Covid pandemic, with more referrals and longer ED waiting lists (Ayton et al. 2022). Access to treatment is often delayed due to insufficient health care resources (Vollert et al. 2019), with wide discrepancies between available specialist out-patient services. One study found three times the number of ED cases identified and treated in areas with specialist services (House et al. 2012).

A more recent issue for practitioners is the emergence of counter-cultural communities on ‘pro-ana’ and ‘pro-mia’ internet forums.⁶ Operating outside of any ‘official’ clinical or medical model, these sites have been variously portrayed as posing a threat to public safety (Christodoulou 2012), as furthering medicalisation by welcoming members with a broad spectrum of disordered eating patterns (Fixsen, Cheshire and Berry 2020 ; Fixsen and Cheshire 2022), as platforms for social support (Tong et al. 2013) and as sanctuaries for the abused (Dias 2003). In the advent of an UK Online Safety Bill, arguments concerning whether (and which elements of) such sites fuel or mirror deviant eating trends require further scrutiny (UK Parliament 2022). A key aim of the current study is to explore how professionals frame lay views and narratives within a healthcare system which, superficially

⁶ A genre of websites disseminating information about eating disorders, primarily anorexia nervosa (pro-ana) and bulimia nervosa (pro-mia) and providing a forum (largely for women) to discuss and share ED information (Dias 2003: 34)

at least, has undergone a process of health democratisation meaning that the know-how of the ‘expert patient’ is increasingly acknowledged (Fox et al. 2004).

Methods

We conducted an interpretive secondary analysis of data from five qualitative studies which explored professional views of eating disorders. Studies one, two, four and five all aimed to investigate views and perceptions on the origins, diagnosis of – and stigma attached to – eating disorders among varying professionals working within the field of eating disorders. Study 2, conducted by the first author, was part of a wider study on eating disorders and explored the experiences and perceptions of professionals working experienced in treating clients with eating disorders, especially where extreme healthy eating attitudes and behaviours were a feature. All five studies were conducted with different cohorts and at different intervals between 2019-2022. The present study explored an overall research question which emerged from the data corpus. This is: how do those working with EDs interpret and use psychiatric labels? Here, we were particularly interested in how professionals engage in the struggle over unruly bodies and eating. We employ the term secondary analysis in the sense that, while the first researcher was involved in all the studies, the research topic itself was new and distinctive, with researchers new to the studies included in the current paper (Heaton 2008). To investigate our research question, we combined and analysed narrative data collected in the five separate qualitative research studies. The first author acted as primary investigator of one study and supervisor for the other studies. Researchers three, four and five used similar interview guides but gathered data separately.

Participants

Data from thirty interviews were analysed in this study: six from study 1, seven from study 2, four from study 3 and six from study 4, and seven from study 5. All participants were professionals who worked in a health-related occupation and had over 2 years' experience of treating people with eating disorders. Most participants worked in the public health and social care sector, but a few operated all or some of the time in the private health sector.

Information on the participants from each study, with pseudonyms, occupation, place of residence is on Table 1.

Table 1: Participants from the 5 studies

Cohort number	Participant Pseudonym	Area of occupation	County of residence	Public/private health sector
1	David	Psychiatrist	UK	Both
1	Catherine	Mental Health Advocate	UK	Public
1	Sophie	Psychotherapist/counsellor	UK	Both
1	Ellie	Medical Registrar	UK	Public
1	Lauren	Associate Specialist Doctor	UK	Public
1	Amy	Counsellor	UK	Private
2	Emma	Clinical Psychologist	UK	Both
2	Daniel	Clinical Psychologist	UK	Public
2	Kate	Psychotherapist	UK	Both
2	Jane	Psychotherapist	UK	Both
2	Anda	Psychotherapist	UK	Both
2	Carol	Registered Dietitian	UK	Private
2	Lucy	Registered Dietitian	UK	Private
3	Mary	Clinical psychologist	UK/US	Both
3	Liz	Clinical psychologist	UK	Private
3	Grace	Clinical psychologist	UK	Private
3	Miriam	Family therapist	UK	Public
4	Joan	Clinical psychologist	UK	Public
4	Tom	CHM social worker/CBT therapist	UK	Public
4	Tricia	MH support worker/ Assistant psychologist	UK	Public
4	Mandy	MH support worker/ Assistant psychologist	UK	Public
4	Karina	Clinical psychologist	UK	Public
4	Louis	CHM social worker	UK	Public
5	Tina	MH nurse (NHS)	UK	Public
5	Martha	Clinical psychologist	UK	Public

