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Should I Tell? Online Accounts of Disclosing an Eating Disorder

by

Emily P. Williams

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILLMENT OF THE REQUIRMENT FOR THE

DEGREE OF MASTER OF SCIENCE

GRADUATE PROGRAM IN EDUCATIONAL PSYCHOLOGY

CALGARY, ALBERTA

SEPTEMBER, 2016

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Abstract

Disclosing one's mental illness can be difficult for individuals, particularly those with eating disorders. Individuals struggling with eating disorders fear that judgment, misunderstanding, and stigmatization may result from disclosing the illness with others. Due to the vulnerability of disclosing face-to-face, online communities created for those with eating disorders have become increasingly popular. These online eating disorder websites (i.e., Grace on the Moon, Daily Strength, My Pro Ana) are considered safe places for individuals to communicate with anonymity. This research project utilized a situational analysis to deeply examine the online accounts of individuals who disclosed or spoke about disclosing their eating disorders. Situational analysis, a postmodern method utilizing mapping techniques to illustrate the complexity of the situation, was used to highlight heterogeneities rather than commonalities from the data. Findings demonstrated (a) fear associated with disclosing one's eating disorder, (b) tensions and differences of recipient's responses to disclosures, (c) conflicting discourses about eating disorders, and (d) various reasons or desires one has that prompt the disclosure of an eating disorder. Findings from this project are relevant to clinicians working with individuals with eating disorders, and shed light on the hesitation to disclose a potentially shameful experience. Further, findings have important implications for the profession of counselling psychology, and suggest the need for family based therapy and offering increased psychological services over the Internet for those with eating disorders.

Key words: eating disorders, situational analysis, disclosure, eating disorder websites

Dedication

To the one whose name is tattooed on my wrist. You have inspired me to do this work. I am so proud of everything you have accomplished, all the places you have fearlessly travelled and explored, and all of the wild child adventures you have made for yourself. You inspire me.

Acknowledgments

Finishing a Master's thesis, what an accomplishment! There are so many people I would like to acknowledge; without my wonderful supports I am not sure where I would be. First, thank you to my best friends back home for your good humour and words of encouragement. You all have an incredible ability of re-grounding me. Another big thanks goes out to my Master's cohort. I have appreciated all of the kind words you have offered, you all have bright futures ahead. To Alana, I cannot thank you enough for your advice, countless edits, and kind heart. I have no doubt you will be a life long mentor. Further, thank you to my supervisor, Dr. Shelly Russell-Mayhew for your support and wisdom, I feel privileged to be your student. Next, to my partner Dan, I am so grateful for everything you have done these last two years. You are amazing, I cannot thank you enough. Finally, I would like to say THANK YOU to my incredibly supportive family. Mum and Faj, thank you for your guidance, mouth watering steak to refuel me during my breaks back home, and teaching me that I can do anything if I work hard enough.

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Chapter I: Introduction

Eating disorders are complex, multidimensional conditions (de Amusquibar, 2000; Striegel-Moore & Cachelin, 2001) that are commonly misunderstood (Ebneter & Latner, 2013; Huon, Brown, & Morris, 1988; Roehrig & McLean, 2010). Eating disorders have been frequently cited as the most fatal mental illness (Arcelus, Mitchell, Wales, & Nielsen, 2011; Keel et al., 2003) and have attracted considerable attention from the media (Saguy & Gruys, 2010), contributing to the stigmatization of the associated behaviours and cognitions. Due in part to the stigma of having an eating disorder, much like other mental illnesses, individuals often try to conceal their eating disorder from others (Cachelin, Rebeck, Veisel, & Striegel-Moore, 2001; Hinshaw & Stier, 2008). The stigma and fear of judgement from others contributes to individuals' anxieties regarding disclosing their experiences and even seeking and continuing treatment (El Badri & Mellsop, 2007; Sirey et al., 2001).

I have chosen to study the disclosure experiences of individuals with eating disorders because research and personal experience suggests that the choice to share intimate details about something that is shamed or misunderstood is difficult (Becker, Grinspoon, Kilbanski, & Herzog, 1999). According to one researcher, one of the many barriers to receiving help with an eating disorder is disclosing that one has a problem (Gilbert et al., 2012). More attention from researchers is required to better understand the experience of disclosure. Individuals must decide whether to share that they have an eating disorder with others who may not understand and react in uninformed and/or insensitive ways. According to literature on disclosing mental illness, research has demonstrated that the anticipation of the recipient's reaction to disclosure is sometimes enough to deter an individual from initiating a disclosure (Rüsch, Brohan, Gabbidon, Thornicroft, & Clement, 2014). Disclosure involves opening oneself up to others, possibly

feeling vulnerable, and being subject to others' reactions, which can be positive, negative, or mixed (Tilton-Weaver, Marshall, & Darling, 2014).

Relatively few studies have been conducted that focus on the disclosure of an eating disorder (Becker, Thomas, Franko, & Herzogm, 2005; Gilbert et al., 2012; Le Grange, Tibbs, & Selibowitz, 1995). Instead, researchers have directed efforts towards the study of prevention, epidemiology, management, and treatment of eating disorders. While these areas of focus are important, the topic of disclosing an eating disorder is imperative to study because the act of communicating that one has an eating disorder is considered the gateway for many individuals to receive professional help (Gilbert et al., 2012). Literature demonstrates that one of the best predictors of recovery from an eating disorder is early diagnosis and referral (Loeb & Le Grange, 2009). The longer an individual experiences symptoms of an eating disorder the lower the probability for a full recovery (Loeb & Le Grange, 2009). For many individuals with eating disorders, they cannot begin recovery without inviting somebody else into their experience. The act of disclosure gives many the opportunity to feel connected to others and allows for hope for recovery (Rüsch et al., 2014). Researchers suggest that variability in experiences and outcomes of disclosing an eating disorder exists including: disclosing to receive help, disclosing because it was the last resort, disclosing because one feels hopeless, not disclosing but being found out unintentionally (Gilbert et al., 2012; Kyriacou, Easter, & Tchanturia, 2009; Mulveen & Hepworth, 2006).

Positionality[1] and Entrance into the Research

[1] Positionality: Refers to the social structure under which a position or point of view/perspective on an issue arises, the factors that maintain that position, and the particular implications of that position with reference to the forces that preserve it (Glesne, 2011).

I entered into this research largely because of an experience that occurred during the first year of my undergraduate degree. My dad called me soon after I had moved away from home to ask if I knew that my sister had an eating disorder. I remember answering his call and was overcome with disbelief and the feeling of complete helplessness. My sister's eating disorder came as a complete surprise to my parents and myself. The thoughts and feelings that the discovery of her eating disorder evoked in me in the days and weeks afterward inspired me to learn more about eating disorders and also the process of coming out to others or being caught unintentionally.

From this personal experience I entered this research project with (a) a stronger alignment to the medical model of eating disorders than the feminist perspective that asserts that these behaviours exist along a continuum (Brown & Jasper, 1993), (b) the belief that eating disorders are severe mental illnesses that require more research and funding, and (c) the notion that eating disorders are highly stigmatized and many people do not understand. In addition to this personal experience, I also worked as a research assistant on a project that highlighted the disclosure experience of individuals who engaged in non-suicidal self-injury. The disclosure process, regardless of the topic, has been and continues to be an area of fascination for me.

Throughout the duration of working on this project I have realized that my initial preference towards the medical model of conceptualizing eating disorders has shifted slightly to incorporate some tenants of the feminist perspective. Namely that associated behaviours and cognitions exist along a spectrum and that many females engage in disordered eating; however, I still continue to classify some individuals as more ill than others, which is consistent with the medical conceptualization of those with eating disorders. I have also noticed that my language towards this experience supports the notion of pathologizing eating disorders. If it had not been

for my journey into this research project I probably would not have become so aware of my positionality. Incorporating reflexivity[2] into my practice has aided in making the research and reflection process more transparent. With this in mind, I acknowledge that eating disorders and disordered eating behaviours exist along a spectrum, namely that core symptoms of eating disorders and disordered eating vary in intensity along a continuum (Brown & Jasper, 1993; Striegel-Moore & Cachelin, 2001). Nevertheless, my views are more closely aligned to the medical model's understanding of the condition. For the remainder of this thesis I have chosen to use the term 'eating disorder' when referring to clinical representations of the illness and 'disordered eating' when I discuss a broad range of sub threshold behaviours.

Introduction to Method

The method I have chosen for this project emphasizes the significance of being transparent regarding researcher positionality. The method also considers reflexivity to be of utmost importance during analytic inquiry. Situational analysis (Clarke, 2005) is a postmodern, qualitative method that stresses the complexity of the focus of the project, also referred to as the 'situation of inquiry.' This method contests approaches that reduce the situation down to the most salient or endorsed positions, and instead opens up the situation of inquiry to include marginalized perspectives and groups that are traditionally silenced by more positivist research (Clarke, 2005). Situational analysis seeks to represent the complexity of a topic of focus by highlighting tensions, differences, elements, relationships, and silences that make up the situation of inquiry.

[2] Reflexivity: Refers to the concept of reflective writing and personal reflection in qualitative research, where the researcher reflects on their own experiences and perspectives that they bring towards the topic of inquiry. Qualitative researchers propose that reflexivity is so integral to the research process that it should be included as a source of data (Carr, 2006).

Operational Definitions

Several terms must be defined before the major elements and positions that make up this situation can be highlighted:

- Eating disorders: Diagnosable psychological conditions that are marked by abnormal or disturbed eating patterns (e.g., consuming great amounts of food, self-induced vomiting, severely restrictive calorie intake) and intense distress regarding the size and shape of the body (American Psychiatric Association [APA], 2013). For the duration of this project, the term 'eating disorders' will include anorexia nervosa, bulimia nervosa, binge eating disorder, and other specified feeding or eating disorder, all of which are explained in chapter two.
- Disordered eating: A broad range of eating behaviours that are considered abnormal (i.e., binge eating, skipping meals, dieting, calorie counting, and fasting). Many disordered eating behaviours are shared with behaviours characterized in classifications of eating disorders; however, the main distinction of disordered eating is that the behaviours are not severe or frequent enough to be considered an eating disorder (Hesse-Biber, Leavy, Quinn, & Zoino, 2006).
- Negative body image/Body image issues: Feeling like one's body does not equate to societal, family, or media standards and feeling that one's body is inadequate when compared to others' bodies. Individuals who experience body image issues typically feel uncomfortable, self-conscious, and ashamed of their bodies (Tylka & Wood-Barcalow, 2015).
- Mental health: An individual's psychological and emotional well-being. An individual who is considered mentally healthy has the ability to cope effectively with typical life

stressors, is capable of working productively, and is able to give back to the community (World Health Organization, 2014). Mental health is measured by positive wellness indicators rather than only the absence of illness (World Health Organization, 2014).

- Mental illness: A broad range of conditions that impact one's mood, cognitions, and behaviours. Mental illnesses are recognized, medically diagnosable syndromes that result from biological, environmental, developmental, or psychosocial factors (Canadian Mental Health Association, 2016). An individual with mental illness experiences significant distress and impaired functioning as a result of altered thinking, feeling, behaving, and relationally connecting with others (Public Health Agency of Canada, 2015).

Throughout this thesis I use the terms that are defined above. Though some terms may sound similar it is important to note the distinctions between definitions.

Introducing the Situation of Inquiry

There are numerous elements and several points of tension that make up this situation of inquiry: *What are the tensions, differences, and positions in online narratives about eating disorder disclosures?* First, and perhaps most evident from the literature is the contradicting positions individuals with eating disorders have about the desire to disclose their eating disorder. Two distinct movements have been formed through the collective action and commitment by individuals with and recovered from eating disorders, as well as families, friends, and professionals who work with people with eating disorders. One movement is a group referred to as 'pro-recovery.' This group conceptualizes eating disorders as illnesses that require professional help and connection with others, and encourage individuals to disclose and seek treatment (Brotsky & Giles, 2007; Wilson, Peebles, Hardy, & Litt, 2006). The conflicting

movement is commonly referred to as ‘pro-eating disorder,’ ‘pro-anorexia,’ and/or ‘pro-bulimia.’ This group conceptualizes eating disorders as a lifestyle choice where an individual has a right to control energy input and output (Meenan, 2003). Given how popular these movements are on social media (Haas, Irr, & Jennings, & Wagner, 2010), it is likely that individuals contemplating or who have disclosed would have considered their position in accordance with these movements and associated beliefs.

Second, the medicalization of eating disorders is considered a key point of tension in this situation. Some discourses, individuals, and groups suggest that an eating disorder is an illness that must be treated. This position is supported through the literature calling attention to the fatality of the condition (i.e., Arcelus, et al., 2011; Keel et al., 2003), inpatient and outpatient treatment facilities specializing in eating disorder care (i.e., de Amusquibar, 2000; Luzier, Sondike, Linton, & Mizes, 2012), and the severe language individuals use when referring to their experience with an eating disorder (e.g., ‘battle,’ ‘fight,’ eating disorder is a ‘monster’; Malson et al., 2011) to name a few. Others believe eating disorders and disordered eating occur along a spectrum and are in part a result of societal pressures to be thin and the socialization of females (Saraceni & Russell-Mayhew, 2007). This belief is mainly held by feminist scholars who contest the notion that some individuals who engage in severe behaviours are pathologized while others considered to be engaging in similar but less severe behaviours are not ‘disordered’ but perhaps even encouraged or praised (Brown & Jasper, 1993).

Third, literature suggests that the decision to disclose one’s mental illness is comprised of multiple factors (Dew et al., 2007; Greene, Derlega, & Mathews, 2006; Williams, 2008), and is a unique experience for each individual. The topic of disclosure, one’s decision making process to disclose, and how one experiences disclosure are central elements in this situation of inquiry.

Research proposes numerous models that explain why, and for what purposes, individuals disclose personal information to others. However, all theories provide a different rational for disclosure which contributes to tensions and different understandings of this experience. Literature suggests that disclosing mental illness to others can invite positive effects (Chen, Lai, & Yang, 2013) such as increased social support and validation, as well as negative effects such as discrimination and feelings of isolation (Rüsch et al., 2014). Finally, some researchers have criticized theories of disclosure, stating that such models oversimplify a complex experience (Goodstein & Reinecker, 1974; Lynch & Gussel, 1996).

Development and Purpose of Study

Disclosing an eating disorder has been demonstrated to be difficult for the individual disclosing, and literature shows individuals with eating disorders are often hesitant to come forward to others (Becker et al., 1999). Thus, learning more about the disclosure experience is imperative to better serve individuals with eating disorders, by way of evidence-informed resources about disclosure and to better advise mental health professionals responding to and discussing the disclosure experience. Given the sensitive nature of disclosing an eating disorder, it is impractical to study the actual interaction in real time and would be next to impossible to schedule observation of such an interaction. Since there were no disclosures to witness first hand, I decided to explore the content of online eating disorder websites instead. While exploring publically available sites, I quickly learned that these online communities were viewed as safe places by those communicating on their message boards and chat rooms (Brotsky & Giles, 2007). Additionally, individuals communicating online are found to not filter themselves in the same way as they might in person, and typically share more personal detail in a shorter period of time when communicating online rather than face-to-face (Attrill & Jalil, 2011).

After realizing the promising potential of using online data to better understand the disclosure experience, I began to familiarize myself with prior research utilizing online sources and research methods. Numerous researchers have collected information from online communities when studying specific mental illnesses (Lewis & Seko, 2015; Nimrod, 2013; Walters, Adams, Broer, & Bal, 2015) and have cited the advantages and practicalities of online data collection and the observation of online communities. Such advantages include (a) access to individuals living in diverse geographic areas, (b) the capitalization of time and resources typically required for face-to-face research interactions, (c) participants feeling less intimidated to share sensitive information or personal accounts while communicating online, and (d) aids with simple handling of data since personal narratives have already been typed out (Mann & Stewart, 2000).

Acknowledging and Welcoming Complexity

It was important to me that I find a research method and a way of conceptualizing the situation of inquiry that would represent and acknowledge complexity without reducing information in order to make it seem neat and easy to understand. With this in mind, I searched for a method that would welcome nuances and help me to illustrate the situation as a complicated experience, just as how real life actually is: messy and complex. Before collecting data, I already had hypothesized that my findings would represent varied experiences and I wanted to utilize a method that did not silence some voices and perspectives in favor of others that are traditionally privileged. The voices of individuals with eating disorders are already difficult to hear among the perspectives of health professionals and the mandates of treatment programs, therefore I sought to find a method that would enable all voices to be acknowledged.

Rationale of Study

After confirming with the university ethics board that I could use publically available information, I began to think about the objective of my study and why it was important. The purpose of my study is to better understand the online narratives of individuals who disclosed and/or who were considering disclosing an eating disorder. More specifically, I was interested in exploring the tensions, differences, and positions in online narratives about eating disorder disclosures. The intended outcome of this study is (a) to gain a better understanding, through online accounts, of what it is like for individuals to disclose their eating disorder, and (b) to further explore the complexities and nuances that make up this situation. The proposed research sheds light on the complexity of the situation when individuals disclose, and elucidates societal discourses about those with eating disorders. This study adds to the limited understanding of disclosing an eating disorder and it could be used to inform resources for disclosing an eating disorder.

Summary

Thus far, I have provided a background and rationale for the current study. I have cited researchers who highlight the importance of early detection and treatment of eating disorders and have emphasized the hesitation individuals typically experience towards disclosure. Key definitions have been offered and researcher positionality and entrance into the situation of inquiry has been provided. In chapter 2, a review of the eating disorder, disclosure, and social media literature will be offered. Next, chapter 3 provides an overarching understanding of the postmodern method of situational analysis. Further, I briefly offer how and why situational analysis was only recently developed. In chapter 4, I present the findings that resulted from situational analysis mapping, and in the final chapter, I conclude with a discussion of the

findings, the strengths and limitations of the project, and implications for counselling psychology.

Chapter 2: Literature Review

In this chapter, I illustrate the theoretical and practical literature relevant to individuals who disclose their eating disorders to others in person, then communicate these experiences online. First, I will define disclosure and present factors that influence self-disclosure of a mental illness. Several theories of disclosure will be described, followed by their utility and relevance to this study. Eating disorders will also be defined according to two theoretical perspectives, representing a tension in the field. Further, research that offers insight into the disclosure of an eating disorder and disordered eating will be presented. The contributions and growth of social media and the role eating disorder websites play in the maintenance and recovery of an eating disorder will be described. Finally, gaps in the current literature and the resultant study will conclude the chapter.

Disclosure

Disclosure is the strategic act of letting one's self be known to others (Corrigan & Rao, 2012). Since many physical and mental illnesses are concealable, individuals face the dilemma of choosing to disclose their illness to others or keep it private. Individuals want to be seen for attributes other than their illness and often keep their illness hidden due to fear of others' judgements after learning of their secret (Charmaz, 1991). People with chronic illness, for example, report fear of negative reactions in others' statements, tone of voice, and gestures in response to disclosure (Charmaz, 1991).

Disclosure can lead to positive experiences including increased social support, closeness to others, greater cognitive resolution, and decreased feelings of isolation (Chen, Lai, & Yang, 2013). It may also result in negative outcomes including rejection, increased trauma-related symptoms, and physical harm (Rüsch et al., 2014). Alternatively, non-disclosure may protect

individuals from stigmatization and discrimination, yet research has indicated that those who keep experiences of mental illness secret have poor long term outcomes and face constant stress due to the fear of others finding out (Brohan et al., 2012; Brohan et al., 2014).

Research indicates that disclosing any type of stigmatized physical or mental illness presents challenges (e.g., stigma associated with mental illness, cancer associated with sexually transmitted diseases or smoking, and Human Immunodeficiency Virus [HIV]; Chang & Bazarova, 2016; Greene, 2000). This may be especially true for mental illness considering the lack of reciprocity involved during the disclosure of a mental illness (Robinson, 2012). Typically, when information is shared between a dyad, the recipient of the disclosure offers information in return about him or herself. However, when the disclosure is about mental illness, according to Robinson (2012) it would not be likely that the recipient of the disclosure also suffers from mental illness. This lack of reciprocity adds to the vulnerability experienced by the individual disclosing (Robinson, 2012). Thus, disclosure of mental illness is a particularly difficult decision an individual must carefully consider, as both positive and negative consequences may result.

Factors Influencing Disclosure of Mental Illness

Sharing stigmatized or misunderstood behaviors is often not well received by family, friends, and employers, and can result in hurt feelings, discouragement, and lowered self-esteem (Dew et al., 2007; Wahl, 1999). Disclosing a mental illness has primarily been studied in a help-seeking context (Dew et al., 2007; Nguyen & Anderson, 2005) and as related to workplace functioning (Jones, 2011; Peterson, Currey, & Collings, 2011).

In a meta-analysis of time trends and stigma, survey results from the years 1990 and 2000 were compared. Accordingly, the public's emotional reactions towards individuals with

mental illness remained largely unchanged in many studies (Angermeyer & Matschinger, 2004). The meta-analysis revealed the public viewed individuals with mental illness as unpredictable and dangerous, and the tendency to distance oneself from another with a mental illness was observed (Angermeyer & Dietrich, 2006). Among the negative attributions, people had more negative attitudes towards others with schizophrenia or alcoholism, than for people with depression or anxiety disorders. Rejection was the most pronounced towards individuals with schizophrenia and who abused drugs (Angermeyer & Dietrich, 2006). Researchers demonstrated that respondents with high educational levels were less likely to believe that a person with mental illness was responsible for their illness, and were more willing to recommend therapeutic interventions for treatment (Angermeyer & Dietrich, 2006).

Researchers were also interested in determining if attitudes and stigma towards individuals with mental illness had changed over time (Angermeyer & Dietrich, 2006). Within many of the 110 articles that met inclusion criteria for this study, researchers demonstrated that the majority of lay people, meaning a person without professional knowledge on a particular topic, were not accurately able to correctly recognize a mental illness. Lay people recognized symptoms of schizophrenia as an expression of mental illness more often than symptoms of depression or alcoholism (Angermeyer & Dietrich, 2006). All studies using vignettes to assess for people's beliefs about the cause of mental illness demonstrated that individuals believed psychosocial stressors predominated biological factors (Angermeyer & Dietrich, 2006). In the case of depression, psychosocial interventions were favoured over medication, while in the case of schizophrenia, medications were more commonly considered more appropriate rather than therapeutic intervention. In the absence of treatment, an individual living with a mental illness was viewed with pessimism and people were of the belief that deterioration would be inevitable

(Angermeyer & Dietrich, 2006). The deterioration of an individual with schizophrenia was believed to be more severe than someone with depression, however, if individuals with schizophrenia and depression were to receive treatment lay people believed the prognosis would be favorable (Angermeyer & Dietrich, 2006).

Stigma. Stigma associated with mental illness is the primary reason individuals do not seek help (Potash, 2007). Stigma is a complex experience that includes prior incidents of discrimination and anticipation of future discrimination by others (Lasalvia et al., 2013; Thornicroft, Brohan, Rose, Sartorius, & Leese, 2009). Stigma may impact at the individual, familial, community, or societal level (Chen et al., 2013). El Badri and Mellsop's (2007) research on stigma and mental illness concluded that 73% of their participants reported not disclosing their mental illness to others due to stigma.

"Public stigma" refers to the negative attitudes held by members of the public towards an undervalued characteristic (Corrigan & Rao, 2012, p. 464). Though partly an external experience, stigma also impacts internal cognitive and emotional processing with regards to self-concept and capacity to cope (Rüsch et al., 2014). When individuals with mental illness believe stigma-related harm exceeds their ability or resources to cope, this is referred to as "stigma stress" (Rüsch et al., 2014, p. 1157). "Self stigma" occurs when individuals internalize societal stereotypes, which can lead to demoralization and low self-esteem (Corrigan & Watson, 2002, p. 36).

Researchers interested in the stigma associated with various mental illnesses conducted interviews with 46 participants, 41 of whom expressed experiencing anxiety when deciding how to manage information about their illness with others (Dinos, Stevens, Serfaty, Weich, & King,

2004). Many people with misunderstood diagnoses were not truthful to others about their exact condition out of fear of negative reactions and embarrassment (Dinos et al., 2004).

Discrimination. Discrimination is related to stigma and refers to "actual experiences of being treated differently due to some defining attribute" (Lakeman et al., 2012, p. 271). Past experiences of discrimination and anticipation of future discrimination are critical occurrences that present as obstacles to disclosing a mental illness. Clement and colleagues (2012) suggested some individuals are hesitant to seek mental health care due to the anticipated discrimination they will face if employers become aware of a diagnosis. Further, individuals may reject employment opportunities due to fear of future prejudice or discrimination if employed (Yoshii, 2014). Anticipated discrimination was also a factor related to why some parents refused to disclose their mental illness to their children (Falkov, 2004).

In a qualitative study examining the discrimination experienced by 30 individuals living with mental illness in Ireland, individuals reported losing friends and romantic relationships as a result of being identified as having a mental illness (Lakeman et al., 2012). Disclosure of a mental illness frequently altered the dynamics of a relationship and the extra sensitivity displayed by recipients of disclosure was often unwelcomed by the disclosee, leading those who disclosed to feel like they were walking on eggshells (Lakeman et al., 2012). Some individuals also reported that after a mental illness was revealed to their family, their opinions were dismissed or no longer valued (Lakeman et al., 2012). Similarly, research conducted in England found that, after disclosing a mental illness, individuals reported overt discrimination, such as colleagues talking down to them and using phrases typically used for communication with children (e.g., "don't be cheeky;" Dinos et al., 2004, p. 178).

Employment obstacles. Studies of disclosing a mental illness in the workplace illustrate the fear employees face when debating whether to share a part of their mental health identity with others. A systematic review highlighted the role stigma and discrimination play as barriers preventing individuals with mental illness from attaining and maintaining employment (Brohan et al., 2012). Job applicants reporting mental illness were commonly judged as less employable compared to individuals with physical disabilities or an applicant without a disability (Brohan et al., 2012).

Krupa, Kirsh, Cockburn, and Gewurtz (2009) proposed four assumptions underlying employer's stigmatizing attitudes towards individuals with mental illness in the workplace: (a) individuals with mental illness lack the competence to perform well at work, (b) individuals with mental illness are dangerous and unpredictable, (c) it is not healthy for someone with a mental illness to be working, and (d) hiring an individual with a mental illness is an act of charity and is not something employers need to engage in. Krupa et al., (2009) published these assumptions after conducting a constructivist grounded theory study with 19 interviews from key informants. Negative beliefs and assumptions held by employers contribute to the difficult dilemma of disclosing a mental illness to others, as related to employment.

Cultural and family considerations. Culture influences the decision making process for self-disclosure (Croucher, Faulkner, Oommen, & Long, 2010). Research demonstrated that females are more likely to disclose, especially when the recipient is female (Croucher et al., 2010). Further, North Americans are far more open to self-disclosure compared to some other cultures such as Chinese, African American, and Chinese Malaysians for example (Croucher et al., 2010). The added difficulties in self-disclosures for individuals from each of these cultures will be described next.

Chen and colleagues' (2013) study of disclosing a mental illness in Chinese immigrant communities illustrated the complex nature of disclosure from a collectivist perspective. Social networks in Chinese cultures are significant, expanding further than immediate family and friends to include relationships with others through blood, marriage, and generations of connection. Chinese individuals value maintaining their family's reputation and status (Chen et al., 2013), and these concepts can be dismantled when there is a disclosure of a mental illness. In Chinese cultures mental illnesses are generally thought to be unpredictable and dangerous (Tsang, Tam, Chan, & Cheung, 2003), and are associated with incompetence and the idea that one with a mental illness has not reached their full potential of adulthood (Yang & Kleinman, 2008). In some Chinese cultures mental illness is believed to be pay back for individual or family wrong doings in a prior life (Chen et al., 2013). Thus, knowledge of a psychological illness severely impacts the reputation of the individual, family, and extended social network. Accordingly, disclosing a mental illness in a Chinese culture remains a delicate issue.

Disclosing a mental illness within the African American culture also remains taboo (Williams, 2008). African Americans who prioritize the Christian church, for example, have reported that admitting to mental illness would contradict the belief that Christians should be cheerful and thankful for their relative fortunate circumstances. Depression is considered a part of life, and those who cannot deal with the low mood on their own are considered weak (Williams, 2008). Research reported that early in life, Black Americans are taught to maintain their families' privacy, leading to reluctance to share personal or family concerns regarding mental illness (Whaley, 2001). This reluctance to share is also consistent with a study conducted on Chinese family caregivers in Malaysia (Chang & Horrocks, 2006).

Chinese family caregivers of relatives with persistent and severe mental illnesses living in Malaysia were interviewed to better understand their lived experiences. Chang and Horrocks (2006) carried out 19 interviews with individuals who cared for relatives with mental illness, and respondents indicated that stigma from others was strong and pervasive. Caregivers with relatives who were unable to take care of their personal hygiene, had to be supervised while taking medications, and who were not able to assist with household work because of their mental illness reported feeling dissatisfied, angry, overworked, and stressed (Chang & Horrocks, 2006). Caregivers also reported feeling burnt out, ashamed, and stigmatized, adding that they often had to endure bizarre, manipulative, and abusive behaviours (Chang & Horrocks, 2006). Individuals interviewed in this study were hesitant to share mental illness related information about their relatives with others outside of the family and reported it was difficult and futile to talk about outside of the family (Chang & Horrocks, 2006). The cultures discussed above are exemplars of cultural influences on disclosure but it should be noted that each culture has barriers and nuances that may impact the decision to disclose a mental illness and each culture has variance within it.

Relationship with target of disclosure. The audience of disclosure is frequently cited as an important factor in the decision to disclose or not. McKillop and Kelly (1996) suggested disclosures should only be shared with recipients believed to be trustworthy, supportive, non-judgmental, and who are capable of offering new insights. Certain variables of a relationship may dictate when a disclosure is likely to occur. Disclosure typically does not happen too early into a relationship as it may alienate the target, and normally does not happen after a substantial period of time has passed as this could be interpreted as a betrayal (Greene et al., 2006). Disclosure is less likely to occur when the target of disclosure is perceived as unreceptive and when the reaction to disclosure is anticipated as negative (Greene et al., 2006). Consequently,

having a positive relationship with someone believed to be trustworthy and supportive are factors strongly predicting disclosure (Greene et al., 2006).

Levels of Disclosure

Corrigan and Rao (2012) described five levels of disclosure. These levels of disclosure are social avoidance, secrecy, selective disclosure, indiscriminate disclosure, and broadcasting. Social avoidance describes individuals who avoid situations and interactions with others in order to evade the potential for others finding out about their mental illness (Corrigan & Rao, 2012). Individuals in this level of disclosure especially avoid social interaction when symptoms of their mental illness are prevalent or intense. The second level of disclosure is secrecy. In this type of disclosure, individuals interact with others but choose to keep their mental illness hidden. During the secrecy level, information including hospitalizations, appointments, and medications are kept private. Selective disclosure is the third type of disclosure, and is characterized by selecting with whom and what is disclosed (Corrigan & Rao, 2012). Most individuals living with mental illness practice selective disclosure, as this type of sharing protects individuals from others who would respond negatively to a disclosure of mental illness (Corrigan & Lundin, 2001). The fourth kind of disclosure is indiscriminate disclosure. Individuals who choose indiscriminate disclosure are open to everyone about their mental illness. These individuals typically are not concerned with who will find out about their illness and are usually able to cope with other's negative reactions to disclosure (Corrigan, 2006). Individuals selectively disclose more often to friends, family, and doctors, and choose to keep knowledge of mental illness away from employers and police (Pandya, Bresee, Duckworth, Gay, & Fitzpatrick, 2011). Finally, the last level is broadcasting. Broadcasting allows individuals to educate others about mental illness and fosters a sense of personal power over mental illness and stigma (Corrigan & Rao, 2012).

