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# CONTENTS

1. **INTRODUCTION**

| 1.1 | An overview of the chapter | 1 |
| 1.2 | Control and health behaviour: An Overview | 2 |
| 1.3 | Measures of Control | 3 |
| 1.4 | Control and Eating Disorders | 5 |
| 1.5 | Binge Eating | 13 |
| 1.6 | Alcohol Problems and Women | 17 |
| 1.7 | Binge Drinking | 21 |
| 1.8 | Theories of Addiction | 22 |
| 1.9 | Attribution theory, perceived control and addictions | 28 |
| 1.10 | Dual Diagnosis | 32 |
| 1.11 | Co-Morbidity of Eating And Drinking Disorders In Women | 35 |
| 1.12 | Self-Control In Relation To Symptoms Of Disordered Eating And Problem Drinking | 37 |
| 1.13 | Rational for Current Research | 38 |
| 1.14 | Aims of the Research | 39 |

2. **METHODOLOGY**

| 2.1 | An Overview of the Chapter | 40 |
| 2.2 | Epistemological Perspectives: an overview | 40 |
| 2.3 | A Grounded Theory Approach to Qualitative Analysis - An Overview | 43 |
| 2.4 | Rationale for Using Grounded Theory | 49 |
| 2.5 | Procedure | 50 |
| 2.6 | Ensuring the Quality of Qualitative Research | 63 |

3. **RESULTS**

| 3.1 | Overview of This Chapter | 72 |
| 3.2 | A Process Model of Self Control | 74 |
| 3.3 | Core Category: ILLUSION | 76 |
| 3.4 | Perceived Need For Self-Control | 86 |
| 3.5 | Attempt to Gain Control | 98 |
| 3.6 | Loss of Control | 106 |
| 3.7 | Attempt to Regain Control | 120 |
| 3.8 | Continued Struggle for Self Control | 125 |
4. DISCUSSION

4.1 Overview of This Chapter 143
4.2 Discussion of the Main Findings 144
4.3 Implications of the Findings 160
4.4 Critical Evaluation 168
4.5 Future Research 178

5. CONCLUSION 179

6. REFERENCES 181

7. APPENDICES 205

1 Confirmation letter from Ethics
2 Participation Invitation Letter
3 Patient Information Sheet
4 Interview Guide
5 Consent Form
6 Example of Open Coding

List of Figures

Figure 1: A Process Model of Control 75
Figure 2: Dissatisfaction: A Passive Victim Role 85
Figure 3: Attempts to Activate Change 97
Figure 4: Development of Problematic Behaviours 105
Figure 5: Maintenance: A Series of Opposing Forces 124
CHAPTE R 1

INTRODUCTION

1.1 An Overview of the Chapter

The chapter begins with an overview of the construct of control in relation to health behaviour followed by an outline of existing measures of control. The relevant literature relating to eating disorders and alcohol problems in women is reviewed, with specific sections on binge eating and binge drinking. An overview of current models of addiction and eating disorders are presented, with some elaborations on particular theories relating to the current research. Psychological theory relevant to addictive behaviours and eating disorders (and the current research), such as attribution theory are also outlined.

As implicated in the title of the study, it was considered appropriate to give a general overview of the concept of ‘dual diagnosis’, as well as a more specific description of the co-morbidity of alcohol and eating disorders in women, in terms of prevalence and then with reference to self-control. The rationale for the current research is summarised, followed by the specific aims of the study.
1.2 Control and health behaviour: An Overview

In a wide variety of both research and clinical settings, lack of control has been shown to have a significant negative impact on people's psychological and physical health, behaviour and motivation (Thompson & Spacapan, 1991; Syme, 1989). In an extensive review of the control literature, Skinner (1995) suggested that 'loss of control is one of the few forms of psychological trauma that researchers can agree is universally aversive'.

The multidimensional nature of the control construct is becoming increasingly apparent from the psychological literature on control. Early studies adopted a narrow definition of control, in terms of the availability of the means to influence an aversive situation or outcome (for example Pervin, 1963; Weiss, 1968). More recently, researchers have expanded their focus to acknowledge the importance of other targets of control, including control of internal states such as emotions, thoughts and physical reactions (Thompson, Berg and Shatford, 1987). This is reflected in the definition of control proposed by Wallston, Wallston, Smith and Dobbins (1987), who suggest that perceived control is 'the belief that one can determine one's own internal states and behaviour, influence one's environment and/or bring about desired outcomes'.

Rothbaum, Weisz and Snyder (1982) proposed a two process model of control. They argued that if control cannot be achieved by acting directly to change the environment (primary control), a sense of control can still be maintained by other less direct means (e.g. the use of cognitive strategies to accept the situation as it is) - secondary control.
Rothbaum et al (1982) argued that primary and secondary control are complimentary processes and that both are adaptive to different degrees in different situations.

There is considerable evidence that low sense of control within a health care context is associated with a variety of poorer outcomes (Seeman and Seeman, 1983). It is therefore likely that personal sense of control will have an important bearing on health matters.

The notion of self-control is closely linked to the ideas of social and individual responsibility. However, viewing self-control in this way is to ignore the complex social and economic factors that are known to be strong predictors of overall health status (Townsend et al 1988). As Rodmell and Watt (1987) argued, too much emphasis on self-control and personal choice can result in a negative backlash when a failure to achieve control results in feelings of inadequacy or even resentment and anger.

1.3 Measures of control

Several measures of control have been devised and described in the literature, including general measures as well as measures that relate to a specific phenomenon. Whilst a detailed discussion of these measures is beyond the scope of the current study, the types of measures that exist will be briefly outlined, as this has an important bearing on the rationale for the current research.
1.3.1 Control of External Events

Most of the research on control has concentrated on the control of external events, with particular locus of control (internal or external) being a major focus. The Internal-Locus of Control Scale (I-E LOC; Rotter, 1966) is one of the most widely used scales within the context of health behaviour and is designed to measure the extent to which respondents believe that reinforcements are a function of their behaviour (internal locus of control) or a function of fate or forces outside of one’s control (external locus of control). The Internality, Powerful Others, and Chance Scales (Levenson, 1981) and Mastery Scale (Pearlin, Lieberman, Menaghan & Mullan, 1981) also measure the extent to which people feel they are able to control the events, outcomes and circumstances of their lives. Whilst some questionnaires include subscales designed specifically to measure control of impulses, desires and emotional behaviours (for example, Reid and Ware’s Internal-External Questionnaire, 1974), none address the meaning of self-control as perceived by the respondents.

1.3.2 Control of Internal States

In an extensive literature review, Pallant (2000) identified only a handful of validated scales that tap some aspect of control of internal states. The Self-Control Schedule (SCS; Rosenbaum, 1980) is aimed at identifying what people do in response to specific situations rather than perceptions or meaning of self-control. The Negative Mood Regulation Scale (NMR; Catanzaro and Means, 1990), similarly does not tap respondents
perceptions of self-control but rather assesses their use of particular behaviours that the authors believe are effective mood regulators. None of the scales found in the literature measure perceptions relating to the meaning of self-control.

1.4 Control and eating disorders

There is now considerable evidence that perceptions of control over eating and food contribute to the development and maintenance of eating disorders, for example, from a family perspective, (Palazzoli, 1978; Vandereycken, Kog and Vanderlinden, 1989); a feminist perspective, (Orbach, 1978; Lawrence, 1984) and a cognitive / cognitive behavioural perspective (Bruch, 1973; Garner and Bemis, 1982; Fairburn, Shafran and Cooper, 1999; Slade, 1982, Casper, 1983). A review of the models is presented below.

A number of authors, for example Garner and Bemis (1985) have compared clinical descriptions of ineffectiveness and the concept of external locus of control, which refers to an individual’s beliefs about the source of control over reinforcements (Rotter, 1966).

Studies have revealed conflicting results in terms of the type of beliefs (external versus internal) held by women with eating disorders. (Williams, Chamove and Millar 1990; Hood, Moore and Garner, 1982).

Tiggeman and Raven (1998) concluded that one possible explanation for these contradictory results is that conventional locus of control scales may not provide a
sufficiently differentiated measure of ineffectiveness. They subsequently designed a study to measure specific aspects of control implicated in eating disorders (desire for control, internal control and fear of losing control).

The results provide further evidence of significance of perceptions of control in eating disorders. The authors suggest that it is the domain of self-control that is important in the etiology and maintenance of eating disorders, rather than control over others or over external factors.

Whilst this study provides a useful distinction between self-control as opposed to control over others (and may partly explain the previous inconsistent results with locus of control, a construct that generally incorporates both aspects of control), the authors used a mixture of standardised and purposely adapted measures to assess control, which may not represent the participants perceptions of the meaning of self-control.

1.4.1 Family Perspective of Eating Disorders

Evidence would indicate that there is no single dysfunctional family type that causes anorexia nervosa and bulimia nervosa (Eisler, 1995; Vandereycken et al, 1989). Selvini-Palazzoli (1988) outlined the following features as being typical in families of women with eating disorders: self-sacrifice, parental rejection of leadership, blame shifting, unclear communication, secret alliances between parents and child and marital dissatisfaction. In a questionnaire study examining the difference between actual and
desired family structure, members from families with an anorexic child described themselves as isolated and constrained by overly rigid expectations within the family (Eisler, 1995). Expressed emotion studies show that families in which eating disorders prevail are characterised by very low levels of expressed emotion, including both criticism and over involvement (Eisler, 1995).

Using cluster analysis, Vandereycken et al (1989) concluded that a range of family types could be identified, with differing levels of enmeshment, rigidity and conflict avoidance. According to this perspective, the parents are seen as having difficulties in finding a balance between appropriate (rationale and flexible) control of their child and the age appropriate autonomy they give the child.

The child's struggle for autonomy and individualisation during adolescence is thought to be complicated by the child's fears that when maturity and autonomy is gained, the parents will have nothing left in common. The child copes by being the 'model child' but eventually the parents focus their attentions on another child or object. The child reacts by pursuing autonomy through self-starvation. In this sense, control of eating and body shape has the dual effect of gaining a type of pseudo-autonomy, whilst also obtaining the 'lost' parental attention (Weber and Stierlin, 1981).
1.4.2 Feminist Perspective of Eating Disorders

A basic premise underlying the feminist perspective, is that the body and mind are gendered constructs. In Western cultures, the body is constructed as passive, untamed, in need of restraint and feminine; whereas the mind is perceived as active, noble, cultured and masculine (Striegel-Moore, 1994). Women’s vulnerability to eating disorders is said to derive from a male-female power imbalance, with an important consequence of women’s inferior social status being the devaluation of characteristics associated with being female. Due to the relationship between power and the pressure to conform to social norms, women experience greater social sanctions than men if they do not live up to gender-specific expectations.

Broad cultural factors such as the idealisation of female thinness specific to particular societies (Szmukler and Patton, 1995) are thought to account for the rise in incident rates of eating disorders over the past few decades.

As highlighted by Striegel-Moore (1994), some researchers have noted that shifts in the female beauty ideal towards extreme thinness have occurred during greater political or personal freedom (Fallon, Katzman and Woley, 1993). For example, in the United States, the ‘flapper look’ was fashionable when women gained the right to vote and Twiggy came to represent the new beauty ideal of a generation of women with unprecedented access to educational opportunities. As women have begun to successfully integrate
multiple roles (such as mother, wife, career women, and so on), the waif look has become increasingly popular in America and Western European countries.

However, there is some conflict among feminists, regarding the role of the thin beauty ideal. Some perceive this as signifying progress towards women's liberation, in that it represents a move away from the 'ample' feminine body, thus providing an escape from traditional sex-role constraints and amplifying characteristics such as independence and self-control and is sometimes described as an act of 'rebellion' (for example, Orbach, 1978). Others, in contrast, suggest that the thin ideal emerged in reaction to women's increased power – to women 'taking up too much space' (Bordo, 1993). Thinness, in this sense, is thought to serve the function of controlling women's social ambitions by directing them to an ideal that is likely to be unachievable, thus undermining their sense of empowerment.

The feminist perspective recognises that a single factor model cannot completely explain the aetiology of eating disorders but argues that cultural factors play a primary (rather than a moderating) role, and that increased exposure to these cultural factors increases an individual's risk of developing an eating disorder.

1.4.3 Cognitive Perspectives of Eating Disorders

Based on a cognitive perspective that still holds today, Slade (1982) suggested that obsessive control over food and weight is not the primary problem but instead it is a
strategy in eating disorders for a characteristic sense of ineffectiveness’ (Slade, 1982). For example, although anorexics may achieve rigid control over food and weight, they paradoxically experience themselves as out of control and may seek weight loss to achieve a sense of effectiveness in at least one area of their lives (Lawrence, 1979; Thompson and Sherman, 1989).

More recently, Greeno, Jackson, Williams and Fontman (1998) found that life satisfaction in general was affected by perceived control over eating, regardless of body mass index figures, supporting the notion that controlling food is not necessarily just about weight.

It has been hypothesised that the excessive tendency to exert control over food is part of a more general cognitive style (Vitousek and Hollon, 1990; Wilson, 1996). This was recently supported by Waller (2000), who found that insufficient self-control was one of only three beliefs from the schema questionnaire (Young, 1999), which differentiated bulimic women from normal control group of women. Garner and Bemis (1985) have highlighted the centrality of cognitive distortions typically displayed by eating disordered individuals, such as ‘all or nothing thinking’, selective abstraction’, ‘overgeneralisation’, ‘magnification’, ‘personalisation’ and ‘emotional reasoning’.
1.4.4 Cognitive Behavioural Model of Eating Disorders

Developed from cognitive principles, the cognitive behavioural model focuses on an initial need for self-control, which is likely to be a result of a more general sense of ineffectiveness and perfectionism and which interacts with long standing low self-esteem (Bruch, 1973; Vitousek & Manke, 1994; Fairburn et al, 1999). At first people who develop anorexia nervosa may experiment with controlling various other aspects of their lives, (Bruch, 1973) but control over eating gradually ‘takes over’ due to its perceived association with ‘success’ in a context of perceived failure in all other areas of functioning (Slade, 1982).

The following five mechanisms are described in more detail in Fairburn et al’s (1999) description of the model but shall be summarised here:

1) successful dietary restriction provides direct and immediate evidence of self-control. The reinforcing properties of dietary restriction are especially salient for those who value asceticism, which is common in people with anorexia nervosa (Bruch, 1973; Vitousek and Ewald, 1993);

2) Controlling eating has a potent effect on others in the immediate environment, particularly the family which may have special significance in a context of pre-existing dysfunctional relationships, as is often the case (Fairburn, Cooper, Doll and Welch, 1998);
3) The focus on eating may be encouraged by the fact that in some families eating is already a highly salient behaviour (Fairburn et al, 1998);

4) The fact that the disorder typically starts in adolescence may be relevant since controlling eating provides a means of potentially arresting puberty which may in itself constitute a threat to self-control (Strober, 1991);

5) The association of dietary restriction with being in control is likely to be encouraged by the value placed in Western societies on dieting to control shape and weight.

According to the authors, the principal focus of treatment should be on the issue of self-control, whilst other factors (such as low self-esteem, difficulty expressing emotion, interpersonal and family difficulties - all of which may be central to the cognitive behavioural approach) do not need to be tackled unless they prevent change.

Fairburn et al (1999) draw an analogy with the cognitive behavioural treatment of bulimia nervosa. A wide range of problems could be the target of treatment, yet the focus is almost exclusively on the concerns about shape and weight and disturbed eating (Fairburn, Marcus and Wilson 1993). This focused approach has been shown to be sufficient to produce full recovery in half to two thirds of cases and is the treatment of choice for bulimia nervosa (Wilson and Fairburn, 1998). The authors have argued that the response rate may be higher in if the treatment were to be broader in scope but there is no evidence for this.
They propose that the particular aspect of self-control that is most pertinent varies at different points in the disorder. It is important to work on self-control alongside other aspects of treatment since control issues are activated by changes in other areas.

1.4.5 Psychometric Instruments in Eating Disorders

Instruments used within the field of eating disorders have been developed to tap constructs relating to the clinical features of eating disorders: the Eating Disorder Examination, (Cooper and Fairburn, 1987); the Clinical Eating Disorder Rating Instrument, (Palmer, Christie and Cordell, 1987); the Structured Interview for Anorexia and Bulimia Nervosa, (Fichter, Elton and Engel, 1990); the outcome of eating disorders (Morgan-Russell Outcome Assessment Schedule (Morgan and Hayard, 1988) and the Eating Disorder Inventory-2 – EDI 2 – Garner, 1991), measuring eating attitudes, behaviour and related personality dimensions. Whilst the EDI 2 includes a sub-scale of impulse regulation, which does relate to one aspect of self-control, it does not specifically measure individual perceptions of the meaning of self-control.

1.5 Binge Eating

Although binge eating has been understood in relation to obesity, it was not until the arrival of bulimia nervosa in the 1980s that a wider interest in this area was developed. Following completion of the DSM-IV multisite field trials (Spitzer, Devlin, Walsh, Hasin, Wing, Marcus, Stunkard, Wadden, Yankovski, Agras, Mitchell and Nonas, 1992;
Spitzer, Yankovski, Wadden, Wing, Marcus, Stunkard, Devlin, Mitchell, Hasin and Horne, 1993), binge eating disorder (BED) was included in the appendix in DSM-IV (American Psychiatric Association, 1994) as a category ‘deserving further study’ rather than as a full syndrome.

Diagnostic criteria for Binge Eating Disorder (BED) is based on those for bulimia nervosa, with additional criteria, to emphasise the notion of loss of control and to describe a more stringent frequency criterion. However, concerns about the diagnostic reliability of BED have been raised, particularly in terms of how to delineate the disorder from non-purging bulimia nervosa (Hay and Fairburn, 1998). Concerns about validity have also been raised from a cluster analytic study (Hay, Fairburn and Doll 1996), research on the disorder’s predictive validity (Hay and Fairburn, 1998; Fairburn, 1999) and a family study of the disorder (Lee, Abbot, Seim, Crosby, Mondson, Burgard and Mitchell, 1999).

For these reasons, binge eating is currently described within a context of bulimia nervosa. According to the diagnostic criteria for bulimia nervosa (American Psychiatric Association, 1994), an episode of binge eating is characterised by both of the following:

1) eating, in a discrete period of time (e.g. within any 2 hour period) an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances

2) a lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating.
The binge eating occurs, on average, at least twice a week for a minimum period of 3 months.

1.5.1 Function of binge eating

Within a cognitive behavioural context, binge eating is a paradoxical, self-defeating pattern of behaviour, in that it occurs amid a general effort to restrict eating, thus contradicting the individual's goals.

Binge eating, especially in alternation with periods of severely restrictive eating, is often regarded as medically unhealthy and may therefore be regarded as self-destructive (Heatherton and Baumeister, 1991).

Self-defeating or self-destructive behaviour is paradoxical because it contradicts the presumed rationality of human behaviour. One review of self-destructive behaviour (Beaumeister and Scher, 1988) concluded that normal people do not demonstrate a desire to harm themselves under any circumstances, self-destructive behaviours that do occur must be understood as either counterproductive strategies (such as arising from misjudged contingencies) or inappropriate tradeoffs such as accepting risks or harm whilst striving to achieve a short term escape from a negative self-awareness.
There is an association between negative affect and binge eating (Johnson, Schlundt, Barclay, Carr-Nagle and Engler, 1995) with negative mood preceding the binge episode (Davis, Freeman and Garner, 1988) and a suggestion that binge eating provides temporary relief from the negative mood state (Kaye, Gwirtsman, George, Weiss and Jimerson, 1986). Binge eating may result from the self-regulation of negative affect as it appears to relieve anxiety (Hsu, 1990). This may occur through the replacement the distressing experience from deeper concerns to the less threatening and seemingly manageable problem of overeating (Schlundt and Johnson, 1990).

However, it has been reported that the relief gained from binge eating is temporary and inevitably, leads to feelings of guilt, shame, disgust, self-disparagement, perceptions of diminished personal control and depression (Elmore and De Castro, 1990).