5	Senna	Assistant psychologist	UK	Public
5	Kaye	Clinical psychologist	UK	Public
5	Alex	Assistant psychologist	UK	Public
5	Elena	Assistant psychologist	UK	Public
5	Pauline	Assistant psychologist	UK	Public

Interview protocol and ethics

All participants were asked to comment on the context of their work, their approach to treating individuals with eating disorders, views concerning the development of eating disorders, and attitude toward, or interpretation of, psychiatric labelling for eating disorders. All interviews followed a semi-structured format and were between thirty and eighty minutes in length. All studies were conducted using scholarly and rigorous methods and were approved by the same ethics committee [anonymised for blinded review]. In all cases, participants received a participant information sheet and consent form, and were made aware of their right to withdraw from the interview at any given time, confidentiality, data protection and anonymity. All signed consent forms prior to interviews. Resources for participant support were included on a debrief form with an eating disorder helpline number. All interviews were transcribed verbatim.

Analysis

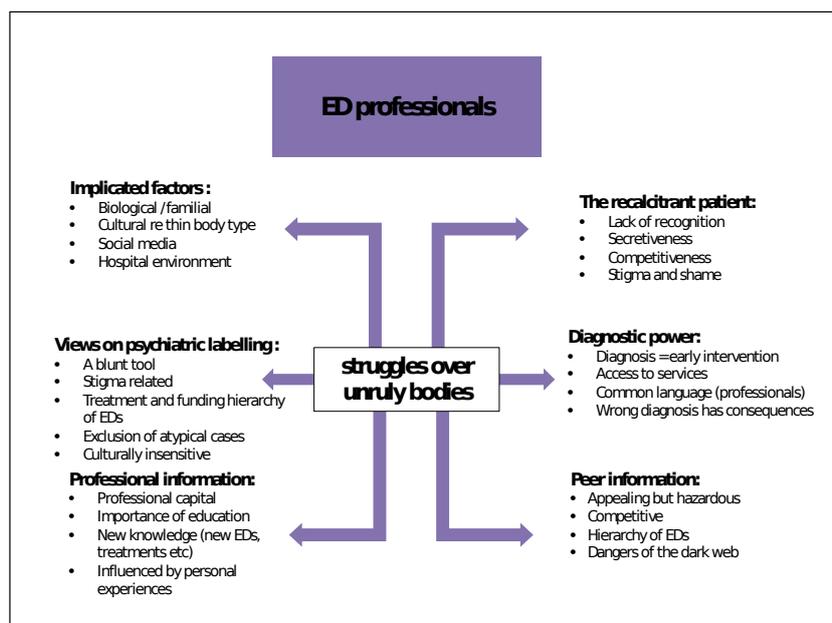
Inductive thematic analysis, focusing on patterns, themes and categories of analysis that emerged out of the data, was combined with a ‘constant comparison’ approach to achieve rigor (Dey and Teasdale 2013). By constant comparison, we refer to combining inductive category coding with simultaneous comparison of all social incidents applicable to each category, integrating categories and properties, and theory building. Coding was done at open level from direct examination of the data to label and define the raw data, then at axial level to connect open codes. Emerging concepts were then cross-referenced with existing theory

and literature (Strauss and Corbin 2015). In addition, we searched for metaphors, which, like Patton (1990), we regard as powerful ways of communicating findings that can convey a multitude of meanings in a single phrase.

The first author, who has experience in qualitative secondary analysis (Fixsen et al. 2015, Fixsen, Cheshire, and Berry 2020) first read and annotated each set of transcripts, to identify key words, concepts and metaphors used by participants. Emerging codes and themes were then discussed for their relevance with other authors who read and commented on drafts of the manuscript. A manual coding system was developed to apply across the four sets of interviews. Manual coding continued until we were confident that all the main themes had been captured. Significant quotes from the transcripts were then sorted electronically under themed headings (see Table 3: Broad themes of interviews). Coding and themes from the original studies were considered only after the secondary analysis had been completed, as a way of checking that no major codes or themes had been omitted in this study. To retain the conceptual and interpretative focus we have assumed a narrative approach in the writing of our findings, emphasizing the use of simile and metaphor. Finally, in considering our findings, we have drawn upon theory concerning interaction ritual (Goffman 1959, 1963), biopower (Foucault 1978, 1989) and narrative power (Plummer, 2020) to aid our interpretation of data. Figure 1 depicts the *themes and tensions identified in findings, and the struggles over unruly bodies*.