Summary

The decision to disclose requires careful consideration by the person with a mental illness. Individuals who disclose can be met with helpful and supportive reactions from others and report greater social support and closeness to others as a result (Chen et al., 2013). Other individuals who disclose face devastating reactions, stigma, and discrimination from family members, friends, and employers (Dew et al., 2007; Wahl, 1999). Further, cultural identity may play a key role when deciding whether to disclose a mental illness. Some cultures may be more accepting of someone with a mental illness and individuals from diverse cultural backgrounds must be careful to weigh the positive and negative effects when deciding to disclose. Choosing how much to share with others also appears to be a strategy for dealing with the reactions to disclosure and identity management when living with a mental illness.

Theories of Disclosure

Individuals are motivated to disclose personal information to others for multiple reasons. One may believe disclosure will lead to personal gains, increased intimacy, or a mutual sharing of information for instance (Tamir & Mitchelle, 2012). As such, numerous theories offering reasons for self-disclosure have been proposed. The following four theories offer particular utility in explaining why an individual may chose to disclose information using online media platforms. It should be noted that numerous other theories describing self-disclosure exist (i.e., emotional contagion theory, strangers on a train conceptualization, social penetration theory), however many of these theories are not relevant for disclosure over the Internet, as they emphasize self-disclosure in face-to-face dyads. Four theories of disclosure selected for relevance to this study will be described in detail below. For a summary of selected disclosure theories, refer to Table 1.

Reciprocity of Self-Disclosure Theory

Reciprocity of self-disclosure theory proposes that disclosure between two people is reciprocal. The degree and depth of disclosure made by one partner is proportionate to the disclosure made by the initiator of the conversation (Barak & Gluck-Ofri, 2007). This theory describes the process of mutual exposure by communicating partners. Disclosure by one person is caused by the disclosure from the initiator of exchange (Barak & Gluck-Ofri, 2007), suggesting that the decision to share private information with another person is based on the give-and-take of the relationship.

In regards to sharing personal information with others online, this theory would suggest that an individual offering only a sliver of information about her eating disordered behaviour would be met with a minor amount of information from another person communicating online. Alternatively, if members of an eating disorder support website felt like the initiator of the conversation offered an in-depth and personal account, others would feel more compelled to meet the higher expectation of information shared online.

Social Contract Theory

Social contract theory proposes that individuals voluntarily provide personal information to others in exchange for a certain service (Chang & Heo, 2014). By exchanging personal information for something in return, the discloser assumes benefits and risks associated with the disclosure (Okazaki, Li, & Hirose, 2009). Regarding the perceived benefits of disclosure, individuals may believe they will receive information that is valuable and of interest to them, in addition to building social connectedness (Chang & Heo, 2014). However, when sharing information with others, individuals expose themselves to risks including judgement and breech

of trust. Only in situations where the benefits are believed to outweigh the risks will the disclosure or social contract happen (Chang & Heo, 2014).

The social contract theory would suggest that if members of an online community believed they would receive help and peer support by disclosing personal and possibly stigmatizing information, then the possibility of help would outweigh the potential negative risks. Individuals valuing social connectedness may perceive greater benefits of disclosure than someone else who does not share the same value (Chang & Heo, 2014).

Functional Model of Self-Disclosure

Sharing intimate details about one's self fulfills fundamental needs for social connectedness and human belonging (Tamir & Mitchelle, 2012). This need is intrinsically rewarding (Tamir & Mitchelle, 2012) and according to the functional model, self-disclosure is motivated by desires of need fulfillment (Bazarova & Choi, 2014). Disclosure can be understood and predicted based on the social rewards anticipated through disclosing. Typically, experiences of social validation, self-expression, relationship development, and identity clarification are expected following self-disclosure (Bazarova & Choi, 2014). By disclosing to others, individuals hope to gain validation of self-concept and personal value. These concepts are strengthened from increased social approval and acceptance from the target of disclosure. By sharing private or traumatic experiences, individuals are also able to vent to others, which relieves the distress of negative experiences. Further, self-disclosure conveys information about one's identity and allows for the discloser to define self to others, ultimately promoting a personally rewarding outcome (Bazarova & Choi, 2014).

The functional model would suggest that individuals communicating online have decided to share their personal story due to their need for social connection. When sharing personal

accounts, individuals disclosing online can gain validation from others and can authentically express themselves. In addition, after communicating online the individual's self-identity and understanding of the self becomes more clear and defined (Bazarova & Choi, 2014).

Social Identity of De-Individualization Effects

The social identity and de-individualization effects (SIDE) model predicts that anonymity and lack of identification common to online communication platforms result in different processes for sharing personal information (Joinson, 2001; Spears & Lea, 1992). When identity is known, individuals typically are self-aware and adhere to social norms when communicating (Joinson, 2001). When identities are not made known, however, people express themselves differently and are unconstrained by concerns of self-presentation (Joinson, 2001). Anonymity online, therefore, may lead to a reduction in conformity to social norms and increased self-disclosure, according to the SIDE model. The SIDE model suggests that members of an online community may be more open and forthcoming with their experiences of eating and body concerns if identities are not revealed.

Table 1

Summary of Selected Disclosure Theories

Theory	Summary
Reciprocity of Self-Disclosure Theory	Self-disclosure between two people is reciprocal. The degree and depth made by one partner is proportionate to the disclosure made by the initiator of the conversation.
Social Contract Theory	Individuals engage in self-disclosure in exchange for other services. Consumers perceive benefits and risks of disclosure, and self-disclose only when the perceived benefits outweigh risks.
Functional Model of Self-Disclosure	Self-disclosure is initiated according to a set of strategic concerns that motivate sharing personal information with another individual.
Social Identity of De-Individualization Effects	Anonymity leads to different ways of communicating online compared to when personal identities are known. Anonymity reduces the impact of social norms, allowing one to express without judgment, leading to increased self-disclosure.

Note. Partial list of disclosure theories chosen for relevance to this study.

Criticism of Disclosure Theories

Some researchers have criticized literature on disclosure, claiming theories of self-disclosure simplify a complex experience "as a unitary phenomenon which is manifested with unfailing regularity in all situations" (Goodstein & Reinecker, 1974, p. 71). The decision to disclose, when to disclose, how to disclose, who to disclose to, and reasons for disclosure are different for everyone and are certainly not experienced universally (Goodstein & Reinecker, 1974). Instead, the researchers critiquing disclosure theories and other literature on self-disclosure, suggest that disclosure is influenced by the intersections of multiple variables

including personal characteristics of the discloser and target, their relationship and history, and the broad situation (Goodstein & Reinecker, 1974; Lynch & Gussel, 1996). Lynch and Gussel (1996) researched disclosing learning and psychological disabilities within a university setting, and suggested that disclosure experiences are unique, and existing theories do not account for variation in the disclosure process.

Disclosure theories offer varying perspectives and conceptualizations about how an individual with an eating disorder might approach a disclosure experience. Similarly, multiple orientations and conceptualizations of eating disorders and other weight related issues are also present in the literature.

Eating Disorders

Over the years, different discourses have arisen in regards to eating disorders and other weight related issues. Based on where one positions oneself in relation to these discourses, there are various ways of thinking about the concept or situation, influencing how the issue is then conceptualized. Two positions are those held by individuals subscribing to the medical model of eating disorders, and those who align with feminist scholars. These discourses primarily differ in their understandings of eating disorders, with the medical model defining them as a mental illness (APA, 2013), and the feminist literature proposing them as a socially constructed product of the society individuals live in (Brown & Jasper, 1993). Although there is no question of the severity of eating disorders by either of these two opposing groups, the opinions towards the development, maintenance, and recovery has been a contention between the positions. In the following sections, I will illustrate the tensions towards the understanding of eating disorders by presenting evidence and literature from both the medical and feminist perspectives.

Medical Perspective of Eating Disorders

According to the medical model, eating disorders are multidimensional illnesses characterized by clinical disturbances in eating behaviours, attitudes, and compensatory behaviours that pose serious risk to physical and psychosocial functioning (Shapiro, 2012). The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM– 5; APA, 2013), recognizes several categories of eating disorders: anorexia nervosa, bulimia nervosa, binge eating disorder, and other specified feeding or eating disorder (OSFED). Despite some shared and psychological features, eating disorders categorized within the DSM – 5 differ from each other in clinical presentation, outcome, and treatment requirements (APA, 2013).

According to the medical/illness model of eating disorders, individuals with anorexia nervosa intensely fear gaining weight, determinedly restrict energy intake, and have a disturbance in self-perceived weight or body shape (APA, 2013). Anorexia nervosa typically develops during adolescence or young adulthood, and "due to severe malnutrition and being underweight, frequent hospitalization is typical" (Shapiro, 2012, p. 5). People with bulimia nervosa experience recurrent episodes of binge eating that is unquestionably larger than what others would eat in a similar time period, accompanied with a lack of control over eating, regular inappropriate behaviors to prevent weight gain, and a self-evaluation that is excessively influenced by body shape and weight (APA, 2013). Inappropriate compensatory behaviors most often include abuse of laxatives, self-induced vomiting, and misuse of diuretics (Mehler, 2003); all behaviors individuals typically keep secret from others. Bulimia nervosa occurs almost twice as often as anorexia nervosa (Gauvin, Steiger, & Brodeur, 2009) and frequently begins after episodes of dieting or food restriction (Shapiro, 2012). People with binge eating disorder (BED) engage in recurrent episodes of binge eating, and consume amounts of food that are larger than

what others would consume in a similar time frame. Unlike those with bulimia nervosa, individuals with BED do not engage in inappropriate compensatory behaviours (APA, 2013). Individuals diagnosed with OSFED are characterized by presentations of feeding and eating disorder symptoms that cause clinically significant distress or impairment, however, the symptoms do not meet full criteria for the disorders classified in the feeding or eating disorder diagnostic class (APA, 2013). An individual may be given a diagnosis of OSFED when presenting with symptoms consistent with bulimia nervosa for example, yet the frequency in which symptoms occur are not regular enough to meet full diagnostic criteria for bulimia nervosa (APA, 2013).

Mortality rates for individuals with eating disorders are understood to be high. The number of deaths out of 1000 individuals with anorexia nervosa and bulimia nervosa are approximately 5.1, and 1.7, respectively (Arcelus, Mitchell, Wales, & Nielsen, 2011). Results from a meta-analysis of 36 studies suggest that 20% of anorexia nervosa deaths are due to suicide (Arcelus et al., 2011), highlighting the psychological and physical severity of these disorders. Those who ascribe to the medical model have highlighted the distress and impairment of functioning and feelings of shame and disgust that often are evident within individuals with eating disorders (Goss & Allan, 2009; Kelly & Carter, 2013).

Eating Disorders and Disordered Eating

Within eating disorder literature there is often mention of disordered eating as well as eating disorders (i.e., mention of the prevalence of eating disorders and disordered eating within the same population; Mahn & Lordly, 2015). The difference in semantics refers to the distinction between a clinical eating disorder and disordered eating patterns employed to attain thinness that do not manifest the range of psychological and physiological traits consistent with

clinical eating disorders (Hesse-Biber, Leavy, Quinn, & Zoino, 2006). Disordered eating behaviours may include acts such as purging, binging, harsh exercise routines, and the use of laxatives to control weight (Hill, Masuda, & Latzman, 2013). Disordered eating cognitions include weight concerns, unhealthy beliefs regarding eating, weight, and the ideal shape, and, body dissatisfaction (Hill et al., 2013). Though individuals with diagnosed eating disorders and others engaging in disordered eating endorse all of these behaviours and cognitions, it is argued that individuals who have disordered eating lack the severe psychopathology and physical signs of someone with a clinical eating disorder diagnosis (i.e., body weight is not less than minimally normal or not less than 17.0 kg/m^2; APA, 2013; Hesse-Biber et al., 2006).

To further clarify the difference between eating disorders and disordered eating, according to a study of college aged women, approximately 91% of the sample attempted to control body weight through dieting, and 50-64% of the women exhibited disordered eating behaviours (Fulton, 2016). In contrast to statistics reporting disordered eating, population studies indicate that lifetime prevalence estimates of anorexia nervosa, bulimia nervosa, and BED among females are .9%, 1.5%, and 3.5%, respectively (Hudson, Hiripi, Pope, & Kessler, 2007). Given the pervasiveness of disordered eating, some scholars suggest that the emphasis on thin bodies in society has lead individuals, women in particular, to have internalized this dominant discourse. Instead of an eating disorder being considered an individual's problem and a mental illness, it then becomes a societal issue that has been socially constructed.

Feminist Perspective of Eating Disorders

In contrast to those more aligned with the medical model, feminist scholars' opinions about eating disorders differ, thus creating a tension in the field. Feminist scholarship aims to counteract the adverse influences of the patriarchy and other privileged structures (Piran, 2010),

acknowledging that gender inequity and its influence on female's social environments (e.g., emphasis on appearance, greater exposure to violation and harassment) must be addressed (Piran, 2010; Piran & Thompson, 2008). Further, feminists have critiqued the medical model in viewing eating disorder pathology as resulting from within the individual, and instead argue disordered eating affects females disproportionately due to the values of Westernized society placing emphasis on a female's appearance and behaviour (Malson & Burns, 2009).

The continuum of eating disorders and weight preoccupation. Brown (1993) argued for a continuum of weight and body preoccupation. She proposed that it was not accurate to stigmatize anorexia nervosa and bulimia nervosa as "individual pathologies or diseases, at the same time we approve, even praise, the behaviour of those women who exercise and diet to attain the culturally prescribed body ideal" (Brown & Jasper, 1993, p. 54). Brown and Jasper (1993) offered that it is difficult to suggest that someone who meets the diagnostic criteria of anorexia nervosa is any more pathological than someone who diets and engages in a rigid exercise routine for the purpose of controlling shape and weight. Feeling negatively towards one's body is a similar experience for women engaging in eating disorders and disordered eating, as women internalize the ideal body image, recognizing that how they look will reflect how they are valued and treated (Brown & Jasper, 1993). Brown (1993) offered that there are more similarities than differences between women with eating disorders than those who diet and exercise to control weight. This notion of a continuum allows feminist scholars to be critical of the traditional medical model. Brown (1993) stated:

> It is therefore objectionable to label those who adopt more extreme measures as psychopathological, disordered, or diseased while simultaneously encouraging and rewarding dieting and weight preoccupation as healthy and normal when much of this

more common behaviour is, itself very extreme. (p. 56)

Piran (2002) suggested that gender should be considered a risk factor for the wide spectrum of body and weight related and eating preoccupations, due to the higher documentation of incidents of eating disorders among girls and women. Approximately 85-95% of individuals affected by anorexia and bulimia are female (Office on Women's Health, 2012). According to feminist perspectives of eating disorders, the primary method by which patriarchal society has objectified females has been through its emphasis on importance of thinness; its promotion of the "culture of thinness" (Anderson & Hesse-Biber, 2008; Gilbert & Thompson, 1996). The culture of thinness glorifies thin bodies, associating small body size to happiness and success, while pairing fatness to laziness and failure (Gilbert & Thompson, 1996). This emphasis on thinness represents a way that women are controlled by society, and in turn dictates the food restriction and rigid exercise regimes females must endure in order to comply with the moral imperative for thinness (Gilbert & Thompson, 1996).

Feminists consider the role of power and privilege in relation to gender and the resulting impact on an individual's esteem, worth, and body experience (Piran, 2010). Feminist scholarship has pointed to the dominant influence cultural messages and icons have made on female body image and self-esteem (Carolan, Bak, Hoppe-Rooney, & Burns-Jager, 2010). Social influences range from the pressures for women to be thin in order to be attractive, and the media's impact on the definition of beauty, leading to chronic dieting and a heightened awareness of body shape and weight for women (Gilbert & Thompson, 1996).

Though the feminist approach to understanding eating disorders is widely accepted, just as the medical model is, some researchers have critiqued the approach. Feminist scholars emphasize the notion of disadvantaged females in a patriarchal society, however the perspective

fails to account for why other genders experience pressures to be thin or have a certain shape, as men also experience eating disorders (Hudson et al., 2007). Among the critics of feminist conceptualizations of eating disorders are feminist researchers themselves. One such researcher claimed that many feminist scholars writing about the topic of eating disorders and disordered eating only referred to White, heterosexual women's experiences, disregarding the experiences of women of color, women of low socioeconomic status, and lesbian and bi-sexual women, to name a few (Thompson, 1994). Further, White feminists often failed to acknowledge the concerns of Black women in their theorizing about body image and eating and weight preoccupations particularly as the unattainable beauty standards are entirely centred on White women; "they chose to write about beauty as though Black women did not exist" (Shayo Buchanan, 1993, p. 39). It is apparent that each perspective of understanding eating disorders (i.e., feminist and medical model) have critics and supporters.

Given that some professionals aligned with the medical model assign a diagnosis to individuals who they consider psychologically disturbed, it is not surprising that individuals conceal the signs of weight control. Individuals experiencing related symptoms (i.e., restricting, extreme exercising, use of laxatives) often hide indicators of an eating disorder from others due to fear of being misunderstood, embarrassed, and negatively judged (Cachelin et al., 2001). Perhaps the tension between the medical model and feminist understandings of eating disorders create even greater fears when individuals consider telling others, as some may react more negatively, purely based on their positionality towards the issue.

Disclosure and Eating Disorders

Individuals struggling with eating disorders are often hesitant to disclose they have a problem (Becker et al., 1999). Although there is no shortage of information available on eating

disorder etiology (Bakalar, Shank, Vannucci, Radin, & Tanofsky-Kraff, 2015), prevalence (Hudson, Hiripi, Pope, & Kessler, 2007), symptomatology and risk factors (Patton, Selzer, Coffey, Carlin, & Wolfe, 1999), information regarding the disclosure an eating disorder is scarce.

From the little research available, individuals with eating disorders tended to score lower on measures of self-disclosure (i.e., the Self Disclosure Questionnaire) compared to individuals not experiencing disordered eating (Le Grange, Tibbs, & Selibowitz, 1995). The reasons for this difference remain unknown. Secrecy and concealment are typical behaviours of individuals with eating disorders, as evidenced by many clinician reports (Basile, 2004). Several research teams have produced evidence suggesting that individuals engaging in various types of disordered eating who experience negative body image (Le Grange et al., 1995) are less likely to share experiences related to eating and weight compared to participants not concerned with these issues. For example, students in high school with high levels of body and weight preoccupation scored lower on the Self Disclosure Questionnaire compared to classmates with less severe eating and body concern (Le Grange et al., 1995). Though this relationship was not significant, researchers proposed that the greater the severity of eating and weight related issues, the less likely students are to disclose (Le Grange et al., 1995). Further, a study examining disclosure among women reporting eating and weight concerns (Becker, Thomas, Franko, & Herzogm, 2005) found differences in disclosure patterns depending on disclosure targets (i.e., mothers, friends, healthcare providers). Friends were the most likely to receive information about disordered eating symptoms, as 86.6% of participants reported sharing concerns with this group. The majority of participants also reported disclosing to a partner (56.5%) and to a parent (52.8%), but alarmingly only 35.6% of the sample disclosed to a mental health professional

(Becker et al., 2005). In addition, researchers studying bulimia nervosa in particular, found that females with symptoms consistent with bulimia nervosa were less likely to share their experiences with their mothers, friends, and partners compared to controls who did not report engaging in behaviours consistent with bulimia (Evans & Wertheim, 2002). Kaufman's (1996) model of shame and eating disorders may explain this finding, which will be discussed next.

Kaufman (1996) considered bulimia nervosa largely to be a function of shame, and used the cycle of binging and purging to illustrate his position. Kaufman proposed that individuals engaged in binge eating to fulfill an interpersonal need for connection, and, once the person realized that the binge eating did nothing to help with this feeling, the experience of shame was elicited. Further, Kaufman emphasized how the experience of shame operates in a fluctuating cycle, with shame peaking during binge episodes and decreasing while one feels more in control during purging behaviours (1996). He suggested there is also shame associated to the concealment individuals often engage in while binging (Kaufman, 1996). Thus, there is evidence to suggest individuals experiencing symptoms consistent with eating disorders, bulimia nervosa in particular, are less likely to self-disclose.

Smart and Wegner (1999) demonstrated that, among a sample of female university students, participants who endorsed characteristics of anorexia nervosa and/or bulimia nervosa reported greater levels of secrecy about their eating patterns and attitudes towards food than participants without disordered eating behaviours. Females in the study who were trying to keep their eating concerns hidden experienced higher levels of intrusive thoughts, requiring additional effort to suppress stigma related to disordered eating thoughts compared to women without these concerns (Smart & Wegner, 1999). Researchers suggested that those with a concealable stigmatized mental illness, such as an eating disorder, may visually appear at ease during social

interactions, however the cognitive focus on personal stigmas may result in cognitive consequences (i.e., preoccupation with stigma and eating disorder related thoughts; Smart & Wegner, 1999).

Several years after the publication of Becker and colleagues' findings (2005), a research team addressed gaps in the study by examining the disclosure process in relation to the target of disclosure and help seeking, the identity of disclosure recipient, and autonomy to disclose (Gilbert et al., 2012). The team retroactively examined a sample of females in treatment or recovery from an eating disorder. The team investigated the interaction between disclosure factors (i.e., age at time of disclosure, forced disclosure, other initiated disclosure) in order to understand the likelihood of help seeking. Being older at the time of initial disclosure was significantly associated to help seeking and specialist treatment, and disclosing to a friend did not predict help seeking (Gilbert et al., 2012). In addition, when someone else initiated the disclosure by asking questions about signs or symptoms of the eating disorder and reacted positively, help seeking was sought faster (Gilbert et al., 2012).

Various factors can hinder an individual from seeking treatment for eating disorders including denial, social fears, and the belief that their behaviours are not severe (Becker, Franko, Nussbaum, & Herzog, 2004; Cachelin et al., 2001). However, one of the most salient barriers to receiving help is the individual disclosing they have a problem (Gilbert et al., 2012).

The Growth of Social Media

Social media was designed to reach and influence mass audiences. Social media is a term used to describe technologies "through which people can exchange ideas and files and create networks of common interest" (Waterhouse, 2015, p. 506). In the last 10 years the number of users of social media including Twitter, Facebook, Tumblr and others have grown

astronomically (Noor Al-Deen, 2012). Consequently, social media has become an integral part of the modern classroom, political and public health campaigns, advertising, and numerous other aspects of daily life (Noor Al-Deen, 2012). In 2013, Facebook reported having approximately 1.19 billion active monthly users, Twitter reported over 200 million active users, and Tumblr reported hosting 138.2 million blogs (Haight, Quan-Haase, & Corbett, 2014). As of October 2015, the Pew Research Centre found that 90% of Americans 18-29 years old, 60% of 50-64 year olds, and 35% of those 65 and older used social media (Perrin, 2015). Since 2005 there had been a 78%-point increase in social media usage for those aged 18-29 in the United States (Perrin, 2015). Evidently, age is strongly correlated to social media usage.

One of the reasons individuals use social media is to experience connectedness and feel belonging to a group or community online (IJsselsteijn, van Baren, & van Lanen, 2003). When communicating via social media, one is able to engage in self-presentation of identity (De Andrea, Shaw, & Levine, 2010) and can stay connected with others that are geographically distant. A study conducted in 2009 found that, on average, college students in the United States used Facebook for approximately 30 minutes a day as part of daily routines (Pempek, Yermolayeva, & Calvert, 2009). Further, in a sample of first year Canadian university students 90% of women and 86% of men utilized social media websites (Hargittai & Hsieh, 2010), demonstrating the significant role social media has in the lives of emerging and young adults.

Eating Disorder Websites

In recent years, social networking sites have become the major form of media by which people have developed personal networks online (Lewis & Arbuthnott, 2014). The term *social networking* falls under the umbrella term *social media*, referring to software that supports social collaboration (Barnes, 2006). Research suggests that the Internet and social networking sites

have materialized as salient for individuals experiencing a mental illness (e.g., isolation, stigmatization, emotional difficulties) for the purpose of connecting with others who share the same struggles and obtaining information (Lewis & Arbuthnott, 2014; Whitlock, Powers, & Eckenrode, 2006). Of the thousands of social networking sites available online, sites created to attract members from specific communities have become popular, for example websites for individuals with cancer, caregivers of children with developmental delays, and supportive communities for individuals in crisis. As such, websites developed for those identifying as having an eating disorder are plentiful, for example Grace on the Moon, Healthful Chat, Daily Strength, and My Pro Ana.

Individuals with eating disorders often use the Internet to discuss eating disorder related activities (Lewis & Arbuthnott, 2014). Prior to the late 1990s, individuals with eating disorders had few opportunities to share their experiences with others, aside from face-to-face conversations with medical professionals and during emotionally difficult conversations with family and friends (Brotsky & Giles, 2007). Today, there are hundreds of online communities developed to support the needs of those with eating disorder behaviours (Brotsky & Giles, 2007), fostering safe and supportive environments for individuals with eating disorders to connect with others who understand what they are going through. Many of these online communities offer various perspectives on eating disorders, including advice from medical and mental health professionals, fostering peer support between community members, and offering advice to family and friends of an individual with an eating disorder. Many of these sites have an interactive component for members to converse with each other, most commonly in the form of message boards and blogs (Brotsky & Giles, 2007). Further, and perhaps most important, the

majority of online eating disorder communities are anonymous, allowing for users to communicate with others without revealing their identity.

Different types of eating disorder websites. Although activities on many websites foster positive interactions, feelings of support, encouragement, and decreased isolation, online eating disorder communities may be detrimental in other ways. Eating disorder websites are categorized either as pro-recovery or pro-eating disorder (pro-ED). Pro-recovery sites cater to individuals who wish to recover from an eating disorder, are in the process of recovering, or have recovered (Wilson et al., 2006). Pro-recovery websites discuss eating disorders as an illness, promote support and recovery, offer information on recovery, and are against material that could be triggering to members (Chesley, Alberts, Klein, & Kreipe, 2003). Pro-recovery sites typically share the DSM – 5 definitions of eating disorders, recognizing the associated behaviours and cognitions to be detrimental to physical and psychological health.

Alternatively, pro-ED websites promote eating disorder behaviours and attitudes as an alternative lifestyle that one strives for (Lewis & Arbuthnott, 2014; Meenan, 2003), rather than as a disorder. Pro-ED sites offer weight loss tips, strategies for engaging successfully in destructive behaviour, and *thinspiration* messages (i.e., words or photos meant to inspire members to lose weight) intended to reinforce eating disorder behaviours (Chesley et al., 2003). Individuals drawn to pro-ED websites typically view their eating and attitudes as an accomplishment and consider their restricting or purging as successful self-control that does not have to end.

Both types of websites demonstrate the contrasting positions individuals take in regards to considering disordered eating either as an illness or lifestyle choice, illustrating the tensions between these groups. Research indicates that individuals with eating disorders access both types

of websites frequently. In 2012, Lewis and Arbuthnott found that "pro-ED" had been searched 13 million times annually on Google, thus demonstrating the degree to which eating disorder websites are being utilized.

Potential benefits of eating disorder websites. Despite concerns associated with pro-ED websites, online eating disorder communities connecting individuals worldwide offer potential benefits. Activity on eating disorder websites offers users interaction with others with similar experiences. Individuals with eating disorders are socially stigmatized and often isolate themselves due to beliefs that others do not understand their circumstances (Lewis & Arbuthnott, 2014), whereas online, individuals are offered the opportunity to share their experiences with others and gain mutual support in a judgement-free environment (Tierney, 2008).

Online communities are different than face-to-face interactions because a large number of people can benefit from viewing conversations posted online. During face-to-face conversations, only the people directly involved benefit from the material discussed. Whereas when information is posted online, community members including *posters* (i.e., members who post in a forum or blog), *feedback givers* (i.e., members who offer feedback to the poster), and *silent browsers* (i.e., members who read posts but do not contribute to the conversation) all potentially benefit from exposure to the dialogues (Lewis & Arbuthnott, 2014). Flynn and Stana (2012) suggested that members of online communities benefit from personal disclosure, giving and receiving empathic messages, feelings of reduced isolation, the belief that others understand, and from receiving informational support (e.g., recovery resources, education about eating disorders).

Further, the Internet can be accessed at any time and from anywhere, therefore serving an important function of connecting individuals together during times where in-person support might not be available. Wesemann and Grunwald (2008) found that 43% of new threads on a

bulimia nervosa-focused forum were posted between 11:00PM and 5:00AM, typically a period in which face-to-face support is less available. Accordingly, online communities have plenty of benefits and serve important functions for individuals living with an eating disorder. Finally, research demonstrated that a variety of topics unrelated to eating disorder behaviours, attitudes, and recovery are discussed online (Wesemann & Grunwald, 2008), thus serving as an open forum for topics considered important by users. Some of these non-eating disorder related topics include relationships, communication of a personal or private nature directed to other members, discussions about the online community itself, and stories of disclosing a mental illness.

Gaps in Current Literature

Many questions remain unanswered in regards to disclosing an eating disorder and factors at play in this complex interaction. Much of the current literature examines targets of disclosure and assesses how one is likely to be more secretive if eating behaviours are more severe; however, much of the story about disclosure remains untold. Some research demonstrates that friends are the most likely targets of disclosure (Becker et al., 2005), yet little is known about the events surrounding disclosures that either encourage support and facilitate help seeking, or prevent the individual from self-disclosing again to others in the future. In addition, numerous theories of disclosure have been proposed, demonstrating the vastness of ideas about why individuals share something private with others. Finally, given that one of the factors preventing individuals from receiving professional help is disclosure (Gilbert et al., 2012), further research is required to gain a better understanding of the complexities of disclosure experiences among individuals with eating disorders or disordered eating.

Chapter Summary

In this chapter I presented information relevant to disclosing an eating disorder to others in person, then discussing the experience through an online platform. Factors preventing disclosure of a mental illness were summarized, demonstrating the obstacles one faces when deciding to disclose to others. Theories exploring the reasons behind disclosure were discussed and criticisms highlight the simplicity portrayed by each theory. Next, I presented the conceptualization of eating disorders according to both the medical model and the feminist perspective, highlighting the tension between these groups. Last, research on social media usage, the prevalence of eating disorder websites, and the potential benefits and dangers for users was presented. Although disclosing a mental illness more generally has been widely studied, research on disclosing an eating disorder, in particular, is lacking in the literature. Individuals with eating disorders and disordered eating concerns are known to be more secretive than others without these issues (Basile, 2004). Further research is required to address gaps in the literature, to highlight the tensions, positions, and differences individuals encounter while disclosing an eating disorder either in person or online.

The Current Study

The research question of the current study is: *What are the tensions, differences, and positions in online narratives about eating disorder disclosures?* In this thesis, I aimed to gain a better understanding of the disclosure experiences of individuals who self-identify as having an eating disorder, by retrospectively examining narratives of disclosure that individuals re-tell online. Our understanding of disclosure among individuals with eating disorders is limited; there is a need to go directly or indirectly (i.e., through an online medium) to those who have disclosed in order to inform our understanding of this experience. Analyzing online posts in which

individuals recount stories of their face-to-face disclosures with others will allow deeper understanding of the tensions, differences, and positions that are involved in the disclosure experience.

Chapter 3: Method

In this chapter I illustrate the theoretical perspective and approach of situational analysis (SA). First, the qualitative approaches, individuals and methodologists that influenced the development of SA are discussed, followed by an explanation of why Clarke believed a new method was necessary. Clarke's views on postmodernism are highlighted, then a description of the current study's procedures, SA techniques, and how they were applied in the current study are presented.