There are several models, which suggest that binge eating represents an attempt to reduce awareness of certain stimuli that are perceived as threatening (Lacey, 1986; Root and Fallon, 1989; Heatherton and Beaumeister, 1991). ‘Escape theory’, proposed by Heatherton and Baumeister, (1991), holds the view that painful self-awareness forces people to escape to lower levels of awareness. Whilst in this state, individuals focus on concrete external cues such as the taste of food and lose sight of higher goals such as maintaining control over eating.

According to this perspective, binge eating serves as a self-regulatory tool to avoid emotional distress at least temporarily. Specifically, binge eating is thought to occur in
response to negative emotional states and to distract the individual from problems (Hawkins and Clements, 1984) or to refocus the emotional distress to eating and / or weight concerns.

Paxton and Diggens (1997) investigated the relationship between binge eating, avoidance coping and depression with reference to the escape theory of binge eating which predicts that binge eaters will exhibit elevated avoidance coping. They found that whilst binge eating scores were significantly correlated with avoidance coping and depression, hierarchical regression analyses indicated avoidance coping did not significantly add to the prediction of binge eating above the contribution of depression. They propose therefore, that it is not appropriate to use findings of elevated avoidance coping in individuals with eating disorder in support of escape theory.

1.6 Alcohol Problems and Women

Many of the 'classic' studies that have contributed to our understanding of the development of alcohol difficulties - including Jellinek and Keller's (1952) research on phases of alcoholism to Vaillant's (1995) 45-year longitudinal study of alcohol abuse - are limited to males. There is a growing body of research which focuses on the factors which relate specifically to women who develop substance abuse problems (for example, Blume, 1997; Centre on Addiction and Substance Abuse, 1996; Miller and Doot, 1994; Thorn, 2000).
Women are likely to have their drinking patterns ‘shaped’ by different contexts than usually affect men, with role strains (for example, as a wife, career woman, single woman and so on) being seen as closely related to the generation of the problem (Edwards, 1997). Other researchers have noted the influence of male ‘significant others’ on the substance use patterns of women (for example, Amaro and Hardy-Fanta, 1995) that are not evident in the literature on male problem drinkers.

Based on results from the 1998 General Household Survey (ONS, 2000), it was revealed that one in five adult women recorded that their maximum daily intake of alcohol exceeded the benchmark of 3 units per day; with 8% recording twice the number of units recommended for safe drinking on one day. Women have been portrayed as less likely to be problem drinkers than men, which is hypothesised to be at least partly a result of social norms that tolerate more drinking among men than women (see for example, Breed and DeFoe, 1981). Social attitudes, however, may act as a double-edged sword for women. On the one hand, the expectation that women will drink lower quantities of alcohol (and at a lesser frequency) can be protective (for example, Kubicka, Csemy and Kozeny, 1995); on the other hand, the intense stigma associated with stereotypes of alcoholic and addicted women can create serious problems for women who drink, in terms of the way they are treated by society (Blume, 1991).

One typical result of this stigma is denial, relating to personal, family and societal factors. This is particularly apparent for females who do not fit the negative stereotype of a ‘drunk’. In addition to individuals and families denying the extent of the problem (‘I am /
she is not like that'), health professionals may too fail to recognise alcohol problems in
women who do not fit the stereotype. As the problem drinking progresses, intense
feelings of guilt and shame typically promote secret drinking, which may exacerbate the
problem in that there is limited scope for others to intervene (see Blume, 1991).

In one of the few longitudinal studies that did include women (Filmore, Bacon and
Hyman, 1979), risk factors for later problematic drinking in college students were found
to be different for men and women. The women who were at the highest risk for later
problems were the ones who reported drinking to relieve shyness, to feel happy, to get
along better with others and to get high.

Sheehan and Ridge (2001) used qualitative methodology to examine the role of drinking
in female students. The narratives revealed that any harm encountered tended to be
filtered through a 'good story', typically describing tales of fun, adventure, bonding, sex,
gender transgressions and relationships. Nevertheless, these women implemented their
own practical harm minimisation strategies.

1.6.1 Control and drinking

Notions of 'loss of control' or impaired control are central to descriptions of drug
dependence and addictions:
'Central to the puzzle of addiction is the fact that addicts do things which, apparently, they neither intend nor want to do: In other words, their control over drinking, is in some sense of the word, impaired' (Heather and Robertson, 1997, p121).

Within the field of alcohol misuse, traditional conceptualisations of 'impaired control' have been criticised on the grounds that impaired control implies little more than the fact that people called alcoholics are more likely to drink to excess on certain occasions; it is too difficult to fully operationalise; it is difficult to distinguish between heavy drinking episodes fuelled by a deliberate intention to get drunk as opposed to being overcome by forces beyond one's control (Marsh and Saunders, 2000).

In order to further understand the mechanisms underlying impaired control over drinking, Marsh and Saunders (2000) used a grounded theory approach to explore drinkers' own experiences and perceptions of both control and impaired control. Four key themes emerged from the analysis of the transcripts: 1) the functionality of impaired control; 2) the role of negative expectancies about impaired control; 3) the role of conflict in impaired control and 4) the role of lack of control explanations in justifying decisions to drink. Whilst the first theme relates to the positive effects from drinking (relaxation, immersion in the moment), the other three themes can be interpreted within the contexts of expectancy theory, (2), excessive appetites theory (3) and attribution theory (4). These are discussed later in this section.
Whilst the Marsh and Saunders (2000) study provided important insights into perceptions of control in relation to drinking behaviour, the meanings of control and impaired control were based on definitions agreed by the authors of the study.

1.7 Binge Drinking

Binge drinking as a specific pattern of drinking has been recognised for some time (for example, Jellinek, 1960; Tomsovic, 1974), yet little progress appears to have been made in terms of establishing a reliable and adequate definition, with poor consistency across researchers and lack of clarity in the criteria for defining a binge. Furthermore, definitions are not sufficiently detailed for either clinical or research use, being purely demographic in nature.

In summary, over the past 40 years a wide range of definitions have been applied to binge drinking, however, none are satisfactory for clinical or research purposes (Heke, 2000). According to a review of the definitions, a binge can range from anything between 4 or 5 drinks in a row (Wechsler, Dawdall, Davenport and Rimm, 1995) to drinking for days, weeks or months, interspersed with successive periods of abstinence (Sanchez-Craig, 1980).

Based on research within a local alcohol service, (Heke, 2000), the following definition was developed, in order to incorporate the salient factors necessary to discriminate binge drinking from other patterns of drinking:
1.8 Theories Of Addiction

Addiction is currently defined as a behaviour over which an individual has impaired control with harmful consequences (Cottler, 1993; Rounsaville, Bryant, Babor and Kranzler, 1993). The character and severity of the addiction may change over time and it may be punctuated by the attempts of the sufferer to abstain or regain control. West (2001) has recently reviewed the literature to identify theories of addiction and subsequently developed a simple classification system based on five main groups of theories.
The first group involves theories that attempt to provide broad insights into the conceptualisation of addiction. Thus addiction can be construed in terms of biological, social or psychological processes. The excessive appetites model (Orford, 1985; 2001) described below is an example of this.

The second group of theories attempts to explain why particular stimuli have a high tendency to become a focus for addiction, a central theme being the positive and negative reinforcement properties of addictive drugs (for example, Bozarth, 1994).

The third group includes theories which focus on why particular individuals are more susceptible to addiction than others, whether biochemically, psychologically or socially. Genetic vulnerability is thus a dominant feature in these theories (for example, Cheng, Swan and Carmelli, 2000; Cunningham, Niehus, Malott and Prather, 1992).

The fourth group of theories relate to social and environmental conditions that increase or decrease the likelihood of addictive behaviour developing. Kenkel, Mathios and Pacula (2001), for example, discuss the role of economic factors in the development of drug use, whilst others focus on external stressors (Breslin, Hayward and Baum, 1995) and social roles (Hajema and Knibbe, 1998).

The final group of theories concentrates on recovery and relapse and includes conditioning processes as well as psychosocial factors (for example, Annis, 1991;
Bradizza, Stasiewicz and Maisto, 1994). The well known transtheoretical model described by Prochaska and Di Clementi (1983, 1992) dominates this group.

1.8.1 The Excessive Appetites Model of Addiction

The excessive appetite model of addiction (Orford, 1985, 2001) is based on a broad concept of what constitutes addiction, accounting for excessive drinking, eating, gambling, sex and a wide range of drugs. Various primary and secondary processes are said to occur within diverse sociocultural contexts, which account for the development of a strong attachment to an appetitive activity, such that self-control is diminished and the resulting behaviour may appear to be disease-like. Primary processes involve a combination of operant reward (usually in the form of emotional change), conditioned responses and cognitive processes. The abstinence violation effect (see below) is a typical example of a secondary process and can be seen as an important area where the fields of excessive eating and excessive drinking overlap (Cummings and Trabin, 1980).

Another important amplifying process is described as the consequences of conflict. The development of a strong appetite alters in a fundamental way the balance that has to be struck between inclination and restraint, leading to conflict resulting from the harms or costs associated with growing attachment to appetitive activity. These might be referred to as consequences of dissonance. Indeed this dissonance should not be thought of as simply theoretical but as something very real, experienced as tension, depression, confusion or panic.
The excessive appetites model can embrace the full range of severity from mild to very severe. Near the heart of the model is a set of very ordinary basic human processes: the development within a social context, of appetite-specific schemata based on different kinds of learning.

One implication of adopting this view, according to Orford (2001), is that we should reconsider the value of the attempts to define certain disease-like conditions such as 'alcohol dependence' or 'bulimia nervosa'. The excessive appetites model would imply that any such attempt is bound to be spurious, since the processes that give rise to strong appetitive attachment are normal ones and there is no point at which normality ends and abnormality begins. Furthermore, at the very core of addiction, according to this view, is not so much attachment per se but rather conflict about attachment. These conflicts are personally, culturally and socially relative. No definition of addiction or dependence, however arbitrary, will serve all people in all places at all times.

The excessive appetites model, according to Orford (2001) should lead to much more comparative research: instead of pursuing mono-substance research, far greater priority should be given to research that includes two or more forms of addiction and particularly to research that combines substance and non-substance addictions in the same study.
1.8.2 Differences Between Eating Disorders and Addictive Disorders

It is generally accepted that the defining characteristics of chemical dependency or addiction are tolerance, physical dependence and withdrawal, craving and loss of control over use of the substance. However, Wilson (1996) questions these features, in terms of the nature of binge eating in cases of bulimia nervosa. He argues that there is no evidence that people with eating disorders experience craving as a direct result of consuming a particular nutrient. Wilson (1996) refers to laboratory studies comparing bulimic patients with 'normal' controls, which suggest that the essential appetitive abnormality of bulimia nervosa is on the control of the amount of food consumed, not in the craving for a specific nutrient.

Wilson (1996) agrees that the notion of loss of control is the defining feature of the classical disease theory of alcoholism, hence the phrase 'one drink away from a drunk'. Similarly, binge eaters often describe being 'one bite away from a binge'. However, Wilson (1996) argues that although sparse, research suggests that the patients with bulimia nervosa do not always necessarily lose control and binge despite violating their dietary restraint by ingesting a high sugar / high fat food, particularly if they know they cannot purge.

Lastly, Wilson (1996) points out that the perception of eating disorders from an addiction viewpoint is 'an instance of the seemingly endless extension of the addiction concept to explain any form of habitual behaviour, including work, sex and watching television'. He
gives an example of the behaviours of anorectics who do not binge, which are explained away by describing them as being ‘addicted’ to starvation. He sees the paradox of how a person can be addicted to both the use and non-use of a substance (as is the case for someone who restricts food and binges intermittently) as reflecting the superficial and misleading concept of addiction.

1.8.3 Expectancy Theory & Alcohol Consumption

Outcome expectancy theory is based on early social learning perspectives (Rotter, Chance and Phares, 1972, Bandura, 1977) and combines principles of observable learning with cognitive constructs. It is explained by individuals having expectations of particular reinforcing effects as the outcome of performing the behaviour in question. Although it is not proposed that expectancy theory provides the sole substrate for alcohol motivations, it has been proposed that its contribution is substantial.

With respect to alcohol therefore consumption is explained by individuals having alcohol outcome expectancies, which are a result of their direct and indirect experience of alcohol. Such histories will be different across individuals of course and the consequent variability in alcohol outcome expectations held is thought to explain the consumption behaviour variability seen. A simple view is that positive expectations (such as ‘I will be the life and soul of the party if I have a few drinks’) represent an important component of motivation to drink whilst negative expectations (for example I expect to have a hangover
if I drink) represent an important component of motivation to restrain (Jones and McMahon, 1998).

Negative expectancies might also provide the motivation for problem drinkers to reduce or stop drinking (Jones and McMahon, 1992). The more favourably people evaluate the impairment effects of drinking, the greater their overall alcohol use (Leigh, 1987; Werner, Walker and Greene, 1993; Fromme and D’Amico, 2000)

1.9 Attribution theory, perceived control and addictions

Attributions are thought to be made so that individuals feel that they can control their environment (Heider, 1958) and so it has been hypothesised that attributions to factors under personal control might be more adaptive than attributions made to uncontrollable factors (Taylor, Lichtman and Wood 1984). Such attributions are therefore crucial in facilitating positive adjustment (Thompson, 1981).

From a psychological perspective, Davies (1997) and Eiser, Vander der Pligt, Raw and Sutton, (1985) suggest that the self attribution of addiction may be a way of making sense of past failures to give up and an excuse to continue the behaviour on the grounds that it is not volitional. In other words, attributing addiction behaviour to impaired control helps people to make sense of it and also to feel comfortable doing things they want and chose to do but which they or others believe are bad for them.
Given the assumptions of attribution theory that people’s beliefs influence their behaviours, Edwards and Gross (1976) questioned whether it would be better to discard the term ‘self-control’ altogether, on the grounds that it might encourage people to see themselves as lacking volition over their addictive behaviours.

1.9.1 Relapse Prevention Model

Attribution theory has formed an important part of our understanding with regards the relapse of addictive behaviours. Marlatt and Gordon (1985) proposed a cognitive behavioural model of the relapse process in all addictions and this has become influential in stimulating research and treatments. The model places an emphasis on the particular ‘choice points’, which set the stage for maintenance or relapse. Examples of these may be: whether to go to the pub soon after deciding to be abstinent from alcohol, whether to sit with a group of friends who are ‘out to get drunk’, whether to drive or walk to the pub and so on. All of these sorts of decisions will effect the probability of relapse.

If the choices that the individual makes do result in drinking, Marlatt and Gordon (1985) found a common cognitive emotional reaction that they termed the ‘abstinence violation effect’. This involves 1) feelings of guilt at having failed to remain abstinent and 2) an attribution that the drinking episode was due to personal weakness. The abstinence violation effect decreases self-efficacy and the motivation to continue trying.
According to this model if an initial lapse is attributed to internal, stable and global factors (for example, 'I lapsed because I am a weak person') then a full relapse is thought to be more likely, than if the initial lapse was attributed to external, unstable and specific factors (for example, 'I lapsed because my friend had a bad day and needed cheering up'). People who have well-practiced coping strategies and use them effectively develop increased self-efficacy beliefs in terms of their ability to exert control over their behaviour.

1.9.2 Self-Efficacy

The self-efficacy model is derived from social cognition theory (Bandura, 1977; 1986), which has been increasingly applied within the context of addictive behaviours and predominantly within the field of dependency (for example Schwarzer and Fuchs, 1996).

Self-efficacy relates to the belief or beliefs that a person has about their ability or competence to perform certain behaviour. The belief may vary according to the situation and therefore whilst self-efficacy may be high in some instances, the same behaviour may be associated with low self-efficacy in other instances.

Bandura (1977) describes 2 main types of outcome expectancy, which are central to self-efficacy beliefs about behaviour. These refer to the belief that engaging in a particular behaviour will provide a specified effect and can be described as 1) situation outcome
expectancy (which refers to environmental contexts of change) and 2) action outcome expectancies (referring to personal contexts of change).

Research into self-efficacy theory suggests that specific efficacy expectations are reasonably good predictors of positive health outcomes, including alcohol dependency (Rees, 1985).

**1.9.3 Outcome Desirability and Motivation**

This self-efficacy view has been challenged by Klar, Fisher, Chinsky and Nadler (1992), who asserted that it is the desirability of the outcome that drives behaviour more than the perceived likelihood of success. They concluded from their reports of some 200 students across over 25 domains of behavioural change that individuals are ready to invest costly resources even when they have a low outcome expectancy or when their past record for change is poor.

From an addictive behaviours point of view, the notion of enhancing the desirability or value of abstinence is well established, with motivational interviewing techniques often being the treatment of choice in many services, particularly when individuals are ambivalent about change (see Saunders, Wilkinson and Towers, 1996). However, from an eating disorders perspective, Vitousek and Watson (1998) points out that few attempts have been made to assess denial and resistance or to examine alternative strategies for enhancing motivation to change.
1.10 Dual Diagnosis

The term dual diagnosis is most commonly used to refer to a person who suffers from a mental disorder based on DSM IV classification (American Psychiatric Association, 1994) plus some substance use. Studies have been conducted with reference to a large and complex group of people, for example, those with concurrent alcohol dependence and social anxiety disorder (Randall, Thomas and Thevos, 2001); substance abuse and schizophrenia (Ziedonis and Nickou, 2001) and depression and substance abuse (McDowell and Clodfelter, 2001).

It is well known that the treatment outcome of severe mental illness is greatly diminished when persons also abuse alcohol and other drugs (Miller, 1997) and recent evidence suggests that treatment of this challenging group typically results in higher costs in multiple settings (Minkoff, 2001).

Research data identifies evidence-based programmes for treating particular subpopulations of individuals with dual diagnoses. However, despite the value of evidence-based models, recent research has indicated some limitations in their potential applicability (Minkoff, 2001; Drake, Essock, Shaner, Carey, Minkoff, Kolar, Lynde, Osher, Clark and Rickards, 2001).
Little (2001) suggested that a harm reduction approach, that focuses on the damage done by drugs and alcohol without insisting on abstinence from all psychoactive substances, can offer a useful way of conceptualizing treatment of dual diagnosis.

Van-Horn and Bux (2001) noted that motivational interviewing (MI) showed promise for engaging clients with dual psychiatric and psychoactive substance use diagnoses in treatment. The authors contend that while MI was initially developed as an individual treatment approach, key motivational enhancement principles may be applied to structured group interventions to facilitate its introduction into inpatient dual-diagnosis treatment.

Several studies have assessed patterns of comorbid psychiatric disorders in female alcoholics, providing evidence for higher co-morbid rates for depression and anxiety disorders compared with controls (for example, Ross, Glaser and Germanson, 1988). Of particular interest, has been the question concerning the order of the onset of the disorders. Vaillant (1995) points out that in dual diagnosis cases, alcoholism was usually the primary disorder in men, whilst studies with females who have diagnoses of alcohol abuse and co-morbid depression support a relationship between earlier reports of depression and later increases in alcohol use.
1.10.1 Current National Health Objectives

The first two National Service Frameworks cover two of the most significant causes of ill health and disability in England – coronary heart disease and mental health and are identified as priorities in 'Saving Lives - Our Healthier Nation'. Delivering National Service Frameworks, it is argued, will require new patterns of local partnerships across all NHS organisations to.....'ensure patients have access to the full services they need'; ..to deliver services in......'the most efficient and cost-effective way; and.......'to provide proper integration of treatment and care' (Department of Health (DoH), 1999).

It is also acknowledged that 'people with drug and alcohol problems have higher rates of mental health problems' (DoH, 1999). As part of the Joint Mental Health Strategy for Leicester (1999), Leicestershire NHS Drugs and Alcohol Services were recently commissioned by Leicestershire County Council Social Services Department to research needs and review provision for people with a dual diagnosis of mental illness and substance abuse or learning disability. It was concluded that despite the existing expertise within Services, clients with a dual diagnosis were typically passed between mental health and specialist Services. This resulted in them 'falling through the net' and thus not having their needs met (Rorstad and Chacinski, 1996).
1.11 Co-Morbidity of Eating And Drinking Disorders In Women

The prevalence of eating disorders generally and bulimia symptomatology in particular, in problem female drinkers has been consistently reported over recent years (Dawe and Staiger, 1998). According to an addictive behaviour model, these 2 disorders share common features, in particular, a compulsion to engage in the behaviour and a sense of loss of control.