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Figure 1 : Themes and tensions identified in the findings



Findings

The recalcitrant patient

Participants in this study concurred with the dominant narrative concerning EDs; that they are a deeply concerning and expanding social problem (Hoek 2006; Nagl et al. 2016). As paediatric dietician Carol who had worked in a local hospital explained; “To be honest, every single case was an eating disorder on the ward, there was very little else I did.” A ‘fact’ about EDs established throughout the narratives concerned the widespread non-compliance among ED patients, typically characterised by poor engagement in the recovery process and deceitful and secretive behaviours. Participants highlighted the lack of recognition among many EDs patients that they were ill and in need to medical help; people with EDs just wanted it to be “them and the eating disorder and nobody else.” (Liz). Non-cooperation of patients was apparent in both in- an out-patient settings but was especially problematic where patients had been sectioned for other mental health problems; “They don't want to be there in the first place so having to sort of make them come round and work with you [is hard].” (Ellie). Mary, an experienced clinical psychologist, shared her own story about an episode of

anorexia many decades earlier, using it to inform her personal interpretation of what a typical young patient might be secretly thinking in a consultation:

They [the patient] create a sense of disgust when they think of people like me eating a normal diet “I don’t want to eat like you and you’re trying to make me eat like you.”

The anorexic would say “why should I be helped? I like being skinny I like being thin it makes me feel proud of myself makes me feel special and different.” *Mary, clinical psychologist*

In the above narrative, the assumed internalised beliefs held by the patient had spoiled their evaluation of the practitioner (i.e., herself). This kind of deeply held recalcitrance can be troubling for the professional attempting to restore order to unruly eating and bodies.

Reportedly, measures were taken by patients to falsify weight by drinking excessive amounts of water or putting on heavy clothes. Theories offered up for these kinds of aberrant behaviours could be biological at times, e.g., “brain starvation,” which assistant psychologist Martha explained in this way, as “the starvation effects cycle... their kind of mind isn’t obviously fed so much so anxiety, depression, all of those things become much more heightened.” Clinical psychologist Karina spoke about the struggles of getting patients to eat and helping them to build a healthy relationship with food. She described the use of tube feeding as “not something I like to see” especially for patients who had developed PTSD symptoms from intense feeds. Assistant psychologist Senna expressed sympathy for patients who found themselves diagnosed with a serious psychiatric disorder and forcibly hospitalised; “Most of the patients are yet to come to terms with their diagnosis or their disorder, so it can be quite difficult to begin treatment when they are refusing even acknowledging that they have a problem.” She could not blame them (as they were

vulnerable and scared), yet it was vexing to deal with patients who saw you as out to get them or as forcing them into recovery:

They pair you with everything bad happening to them and slowly they like withdraw speaking to you. Which as you can assume is the opposite of what we want so yeah, I think that's a big problem. *Elena, assistant psychologist*

Participants were in general agreement that stigma played a significant role in stopping people from seeking help and support for their mental health and eating issues. Most people were thought to misunderstand the nature of EDs; "They don't understand that it is a mental health disorder and something out of the persons control" (Kate). Some participants were from black or ethnic minority communities and spoke of how mental illness could seem like an especially "taboo topic" bringing shame to families. Ironically the stigmatisation process was reversed in the pro-ana community, where the message was to carry on the weight loss until you were "perfect."

Psychiatric labelling: "a blunt tool"

Although only those in more senior positions in our sample were engaged in diagnosing patients, all participants in our sample had some familiarity with the diagnostic categories of the DSM and/or ICD. In general, the idea of psychiatric labelling did not sit well with most participants' personal philosophies. Those who worked in hospital settings spoke about the use of labelling in the context of a medicalised, as opposed to wholistic approach. The ward environment was described as "just so medical"; patients were placed in hospitals with some label/diagnosis being applied: "It can sometimes completely throw them off and they don't know how to go about it from there." (Tina). Social worker Tom described labels as "a blunt

tool,” which helped to guide clinicians if they took other factors into account. Medical registrar Ellie spoke of how, in their obsession with labels, professionals could miss other aspects relating to the patient; “I think that clinicians can get very hung up on having the label and then I’m not sure how useful it is.” As part of her role as GP in the emergency department, Lauren routinely checked for psychiatric and physical symptoms prior to making a hospital admission. She did not really hold an opinion about the DSM/ICD because, “as opposed to a psychiatrist,” Lauren and her team were in the business of deciding whether a person was safe to go home or if they needed to be admitted.

I’ll often talk to them and go through the checklist et cetera. To see what their physical risk to health is like whether they were high risk, and then will attempt to refer them for admission. *Lauren, Associate specialist doctor.*

David – the only psychiatrist in our sample – spoke rather dismissively about the use of psychiatric labels in every day clinical practice. He thought medical practitioners should not become a “slave” to the diagnostic system; “I think it’s a bit like rearranging the chairs on the Titanic at times...making sure you get the diagnostic label right, but [you] forget to look at the patient.” Here narrative distance is inserted between these practitioners’ tacit acknowledgement of the leverage provided to medical staff over patients’ bodies through a checklist of symptoms based on DSM-5 categorisations, and the practices of care that patients need. The establishment of competent and moral professional selves is also a feature of these narratives.