Situational Analysis

Situational analysis is a recently proposed method, developed by Adele Clarke in 2005. Clarke wished to revamp Grounded Theory (GT) created by Barney Glaser and Anselm Strauss (1967) by supplementing this traditional qualitative approach with greater postmodern finesse. Glaser and Strauss published *The Discovery of Grounded Theory* (1967), offering an approach to the study of social and psychological processes through analytic codes formulated through inductive reasoning. During a time and culture dominated by quantitative positivist approaches to research, Glaser and Strauss presented a rigorous, empirically based approach that resulted in a substantive theory. Central to GT was the constant attempt to represent data in authentic ways, portraying truthful illustrations of perspectives, positions, intentions, and interpretations of research participants. Unique to GT is the requirement that analysis begins as soon as data is available, with theorizing quick to follow (Glaser, 1978). Grounded theory proposed that in order to produce or discover theory, "one generates conceptual categories or their properties from evidence" (Glaser & Strauss, 1967, p. 23), then this evidence is used to develop the theory or concept.

While Clarke commended Glaser and Strauss for their transformational work, she identified reasons for why and how GT must be remodeled. Clarke, a former student of Strauss, argued that while Strauss's version of GT possessed some elements of postmodernism (e.g., illustrating truthful depictions of participants), largely positivist assumptions of single realities remained (Clarke, 2005). Though Clarke did not dismiss the contribution of GT entirely, she offered critiques and alterations to the traditional approach in order to "push grounded theory more fully around the postmodern turn" (Clarke, 2005, p. 11).

Roots in Social Constructionism

Traditionally, scholars making use of GT came from predominantly positivist orientations, however, a shift towards social constructionist tendencies can be seen in more recent iterations of GT (Clarke, 2014) such as Kathy Charmaz's constructivist approach (Charmaz, 2000, 2006). Charmaz referred to her adaptation to traditional GT as constructivist grounded theory (CGT). The term *constructivist* was chosen to acknowledge the subjectivity and researchers' contributions in constructing and interpreting data (Charmaz, 2014). Constructivists view learning and knowing as implanted in social life and stress interaction, sharing perspectives, and interpretive understandings (Charmaz, 2014). Thus, Charmaz (2014) contended that her use of *constructivist* is consistent with current understandings of social *constructionism*.

Social constructionism is a theoretical perspective whereby researchers assume individuals create social realities through collective or individual actions (Bryant & Charmaz, 2007). Instead of assuming external realities, this perspective looks into what individuals at a certain time and place consider real and how these realities are constructed (Bryant & Charmaz, 2007). Charmaz's CGT emphasized reflexivity, acknowledging the researcher as a co-

constructor of knowledge with participants rather than a distant expert (Mills, Chapman, Bonner, & Francis, 2007).

Constructivist grounded theory contrasts with traditional approaches to GT such as Glaser and Strauss (1967) in multiple ways. First, researchers' views toward data are interlinked with their personal values, meaning the emerging data becomes value laden (Bryant & Charmaz, 2007). Second, theories discovered tend to be "plausible accounts" (Charmaz, 2006, p. 132), rather than theory that make objective claims as in traditional GT. Third, CGT aims to offer fluid theories explaining social processes that are not locked in time (Charmaz, 2006).

Clarke appreciated Charmaz's CGT perspective and adaptation to GT, though still felt it necessary to move SA beyond Charmaz's work (Mills et al., 2007). Accepting the central constructivist element of CGT, that theories are specific to particular times, places, and individuals, Clarke continued to view this approach as problematic due to enduring positivist shortcomings (Clarke, 2005).

A Postmodern Turn

Clarke (2003, 2005) sought to transform the traditional GT approach into a postmodern adaptation capable of illustrating differences, variations, and multiplicities. Clarke contested GT's universal grand narratives, and instead wished to develop an approach that explicitly mapped and represented complexity and untidiness (2005). For at least a century, social science research was overrun by techniques that erased background framework, variation, and complexity (Clarke, 2003). Clarke argued that individual voice was missing and often erased in research, essentially removing the positions and contradictions apparent in data. Clarke noted that "variation or difference is even called 'noise' in some approaches to research" (2003, p. 556).

Postmodernism itself is not a system of beliefs or assumptions, but instead a way of conceptualizing and thinking about possibilities (Clarke, 2003). Postmodernists acknowledge that all knowledge is socially and culturally constructed (Fulton & Hayes, 2012; Gergen & Thatchenkery, 1998). All knowledge has been created and consumed by particular groups taking up an issue from a certain lens. As a postmodernist, Clarke challenged the modernist notion of universality and argued claims of universality are meant to silence different groups and positions (Clarke, 2005). An important tenant of postmodern literature refers to human relatedness, highlighting the importance of human interactions, dialogues, interpretations, and shared meaning that constitute social processes (Gergen & Thatchenkery, 1998). Clarke claimed that in order to effectively study emerging heterogeneous worlds, traditional approaches with modernist assumptions must be left behind.

Regenerating Grounded Theory

Clarke (2003, 2005, 2015) viewed Glaser and Strauss' (1967) GT as preserving the positivism and scientism of the 1950s and 1960s, and additionally proposed that Glaser and Strauss's GT was comprised of positivist "recalcitrancies" (2005, p. 11) requiring modification. Influenced by feminism, antiracism, and commitments to equality, Clarke was determined to develop an approach "taking situatedness, variations, complicatedness, differences of all kinds, and positionality/relationality very seriously in all their complexities, multiplicities, instabilities, and contradictions" (Clarke, 2003, p. 556).

Clarke emphasized five recalcitrancies of traditional approaches to GT, such as Glaser and Strauss (1967). The first is the lack of reflexivity of the researcher and research process (den Outer, Handley, & Price, 2013). This includes the notion that a researcher can and/or should be invisible, and putting a voice to silenced actors from the researcher's own perspective. Second,

Clarke criticized GT's approach that emphasized commonalities in data that silenced heterogeneities or elements of data that are different. Third, Clarke contested the pressures apparent in GT to select one main social process and refer to others as sub-processes, undermining the complications of real situations and the richness of the real world. Fourth, Clarke argued against interpreting abnormal instances in the data point as negative cases, and opposed perceiving social life and processes in terms of binaries. Finally, Clarke considered GT's quest for objectivity and purity to be a shortcoming (Clarke, 2005). Situational analysis was developed with these criticisms in mind, and all play an important role in the formation of Clarke's SA.

Influenced by the five recalcitrancies of traditional approaches to GT noted above, Clarke indicated six strategies to "push grounded theory/symbolic interactionism even further around the postmodern turn" (Clarke, 2005, p. 19):

1. Acknowledging researchers' reflections and past experiences as fundamental to the research process, while accepting there may be simultaneous realisms of multiple realities and knowledge.
2. Making the topic of inquiry both the research phenomenon and site for analytic grounding.
3. Evolving from strategies of simplifying and homogeneity to representations of complexity, variations, and heterogeneities.
4. Transitioning from generating substantive *formal theory*, to accepting sensitizing concepts and "theoretically integrated analysis" (p. 28) and *theorizing*.
5. Analyzing the site of inquiry through multiple examinations and re-representations in order to understand most salient elements of situations; and

6. Incorporating discourses (i.e. narrative, visual, and historical) in analyses to enrich the description of social life and processes under examination.

Clarke outlined these six characteristics as ways in which traditional approaches to GT, could be enhanced by SA. Situational analysis pushes past GT by utilizing techniques and perspectives that emphasize "addressing and engaging important postmodern theoretical and methodological concerns about differences and complexities of social life" (Clarke, 2003, p. 558).

SA offers a relational modality of representations of the positions and discourses humans and non-human actors take on the situation of inquiry (Clarke, 2005). SA mapping techniques break situations down into elements making it easier to see components of the situation in relation to each other. The method also facilitates an understanding of the positions separate groups take towards a topic of inquiry, as well as the relationships human actors have with non-human elements. Human and non-human actors are considered equally important in SA, as inanimate objects can be protagonists in the situation and can largely influence human interaction (Fulton & Hayes, 2012). Differences in a situation are highlighted with SA, and mapping makes contrasting positions explicit.

Situational Mapping and Analysis

SA is comprised of three "analytic exercises" designed to promote deep examination of the data: (a) situational maps, (b) social worlds/arenas maps, and (c) positional maps (Clarke, 2005). These distinctive mapping techniques encourage new ways of thinking about data with the intention of opening up the data to provoke further analysis (Clarke, 2005). Mapping is not typically part of researchers' work, therefore, this new approach to research, that offers visualized research questions, might generate new insights (den Outer et al., 2013). Clarke, Friese, and Washburn (2015) proposed that focusing on "pictorial representations with maps

allows researchers to think about their data in new ways" (p. 172). The pictorial representations of data also allow researchers to locate themselves in the situation of inquiry, enhancing reflexivity.

Before embarking on SA mapping however, Clarke (2003) made clear multiple caveats. First, mapping is not necessarily intended to represent the final analysis. Instead, it is anticipated that mapping exercises will help researchers become more familiar with data and allow researchers to "come into the material" more deeply (den Outer et al., 2013, p. 1507). Second, mapping approaches should be conducted using coded data or at least material researchers are familiar with. Third, because mapping is meant to encourage thinking, researchers should concurrently be keeping memos. Memos serve as an "analytic placeholder" (Clarke, 2005, p. 103) to record any thoughts, questions, or tentative theorizing that come to mind during analysis. Memos become data to analyze as well, and serve an important function. The final caveat Clarke claimed was the most radical. She insisted that when scholars performed inquiries and noticed that certain things they expected to find in the data were actually missing, they had an ethical obligation to represent the silences in the data. Clarke (2005) asked "what thousand-pound gorillas are sitting around in our situations of concern that nobody has bothered to mention as yet?" (p. 85).

Situational Maps

Analyses begin by identifying the most important human and nonhuman elements (e.g., technologies, material things, specialized information) that make up the situation of inquiry (Clarke, 2005). The primary goal of situational mapping is to broadly lay out the site of inquiry and the elements that comprise it, regardless of how peripheral they may appear to be (Clarke, 2015).

Abstract and messy situational maps. Situational maps aim to illustrate: Who and what make up the situation? What matters in the situation? What factors or actors make a difference to the situation? (Clarke, 2005). In initial stages of situational maps, researchers create abstract/messy situational maps that serve as illustrations depicting all influential analytic human, nonhuman, symbolic, discourses, concepts, sites of debate, and material elements comprising the situation in an unordered format (Clarke, 2005). Generally, a large piece of paper is used to record anything and everything seemingly pertinent to the situation, as well as the researcher's prior knowledge about the situation (Clarke, Friese, & Washburn, 2015). Viewing all elements on a large surface provides the researcher with an overview of the complexity of the situation, and ultimately enables further analysis to move forward. Next, researchers organize maps into an ordered/working version, allowing categories to be listed neatly. Elements are typically organized into categories including individual human elements, political economic elements, silent/implicated elements, and discursive elements (Clarke, 2015). In this version, the same elements from the abstract/messy map appear, however the organization of categories allows for easier viewing of elements making up the situation. Researchers should continue work on situational maps until "analytic sufficiency" (Clarke, 2005, p. 28) has been met, or until there is an extended period since major changes have been made. Analytic sufficiency refers to a point in the analysis/mapping process when no additional information can add any further properties to understanding the topic of inquiry (Glaser & Stauss, 1967).

Relational analysis. Once the ordered situational map is complete, researchers may begin to ask questions of their work and start to look at relations among elements of the inquiry. Clarke suggested making multiple photocopies of situational maps, allowing researchers to look at each element in isolation and consider it in relation to other elements on the page (2005).

Systematically, relationships between each element and all others are considered. Lines are used to connect related concepts, and also to describe the nature of relationships. Clarke suggested using a highlighter to connect elements related to each other so it is clear where connections exist and where they do not (2005). Relational analysis mapping can also aide the researcher in deciding which stories to tell, and what relations to pursue in future mapping sessions (Clarke, 2015). In addition, when relations are absent silences can be made evident.

Social Worlds/Arenas Maps

The second stage of mapping focuses on better understanding social groups or collective action involved in situations (Clarke, 2005). This level of mapping is concerned with the level of social action and how individuals become committed to specific social worlds by their participation in certain activities. Social worlds are defined as "universes of discourse" (Strauss, 1987), in which individuals come together or act as a group for the purpose of a particular issue. Many social worlds may be found inside arenas, as arenas serve to identify a common theme of interest, thus arenas are larger than social worlds. The worlds in arenas can be "allies, enemies, odd bedfellows, and so forth, and arenas are commonly sites of dispute and contestation" (Clarke, Friese, & Washburn, 2015, p. 174). Social worlds/arenas maps help researchers to see which worlds are centrally located within arenas, and from here, researchers can consider why certain groups/worlds may hold greater power than others (Clarke, 2015).

The researcher enters the situation and tries to make sense of the patterns of collective commitment to social worlds and why they emerge in certain arenas (Clarke, 2005). This mapping process utilizes broken lines to illustrate porous boundaries, indicating analyses as flexible and open to adaptation. Boxes within social worlds are also frequently apparent, representing organizations (Clarke, 2005). Social worlds can exist in multiple arenas, and it is

common for social worlds and arenas to overlap. Further, individuals can exist in multiple worlds, demonstrating that individuals and collective groups participate in more than one world/arena, which can also identify a site of tension.

Thus, Clarke suggested that once social worlds/arenas maps are finished, researchers should consider the following: What is the work of each world? What are the commitments of each world? What actions have been taken in the past and are anticipated in the future from each world? What technologies are used by each world? (2005, p. 115). The outcome of these maps is to visualize the relations and collective actions that are either central to the research question or that inform and influence the subject of the research site of inquiry (Clarke, 2015).

Positional Maps

The last mapping process offers a visual representation of major positions within the situation of interest. At a micro-level, positional mapping lays out the major positions taken on issues, absence of positions, silences, or differences of positions with regard to a particular controversy or situation (den Outer et al., 2013). Clarke stressed that positional maps are not representations of individuals, institutions, or groups, but instead positions in discourses (2005, 2015). Controversy, areas of tension, and heterogeneity are dimensionally displayed across two axes chosen by the researcher (Clarke, 2005, 2015; den Outer et al., 2013) in this last kind of mapping. Basic and often contested issues are located across the map allowing one to view various positions evident in the data (Clarke, 2005). Clarke noted there are no "negative cases" (p. 126) represented in this type of mapping, since displaying a position as such would require the researcher to align with a specific discursive position (2005). Instead, positions are represented as other, less common, and more peripheral. Positions are depicted as they appear within the data and taken up in the discourse, and not based on the terms of the researcher.

Further, positional mapping allows researchers to illustrate silences within the situation, thus representing a great benefit to this final stage of mapping.

Rationale for SA

This method acknowledges the complexity of situations and is capable of portraying the intrapersonal and relational aspects of online narratives about disclosing an eating disorder. Situational analysis is flexible in terms of what constitutes data, and materials already existing can be retrieved from websites and lend themselves well to this method. Extracted online conversations represent pieces of a situation that have not been co-produced with the researcher, unlike interview data for example (Clarke, 2005). This is important because it eliminates the potential for the researcher to influence the accounts of lived experience expressed by individuals communicating online. Online posts represent two types of "narrative discourses" (Clarke, 2005, p. 181): personal narratives and narratives produced by individuals about subjects other than themselves. Narrative discourses are a written account that describe events, actions, experiences, and are often seen as not connected to any particular situation (Clarke, 2005). For this reason, it is important that narrative discourses be examined as they can become situated by applying SA techniques.

The use of SA also was a good fit with my own epistemology. While exploring this situation, I was compelled to go beyond the realm of the observable, and instead learn more about human interactions and processes by taking into account non-human elements. The method of SA is especially appreciated, as the assumptions that Clarke (2005) proposed to make up the method are in line with my beliefs about the process of research, namely that, the researcher comes to the project already "knowing" and invested. This emphasis on researcher

subjectivity, coupled with studying data that cannot be and should not be objectively measured frames my epistemology.

Procedures in the Current Study

Pilot Study

A pilot study was completed in June 2015 with two eating disorder recovery and support websites as a requirement for a graduate level qualitative research methods class. The objective of the pilot study was to examine how the most supported theories of disclosure applied to anonymous online eating disorder discussion threads. I analyzed 58 discussion threads where users identifying as female clearly stated they had disclosed their eating disorders to others or stated the reasons that prevented them from disclosing to others. Then, I determined which, if any, of the theories describing why disclosure occurs applied. Conducting the pilot study was educational as it provided insight into the complexities experienced by individuals with eating disorders. This impacted the direction I took for the current study, as I was constantly reminded of the opposing perspectives individuals held towards having an eating disorder (e.g., eating disorder as a lifestyle choice, eating disorder as taking over one's life, eating disorder as an illness), and various stages of recovery evident in communications. Refer to Appendix A for a poster version of the pilot study.

Data Collection

Websites emphasizing eating disorder support, recovery, and maintenance were chosen for analysis. Online eating disorder platforms offer individuals the opportunity to communicate their experiences without censorship, providing an anonymous environment. As such, previous researchers in the area of disclosure have utilized online communities (e.g., Brotsky & Giles, 2007; Knop et al., 2016).

This study incorporated several types of eating disorder websites. I wanted to include websites created to support individuals wishing to recover, typically associated with treatment facilities or advocacy groups, as well as websites promoting the maintenance and secrecy of eating disorders, known as pro-eating disorder/pro-ana websites. Pro-eating disorder websites have emerged on the internet to connect individuals around the world who live with eating disorders. Pro-eating disorder websites are known to promote the maintenance of eating disorders, provide tips about weight loss and hiding disordered eating from others, and include *thinspiration* quotations and images of emaciated celebrities (Rouleau & von Ranson, 2010). Most pro-eating disorder websites contain an interactive component where users can share tips and tricks (Norris, Boydell, Pinhas, & Katzman, 2006) and website members usually share their *goal weight* or the weight they hope to reach by engaging in disordered eating behaviours (Custers, 2015). Websites are known as *pro-ana* when supporting anorexia nervosa behaviours and *pro-mia* when endorsing bulimia nervosa behaviours (Lipczynska, 2007).

Analyzing both types of data allowed me to understand the broader picture and the various discourses existing among individuals reporting disclosing an eating disorder. The first stage of data collection began with the observation phase, marked by searching through the top three search engines as indicated by Nielsen Netratings: Google, Yahoo, and MSN (Harshbarger, Ahlers-Schmidt, Mayans, Mayans, & Hawkins, 2009). I searched for the following terms in all three engines: pro ana, pro anorexia, pro mia, pro bulimia, pro eating disorder, eating disorder support group, online eating disorder support, eating disorder recovery, and online recovery for eating disorders. During this phase, I explored the first three pages of search results and viewed websites that offered online chats or forums for individuals with eating disorders. I searched for website statistics including number of members and number of total blog postings to become

acquainted with the popularity of each site. However, soon into my search I realized that websites could not be compared in such a way as not all websites posted equivalent information. I also learned that pro-eating disorder websites often appeared to be under construction or no longer existed beyond the first search page.

I consulted a former professor on the applicability of using analytic software to monitor the traffic of particular eating disorder websites. Initially, I hypothesized this as being an efficient method of selecting websites, though after consultation I learned that the view ratings of eating disorder recovery or maintenance sites would not appear popular at a global level, therefore, websites would not receive enough global traffic to generate statistics (S. Lewis, personal communication, July 31, 2015). Thus, I elected not to utilize tracking tools to determine popularity of websites.

During the observation phase, I developed an understanding of the eating disorder content available online. This initial work influenced my decisions for the inclusion criteria of websites to be considered for collection:

1. Websites must include discussion on or related to disclosing an eating disorder (e.g., coming out to parents, getting caught, how not to get caught, factors preventing disclosure).
2. Websites must include at least five original posts discussing the disclosure of an eating disorder, ensuring the website is active.
3. Websites must be publically accessible, not requiring a username or password to review content.
4. Website content must be in English.

This method of collecting information from publicly available websites has been widely used in past research, especially among researchers studying online eating disorder support groups and pro-eating disorder websites (Bates, 2015; Brotsky & Giles, 2007; Giles, 2006; Harshbarger et al., 2009; Keller, Rosenthal, & Rosenthal, 2005; Lyons, Mehl, & Pennebaker, 2006; Wolf, Theis, & Kordy, 2013). Websites requiring a password and username were excluded from this study because I wanted to avoid using deception to gain access to information individuals posted. Falsifying a persona and entering private websites has potential to break the trust of users, and since online communities are considered safe places for individuals with eating disorders to connect, I wanted to avoid any actions that may have caused users to feel unsafe and exposed. Further, publicly accessible personal blogs were excluded as these websites featured only one voice/perspective.

The results of the observation stage yielded 11 potential websites that met inclusion criteria, including three pro-eating disorder websites and eight eating disorder support websites. During the process of coding and selecting websites I extracted 200+ original blog postings and replies for analysis. Data was collected and coded in July, August, and September 2015.

Once collected, data was uploaded to Nvivo computer software for analysis. Nvivo allows for the collection, organization, and analysis of various types of qualitative information and enabled me to structure and visually portray the data in an organized manner. Nvivo does not assign codes or analyze information itself, however, asking questions of the data was simplified using the features of this software. Nvivo has been used to assist researchers using SA previously (e.g. Reisenhofer & Seibold, 2013; Smith et al., 2014).

Data Analysis using SA Techniques

Mapping Procedure

The SA analysis process consisted of three types of mapping. Each map was revised numerous times, and memos were recorded throughout the entire analysis. Messy situational maps were created first, in order to give me a better understanding of the complexity of the situation of inquiry. Next, I made the ordered/working version of the situation map, during which I organized the elements that I proposed to make up the situation and sorted the elements into some of Clarke's pre-set categories (2005), and other categories I created myself. After this stage, I moved onto the relational analysis where I asked questions of the elements on the map in order to learn more about each element's relationship to the other. I made simplified relational analysis maps to satisfy my initial curiosities about the situation of inquiry and in doing so I was able to better understand the relations salient and relevant to the situation. Through this relational analysis process my research question emerged from a natural evolution of becoming more familiar with my situation. After this stage, I completed the social worlds/arenas map. During this mapping phase I portrayed discursive worlds and represented the social action and commitment that make up the situation of inquiry. Last, I created several positional maps illustrating the discursive sites of major issues, tensions and silences in the situation.

The situational maps were created using an online mapping software, *MindMeister*. The remainder of the maps were created manually on large bristol boards, as I found working with the data on a large scale helped with becoming more familiar with the situation. I also used Microsoft Power Point to create maps; using this software made revisions less tedious. The outcome of the mapping process yielded rich descriptions of the situation of inquiry. Clarke

(2005, 2015) suggested that the most important result of mapping is to provoke the analyst to explore more deeply.

Coding

The SA coding process exclusively relied on traditional GT coding techniques outlined by Strauss and Glaser (1967). I adhered to several levels of coding beginning with open coding. Open coding allows researchers to ask questions of the data while encouraging comparison of incidents within the data. Original posts and replies extracted from online eating disorder communities were coded line by line, which minimized the potential of missing relevant categories and ensured that coded categories were complete. The first level of coding influenced which direction I took during theoretical sampling, helping me to better understand which categories were apparent in the data before closing in on a particular issue within the posts (Bryant & Charmaz, 2007).

The second level, selective coding was undertaken only after I indicated core themes. Once core themes and related categories had been noted, subsequent data collection and coding were delimited to information that seemed relevant to the situation (Bryant & Charmaz, 2007). This step allowed me to efficiently satisfy categories without spending a great deal of time searching for further data, as I was focused on coding for relevant variables and the emerging framework evident from open coding and ongoing theoretical sampling.

Constant Comparison Method

The constant comparison method (Glaser & Strauss, 1967) is an analytic and reflexive strategy researchers use to constantly compare data, codes, and categories to promote the generation of a more abstract understanding of the inquiry (Harper & Thompson, 2012). Constant comparison method was employed during open and selective coding, allowing me to

compare instances emerging from the data. This process allows researchers to continually establish the uniformity or inconsistencies within categories (Bryant & Charmaz, 2007) and requires researchers to keep their minds open to new insights within the analysis. As new codes emerge, the constant comparison method aids the researcher in analytic sufficiency or elaborating on existing or new categories. As a final point, emerging concepts were compared with each other for the purpose of finding a best fit to describe the data (Bryant & Charmaz, 2007).

Theoretical Sampling

Theoretical sampling is the process of deciding where to gather data next in order to code a category to sufficiency (Bryant & Charmaz, 2007). This traditional GT method is a concurrent process that occurs along with coding and in conjunction with the constant comparison method. The purpose of theoretical sampling is to prevent researchers from experiencing "data overwhelm" (Glaser, 2003, p. 24), which is occasionally felt when large amounts of data support the same code, completely oversupplying a category (Bryant & Charmaz, 2007). Researchers should be "sufficiently theoretically sensitive" (Glaser & Strauss, 1967, p. 46) meaning the ability to conceptualize and formulate emerging themes from the data without being blinded by preconceived notions or being drawn to only one emergent category. After identifying gaps in the data, I was guided to collect additional information that either acted as a comparison group or to build and further fill emergent codes.

I stopped collecting online posts once analytic sufficiency had been met, and I was satisfied that no more codes emerged from new information gathered. Theoretical saturation refers to the process of judging when to stop collecting and coding data that supports a specific category. In traditional GT, sufficiency is met when no additional information can add any

further properties to a code (Glaser & Stauss, 1967). When I saw the same illustrations repeatedly emerging from the data I knew that particular category had sufficient data. Sufficiency was met after posts extracted from ten websites were coded.

Memoing and Role of Researcher

Memo writing was a continuous process, as it served to connect the data on a conceptual level. During this process, I was able to draw connections between categories and associated codes. Critically important to both SA and GT, memo writing allows researchers to conceptualize data in a narrative form, and acts as both a methodological practice and a process encouraging exploration of the situation of inquiry (Lempert, 2007). Memoing occurs concurrently during the data collection, coding, theoretical sampling, and mapping stages and is an essential practice to jot down new insights, ideas, questions, and concerns about the data. Later these memos become part of the data and often highlight shifts of emphasis, narrowing of focus, new concepts, and/or call for further sampling (Clarke, 2003). Clarke (2003) attested that inadequate memoing was often the downfall of many research studies. Therefore, throughout the data collection and coding process I jotted down memos in my research journal simultaneously. My initial memos consisted of overall first impressions of the posts, salient discourses that seemed to jump off the page, and anything that surprised me.

Further, as Clarke recommended, researchers must become more visible in their research and accountable to it (2005). During coding and mapping, I was conscious of my experiences and acknowledged the perspective I held was neither right nor wrong. Engaging in reflexivity helped me to answer how and why I came to study online narratives of eating disorder disclosures, what my goals were, and who I was trying to benefit with my research. Clarke, Friese, and Washburn (2015) reminded readers that “analyzing the possible consequences of the

researcher's position and perspectives is a fundamental aspect of reflexivity that SA emphasizes" (p. 21). Writing in my research journal helped me to understand my biases and how certain discussions on the eating disorder websites impacted me. During the mapping processes I also included my own positionality into the situation, and made note of when I did this. I want for those who read this thesis to understand why I have become interested in the topic of disclosure, and how I have personally been influenced by a disclosure of an eating disorder.

In addition to memos being written to keep track of researcher's positionality and prior knowledge, memo writing also served a methodological function. The process of reflexivity allows researchers to demonstrate how they are actively constructing the situation of inquiry (Clarke, 2005), by representing their curiosities, entrance into the project, and conversations with others. As mentioned above, memos became a source of data, and reviewing my explicit decision making processes while trying to make sense of the situation enabled me to fairly represent the individuals, groups, discourses, and other non-human elements making up the situation of online accounts of disclosing an eating disorder.

Aside from using the process of memo writing to help me authentically represent perspectives from the individuals communicating on online eating disorder websites, I also welcomed others into the situational mapping process in order to share ideas and directions of the research. Consultation meetings with my supervisor and a PhD mentor regarding my situational maps and why I had chosen to represent the situation in the way that I had contributed significantly to my understanding of the situation of inquiry. Inviting others who were knowledgeable about eating disorders into these conversations generated new ways of thinking about the elements and their relationships, and also challenged me to conceptualize the situation in different ways. As Clarke (2005) mentioned, all researchers coming to study a particular

situation bring their own subjectivity, therefore, I found the different perspectives of my consultation team to be very helpful in thinking about alternate possibilities. As a result of these generative conversations, my situational maps visually changed and were modified to account for various perspectives towards the situation.

In the absence of sharing my research findings with the individuals communicating online in order to confirm I was representing them as fairly and authentically as possible, I instead invited my consultation team to discuss my findings and the directions I was headed towards. By incorporating others into this process, I was able to hold myself accountable to illustrating trustworthy and plausible findings. The act of inviting others into the research process allowed me to test the credibility of the results and served as a tool to ensure trustworthiness of the data.

Ethical Considerations

I corresponded with a representative of the Conjoint Faculties Research Ethics Board at the University of Calgary and confirmed my study did not require research ethics review.

Chapter Summary

This chapter presented the theoretical perspective and methodology of SA. The history and development of SA was described as well as the key figures who's work influenced Clarke to create a new methodology. SA mapping and coding processes were offered, and the procedures I followed while working with data from online eating disorder websites were illustrated. The following chapter will present findings that emerged from my SA of online narratives of disclosing an eating disorder.

Chapter 4: Findings

The purpose of this chapter is to illustrate the findings that resulted from numerous situational analysis maps. Selected maps and corresponding memos that were created simultaneously during the mapping process will be described. The aim of this thesis was to better understand the tensions, differences, and positions in online narratives about eating disorder disclosures, shared by individuals who self-identified as have an eating disorder.

Situational Analysis Mapping

I employed SA to better understand the online narratives of disclosing an eating disorder. The data I analyzed was extracted from 10 online eating disorder communities, seven pro-recovery and support websites and three pro-eating disorder websites:

1. ANAD (Anorexia Nervosa and other Associated Disorders)
2. Daily Strength
3. eHealth Forum
4. Grace on the Moon
5. My Pro Ana (Pro-eating disorder website)
6. NEDA (National Eating Disorders Association)
7. Pro. Anorexia Live Journal (Pro-eating disorder website)
8. Psych Forum
9. Support Group
10. Why Eat (Pro-eating disorder website)

I used SA maps to recognize the human actors, materials, privileged knowledge, positions, tensions, and discursive elements in the situation of inquiry, and the relationships between these

elements. As Clarke (2005) noted, SA mapping procedures are not intended to form a finalized product, instead mapping techniques are meant to open up the site of inquiry and encourage researchers to examine data in new ways. Mapping processes stimulated my thinking, leading me to revise my maps multiple times. I continued working on the maps until no new elements or relations were generated, and I also shared my maps with my consultation team, consisting of my thesis supervisor and a PhD candidate, to elaborate on my thinking and explain why I chose to create the maps the way that I did. Selected SA maps are presented in the following sections, including various stages of analytic inquiry.

Messy Situational Map

I relied on the messy situational maps to initiate the research process and to demonstrate the complexities of a situation. Researchers descriptively lay out all human actors, nonhuman elements, and discourses broadly related to the situation of inquiry "as framed by those in it and by the analyst" (Clarke, 2005, p. 87). My aim of this exercise was to illustrate every element related to disclosing an eating disorder to others, while thinking broadly enough to include sociocultural, political, and temporal elements that could have perhaps influenced one's disclosure experience.