Wiederman and Pryor (1996) investigated substance misuse among 134 women with anorexia nervosa and 320 with bulimia nervosa. Even after controlling for age and eating disorder symptom severity, bulimia nervosa subjects were more likely to have used alcohol, amphetamines, barbiturates, marijuana, tranquillisers and cocaine.

The potential nature of this co-morbidity is highlighted in a study by Catterson, Pryor, Burke and Morgan (1997), who described the case of a 26 year old woman who developed a severe eating disorder in her early teens that was followed by alcoholism. The combination of eating disorder and alcoholism in this patient led to approximately 70 hospitalisations for medical complications of her alcoholism and was ultimately the cause of her death.

Following the realisation that a significant number of bulimics and / or alcoholics were reporting a crossover in addictions (Pyle, Mitchell, Eckert and Halvorson, 1983), attempts were made to account for the perceived notion of ‘symptom substitution’ in
substance abusing populations. Brisman and Seigel (1984) considered substance abuse within a framework of ego growth, claiming that alcohol food and drugs all serve as attempts to minimise the impact of ego growth. According to this perspective, to view bulimia and alcoholism as unrelated addictions is to ignore their common ground. Brisman and Seigel (1984) argued that unless significant changes were made to the self-structure, substance substitution will continue as a way of self-soothing. In this sense, the theory supports Rado's (1933) early view that it was the impulse to use a substance, rather than the substance used, that was at the crux of addictive behaviour.

Brisman and Siegel (1984) proposed that the choice of substance abused may be a result of exposure to particular cultural pressures or factors (such as family alcoholism, media pressure to be thin). However, they concluded that substance abusing populations have a core personality structure in common that is deficient in emotional and self-regulatory functioning, and unless this structure is changed, abused substances may be used as alternates to the search for self-care.

Wilson (1996) postulated that eating disorders seemed to precede the development of substance misuse and suggested that psychoactive substances served as a reward following successful dietary restriction. However, he went on to acknowledge that the finding that it was predominantly bulimic and not restrictor anorexia nervosa patients that abused alcohol / drugs did not support this view. He subsequently suggested that the two behaviours represented different expressions of an underlying impulse control disorder. However, this would predict that the removal of the eating disorder should increase the
probability of substance misuse and yet there is no documented evidence of symptom substitution in successfully treated bulimia nervosa patients.

1.12 Self-Control In Relation To Symptoms Of Disordered Eating And Problem Drinking

Although much research has focused on establishing the relationship between eating and drinking, and describing the extent of the co-morbidity, little empirical research has investigated the possible mechanisms underlying this relationship. Peluso, Ricciardelli and Williams (1999) designed a study to examine the nature of the interrelationships among problem drinking and symptoms of disordered eating and cognitive self-control. A principle component analysis was conducted using responses from various questionnaires (assessing drinking / eating beliefs and behaviours and cognitive, emotional and behavioural control measures). They found that individuals who were high on cognitive self-control (cognitively preoccupied with controlling their behaviour) but who were also reporting higher action oriented behaviour (actively engaged in attempts to control their behaviour) were more likely to engage in increased bulimic behaviours and higher levels of drinking. This pattern of control is therefore unsuccessful and links with Baumeister and Hetherington’s (1996) notion of misregulation, which refers to active efforts to exert control over one self that are ineffective or counter productive.

1.13 Rationale for Current Research

Based on the literature review described above, justification for the current research can be summarised as follows:

- There have been a large number of studies over recent years reporting the co-morbidity of alcohol problems and eating disorders (particularly bulimia nervosa) in young women.

- There has been little empirical research investigating the specific mechanisms underlying the relationship between bulimia nervosa and alcohol abuse.

- Problematic styles of control have been shown to be important in underlying problematic eating, problematic drinking and in dual diagnosis cases.

- Notions of self-control and related psychological constructs are important in terms of outcome in a variety of health behaviours, including addictive behaviours and eating disorders.

- Research investigating self-control have used pre-defined measures of self-control, which differ according to the group being studied and / or define the concept according to the researchers.
• Imposing a pre-defined conceptualisation of self-control is likely to detract from our understanding of the construct, as it applies to women with this specific combination of disorders.

1.14 Aims of the Research

The specific aims are:

• To identify what self-control means to women with binge eating and binge drinking problems

• To identify perceived factors underlying the perceived need for self-control

• To develop an understanding of the perceived relationship between eating, drinking and perceived self-control.
CHAPTER 2

METHODOLOGY

2.1 An Overview of the Chapter

This chapter begins with an overview of epistemological perspectives, after which a more specific account of the methodology used in the current study and the rationale for doing so will be presented. A detailed account of the procedure used will then be described, followed by a consideration of issues concerning reliability, validity and generalisability of the findings.

2.2 Epistemological Perspectives: an overview

Epistemology refers to the theory of knowledge (Holloway, 1997) and should be differentiated from the theoretical analysis defining the research and the research method employed. The idealised and actual practice of science has been placed under increased scrutiny, centring around this question of knowledge and how it can be produced. There are two fundamental approaches at the heart of the debate and these shall be briefly outlined.

The realist or positivist approach is based on the common philosophy (traditionally adopted by scientists) of the need for objective observation and measurement which can be replicable and generalisable. Such traditional methods of scientific investigation have
been preoccupied with the need to quantify data, in order to test out a priori ideas on the basis of existing knowledge. This enables scientists to make assumptions about their findings based on standardised, objective methodology, which emphasises the need to produce reliable findings, referring to the consistency, stability and repeatability of the results (Brink, 1991).

A fundamental belief is that an objective reality exists and the aim of the researcher is to unveil the truth (Warner, 1996). Within this approach, the subjectivity of the researcher is seen as detrimental to the process of knowledge generation, producing biased and therefore inaccurate accounts. Attempts to minimise such bias are therefore central to the process (Henwood and Pidgeon, 1992).

Over the last few decades, the possibility of producing reliable and objective knowledge within social sciences has been a major source of debate (Sherrard, 1998; Danziger, 1990), with alternative qualitative approaches being proposed as more appropriate ways of investigating human phenomena.

The development of constructivist approaches has questioned the concept of an objective reality and ascertains that human beings actively construct their own social world and that this is an evolving process (Holloway, 1997). This perspective assumes an active as opposed to a neutral observer, and sees the generation of knowledge as a product of the social relations embedded within a social, historical and cultural context. Rather than attempting to minimise potential researcher biases, the task of the researcher is to openly
acknowledge such biases, so that the processes by which the data is constructed are made explicit (King, 1996).

To view qualitative and quantitative approaches as opposite ends of the spectrum, however, may be unhelpful and, in fact, different epistemological positions exist within both qualitative and quantitative paradigms: just as qualitative methodology may be seen as holding a position of 'strong objectivity' (see Harding, 1992), not all quantitative research is conducted from a positivist position (Parker, 1994). Indeed, both qualitative and quantitative approaches can be construed as ways of making sense of multifaceted information, and, in this sense, either approach could be viewed as constructivist (Latour, 1987).

As stated by Hammersley (1992):

"Our decisions about what level of precision is appropriate in relation to any particular claim should depend on the nature of what we are trying to describe .......... not on ideological commitment to one methodological paradigm or another" (p163).

Moon, Dillon and Sprenkele (1991) proposed a position of 'post positivism', which can be seen as taking a middle ground, in that whilst accepting that there is indeed a social world out there, human perceptual and cognitive limitations mean that this can never be accurately represented. The grounded theory approach (Glaser and Strauss, 1967) used in the current study has been described as a post-positivist strategy.
2.3 A Grounded Theory Approach to Qualitative Analysis - An Overview

As qualitative methodology *in general*, has a central role in the development of psychological theory (see Rennie, Phillips and Quartaro, 1988), Grounded Theory in particular, has been proposed as being particularly well suited to the study of social psychological topics such as personal and emotional experience (Charmaz, 1995). A Grounded Theory approach enables the researcher to conduct an analysis of the wide themes and content of participants' accounts of their experiences (Pidgeon and Henwood, 1997) and this has been done recently within the fields of eating disorders (Serpell, Treasure, Teasdale and Sullivan, 1999; and addiction, Kearney, 1998).

The Grounded Theory method was proposed by Sociologists Glaser and Strauss (1967) in response to criticisms that data was being forced to fit theory. Grounded Theory was put forward as an opportunity to generate theory through an inductive exploration of real life experiences.

The original conception of the method is based on a positivistic epistemology, and implies that real world phenomena do exist and are 'awaiting discovery' by the researcher. Rather than providing a definitive theory, this method attempts to develop theory by moving it to another more abstract level. Unlike positivistic research, which places its emphasis on confirming or refuting existing theory, grounded theory places an important emphasis on the discovery or generation of new theory, which, by its very
nature, draws attention to the complex nature of human experience and the specific context in which it occurs (Elliot, Fischer and Rennie, 1999).

Grounded Theory does not suggest that the research findings are only applicable to the specific situation or participant being studied. As Miller and Glassner (1997) have pointed out, through acknowledging the interdependent nature of the research process, it is possible to develop ‘intersubjective depth’ and ‘knowledge of social worlds’.

Glaser and Strauss (1967) suggest that sections of text are reduced to codes, which are sorted into low level categories initially; followed by more complex, higher level categories. Researchers are encouraged to stay close to their data by continuously asking questions about the meanings of categories and the relationships between them, which may subsequently change the direction of the emergent theory. In this sense, the researcher is simultaneously involved in the data collection and analysis, which is in contrast to several other social science approaches, which imply that these two phases are separate. Grounded Theory, therefore, uses the emerging categories to inform the data collection as well as to structure the analytic processes of coding, memo making, integrating and writing the developing theory (Charmaz, 1990). This has been termed the ‘Constant Comparative Method’ by Glaser and Strauss (1967), and allows links to be made between categories at various levels of abstraction.

Central to the Grounded Theory approach is the use of theoretical sampling, whereby negative or deviant cases which do not ‘fit’ the emerging theory are sampled. This
enables the researcher to ‘check’ theoretical categories and subsequently confirm or refute existing findings and thus help to further generate the theory. It can be argued, therefore, that Grounded Theory is not merely an inductive process but rather one that incorporates an element of ‘testing out’ in order to extend the emerging theory. In his account of the techniques of Grounded Theory, Strauss (Strauss and Corbin, 1990), described an interplay between induction and deduction, suggesting that his conceptualisation of the method was not a purely inductivist one, as favoured by Glaser (1992) since he argues that by incorporating hypothesis testing, the approach is no longer true to the ideals of the original account. Indeed, the concept of pure induction is highlighted in the original proposal that reading of the relevant literature should only occur after the categories have been developed. Other researchers, however, support the notion that Grounded Theory cannot be a purely inductive process (Henwood and Pidgeon, 1995; Charmaz, 1995) and this is discussed further in the following section.

2.3.1 A Constructionist Approach to Grounded Theory

Based on concerns that Grounded Theorists’ search for an ‘objective reality’ was becoming increasingly distant from the real life experiences of interacting human beings, a constructionist revision of the theory has been favoured (Charmaz, 1990; Henwood and Pidgeon, 1992), which emphasises the interplay between the researcher and the participant in generating theory. According to this view, the ‘tabula rasa’ view of enquiry described by Glaser and Strauss is open to serious doubt (Bulmer, 1982) as the
Researcher needs at least some theoretical resources in order to engage in the process of interpreting the data (Riessman, 1993).

According to Charmaz (1990), researchers should be explicit about the perspective with which they approach the research - this should involve their philosophical stance, as well as their personal values, opinions, interests and experiences. The researcher's perspective influences the connections that are made within the data. Without an initial theoretical interest, such connections might be missed. From this perspective, Grounded Theory accounts can be enriched by illuminating the researcher's perspectives and by reaching back into existing theory. Whilst some may hold the view that reaching back into theory is not conducive to the Grounded Theory approach, Charmaz (1990) argues that having a strong theoretical perspective guides the process of data gathering and analysis and gives the research 'greater conceptual depth and breadth whilst firmly situating it within the discipline'.

It should not be ignored, however, that bringing a strong theoretical perspective to Grounded Theory can be problematic in terms of preventing the generation of fresh ideas and encouraging a 'blinkered' perspective. However, through the process of 'reflexivity' as described in Glaser and Strauss's original account of Grounded Theory, the researcher is required to fully describe their values, attitudes and thus biases. If indicated in the final write up of the theory, this enables the reader to evaluate the report more effectively (Rennie et al 1988).
As described by Pidgeon and Henwood (1997):

"... bringing to public light researcher subjectivities, tells a more complete account of the research process than is to be found in the customary sanitised version of scientific report writing" (p270).

Given that contextualism reflects the position that all knowledge is local, provisional and situation dependent (Jaeger and Rosnow, 1988), the context in which data is collected and analysed is therefore imperative to understanding the knowledge. Pidgeon and Henwood (1997) have identified four dimensions which may effect the production of knowledge: 1) participants’ own understandings; 2) researchers’ interpretations; 3) cultural meaning systems which inform both participants’ and researchers’ interpretations and 4) acts of judging particular interpretations (in Madill, Jordon and Shirley, 2000). Whilst all accounts are assumed to be subjective, constructionist researchers take on the responsibility of representing the perspective of the participants by basing their findings in participant actual descriptions.

2.3.2 Goals of Grounded Theory Research

A range of goals for Grounded Theory research exist and these have been described by Pidgeon and Henwood (1997), under the three headings of taxonomy development, local theoretical reflection and ‘fully fledged’ grounded theory. These will briefly be considered in turn:

47
1. **Taxonomy Development**: This refers to the early categorisation of concepts as they emerge from the data. It may be seen either as a goal in itself (particularly in small scale projects, for example involving a small body of data and/or with limited opportunity for theoretical sampling) or as part of an ongoing research process, in which it may provide a useful initial goal, guiding further exploration.

2. **Local Theoretical Reflection**: When faced with a large body of data, from which multiple potential interpretations are present, a midway stage of analysis following the initial coding provides the researcher with several options in order to focus and localise theoretical reflection. For example, one route might be to focus on a single case, using the constant comparative approach to explore relationships and contradictory aspects within rather than across accounts. This can be argued within a constructivist view of grounded theory in that one should not automatically assume that participants' accounts of their experiences are internally consistent. Another opportunity for local reflection would be to attempt theoretical comparison between the emerging theory and existing theoretical accounts of the problem domain. Again, this is in line with social constructionist revisions of grounded theory which encourages such reflection and can be seen as crucial in the latter stages of the analysis.

3. **Fully-fledged grounded theory**: This refers to accounts which go beyond taxonomy development or local reflection, or are based upon sample groups that
can be justified in some way as theoretically complete. However, a social constructionist approach would argue that any interpretation of data is tentative and subject to change rather than a final account of 'the truth'. A fundamental flaw of grounded theory, is that the important step between the generation of individual components and of 'full theory' is not satisfactorily explained and therefore 'fully fledged' grounded theory, it can be argued, remains an implausible goal to achieve.

2.4 Rationale for Using Grounded Theory

The Grounded Theory method provides an opportunity to create theory in subject areas that are difficult to access with traditional research methods. The emphasis in the approach is on the generation of theory through the inductive examination of information, rather than the more traditional approach of using information to verify existing theory. However, that is not to say that verification activities hold no place in the grounded theory approach (Rennie et al, 1988) and indeed this was felt to be relevant to the current research.

There is an extensive body of literature describing the notion of self-control as a general construct and as it relates to various models of eating disorders. There is also a wide knowledge base as regards lack of control over drinking behaviours. However, the aim of the current study was to further understanding of the meaning of self-control in women with both disorders. Existing measures were felt to be inappropriate in that they would
have imposed pre-determined meanings, which may not be of relevance (see introduction).

A social constructionist framework was adopted for the current study, as this appeared suited to the research question due to the complexity and wide range of experiences of women with self-control difficulties. The interactive process between the researcher and the participants was considered to be important in generating knowledge about the phenomena of self-control in relation to binge eating and drinking and thus understanding the researcher’s perspective is central to this study.

2.5 Procedure

2.5.1 Ethical Approval

Ethical approval was sought from Leicestershire Research Ethics Committee, and following minor amendments, approval was granted on 22.9.00. A copy of the confirmation letter can be found in Appendix 1.

2.5.2 Participant inclusion / exclusion criteria:

As stated in the ethics form, participants were considered as eligible for the study on the basis of the following criteria:
The inclusion criteria was defined as:

- female
- meet DSMIV criteria for Bulimia Nervosa
- meet DSMIV criteria for Alcohol Dependence / Abuse
- self-define drinking as problematic
- binge (as opposed continuous) drinkers

Participants had to meet all of the above criteria to be considered eligible.

The exclusion criteria was defined as:

- male
- children under the age of 18
- intoxicated at time of interview
- enduring/psychotic mental illness

Those meeting one or more of the above criteria were not considered eligible for the study.

2.5.3 Selection and Recruitment of participants

Two initial meetings were held, one at the Community Alcohol Team and the other at the Eating Disorder Team, to which all members of the teams were invited, in order to inform them of the nature of the study. They were then asked to identify any potential
participants based on the criteria outlined above. All of those selected as eligible were approached by an appropriate member of the team (e.g. psychologist, keyworker) in writing. A copy of the invitation to participate letter and the accompanying information sheet can be found in Appendices 2 and 3 respectively. In cases that were considered to be particularly sensitive, a verbal format was also adopted. The participants were invited to return a reply slip at the bottom of the information letter. Once this had been received, the researcher contacted the participant to arrange a time to conduct the interview. In some cases, for example, when verbal agreement to participate was given via the key worker, the researcher contacted participants without having received a reply slip. In all cases, there was a gap of at least 48 hours between information giving and consenting into the study.

Three patients were selected from the Eating Disorder Team as being eligible for the study, with three agreeing to participate. One patient failed to turn up for the interview and it was later revealed that she had taken an overdose. Due to ethical concerns, it was felt that there should be a period of time before re-contacting this participant. However, the participant failed to turn up to a subsequent interview and as this was the last scheduled interview, it was not feasible to rearrange it at such a late stage.

Three patients from the Clinical Alcohol Team were selected as being eligible for the study, and all agreed to participate. However, one patient ended her contact with the service (and moved areas) shortly after giving consent and it was therefore no longer
possible to include her. The remaining 2 participants were selected using theoretical sampling (see below).

The total sample of six is in line with standards recommended by Turpin et al (1997) for Clinical Psychology Doctoral Projects.

The characteristics of the participants are summarised in the following table:

Table 1: Participant Characteristics

<table>
<thead>
<tr>
<th>Participant Number</th>
<th>Current Age</th>
<th>Service in Contact With</th>
<th>Clinical Diagnosis</th>
<th>Theoretical Sampling – yes/no</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>28</td>
<td>CAT</td>
<td>BN + AA</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>30</td>
<td>EDT</td>
<td>BN + AA</td>
<td>No</td>
</tr>
<tr>
<td>3</td>
<td>25</td>
<td>EDT</td>
<td>BN + AA</td>
<td>No</td>
</tr>
<tr>
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</tr>
<tr>
<td>6</td>
<td>45</td>
<td>CAT</td>
<td>AA</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Key to table:

BN = Bulimia Nervosa

AA = Alcohol Abuse

EDT = Eating Disorder Team

CAT = Clinical Alcohol Team
As can be seen from the table, four of the participants were recruited from the Community Alcohol Team and two from the Eating Disorder Team.

2.5.4 Development of the Interview Guide

2.5.4.1 Use of Interviews

The aim of structured interview formats is to: 'capture precise data of a codable nature in order to explain behaviours within pre-established categories........(the unstructured interview) is used in an attempt to understand the complex behaviours of members of society without imposing any a priori categorisation that may limit the field of enquiry (Fontana and Frey, 1994).

Whilst the unstructured interview may be favoured because the focus is on participants own conceptions (with the researcher’s expectations being kept in the background), without having a specific agenda, there is a danger that a large amount of data, which is not closely related to the research, may be produced.

The semi-structured interview is situated between these two extremes. It provides a flexible research tool, which enables the participant to raise new issues, which had not been considered as relevant to the research question, whilst allowing the researcher to confront his/her own perspective within the research process. It is well suited to a
qualitative approach and is an appropriate method for exploring complex issues and processes whether these are controversial or personal (Smith, 1995).