Much has been written about the negative association between psychiatric labelling and stigma (e.g., Scheff 1966; Goffman 1963) and how this balances with the relief sometimes

felt by patients in receiving a diagnosis that can explain their experiences. Psychiatric labels were seen as helpful in getting people the support they needed but, “we have to remember that labels stick once you have a label.” (Louis). A flaw of ED categories was their failure to encompass the multiple dimensions of, and influences on, eating behaviours. Participants in this study cited a whole range of contemporary social factors (family dynamics, fashion, fitness, social media and more) they saw as promoting eating disorders in those who were vulnerable:

There is a link between [EDs and] things like [social media and family], it can also be your friends, like getting into negative friendships where the comparison comes in where you're just looking at each other and you are in this competition to be the best looking— it can be very detrimental to people who are prone to mental health disorders. *Tina, mental health nurse.*

The ED hierarchy

Participants spoke at length about a diagnostic treatment hierarchy for EDs and the problems that this created. Having a diagnosis such as anorexia nervosa helped to secure a hospital bed in a pressured system, whereas, according to NHS dietician Lucy, very few services were provided by the NHS for conditions such as binge eating, because “people aren’t actually dying” from those conditions. As a result, those with a less severe, non-specific or an ‘atypical’ diagnosis missed out on diagnostic validation and potential treatment:

I think that patients that don't just have anorexia... for example [those who] are deemed atypical anorexia... they don't feel as worthy of treatment because they maybe are not as underweight and things like that. *Ellie, medical registrar.*

Mental health nurse Tina thought that the differences created between people on paper were bound to reflect on them in real life. For example, if a patient needed to be below a certain BMI to be classed as anorexic, others who were above this weight but were still seriously ill would fail to see themselves as sufficiently sick to seek help. This bias toward the treatment of anorexia nervosa and emphasis on low BMI was spoken about over and over again by participants working in NHS settings e.g., “It’s the sad truth that if your BMI is not at a certain point, you will not be able to receive the treatment because you are essentially not sick enough which is appalling’ (Kaye); or “Anorexia is glorified but does that mean the people who suffer with other disorders just get overlooked? Like that completely invalidates their experience?” (Elena).

Rather than having different categories, Tina raised the idea of having one umbrella term; “To create a sense of community for people who are suffering.” The most important thing in her opinion was to build a strong support system in which more people were able to support one another towards recovery.

A badge of honour

Another issue linked with this diagnostic hierarchy is the strong competition it reportedly encouraged amongst young people with eating disorders (Mortimer 2019). Reaching the weight loss level that awarded one the ‘title’ of anorexia was, according to clinical psychologist Daniel, seen as a “badge of honour” by some patients, so people did not want to lose it. This was thought to encourage some patients to starve themselves to the point where they were entitled to the anorexia label, as in: “I have to do even better than that, which means I have to be sicker.” Jutel (2014) explains how a diagnosis for patients provides a way of understanding their world and an over-arching structure to their illness experience.

Psychiatrist David's story confirms this: nowadays patients often came to him with a label/term they had found on the Internet, and he would then have to contextualise their situation before referring them on to an ED specialist:

I talk to them about the difference in...bulimia as a symptom or anorexia as a symptom rather than just a disorder on its own account and therefore we will often talk about the bigger picture than just purely bulimia or anorexia. I'll refer them on to specialist eating service because it's a highly specialist treatment. *David, psychiatrist*

At the other end of the spectrum were those who, in a society that values thinness, were avoiding treatment due to 'fat-shaming.' As GP David expressed it: "If you had a pathological eating disorder and you're profoundly overweight, that is stigmatising." The above statement illustrates a society-wide contradiction- that judging other people according to weight and appearance is considered morally suspicious, while the list of eating behaviours officially classified as abnormal psychiatric conditions demanding medical treatment continues to expand (Pirie 2016).

Participants were aware of the under-funding of eating disorders in the NHS medical system, which meant that resources went on cases where health risks appeared greatest. However overlooking other cases such as bulimia, could lead to people's conditions worsening and "really getting out of control." In clinical psychologist Martha's opinion, the use of labels and different diagnoses of eating disorders created a problem long before even entering a hospital environment. People engaging in binge eating disorders or orthorexia ("which is made out to be the most ideal eating disorder, since you are still in a way eating healthy") generally flew under the radar of professional services.