The construction of my messy situational map began after I had coded the data according to steps outlined by Bryant and Charmaz (2007). While explaining the emergence of situational analysis, Clarke said "what I propose is to supplement basic grounded theory with a situation-centred approach" (2005, p. xxxii), further she stated "the approaches can be used with coded data (using conventional grounded theorizing approaches to coding)" (2005, p. 84). Clarke (2005) proposed "exercises won't work well at all unless researchers are quite familiar with the data" (p. 84), therefore I rigorously reviewed codes that came from earlier coding processes.

Mapping the messy situational map took one week to complete and visually changed as I added and combined similar elements. Clarke stated "despite their appearance of fixity, these maps are not static" (2005, p. 90). The actors and actants displayed on maps were added and deleted over time, indicating the fluidity of elements comprising the situation. I spent a considerable amount of time considering my research project and at times was perplexed as how to continue, as noted in my research journal on January 24, 2016:

> I'm surprised to see how quickly my map grew. It was difficult at first to generate the elements in this map. It seemed like ideas, words, actors, discourses, materials, et cetera came onto the page in waves. Thinking of one thing reminded me of another, and it was in this pattern that I filled two pages of my notebook with items that seemed salient to this situation.

At times during the creation of the messy situational map I felt unsure of the elements I included on my paper. I attempted to include as much of the situation in the form of actors, non-human objects influencing the situation, positions taken by different groups, assumptions, and imagined responses from silent/implicated actors as possible. Occasionally, I experienced analytic paralysis, a term referring to the experience when a researcher does not know where to start or how to move forward (Clarke, 2005). Occurring shortly after my paralysis, I took Clarke's suggestion to use my own experiences as data for making SA maps. The following is a memo exert from my research journal, written January 24, 2016:

> At times when I struggled to add more to the paper I reflected on my experience of learning of my sister's eating disorder. I remember I was in disbelief, I had a hard time accepting the news, I was sad, and I didn't think that I could be so oblivious.

Reflecting on how I personally reacted to a disclosure of an eating disorder opened my perspective to the situation and I was better able to generate elements involved in how others might react to a disclosure, the emotional experience of learning a loved one has been struggling in secrecy, or imagining how someone may react. Further, during this process I kept the following questions in mind: (a) Who and what are in this situation?; (b) Who and what matters in this situation?; (c) What elements 'make a difference' in this situation? (Clarke, 2005). Refer to Figure 1 for the original messy situational map.

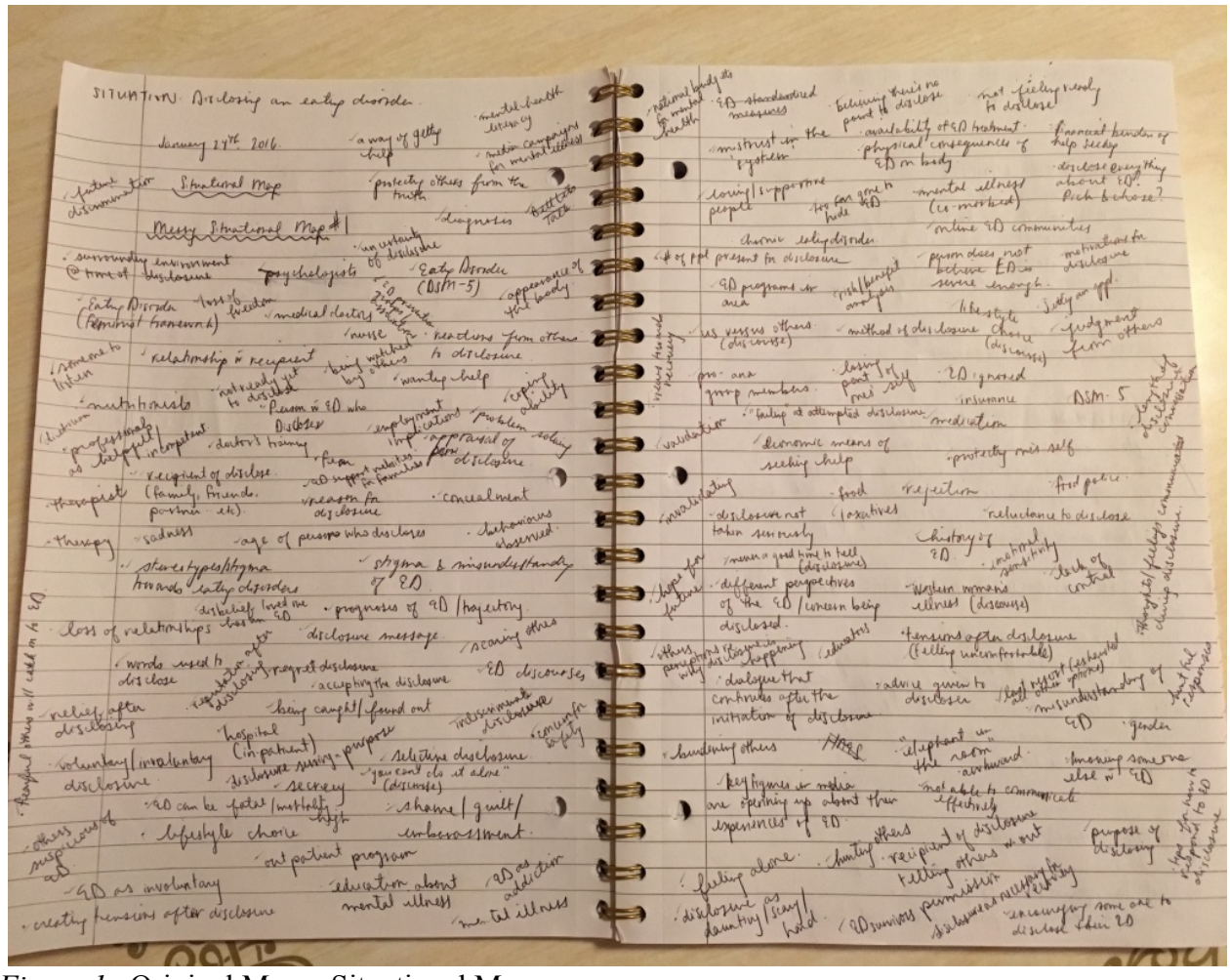

Figure 1. Original Messy Situational Map.

It is important to note that multiple elements included in early versions (i.e., Figure 1) were eliminated in revised maps due to narrowing focus. It is typical that over time, not all

elements remain of interest and do not help to answer the research questions, nevertheless, engaging in this process encourages researchers to begin with all elements of the situation broadly conceived. A more polished messy situational map can be seen in Figure 2.

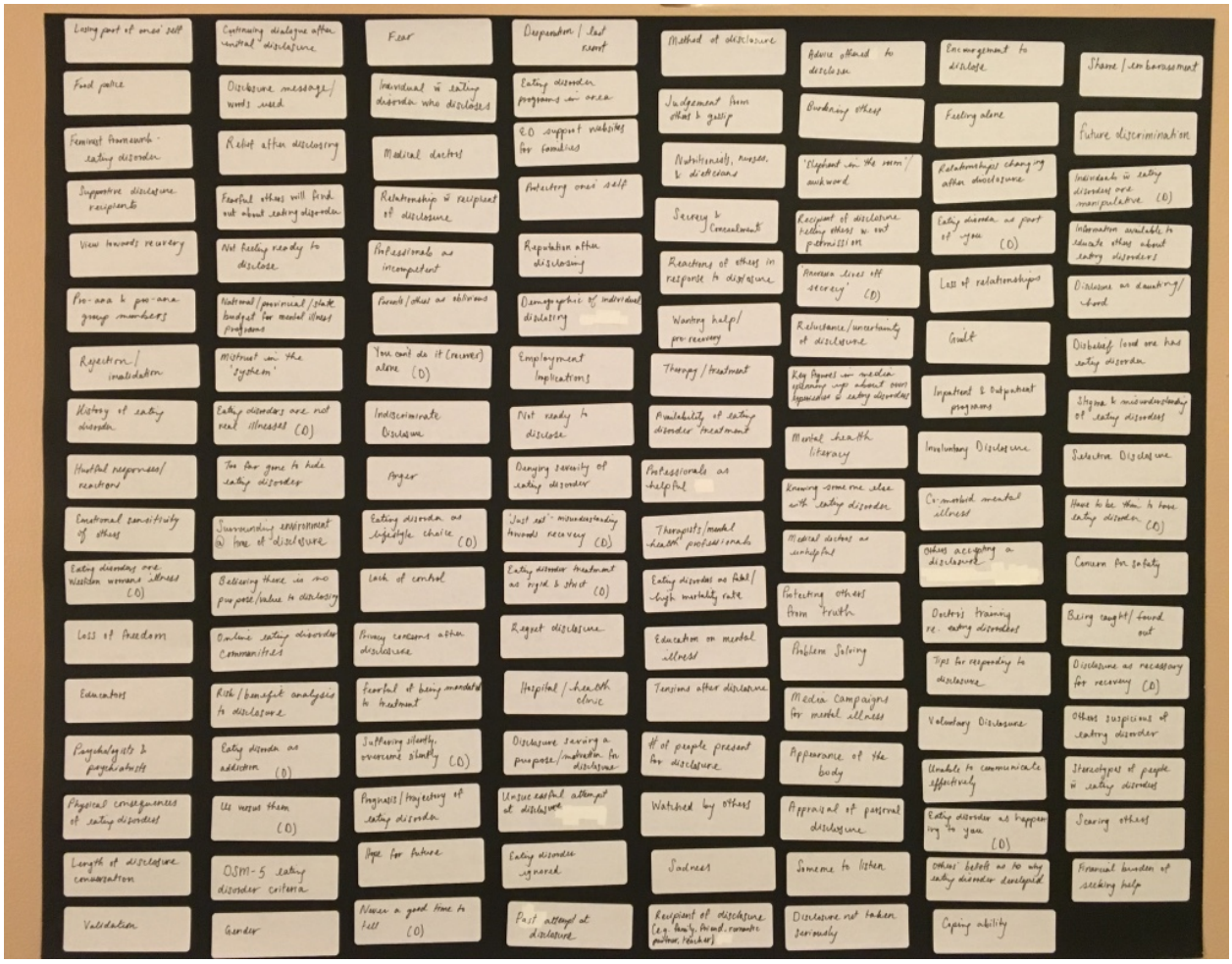

Figure 2. Messy Situational Map Version 2.

The process of creating labels and adding elements to the situation allowed for further consideration of each element's relevance to the situation. After I was comfortable with the elements, and believed there were no further major revisions, I was ready to order the situational elements.

Ordered/Working Situational Map

Researchers create ordered/working situational maps to impose categorical order to data. After visually portraying 136 elements in my messy situational map, I began to organize the elements into general categories. Clarke (2005) offered thirteen pre-set categories to assist researchers with the analytic procedure, however she noted there is no need to use all categories. Rather than searching for elements to fit into each category Clarke communicated the flexibility of this mapping approach, "what appears in your situational map is based on your situation" (2005, p. 89).

After reviewing the coding and spending many hours staring at the elements on the messy situational map, I began to sort my elements into Clarke's thirteen pre-set categories. After the initial sorting, I realized that not all of the pre-set categories were relevant to disclosing an eating disorder, and additional categories were required in order to appropriately represent what was emerging from the situation. The following are two exerts from my research journal written on January 31, 2016:

> I am sorting labels and arranging in accordance to categories of an ordered/working situational map. Many of my elements are being placed into 'other kinds of elements' and this category does not adequately sort or describe all of the elements being placed there. This is an indication to me that I must make sub-categories to better display my elements.
>
> I would like to add an additional category that represents human reactions. It seems that an important element of disclosing an eating disorder are the thoughts and emotions cycling through an individual's head when considering, deciding, and carrying out a

> disclosure. So many of my elements describe inner processes, fears, perspectives, future oriented thinking, et cetera. I must develop a category to accurately sort these.

As categorizing commenced I decided to eliminate Clarke's pre-set sociocultural/symbolic elements and other kinds of elements. I also decided to collapse individual human elements/actors with collective human elements/actors as I considered these categories to overlap. I felt it was necessary to create additional categories that organized and represented the elements that did not comfortably fit within the remaining categories, therefore I introduced (a) intrapersonal elements, (b) relational elements, and (c) disclosure incentive elements. As seen in the research journal excerpt above, I had difficulty finding an appropriate home for elements that described human reactions, inner processes, and relational factors.

After consultation with my PhD candidate mentor, I named my self-imposed categories *intrapersonal elements*, to capture the inner processes that individuals experience while disclosing an intimate part of themselves with others. I titled the second category *relational elements*, representing the ways others respond to disclosure and how relationships can change, and I titled the third category *disclosure incentive elements*, representing motivations and reasons for one to disclose. Further reasoning for these categories is offered in the following research memo written January 31, 2016:

> Intrapersonal elements and relational elements are two categories that I created to organize elements making up this situation. Disclosure is a very personal experience and these categories emerged out of demand. All elements now paired with these categories were grouped with the 'other kinds of elements' initially. I believe these codes materialized and are critical to the situation, as disclosure is an intimate decision that requires an incredible amount of thought and deliberation (intrapersonal elements)

and the act of disclosure invites relations with others to change, strengthen, and tensions are sometimes created (relational elements).

Before continuing my explanation of the steps I took for SA mapping, it is important for me to highlight my understanding that the categories and elements I propose that make up the situation are socially constructed. I acknowledge that I have constructed and sorted the elements on the map myself, and although some may argue that intrapersonal elements and relational elements are intertwined, I propose that these elements are different enough to require being placed into separate categories. In many ways intrapersonal and relational elements do not exist without the other, for instance, before a disclosure an individual may be reacting to the response they anticipate to receive from the recipient of the disclosure. However, I was careful to include inner dialogues and personal emotions in the intrapersonal elements, and I included the actions of others reported by individuals communicating online in the relational elements. I believe that feelings such as anxiety, happiness, shame, and relief are representative of abstract inner human experience, which are different than the tangible manifestations of others' actions including saying an insensitive comment, making a joke, or giving another person a hug for comfort. I argue that the recipient's response is a separate action from how the person who disclosed is feeling about the disclosure.

The process of sorting elements into categories required making analytic decisions based on the broad question 'What makes a difference in this situation?' The process also included eliminating elements that appeared too peripheral to the situation and adding relevant elements not considered previously. Figure 3 represents the early stage of my working/ordered map.

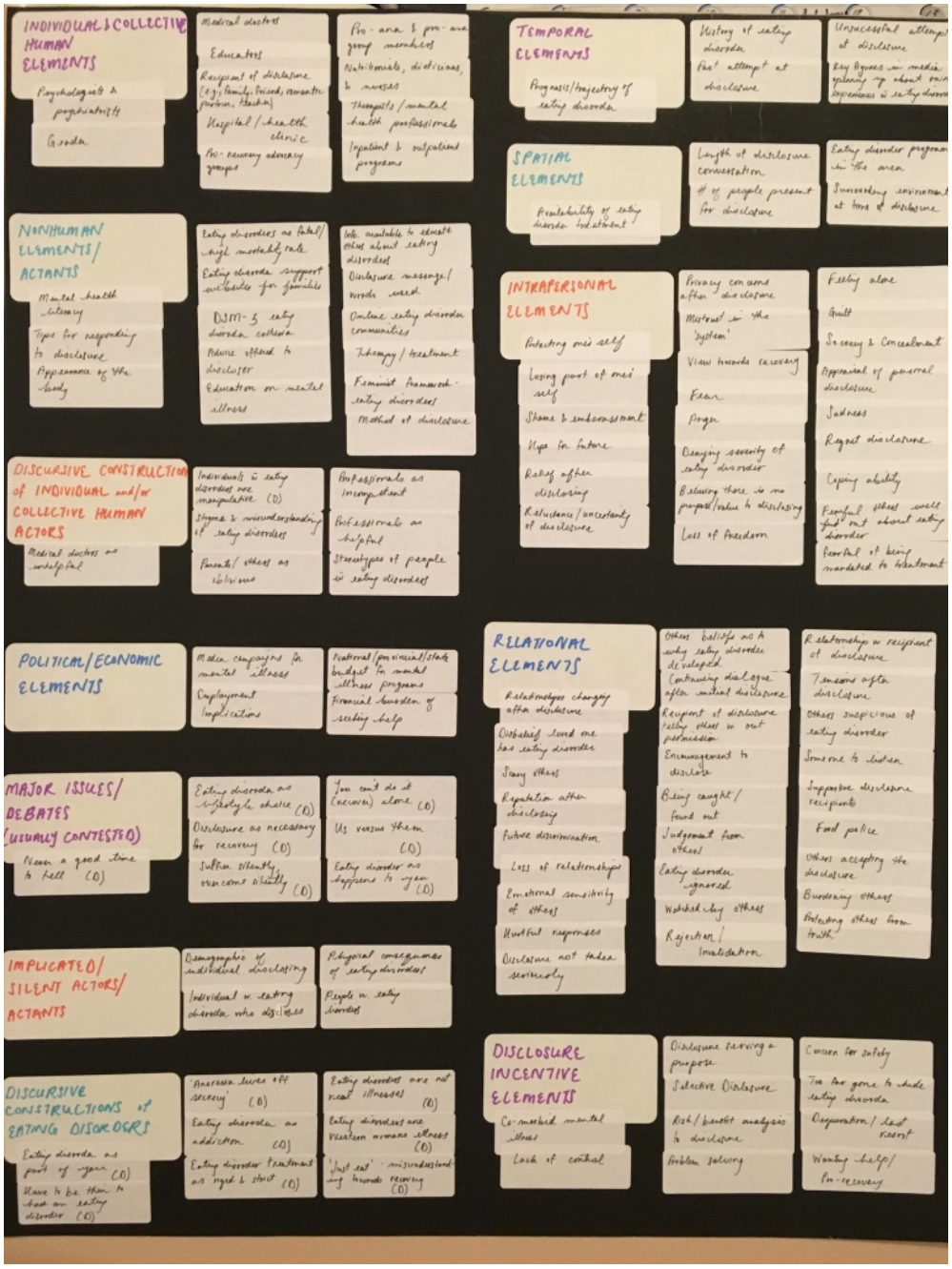

Figure 3. Early version of ordered/working situational map.

Clarke (2005) stated making multiple copies of maps is helpful and encouraged researchers to examine the situation of inquiry more thoroughly. In addition to continuously revising my situational maps, I also believed creating large-scale maps would invite deeper analysis and welcome creative and critical flexibility.

After completing and working with the large scale early version of the ordered/working situational map, I used Mindmeister (https://www.mindmeister.com) an online mapping software, in order to demonstrate the latest version of the map. I became satisfied with the state of my ordered/working situational map once I felt the category titles and the elements were paired appropriately. An analytic framework for better understanding the narratives individuals tell about disclosing an eating disorder is evident in Figure 4. After this map was no longer being altered I believed I was ready to begin the relational analysis. A larger version of the map can be accessed with this link: https://mm.tt/646180027?t=TugSRZmjCD .

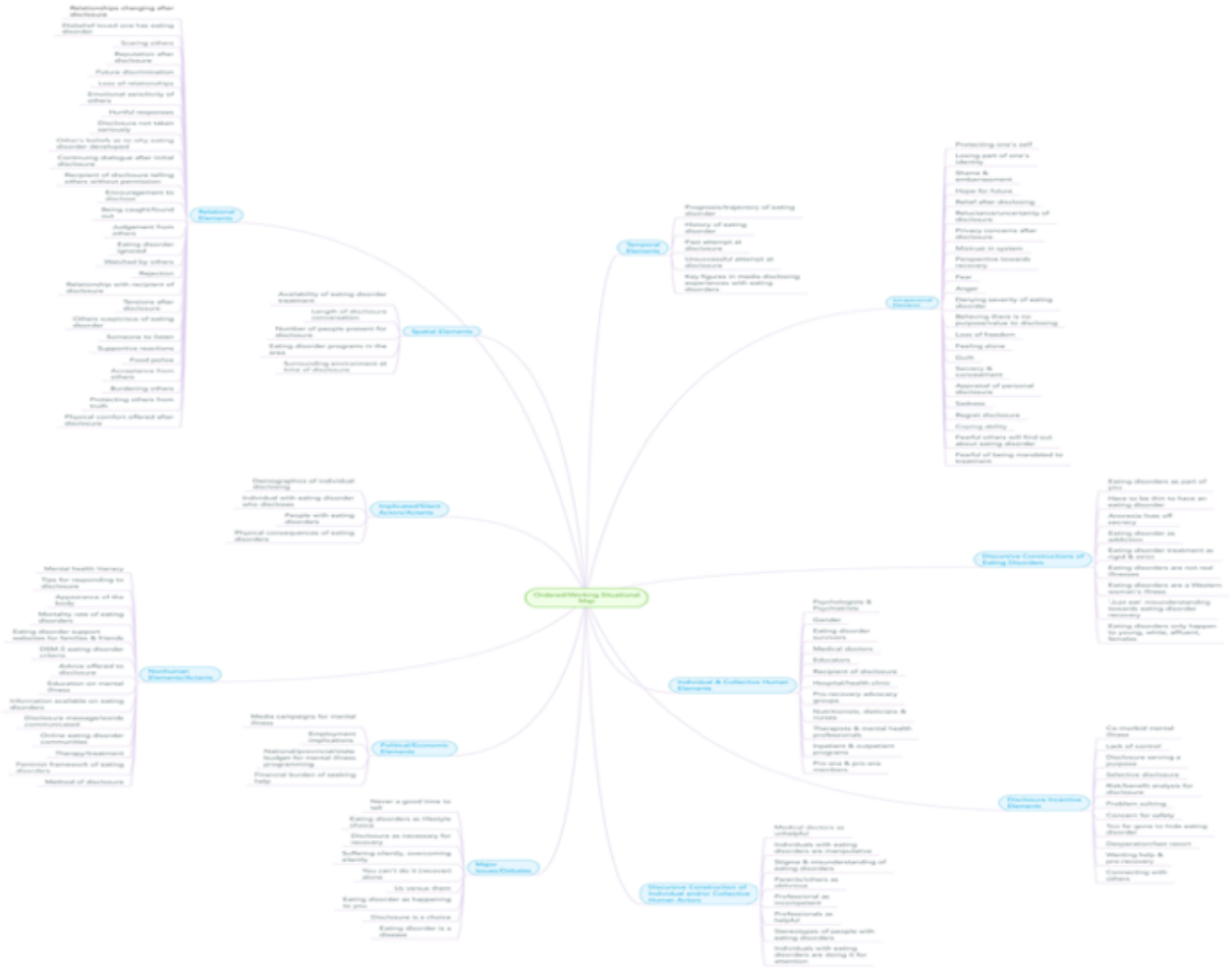

Figure 4. Latest version of ordered/working version situational map.

Relational Analysis

Relational analysis is an analytic process where researchers ask questions of their current situational map. Elements are considered one at a time and relations between various elements are illustrated. Relational maps assist the researcher when deciding what parts of the situation to focus on and which relationships to pursue (Clarke, 2005). After systematically thinking about the relationship between each element, relational maps demonstrate where the majority of relations exist and where they do not. It is through this process, as well as during the positional mapping process (explained later in the chapter) that silences in the data can be recognized. Early stages of relational analysis can be particularly helpful when researchers feel unsure of what direction to go and which questions and relationships to memo (Clarke, 2005). As such, I entered into the situation of inquiry by using relational analysis maps and analyzed the situation according to my broad interests and curiosities. Refer to Appendices B-G for simplified relational maps and corresponding memos created to satisfy my initial interests regarding the broad situation.

Clarke, Friese, and Washburn (2015) stated that research questions may evolve as one gets deeper into the analysis process. Further, situational maps are helpful in "guiding data collection and can also help researchers develop stronger proposals" (Clarke, Friese, & Washburn, 2015, p. 13). As a result of working through the relational mapping process my research question emerged: *What are the tensions, differences, and positions in online narratives about eating disorder disclosures?* This question was a natural evolution of the interests and curiosities I entered the situation of inquiry with, and the question emerged from the exploratory work I did while creating and memoing the relationships in the simplified relational analyses.

Social Worlds/Arenas Map

Social worlds/arenas maps are meant to illustrate collective groups of social action, and highlight where individuals "become social beings again and again through their actions of commitment to social worlds and their participation in those worlds' activities" (Clarke, 2005, p. 110). Often "the worlds in an arena can be allies, enemies, odd bedfellows, and so forth, and arenas are commonly sites of dispute and contestation," (Clarke, Friese, & Washburn, 2015, p. 174). While creating social worlds/arenas maps researchers focus on collective action, establishment of regulation, social formations and discourses produced by each social world. Clarke (2005) suggested asking oneself, "what are the patterns of collective commitment and what are the salient social worlds operating here" (p. 110). The researcher determines what social worlds exist within certain arenas and why. During the social worlds/arenas mapping process, each worlds' collective action and perspective towards particular topics are considered. Arenas in my social worlds/arenas map represent a larger overall topic of interest and contain multiple smaller social worlds (Clarke, 2005). Social worlds exist within larger arenas, and each world has a unique and particular stake/perspective towards a topic. The unique stance each world has towards a particular topic may be different than other worlds existing within the same arena.

While creating the social worlds/arenas map, I made note of Clarke's emphasis on drawing porous lines around arenas and worlds, as I recognized these boundaries to be fluid. I acknowledged that each collective I portrayed on the map had the ability of changing in the future and I made sure to represent this flexibility. Further, I made sure to draw porous lines to indicate that individuals may move in and out of worlds, demonstrating that commitment to a world is not stable.

My social worlds and arenas map underwent multiple revisions. I found myself struggling to decide what collective actions and groups to present on the map and felt overwhelmed with the big picture of the situation. When feeling unsure of how to proceed, I referred back to my research question: *What are the tensions, differences, and positions in online narratives about eating disorder disclosures?* Clarke (2005) stated that it is unlikely researchers will be able to present the whole story of their situation, however, the mapping process should assist in deciding which stories to tell and pursue in later analysis. Clarke (2005) suggested "specifying the key social worlds is the major analytic task for this map" (p. 112), and with this advice I started the social worlds/arenas mapping process. Refer to Figure 5 for an early version of my social worlds/arenas map with edits after a consultation meeting.

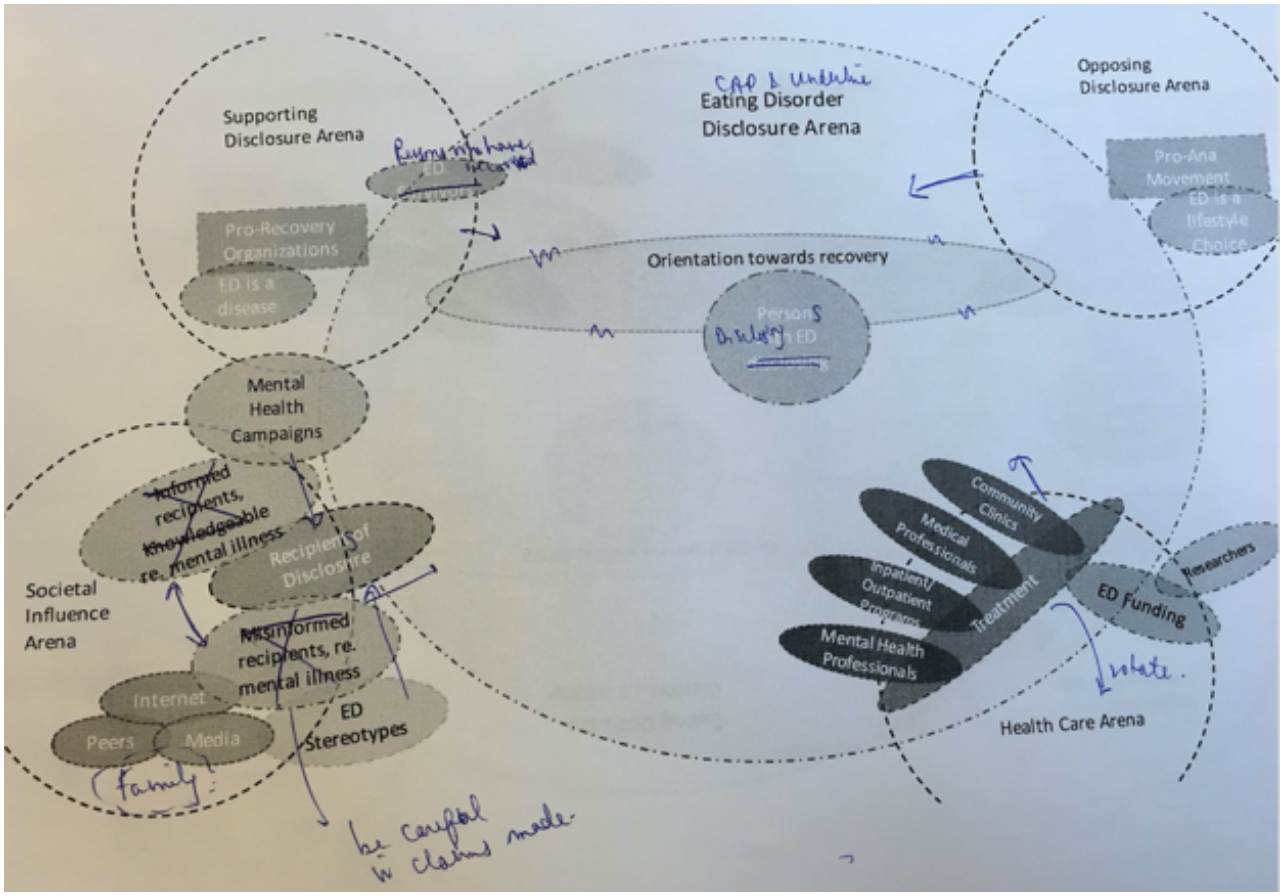

Figure 5. Social worlds/arenas map with edits.

While describing (a) each major social world, (b) the key discourses found within each

world, (c) the worlds' commitments, and (d) the actions taken by the worlds, I felt like I had sufficiently captured the key social worlds relevant to my situation. I wrote memos describing the past and future actions, beliefs, agendas of each social world, and after typing out these narratives felt I could proceed with further analysis. After each revision to my map I felt more grounded in the situation, and I continued modifying my maps until I felt satisfied. Figure 6 and 7 portray the further modifications I made to the social worlds/arenas map, and Figure 7 is the most recent social worlds/arenas map.