A semi structured interview format was adopted as it was felt that this would provide both the researcher and the participant with some structure whilst remaining flexible enough to incorporate new ideas as they emerged during the interview. As described by Mason (1996), it is important in interviewing to encourage a communication that moves easily between topics and questions and it was therefore felt that a degree of flexibility offered by a semi-structured approach would support this process. This meant that the interview questions would be open ended, and would enable the researcher to gain a deeper understanding of the ‘lived experience’ of the participants (McLeod, 1996).

An interview guide was designed (see Appendix 4) based on the following:

- clinical experience of working with this client group
- knowledge of the literature within the fields of addictive behaviours and specifically pertaining to eating and alcohol disorders
- discussions with supervisors
- the research question
The initial interview schedule had the following three broad objectives:

- To identify what self-control means to the population being studied
- To identify the women's perceptions of factors underlying the need for self-control
- To identify the perceived relationship between eating and drinking habits and perceived self-control

As pointed out by Charmaz (1995), once the initial coding of interviews has taken place, researchers may be led into new areas which had not been considered prior to the interview process. This may require the researcher to use different questions in order to accurately pursue the subjective experiences of those being interviewed. As described earlier, the notion of simultaneous data collection and analysis is central to the grounded theory approach and it is therefore expected that the content of the interview will evolve alongside the analysis.

For example, as the emergent themes became apparent from the earlier interviews, specific issues pertaining to the perceived function of eating and drinking and the relationship between the two, became a major focus of subsequent interviews.
2.5.5 Interview Procedure

Participants were given a choice of location for the interview, to encourage them to feel more at ease during the process. Three of the women opted to be seen at home whilst the other three were seen at the team base. Attempts to help the participants to relax were initiated immediately, for example through general conversations relating to their interests and the like.

If participants reported feeling overly anxious about the interview and were having second thoughts about participating, they were given the option to rearrange it. This happened with one of the participants.

Most of the interviews lasted approximately 45 minutes (range 20 minutes to 1 hour). The shortest interview was atypical in that the participant seemed to find it difficult to elaborate, despite various attempts to gently prompt her to explore some of her responses further. It was nevertheless felt appropriate to include this interview, as it was important in the development of the interview schedule and thus the emergent theory.

Prior to each interview, the researcher reiterated the content of the information sheet and invited the participant to raise any concerns or unanswered queries she may have with regards the study. Particular attention was given to issues of confidentiality and of the voluntary nature of their participation. Once it was clear that the participants were fully
aware of the details of the project, they were asked to sign a consent form to confirm this (see Appendix 5). All subjects were happy to do this.

The researcher went through a checklist based on DSM IV criteria (American Psychiatric Association, 1994) to ensure that the participants met criteria for Bulimia Nervosa and / or Alcohol Abuse / Dependence (with binge drinking as defined in Heke, 2000).

Following the interview, participants were given up to one hour to discuss any concerns they may have had and to ensure that they did not leave the interview feeling distressed.

As recommended by Charmaz (1995), the researcher described the context of the interview and relating thoughts in the research journal immediately after the interview. In line with the social constructionist framework, particular attention was paid to the perceived interaction between the researcher and participation and how this may have shaped the interview. This had important implications for the analysis and will be discussed in more detail below.

Abstract from research journal

14/11/00 – thoughts re. Interview 1
- Having self-control is clearly important to her – WHY?
- Struck by ambiguity re. nature of self-control. On the one hand, she was adamant that she had strong self-control, but on the other hand, not really sure. Maybe she isn’t sure what it means to her. – always searching for it?
- Seemed more concerned about eating – interesting despite being in contact with Clinical Alcohol Team
- Described being less likely to binge eat following a drinking session – thought this would be opposite because of inhibition associated with drinking – need to explore with others – maybe this is atypical
- Commented on me being ‘slim’ wonder how this made her feel?
Charmaz (1995) recommends that the act of transcribing be undertaken by the researcher in order to increase familiarity with the data. The researcher transcribed each interview within one day of conducting each interview so that this ‘familiarising’ process could begin as early as possible. Tapes were transcribed verbatim to ensure that nothing was lost during this procedure. Long pauses (5 seconds or more) were denoted by the following (.), and sections of the interview which were incomprehensible by ****. Pseudonyms were used to replace any information that may compromise participants’ confidentiality, such as names, work places and so on. Text in brackets refers to summarised text. The transcripts are included with this thesis as an addendum.

2.5.7 Data Analysis

2.5.7.1 Open Coding

Open coding refers to the part of the method that deals with the labelling and categorising of phenomena as indicated by the data. This labelling and categorising provide the basic building blocks in Grounded Theory construction. The specific mechanics of coding interviews may vary among researchers. Perhaps the most detailed form of open coding is the line by line method (Glaser, 1978; Strauss and Corbin, 1990), which involves examining each line of the data and giving it a label or code which is written on to the text. This may be a single word or a lengthier description of the conceptualisation of the text. This approach was adopted for the first three interviews, as it was considered to
minimise any likelihood of ‘missing’ important aspects of the data (See appendix 6 for an example of open coding).

Other researchers suggest that the transcripts are broken down into meaningful units with codes being assigned to each unit (Rennie et al, 1988; Pidgeon and Henwood, 1997). This is a more focused type of coding and was used for the last three transcripts because the process of line by line coding felt rigid and somewhat abstract from the text as a whole and it was difficult to remain aware of the surrounding context. As Silverman (1993) points out, using a tight framework may restrict creative thinking, which does not seem conducive to a constructionist approach. Strauss and Corbin (1990) themselves acknowledge that it is appropriate for the researcher to move freely between different methods of coding, depending on the stage of the analysis.

2.5.7.2 Developing Categories

Following the initial coding described above, related concepts were grouped together to form categories. This can be described as a conceptual process, as it requires some selection of codes that appear to be related to the research question (Charmaz, 1995). Each category was given a label which best seemed to describe the concepts within it.

As noted by Strauss and Corbin (1990), developing categories is a complex process, as the researcher has the dual task of examining the relationship between existing concepts, whilst continuing the exploration of further concepts to fill in any gaps within the
categories. Useful questions to ask were: What does this mean? What seems to be going on here?

To facilitate this process, an index card was developed for each preliminary category. Each of the concepts relating to the category was written on to the card, with accompanying examples from the text (identified by the participant and line number). As the research progressed, categories that seemed to cover the same material were merged together – this was an ongoing process.

**Example of an Index Card:**

<table>
<thead>
<tr>
<th>Relationship difficulties (as pre-cursor to eating difficulties)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I1: 103  splitting up with partners, death of relative</td>
</tr>
<tr>
<td>I2: 97   feelings of rejection: sexual difficulties</td>
</tr>
<tr>
<td>I2: 254  racism – blacks against whites</td>
</tr>
<tr>
<td>I2: 52   loneliness – partner out a lot of the time</td>
</tr>
<tr>
<td>I3: 9    having personality criticised by parents</td>
</tr>
<tr>
<td>I3: 23   death of grandfather - bingeing</td>
</tr>
<tr>
<td>I3: 306  being dictated to and brought up with diets</td>
</tr>
<tr>
<td>I4: 283  being bullied at early age – always told she was fat</td>
</tr>
</tbody>
</table>

Links with:
- Use of food to gain control
- Comparison with others
- Self-identity
- Need for self-control
- Use of alcohol as avoidance
- Self-efficacy
2.5.7.3 Use of Memos

The act of memo writing proceeds in parallel with data collection and coding and is important in order to 'raise the description to a theoretical level through conceptual rendering of the material (Glaser, 1978). They can be described as notes, which the researcher makes, about emerging categories and the relationships between them. They help the researcher to gain a deeper insight by encouraging him/her to think beyond single incidents to themes and patterns in the data and are therefore central to the developing theory.

An example of memo writing

<table>
<thead>
<tr>
<th>Perceptions of self-control</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Surprised at how 'H' seemed so convinced that she had self-control despite giving examples which suggested the opposite.</td>
</tr>
<tr>
<td>• Is self-control always seen as positive? Can it ever be negative?</td>
</tr>
<tr>
<td>• Why is it so important to have self-control?</td>
</tr>
<tr>
<td>• Would it be helpful to see self-control in a different way?</td>
</tr>
<tr>
<td>• What are the consequences of not having self-control?</td>
</tr>
<tr>
<td>• Is there awareness that other people may see self-control differently?</td>
</tr>
</tbody>
</table>
2.6 Ensuring the Quality of Qualitative Research

2.6.1 Reliability and Generalisability

Positivistic notions of reliability and generalisability as applied in traditional quantitative research methods are not applicable to qualitative methodology. The generalisability of qualitative research is likely to be conceptual rather than numerical (Fitxpatrick and Boulton, 1994). Replication in qualitative research has "...more to with reinterpreting the findings from a different standpoint or exploring the same issues in different contexts rather than expecting or desiring consistent accounts" (Banister, Burman, Parker, Taylor and Tindell, 1994). However, if the study were repeated with similar participants and within a similar context, it is generally assumed that there would be a replication of the findings (Lincoln and Guba, 1985). This highlights the importance of documenting the research process in a clear and precise manner. Sherman and Webb (1988) have identified six categories, in order to provide some criteria by which grounded theorists can ensure rigour and empirical grounding of their research. These shall be briefly outlined below:

Degree of fit: This refers to the codes and categories which are derived rather than forced from the data and enables neutral observers to understand how the theory was developed. As pointed out by Glaser and Strauss (1978), "since most categories of grounded theory are generated directly from the data, the criteria is already met and does not constitute an unsatisfactory struggle of half fits".
Functionality: This is Sherman and Webb’s (1988) description of a theory that ‘works’ and refers to the variation in the data and relationships between constructs which provide a predictive element to the theory.

Relevance: This has been described as the ‘ahhh haaa’ phenomenon and is something which evolves through the emergence of the core category forming the basis of the theory.

Modifiability: This refers to the flexible nature of the grounded theory approach, which allows the researcher to reflect upon and accommodate the ever changing properties of the phenomena being studied.

Density: A theory is described as dense when it ‘possesses a few key theoretical constructs and a substantial number of properties and categories’ (Sherman and Webb, 1988).

Integration: This refers to the relationship between the categories which enable an ‘appropriate fit into a tight theoretical framework’ (Glaser and Strauss, 1967).
2.6.1.1 Constant Comparative Method

The constant comparative method forces researchers to stay close to their data by comparing and contrasting participant accounts and therefore enabling them to 'tease out the emerging category by searching for its structures, temporality, cause, context, dimensions, consequences and relationship to other categories' (Hutchinson, 1988). By constantly comparing the responses of participants, common dimensions were identified, which were then tested out with future participants and modified accordingly. This technique was thus central to the developing theory.

2.6.2 Validity

Validity, according to Hammersley (1990), is another word for 'truth.....interpreted as the extent to which an account accurately represents the social phenomena to which it refers'. Whilst one of the strengths of qualitative research is its ability to provide a depth of information which may otherwise be missed, this has also been described as its weakness, in that researchers may have a tendency to use anecdotal evidence which may not be generalisable to other instances; and as examples are abstracted from the data, the original form of the material is lost, making it difficult to explore alternative explanations of the data (Mehan, 1979).

Various methods of addressing the problem of validity in qualitative research have been put forward and some were used in the current study. An outline of the techniques will be
given here, with a more critical discussion relating to the methods employed in the current research being presented in chapter 4.

2.6.2.1 Triangulation

Triangulation refers to the attempt to gain an accurate understanding of the phenomena being studied by combining different ways of looking at it or examining different findings. It refers to the use of multiple researchers, methods or theories as a way of assessing the accuracy of findings. Denzin (1989) proposes that the ‘triangulation of method, investigator, theory and data remains the soundest of theory construction’ (p236).

2.6.2.2 Investigator Triangulation: Qualitative Research Group

A qualitative research group provided a forum for discussing theoretical / methodological issues relating to the research and was an opportunity to receive feedback on the developing theory as it was perceived by the researcher. This enabled the researcher to consider the data from alternative perspectives and pursue avenues, which may not previously have been considered relevant.
2.6.2.3 Data Triangulation

Data triangulation refers to the use of different data sources, such as distinctions between time, persons and space. Of the participants with both an eating and drinking disorder, half were taken from an eating disorder service and half from an alcohol service.

Data triangulation can be linked to the theoretical sampling strategy, which is inherent within the grounded theory model. This refers to the process of data collection whereby the researcher jointly collects, codes and analyses the data and decides what data to collect next and where to find them in order to develop the emerging theory (Glaser and Strauss, 1967). This may involve negative case analysis, which involves the exploration of cases that do not fit with the emerging conceptual system.

Whilst it was initially hoped that the 6 participants would all meet the inclusion criteria, sampling problems encountered suggested that this would be unlikely in the available time scale. The remaining two participants were thus obtained using theoretical sampling, which involved asking the team to identify women who abused alcohol, characterised by binge drinking (as opposed continuous drinking) as defined by the Clinical Alcohol Team. This decision was reached on the basis of the theoretical account, which was developing and is discussed in more detail below.
2.6.3 Reflexivity

Reflexivity refers to the consideration of the researcher as part of the setting, context and culture that he or she is studying and is a central part of all qualitative research. The subjectivity of the researcher (for example in terms of setting, context and culture) is central to the grounded theory approach and influences the course of the observed event radically as inspection influences the behaviour of an electron’ (Behar, 1996)

The research account is thus not only a presentation of the data but also an explanation of how the researcher defined their data, how did their considerations change and how did their presence in the setting change that setting? The researchers attitudes should be fully described and discussed and their values openly acknowledged.

A reflexive journal was kept throughout the course of the research, which enabled the researcher to note down her own biases and reflections, which affected the development and direction of the research. Some examples of this are included within this thesis and all interview transcripts are also available to the reader.

This process can thus be seen as attempting to lessen the gap between reality and the interpretation of reality by filling in contextual factors which impact on how the researcher developed certain constructions (Stevenson and Cooper, 1997).
As noted by Harding (1991), this facilitates a more complete account of the research process than can arguably be found in the customary versions of scientific report writing and is a move therefore towards 'strong objectivity'.

2.6.3.1 The Researcher’s Perspective

The researcher was a Trainee Clinical Psychologist at the University of Leicester and the research was in partial fulfilment of the Doctorate in Clinical Psychology.

Prior to starting the course, my background was primarily one of research, however, projects were generally conducted within a positivistic framework. This did not sit with my personal opinion regarding the relevance of the researcher, in terms of the interaction with the participants, and their subsequent interpretation of that interaction. This viewpoint was initiated during a placement as an Assistant Psychologist, at a secure unit for adolescents with severely challenging behaviour. Psychometric questionnaires were routinely administered to assess current mood and functioning and the variances in the results were seen as an indication of change. However, these results were often 'at odds with' clinical judgements made by the team – judgements which were made in relation to the individuals' social and personal contexts – and which ultimately formed the basis of any formal decisions regarding their treatment.

Whilst the appropriate use of questionnaires, as an adjunct to clinical observation, remains integral to my work as a psychologist, I remain interested in understanding some
of the more subtle factors which influence behaviour and which may not always be picked up using quantitative methods. From my knowledge of the literature pertaining to the current sample, I felt a qualitative approach was not only appropriate but necessary to explore the issues being studied.

My initial interest in the area of eating disorders, stemmed from personal experiences of having friends suffer with anorexia nervosa, despite otherwise leading a seemingly normal life. I became interested in understanding the maintenance of the disorder, in terms of its positive function(s), aside from the obvious effect of weight loss. Subsequent clinical experience with young women with eating difficulties highlighted the centrality of self-control issues, which seemed to make sense in retrospect.

Recent media portrayals of women suffering from eating disorders, some going on to substance misuse rehabilitation clinics, drew my attention to the literature on addictive disorders in women. This highlighted the prevalence of the co-morbidity of eating and drinking disorders in women.

Due to the different sources from which my interest developed, I became interested in studying women who had been clinically diagnosed as having eating and alcohol disorders. As the notion of self-control seemed to make most sense to me, and indeed forms a central part of the cognitive behavioural account of eating disorders (discussed elsewhere), this became a focus of the research.
Lastly, it is important to note my own self-identity as a young, reasonably successful woman; social non-problematic drinker; some previous experience of dietary restriction although not currently. My own presentation, as perceived by the women, was assumed to have some affect on the content of the interviews. For example, just as they would be expecting me to make judgements about them, based largely on the content of their responses, it was likely that the participants would also be making some judgements about me. Information initially available to them was likely to be limited to physical appearance, age and profession. I felt that these factors alone could influence the way they responded to my questions (for example, they could have felt relieved and relaxed, which may have encouraged openness, or they may have felt envious and threatened, which could have led to a more defensive style). It was therefore particularly important to me to make a concerted effort to put the participants at ease prior to the interview and to make my role within the research procedure explicit.
CHAPTER 3

RESULTS

3.1 Overview of This Chapter

The results section describes the categories that were derived from the interviews and form the basis of the grounded theory. These are illustrated with excerpts from the interview transcripts, denoted by italic text, followed by the participant number and line of text.

For example: 'As soon as I see the worry on other people's faces about me, that's when it really clicks in that the self-control is slipping a bit' (I: 4, 364-366).

To enhance clarification for the reader, the categories have been formatted differently according to the level of abstraction:

CORE CATEGORY (bold, underlined, upper case).

MAIN CATEGORY (bold, upper case).

Intermediary Level Category (bold, lower case).
Sub-category (bold, italic).

The main categories are relevant to all of the participants; the intermediary level categories are relevant to all of the women with a dual diagnosis of binge eating and binge drinking; the sub-categories are relevant to at least two of the participants. When categories were found to also relate to the women with alcohol only problems, appropriate examples were given. Similarly, categories which were exclusive to the women with dual problems were described.

One core category was identified, termed by the researcher: 'ILLUSION'. This featured throughout the analysis, relating to all of the other categories. Five main categories were identified and formed a process model of self-control. These were:

- DISSATISFACTION: PASSIVE VICTIM ROLE (perceived need for self-control)
- ATTEMPTS TO ACTIVATE CHANGE (attempt to gain control)
- DEVELOPMENT OF PROBLEMATIC BEHAVIOURS (loss of control)
- ATTEMPTS TO CONTROL DRINKING (attempt to regain control)
- MAINTENANCE: A SERIES OF OPPOSING FORCES (continued struggle for self-control).
3.1 Process Model of Self-Control

The process model of self-control as derived from the analysis is presented in Figure 1. This starts with Dissatisfaction: Passive Victim Role, leading to a perceived need for self-control. This is divided into three intermediary level categories of Interpersonal Relationships, Work/Study and Self-image.

In response to this dissatisfaction, efforts to bring about change are activated, in an attempt to gain control. This is described in terms of controlling food intake, use of alcohol, external/tangible control, use of drugs and self-harm.

The next stage involves a loss of self-control and the development of problematic behaviours, in the form of binge eating and regular drinking. There appears to be an interaction between the two processes.

Attempts to regain control are activated through control over alcohol intake, which leads to binge drinking. The struggle for self-control continues through a set of conflicting forces, and thus the cycle is maintained.

An account of the analysis is described below, starting with the core category of Illusion, followed by the main categories (and relating intermediary and sub-categories) as identified in the process model.
Fig. 1

A Process Model of self-control

MAINTENANCE: A SERIES OF OPPOSING FORCES - continued struggle for control

DISSATISFACTION: PASSIVE VICTIM ROLE - perceived desire for control

ATTEMPTS TO ACTIVATE CHANGE - attempts to gain control

ATTEMPTS TO CONTROL DRINKING - attempts to regain control

DEVELOPMENT OF PROBLEMATIC BEHAVIOURS - loss of control
3.2 CORE CATEGORY: ILLUSION

The core category which emerged from the analysis has been termed ‘Illusion’. This notion of illusion refers to a ‘false impression’ or ‘deceptive appearance’ and shall be discussed further in section 4. This category was found to relate to main categories describing the women’s struggle for self-control and was therefore seen as underpinning the analysis as a whole.

The category of ‘illusion’ as it relates to self-control has been divided into three parts.