Another problem consistently raised was that ED diagnosis failed to account for the seeing of patients between different mental health states and diagnoses. Clinical psychologist Emma considered it, “much more likely for them [patients] to move into different categories over the course of treatment.” Those working on the therapeutic side of ED treatment explained how most therapy is designed to; “capture a whole scope of things- lots of people with a bulimia nervosa presentation also have difficulties with depression, with self-esteem- our group [therapies] include all that.” (Sophie). Another problem concerned the underrepresentation of certain groups in treatments; people (including GPs) still thought of, “a young, private school white girl” in relation to EDs, meaning EDs in men and those from ethnic and non-privileged communities were often ignored or dismissed.

Practitioners also spoke about how the boundaries of EDs were permeable, including instances where patients could turn the power of labelling against professionals.

Psychotherapist Kate described two instances (one personal, one anecdotal) when a label had been used to challenge staff about their own weight or eating behaviours. Here we see an example of how those in apparently less powerful positions (i.e., as patient) can challenge institutionalised power:

Just before I got diagnosed with breast cancer, I lost ten pounds.... I had a patient [openly] criticise me that I was hiding, and I still had an eating disorder.... and I was devastated... I did get a bit angry with her...but yep, my colleague X who runs the therapy group with me, the patient accused her of having binge eating disorder.

Kate, psychotherapist

The power of labels

From the treatment pathway perspective, psychiatric diagnostic criteria give certain professionals (mostly psychiatrists and GPs) power, in that they are the gateway to access and get permission to treat patients, with, and sometimes without, patient consent (NICE 2021). For those involved in commissioning, ‘putting a name’ (Jutel 2014) to a condition was often the only way of securing resources from the public and private sector, as well as from charitable bodies. Having a psychiatric diagnosis could facilitate early intervention, a factor which professionals agreed was key to successful treatment. As therapist Tom explained; “a diagnosis given by a consultant psychiatrist is your key to the door for services.” Diagnostic terminology was like a common language, which could aid communication between practitioners and other professionals as well as limit understanding:

I’m not in a position to diagnose psychiatry, but if I have a referral saying its anorexia nervosa that is useful, that’s helpful [in] the initial stage of understanding. What is less helpful is that it leaves less room for other areas to be considered.

Sophie, counsellor

Debates concerning psychiatric labelling were far from straightforward and Catherine, who worked as a mental health advocate, could see both sides of the equation. On the one hand, different ED categorisations allowed for standardisation of procedures; “I think in these [hospital] settings, they do need a high intervention of care. And so, I think labelling then is necessary to follow...the NICE ⁷guidelines.” On the other hand, criteria could be subject to interpretation; participants pointed out the adverse consequences of a patient being wrongly

⁷ National Institute for Health and Care Excellence

diagnosed with an ED or having an ED diagnosis overturned by another consultant. Tricia, a support worker on a child/adolescent psychiatric ward, spoke of the negative side of enforced hospitalisation, including lack of self-governance and privacy, especially for underage patients:

Obviously when you're sectioned you have no control over any part of your life anymore and that must be so terrifying and scary...the kids in like the CAMHS⁸ ward, people were having to watch them go to the toilet and shower and things and it's like "god you literally have [no privacy]." *Tricia, assistant psychologist*

One of the features of professional life is the possession of 'strategic knowledge,' that is the special knowledge professionals can employ in the designing and planning of future actions (Goffman 1959:141). Among and between teams it was standard practice to share ideas about eating disorders, which led to a "real sense of teamwork." At the same time, team members hold different ranks and, while this can strengthen cohesion, it can also create divisions in the organisation (Goffman 1959:88) whereby, "certain disciplinary voices were silenced." Coupled with this was a strong sense of ED services themselves being stigmatised and seen as the "poor relations" of the public health service, such that, despite having the highest mortality rates of psychiatric services, the ED profession struggled for recognition and support. This situation placed those lower down the 'ranks' on the defensive:

I think eating disorders is such as postcode lottery... it is kind of forgotten if I'm honest in some areas. Certainly, it's been the history of Manchester, where the

⁸ Children and Adolescent Mental Health Services (NHS)

population we serve...the funding has just not been there. But we work quite hard to secure and talk about different funding avenues. *Daniel, clinical psychologist.*