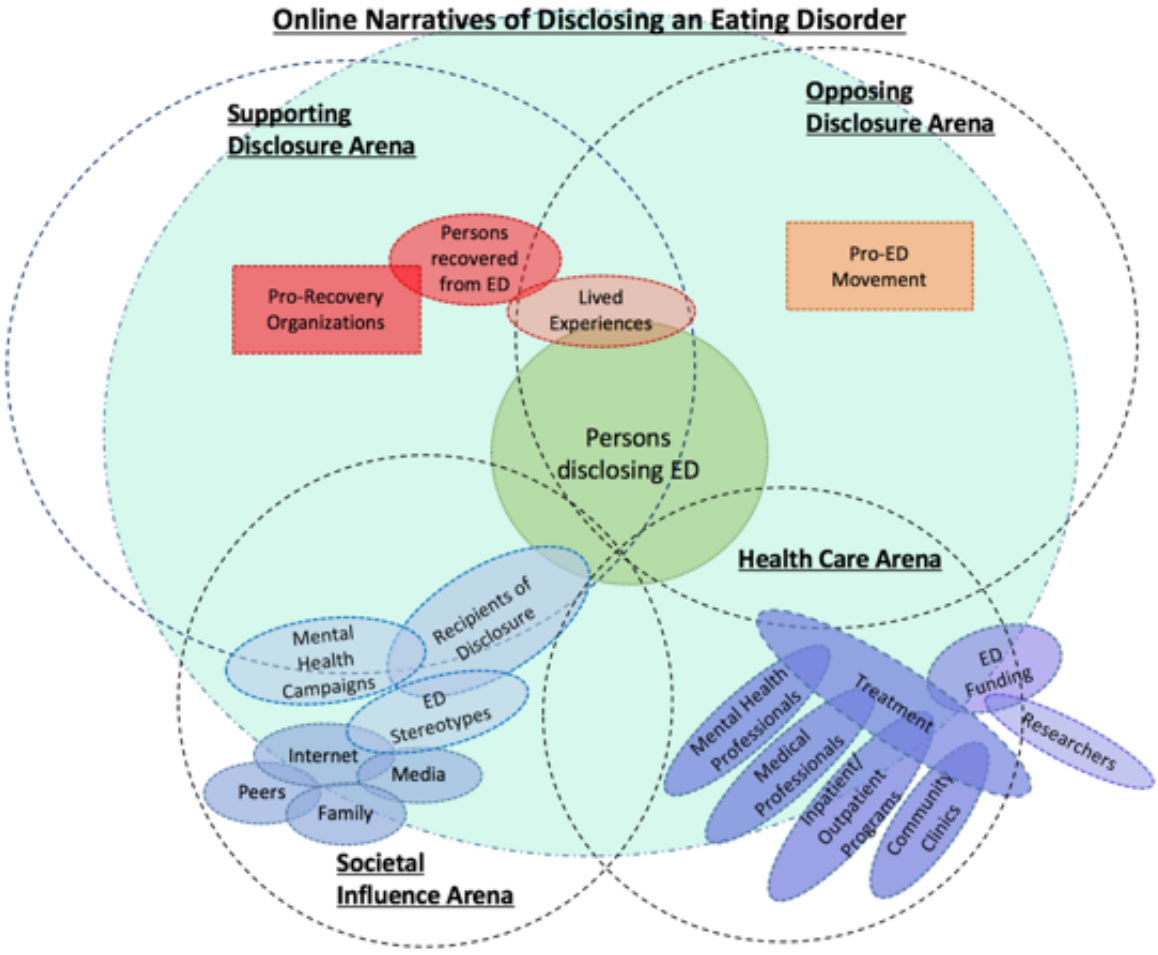

Figure 6. Modified social worlds/arenas map.

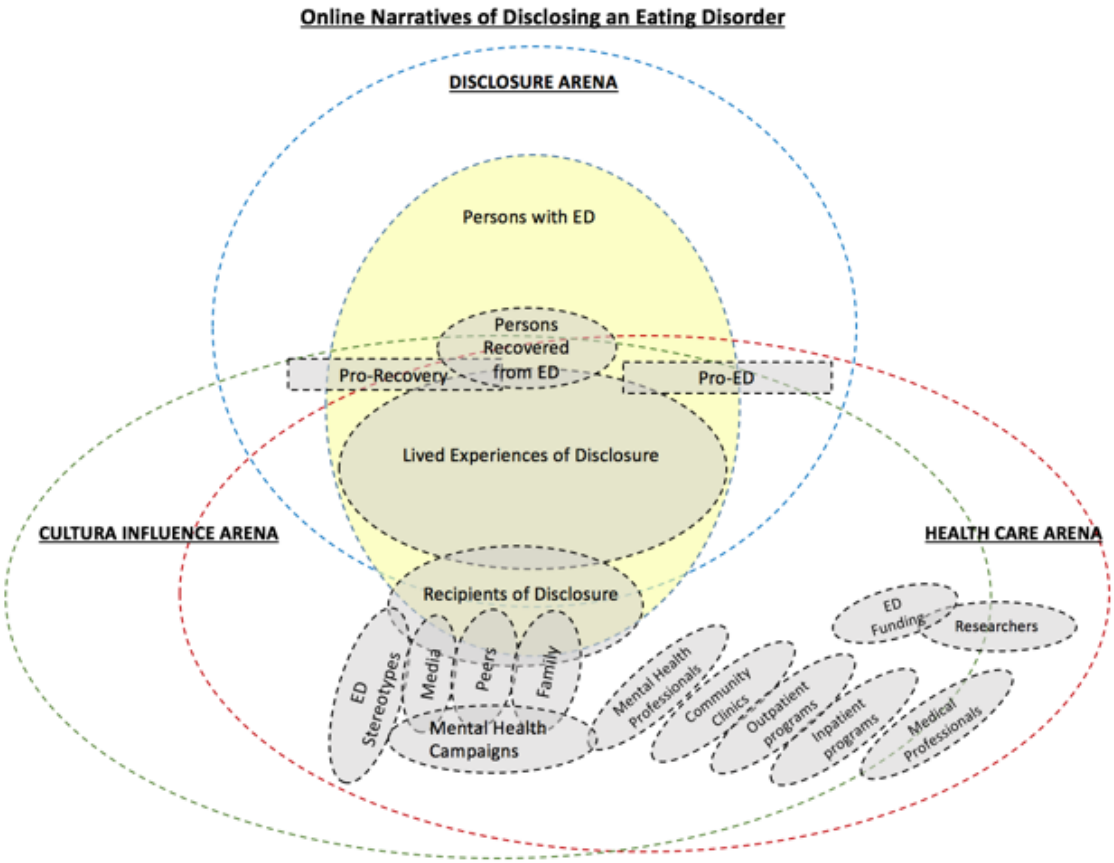

Figure 7. Most recent revision of social worlds/arenas map.

In this project I illustrate three arenas that represent the social action and commitment that make up the situation of inquiry: (a) disclosure arena, (b) cultural influence arena, and (c) health care arena. Within the arenas are many social worlds, representing "a group of people who come together through a shared interest on which they are prepared to act and who use similar technologies and discourses in pursuing their mutual concerns" (Clarke, Friese, & Washburn, 2015, p. 174). As seen in Figure 7, all of the arenas overlap, indicating the multidirectional influence each has on the other. Below I will provide further detail about my decision making process on placing and naming the discursive worlds and arenas the way I did.

Disclosure arena. This arena is made up of various groups and collective movements that advise individuals either to seek help and disclose their eating disorder or to not disclose for

multiple reasons, including avoiding judgement, fearing stigmatization, and because of the belief that an eating disorder is a lifestyle choice rather than a pathology. The disclosure arena is positioned as the most central of all arenas on this map to represent the pervasiveness of this topic throughout the data from eating disorder websites. This arena also contains the largest social world, *persons with ED*. I coloured this world yellow and left all other worlds grey as I wanted to visually refocus myself and the readers to the main social world of interest in the situation, which are the experiences of people with eating disorders as opposed to those who have recovered from an eating disorder or those who are the recipients of a disclosure. The *persons with ED* social world overlaps with all of the arenas and various other social worlds in order to signify how other worlds have influenced the experiences of disclosing to others and also how there are shared commitments to action within these sites of overlap.

Clarke (2005) stated "discourses per se are not explicitly represented on social worlds/areas map. This is not because they are not present in worlds and arenas but because social worlds *are* universes of discourse" (p. 114). With this in mind, multiple discourses that emerged from the online data were not included on the map, however are reflected in the represented social worlds.

I created *pro-recovery* in the shape of a rectangle instead of an oval because it represents an institution. Institutions can be considered places where discourses become crystalized and coordinated by the collective action and groups involved within it. This institution includes several discourses proposing that an eating disorder is an illness and that professionals are helpful and will be a beneficial support in recovery. Within *pro-recovery*, not-for-profit groups, advocacy groups, and medical and mental health professionals offering support to those experiencing eating disorders, come together to collectively support disclosure.

I overlapped the *persons recovered from ED* social world and the *pro-recovery* world because individuals in both worlds communicated online about their personal stories of disclosure and frequently encouraged others to disclose, mostly for the purpose of receiving help. In support of the shared commitments of these social worlds, one individual online stated, "talking about an eating disorder isn´t necessarily easy, especially at first, but it does get easier with time. So if there´s a friend you trust there try to confide in him/her" (Username: kathywonders, Daily Strength). The *persons recovered from ED* social world does not overlap with the *pro-eating disorder* world, indicating there is not likely to be any shared commitment between the two worlds, primarily because there is no shared social action. I will explain this world's connection to *pro-eating disorder* world in detail later.

I decided to make the *lived experiences of disclosure* social world very large on this map to portray the many experiences, shared commitments, and actions to specific discourses that are discussed online by groups recovered from eating disorders or still experiencing eating disorders. Online it seemed that the majority of discourses coming from this world were from people offering advice and support to others often relying on personal experiences. One individual offering support in the form of lived experience stated:

> I had to admit I needed help first, and learn to ask for it, not something I like to do. Anyhow, go and keep going until you are heard. Hopefully they will do what they should and take full labs, & check your heart. (Username: Eshaw, Daily Strength).

Towards the left side of the map, within the disclosure arena, I have illustrated *pro-eating disorder* as an institution that is supported by the discursive notion that an eating disorder is a lifestyle choice rather than an illness. *Pro-eating disorder* was placed within a rectangular shape to illustrate the large scale social action that reifies this organization of individuals and groups

through shared beliefs and values. Online pro-eating disorder communities, both private and public, largely make up this organization. *Pro-eating disorder* was positioned close to *persons recovered from EDs*, but not overlapping, because although an individual may be positioned within either group, the collective action of the groups does not overlap. From the online data, it seemed as though collective groups supporting the *pro-eating disorder* institution argued that individuals should not share their eating disorder with others because what they are doing is not serious enough: "I guess I am still at the moment where I don't feel that I need to be worried about anything and that if I ever am about a side effect then I'm just being paranoid or a hypochondriac" (Username: TheED, Daily Strength). An important point to consider is that "an arena is an area of sustained interest and concern that brings multiple social worlds together over time" (Clarke, Friese, & Washburn, 2015, p. 174). The worlds found within the disclosure arena, although all have some aspect of disclosure in common, have disputed interests (e.g., disclose, do not disclose), making it clear that there is more than one approach and multiple commitments to action contributing to this area of interest.

Cultural influence arena. This arena is second largest in size and represents the many social worlds that influence the perceptions society has towards those with eating disorders. Disclosure is a relational process, and the recipients of eating disorder disclosure appeared to play a significant role in how the disclosure was believed to have gone, therefore, I represented these individuals' experiences as a group. The *recipients of disclosure* world overlaps with *persons with eating disorder* and *lived experiences of disclosure* social worlds because the *recipients of disclosure* world's actions often have an impact on the person disclosing. I positioned these worlds to overlap to indicate shared commitment towards responding to and addressing eating disorder disclosures, while facing the issue head on, in most cases.

Recipients appeared to respond in a variety of ways to eating disorder disclosures and it seemed like their responses may have been influenced by stereotypes prevalent in society about people with eating disorders (e.g., people with eating disorders are doing it for attention, people with eating disorders are manipulative). While communicating online, one individual described how their father responded to disclosure "he thinks I starve myself because my brother gets all the attention. So basically he thinks I'm doing this all for attention" (Username: C., Support Group). *ED stereotypes* and *media* social worlds share some overlap and are positioned intersecting with the *recipients of disclosure* world to illustrate how specific discourses or images from media exposure have the potential to influence how one responds to a disclosure of an eating disorder. Eating disorder stereotypes are often perpetuated by the media. One individual communicating online said, "misinformation and harmful stereotypes about EDs are so common that they'll probably judge you harshly owing to their own ignorant prejudice" (Username: Bulimiargh, Why Eat). This quotation illustrates the firsthand experience individuals have endured, highlighting the powerful impact that recipients' biased views can have over the person with the eating disorder.

Some of the recipient's responses to disclosures also seemed to reflect anti-stigma and pro-recovery information that has been shared through public campaigns aimed at normalizing and validating mental illness (e.g., Bell Let's Talk, Shatter the Stigma Mend the Mind, Opening Minds). Social worlds to conceptualize the role of family, peers, and the media were also included within this arena, as the messages shared by these groups often times influences the world's committed actions and positioning towards others with mental illness.

Finally, the *mental health campaigns* social world has been intentionally overlapped with *media*, *peers*, and *family* social worlds to represent how these world's commitments influence

each other and how the individuals within each world likely share some of the same actions. Further, *mental health campaigns* also overlapped with *mental health professionals* world, belonging to the *health care arena*. The overlap between these worlds indicates shared commitment towards the promotion of accurate education regarding mental health, and I intentionally aimed to demonstrate that *media*, *peers*, and *family* worlds shared in this commitment. While creating this social worlds/arena map I was aware of the great extent to which culture shapes current health care, and vice versa. The information and expertise from *mental health professionals* social world presumably was used to inform the *mental health campaigns* social world, therefore I have illustrated the two to be overlapped and in fact acting as a tangible bridge between the cultural influences arena and the health care arena.

Health care arena. The third arena represented in this map illustrates the health care system. The discursive worlds comprising help seeking were included to show the various groups involved and their shared commitments towards recovery and treatment of eating disorders. Groups including mental health professionals, medical professionals, inpatient programs, outpatient programs, and community clinics have been included in the map as social worlds as they are made up of different collective actors and offer diverse services/actions to individuals with eating disorders. The approaches of medical professionals are generally different than the approaches mental health professionals take towards the care and treatment of individuals with eating disorders. Both of these worlds are committed to action that supports individuals struggling, therefore, they have been positioned in the same general area within the health care arena. Despite a similar location, I intentionally positioned *mental health professionals* and *medical professionals* social worlds at opposite ends of the worlds representing treatment or recovery options, as these groups have received different training and utilize distinct

treatment protocols, representing quite different social commitments and actions. One individual described the support received from a medical doctor, "my doctor was really supportive when I told her about my ED a few years ago and ran a bunch of tests to make sure my organ function and nutrient levels were okay," (Username: IfYouCould, Daily Strength). The care received by a medical doctor is contrasted with how a mental health professional responded to an eating disorder disclosure, "you can discuss all your feeling with a therapist who will regulate things and help solve problems," (Username: Ivykat, NEDA).

In addition, I included *eating disorder funding* and *researchers* within the health care arena because of the possible impact they have towards options for treatment. A commitment to increased research, possibly pointing to the need for more services, or different treatment protocols may influence the treatment available to individuals who require it. Clarke (2005) suggested that researchers reference their own positionality while making the social worlds/arenas map as well. Consequently, I included *researchers* as a social world in order to illustrate the collective action generated by this group towards better understanding eating disorders in general.

In summary, my social worlds/arenas map illustrates what collectives come together within the situation of inquiry, and as Clarke, Friese, and Washburn (2015) stated "social worlds/arenas maps make it clear that there are more than two sides to a debate by showing the multiple voices involved" (p. 174). Although tensions are not the purpose of this map, they were implied through the positioning of some of the social worlds. The tension perhaps most apparent within this map are the conflicting discourses and groups of action that emerged and are intertwined within the social worlds that make up the disclosure arena. I represented these social worlds as (a) those that support disclosing and (b) those that do not support disclosing, and I

visually displayed these worlds from the left side of the social worlds/arenas map to the right. Further, I included the *persons recovered from ED* world overlapping with the *pro-recovery* world to represent shared action between the groups and to suggest that discourses about pro-recovery and the desire for treatment are evident in both groups. It is also important to acknowledge the orientation towards recovery in this situation. This perspective, either falling closer to the wanting to recover side of the map or being closer to the not wanting to recover side of the map seems to influence the social action of collective groups. These differing collective actions practiced by each world demonstrate complexity in this situation. Within the three arenas presented in the social worlds/arenas map, it became evident there were often sites of discord because of the multiple social worlds and their associated collective actions present. Clarke (2005) suggested that before the researcher makes a decision about what is really interesting within the social worlds/arenas map and pursues that direction further, one should begin to think about the positional maps, which is exactly what I did next.

Positional Maps

The final mapping process I embarked on was positional mapping. This type of map illustrates the major positions taken and not taken within the data, as well as highlights major issues, positions of concern, and sites of tension. Through this process, sites of silence are recognized and differences in position towards a particular topic become the focus. Clarke (2005) stated in this type of map there is no such thing as normal versus abnormal, and declared that positional maps simply demonstrate positions and differences in position that may be less common, more common, or even marginalized. Clarke (2005) articulated that positions should be demonstrated "on their own terms" (p. 126) and should not represent how the researcher views the discursive positions.

To create positional maps, the researcher must first identify basic issues in the situation of inquiry or 'hot button' issues. These elucidated issues are often times contested, and the researcher arrays positions related to these issues dimensionally across two axes. Typically, axes are arranged in terms of "more versus less" (Clarke, 2005, p. 128). Clarke stressed the importance of understanding that positions illustrated on the maps are not associated with actors or groups, but instead represent positions in discourse (2005). While mapping I kept this in mind, and referred back to my simplified relational analysis maps (see Appendices B-G) to remind myself of the major issues, relationships, and sites of tension and silence.

Like many of the other mapping processes, I felt unsure of how to proceed. Clarke (2005) noted that positional maps may at first seem "too procedural, formal, or even formulaic" (p. 136), however, creating them and simply jumping into the process seems to ease concerns. At one point, when I felt particularly stuck, I consulted with my PhD candidate mentor and spent several hours discussing the positions I had included on my initial maps and why I believed these positions needed to be represented the way they were. This conversation was incredibly generative and the situation of inquiry somehow became more dynamic once I involved another person in the conversation. Having a fresh set of eyes on the situation assisted me with elucidating various discursive positions. The following is a memo exert from my research journal, written May 13, 2016:

> I have come back from my consultation meeting feeling refreshed and like I have a brand new set of eyes to look at this situation. Discussing my maps with Alana was incredibly helpful and I found that inviting another person knowledgeable about eating disorders into the conversation helped me to clarify ideas and further confirmed some of the directions I was heading in. During this meeting I also realized that I was getting stuck

trying to conceptualize why two separate issues came together to make up a bigger story. By talking with Alana I was able to instead first focus on the hot button issues of the situation (starting with the bigger picture) then I narrowed it down to the most appropriate issues that influenced that controversial situation (what I plotted on the two axes).

Below is an image of the product of my brainstorming session with the colleague mentioned above:

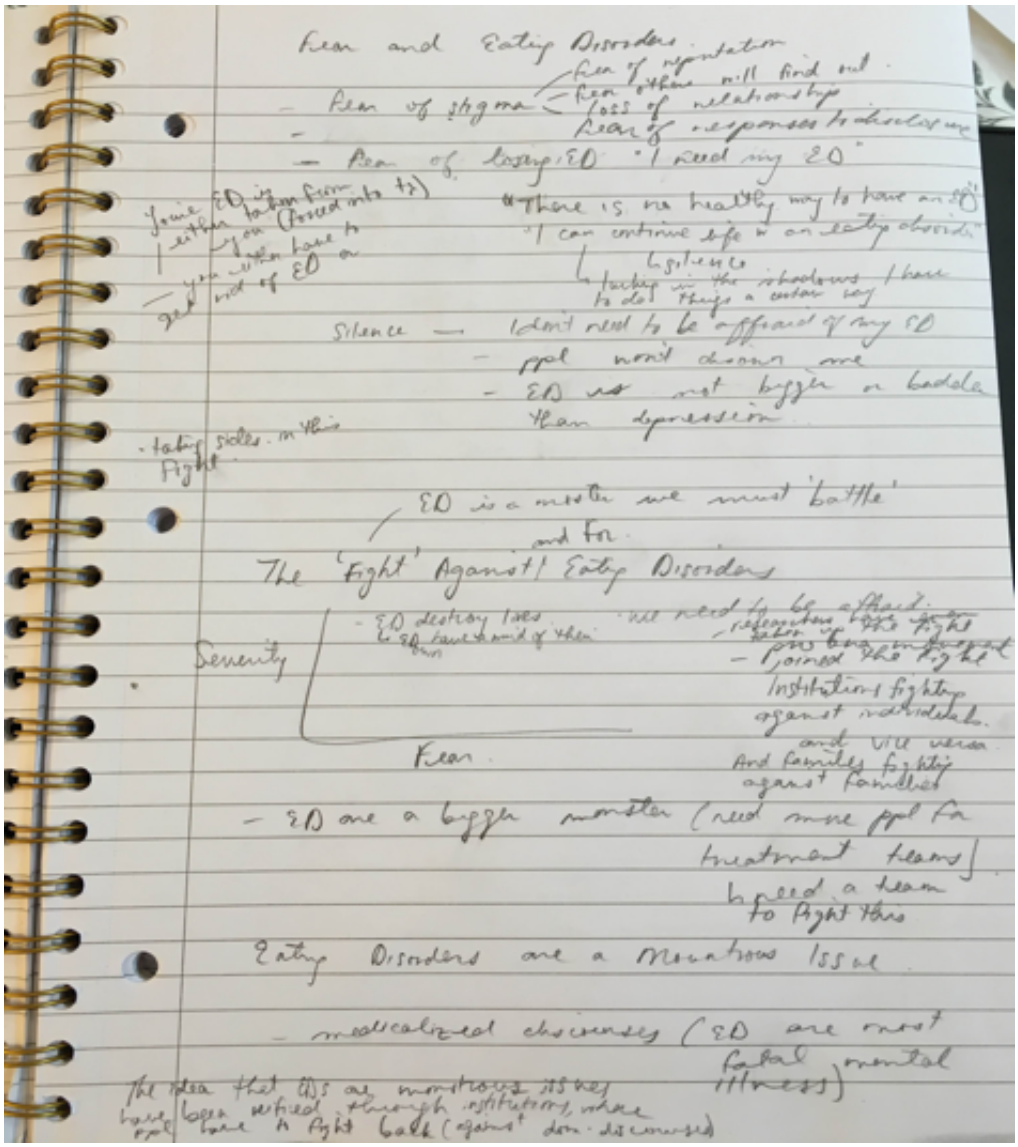

Figure 8. Brainstorming notes.

While creating multiple copies of maps, representing the concepts in visually different ways, and discussing with my mentor I eventually began to see the salient issues and debates emerging from the situation and the related tensions and complexities. Below I present and explain two positional maps.

While considering what controversial, hot button issues to illustrate in my positional maps I referred back to my simplified relational analysis maps to remind myself of the sites of tensions, contesting elements, and silences appearing in the situation. Recurring themes of pathology, agency, desire to disclose, and the notion of fear and loss seemed salient, therefore I embarked on a mapping task to represent these issues visually. After a month of mapping and multiple consultation meetings I figured that mapping: *the stigmatization of eating disorders*, would adequately capture the complexities and contested positions in the research project.

Positional Map I: The Stigmatization of Eating Disorders

Positional map I (Figure 9) demonstrates the controversial issue of the stigmatization of eating disorders according to two axes (a) pathology and (b) desire to disclose. Below I list the five discursive positions and one silenced position:

- Position I: Having an ED Makes Me Ill
- Position II: Us Versus Them
- Position III: Oblivious Outsiders
- Position IV: 'Too Far Gone' to Hide ED
- Position V: ED is a Lifestyle Choice
- Silenced Position: Disordered Eating Exists on a Spectrum

I chose to emphasize *pathology* and the *desire to disclose* on axes in order to demonstrate how these issues come together to create a situation that in part explains the stigmatization of an

eating disorder. I will explain each of these positions in isolation, then I will discuss the bigger picture of positional map I by integrating discursive positions.

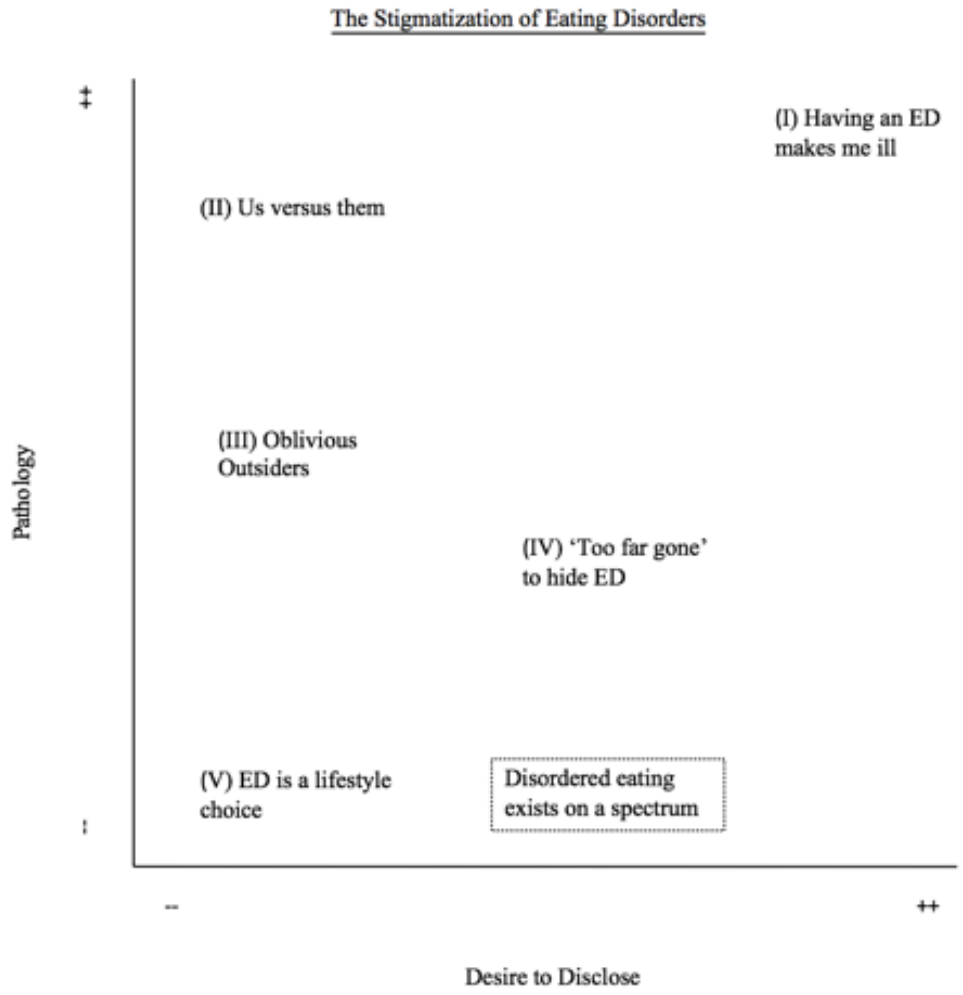

Figure 9. Positional map I: The Stigmatization of Eating Disorders.

Position I: Having an ED makes me ill. This discursive position characterizes an eating disorder as a pathology. Those who see experiencing an eating disorder as an illness feel like they must disclose in order to receive help. Some individuals communicating online reported beliefs portraying the notion that one cannot recover from an eating disorder alone and must also seek the help of families, peers, and mental health and medical professionals especially. One individual communicating online stated "this isn't something that one can do on their own. You

need to get the professional help" (Username: SuzanneKZ, Daily Strength). The same person communicating to another individual online said "you need a mental health professional to help guide you through the process and a program where there is a physical doctor as well so that they can monitor your overall health as well" (Username: SuzanneKZ, Daily Strength). These quotations illustrate the discursive positions taken on the issue of eating disorder pathology, implying that eating disorders are illnesses and are believed to require professional help to overcome. Another individual stated "It's not your fault you are unwell" (Username: Clairesfe, ANAD). The notion that having an eating disorder is not healthy or within the normal range of behaviours is echoed by some individuals communicating online, placing this discursive position high on both the pathology and desire to disclose axes. Further, staying true to the reflexive practice that is imperative to situational analysis, below is an excerpt from my research journal, written May 17, 2016:

> After interacting with two family members who have had eating disorders I have always been of the belief that these people required professional help. I have observed dramatic weight loss, intense control over making sure certain foods are available, denial on the part of the individual with the eating disorder, and parental dismissal of the issue. Based on these experiences I have thought that the person required outside, professional assistance, as addressing the eating disorder seemed too big for the family to help with on their own.

Based on personal experience with individuals with eating disorders and disordered eating, I suppose that my beliefs would be placed within position I on this map. I considered these individuals to be unwell when I noticed a significant change in how they interacted with others and the world around them while experiencing eating disorders, compared to how they behaved

prior to the eating disorder. The impairment of daily functioning was evident in these people, a characterization that contributes to someone being mentally ill.

Position II: Us versus them. The 'us versus them' discourse acknowledges how individuals with eating disorders feel when others (e.g., parents, families, friends, partners, doctors) do not appear to understand their eating disorder. One person said "you are right: it is a sad reality that no one without an ED truly understands what having an ED feels like" (Username: KDekyi:D, NEDA). Some individuals communicating online expressed frustration when opening up to others and being met with responses that demonstrated others' perceived misunderstanding of their experience. Further, individuals reported feeling like even medical professionals did not understand what having an eating disorder was like, "my doctor, who is aware of my past with anorexia and current issue with bulimia...offered me prescription diet pills *sigh* I'm tired of trying to educate my doctors" (Username: Bosley, Daily Strength). Unfortunately, it appears that once individuals have built up the courage to ask for help they are occasionally met with offensive or uninformed responses, reinforcing the notion that they are misunderstood and left alone to fight their battle:

> I went to the doctor. He didn't seem to know what to do when I told him I thought I had an ed. He left and wouldn't come back, even when I asked the nurse if I could finish talking to him. She just brought messages from him. He asked me to do blood work at a lab, and said he'd call after that. I don't know quite how to react. I thought it would be more helpful? I didn't really leave with more ideas of what to do that when I went. I don't know if it was worth it... (Username: Dreamer, Grace on the Moon).

Another person online said "no they cannot understand at all and will never be able to 'help' the way sometimes we want them to" (Username: Queen_mab, Why Eat), reflecting that this

discourse represents feeling like everyone without an eating disorder is against those with an eating disorder. The 'us versus them' discourse not only relates to feeling misunderstood but also further pathologizes those with eating disorders. When recipients of disclosure are perceived to not understand, their actions or inactions further stigmatize those with eating disorders by either advertently or inadvertently communicating that the 'other' does not understand or can possibly relate to the experience of someone who is ill.

Position III: Oblivious outsiders. This position became apparent during the early coding phase, as multiple individuals voiced their beliefs that others did not recognize what was happening in regards to their eating disorder. One person online stated "I sometimes wonder how others dont know? they see me eat a ton and lose weight.....makes me sad to think they are that oblivious to whats going on" (Username: Brody803, NEDA). This position represents how some individuals communicating online feel when others either do not notice seemingly obvious changes in body appearance or are perceived not to be concerned about those with eating disorders. Some discourses making up this position are centered around others not noticing red flags of an eating disorder (i.e., weight loss, not eating with family during meals, vomit in the garbage), whereas other discourses about others not understanding the recovery process also contribute to the experience of 'oblivious outsiders.' One individual reported about her family, "they think since I told them I'm magically cured since they become the food police. God they're so naïve it literally makes my brain hurt" (Username: skinthinbod, My Pro Ana). A sense of frustration is apparent from this position as individuals with eating disorders are not able to comprehend how those around them are not able to see the truth that they are struggling, "I think a lot of people without eating disorders don't really see the red flags bc it's so foreign to them" (Username: Oncrn25, NEDA). I argue that because others are not demonstrating their

concern for the individual experiencing the eating disorder, that the others might not recognize an eating disorder as an illness. If others did see patterns of behaviour or visual signs that were cause for concern perhaps they would take action and no longer be considered 'oblivious outsiders.'

Position IV: 'Too far gone' to hide ED. During online discussions regarding the desire to disclose some individuals endorsed the belief that they were 'too far gone' to conceal their eating disorder anymore. Demonstrating that eating disorders can become extreme both physiologically but also on an individual's spirits, one individual stated "i used to lie to my parents a lot, but then my problems just became so prominent that i couldn't hide them anymore so i've just stopped caring (Username: sick boy, My Pro Ana). This discursive position contrasts positions where individuals are either very committed to disclosing or are extremely against disclosing to others. One person online stated:

> the last 3.5 years I've had 5 long ED IP stints and have been on an involuntary treatment order the whole time. There's not much to hide and frankly I'm too far gone to bother, and too tired to try (Username: Hypokalemic, My Pro Ana).