1. Illusion of ‘self’ in self-control.


3. Illusion of being in control of drinking.

**Illusion of ‘self’ in self-control.** The analysis revealed that self-control does not necessarily relate exclusively to the ‘self’. The role of others in contributing to the need for self-control, the prevention of self-control and the re-gaining of self-control was consistently reported. This was mainly described in terms of the women’s alcohol use but also related to their general perceptions of self-control.
Even in the face of difficulties that are clearly external to the individual and outside their control, the women's own sense of self-control was threatened. For example, when asked about the factors contributing to her losing control, one participant replied:

'It's like I said before, when my uncle passed away – that affected my self-control' (I: 1, 146-147).

The following participant was aware that her ability to exert self-control was dependent on how much alcohol her husband brought into the house:

'If I knew there was only one (can of lager) I will have no choice but if I knew there was more in the house, then I wouldn't (have sufficient self-control). I would hit the lot' (I: 2, 346-347).

Another described needing to have someone there to tell her when she had had enough to drink:

'You do need the support, you need someone to take you to one side and say 'you've had enough now'. I got into deep fights about that... ...but you never realise in yourself how much (you've had)' (I:4, 258-262).

The analysis revealed similar examples from the women with alcohol only problems, such as the tendency for them to hold others responsible for their lack of control:
'I think if my husband weren't here, I could do it on my own but he brings it (alcohol) in and I get annoyed and when I get annoyed, I have a drink' (I: 6, 98-99).

**Visual Illusion of self-control.** For women with eating disorders, the visual illusion of thinness equalling feelings of control is well known. However, the importance of how things looked on the outside was mentioned with some frequency by all of the women, whether it was related to looking slim, having a tidy home, or not looking like an alcoholic.

One participant made a direct link between control and her outward appearance:

'It's like my make up, that is me, that is my control. My hair is my control, my dress is my control' (I: 2, 240-242).

There was an indication that portraying a picture of being in control would make up for not feeling controlled inside:

'Well, I do make sure my house looks nice........ Something has to be organised in my life. But other stuff – I can't seem to sort anything else out' (I: 1, 57-61).

Covering up visible signs of alcohol use was seen as portraying an image of being in control of drinking:
'If someone comes round to the house and I've got – 'cause I usually have like a bottle of red wine sitting on the table and I put that away 'cause I think that seems really sort of alcoholic to do that' (I: 3, 197-200).

For women with alcohol only problems, 'looking' controlled was also significant:

'I don't think he realised how depressed I really was 'cause I used to put on this happy, smiley, oh everything's alright, to my family' (I: 5, 71-73).

**Illusion of being in control of drinking.** All of the women reached a point at which they considered their drinking to be problematic. However, unlike the women with 'alcohol only' problems, who perceived their current binge drinking to be problematic, the women with both eating and drinking problems felt that they were in control of their drinking, comparative to before:

*I go through phases. I don't drink all the time like I used to so it's not really so bad' (I: 1, 89-90).

'Although it's too much (current drinking level) it's not like it was before' (I: 3, 121).

This was in contrast to binge drinkers without eating problems, who did not associate any benefits with their current drinking pattern. When asked about the positives of drinking, a typical response was:
'Nothing. Absolutely nothing. I don't even like the taste of it' (I: 6, 34).

There was an indication that the main sample was less likely to be aware of the impact of their drinking upon significant others. For example, one participant believed that her parenting skills were better when she was drinking, (despite contrary evidence from others):

'Left up to me I'll be merry around the children. I would never get drunk around the children, in fact I never do. I play with them more' (I: 2, 351-353).

Greater awareness was reported by the women with alcohol only problems:

'I wasn't really being a fit mother' (I: 5, 96).

The belief that the women were in control of their drinking was present from the onset, despite them admitting to drinking in secret or whilst still at school:

'(when eating first became problematic at age 15, my drinking) wasn't bad at all. Well obviously, going into the pub underage is not a good thing, but I'd get there about 1 o'clock and I'd leave – I always had to be back for about 7 so I'd always be back by then but my tolerance was a lot lower so it would only be about 5 pints' (I: 4, 53-57).
This was also the case when the eating disorder had developed from a restrictive type to a binge-purge type:

'I was bingeing (eating) all the time. I certainly used to drink from my parents’ drink cabinet without telling them....but I wouldn’t really say it was like a thing then, it was just something that I did sometimes, it wasn’t a problem and it didn’t last very long' (I: 3, 39-42).

Whilst the women with a dual diagnosis did not see the need to give up drinking completely, there was a suggestion that they would be able to give up if certain situations arose. However, they described situations which either 1) were unlikely to happen, or 2) had already happened on previous occasions but had not resulted in abstinence. This was interpreted by the researcher as implying a false sense of control:

'(I could probably give up if I had to) – if I was told I’d die or something’ (I:1, 93).

'I absolutely 100% know that if the doctor said that I had to (give up alcohol) I would. But having said that, ‘cause I had a liver function test a while ago......... and he said you really should cut down on the amount of alcohol that you take in and I haven’t been able to’ (I:3, 254-260)
This was echoed by the women in the alcohol only group. For example, the following statement was made just 2 weeks after being discharged from hospital with alcohol related problems:

‘If somebody told me that my liver was so bad that I was gonna die if I didn’t give up (that would stop me drinking)’ (I: 6, 385-386).

As can be seen from the above description, the notion of ‘Illusion’ has an over-arching presence at all of the stages relevant to the women’s struggle for self-control. A process model of self-control has been devised to describe these stages in more detail and this shall be presented in the following section.

Summary of Core Category of Illusion

As has been described, the core category of ILLUSION has been split into three areas: illusion of self; visual illusion of control; and illusion of being in control of drinking. The first two relate similarly to all of the women, regardless of whether their difficulties were just with alcohol or with food and alcohol. Whilst the illusion of being in control of drinking also relates to all of the women, some specific differences were identified. For example, the women with a dual diagnosis did not consider their current binge drinking to be problematic, in contrast to women with alcohol only problems. However, there was an indication that these women too had an illusion of being in control of their drinking as
highlighted by their belief that they *could* give up if faced with certain situations — however, this did not fit with either current or previous experiences.
Special Note

Page 84 missing from the original
Fig. 2

DISSATISFACTION: PASSIVE VICTIM ROLE

Interpersonal Relationships
- criticism
  - control

work / study

self-image
- self-esteem
  - Self in relation to others
3.3 Perceived Need For Self-Control

Main Category: DISSATISFACTION: PASSIVE VICTIM ROLE

A first main category of DISSATISFACTION: PASSIVE VICTIM ROLE was derived from the analysis. This can be described as feelings of unhappiness and frustration that the women identified in relation to their situation, prior to them becoming aware of difficulties with eating and / or drinking. Within the process model of self-control, this category represents 'the perceived need for self-control'.

This category consists of three intermediate level categories, described as Interpersonal Relationships, Work / Study and Self-Esteem, and a set of related sub-categories. Figure 2 shows how these categories have been organised. An account of the intermediate and sub-categories is described below.

Intermediate Level Category: Interpersonal Relationships. This category refers to the passive role which the women adopted within their relationships and which was felt to play a significant role in contributing to the difficulties that they had encountered. Some of the relationships were ongoing, whereas others were remembered from previous experiences, for example, going back as far as early childhood. Some of the women focused on one particular relationship, whereas others referred to dissatisfaction within a number of relationships.
The following excerpt gives an example of the sorts of relationships the women tended to refer to. When asked about situations or events that have happened which have threatened feelings of control, she replied:

'When I split up with boyfriends mostly — ex-boyfriends. When I've split up with partners in the past. When I've had any sort of trouble with my family. And the time that my uncle passed away, that really upset me'. (I:1, 118-120).

For the women with alcohol only problems, relationship difficulties, involving themselves as the passive victim of external experiences, were also prominent in their accounts of the onset of their problematic drinking. One of the women described a breakdown in relationships during a period of post natal depression whilst the other described an earlier relationship she had had with a married man:

'............he actually talked me into leaving my husband...........and I was quite willing to do that until I did and he saw less of me...........and that's what started me drinking' (I: 6, 139-143).

Relationships were described between partners, friends and family members, particularly parents. However, interestingly, the analysis suggested that it was not so much 'who' the other person (or persons) in the relationship was, as much as the specific nature of the relationship, which had a negative impact on the women. The following two sub-categories describe the nature of these relationships.
Sub-category: Criticism: This refers to the critical nature of the relationships that the women described, usually in retrospect but also with reference to current relationships in some instances. Again, there was an indication of passive victimisation within these critical relationships.

For some of the women, this was experienced as a direct criticism of the person that they were:

'I think I had a lot of issues with my family as well, over them being very critical of the person that I was. Not of my achievements because I've always been a very high achiever, but because of my personality and the way that I dealt with things' (I: 3, 310-314).

Being bullied or picked on either physically or verbally was another reported experience. In women with eating and drinking problems, this kind of criticism was typically about 'being fat'.

'One of my first memories is being kicked when I was at school - and I've been bullied all the way through' (I: 4, 283-284)

When asked about the development of her eating problems, she goes on to say:

'I think it's because of the bullying because I was always told I was fat' (I: 4, 297).
These experiences were reported as being crucial not only in terms of heightening their awareness of how they looked physically to others, but also in terms of making them more sensitive to the opinions of others in general.

One women described being criticised in terms of her racial identity:

"Then they gave us a flat on (address omitted) which was a complete white area, but they were racist – and I mean very common racist people and that made me a lot worse because it got to the point where I couldn't even get out of the flat, so I got all my friends to get the alcohol in for me, sat inside, got drunk every night" (I: 2, 31-35).

Whilst there was some awareness that the criticism was unlikely to have been directed towards her personally, it nevertheless had a negative impact and was dealt with in a personal way. Her coping mechanism can be described as 'passive' rather than active, in that she hid herself away, got others to buy her alcohol and stayed in and drank alone.

Sub-category: Control. This category refers to the tendency for significant others to inflict control on to the women which seemed to alter the balance of the relationship and create a feeling of helplessness in the women experiencing it.

Sometimes, this experience of being controlled was directly related to food, both explicitly and also in a more subtle way:
'I've always felt that my parents have tried to control what I eat...........I've been brought up with people dictating what people can and can't eat all the time, all the time. And I think I hated that - not necessarily people saying yes you can or no you can't, but them being there, so I felt like I had to say no when I wanted to say yes – so that kind of control, like a subtle control, not necessarily spoken' (I: 3, 317-318; 324-328).

Whilst this participant was angry at having her food intake controlled, she felt unable to retaliate and thus adopted a passive role.

Feeling controlled by others was also experienced by the women with 'drinking only' problems. However, some references to feeling controlled in these two women were made in the context of an existing drink problem. It may therefore be that this was as a result of a perception that these women were incapable of being in control themselves:

'I don't like to feel controlled because my husband was very much a – you know, he liked to be in control........he quite liked it when I was dependent on the drink because I wasn't capable of doing anything, he was kind of in control whereas I was just, oh, you know, whatever, yeah do this........' (I: 5', 380....384-386).

With hindsight, the women were able to identify the passive role that they had previously adopted in terms of allowing themselves to be controlled by others. This seemed to encourage feelings of determination that they would not be controlled again.
'Because my parents were so controlling I thought now no one in the world is ever gonna control me. Only I will do it. I will do what I want and when I want'. (I: 2, 133-134).

Intermediate Level Category: Work / Study. Factors relating to participants’ work or study were also revealed in the analysis to be connected to their sense of dissatisfaction.

Two of the participants were students, and both of them suggested that there were connections between problematic eating and difficulties at college / university. One talked generally about her difficulties while she was doing her A’levels and later her degree, whereas the other participant made more specific references about not being able to cope with college, again, implying a victim role:

'I think when I was really bad, I was about 16, because it was after my GCSEs and I’d started a new college course and I couldn’t hack it’ (I: 4, 78-80).

The other women were not working and this seemed to be associated with a sense of inadequacy and frustration. However, little responsibility was taken for getting a job, again implying a passive victim role. For example, whilst one of the women did not refer to this in the interview, in a later conversation she talked with some envy about the high powered jobs held by other members in her family and expressed regret that she had not had the same opportunities, which had contributed to her problems.

Another participant had not attempted to get a job and stated:
'It's not easy to get jobs. With redundancy and all that' (I:1, 61).

Dissatisfaction with work was also identified by the women with alcohol only problems although again, this was typically in the context of their existing alcohol related difficulties. Losing jobs through redundancy was typically reported, which also suggests that the women were forced into adopting a passive role:

'I got made redundant last July so of course that triggered it off again' (I: 5, 35-36).

Intermediate Level Category: Self-Image. This category refers to the way in which the women perceived themselves, for example in terms of the sort of person they were or the characteristics they possessed. All of the participants appeared to be dissatisfied with their own image and / or tended to over evaluate the importance of the image they portrayed to other people. This relates to the notion of being a passive victim in that they felt unable to 'change' who they were and did not perceive having any control over other people’s opinions of them.

For one of the women, the struggle to define a self-image was heightened by the fact that she was a tomboy at school and did not fit in with the other girls:
'I didn't know who I was .... I've always been more of a tomboy as well, a lot of the girls picked on me 'cause the lads always thought of me as one of the lads' (I: 4, 108 .... 299-300).

Her discomfort with her emerging sexuality made it increasingly difficult for her to be seen 'as one of the lads' which fuelled her sense of not fitting in anywhere. In this sense, she was a passive victim of her developing body.

... ... ... I developed fast, so I would wear black t shirts under my white shirts to make sure I looked smaller than I was, until one of the guys at school just turned round and said my God, you 've got huge breasts ' (I: 4, 313-316).

Eating in front of other people was experienced as difficult because of the anxiety associated with the image that the women perceived other people would have:

'I used to hate eating in front of anybody, especially strangers because I would think that they'd think Oh my God, she's so fat and she's eating chocolate or she's eating anything. I mean I wouldn't mind maybe eating lettuce or something but that's all - anything with any calories in it, certainly not' (I: 3, 285-291).

Sub-category: Self-Esteem. Even when the women were able to acknowledge positive aspects, such as being intelligent, the overall level of self-esteem was low, which added to the feelings of dissatisfaction:  

93
'I had great confidence in my academic ability but in my actual, my social ability if you like, I had zero confidence, no self-esteem at all' (I: 3, 512-514).

Others described themselves in negative terms or made derogatory assumptions about themselves:

'I'm no good for anything, I suppose I've just always been fucked up' (I: 1, 68)

Sub-category: Self in Relation To Others. This category described the tendency that the women had to compare themselves to other people – usually (but not exclusively) to women.

A common experience reported by the women with dual disorders was comparing themselves to other women in terms of the way they looked – most typically measured by how thin they were. Describing a pornography video belonging to her husband, one participant said:

'All I could see was skinny, white women, naked, that's all I could see.' (I: 2, 277-278).

One participant made a direct comparison with the researcher:

'You're quite slim aren't you?' (I: 1, 63-64).
Comparisons to other women tended to be unhelpful, in that they would result in the women feeling inferior, either in terms of the way they looked or what they had achieved. There was a sense that other women were ‘normal’ and that was something that they themselves should be striving for and seemed unable to move away from the passive victim role. When asked how she would like things to be different, one participant said:

‘All I ever wanted was to be normal I suppose – to have a decent job and a decent relationship like normal people’ (I: 1, 56-57).

Whereas women in the main group tended to classify ‘normality’ as being something which other people had, the women in the ‘drinking only’ group were more likely to make a comparison between themselves as ‘problem’ drinkers (negative) and themselves as ‘normal’ drinkers (positive). In this sense, they were striving to be ‘how they used to be’ rather than like other people. The implication was that these women were reasonably happy with themselves prior to the drinking problem and did not have the same tendency to compare themselves to others in the same way that the women in the main group did.

‘I want to be the way I used to be ‘cause I’ve only been an alcoholic for probably about 8 years’ (I: 6, 58-59).

Summary of main category: DISSATISFACTION: PASSIVE VICTIM ROLE

This category described sources of dissatisfaction for the women, prior to developing eating / drinking problems. Within the process model of self-control, it represents ‘the
need for self-control'. All of the women talked about their unhappiness regarding relationships and work or study. Whereas self-image was described as being a major area of discontent among the women with eating and drinking problems, this was not prominent in the binge drinkers’ transcripts.
Fig. 3

ATTEMPTS TO ACTIVATE CHANGE

Attempts to be thin

Use of alcohol

External /tangible control

Mood enhancer

Confidence builder

Fitting in

work

home
3.4 Attempt to Gain Control

Main Category: ATTEMPTS TO ACTIVATE CHANGE: This main category describes the ways in which the women attempted to bring about changes to their perceived situation and thus enhance feelings of control. As can be seen from Figure 3, this has been split into three intermediate level categories of Attempts to Be Thin, Use of Alcohol and External/Tangible Control.

Intermediate Level Category: Attempts to Be Thin: This category refers to attempts by the women to alter the way they looked through slimming. The opinions of others were described as being central to the eating behaviours in all of the women and thus 'being thin' was largely about looking thin to other people.

All of the women seemed to believe that being thin was perceived as more positive by others and that achieving this would mean that they would be more accepted by others:

'I thought I'd be more popular if I was thin. People would think better of me' (1:1, 15-16).

Another participant believed that her husband reacted differently to her when she was thin and that by losing control over her eating and therefore gaining weight, she might lose him:
'If I start eating again like normal people – I don’t want to risk that because I can’t afford to lose that. Because if I lose that I lose – I mean, ‘Sam’ used to treat me like crap before (I lost the weight)’ (I: 2, 325-327).

Despite feeling physically unwell from starving themselves, there was still a desire to be thin:

'I would just starve myself for about three weeks and then I’d have an apple or something and I’d start to feel really faint in the hope that I would get thinner’ (I: 4, 31-33).

Intermediate Level Category: Use of Alcohol: The analysis revealed that for all of the women with both eating and drinking problems, the eating disorder started before they perceived their drinking as being out of control, despite all of them admitting drinking to some degree during that time. They described a picture of occasional as opposed continuous or binge drinking to begin with, which was usually within the context of a social situation, for example a family meal:

'Alcohol has always been a big part of my family as well, so you know, there was always alcohol in the house and we were always allowed a couple of stubbies and wine at Sunday dinner’ (I: 4, 61-63).

For the women with alcohol only problems, early drinking behaviour was also described within a non-problematic, social context:
'I can remember living on my own and having a bottle of sherry in the flat and just keeping it in case somebody came over at Xmas and I had that sherry for a year and I never touched it' (I: 6, 63-66).

Sub-category: Mood enhancer: It is well known that alcohol can have an uplifting effect in the short term and this was reported by all of the women. Sometimes, the alcohol served as a general mood enhancer but it was also described as enabling the women to feel better about themselves:

'I want to have a drink because it makes me happy' (I: 2, 185-186).

'It (drinking) just makes me feel better about myself' (I: 1, 41).

Similar descriptions were given by the women with alcohol only problems, before their drinking was perceived as being out of control:

'The first couple of drinks used to be lovely, 'cause you'd get that sort of warm feeling - a couple of drinks and I'd sort of think oh I feel better, I can cope with this and I'd feel happy' (I: 5, 542-545).

Sub-category: Confidence Builder. This category refers to the use of alcohol to enable the women to become more confident in social situations.
'It (drinking) gave me more confidence. Instead of feeling shy I'd feel louder (I: 1, 24).

'I've got a lack of self confidence, I know that and I think that sometimes if I had a couple of drinks it used to give me a bit more confidence' (I: 5, 291-294).

'I've always been very quiet and shy so the drink helped me bring myself out a little bit' (I: 4, 203-204).

Sub-category: Fitting In. Whilst all of the women reported drinking alone as their difficulties became more pronounced, in the earlier stages, all of them described drinking in terms of fitting in with other people or situations.

'I actually started drinking 'cause I wanted to fit in with the crowd' (I: 1, 19).

Social drinking was perceived as non-problematic but rather acceptable within their own social groups. For example, one participant talked about being heavily into the 'rave scene', whilst another described drinking as being a normal part of going out to clubs:

'When I started to really drink – it was only when I was really out at clubs, but to me that was part and parcel of it, you know, a lot of friends would buy drinks 'cause I didn't have a lot of money' (I: 4, 70-73).
In light of their negative self-image, together with their tendency to be hyper-sensitive to others’ opinions of themselves, this feeling of ‘belonging’ served a positive function for the women.