Despite their reservations about labelling, acquiring a professional knowledge about ED presentations and corresponding treatments was regarded as of high importance by participants. Early intervention for EDs is considered crucial, yet GPs—who are usually the first point of contact for patients—still lack training in and knowledge of EDs, meaning many sufferers are not referred to support services (BEAT 2022). Education around working with ED patients should, in psychiatrist David’s opinion, begin ‘at the top’ by teaching medical students about patient-centred communication; “We turn out extremely clever doctors and clinicians [but] at the end of the day you've got to listen to what patients have to say.” As GP Lauren explained; “Nurses need to have some education [of EDs] as well because they don't want to just be planted [in an ED role].” Continuing professional development (CPD) was emphasised as a means of developing new knowledge; for instance, at lectures and conventions professionals could learn about new or emerging EDs and how to identify them, as explained here by Tom:

They were talking about the developments of sort of new diagnostic criteria, so things like orthorexia were mentioned and that kind of fits some of the presentations that we are seeing... They talked about ‘reverse anorexia’ for males with that kind of emphasis on muscularity and leanness, bigorexia— you see a lot of it...

Tom, mental health social worker

In Goffman’s time, opening UP about one’s personal health experiences might have led to loss of face, whereas in contemporary times it has become a kind of social duty for

professionals to share their “dark secrets” (Goffman 1959). Counsellor Amy expressed surprise at the number of therapists who had spoken up to having “personal problems with weight and body shape.” Having a child who had developed anorexia nervosa encouraged GP Lauren to be actively looking out for ED symptoms; “I guess my interactions with them [patients] tend to be slightly different than other emergency doctors because I kind of understand this [EDs] better.”

Lay information as hazardous

In stark contrast to the sharing of professional knowledge, information shared on non-medical platforms and among peers was seen as hazardous and as contributing to ED development. Social validation effects of social media and internet forums were recognised (Tong et al., 2013) but were seen as adding to the dangerous nature of most peer-to-peer discourse; “There’s a very competitive and nasty kind of sort of world out there on social media in terms of eating disorders.” (Karina). Mandy described Pro-Ana and Pro-Mia websites as “really horrifying;” they should, she thought, be met with the same sense of outrage as sites which feature self-harm and suicidal behaviours. An assistant psychologist pointed out the “cruel” nature of pro-eating disorder Instagram pages or websites which target vulnerable young adults and make them believe that they are not good enough and should be engaging in these behaviours for them to feel better about themselves. Covert patient platforms were regarded as particularly dangerous. Tom spoke about an ED “dark web” which preyed on the lonely and vulnerable in a similar way to paedophiles and extremists:

I mean we know...there is almost a kind of dark web of patients who admitted to eating disorders sharing information across all the specialist eating disorder units in

the UK we saw a similar thing happen with paedophile rings when I worked in social services.

Along with social media, the hospital environment itself was identified as problematic (by those who worked there) as a site for incubating rivalry between those attempting to be the thinnest or sickest. Assistant psychologist Senna thought that these and other under-recognised aspects of in-patient care needed to be factored in as important barriers to recovery programmes:

These young people will not want to engage in recovery if they think they are exactly achieving the desired body weight or appearance. So, I think change in [ideas about] recovery and how many people access recovery is not just going to come from small things; there are massive barriers that need to be addressed.

Discussion

We set out to explore the assorted professional constructions and negotiations of EDs, where there is no single locus of power (i.e., psychiatry) in defining mental illness, such that navigating diagnostic labels and the deeper existential concerns that patients present is necessarily complex. In this respect, our study adds to the literature exploring the expansion and use of psychiatric categories beyond that which counts as strictly psychiatry, including among patients and what Cohen (2015) has called “psy-professional” actors, such as psychologists, therapists, counsellors, mental health nurses, and mental health social workers. Our findings suggest that professionals engage in various struggles over eating disorders, which are frequently compounded by the labelling process itself. Although person-centredness was valued by our professional participants, as in other studies, eating disorder

patients were framed as outstandingly problematic in terms of treatment resistance. Patient bodies and minds were seen as at risk of becoming unruly, spurred on by opaque and dangerous ideas from online activities, but also among peer group rivalries in medical and other settings. Paradoxically, the labelling of eating disorders and their medicalisation was thought to create further expectations on individuals in terms of achieving specific weight levels and diagnostic labels, which can promote competition over who was sickest, which mirrored hierarchical treatment waiting lists within the public health system (Vollert et al. 2019). This raises interesting questions about the meaning and value of labels to lay people, which our larger programme of research seeks to answer. Participant narratives also point to interesting tensions between professionals speaking as professionals and rationalising their work with patients, and professionals acknowledging themselves as members of society and as potentially vulnerable to pressures they see as promoting ED development, including social media. Younger professionals (largely assistant psychologists) in the study appeared to feel these tensions most keenly, possibly because they were more able to identify with the issues facing their young patients, such as the strong influence of social media on body image and eating behaviours. There were limitations to this study. The sample was non-homogenous, with no real distinction made between categories of professionals. The different studies posed certain interview questions in different ways and different orders. Caution needs to be exercised in generalising beyond this sample and any conclusions we make in our article are therefore tentative. Nonetheless, our study contributes to understanding the convoluted constructions of EDs, wherein power resides in different places, and the negotiating of diagnostic labels and deeper contextual understandings is a complex process, fraught with struggles and contradictions.