This person's statement is a demonstration of the 'too far gone' position and reflects the mindset that occurs for individuals feeling like they have no control over their self presentation to others because their eating disorder has become so prominent. This position acknowledges how some individuals have given up trying to show others that they are okay and not at the hands of an eating disorder, and instead feel like they have no more power to hide it from others.

Position V: ED is a lifestyle choice. This discursive position reflects the pro-anorexia and pro-bulimia movement, stating that an eating disorder is not an illness but rather a way of living that requires self-control and hard work. Individuals who self identify as a member of the

pro-ana group do not consider an eating disorder to be an illness, and if they were to disclose it would likely make it more difficult to continue with the behaviours that would allow for them to maintain their eating disorder. One person online communicated "I don't always think you need someone to help you" (Username: mnvalles, ANAD). This position represents the mindset of those who believe their behaviours and cognitions are part of a rigid way of purposeful living. Below I have included a memo from my research journal, written February 13, 2016:

> As noted from the literature and from the data collected from pro-ana websites, individuals supporting this group believe eating disorders are a lifestyle that requires dedication and self-control (Lewis & Arbuthnott, 2014). Disclosing an eating disorder would arguably make it more difficult for pro-ana individuals to continue disordered eating behaviours and reach lower weight goals without others trying to intervene. It seems clear that individuals supporting the pro-ana movement are against acting in a way that will make continuing living their restrictive lifestyle more difficult, "tell them as little as possible, that way you can't be taken advantage of, you have the upper hand to your secrets" (Username: Annaliese, Why Eat). It appears then that this group may believe there is no value to disclosing, and believes that secrecy and concealment are a must.

Silenced Position: Disordered eating exists on a spectrum. While plotting this map, I could not help but notice that discourses consistent with the feminist perspective towards eating disorders were not represented. This absent position depicts a silence in the situation. Rather than viewing an eating disorder as an illness, others contest this view and propose that disordered eating behaviours exist along a spectrum. This position, typically held by feminist scholars, is traditionally silenced in the field of psychology in favour of the medical model and dominant

discourses supporting the pathology of eating disorders. Medical and mental health professionals, many of the actors that individuals communicating online are referring to, demonstrate their pathologizing philosophies and beliefs towards eating disorders by the treatments they offer and the ways in which they converse with those with eating disorders. I have placed this silenced position nearby the *ED is a lifestyle choice* position along the same horizontal axis, as both do not support that an eating disorder is a pathology. Although these positions are placed beside each other on the pathology axis, these positions are fundamentally different. Tension between the two positions ultimately stems from how these discourses were created through social action. The silenced position comes from the work and beliefs of feminist scholars who strongly propose that many females in western society partake in dieting and rigid exercise in order to look a certain way (Piran, 2002). Further these scholars propose that eating disorders are a social construction and adaptation to the society individuals live in (Brown & Jasper, 1993). These scholars do not believe that individuals on the far end of the spectrum should be stigmatized with labels when the majority of females also practice some of the same behaviours (Brown, 1993).

To summarize positional map I, the primary issues contested in this visual are the discursive positions that add to the stigmatization of those with eating disorders versus the positions that do not. For some individuals disclosing seems like the only answer and way to receive help for their eating disorder, as they view it as an illness that needs to be cured by professionals. Alternatively, others do not have a desire to disclose because they are of the position that an eating disorder is really a lifestyle choice, and why would a lifestyle choice require intervention? Further, positional map I illustrates positions reflecting responses from others that further imply that an eating disorder is a pathology, as others are perceived to be

ignorant and to not understand. Taken together, the five discursive positions on this map tell the story of a controversial issue, the stigmatization of eating disorders. It appears like we need all hands on deck to fight this illness and the stigma that comes along with it.

Positional Map II: The 'Fight' Against and For Eating Disorders

Positional map II demonstrates the hot button issue that eating disorders are a bigger monster compared to other mental illnesses and are something that must be battled. I plotted discursive positions along the axes (a) severity and (b) fear to illustrate the following five positions and one silenced position:

- Position I: EDs Destroy Lives
- Position II: We Need to be Afraid
- Position III: Sides Must Be Taken
- Position IV: I will be Stigmatized
- Position V: I Need my ED
- Silenced position: I Can Continue Living Life with an ED

After consulting with the colleague mentioned above, it seemed clear to me that eating disorders have been positioned in Western society as a bigger battle and a monstrous issue compared to other mental illnesses. From knowledge learned prior to embarking on this project, and also as a consumer of media messages, I am aware of how the outside world views those with eating disorders. While coding data I was also cognizant of the particular language individuals communicating online used to describe their experiences with some referring to their 'battle' and 'fight' with their eating disorder. Below I explain each of the positions and why I have included them in positional map II (Figure 10) and I conclude by integrating the positions to illustrate the bigger picture.

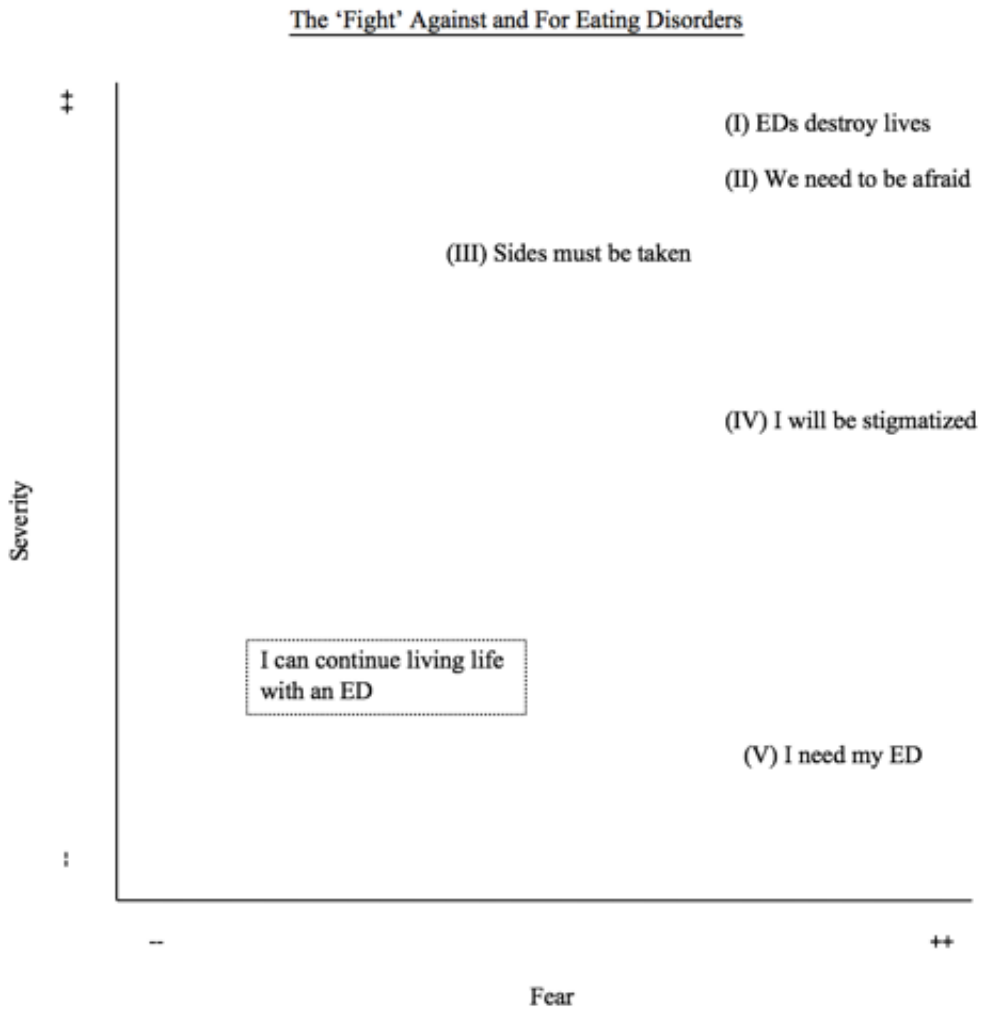

Figure 10. Positional map II: The 'Fight' Against and For Eating Disorders

Position I: EDs destroy lives. Position I acknowledges the discourse that eating disorders destroy lives and are a monster that consume people. From prior exposure to articles articulating lived experience of those with eating disorders, I have read several items composed like letters addressed to eating disorders published on informal news media platforms (e.g., Puckmob, Buzzfeed, Thought Catalogue). I describe these pieces in a memo written in my research journal on May 19, 2016:

I recently came across an article addressed "Dear ED (Eating Disorder)" on PuckerMob.

> In this article the author spoke about her eating disorder taking years of her life away, robbing her of relationships with others, and having both mind and body being taken over. I have read other letters addressed to the eating disorders of family members, in which family members have described how their mother was taken from them, for example. In some letters children write that an eating disorder had taken their productive and once warm and supportive mother from them, and as a result the children were forced to take care of themselves because their mother's eating disorder prevented her from being the person she used to be. These letters represent the experiences of individuals with eating disorders and those close to them and illustrate how destructive and consuming eating disorders can become.

Though none of these pieces were found in the online data I coded, I felt it was important to include in the positional map as the notion of an eating disorder being a destructive force on lives is important and salient from other sources. One individual communicating online said "my biggest fear is my daughter catching on, every morning I have to shoo her away from the scales I never want her doing the same rituals as learnt behaviour" (Username: Liability, My Pro Ana). This quotation reflects the idea that eating disorders wreak havoc on lives, and even those with eating disorders do not wish for their loved ones to develop them.

Position II: We need to be afraid. Another position filled with tension is the notion that we must be afraid of eating disorders. Factors including medical discourses, current treatments, and the ways individuals have been socialized to speak about eating disorders have led us to fear eating disorders more so than other mental illnesses. While reviewing with the literature, I was constantly reminded that eating disorders are the most fatal mental illness and I wondered if those of us within academic literature were the only ones being reminded of this piece of

information. While coding I realized this was not the case and those in treatment for an eating disorder are also told of this alarming statistic, “yes it is scary - I used to always end up in tears if I talked about my eating disorder - but that´s OK - we´re talking about a life-threatening disease here” (Username: kathywonders, Daily Strength). This dominant discourse referring to the fatality of eating disorders fuels people’s fear and contributes to the position that eating disorders are a monstrous issue. In addition, best practice for eating disorder outpatient or inpatient treatment typically involves a team of professionals (de Amusquibar, 2000; Luzier et al., 2012), all contributing a different specialty to the recovery process including medical doctors, psychiatrists, psychologists, nurses, and nutritionists. The idea that eating disorder treatment requires a team rather than a single professional also adds to the fear that eating disorders are a bigger monster than other mental illnesses.

Aside from the dominant medial discourses that are contributing to this position, the way individuals speak about their experiences also adds perceived legitimacy to this notion that we must be afraid. One individual online stated “at least still nobody knew I was starving because I didn't want to be a monster. That's what I was scared of people finding out” (Username: atelophobicatelophile, My Pro Ana). Calling oneself a monster and being fearful of others learning of one’s eating disorder was echoed by several individuals communicating online, and points to the use of language (e.g., monster) and how it is perpetuating this position. Another person online stated “I’m scared the therapist will think I’m being ridiculous. It’s not that easy of a battle, and I’m scared that he or she will write me off” (Username: horsegirl10, ANAD). Again the use of language (e.g. battle) is used by individuals to describe their experience of living with an eating disorder and further demonstrates how eating disorders are something to be feared, because once an eating disorder is developed one must ‘fight’ and ‘battle’ to overcome.

Below is a memo from my research journal, written May 11, 2016:

> It appears that fear acts as a motivating force that promotes action, prevents action, and at times invites a response from the recipients of disclosure. I argue that fear is an actant, meaning that fear has agency in the situation. According to the data, fear forces people to do things and it suppresses people to not do things. Fear was mentioned copious times by numerous voices making up the data that I analyzed. These individuals expressed fear of losing relationships if others were to find out about their eating disorder, fear of being stigmatized, fear of burdening others, fear of eating disorders themselves, and fear of losing one's eating disorder and the loss of perceived control that accompanies it. These messages and societal apprehension towards eating disorders fuels the discourse that eating disorders are something to be afraid of.

Position III: Sides must be taken. Not only is an eating disorder seen as something to be battled, but those involved must also take sides. Most commonly the lived experience of those with an eating disorder being forced into treatment have been visible within the online data. One individual stated "I am currently being threatened to go to residential at the hospital" (Username: SuicidalAddictions, Psych Forums). Another individual said:

> my mom is threatening to have me committed to an inpatient hospital (the same one I went to when I was 17). I just had a conversation with her and it ended with her yelling at me and saying she's going to call 911 and have me taken to the psych hospital. I honestly cannot take her threats and yelling anymore… I've tried telling her that threatening me is unhelpful. But truthfully, I'm scared she will actually commit me...I am an adult now, but can she still force me into inpatient against my will? (Username: Wildfower, Daily Strength).

This position was reiterated by numerous others communicating online and reflects the discourse that all that are involved with this issue are taking a side. In both of the above quotations, the individuals were referring to family members who were threatening treatment, and according to the online data this appears to be a common occurrence. Not only do families have to take sides but hospitals and treatment facilities also take sides, most often to eradicate the eating disorder whether the individual with the eating disorder wants this or not. The sides different groups take against an eating disorder are often not subtle and agendas are pursued forcefully. One individual described her experience at the hospital "the last time I slipped up it took a quick trip to the hospital and being threatened with a feeding tube then being damn near force fed" (Username: Precious97, Daily Strength). From past experiences of either being threatened or admitted to health centers, individuals with eating disorders have learned that others (e.g., medical staff, families) have decided to fight against the eating disorder and do so physically and forcefully.

Families have also joined the fight against eating disorders and appear to take action against the eating disorder either by trying to solve the issue themselves or by intervening with medical or mental health support. Where the fight is particularly visible is in the circumstances with those with eating disorders who do not want help and do not want to stop. Severe tensions are articulated online reflecting the idea that eating disorders have turned families against families, "yesterday my parents keep trying to talk to me and even bombarded me with this huge envelope of eating disorder information. My mom even went to a support group thing the whole afternoon yesterday" (Username: Bianca, eHealth Forum). It seems as though families have evidently chosen sides against the eating disorder.

Researchers have also taken up the fight against eating disorders as evidenced by

research interests to prevent eating disorders within school aged children, to identify risk factors, and to find most effective eating disorder treatments, to name a few. In addition, researchers have looked closely at the pro-eating disorder movements focusing mostly on pro-ana websites. It is clear from the literature that researchers have taken a side against the beliefs and philosophies of those supporting the pro-ana lifestyle and in response have authored numerous articles on the dangers of this movement (Chesley et al., 2003; Lewis & Arbuthnott, 2014; Meenan, 2003).

Position IV: I will be stigmatized. Position IV acknowledges the fear of stigmatization. This position was evident from the numerous accounts of individuals communicating online who spoke about fearing losing their reputation and fear of burdening others with the knowledge that one had an eating disorder. One individual stated "I'm just afraid there're gonna get mad at me or call me a freak" (Username: Percious97, Daily Strength). This quotation represents the fears that many individuals communicating online reported, the apprehension of not being understood and judged negatively. Others mentioned being fearful that if others knew about their eating disorder that they would no longer be interested in continuing a relationship, "I'm ashamed and afraid that people finding out will only push them away and that they won't understand" (Username: Caroline411, eHealth Forum).

Further, this discursive position is also made up of the anticipated fear individuals have when thinking about who else will find out about the eating disorder. One person online said "hellz to the no. Don't tell such an intimate secret after knowing them for only one month. You don't know how they will react and who THEY will tell" (Username: Hershey, Why Eat). It seemed that individuals communicating online recognized that they had no control of what others would think of them after they found out about the eating disorder, and this uncertainty

lead to further unrest and concern about stigma.

Position V: I need my eating disorder. This last position plotted on positional map II acknowledges the fear individuals experience when thinking about the possibility of losing their eating disorder or it being taken away against their will. If eating disorders are to be conceptualized as a fight, then this position would characterize the fight 'for' eating disorders. It was evident from the online data that some individuals did not feel ready or had any desire to let go of their eating disorder, "I am 16 so having a diagnosis means that somebody can try to stop me, they can make me gain weight" (Username: Ganja Gremlin, My Pro Ana). The notion of wanting to maintain one's eating disorder and being against interference is the salient issue within this discourse. Many individuals with eating disorders believe what they consume and the energy they exert is the only control they have in life, therefore, it is not surprising that these people would fight even harder to maintain the one thing in their life that gives them the feeling of control. To support this claim, one individual stated "I just feel like I can't tell them because they will send me to theripist and make me stop and I really dnt wanna" (Username: Kammij, eHealth Forum). Others mentioned having no desire to stop engaging in disordered eating practices, "not wanting anyone to know because I dont really want to stop" (Username: Brody803, NEDA). Ultimately, this discursive position represents the fear of losing one's eating disorder against their will.

Silenced position: I can continue living life with an ED. *I can continue living life with an eating disorder* is a largely silenced position that does not place emphasis on fearing or believing eating disorders are severe. I plotted this as a silence as I did not notice voices within the online data or within the literature that suggested that one can live with an eating disorder and go about their daily life not impacted by the effects of an eating disorder. In contrast to the

positions that have pathologized eating disorders through medical and dominant discourses, this silenced position instead represents the other side of the spectrum and suggests that eating disorders do not need to be feared and that families and friends will not turn their backs on an individual if they disclose they have an eating disorder. This position also contests the discourse that eating disorders should be feared and are a monstrous issue. Instead, this silenced position represents the belief that eating disorders are just another type of mental illness, not bigger or more serious. Further, within the complex situation of the 'fight' against and for eating disorders, it is important to note that when an individual is confronted by others or willingly discloses their eating disorder it is either taken from them (i.e., forced into treatment) or the person fights back against the intervention and the maintenance of an eating disorder persists. There seems to be no middle ground in traditional recovery discourses, thus further adding to the silenced position that individuals can in fact live their lives with an eating disorder.

In summary, positional map II attempts to illustrate the 'fight' against and for eating disorders. Multiple contested discourses contribute to this situation and have impacted why and how individuals use words like *battle* and *fight* when referring to their experiences with eating disorders. It is compelling and dynamic to consider how the fear of being stigmatized, the pathology attributed to eating disorders, the taking sides against eating disorders (i.e., individuals, families, and institutions), and the perceived need to be afraid together contribute to this 'monstrous' issue.

Chapter Summary

In this chapter I presented findings that were a result of the multiple situational analysis mapping processes outlined by Clarke (2005; Clarke, Friese, & Washburn, 2015). Memos written simultaneously to the analytic mapping process were also included as a source of data

within this chapter and were presented to further show the tensions, differences, and positions that arise during online accounts of disclosing an eating disorder. In the next and final chapter, I will present the key findings articulated above in relation to literature on eating disorders, mental illness, and disclosure. Further, I will also discuss implications for counselling psychology, future directions, and conclusions as they relate to my research question.

Chapter 5: Discussion

In this final chapter I review the findings produced by situational analysis mapping procedures and I discuss them in relation to relevant disclosure, mental illness, and eating disorder literature. In addition, I offer a project map of the study that conceptualizes particular aspects of the project that I consider especially compelling to share with intended audiences. While situating my findings, I also highlight the sites of tension depicted in the project map, and discus how these positions and differences are taken up within the literature. Finally, I conclude with implications for counselling psychology, as well as the strengths and limitations of the project, followed by recommendations and future directions.

Project Map and Key Findings

Within this project map, I have chosen to highlight salient positions and hot button issues that surfaced throughout the research project. Clarke described project maps as "tailored to explicate particular aspects of a specific project to intended audiences" (2005, p. 137). Essentially, project maps are based on the three types of situational maps and are created with the purpose to "travel well" (Clarke, 2005, p. 137). This project map points to the (a) obstacles individuals face when disclosing their eating disorder, (b) fight that frequently occurs after an eating disorder disclosure, (c) sides being taken, typically against the eating disorder, (d) potential fear and stigmatization one experiences after disclosing, and (e) notion that eating disorders are serious with potential to destroy lives. Below I outline the compelling elements of the situation that I would like to reflect back to the individuals considering disclosure, see Figure 11.

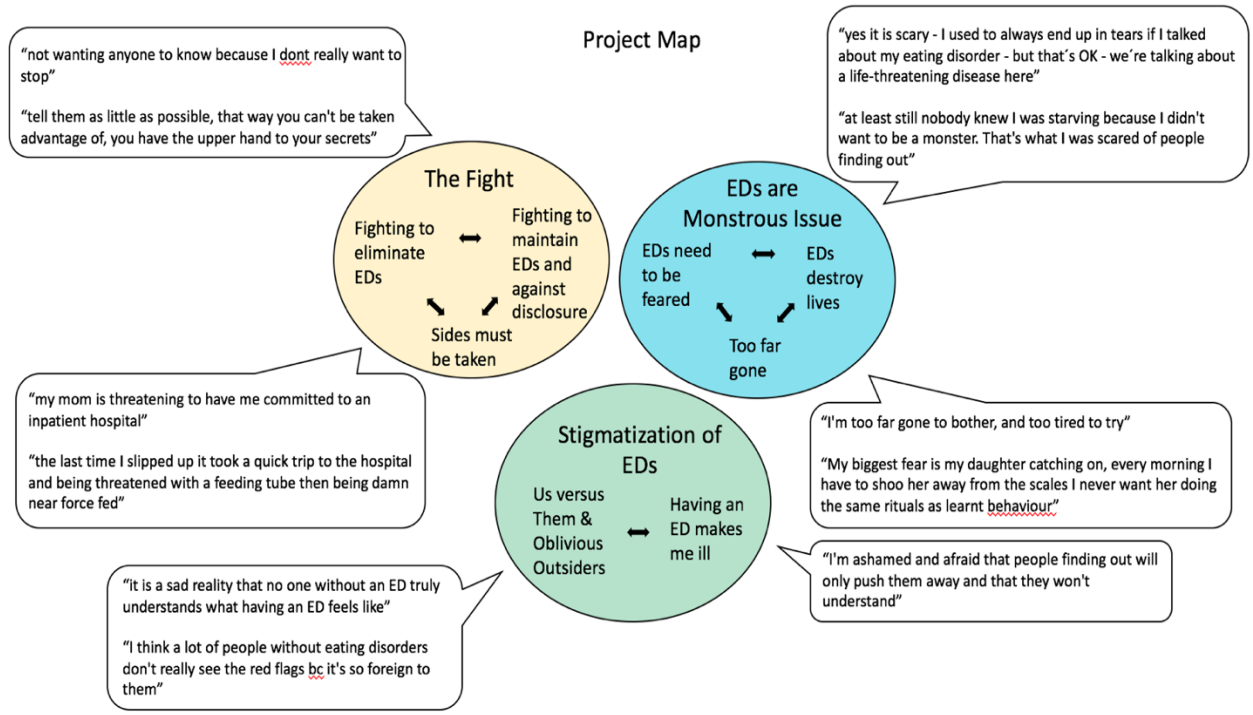

Figure 11. Project map

Main findings presented on the project map include (a) the fight for and against eating disorders, (b) eating disorders as a monstrous issue and the role of language, and (c) stigmatization of eating disorders and disclosure. I will explain why I believe elements from the project map stood out to me as exceptionally salient and the particular reasons I am compelled to reflect these findings back to individuals considering disclosing an eating disorder.

The Fight For and Against Eating Disorders

I have chosen to represent this finding in my project map with the intent to highlight the tensions that exist once a disclosure has been made. Individuals communicating online often spoke about being fearful that others would take their eating disorder away, whether that be through treatment or others keeping a closer eye. Individuals considering disclosure may not be aware of this fight so to speak, and it is my intention that by sharing this project map I will reflect the tensions that arise after the disclosure of an eating disorder.

Many people communicating online mentioned the stress within their families after they had disclosed their eating disorder. The tension between family members could be understood as a fight, against eating disorders from the perspective of families, and the fight for eating disorders by individuals who disclosed. Literature demonstrates numerous treatment options available to decrease eating disorder behaviours and cognitions, and one such piece of literature refers to the roles families play in the strain filled recovery process. Brown (2011) recounted personal experiences of feeling helpless and passive in the recovery process of her daughter's struggle with anorexia nervosa. Brown positioned a parent's role to a child with an eating disorder akin to being "locked in a kind of mortal combat with someone we could not and did not want to understand" (2011, p. 457). This arguably severe use of language paints a picture of a tense situation where parents want to take action against the eating disorder that is taking hold of a child. Conversely, Brown (2011) also acknowledged a contrasting position that described some individuals with eating disorders as insisting nothing is wrong and they are in fact healthy. The insistence of health and denial that anything is wrong, according to Brown (2011), leads to a treatment process marked by a challenging trajectory that often resulted in parents and children taking opposing sides. This struggle was also reflected in my project. I have intentionally included this point on my project map because individuals may not expect for families to take such severe stances against eating disorders and I think it would be beneficial for individuals to be aware that this might occur. I also believe that representing 'the fight' on my project map helps others better understand that a disclosure is not a singular event, but rather a build up of tensions and fights within the family unit that lead to the intentional act of disclosure.

Eating Disorders as a 'Monstrous' Issue and the Role of Language

As discussed in Chapter 4, discourses about fearing eating disorders were present within the data. Words including *battle*, *fight*, and *monster* were used online to describe the personal experiences of those with eating disorders. I have chosen to reflect this position in my project map as I believe the language individuals communicating online used is compelling to share with others struggling with eating disorders. I argue that the function of language plays a large role in the idea that eating disorders are monstrous issues compared to other mental illnesses.

Individuals in the online forums communicated that eating disorders were a bigger, scarier issue compared to other mental illnesses. The positions making up this situation included (a) eating disorders destroy lives, (b) we need to be afraid, and (d) too far gone. The importance of how language is used when describing an eating disorder has also been taken up in related research. Researchers curious about the role that language plays in constructing meaning, making sense of eating disorders and recovery conducted interviews with 39 individuals hospitalized for anorexia nervosa and bulimia nervosa (Malson et al., 2011). When inquiring about recovery, participants frequently mentioned that imagining themselves recovered from an eating disorder was "impossible" (Malson et al., 2011). The inability to even imagine oneself as recovered points to the self-constructions of participants involved in the research, but is also echoed in the cultural discourses regarding eating disorders prevalent within Western society. Malson and colleagues (2011) described the common experience of body dissatisfaction in Western societies, especially for females, and indicated that imagining a time when participants might expect to be free from these concerns seemed unlikely. Individuals interviewed also described having an eating disorder as "wasting your life" and one participant described "feels as if I've been asleep for four years" (Malson et al., 2011, p. 31). Malson and colleagues used

discourse analysis and suggested that individuals feared missing out on important life events and were also concerned about their eating disorder taking over their lives and potentially enjoyable moments in the future. Participants in Malson et al.'s (2011) study also used language similar to, if not the same as, the participants in the current study used. For example, one individual described her experience with her eating disorder as a "constant battle" (Malson et al., 2011, p. 29). Participants in my study also used *battle* and *monster* to describe their experiences with eating disorders. When explaining their findings Malson et al., (2011) stated, "being 'anorexic' is constituted here in clearly negative terms as a life-long and potentially fatal 'constant battle'" (p. 29). The fact that individuals are referring to their experiences of living with eating disorders as *battles* and *fights* reinforces the notion that we must be fearful. The positions within the blue circle on the project map are intended to demonstrate that social forces, such as the use of language, add to the perceived severity and fear of eating disorders. Also, when eating disorders are referred to as *constant battles* and those experiencing them are referred to as *monsters*, it reinforces the notion that eating disorders are powerful enough to destroy lives.

Stigmatization of Eating Disorders and Disclosure

Experiencing and anticipating stigma prior to and after disclosing an eating disorder was a widely presented experience within the online data utilized in this study. Individuals communicating online frequently reported being fearful of what others would think and how others would respond after a disclosure. I have chosen to reflect this finding in the project map because of the anticipated or real stigma experienced by those with mental illness either prior to or after disclosing (Brohan et al., 2013; Dinos et al., 2004; Falkov, 2004; Lakeman et al., 2012). The green circle in this project map is important because of the contrasting discourses that are prevalent in Western society about eating disorders.

The experience of stigma in some instances was more intense when the recipients of disclosure placed blame and/or attributed the development of an eating disorder to personal fault or choice. Reactions to disclosure were reported as particularly hurtful when (a) the recipients held negative beliefs about eating disorders, and (b) recipients believed that vanity and attention were the purposes of an eating disorder. These experiences are reflected in stigma research regarding eating disorders. Dimitropoulos and colleagues (2016) proposed that the general public believe individuals with eating disorders can simply (a) pull themselves out of it and (b) only have themselves to blame for their eating disorder. This research supported the notion that individuals with specific mental and physical illnesses are further stigmatized because of the blame attributed to their condition (Dimitropoulos et al., 2016). Research emphasizing the stigmatization towards individuals with HIV/Acquired Immune Deficiency Syndrome (AIDS) also emphasized the added stigma individuals have to cope with, since many people attribute blame to those who contract these conditions. Greene (2000) indicated that for individuals with HIV/AIDS there seems to be a stigma towards the overall illness, but also additional stigma when the person is blamed or believed to be in control of contracting the illness. The experience of double stigma can also be related to the concept of "double coming out" (Greene, 2000, p. 128), where disclosing one part of an identity means that another piece of one's identity is also shared; for example, disclosing HIV through sexual activity with a same sex partner. Greene also introduced the notion of a continuum of blame from *deserving* to *being innocent*. This continuum of blame on the individual who is already being labelled/stigmatized by the general public is perhaps not unique to research on gay men contracting HIV/AIDS (Greene, 2000). This continuum could potentially be applied to eating disorders.

I cite Greene's (2000) research to draw a parallel between the stigma and blame associated with HIV/AIDS and apply it to individual's with eating disorders. Specifically, eating disorders are a stigmatized condition, in addition, people who carry the belief that the individual is to blame for his/her eating disorder add double stigma for those with eating disorders. In other words, 'you have a mental illness and it is your choice.' Some research about stigma directed specifically towards individuals with anorexia nervosa has been conducted. Dimitropoulos and colleagues (2016) conducted 19 qualitative interviews with females receiving intensive inpatient treatment for anorexia nervosa, and demonstrated that all participants believed that the general public did not view eating disorders as an illness. Instead, participants used words like *crazy* or *weird* to describe how they believed the public viewed them (Dimitropoulos et al., 2016). The perception that the public did not consider eating disorders to be real illnesses often lead participants to conceal their eating disorders, due to fear of further stigmatization (Dimitropoulos et al., 2016). Further, participants expressed that the general public misjudged the causes of eating disorders, giving examples that the public believed that people with eating disorders had "simply a desire to emulate celebrities and models" and engaged in extreme practices for vanity (Dimitropoulos et al., 2016, p. 50). Taken together, the ignorance and/or misunderstanding that the general public has towards those with eating disorders plays a role in the stigma experience. Within the green circle on the project map the position 'us versus them' is illustrated. I argue that this position is particularly compelling as it may partially explain the perception that others do not understand what it is like to have an eating disorder. I argue that this positioning impacts the stigmatization experience and is thus a particular aspect of the situation important to draw attention towards.