Intermediate Level Category: External/tangible control. Regardless of the situations the women were in and of how negative they felt, there was a need for some ‘tangible’ evidence that they were able to be controlled / organised in at least one area of their life. This was a source of pride for them and seemed to be related to their sense of having self-control. This has been split into two sub-categories of work and home.

Sub-category: Work. This was evident in the work setting:

'I’m extremely organised and very efficient in my job and I take a lot of pride in that. I’ve made it like an achievement for myself to do these things' (I: 3, 547-49).

The women with alcohol only problems also described jobs that they had been able to hold down which required a high degree of control and seemed proud at having achieved this:

'I’ve had jobs, you know, where I’ve had to have control.... I’ve taught martial arts, which takes a lot of control you know' (I: 6, 243-246).
Sub-Category: **Home.** Having an organised home environment was also seen as important:

'It's almost like I have to control this room... my nurse saw it and she thought it was absolutely beautiful because I made it the way I wanted it. So now this living room is mine. When 'Sam' moves my plants, if he moves anything that is mine, I am angry and I start to go mad. I'm like, do not touch a single thing, this is my space, stay out, you know?' (I: 2, 163-170).

The degree to which environmental factors need to be controlled seems to be dependent on the degree to which other areas are perceived as being out of control. This is connected to the need to have some sense of achievement in at least one area.

Speaking about her house which she had just acknowledged as being 'nice and tidy', one participant said:

'Something has to be organised in my life. I can't seem to sort anything else out' (I: 1, 60)

**Summary of main category: ATTEMPTS TO ACTIVATE CHANGE:**

This category provides an account of the ways in which the women tried to alter their situation, in an attempt to gain self-control. Self-starvation was initially attempted by all
of the women with eating problems, with a particular emphasis on the hope that being thin would improve their relationships. Other external forms of control (such as having a tidy house) were described by the women with eating and drinking problems as well as by the binge drinkers. In the earlier stages, alcohol use was described by all of the women as social and controlled, and this served a similar (positive) function for all of the women.
Fig. 4

DEVELOPMENT OF PROBLEMATIC BEHAVIOURS

Development of Binge Eating
  - Binge eating as an Index of control
  - Emotional regulation
  - Regret
  - Weight gain
  - Long-term effects
  - Self-disgust

Regular Drinking
  - Avoidance

Relationship Between Eating and Drinking
  - Positive effect of alcohol relative to binge eating

Drug Use
  - Speed as a diuretic
  - Cannabis as a mood enhancer

Self Harm
3.5 Loss of Control

Main Category: DEVELOPMENT OF PROBLEMATIC BEHAVIOURS: In the earlier stages, the women’s eating habits were described as ‘restrictive’ and drinking was ‘occasional’. Neither were perceived as being out of control. However, gradually, the two became out of control, through the development of binge eating and regular drinking. The first two intermediary level categories refer to the gradual loss of control through problematic eating and drinking habits, followed by a third category, detailing the perceived relationship between the women’s eating and drinking patterns. Self-harming behaviours and drug use are also referred to.

Intermediary Level Category: Development of Binge Eating. Eventually, the strict boundaries of control that the women had imposed on themselves became too difficult to adhere to and they inevitably ended up in a restriction - binge – purge cycle. This category describes the development of the binge eating followed by six sub-categories, referring to the effects that this had on the women.

‘I’d say .....I’m going to be good starting from tomorrow so I’d say right, today I’m just gonna go mad and eat everything I can. So in that sense it was quite controlled because..... I was sort of controlling what I was gonna do tomorrow, but then tomorrow would always go down the drain’ (I: 3, 398-403).
'Once I realised that that wasn’t going to work (self-starvation), I started to eat quite a lot but I’d hoard it... ...and I would take them (foods) upstairs but not all in one go, it would be sort of like 3 trips, so it didn’t look too – and I’d just binge'. (I: 4, 34-37).

Sub-category: *Binge eating as an index of control*. This category refers to the conscious decision making process to binge eat which initially, seemed to have an impact on the women’s sense of being in control:

'I remember when I was younger thinking I can’t wait to have my own house, with my own kitchen cupboards, and in my kitchen cupboards, I’ll have a packet of biscuits and I’ll have a cake and when I want to go to it I will eat the biscuits and I will eat the cake' (I: 3, 407-410).

Sometimes, the act of controlling food intake was described very specifically:

'I remember having biscuits in the house and me eating you know, mum saying you can have 2 biscuits and then I would eat like 4 or 5 and like sneak it out....maybe it was because I wanted to defy her or I wanted to control what I was putting in my mouth maybe' (I: 3, 422-424..... 430-1).

This was particularly apparent when other areas in their lives were perceived as being outside their control:
'I couldn't control how much school work I got... and I couldn't control other things that were going on in my life so to me that was my thing – no-one else could take that away from me' (I: 4, 47-51).

Sub-category: Emotional Regulation. The use of food to alter negative emotions was another experience described by the women. An interesting point to note, however, is that the choice of food seemed to be made in the absence of alcohol being available, and suggests that alcohol was more powerful than food in dealing with direct emotional pain.

After feeling that her partner had rejected her sexually, one participant said:

'I wanted to come down and have a binge and vomit because I was so angry, so upset... ... on food, because there was no alcohol in the house' (I: 2, 102...105).

Another participant said:

'If I was feeling really down and there wasn't any drink around I would (binge eat) ' (I: 4, 14-15).

One participant described binge eating in response to emotional upset following the death of a relative:
'... the time of my grandfather's death, who was the first person I knew to die in my life who's close to me, I started bingeing' (I: 3, 24-25).

Sub-category: Regret. For all of the women, binge eating was soon seen as a futile exercise, followed by immense regret and frustration at having giving in to their compulsion:

'I'd just think why did I do that, what did I get out of doing this – nothing – and I knew that I would get – I had nothing gained. There was nothing good about it at all yet I still had to do it and I don't know why' (I: 3, 383-386).

'It's pointless. You just end up feeling really peed off with yourself' (I: 1, 47 - 48).

Sub-category: Weight Gain. The most obvious effect of the binge eating was weight gain, which impacted on the women at different levels, in that not only was it an indication to the women themselves that they were losing control, but it was also visible to other people. This increased the likelihood that others would intervene (seen as interference) and - according to the women, this would further contribute to other people's negative perceptions of them.

'I'd started to binge all the time and was starting to put on a lot of weight and my parents began to notice and they didn't know how to deal with it' (I: 3, 29-30).
Sub-category: Long term effects. There was some concern about the potential long-term physical health problems caused by repeated binging and vomiting. These concerns only appear to be apparent in hindsight and only when a considerable amount of insight into the illness had been gained.

'It makes me feel ill actually, sort of thinking how stupid I was because it was when I was 15 or 16 that I started (binge in g and making myself sick) and now I'm like, what harm have I done to myself in the long run' (I: 4, 41-44).

Two of the women expressed a concern about the fact they had started to 'spontaneously' vomit as opposed to this being self-induced:

'I have this weird thing now, I'm seeing the doctor about it.......I spontaneously vomit all the time. And I suspect that may be because my stomach is just really screwed basically from all the drugs and the alcohol and the vomiting in the past' (I: 3, 155-160).

'I was getting really bad pains and I was getting worried and I wasn't able to hold food down. I ate something and just immediately it was a knee jerk reaction I would need the loo – I don't even need my fingers now to make myself sick I've got that practiced now which is really scary' (I: 4, 221-225).
Sub Category: **Self-disgust.** The actual act of bingeing evoked feelings of disgust in the women, which inevitably contributed to the overall negative self-image, which they all held:

'You feel a bit disgusted in yourself (when binge eating)' (I: 1, 46-47).

'I hated myself at the time, bingeing, definitely. I felt disgusting and just, oh, so gross, I just couldn't bear to think about myself' (I: 3, 233-236).

Intermediate Level Category: **Regular Drinking.** This category describes the shift towards regular, problematic drinking, followed by a description of the effects that this had on the women.

The women's drinking gradually increased from occasional, social drinking to regular drinking – typically on a daily basis:

'...I remember drinking a bottle of wine every night which gradually increased to 2, to 2 ½... ...I just used to sit in and smoke and drink every night' (I: 3, 68-71).

'...that's when I think it really changed from not so bad – drinking sort of at weekend and maybe one or two days in the week, to at least every day, I couldn't go a day without having a drink' (I: 4, 96-98).
'I drank every night to the point where I got drunk, fell asleep, carried on' (I: 2, 30-31).

The drinking was still not perceived as being problematic at this time:

'...What I was doing was signs of bulimia whereas I'm eating and eating and eating to the point where I'm not stopping... ...at that time I was drinking too but it was in hand' (I: 2, 50-51 .... 55-56)

This pattern of continuous drinking lasted for varying lengths of time and was reinforced by the positive effects from alcohol, which had been learnt from the earlier experience of drinking. However, the women had also begun to learn that alcohol was an effective form of avoidance, which is described in the subcategory below.

Intermediary Level category: Avoidance. This category refers to the ways in which drinking alcohol enabled the women to avoid certain situations or negative feelings which thus reinforced their drinking as a useful coping strategy.

Whereas sometimes, the alcohol enabled the women to avoid facing up to their responsibilities, such as going to work or college or looking after the children, it was more often described as a way of blocking out emotional pain and unwanted thoughts:
'It (drinking) was to escape from a lot of the feeling I was feeling inside...I felt very unwanted and with the alcohol, you know, it numbed it. It numbed everybody else’s words. If somebody said anything to me I could blank it really really easily and then I wouldn’t remember it’ (I: 4, 173-177).

'It (drinking) stops me thinking about everything else about my life’ (I: 1, 93).

This was also the case for the women with alcohol only problems:

'It takes away the pain – it takes away the pain of not being able to cope with life (I: 6, 108).

'It (the drink) was more about blocking things out’ (I: 5, 452).

Intermediate Level Category: Relationship Between Eating and Drinking. This category refers to the direction of the relationship between the women’s eating and drinking and therefore facilitates an understanding of why the women’s drinking became increasingly out of control.

All of the participants revealed that binge eating and drinking would go together on some occasions:
'I was just eating and eating and eating and eating. Every time I'd get upset, eat-get drunk, eat-get drunk, eat......, that was it' (I: 2, 73-75).

'I was bingeing just all the time basically and I put on more weight and I was drinking a couple of bottles of wine and a bottle of vodka a day sort of thing, quite a lot' (I: 3, 82-84).

Sub-category: Positive role of alcohol relative to binge eating.

In response to the question: ‘does the alcohol affect your eating’ the same participant replied:

No I don’t think so. I can’t think of a time which it did. I mean there’s been times years ago when I used to drink a lot and I’d go into a club or something with my friends and come out at 2 o’clock in the morning and want chips but that’s about it really......but no, if I just were to drink, I wouldn’t have like a munchie like gotta eat something affect, not really’ (I: 3', 654-660).

Another participant was asked:

‘And so when you’ve eaten loads, would it tend to be after you’ve been drinking a lot or would you ever eat loads without the drink?’
The reply was:

'It depends. Sometimes. If you're eating you don't really feel like I'm drinking' (I: 1, 52).

The direction of the food-drink relationship seems to be important in understanding the connection between the two. In the two examples above, the participants were asked about their likelihood to binge eat following a drinking binge. Both denied any connection. However, there was evidence to suggest a relationship in the opposite direction: that binge eating would tend to be followed by binge drinking, for example, to relive the guilt associated with the food binge:

'I would (binge) – once I'd ate loads, I'd feel really guilty and want a drink, but knowing I couldn't, so I'd make myself ill (purge) so I could have a drink' (I: 4, 15-17).

'It (drinking) makes me feel better about myself. Especially if I've been a pig and eaten loads' (I: 1, 41-42).

Intermediary Level Category: Drug Use. All of the women with both eating and drinking problems reported using drugs. A variety of drugs were tried, with all of the women reporting smoking cannabis and / or using speed.
'I remember I used to take speed. We didn't have no children and at that time I could smoke cannabis... we always used to do stupid things, you know when you're younger you do it, I mean I tried the tab (acid)' (I: 2, 56–59)

'I started taking ecstasy and a load of speed... smoking an absurd amount of cannabis' (I: 3, 57–58; 84–85).

In contrast, neither of the women with alcohol only problems described using drugs and in fact gave the impression of being 'anti' drug use:

'I've never ever done drugs and I wouldn't – I don't think I'd dare do it 'cause I've always thought drugs, you know, serious drugs and that are really bad' (I: 5, 752–754).

Sub category: Speed as a diuretic. Two of the participants who reported using speed referred to notion of speed as enhancing weight loss:

'I started on speed – that was a right way to slim that was – dancing all night and everything' (I: 4', 181–182).

'I was taking speed every day and that gradually increased and once again I lost a lot of weight very quickly' (I: 3, 59–60).
Sub-category: *Cannabis as mood enhancer*. The participants claimed that they were currently not using any drugs other than cannabis, which they did not see as problematic and felt that it was enjoyable and lifted their mood:

'I smoke a bit (cannabis). Just to chill out a bit.' *(I: 1, 153)*

'Actually, I'm not sure that I would (like to give up cannabis) because I just really like it' *(I: 4, 193)*.

Intermediary Level Category: *Self-harm*. All of the women with both eating and drinking difficulties reported engaging in self-harming behaviour either previously or currently. One of the women only mentioned this after the tape recorder had been switched off but the others were open in their disclosures:

'I would sit in my room loads and loads hacking with razor blades, hacking into myself' *(I: 4, 189-190)*.

'I'll just sit there and cry and put my music on if the kids are in bed or I'll hurt myself' *(I: 2, 302-303)*.

One participant described how injecting drugs was a form of self harm, sometimes resulting in her injecting an empty needle into herself to draw blood:
mean it’s just the most stupid thing to inject something into your arms and legs and wherever else, I actually used to do it into my breasts as well, just stupid because it hurts, you don’t know what’s in it, it could kill you, I overdosed a lot of times... ...sometimes I would just sit there with an empty needle and draw blood out of myself” (I: 3, 624-627; 362-363).

Whilst specific functions of the self-harming behaviour were not made explicit, there was some indication that this was engaged in during periods of severe emotional upset and was a way of dulling emotional pain. For example, in response to finding a pornography video belonging to her husband, one participant said:

“I remember cutting myself, I remember crying; I was absolutely heartbroken” (I: 2, 272-273).

The binge drinkers were not asked about self-harm, although discussions with key workers revealed that both of these participants had engaged in self-harming behaviour, and one of the women referred to previous overdoses which occurred on a regular basis:

‘Only a week ago I was in hospital with an overdose and that was because ‘Peter’ and I had both had a drink and he’d said some horrible things that I couldn’t cope with and I just didn’t want to live anymore, ‘cause that’s the pattern with me’ (I: 6, 358-361).
Summary of main category: DEVELOPMENT OF PROBLEMATIC BEHAVIOURS

This category described how attempts to restrict food intake became too difficult to maintain, resulting in binge eating. Whilst this was initially seen as having a positive function, (this was still something that the women could physically control, and enabled them to block out negative emotions), it’s effects were soon perceived as negative. These are described here. The women’s alcohol intake gradually increased, reinforced by the positive effects described earlier, as well as enabling the women to avoid certain aspects of their life. Drinking appeared to have a specific function with respect to binge eating, in that it relieved guilt after a binge-eating episode. It also had the positive function of increasing a sense of fullness, which minimising the likelihood of wanting to binge eat.

All of the women engaged in self-harming behaviours. Whilst the women with both eating and drinking problems also described using drugs, the women with alcohol only problems specifically reported that they had never used drugs.
3.6 Attempt to Regain Control

Main Category: ATTEMPTS TO CONTROL DRINKING: This category refers to attempts by all of the women to control their drinking, either by cutting down or giving up completely. Self and other perceptions of the problem were important in terms of the decision to control their drinking and are therefore central to this main category.

In order to meet the inclusion criteria, all of the women had to self-define their drinking as problematic to some degree. All of the women, therefore, whether in contact with the Clinical Alcohol Team or the Eating Disorder Team, accepted that their drinking was problematic. However, there was a difference between the women with alcohol only problems and the women with both eating and drinking problems.

Despite acknowledging some positive functions of alcohol (in the earlier phases of their drinking), for both participants without eating difficulties, the overall perception of their drinking was seen as negative and futile:

'I can't honestly say that any good's come out of it' (I: 5,245).

Controlling drinking for them, was therefore about complete abstinence:
‘I’m scared that if I have, say a couple of glasses of wine, I’d probably think oh well, I’ll drink the whole bottle, I can’t just stop at two, so I’ve gotta realise now that I can’t go out and socially drink really, if I’m honest’ (I: 5, 120-123).

For the women with eating and alcohol problems, attempts to cut down on drinking were mainly as a result of other people’s negative perceptions about their drinking, which have been described above. Even when the women saw the problematic eating as the primary problem, the need to get help with the substance abuse was typically seen as more pressing by others:

‘(My) eating was not brilliant but my parents had pretty much decided to at that time that the main thing was to get the drugs and the alcohol sorted out’ (I: 3, 102-104).

One participant was asked about her perceptions of her eating and drinking and replied:

‘I wish I wasn’t so bothered about food’ (I: 1, 71).

When the question was repeated with an emphasis on her drinking, she answered:

‘My partner’s always going on at me about it (drinking) – telling me to pack it in’ (I: 1, 75).

Whilst their current drinking was seen as problematic, this was to a much lesser degree,
and was not perceived as warranting abstinence. This was related to previous (more serious) experiences of continuous as opposed binge drinking:

'Yes, I do drink but I don't binge and I only drink a few days in a month compared to only a few days in a month where I wasn't' (I: 4, 270-272).

'I certainly was an alcoholic and they say once an alcoholic always an alcoholic but now I disagree with that because I don't think I'm an alcoholic now' (I: 3, 245-247).

'It's just one can of beer, a weak can of beer, what is that going to do to me? Nothing......Somebody who drinks a full bottle of sherry is settling down for one can of beer, even though she is on de-tox, what is that gonna do? Nothing (I: 2, 339-343).

Being able to cut down on their drinking was perceived as successful (relative to before) and complete abstinence was not something that they wanted to consider.

Summary of main category: ATTEMPTS TO CONTROL DRINKING:

This category refers to the women’s attempts to control their drinking. Whilst all of the women perceived their drinking to be problematic to some degree, the women with both eating and drinking problems did not perceive their drinking to be as bad as it was previously and therefore did not feel the need for complete abstinence. Regaining control, in this sense, was about reducing their drinking from its current continuous level, not
least as a result of social pressure associated with the stigma of drinking. These women considered their eating to be the bigger problem, which was in contrast to other people's perceptions, who felt it was more important to get the drinking under control. The binge drinkers, on the other hand, saw their drinking as futile and felt that they needed to be completely abstinent.
Fig. 5

MAINTENANCE: A SERIES OF OPPOSING FORCES

Internal versus external control
 restricted choice
 moving the goal-posts
 blame

Openness versus secretiveness
 negative connotation of label
 over-protectiveness / vigilance

Meaning of self-control: Complete control versus controlled
 personality

Using the past as a model: positive versus negative
3.6 Continued Struggle for Self Control

Main Category: MAINTENANCE: A SERIES OF OPPOSING FORCES. This main category refers to the ways in which difficulties with food and/or alcohol are maintained, through a series of contradictions. The women appear to move between polar opposite ends of the same spectrum and this leads to a confused sense of self-control.

Linked to this, is the notion of opposing identities which the women described when they were binging/not binging. This was described by women with eating and drinking problems as well as alcohol only problems and is captured by the following excerpts:

'It's this whole thing of having 2 people inside me ....... I felt like there was this demon person and there was this more controlled person and this more controlled person knew what I had to do and what I should be doing, and this demon person would take over and I first noticed it with the food because I used to be absolutely, I'm gonna have this meal, this meal and this meal and drink this and be very controlled about it and then suddenly I'd be possessed by this complete mad thing and I'd eat everything' (I: 3, 368-374).

'I can remember just having a few drinks and then the drink took over and, you know, the other person came out, you know, and the other person's not very nice' (I: 6, 182-184).

Intermediary Level Category: Internal versus external control. As highlighted in the core category of 'illusion', the notion of 'self' in self-control appears questionable. Even
when participants stressed the importance of being in control of themselves, references were still made about the need for external forces as mediators of control. This was described in relation to alcohol use but not eating. Having external restrictions placed on eating were perceived as negative at all stages of the eating difficulties and more likely to exacerbate the problem.