Aside from the psychological pressures and mental health issues facing those with eating disorders, including self-stigma and social stigma, the underfunding of publicly

provided eating disorder services was identified as the main reason for excluding certain groups from face-to-face treatment, and prioritising cases characterised by excessive weight loss. Together these issues create problems for those working at the grassroots level of eating disorder treatment whose job it is to overcome patient resistance to recovery and contest peer group narratives. These arguments illustrate the complexity of the power struggles that take place between professionals and patients classed as having ‘unruly bodies.’

Labels as cultural capital

Goffman provides an interesting summation of the language of psychiatry: it is, he writes, “a rather special and hardening language” (1967: 138). Schooled in the softer language of humanism or complexity of life, many of our professionals were inclined to distance themselves from the value of harder categories and uses of the DSM or ICD. A whole range of ontological, ethical, and psychological reasons were given as to why labelling was a “blunt tool” which on its own was neither person-centred nor sufficiently inclusive of the patients they see. Yet pragmatism dictates that professionals are unlikely to distance themselves entirely from the language of psychiatry, as they recognise its value as professional and cultural capital. According to Bourdieu (1986), cultural capital exists in three forms: in the embodied state (mind and body); in the objectified state as cultural goods (e.g., tools and instruments) and in the institutionalised state, as educational qualifications, or professional skills. For those in ED professions, psychiatric labelling fits all three forms of cultural capital. Having the authority to deliver a psychiatric diagnosis to a patient, “establishes and supports the professional’s claim to honour, income and power” (Freidson 1970: 244), which for professionals includes the power to make decisions about other peoples’ bodies. Additionally, most evidence-based treatments in mental health care are designed according to the diagnosis given to the patient (Vanheule 2012), while funding bodies, such as charities and other

industries— upon which many health organisations rely – often only cater for specific named conditions.

In parallel to their use in professional arenas, consumers have been increasingly claiming ED labels as part of their own cultural capital. As emphasised by participants, a diagnosis of a validated ED enables access to services. ED labels can be highly stigmatising, but equally can confer status and membership to peer certain circles (Jutel 2009; Koski 2013). Professionals in our study spoke of how their predominantly young patients were well-versed in the language of psychiatry, prioritised certain ED labels, and used them among peers and sometimes with health workers for their own ends, including in power plays. So how do ED professionals manage this ‘tug-of-war’ over labels, especially given that they are now the common vocabulary of subversive ED platforms? It becomes incumbent on professionals to draw on other forms of professional knowledge to display their superior understanding of ‘troubled’ eating as complex and labels as an imperfect instrument to be used in their therapeutic armoury. In this way professionals can “transcend a priori reductionisms” (Weinberg 2021), without denying the validity of psychiatric labelling in specific contexts. An important part of how professionals conceive their role is therefore educating students, patients, and families about the complexity of EDs and the perils out there, such as on the ‘dark net’ and pro-Ana chat forums.

Plummer (2020) identifies four sources of dialogic narrative power; institutional (which includes narratives focusing on social institutions), communication (largely relating to the media), positional (relating to inequalities, identities, and social movements) and everyday narratives (stories of everyday life and encounters). Some forms of narrative empower people, others degrade, control, and dominate. While the committees writing the DSM/ICD pay scant attention to everyday and positional narratives when compiling psychiatric categories, these labels will remain insufficient to account for patient individuality

and diverse experiences. Although psychiatric discourses have emerged from institutional power (Plummer 2020), they filter down to the public arena via traditional media, social media, and everyday stories. This ‘medicalisation from below’ appears to some to threaten the authority of psychiatry (Charland 2013) However, it does not mean that the narrative power of medical professionals and that of lay people is equitable. Indeed, in the case of EDs the authoritativeness of these discourses are very much weighed in favour of psychiatry. Backed up by the DSM, eating disorders can result in compulsory detention and complete removal of physical autonomy (NICE 2021). Conversely, coming from what Plummer calls a ‘subordinated standpoint,’ authors of counter-cultural stories are frequently excluded from decision-making discussions, ostensibly for their own safety and welfare.