Us versus them: Feeling like others do not understand. As demonstrated in my study, individuals communicating online expressed concern, frustration, and even agitation when others around them were not able to understand what it was like to have an eating disorder. This position is reflected in the project map as it seemed particularly salient within the data and has important implications for counselling psychology. The notions of 'us versus them' and 'oblivious outsider' were demonstrated with examples about doctors prescribing diet pills to patients they knew had struggled with disordered eating, parents pushing quick fixes on a child who had disclosed an eating disorder, and frustrations surfacing when others did not notice concerning behaviours or weight loss. Some individuals also made comments about health professionals not being able to understand what having an eating disorder was like if they had never personally experienced one. This notion of not trusting others to be helpful if they have not personally experienced an eating disorder is important to consider for professionals working in this area.

Implications for Counselling Psychology

Counselling psychologists could offer unique perspectives towards the field of eating disorders, and the experience of disclosing an eating disorder more specifically. First, the current study points to the complexity of the experiences of those who disclose or consider disclosing their eating disorder to others. Many individuals communicating online mentioned concealing their eating disorder behaviours from others due to fearing loss of reputation, rupturing relationships, and being stigmatized, to name a few. Research conducted by Barth (2008) discussed the common occurrence of clients disclosing eating disorder symptoms to therapists well into the therapeutic relationship. Barth (2008) described that when this happens it is typical for therapists to (a) doubt themselves, (b) question the effectiveness of treatment, and

(c) worry that the client may be struggling more than originally conceptualized. This literature is important for counselling psychologists to understand. It is equally imperative for psychologists not to feel discouraged that clients chose to conceal serious eating behaviours until a well-established working relationship exists. For many individuals with eating disorders, shame immobilizes help seeking behaviours (Dimitropoulos et al., 2016; Swan & Andrews, 2003), and only when individuals feel comfortable do they share with others, namely their therapists. Though a disclosure well into the working relationship can seem disheartening for therapists, Barth (2008) suggested that disclosures of eating disorder symptoms are generally made when an individual feels she/he can trust the therapist and the therapist's ability to appropriately deal with corresponding emotions. These findings point to the importance of therapists understanding that trust and comfort within the therapeutic relationship will increase the likelihood of a future disclosure.

Second, counselling psychologists could offer disclosure training, psychoeducation groups, and/or support groups for individuals considering disclosing their eating disorder. Such groups would emphasize the process of disclosure, teach techniques that might be helpful for communication during disclosure, and strategies for gauging the recipients of disclosure. Findings from this research suggest that disclosure evokes anxiety and apprehension and it is a decision that people consider deeply prior to coming forward to others. For those already in counselling but not yet disclosed to their families or friends, the introduction of these groups could be helpful. Not only would individuals benefit from learning strategies that might make the disclosure process more positive, but would be supported by other group members struggling with similar concerns. With this in mind, counselling psychologists must also be cautious and use clinical judgement when recommending an individual disclose their eating disorder to others.

Healthcare providers widely recommend disclosure due to the literature supporting positive physical and mental health after disclosing (Greene, 2000), however, psychologists must also keep in mind the possible danger and stigma that disclosure brings.

Further, many individuals communicating online mentioned that their family members were commonly the recipients of disclosure. Presumably, not only is the person disclosing feeling distressed, but family members may also need support from a professional after learning a loved one has an eating disorder. Counselling psychologists could offer family-based sessions for individuals who disclosed an eating disorder and their loved ones. Family sessions could provide a safe and constructive place for all members involved and professionally facilitated conversations might be appreciated by all parties impacted by the disclosure. Literature suggests that incorporating family-based therapy into the recovery plan of adolescents with eating disorders, particularly those with anorexia nervosa, is a highly recommended and utilized form of treatment (Lock & Le Grange, 2005). Eating disorders can interfere with family functioning and structure (Brown, 2011), therefore, family treatment has been widely utilized, especially with adolescents living within the family home.

In addition, research indicates that family members of those with a mental illness are impacted by the stigma associated with their loved one's mental illness, as well as experience another form of stigma referred to as *stigma by association* (van der Sanden, Bos, Stutterheim, Pryor, & Kok, 2013). *Stigma by association* represents the process through which the companions or loved ones of a stigmatized person are discredited (Pryor, Reeder, & Monroe, 2012). The notion of *courtesy stigma* or stigma spreading to others because of their proximity or closeness with an individual are endorsed by family members of those who are publically living with a mental illness (van der Sanden et al., 2013). Stigma by association contributes to

psychological distress among family members and the additional belief that mental illnesses are hereditary furthers the level of distress experienced (van der Sanden et al., 2013). Given that families serve a critical role in providing social support for those with a mental illness, it is important that counselling psychologists offer education to families in regard to mental illness, the impact on functioning and family dynamics, possible treatment options, and the extent to which the specific mental illness is hereditary.

Finally, with the increasing number of individuals using online communications and social media platforms it may be wise for counselling psychologists to offer increased services over the Internet. Specifically, online communities similar to those that the data was extracted from could be set up and moderated by counselling psychologists. These online communities would be very similar to those that individuals with eating disorders and disordered eating already belong to, except that the content would be monitored by and perhaps facilitated by professionals trained in the area. Psychologists could offer their support and professionally sound advice to those belonging to these online groups. Literature shows that individuals with mental illnesses feel apprehensive, embarrassed, fearful of stigma, and uncomfortable disclosing or seeking treatment from doctors in primary care settings (Collins, Westra, Dozois, & Burns, 2004; Kravitz et al., 2011). Research has demonstrated that those with stigmatized mental illness were more likely than those without mental illness to use the Internet for health information and to communicate online with clinicians about health information **(**Berger, Wagner, & Baker, 2005), therefore, it may be helpful for psychologists to make themselves available via online platforms. The online method of communication may make the process of seeking information or treatment simpler and less intimidating. Leibert, Archer, Munson, and York (2006) proposed that online counselling would be especially helpful for populations experiencing anxiety, social

phobias, as well as eating disorders. Online interactions with counselling psychologists could also aid those living in geographically distant locations and those who feel more comfortable receiving help while behind a screen.

Providing counselling services online offers many advantages, however clinicians practicing on the Internet must also be aware of the legal and ethical implications that might arise. In order to ensure counsellors are practicing ethically, the American Counseling Association (ACA, 2014) released *Distance Counseling, Technology, and Social Media* as section H in the Code of Ethics. Key considerations included that clinicians (a) practice within their area of competency, (b) provide services through secure websites, (c) provide a complete background of their education and licencing to online clients, and (d) obtain contact information from clients, in the case of an emergency.

Strengths and Limitations

There are both strengths and limitations to this study. First, to the best of my knowledge, this is the first project to use situational analysis when studying online communities. This speaks to the innovation of the current study, as it has not only added to the limited understandings of disclosing an eating disorder, but has also introduced a new way of studying the experience. Utilizing the method of situational analysis allowed me to give voice and space to all elements, actants, actors, and groups that comprised the situation of inquiry. In traditional positivist and post-positivist methods, the most dominant voices are represented as better or more truthful than perspectives that do not appear as often (Clarke, 2005). By using situational analysis, my project allowed positions that are traditionally silenced to be heard and recognized.

Second, the individuals communicating on the online eating disorder communities represented many groups involved in eating disorders from pro recovery to pro eating disorder

perspectives. Online communities also included the perspectives and experiences of those who recovered from an eating disorder. The multiple perspectives visible in the data offered numerous insights into the situation of inquiry. Also, the sheer number of posts that I coded and included in the analysis is another strength of this project. I collected data from 10 websites, including both pro-recovery and pro-eating disorder websites, which added diversity of perspective to my findings.

Though my study had several notable strengths, it was not without its limitations. First, although online data was practical and simple to access, I could not directly ask participants with eating disorders my research question. In the absence of direct contact with the population of interest, I had to interpret already existing dialogues, looking for information that would help me better understand the situation. I was not able to ask follow up questions or ask for further information to clarify, thus representing a shortcoming of using this type of data.

Second, and similar to the first limitation, since I studied the online narratives of individual's disclosure experiences I am aware that these online accounts were communicated in retrospection. Literature proposes shortcomings of research methods that utilize retrospective accounts, suggesting that when recalling events or experiences from the past, accounts are not always accurate (Brewin, Andrews, & Gotlib, 1993; Hinton, 1996). Researchers indicate that retrospective accounts can lack validity and reliability of autobiographical memory and can be influenced by the specific mood the individual was experiencing associated with mental illness during the time of the event (Brewin et al., 1993). In addition, while interpreting the data I was also aware of the subjective nature of the experiences being documented. The process of disclosure is complicated and involves many moving parts. One person's perceptions of how the disclosure was perceived by others may be drastically different compared to another individual's

perception. Despite recall inconsistencies reported in the literature, retrospective personal accounts need not be dismissed, and according to SA, rather need to be interpreted as situated.

Third, due to the nature of data collection and gathering information from anonymous websites, a major limitation to this project is that I do not know who my participants are. The majority of individuals communicating online included photos and screen names, however I cannot make assumptions about intersecting cultural identities from this limited information. The few characteristics I have about my sample include (a) English speaking, however English may be a second language, (b) access to a computer and Internet, (c) many discussed receiving inpatient and outpatient treatment, possibly suggesting they live in countries with free healthcare or they/their families had financial means to cover these costs, and (d) in contrast, some individuals discussed the financial stress of treatment.

Though I do not know a great deal about the individuals communicating online, research suggests that non-dominant populations and individuals belonging to stigmatized groups utilize anonymous online communities to a great extent (Berger et al., 2005; Willis, 2012). Online research methods and online communities are ideal locations for populations who may feel uncomfortable or not safe disclosing their identity in public arenas (Mann & Stewart, 2000). Mckenna and Bargh (2000) suggested that individuals feeling lonely, socially isolated, and struggling to form face-to-face relationships are more likely to develop relationships online. Internet communities may also be especially helpful for individuals who desire a high level of anonymity when discussing their identity, especially those with invisible stigmas (e.g., LGBTQ populations, individuals with mental illness; Trau, Härtel, & Härtel, 2013).

Finally, although the research method added many strengths to my project it could also be considered a weakness. Utilizing SA afforded me great flexibility and creative freedom, however this method provided less structure and step-wise procedures than some other methods.

Future Directions and Recommendations

This project was largely an exploratory study of online narratives of individuals who disclosed an eating disorder, and many questions remain. As such, there are numerous future directions researchers could employ in order to gain a better understanding of the complexity of the situation. First, this research topic could be built upon by simply changing the data source. Instead of analyzing online accounts of this experience researchers could invite participants to discuss their experiences in face-to-face interviews. Data collected in this format would allow researchers to ask follow up questions, elaborate on points of interests, or clarify statements when required. Utilizing face-to-face interviews would also allow for researchers to collect demographic information.

The current research project emphasized the voices and experiences of those with an eating disorder who were in pre-contemplation, contemplation, or who had already disclosed to others. In future projects it would be interesting to include the recipients of disclosure as a source of data. This addition would allow for insights into the experiences and perceptions of those who were on the receiving end of the disclosure. This new perspective would add to the overall understanding of the disclosure experience and process. To the best of my understanding, research including the experiences of recipients of eating disorder disclosure has not been conducted. In the future, interviewing recipients of disclosure could provide valuable understandings of the phenomenon that would not have been possible by simply interviewing the individual who disclosed. It seemed apparent from current literature on disclosure that the

experience is a relational process, therefore including perspectives from all involved would enrich our current understanding.

Finally, the findings of this project demonstrate that stigma plays a large role in an individual's decision to disclose. It might be helpful to increase training and awareness of eating disorders among the general public. Multiple individuals communicating online described responses to their disclosures that appeared to be influenced by misconceptions about eating disorders (e.g., recipients telling those with eating disorders to simply eat, or accusing them of starving themselves for attention). These insensitive reactions might decrease with initiatives aimed at enhancing the publics' mental illness literacy. Awareness initiatives containing messages that mental illnesses (a) do not discriminate, (b) are prevalent and largely invisible, and (c) have multiple causes, could be starting points in public awareness campaigns. Further, awareness specifically intended to break the stigma of eating disorders is also needed, as the majority of campaigns in Canada bring awareness to mood disorders. In recent years, there has been a noticeable increase in public awareness campaigns (e.g., Bell Let's Talk, Not Myself Today), however a great deal more exposure to mental illness and eating disorders in particular are needed to combat the rampant stigma in society.

Particular researchers have demonstrated that disease prevention programs targeting eating disorders may be potentially harmful (Rosenvinge & Westjordet, 2004). The programs deemed as problematic and potentially harmful have included information on symptomology, risk factors, and complications and prognosis of eating disorders (Rosenvinge & Westjordet, 2004). Though designed with the best of intentions, researchers have argued that education about the symptoms actually teach individuals about how to engage in disordered eating (Rosenvinge & Westjordet, 2004), and some prevention programs have resulted in higher levels

of restrictive eating behaviours following the program (Carter, Stewart, Dunn, & Fairburn, 1997). I am not suggesting more of these types of education programs, but instead campaigns that emphasize the unique stigmas and discourses that have been generated about those with eating disorders. Many individuals communicating online conveyed their devastation after disclosing to somebody who held misconceptions about eating disorders and believed that those with eating disorders were (a) vain and (b) doing it for attention. In changing our efforts to manage stigma perhaps individuals would not have to struggle so much with their decision to disclose in the future.

Summary

In conclusion, conducting a situational analysis of the online accounts of individuals who disclosed an eating disorder has opened my eyes to the complexity of this situation. Many elements come together to create this situation and my personal experiences, by way of memos, also contributed to my understanding of the tensions, differences, and positions of the online accounts of eating disorder disclosures. I acknowledge the method of situational analysis as it has taught me to view positions as different, rather than better or worse, and has helped me to appreciate the complexities, nuances, and silences that comprise the situation of inquiry.

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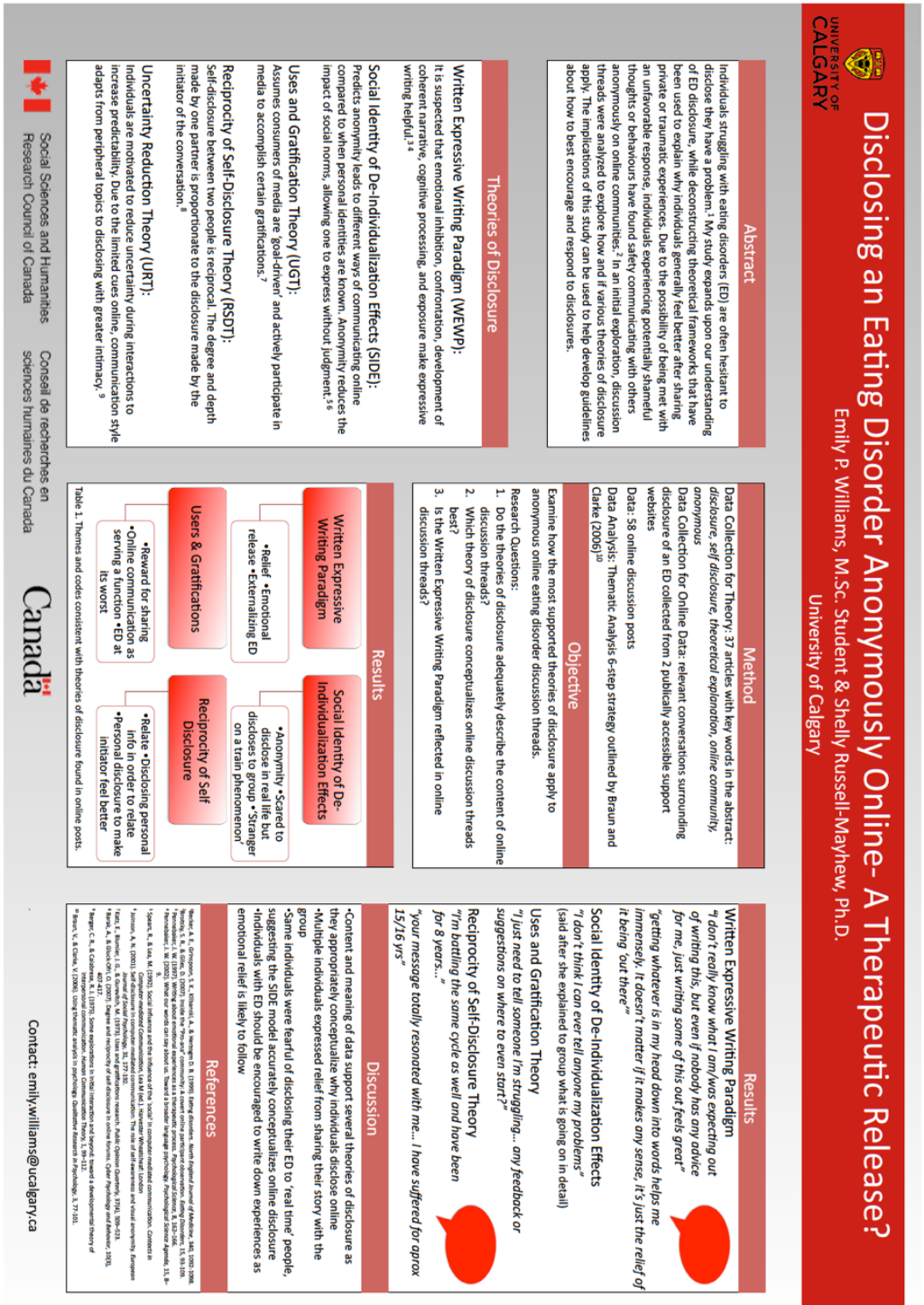
Appendix A

Poster Version of Pilot Study



Disclosing an Eating Disorder Anonymously Online- A Therapeutic Release?

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University of Calgary

Abstract

Individuals struggling with eating disorders (ED) are often hesitant to disclose they have a problem.[1] My study expands upon our understanding of ED disclosure, while deconstructing theoretical frameworks that have been used to explain why individuals generally feel better after sharing private or traumatic experiences. Due to the possibility of being met with an unfavorable response, individuals experiencing potentially shameful thoughts or behaviours have found safety communicating with others anonymously on online communities.[2] In an initial exploration, discussion threads were analyzed to explore how and if various theories of disclosure apply. The implications of this study can be used to help develop guidelines about how to best encourage and respond to disclosures.

Theories of Disclosure

Written Expressive Writing Paradigm (WEWP):
It is suspected that emotional inhibition, confrontation, development of coherent narrative, cognitive processing, and exposure make expressive writing helpful.[3,4]

Social Identity of De-Individualization Effects (SIDE):
Predicts anonymity leads to different ways of communicating online compared to when personal identities are known. Anonymity reduces the impact of social norms, allowing one to express without judgment.[5,6]

Uses and Gratification Theory (UGT):
Assumes consumers of media are 'goal-driven' and actively participate in media to accomplish certain gratifications.[7]

Reciprocity of Self-Disclosure Theory (RSDT):
Self-disclosure between two people is reciprocal. The degree and depth made by one partner is proportionate to the disclosure made by the initiator of the conversation.[8]

Uncertainty Reduction Theory (URT):
Individuals are motivated to reduce uncertainty during interactions to increase predictability. Due to the limited cues online, communication style adapts from peripheral topics to disclosing with greater intimacy.[9]

Method

Data Collection for Theory: 37 articles with key words in the abstract: *disclosure, self disclosure, theoretical explanation, online community, anonymous*

Data Collection for Online Data: relevant conversations surrounding disclosure of an ED collected from 2 publically accessible support websites

Data: 58 online discussion posts

Data Analysis: Thematic Analysis 6-step strategy outlined by Braun and Clarke (2006)[10]

Objective

Examine how the most supported theories of disclosure apply to anonymous online eating disorder discussion threads.

Research Questions:

1. Do the theories of disclosure adequately describe the content of online discussion threads?
2. Which theory of disclosure conceptualizes online discussion threads best?
3. Is the Written Expressive Writing Paradigm reflected in online discussion threads?

Results

Table 1. Themes and codes consistent with theories of disclosure found in online posts.

Results

Written Expressive Writing Paradigm

"I don't really know what I am/was expecting out of writing this, but even if nobody has any advice for me, just writing some of this out feels great"

"getting whatever is in my head down into words helps me immensely. It doesn't matter if it makes any sense, it's just the relief of it being 'out there'"

Social Identity of De-Individualization Effects

"I don't think I can ever tell anyone my problems"
(said after she explained to group what is going on in detail)

Uses and Gratification Theory

"I just need to tell someone I'm struggling... any feedback or suggestions on where to even start?"

Reciprocity of Self-Disclosure Theory

"I'm battling the some cycle as well and have been for 8 years..."

"your message totally resonated with me... I have suffered for aprox 15/16 yrs"

Discussion

- Content and meaning of data support several theories of disclosure as they appropriately conceptualize why individuals disclose online
- Multiple individuals expressed relief from sharing their story with the group
- Same individuals were fearful of disclosing their ED to 'real time' people, suggesting the SIDE model accurately conceptualizes online disclosure
- Individuals with ED should be encouraged to write down experiences as emotional relief is likely to follow

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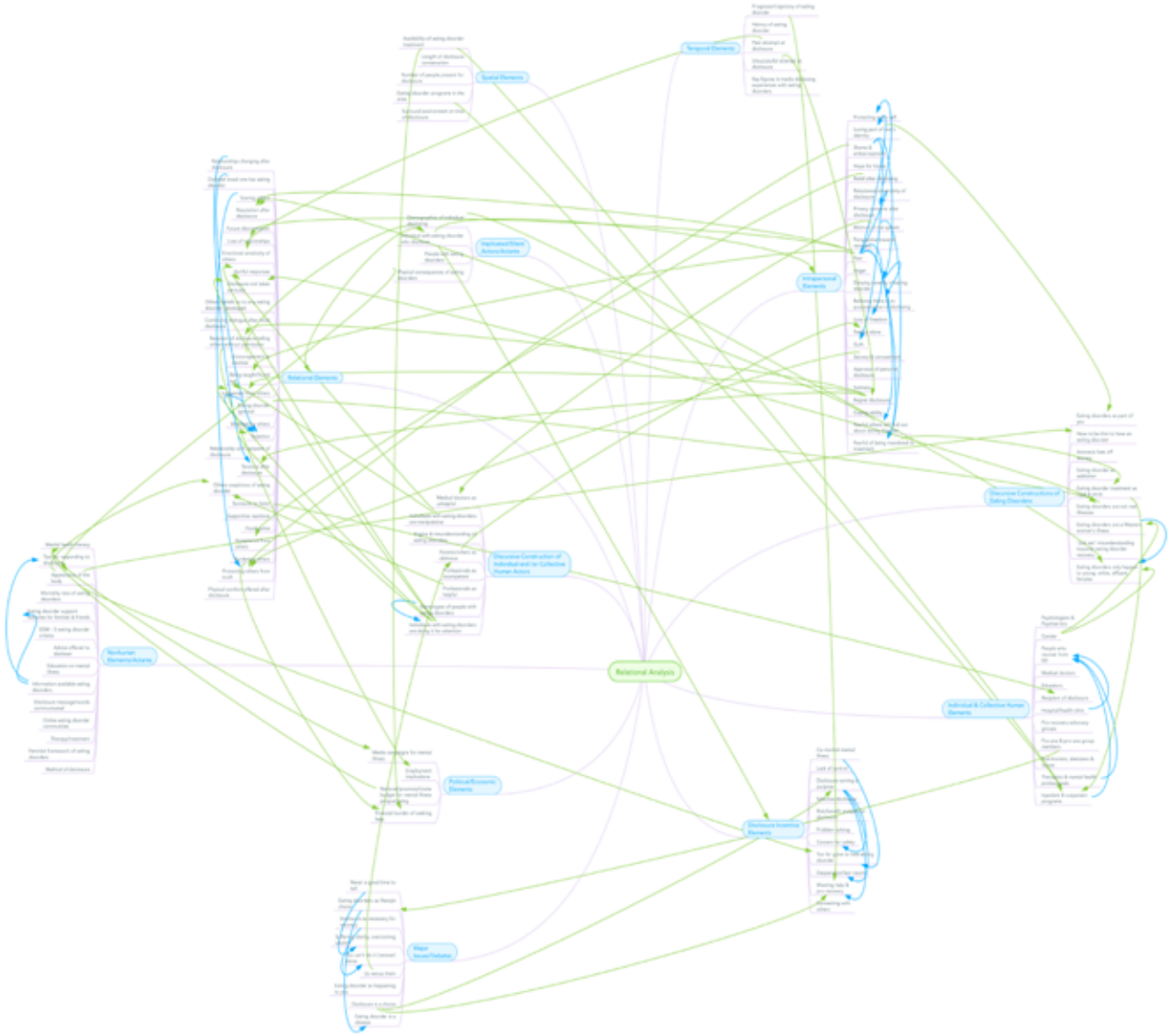
Appendix B

Preliminary Relational Analysis and Memos



Blue lines represent relations between elements within the same category and green lines represent relations between categories. A larger version of the map can be accessed with this link: https://mm.tt/643671666?t=RbcSWdeo3q.

Research journal memo written February 2, 2016:

- After completing the preliminary relational analysis, I was struck by the complexity of the situation. In the preliminary map I wanted to demonstrate the various elements that interacted when an individual disclosed an eating disorder then discussed it online, while also indicating the silences in the situation. Areas of discursive silence can later be elaborated on in the positional maps, so I made sure to pay particular attention to these.
- Clarke (2005) recommended researchers memo the nature and range of relationships, while also memoing questions to later ask of the data. In this situation, I was curious about what individuals disclosing an eating disorder would have to say about all the other elements I considered to make up the situation. I started by considering this idea, and soon realized that other elements appeared important to the situation as well.
- I decided that I should use relational analysis mapping as an analytic tool like Clarke (2005) suggested, and through this process I became familiar with the situation.

Research journal memo written February 3, 2016:

- I have been working on the relational analysis for three days now and every time I go back to it I add another connection. So many elements in this situation are related. When one discloses an eating disorder he/she must consider the benefits and consequences of doing so (mostly taking the form of *intrapersonal elements*), one considers who they are willing to disclose to (recipient), and how that recipient may react positively, negatively, or mixed (*relational elements*). The disclosure decision is also influenced by societal messaging about what it means to have an eating disorder (e.g., people with eating disorders are manipulative, doing it for attention, only happens to thin, white, young,

women). The recipient's reaction to the disclosure may be influenced by credible information, which could increase the likelihood that person responds in an appropriate manner, however, if the recipient is not emotionally sensitive or informed about mental illness, this may increase likelihood for insensitivity or perceived rejection.

Appendix C

Simplified Relational Analysis and Memos

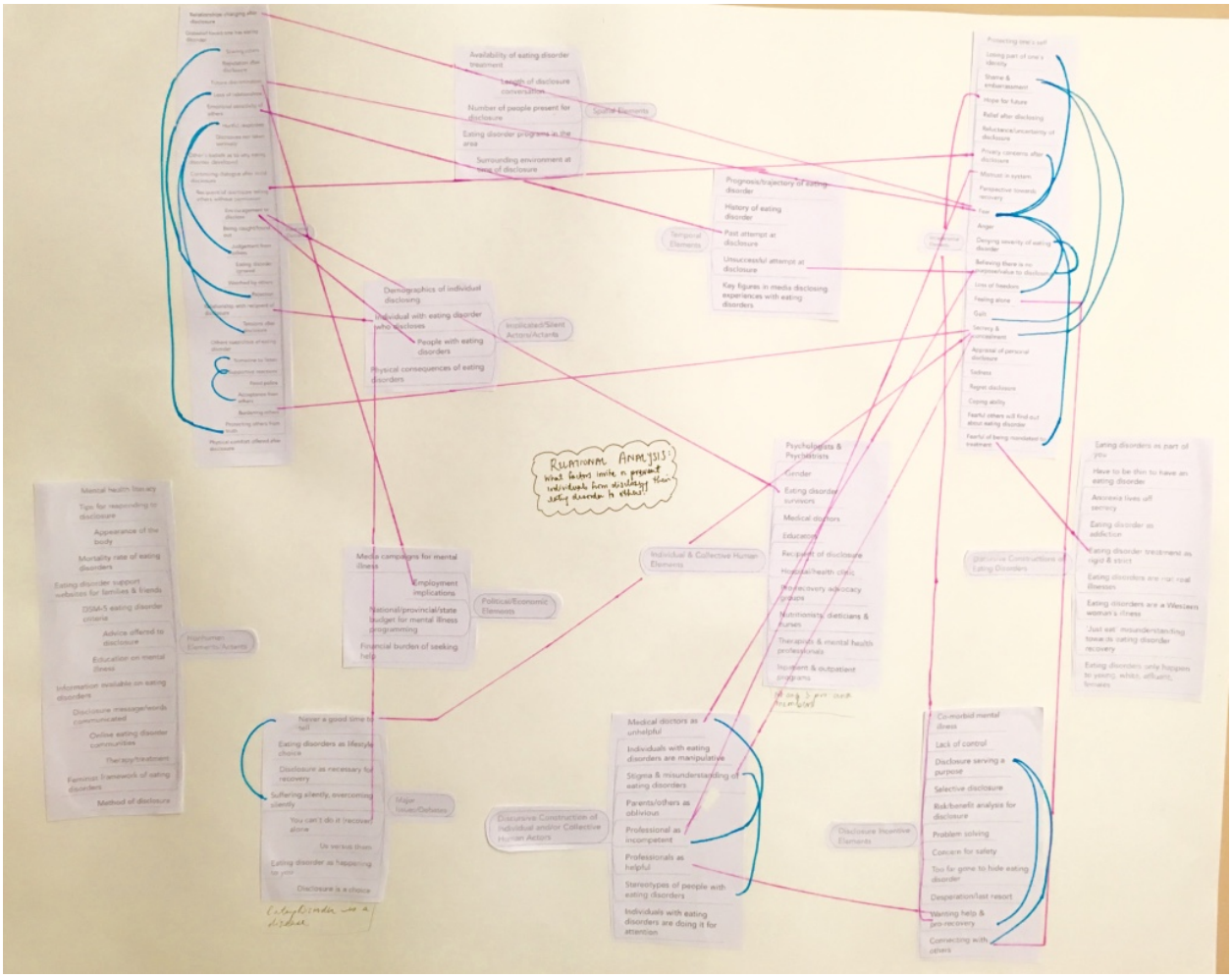
Research journal memo written February 6, 2016:

- Clarke (2005) reminded researchers that the multiplicity of relations and the extensiveness of data can easily become overwhelming, making it difficult to focus on the objective of the project. After viewing the preliminary relational map, I have decided that I will be make four additional maps so I can focus on the elements and relations specific to each of my initial curiosities about the situation.
- The following four maps were created to highlight the most significant relationships within categories, between categories, major tensions, and inadvertently the silences:
  - Relational Analysis I: Factors inviting or preventing disclosure
  - Relational Analysis II: Tensions, differences, and positions that arise during disclosure
  - Relational Analysis III: Relational effects of disclosing
  - Relational Analysis IV: Salient discourses used by individuals disclosing
- In my relational analysis maps, I used blue lines to represent relations between elements within the same category, pink lines represent relations between elements in different categories, and red lines represent tensions between elements.
- While creating the simplified relational maps, I will remain aware of the complexity of the situation and the possibility of additional relationships, however, I will purposely try to demonstrate relationships and elements that are specific to my interests about the broad situation of disclosing an eating disorder.
- I will treat creating these simplified relational maps as my entrance into the research

project, and I hope that by learning more about the elements that make up the situation, it will help me to land on my overarching research question.

Appendix D

Relational Analysis I: Factors inviting or preventing disclosure and memos



Relational Analysis 1: Factors inviting or preventing disclosure.