Negative Case: One of the participants described how having somebody else control her eating helped her to regain a sense of self-control. On the one hand, this participant was adamant that her eating was the one thing that was within her personal control:

"That was the only thing I could control - me. That was the point. Everything else (well I couldn't control it) but that one thing....if I could do that everything else would be fine' (I: 4, 136-141).

However, when asked about key factors that she perceived helped her to regain some control, she said:

'I think it was due to a boyfriend who wouldn't let me drink that much and he would make sure I ate his cooking and that and he would make plates of food and as long as I ate half of it I was alright....he would make me eat and then if I felt ill, I could be sick but only if it were a natural reflex but not me helping myself which was a great help. I think that's started me on my way to thinking that I could get myself control back' (I: 4, 153-159).
'My eating, I try and keep a regular sort of control over it – my mum's like, what have you eaten today....and I'll say a couple of cups of tea and she'll say, that's not healthy, go and have a bowl of cereal’ (I: 4, 358-363).

This has been classed as a negative case example because the other women did not give any indication that having their food controlled externally would have been helpful.

However, other descriptions of external control were given by all of the women in relation to their drinking, and these form the sub-categories below.

Sub-category: Restricted Choice. The women appeared to perceive themselves as better able to exert control over their drinking if the opportunity or choice was taken away from them:

'If I knew there was only one (can of lager) I will have no choice but if I knew there was more in the house then I wouldn't, I would hit the lot' (I: 2,346-347).

Having the alcohol readily available or having the money to buy it was typically perceived as an important factor in whether or not the women would exercise control over their drinking:

'If depends on how much money I've got. If there's drink there I'll have it, If there isn't I won't bother. I can't really, can I?' (I: 1,88-89)
This was also described by the women in the alcohol only group:

'I've often thought oh, I fancy a drink but if it's not there, I think, well, you can't have one, you've got no money' (I: 6, 355-357)

Other external restrictions involved the presence of significant others:

'I think oh well I can't really have a drink 'cause my mum's here but if I'm on my own I might think, hmm' (I:5, 730-731)

There was a sense that not having anyone there to prevent her from drinking would pose a real test of her ability to exert self-control:

'But it's in the back of my mind that it would be a temptation that I've gotta be really strong and not do it because there would be nobody there to stop me so part of me might think well there's nobody here to tell me what to do, if I want a drink I'll have one' (I: 5, 736-738).

Sub-category: *Moving the goalposts*. There was a tendency for the women to 'move the goal posts' with regards to giving up alcohol, resulting in self-devised ultimatums which were unlikely to be realised.
When asked about factors, which might help her gain control, several of the women said that being told that they were going to die would spur them on.

'(I could probably give up if I had to) If I was told I'd die or something (I: 192).

The same was true for the women in the alcohol only group, despite having had regular hospital admissions and numerous physical health problems.

'...or if someone told me that my liver was so bad that I was gonna die if I didn't give up (that would stop me drinking)', (I: 6, 385-386).

Whilst a lack of awareness of this was more typical, sometimes, the women were able to acknowledge that they were being unrealistic in their assumptions. When this was the case, the women had a tendency to move the goal posts still further, by implying that they could give up if they really wanted to:

'I absolutely 100% know that if the doctor said that I had to (give up alcohol) I would. But having said that, 'cause I had a liver function test a while ago.... and he said you really should cut down on the amount of alcohol that you take in and I haven't been able to. But if he told me I was gonna die then I would. I suppose, I don't know. But the bottom line is I don't want to, I don't want to give it up' (I: 3, 254-262).

Even when drinking was felt to be under control, there was evidence of goalposts moving, for example, the following participant moved from not wanting to drink alcohol at all, to not wanting to drink spirits, to wanting only a particular type of spirit, and so on:
'one rule I have said to my friends is don't let me have shots, I don't want any shots. If I'm gonna have shots, it'll be Baileys but I want at least 4 pieces of ice in the Baileys to water it down' (I: 4, 275-276).

There was also some evidence of this with respect to eating. For example, one participant felt that living on her own would be sufficient to encourage her to adopt a healthy eating pattern. However, when this did not work, she chose something else to focus on, such as doing a PhD. This participant had not applied to do a PhD and it was therefore not something which was imminent. However, this represented an external factor which may spur her on to eating healthily.

'with the PhD that I want to do there may be some field work and I would find it very difficult to do field work with the weight that I am at the moment so I would have to lose weight and get fit but if I knew that I was gonna be doing that then it might be the edge that I need to make me do it' (I: 3, 601-604).

Sub-category: **Blame.** The notion that external factors caused the women to abuse alcohol have already been described; however, there was a more specific indication that others were in some way to blame for their lack of self-control over their drinking.

For example, one participant felt that other people serving her alcohol underage had contributed to her problems:
'Because I looked older there wasn't much of a difficulty getting into pubs and clubs, it was quite easy, and if I hadn't had that, if I'd been turned down, I don't think that I would have had such a problem but I think it's 'cause I got let in no questions asked, I got served every time' (I: 4, 116-120).

Another participant referred to her husband's use of alcohol, which threatened her sense of control over her own drinking:

'...him coming home smelling of alcohol – what is that supposed to do to my brain?' (I: 2, 285-287).

A sense of blame was also described by the alcohol only group. One participant reported that being 'given permission' to drink by her psychiatrist made her worse:

'I've seen a psychiatrist and he's actually said to me I'd rather you pick up the sherry than have tranquillisers and you know I thought well he doesn't realise how much I will drink, you know,... .....I think it did (make me worse) unless I just wanted somebody to blame' (I: 6, 71-77).

Intermediary level Category: Openness versus secretiveness. This category refers to the dilemma faced by the women of whether to be open about their difficulties or to keep them hidden. As a result of this dilemma, they seem to oscillate between the two.
For example, despite all of the women describing previous social drinking, all of them described hiding their drinking from others at some point, usually from significant family members but also from work colleagues and friends:

'I hid the drinking so well, my mum didn't even notice' (I: 4, 206)

'I've been taking money from his wallet without him knowing and getting the bottles' (I: 2, 297-298)

This was also true for the women with alcohol only difficulties:

'I'd hide bottles in the bedroom but then he used to find my hiding places so I'd have to find another (I: 5, 588-590).

Binge eating in secret was also commonly reported:

'I'd eat in secret and have stashes of chocolate and cakes and things up in my room and I'd go and eat up there' (I: 3, 76-78).

'I started to eat quite a lot but I'd hoard it...... and I would take them upstairs but not all in one go, it would be sort of like 3 trips, so it didn't look too (obvious)' (I: 4, 34-37).
At the time of the interview, all but one of the women with both eating and drinking problems no longer described themselves as social drinkers, preferring to drink in their own home, sometimes in front of their partners, but more frequently alone.

'I mean, it's Xmas time, it's New Year time, people are out enjoying themselves. I can't remember the last time I went out anywhere. I haven't been to a pub for how many years?' (I: 2, 242-244).

Despite having previously described social drinking with friends during her university days and as part of the 'clubbing scene', on participant reported that she now prefers to drink at home alone:

'(drinking alcohol) does kind of stop me having a social life in a way as well because I prefer to sit at home on my own with my cat, watching the telly, than to go out to the pub (I: 3, 200-202).

Despite being adamant that her drinking was under control, this participant still felt the need to keep her drinking secret from her parents (1) and would remove alcohol from public view in case they thought she had a problem (2):

(1) 'My parents don't know that I drink now' (I: 3, 123).
(2) 'I usually have like a bottle of red wine sitting on the table and I put that away 'cause I think that seems really sort of alcoholic to do that' (I: 3', 198-200).
Negative Case: One of the women with both eating and drinking problems reported that she had recently started to attempt social controlled drinking although it is unclear at this stage whether these attempts have been successful:

'It can get difficult sometimes if I'm in a really good mood when I'm out and I think everything's alright and I can have a drink and a bit more of a drink....' (I: 4, 272-274).

Whilst the women with alcohol only problems did drink on their own, they were just as likely to drink with others. This tended to involve them seeking out likeminded people who were unlikely to criticize their drinking, which made it seem more acceptable. For example, despite referring to her main group of friends as 'normal' women who were not particularly heavy drinkers, one participant described a man she became friendly with whilst in hospital for a detox, who subsequently provided her with a social environment in which her drinking was acceptable:

'Everyone that was there or who came round or whatever was drinking so that's why I was alright, 'cause I could drink and they couldn't say oh you can't drink 'cause they were all drinking' (I: 5, 638-640).

There was an indication that the women would prefer to be able to be open about their difficulties, but this had several negative implications that perpetuated the secretiveness. These are described in the following sub-categories:
Sub-category: *Negative connotation of label*. Concern was expressed by the women about being labelled ‘alcoholic’ or ‘eating disordered’. Sometimes this reflected their own negative associations with these labels whilst on other occasions, the concerns were more to do with how other people might view them:

‘I hated having a label of eating disorder, I really hated it.....and I feel the same way about alcoholics as well. I look down on alcoholics’ (I: 3, 241-245).

One participant, who was regularly engaging in secret binge eating and drinking, described being regularly criticised by her partner for being anorexic and / or alcoholic:

‘When I needed that support, it wasn’t there. All I got was anger – you’re an alky, you’re an alky, you’re anorexic, you look skinny, you’re this you’re that, you know, that’s all I got. Are we drinking again are we, you know, taking the piss.’ (I: 2, 332-336).

Both of the women with alcohol only problems accepted the label of ‘alcoholic’ themselves but felt that other people had a more negative interpretation and did not understand what this really meant:

‘Other people don’t think it’s very nice (to be classed as an alcoholic) because other people just don’t understand; they just see an alcoholic, they don’t see what’s underneath, they don’t see that nearly every alcoholic suffers with some sort of depression or some sort of nervous disability’ (I: 6, 28-31).
'People don't realise it's an illness.......and I would never have thought of it as an illness before, it's not something you do because you want to become an alcoholic, but it is a kind of disease and an illness' (I: 5, 568-571).

Sub-category: *Over-protectiveness / vigilance*. This category refers to the feeling that being open about their drinking resulted in those who knew being too invasive or protective, which made them feel at best frustrated and at worst more likely to go off and drink in secret:

'I think just leave me alone let me get on with it myself— if I'm gonna go off the rails I'm gonna go off the rails whether you're saying this or you're saying that. If I'm going to do it, if I'm going to have a drink, I'll have a drink no matter what' (I: 5, 398-401).

Even the participant who had recently started to attempt social, controlled drinking, referred to the potential consequence of doing this:

'I never told like lots of people, it was just the people that were very close to me that knew my mood changes, how they changed and they would watch but not in a way that I would become very aware of and be very conscious of it otherwise I would become (bad again)' (I: 4, 266-269).

Intermediary Level Category: **Meaning of self-control: Complete control versus controlled enough.** This category refers to the meaning of self-control, which seemed to
be a confusing concept in that it had different implications for the women at different times. On the one hand, there was a desire or need to have complete control, (manifested in extreme behaviours such as self-starvation, or sudden periods of abstinence from alcohol which they are unable to maintain), whilst at other times, there was a desire to have 'enough' control. The two were at odds with each other and this seemed to exacerbate the confusion surrounding what self-control actually means.

Despite her extreme measures to gain control, one participant described what her preferred situation would be with respect to self-control:

'I would like to be controlled enough to eat a healthy diet and to be able to lose weight and not be able to drink so much, I'd like to be able to have maybe just a bottle on Friday nights' (I: 3, 189-189).

When asked about the meaning and the importance of self-control, another replied:

'To me it means everything .... .... if I let go, everything falls to pieces' (I: 2, 119; 156).

However, later on in the interview, it was revealed that her preferred situation was to adopt a more relaxed approach to her eating and drinking in line with other people:

'Oh, yeah, (I want to be able to eat and drink normally in the long term) because I know it's normal, I know it's normal' (I: 2, 332).
As described earlier, one participant felt that her self-control was embedded in being able to control her eating, and expressed the view that everything else would be okay if she could do that: *(repeated extract)*

'That was the only thing I could control. I needed that one thing. That was the only thing I really could control was me....that was the point, everything else, (well I couldn't control it). But that one thing....if I could do that then everything else would be fine' *(I: 4, 136-141).*

However, having recently been successful in reducing the frequency of starve-binge cycles, as well as reducing the number and intensity of drinking binges, she reported that self-control was an all or nothing thing for her now -- whereas with hindsight, she realised that she did not have self-control previously:

'I didn't have self-control up until recently. I always thought I had. It is (an all or nothing thing) now, yeah, 'cause now I've found it I don't want to lose it' *(I: 4, 124; 353).*

The all or nothing mentality regarding self-control was also evident in the women with alcohol only problems

'I'd rather not drink at all than have say a low alcohol or an alcohol free lager....I suppose my self-control - I'm better if I have none' *(I: 5, 117... 120).*
However, this was in contrast to the way she felt her self-control should be and indeed wanted it to be:

'Yeah, yeah, (what I’d like my self-control to be and what it is at the moment are two different things). I mean I’d like to be a social drinker like what I class as normal people but at the moment, I’m just not... .....' (I: 5, 132-134).

Sub-category: Personality. Reasons for adopting an 'all or nothing' approach to self-control were partly attributed to personality factors:

'Without a doubt (I am) an all or nothing person. Absolutely. I can’t do things by halves. Absolutely not' (I: 3, 480-481).

Another participant made numerous references to her personality traits, implying that an all or nothing thinking style was an important part of who she was:

'You start a job, you finish it, otherwise you don’t start it, you know. That’s my way of looking at things' (I: 2, 207-209).

Intermediary Level Category: Using the past as a model: positive versus negative. This category describes the women’s tendency to refer to past behaviours and situations in which they perceived themselves as either successfully exercising self-control or being
out of control. This seemed to confuse their sense of self-efficacy in terms of whether or not they would be successful in controlling their problem behaviour(s).

When talking about giving up alcohol altogether, one participant said:

*I could give it up like that (snaps fingers) – I know I could because I’ve done it before and I know the way that I think, I just drink now because I like it, that’s why’ (I: 3, 247-250).*

This indicated that her past behaviour served as a positive model, increasing her confidence in controlling her drinking. This also ties in with the notion of moving the goal posts, as described earlier, in that she justified her current alcohol consumption by asserting that she drinks because she wants to and is therefore ‘in control’ of it.

Later in the interview, this participant gave a negative example of using the past as a model of self-control:

*‘The thing that worries me is that if I try and control, make a conscious decision to control my eating and drinking then I will become out of control because that’s what’s happened before and that terrifies me, it really does’ (I: 3, 605-608).*

When asked about the notion of self-control, one participant used her past experience of being able to (successfully) restrict her eating as being indicative that she did possess
self-control. However, she later indicated that her past experiences of binge eating would indicate a potential loss of control:

‘I have got self-control, ‘cause I do know that I can stop eating when I want to....... ...I wouldn’t feel in control of it because I know that I can just go off on a binge’ (I: 1, 106-107; 159-160).

One participant described how, with the benefit of hindsight, she had realised that just because she had been successful at controlling her drinking before, this did not mean that it would always be that easy:

‘Before, I always thought it (exercising self-control) was an easy thing but it’s not..... ...I’d managed to stop drinking before myself so I thought I can do it. It was like, next day, I’ll give up next day after that and the days would add up’ (I: 4, 132-133; 218-220).

The women from the alcohol only group also used the past as a model for the future, similarly, giving both positive and negative examples which contradicted each other and lead to a confused sense of self-efficacy with regards controlling their drinking:

For example, one of the women backed up her belief that she did have self-control by giving evidence of previous ‘successes’, such as being able to give up smoking and meat:
'I think I've got a lot (of self-control), you know, underneath, I think I've got a lot...

....there's been a lot of things I've given up because I've known it's not the right thing
for me, you know, like becoming a vegetarian, ... giving up smoking' (I: 6, 188-193).

However, her drinking history meant that she would always perceive herself as an
alcoholic which seemed to reduce her sense of control over her drinking:

'I'm an alcoholic, I'll always be an alcoholic, even if I don't take another drink from this
day 'I'll always be because that thing will always be there - that I've got a problem with
alcohol and that's hard' (I: 6 200-202)

Summary of main category: MAINTENANCE: A SERIES OF OPPOSING FORCES:
This category described various sources of conflict experienced by the women, which
exacerbated their sense of self-control with respect to their eating and drinking. The
notion that the women felt like they were two different people, according to whether they
were in a binge or abstinent period, was felt to be central to this category. Other
important sources of conflict were described, between the internality versus externality of
self-control; the decision to be open versus secretive about eating and drinking; and
lastly, the discrepancy between self-control as an 'all or nothing' concept versus the
desired position of being 'controlled enough'.

CHAPTER 4

DISCUSSION

4.1 Overview of This Chapter

The main findings from the study are discussed, with reference to the aims of the study, which were:

- To identify what self-control means to the population being studied
- To identify perceived factors underlying the perceived need for self-control
- To identify the perceived relationship between eating, drinking and perceived self-control

The existing relevant literature revealed that the notion of self-control is pertinent to alcohol and eating disorders and that the co-morbidity of these disorders is highly prevalent in women. However, the specific meaning attached to self-control is poorly understood.

The findings are discussed from a service, clinical and theoretical perspective, with gaps in the literature being highlighted. Lastly, the methodology used will be critically discussed and recommendations for further research suggested.
4.2 Discussion of The Main Findings

The interviews revealed a common process that was involved in the women’s ongoing struggle with self-control and therefore a process model of self-control was devised to summarise the results. A core category of 'Illusion' was described as this was felt to underpin all of the interviews.

To facilitate the discussion, the next section has been divided into 4 sub-sections, according to the main categories being discussed. Where appropriate, references will be made to additional relevant categories.

4.2.1 Perceived Desire For Control And Attempts To Gain Control

In order to more fully understand the concept of self-control in the women being studied, it was considered useful to look at the main predisposing factors that contributed to the initial desire for self-control. The analysis revealed a sense of dissatisfaction characterised their role as a passive victim of circumstances, rather than as an active agent of change. Two specific areas of dissatisfaction were in their interpersonal relationships, their current work or studies. The women with alcohol only problems reported a specific incident, which they felt, had triggered their problematic drinking, which is consistent with the literature on the development of alcohol disorders in women. The women with both eating and drinking problems described a more general dissatisfaction, with feelings relating to low self-esteem / self-image being much more
apparent. Unlike the other women, those with alcohol only problems did not describe particularly low self-esteem prior the onset of their problems, but were more likely to currently describe themselves in negative terms.

Whilst low self-esteem and poor self-image are common to all mental health problems, the current findings suggest a specific relationship between eating and drinking disorders and low self-esteem. As highlighted in the introduction, it is well known that low self-esteem is crucial in the development of eating disorders as is the notion that westernised cultural and societal beliefs often encourage the desire to be thin for many women (for example, see Fairburn et al, 1999, Striegel Moore, 1994). In the women with eating problems, the pre-morbid presence of low self-esteem and poor self-image – particular in relation to their perceptions of others – is consistent with the eating disorders literature and offers some explanation for why they were more likely to go on to develop an eating disorder. In the context of the current findings, it is suggested that the role of passive victim is likely to enhance such feelings of low self-esteem.

All of the women with a dual disorder described a desire to be thin and from their descriptions, it seems likely (researcher’s impression) that they would have been eligible for a diagnosis of anorexia nervosa some time previous to the current study. The driving force for these women was to increase their popularity with others by looking a certain – ‘perceived ideal’ way. This supports the notion put forward by Klar (1992), that it is the desirability of the outcome that is particularly potent in driving the behaviour. This would
indeed account for the prospering weight loss industry and increased attempts of women
to diet.

Controlling eating (and thus weight), therefore, had an impact on the women’s
relationships with others, for example by enabling them to begin to lose their role as a
passive victim (as described in the first category). This supports a family perspective of
eating disorders (Vandereyecken et al, 1989) and Fairburn et al’s (1999) assertion that
controlling eating has a potent effect on others in the immediate environment, especially
the family. This, he reports, may have particular significance if there are pre-existing
dysfunctional relationships, as was described in the current study.