Biopower and unruly bodies

Fundamental to Foucault’s ideas on governmentality is the control of ‘unruly bodies’ through various technologies of power, from coercion to self-discipline (Foucault 1978). Biopolitics, a form of biopower, consists of all kinds of techniques used to intervene and maintain the production of ‘docile bodies’ (Foucault 1978, 1989). These interventions— from mental health legislation to clinical treatment pathways— require the collection of vast amounts of data about populations to substantiate them scientifically, legally, and financially. Here we can include the volumes of statistical information collected on EDs (Galmiche et al. 2019). It is through this constant refreshment of the empirical ‘evidence’ concerning EDs that professionals can maintain both patronage and clinical power over bodies (Foucault 1978).

Foucault was also interested in new forms of power and stressed the value in attending to claims for attention of ‘local, discontinuous, disqualified, illegitimate knowledges,’ which challenge ‘centralising powers...linked to the institution and functioning of an organised scientific discourse’ (Foucault 1980: 83). In later years, Foucault’s interest

turned to the study of self-care technologies, that is techniques that human beings use ostensibly to understand themselves, but which act as a form of governance by directing people to perform operations on their ‘bodies and souls, thoughts, conduct, and way of being, so as to transform themselves,’ thereby fitting well with the individualistic ethos of neoliberal society (Foucault 1989). What Foucault could not have predicted (the global online market being at that time the stuff of dreams) is the explosion of ideas around diet and body aesthetics emerging as self-care discourses. Nor could Foucault have predicted the role that social media would play in encouraging a culture which thrives on self-revelation (or *alèthurgie*) outside of mainstream medical jurisdiction. Ours is not the first society to declare the unfit and overweight body as deviant and the thin, fit body as virtuous, but through globalisation these discourses wield unprecedented social and economic power. Their ubiquity leaves many of us (including professionals as private individuals) questioning our own efforts and place on the scale of normality.

How best then to present these different players in the larger ED narrative? If, as Foucault states, to challenge power requires, ‘detaching the power of truth from the forms of hegemony, social, economic, and cultural, within which it operates at the present time’ (Foucault, in Rabinow 1991:75), do we still represent those with EDs as victims of cultural constructions of ideal bodies, those on social media platforms as social pariahs, and professionals as moral saviours? It should be noted that authorities have long raised suspicions about lay people (such as religious sects) meeting together covertly, such that their beliefs and behaviours may be regarded as dangerous and even immoral (BBC 2022). An interesting question for those in authority is whether the ‘hard-liners’ in these groups can be separated from those who might be more willing to embark on a recovery programme. The vilifying of pro-ED site attenders is particularly sensitive because it is difficult to identify who they are and what their varying vulnerabilities might be. Arguably, while lay narratives

around mental health and eating disorders continue to be framed by psychiatrists and doctors as unruly behaviours in deviant individuals, the gap between officially sanctioned and illicit ED discourses will widen. Without a clear understanding of the motives underlying eating disorders as social rather than just individual phenomena then the medical model will continue to struggle to assist many individuals presenting with eating disorders.

Conclusion

Social research into areas traditionally defined by bio-psychiatry has drawn attention to the fact that the instruments (symbolic language, techniques) of psychiatry have increased their value as resources to both commercial and lay sectors. The therapeutic market depends on the continued supply of people with new troubles; hence it would be naïve to ignore the powerful interests underpinning the expansion of psychiatric categories. If psychiatry is a “chimera,” (Harbusch 2022: 8), it is an illusion which has infiltrated the everyday practices of non-psychiatric actors with great success. Our findings illustrate how professionals are briefed to work with ‘objectified’ categories to control practices, and finally people, who fall outside of definitions of normal. Messages concerning EDs are reinforced by ‘science’ and reinvigorated via the government and media. In real life terms, problems defined as EDs are not sets of stable diagnoses but are on-going human processes requiring an array of approaches if their treatment is to be successful (Weinberg 2016). We query whether successful treatment of eating disorders requires the construction of new psychiatric categories, where many such disorders represent a tension between individual biographical-familial constellations on the one hand, and on norm-driven attempts at improved symptom lists linked to the formation of professional identities, on the other. This is not to shed doubt on the fact that aberrant and restricted eating behaviours, along with other personal and psychological problems, do not constitute serious conditions requiring treatment. Rather we

suggest that to categorise them further psychiatrically created on-going problems. As formulated in this and other studies, these behaviours appear to be primarily generated and reinforced by social as well as medical expectations. Whatever the difficulties of doing so, it remains incumbent on the critical researcher to search out the distinction between what society assumes to be a problem because it has been defined by others as such, and the nature of a social ill as evidenced from narrative and historical perspectives.

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