Research journal memo, written February 7, 2016:

- The possibility of relationships changing as a result of disclosure appeared likely from the online data. Elements including burdening others, tensions after disclosure, and loss of relationship seemed to be salient factors in the situation that would prevent disclosure. Alternatively, numerous elements representing positive relational factors appeared in the situation and elements including emotional sensitivity, acceptance, and someone to listen

seemed to invite a disclosure of an eating disorder. Important to keep in mind, when viewing the first simplified relational map, it is not evident if relational changes are an anticipated consequence of disclosing or if individuals with eating disorders have experienced relational changes in prior situations.

- Past attempts at disclosure may influence one's decision to disclose. Depending on how recipients responded in previous interactions, past experiences may strongly predict future sharing of private information. The emotional sensitivity of others in particular, may influence what an individual believes about others' capacity to accept, and alternatively if other's reactions are hurtful, what it means to have an eating disorder.
- Fear appeared to be a powerful factor individuals experienceed when deciding to disclose to others. During analysis I became aware of fears' salience in this situation, and noticed that individuals considering disclosing were fearful of anticipated loss. Loss of freedom and loss of personal identity were commonly cited concerns by individuals communicating online. Individuals who believed the only thing they had control over was their eating and exercise behaviours appeared especially concerned with potential loss of personal freedom. Individuals also reported fear that recipients of disclosure would tell others without permission and were fearful of being mandated to treatment.
- A sense of vulnerability was apparent within this situation, and individuals with eating disorders were commonly faced with considering the advantages and disadvantages of disclosing, along with the likely factor that once the information was shared, there was little control over who it was shared with and for what purposes afterwards.
- Shame and embarrassment were frequently reported experiences among individuals with eating disorders, "I'm ashamed and afraid that people finding out will only push them

away and that they won't understand" (Username: Caroline411, eHealth Forum). Feeling shameful of an eating disorder appeared to be a factor preventing individuals from disclosing to others, and was presumably related to secrecy and concealment, "I can't tell anyone in person because I'm too ashamed of what I do" (Username: Heydayarcade, NEDA). Feeling guilty because of one's actions or inactions appeared to act as a powerful agent in the maintenance of an eating disorder, and understandably individuals embarrassed by their own actions may find it difficult to admit shameful behaviours to others.

- An individual's beliefs about the necessity of disclosing seemed to play an important role in understanding if disclosure was likely to occur. Individuals who perceived past disclosures to have been unsuccessful reported skepticism towards disclosing again. It could be possible that if disclosing one's eating disorder was not considered helpful or a success in the past, individuals may have a difficult time believing a future attempt would yield a different outcome. Similarly, the discourse that doctors are unhelpful was occasionally mentioned within the eating disorder website discussions, and it appeared that individuals believing doctors and the medical system were unhelpful were unlikely to believe there was a purpose to disclosing, "I've just heard horror stories that doctors will turn a blind eye to eating disorders because they don't know how to handle the situation or just put you on meds and call it good," (Username: Em Bel, Daily Stength).
- Many of those who believed there was no value to disclosing did not perceive their eating disorder to be of great concern. Regardless, whether (a) these individuals were denying the severity of their behaviours or (b) were not ready to disclose to others, if an individual did not believe he/she had a problem, it appeared that it was unlikely they would put

them self in a vulnerable situation to disclose.

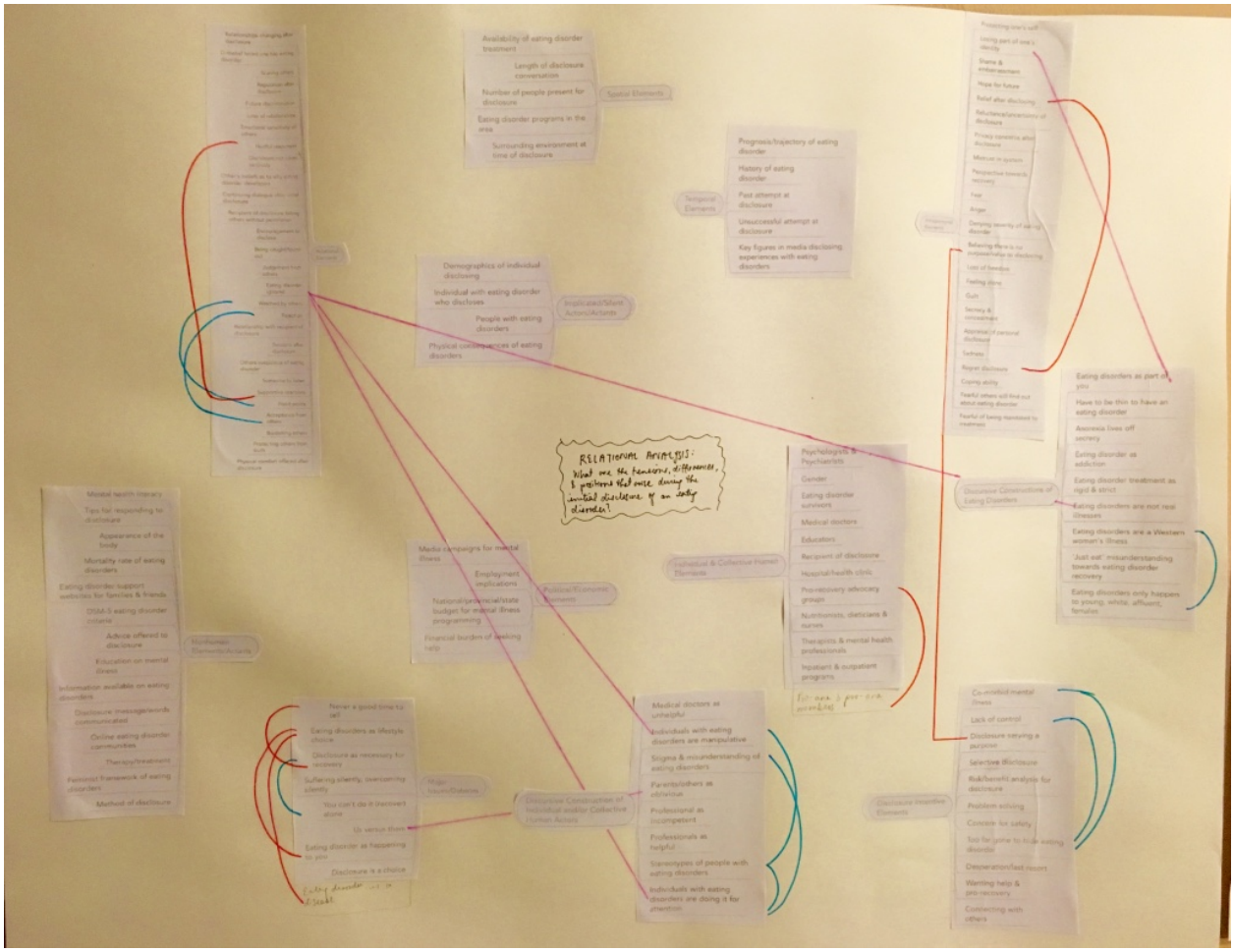
Research journal memo, written February 8, 2016:

- As evidenced from the *disclosure serving a purpose element*, individuals who disclosed may have done so because they came to believe they could not overcome an eating disorder on their own. Realizing one was in danger and required the support of others appeared to be powerful factors that invited disclosure. Having the belief that professionals were helpful and provided comprehensive care also seemed to invite disclosing an eating disorder.
- Orientation towards the future and a sense of hope may further influence individuals to disclose. It is common for individuals with eating disorders to conceal their behaviours (Basile, 2004), arguably leading one to feel lonely and isolated. The act of sharing an intimate part of one's self with others may fill an individual's need for human connection, thus representing another factor that may invite disclosing an eating disorder.
- Although this map highlights the factors that invite or prevent disclosing an eating disorder, demonstrated predominantly by the relations between and among the *relational*, *intrapersonal*, and *disclosure incentive elements*, it is important to consider the influence that discursive elements have on the situation.
- Due to the negative stereotypes, discourses about eating disorders, and the seemingly likely judgemental response from others, this relational analysis suggests to me that individuals may be consumed with anxiety in regards to disclosing their eating disorder.
- Discourses about doctors being unhelpful, and it never being a good time to share one has an eating disorder appeared to be associated with the prolonged secrecy and concealment

of an eating disorder. In addition, the common knowledge (from a graduate student in psychology's perspective) that mental illness, particularly eating disorders are misunderstood and stigmatized in society may be related to individuals seeing no point in disclosing.

Appendix E

Relational Analysis II: Tensions, differences, and positions that arise during disclosure and memos.



Relational Analysis II: Tensions, differences, and positions that arise during disclosure.

Research journal memos, written February 9, 2016:

- Numerous conflicting discourses regarding secrecy and ways of viewing an eating disorder are apparent within relational analysis II, thus alluding to the heterogeneity of beliefs and responses towards those with eating disorders.
- As demonstrated by the data collected from online eating disorder communities, individuals were met with a variety of responses after disclosing an eating disorder, both

supportive and hurtful. Supportive reactions included someone to listen, recipient assisting with help seeking, and reassuring the individual that the recipient cared about them, "she was really nice about it, listened and asked questions, but more than anything she didn't judge me, or think anything less of me" (Username: Hopeful, Grace on the Moon). Although individuals experienced positive reactions after disclosure, others unfortunately faced harmful and damaging responses, demonstrating a tension that emerges during the disclosure of an eating disorder, "I just had a conversation with her and it ended with her yelling at me and saying she's going to call 911 and have me taken to the psych hospital" (Username: Wildflower, Daily Strength Data).

- Harmful responses from others included friends and family yelling at the individual for not eating, recipients of disclosure becoming angry and not understanding the long journey of recovery, and recipients crying upon discovery and making the individual with the eating disorder feel guilty for their actions. One particular individual described a hurtful reaction from her mother:

> I ended up telling my mom everything I did and that I had an ED in the past. She said nothing when I told her about the bulimia. Until a few days later when she made fun of me because I was bulimic. Shes made a couple jokes since then too, but never once has had a serious conversation with me about it. Didn't even care about how I felt. I was hurting SO bad (Username: Justwonderful04, ANAD).

- Many individuals communicating via online eating disorder communities expressed regret or anger with themselves for disclosing after being met with unfavorable responses. The idea that things became worse after disclosing was endorsed by multiple individuals, "the more I let people know, the more I refuse to eat. And the more I try to

eat the guiltier I feel, more ashamed" (Username: C., Support Group).

- After disclosure, individuals reported they were made to feel guilty about their behaviours and experienced greater shame after sharing with others. The experience of regretting disclosure was sharply contrasted with feeling relieved after disclosure, representing another tension in relational analysis II. Individuals expressed (a) feeling proud of themselves for telling others, (b) feeling validated, (c) having more self-acceptance after disclosing, and (d) feeling more confident that recovery is possible, "whilst currently nothing is sorted, I feel proud that I was able to talk" (Username: Alycat, Grace On the Moon).

Research journal memo, written February 10, 2016:

- Several relations emerged within the *disclosure incentive element* category. Individuals communicating online endorsed numerous reasons for disclosing, one of which was the idea that an individual was too far gone to conceal an eating disorder for any longer. The notion of no longer being able to hide was related to a perceived lack of control and co-morbid mental illness. Individuals supporting this view towards disclosure reported their behaviours to be too frequent to be concealed, breaking down after forced family meals, and the appearance of the body as too obviously small to hide from others. In these circumstances the idea that disclosure was a choice did not seem accurate, instead disclosure may be a choice only for individuals who are able to control their behaviours in the presence of others or those whose bodies appear closer to average size. Meanwhile, some individuals reported that due to co-morbid mental illness, keeping their eating disorder concealed from others was too difficult and the effort required to conceal

more than one illness was simply impossible.

- Alternatively, some individuals believed there was a purpose to disclosing an eating disorder. Whether disclosing was believed to lead to receiving help, connecting with others, or feeling less isolated, the act of disclosure was believed to be a means to some end. While some believed the cost-benefit analysis weighed in favor of disclosure, others had a more pessimistic perspective. This tension between beliefs about disclosing an eating disorder to others became apparent in relational analysis II. It appeared that one's belief about disclosure being in any way helpful or serving a function was contradicted by individuals who believed there was no value to disclosing.

Research journal memo, written February 13, 2016:

- Most of the tensions demonstrated in relational analysis II are rooted in the fundamental belief differences between individuals subscribing to the pro-ana movement versus those who would like to recover. The vast difference of opinions between individuals self-identifying with the pro-ana movement versus individuals who see an eating disorder as a disease, represents a significant tension in this map. This fundamental perspective difference among individuals with eating disorders appeared to influence one's choice moving forward with their eating disorder.
- Numerous tensions exist within the *major issues/debates* category. The notion that it is never a good time to disclose an eating disorder is contradicted by the view that disclosure is necessary for recovery. The conflict between viewing an eating disorder as a lifestyle choice versus a disease is also a salient tension. The premise behind both of these tensions appears to stem from the distinctive belief systems of pro-ana group

members versus pro-recovery group members.

- Individuals who had a desire to recover and had hope for the future encouraged others that disclosing one's eating disorder was the first step to recovery. The notion that one cannot recover alone was prominent within the pro-recovery eating disorder website data. It appeared that individuals recovered from an eating disorder communicating online encouraged others currently struggling with an eating disorder to disclose and connect with others. One individual communicating to someone who was hesitant to disclose said, "I think that having your family involved can be a really important part of recovery, although I think you need to be prepared that they will not always be able to tell you what you (or your eating disorder) wants to hear" (Username: Nicolelee86, Daily Strength).
- Those in recovery or recovered warned that disclosing might be uncomfortable for individuals to initiate, but most claimed that disclosing an eating disorder was (a) worth it, (b) would lead to receiving necessary help, (c) would feel like a weight was lifted, and (d) would help individuals feel like they would not have to deal with an eating disorder alone.

Research journal memo, written February 16, 2016:

- After additional pondering of relational analysis II, it became apparent that one response from recipients of disclosure was particularly important to understand in this situation: disclosure being ignored. Having one's eating disorder disclosure ignored was reported as especially difficult by individuals communicating on online eating disorder communities:

> I feel uncomfortable calling my mom a 'mom.' One of the reasons is when I told

> her I've had bulimia for 5 years she was indifferent. She didn't really respond. So I kind of said it again, and she was like "just stop" and ignored me. This has really bothered me because I felt so stupid and unloved (Username: Jen87, Psych Forums).

This invalidating response was related to the belief that individuals with eating disorders are manipulative and individuals with eating disorders are doing it for attention.

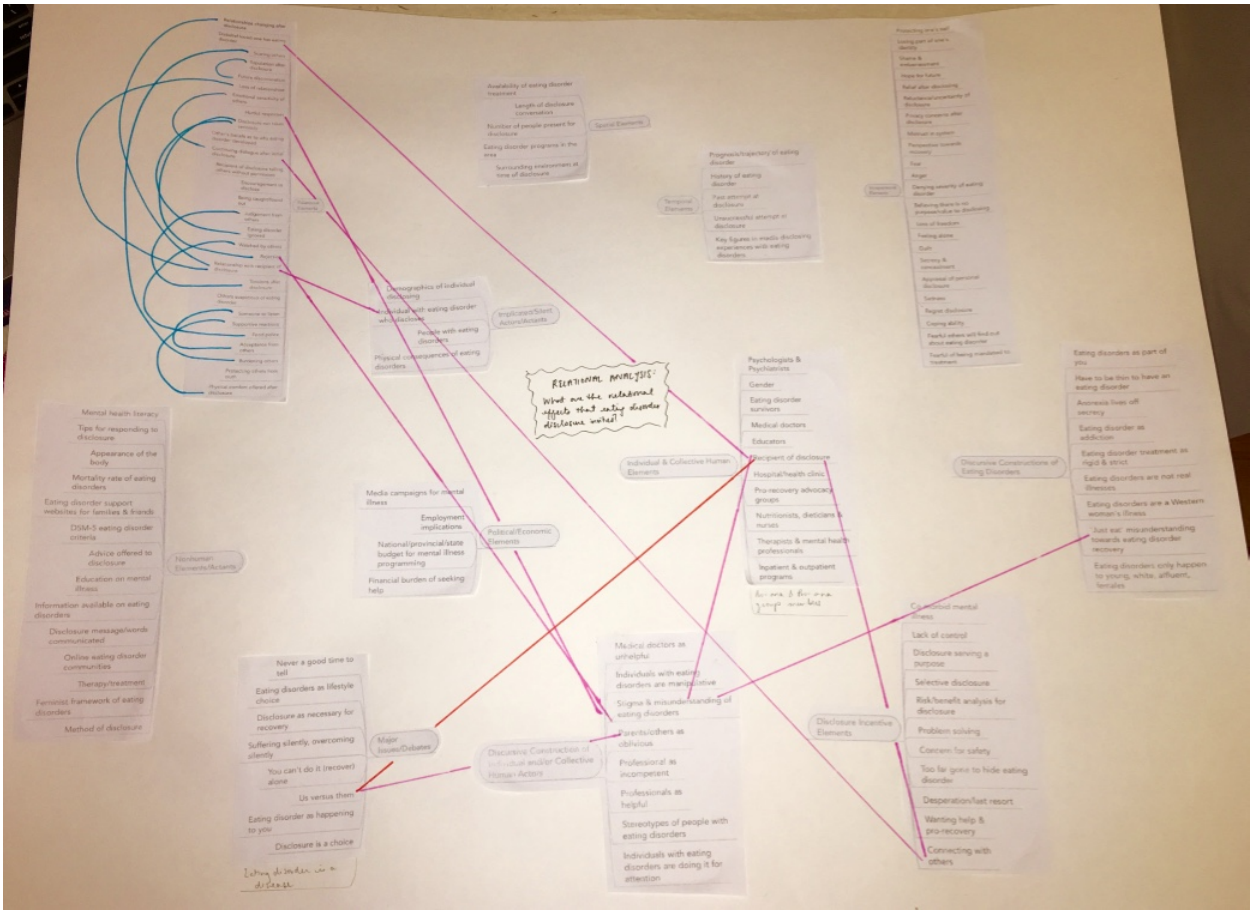
- The idea that eating disorders are not real illnesses was also related to a disclosure being ignored.

Research journal memo, written February 17, 2016:

- After disclosure, multiple individuals reported that their eating disorder was ignored. The misconception that eating disorders are not a real illness may be one of the reasons accounting for this insensitive reaction. Also, individuals who believe that people with eating disorders are doing it for attention may not believe a disclosure, and therefore, not take it seriously. It appeared that some recipients of disclosure responded unfavorably when they thought the disclosee was trying to get something out of disclosure. It seemed these reactions ultimately stemmed from the general misunderstanding of eating disorders and other's unawareness of the severity of eating disorders.
- Discourses about individuals with eating disorders appeared to influence recipient's reactions to disclosure. Unfortunately, these notions seemed to be based off misunderstandings and stereotypes of individuals with eating disorders.

Appendix F

Relational Analysis III: Relational effects of disclosing and memos



Relational Analysis III: Relational effects of disclosing.

Research journal memo, written February 19, 2016:

- Individuals communicating online acknowledged many ways in which disclosure could impact their relationships with others. Relational effects reported by individuals communicating online were organized into two categories, positive relational effects and negative relational effects.
- Relational effects that I considered to be positive include supportive reactions and acceptance from others. Having someone available to listen to the individual who

discloses appeared to be a helpful response, “my mom is a control freak, but since she found out about my anorexia, she is always there to listen to what I have to say” (Username: Ashtonrburg, NEDA). Individuals also emphasized that a continuing dialogue about the eating disorder, after the initial disclosure, was a positive response and helped to feel like others were not afraid of discussing the topic further:

> The turning point in my ED was when I told my best friend. Her response was simply “What do you need me to do?" and she did exactly what i needed (which in may case was coming into my dorm room everyday and asking my how my day was)” (Username: Dark blue, Grace on the moon).

- Related to the concept of a continued dialogue, the emotional sensitivity of recipients of disclosure seemed to be a factor in whether the disclosure conversation could be continued in the future. Recipients displaying poor emotional sensitivity and exhibiting signs of ignorance, appeared less capable of withholding judgement, and seemed more likely to ignore the eating disorder disclosure. Those with greater emotional sensitivity on the other hand, responded gently and provided support.
- Unfortunately, it seemed like negative relational effects outnumbered the positive relational effects. While mapping, I realized that the situation was predominantly filled with elements characterizing negative relational effects. Though there are numerous factors contributing to negative reactions, it appeared that misunderstandings of eating disorders had the potential to illicit many hurtful responses after disclosure. Not understanding or being unaware of mental illness and eating disorders in particular, may lead to rejection, hurtful responses, misunderstandings of recovery, and insensitive responses.

- Numerous individuals communicating online reported recipients of disclosure suggested to ‘just eat,’ a reaction that poorly conveyed empathy or support, “I told him about my ED on the day I broke up with him. His reaction? ‘That's all? I though[t] something serious was coming’ and then ‘Just eat right’” (Username: PipPip, My Pro Ana). Misunderstanding of eating disorders and recovery is apparent from this quotation. Overall, from the online data it appeared that if the recipient of the eating disorder disclosure was misinformed about the severity of eating disorders or the process of recovery, it seemed more likely to result in harmful relational effects.
- Another relational effect reported to be harmful was the concept of being watched by others:

  > My mom's going nuts and writing down crazy amounts of food that I have to eat every day now. I hate lying to her, but I'm already hiding food, and I think it might lead to bulimia. My mom just doesn't realize that she's doing me more harm than I've done to myse[l]f all of these months (Username: BornTHisWayMe, ANAD).

- Learning a loved one was struggling with disordered eating or an eating disorder appeared to be upsetting to recipients of disclosure, however, individuals communicating online indicated how behaviours such as being observed quickly became harmful patterns. This experience of added surveillance lead some individuals to feel tensions in their relationships, “there is so much tension in my house over this right now, he's either belittling me for purging, trying to control me (which only makes things worse) or not speaking to me at all” (Username: Mhall09, NEDA).
- Another negative relational effect resulting from disclosing an eating disorder was the

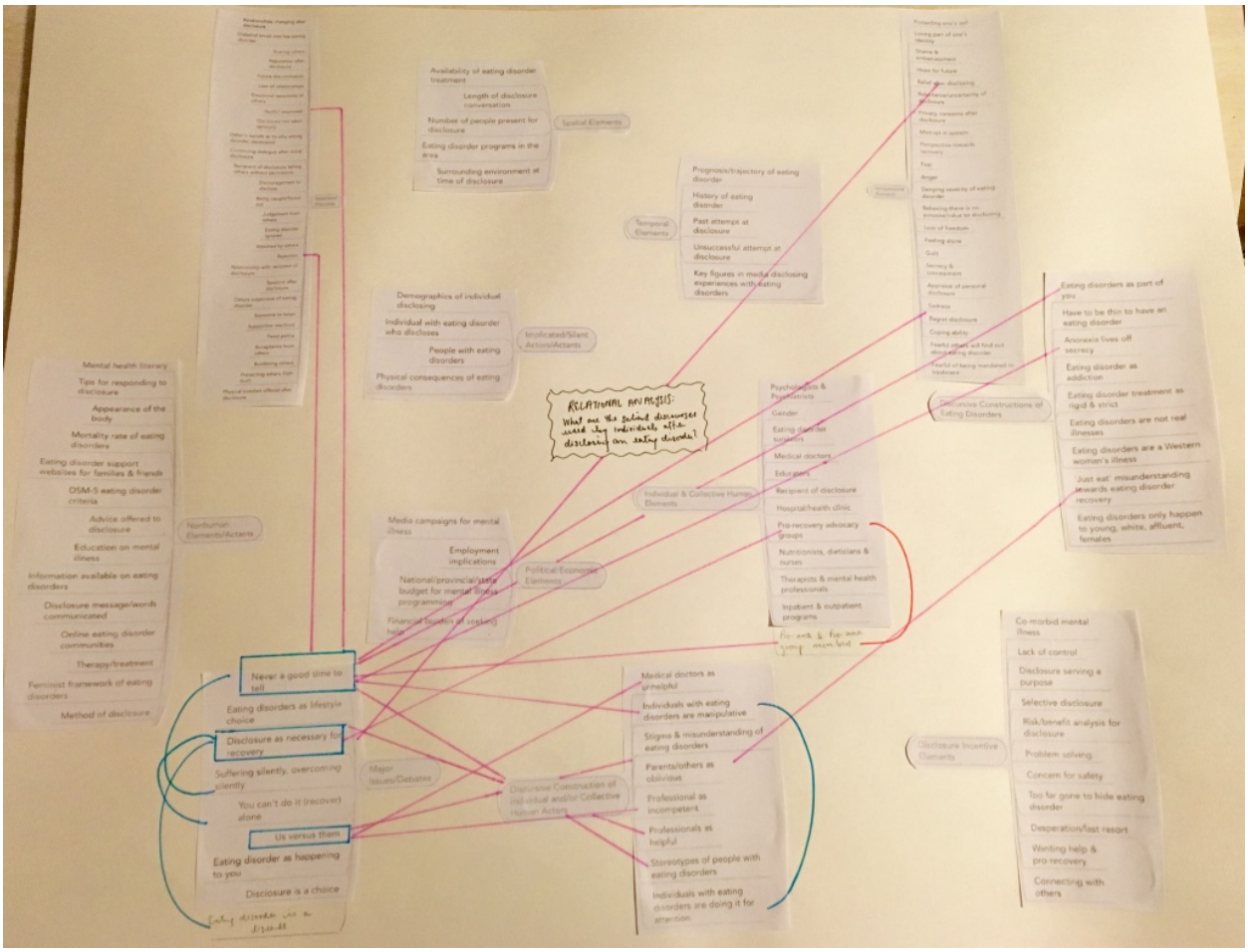
loss of a relationship. Individuals reported a variety of responses that either indicated others chose to end the relationship because of the eating disorder or relationships were strained and then lost due to the reactions of the recipients.

Research journal memo, written February 20, 2016:

- The discourse 'us versus them' was repeatedly mentioned by individuals communicating online, referring to the tensions felt between those who had experienced an eating disorder and those who had not.
- 'Us versus them' and 'parents as oblivious/outsiders' appeared to be a salient connection on this map. This connection represents the loneliness and isolation individuals with eating disorders felt when they were unable to connect with the recipient of disclosure. Individuals indicated that others without an eating disorder were incapable of truly understanding and therefore, were more likely to respond with judgement, "people without EDs have 'no clue' what we're dealing with, and they can be judgmental and not understanding or helpful at all" (Username: Hopeful, Grace on the Moon).
- I believe the relation between 'recipient of disclosure' and 'us versus them' represents a tension on this relational map because of the invalidating experience of opening up to another person, sharing an intimate piece of information, and being met with a response that conveys a lack of warmth or a willingness to learn. One individual communicating online stated, "that sucks :/ have you tried explaining to him that you've been like that for a long time and that your ed had nothing to do with him? Normal people are difficult" (Username: GodsAndMonsters, My Pro Ana).

Appendix G

Relational Analysis IV: Salient discourses used by individuals after disclosing and memos



Relational Analysis IV: Salient discourses used by individuals after disclosing.

Research journal memo, written February 23:

- The discourses that I determined to be of most salience are indicated by blue rectangles.
- Based upon how a disclosure was personally appraised by the individual sharing her or his eating disorder and based on how recipients responded, individuals took up certain discourses to make sense of the situation. Discourses about oneself and about those with eating disorders seemed to be triggered by others' reactions to an eating disorder

disclosure, personal insight, and the manifestation of discursive constructions of individuals with eating disorders.

- While creating and modifying this map, I challenged myself to stay focused on the cognitions and feelings relevant to the outcome of an eating disorder disclosure. Three discourses seemed to jump off the map at me, and consequently, I determined these three represented some of the most salient discourses used by individuals after disclosing an eating disorder. Individuals most commonly recounted the following narratives of their disclosures: (a) that went poorly, it is never a good time to tell, (b) I am happy I told someone, disclosure is necessary for recovery, and (c) I feel misunderstood, it seems like it is us versus them.

Research journal, written February 27, 2016:

- The discourse 'never a good time to tell' was conveyed by many individuals communicating on online eating disorder websites. Some individuals recommended that others protect themselves by keeping their eating disorder private, "some people just react really badly and you shouldn't risk it" (Username: Skirefly, Why Eat). While others stressed that once an eating disorder was disclosed, there was no certainty that their disclosure would remain private, "hellz to the no. Don't tell such an intimate secret after knowing them for only one month. You don't know how they will react and who THEY will tell" (Username: Hershey, Why Eat).
- It seemed that those using the discourse 'never a good time to tell' had some negative experiences in their past, and this adamant notion of not telling anyone about an eating disorder may be a form of protection for these individuals against future harm and

judgement.

Research journal memo, written March 2, 2016:

- Individuals reported they were met with unfavorable reactions from others, who they assumed to be judging them based on stereotypes. One individual stated, "I agree with the above posters—misinformation and harmful stereotypes about EDs are so common that they'll probably judge you harshly owing to their own ignorant prejudice" (Username: Bulimiargh, Why Eat). It is unfortunate that this individual appeared to have been met with harmful judgement from others, and the quotation perhaps gives reason to why some individuals suggest that information about eating disorders should be kept private and concealed.
- Individuals aligning with pro-recovery groups shared messages of hope for the future and the importance of connecting with others. Individuals seemed to favor this discourse after disclosing their eating disorder to others when they believed an eating disorder was an illness that required the assistance of others, "it's not your fault you are unwell and with help and support you can get better. Please reach out to your Mom" (Username: Clairesfe, ANAD).
- Individuals expressing the importance of reaching out for support from others also appeared to have been recalling their own experiences of disclosing. It was evident from the data that many individuals considered disclosing their eating disorder to be a significant and potentially frightening experience.
- Individuals echoing this sentiment appeared to support others disclosing their eating disorders to receive help and to pull themselves from suffering in isolation. The

'disclosure as necessary for recovery' discourse was also related to 'you can't do it (recover) alone' discourse, as these concepts implied that an individual needed resources and support in order to start healing, "talking about an eating disorder isn't necessarily easy, especially at first, but it does get easier with time. So if there's a friend you trust there try to confide in him/her," (Username: Kathywonders, Daily Strength).

- The final discourse I determined to be of importance in this situation based on the number of connections with other elements was 'us versus them.' This discourse appeared to be used by individuals who were met with unhelpful advice or treatment from medical and mental health professionals

Research journal memo, written March 4, 2016:

- It is important to draw attention to the tensions that exist in relational map IV. It is evident that individuals who align with the pro-recovery/advocacy movement differ from individuals who support the pro-eating disorder groups, in terms of the salient discourses they use after disclosing an eating disorder.
- A significant tension lies between the pro-recovery advocacy groups and the pro-ana groups. It appears from this map that individuals aligning with pro-ana use the 'never a good time to tell' discourse. Whereas, individuals who are hopeful for recovery and advocate for others to recover use the 'disclosure as necessary for recovery' discourse after disclosure. I believe that these discourses predominantly arise because of individual's orientation towards recovery, and I believe this tension will always be a significant part of the situation of inquiry, as long as these opposing groups exist.
- The conflicting discourses and beliefs coming from pro-recovery and pro-eating disorder

groups were echoed throughout the maps, leading me to believe this tension must be explored further in future maps. Also, the many connections between *relational* and *intrapersonal elements* seemed prevalent during relational mapping, therefore these categories will be analyzed with greater detail in forthcoming phases of analysis.

Research journal, written March 5, 2016:

- After reviewing my extensive memos from the relational analysis mapping procedure, I feel like my research question has emerged from my systematic review of the elements and corresponding relationships.
- The four simplified relational maps I spent several months working on were in fact my entry into the research, and now that I have become familiar with the actors and actants that make up this situation, I feel I am ready to continue with the social worlds/arenas and positions maps. I can draw on my experience of creating relational maps and simultaneously memoing to inform the rest of my analysis.