The women also described attempts to enhance feelings of control through other means,
such as having an organised / tidy house or being organised and efficient at work. This is
also reflected in the Visual Illusion of Control, which refers to the emphasis that all of the
women placed on external, visual displays of control, for example, with reference to their
physical presentation to others. This is consistent with a compensation model of control
(Baltes and Baltes, 1986), the notion of ‘secondary control’ (Rothbaum, 1982) and is also
acknowledged in cognitive accounts of eating disorders (Bruch, 1973). Qualitative
reports from anorexic women have also shown that extreme forms of restrictive eating
pertinent to the disorder may provide the women with something to focus on, in the face
of other difficulties, such as interpersonal relationship difficulties and poor self-esteem
(for example, Button, 1998).
For all of the women, descriptions of their initial alcohol use revealed occasional, non-problematic drinking. The purpose of their drinking was described as lifting mood, increasing confidence and fitting in.

4.2.2 Loss Of Control

Loss of control in the current study refers to the behaviours of binge-eating and regular (excessive) drinking (and the relationship between them), as well drug use and self-harming behaviour.

With reference to the development of binge eating, it is of particular interest that most of the women interviewed implied a conscious decision-making process. There is an indication that the initial binge eating represented a continuation of the desire to exert control through food. This fits in with the views recently expressed by Fairburn (2001), that different classifications of eating disorders share similar features and should therefore benefit from a single treatment of choice. One implication here is that food intake had become an index of control.

This sense of control through binge eating was related to ‘blocking out’ of painful emotions, which was positively reinforcing to begin with. However, this positive effect was short-lived and was soon overwhelmed by the negative effects of weight gain, guilt, self-disgust and potential health risks. The act of binge eating always left the women feeling bad about themselves, with the word ‘disgust’ being used frequently. This lends
support to the notion of temporary relief gained from binge eating described in the literature (Elmore and De Castro, 1990; Schlundt and Johnson, 1990).

The women in the current study were unable to pinpoint a specific time when their alcohol intake increased to a point where they were drinking daily (which preceded the development of binge drinking) although the use of regular drinking as a means of avoiding negative emotions / situations, was consistently reported by all of the women.

It may be that excessive eating and excessive drinking in binges serve a similar function, which is consistent with the notion of ‘symptom substitution’ described in the introduction and typically favoured in psychodynamic accounts of bulimia nervosa and alcoholism (for example, Brisman and Siegel, 1984). If this is the case, then the function served by both excessive eating and drinking (as indicated by the current transcripts) must relate to the avoidance or escape from negative feelings. The escape theory (Hetherton & Baumeister, 1991) postulates that self-destructive behaviours provide an escape from negative and painful self-awareness. Not only would this account for problematic eating and drinking but also for the behaviours of self-harm and drug abuse, as described in the current study by the women with a dual diagnosis. However, in his study of binge eaters, Paxton and Diggens (1997) warned against using findings of elevated avoidance coping in individuals with co-morbid depression, as being supportive of escape theory.
In the context of the current study, any link made between these behaviours and escapism would be at best, simplistic and at worst, spurious, given that this was not an issue which was explored in detail.

Furthermore, for the women with a dual diagnosis, there appeared to be a more specific relationship between their eating and drinking. Firstly, their reports of excessive drinking were associated with periods of binge eating (and intermittent periods of food restriction), as opposed to the more continuous food restriction characteristic at the onset of their eating disorder. Secondly, when this relationship between food and alcohol was explored further, it was revealed that whereas excessive drinking was likely to follow binge eating, the women were highly unlikely to eat excessively following a binge drinking episode. It is suggested, therefore, that one important function of alcohol is to relieve the guilt and associated feelings, following a binge eating episode. This was indeed reported directly by some of the women. In line with an excessive appetite model (Orford, 1985; 2001), the costs associated with drinking did not outweigh the benefits for these women. Given the significance of low self-esteem and poor self-image in this group, one can see how the positive effects of alcohol (mood enhancer, confidence-builder and so on) may have been perceived as being able to help re-dress the balance for them.

This is not to imply that problematic drinking only occurs in connection with binge eating episodes. The other positive perceived functions of alcohol described earlier play a key role in maintaining drinking patterns, for all of the women, regardless of the eating disorder.
4.2.3 Attempts To Re-Gain Control

The category labelled: Attempts to regain control referred to the attempts by the women to control their drinking, which had become excessive – typically described as daily drinking. Beliefs about the severity of their drinking as well as their perceptions of how the rest of society viewed their drinking played an important role here. A notable difference was found between the women with alcohol only problems and the women with both eating and drinking problems. Whilst all of the women were aware of the stigma attached to their drinking, those with alcohol only problems were more likely to self-define their drinking as futile. This is also reported in the category ‘Illusion’. At all stages, the women with a dual diagnosis did not perceive their drinking to be particularly problematic and there was a tendency for them to see their eating as the main problem, whether a client of the alcohol service or the eating disorder service*. Attempts to cut down on drinking seemed to be related to what other people expected of them rather than this being their own choice. This has been described as a form of denial, in response to the social stigma attached to female drinkers (Blume, 1998). If the women were denying the seriousness of their alcohol use, this would indicate a poorer long term outcome (Farid, Clark and Williams, 1998).

As Saunders, Wilkinson and Towers (1996) pointed out, even the most skilled therapist will encounter clients who are reluctant to discuss fully the extent and nature of their

*All of the participants met the criteria described in section 3, which included a self-definition of problem drinking.
alcohol difficulties. However, they go on to argue that whilst there may be a temptation
to label this as 'denial', a more helpful alternative perspective might be to consider this as
a psychological defence induced by cognitive conflict. For example, Oppenheimer and
Stimson (1982) carried out a longitudinal study of heroin users attending drug
dependence clinics. From their findings, they suggested that rather than being unaware of
the negative consequences of their actions (being in denial), drug users are typically
involved in an internal battle between the pros and cons associated with their behaviour.
This fits in with cognitive conflict models of addiction, such as Orford's (1985, 2001)
excessive appetites model and Prochaska and DiClemente's (1983, 1992) stages of
change model.

It may be, therefore, that the women were in fact aware of their problematic drinking –
certainly, with hindsight, they were able to admit that it was excessive. (Admitting that
they had a problem which was now under control is much safer and less stigmatising than
admitting to a current problem). By attempting to cut down - seemingly at the will of
others, this had the dual effect of keeping others happy, whilst allowing them to retain a
behaviour that they were not sure they wanted to give up. This resulted in the oscillation
between drinking and abstinent periods characteristic of binge drinking.
4.2.4 Meaning Of Self-Control And Continued Struggle For Self-Control

The women’s perceptions of the meaning of self-control are best understood through the core category of ‘Illusion’ and the main category of ‘Maintenance: a Series of Opposing Forces’ and these shall therefore be the main focus of the remainder of the discussion.

Both the categories of ‘Illusion’ and ‘Maintenance’ demonstrate the ambiguity surrounding the concept of self-control. This reflects the multiple meanings given to self-control as it applies to eating disorders and which have been reviewed in the Introduction.

Definitions of the term illusion, include ‘false impression’, ‘delusion’, ‘deception’, ‘misapprehension’, ‘fantasy’ and ‘fallacy of vision’. The author’s description of self-control as an ‘Illusion’ could be argued as being controversial, in that it implies a ‘false’ meaning to a construct that plays a key role in our understanding of addictive behaviours.

It is not proposed here, that the notion of self-control is discarded – rather, it is suggested that people’s interpretations of the meaning of self-control may be unhelpful and unstable, in that they are contradictory and encourage a sense of failure. Various factors are thought to contribute to this meaning (and will be discussed below), including: personality (e.g. view of self as all or nothing person), cognitions (e.g. attributions, abstinence violation effect); social (e.g. perceived stigma attached to drinking).

The most obvious contradiction in the interpretation of self-control relates to the notion of ‘self’. This was apparent at all stages in the process model of self-control and
highlights the role of other people in contributing to the perceived need for self-control and attempts to gain self-control. Of particular note, was the feeling described by all of the women of potentially having an increased sense of self-control if external restrictions were placed upon them. This was described universally with respect to drinking behaviour, but not in terms of eating behaviour. Interestingly, the one participant who did refer to the positive effect of having someone else take control of her eating could be described as being further along the path to recovery*. This woman described the importance of the relationship with the person(s) exerting the control and stressed the need for mutual trust and understanding if the outcome is to be favourable.

Further conflict is described by the women’s decision regarding whether to be open or secretive about their difficulties. Perhaps the main benefit of being open is that it enables others to take a supportive role but the potential costs are that others will reject them or be over protective. It should be noted, however, that other qualitative studies have reported that imposing control on women with eating disorders can have a negative impact, only serving to exacerbate feelings of loss of control (for example, see Payne, 1998). This may encourage the women to remain in (or retreat to) a passive victim role as described earlier. This is clearly a sensitive issue, which needs further consideration and exploration within local settings.

This questionable notion of self in self-control, relates to the conflict between the internal

*no. of binges per week had substantially reduced over recent months, comparative to the other women.
versus external nature of control described in the ‘Maintenance’ category. For example, the women were able to retain an overall sense of (internal) control by convincing themselves that ‘if it really came to it’, they could exert control. They did this by describing situations which would force them into taking action. Interestingly, these situations were either unlikely to occur in the near future, or had already occurred, but had not resulted in them taking any action such as being told by the doctor that their drinking was causing serious health risk).

Another major source of conflict in the meaning of self-control, was between the notion of this as being either a rigid or flexible concept. There seemed to be a mismatch between the meaning that the women had come to accept as signifying self-control (all or nothing) and their desired position of having ‘enough’ self-control. On the one hand, there was an unrealistic desire to have complete control over eating and drinking, expressed through self-starvation and total abstinence from alcohol, which, for them, inevitably resulted in binging. On the other hand, however, there was a desire to adopt a more ‘moderate’ approach to eating and drinking, but any attempts at this did not seem to fit with their dichotomous personalities or their ‘built in’ belief about the meaning of self-control as an all or nothing concept. This is discussed further below.

The notion of conflict as being central to impaired control supports early findings relating to impaired drinking (Edwards and Gross, 1976) and is a key aspect of Orford’s (1985; 2001) psychological theory of addiction, which describes the ‘addicted’ individual as literally being in two minds regarding whether to engage in a particular behaviour.
According to his excessive appetite theory, the greater the costs associated with a particular desirable behaviour, the more likely the individual will be to attempt to restrain that behaviour. It is these conflicts that result in the cycle of behavioural restraint and excess.

The decision to engage in or abstain from binge drinking and/or binge eating behaviour appears to be influenced by a number of cognitive processes, which also provide support for psychological models such as the excessive appetite model. The abstinence violation effect (see introduction) is one example, described by all of the women, usually with regards their drinking but also in terms of their excessive eating.

According to outcome expectancy theory, positive expectations about the outcome of a particular behaviour are said to result in decreased likelihood in abstaining from that behaviour, than if the expectations are negative. With respect to alcohol use, all of the women with a dual diagnosis did not see their current binge drinking as producing significantly negative outcomes. Whilst there was some evidence of a desire to have more control over their drinking, this seemed to be more of a passive (as opposed active) desire. In contrast, when they were drinking on a more continuous basis, the outcome was considered to be less favourable, mainly due to the stigma attached to their drinking in the pattern of ‘an alcoholic’. As a result, motivation to cut down on their drinking was enhanced. For the women with drinking only problems, the outcome of their binge drinking was seen as consistently futile and motivation to become abstinent was accordingly extremely high, despite their unsuccessful attempts to achieve this. Similarly,
the outcomes associated with binge eating were perceived as being entirely negative and although motivation to stop this was high, success at controlling their behaviour was relatively poor.

It should be pointed out that expectancy theory does not claim to provide a whole account for behavioural motivation, but rather proposes that it offers an important contribution to our understanding of this. Indeed, the current study offers some support for this model. However, in line with the theory, whilst motivation undoubtedly plays a crucial role in the maintenance of addictive behaviours, it does not provide a ‘full story’, which necessitates a fuller understanding of other key processes underlying the women’s struggle for self-control.

It may be that thoughts about the actual outcome of the binge eating or drinking are less prevalent for the women than thoughts about whether or not they will be successful at controlling their food/drink intake. As this is essentially the first hurdle for the women to get over, they may not get too far beyond this worry. Indeed, in the ‘Maintenance’ category, fears relating to their self-efficacy (beliefs about one’s ability to perform a certain behaviour) were highlighted in the conflict resulting from using their past behaviour as a model.

The notion of self efficacy has been highlighted in the Introduction and is an important predictor of positive health outcomes. If, as the current findings suggest, the women are concerned about their ability to control their eating and / or drinking, their past behaviour
will undoubtedly provide them with conflict. By the very nature of their disorder, the binge periods have been intermittent, with relatively controlled periods in between.

Central to self-efficacy beliefs, is the nature of the attribution(s) that individuals give to their behaviour. Marlatt and Gordon (1985) applied attribution theory in their description of a relapse prevention model. According to the model, whether the initial lapse from abstinence progresses to a full relapse is seen to depend on the attributions that the individual makes as to the cause of that lapse. If it is attributed to internal, stable and global factors (for example, ‘I lapsed because I am a weak person’), rather than external, unstable and specific factors (for example ‘I lapsed because my friend needed cheering up that day’) a full relapse is said to be more likely.

As described in the intermediary level category ‘Meaning of Self-control: complete control versus controlled enough’, conflict was expressed between the women’s current ‘all or nothing’ approach to self-control and their desired more flexible approach to self-control. The latter approach would signify a better outcome with respect to bingeing behaviour. However, it is interesting to consider the attributions that the women made about their behaviour. Subsumed beneath this category is ‘personality’, which refers to the tendency for the women to explain their all or nothing approach in terms of their identity as an ‘all or nothing person’. By describing themselves in this way, the women avoid having to identify as an ‘addict’ (which has numerous negative connotations) but at the same time provide themselves and others with some justification of their behaviour. As revealed in the category ‘using the past as a model’, the women with alcohol only
problems, on the other hand, described themselves as being ‘alcoholic’ and felt that this was a part of them that would always be there to some degree.

In the context of low self-esteem as described in the eating disorder literature, the notion of being ‘all or nothing’; ‘not doing things by halves’ may imply a sense of strength in self-identity, which would help to redress the balance. This would not be applicable to the women with alcohol only problems, whose low self-esteem and self-image was not present to the same degree. Accepting themselves as addicts, on the other hand, would imply weakness and would likely enhance feelings of low self-esteem, which the women with alcohol only problems described after (as opposed to prior to) their drinking.

It should also be noted that in the current study, the women with alcohol only problems were older than the women with a dual diagnosis and had experienced more binge-abstinence cycles (with respect to drinking) than the women with co-morbid eating problems. In this sense, they may have been more resigned to the fact that they would always have difficulty exercising control over their alcohol intake. By labelling themselves as ‘alcoholic’, as favoured by the disease model of addiction, they legitimise their previous failures and diminish their responsibility for controlling their future drinking.

In any case, factors attributed to loss of control can be seen as internal, stable and global, which would suggest poorer outcome. This fits in with Davies’ (1997) and Eiser et al’s (1985) assertion about self-attributions of addiction as providing a way of making sense
of the impaired control and promoting maintenance by reducing an individual's sense of 'volition' over his or her behaviour. For this reason, they question the use of the term 'impaired control' on the basis that it may encourage resignation to the addictive behaviour pattern. Not only would this encourage a return to the passive victim role, but this resignation to addictive behaviour may serve to abandon any need for self-control.

The notion of self-efficacy can also be understood in terms of the abstinence violation effect, for example as described in Orford's (1985, 2001) excessive appetites model and by Cummings and Trabin (1980) as being one area in which eating and drinking disorders overlap. For the women with a dual diagnosis, the guilt associated with each binge-purge episode, together with their self-perception as having an all or nothing personality ('not being able to do things by halves') is likely to reduce their self-efficacy. This is less likely to apply to their drinking behaviour, due to the lack of guilt and denial that it was a major problem. This is in contrast to the women with drinking only problems, who felt guilty about their drinking and interpreted their lack of control over it within a disease model.
4.3 Implications of the Findings

4.3.1 Theoretical

From a dual diagnosis point of view, the findings show that for all of the women with both eating and drinking difficulties, the eating was perceived as the primary disorder with a clearly identified earlier onset than for the alcohol problem. Whilst this has been suggested by some theorists (for example, Wilson, 1996), this does not seem to have been formally tested.

All of the eating disorder models described in the introduction could be related to the women in the current study to some degree. For example, the family model (extreme control over food intake as a means of gaining a type of pseudo-autonomy in the context of family dysfunction; Vandereycken et al, 1989); the feminist model (control over food and weight in response to societal idealisation of female thinness; Striegel-Moore, 1994); the cognitive model (obsessive control over food as a strategy in eating disorders for a characteristic sense of ineffectiveness; Slade, 1982).

However, the cognitive behavioural model (Fairburn et al, 1999) appears to be most applicable to the women in the current study, in that it encompasses a variety of interacting factors, such as a perfectionism, long standing low self esteem, dysfunctional relationships and the impact of Western society values. This model also places a particular emphasis on the notion of self-control.
In cases of anorexia nervosa, it is feasible to assume that the meaning of self-control may be a fairly static concept (all or nothing), characterised by the desire to be thin. In cases of bulimia nervosa, however, the meaning of self-control may be ever changing. As highlighted in the current study, the women switched from having an ‘all or nothing’ approach to self-control, to a desire to have ‘enough control’. This is not to support Potter and Wetherell’s (1987) rejection of cognitivist assumptions that expressions of attitudes and beliefs are reflections of stable underlying cognitive structures. It is proposed that it is because of these underlying cognitive structures that individuals living in a social world experience confusion and paradoxes. In this sense, support is offered for Billig’s (1987) claim that thinking is an inherent dilemmatic process.

Indeed, it has been pointed out that about one quarter of bulimia nervosa sufferers do not respond to treatment (Wilson and Fairburn, 1998, Fairburn, 2001). It is suggested that the cognitive behavioural model may be developed further, by improving understanding of the different meanings of self-control at different stages of the eating disorder.

Whilst this model is useful in understanding the development and maintenance of eating disorders, it does not specifically account for the interacting effect of alcohol use.

The notion of symptom substitution within binge drinking and binge eating disorders was not supported in the current study. Rather, there seemed to be a specific relationship
between eating, drinking and perceived self-control, involving several possible interacting forces.

Orford's (1985; 2001) excessive model of addiction was put forward as a potential means of understanding a variety of addictive behaviours. However, the research has tended to focus on mono-substance misuse, which has recently prompted Orford (2001) to call for greater emphasis to be given to research which includes 'two or more forms of addiction, and particularly to research that combines substance and non-substance addictions in the same study'.

The maintenance of eating and drinking difficulties described by the women here could be described in terms of an interacting set of learning and cognitive processes, exacerbated through secondary amplifying processes, such as the abstinence violation effect and cognitive conflict (described in the excessive appetites model). The specific cognitions relating to the dual diagnosis women's alcohol use, were different to those held by the women with alcohol only problems, suggesting that there may be a specific interaction between eating and drinking behaviours. For the women in this study, it was possible to conclude that 1) drinking relieves the negative affect of binge eating and 2) binge drinking is perceived as being non problematic relative to binge eating. Further exploration may reveal other important beliefs, which could serve as maintenance factors.
4.3.2. **Service implications**

When clients are referred to mental health services with a co-morbid substance misuse problem, there is a tendency for clinicians to perceive the substance misuse as a 'complicating' factor that needs addressing before the other mental health disorder can be resolved. In some of the more severe cases, this may well be true, with hospitalised detoxification treatments being necessary in only the most extreme cases. However, more commonly, clients are referred on to services that offer specialised treatment for substance misuse problems, who may not always see themselves as having the necessary resources or skills to deal with other problems of serious mental illness. This can result in clients being passed back and forth between services (Rorstad and Chacinski, 1996). A similar pattern can be seen in primary care and hospital settings, where patients may be refused services 'until the substance abuse problem is sorted out'.

Whether patients present to services with an eating disorder, or with a masking mood disorder – they may be referred to drug and alcohol services via the same process. The effect of being passed between services is likely to further impact on their feelings of self-control.

As already mentioned, the findings in the current study supported the notion of the eating disorder as the primary problem, with the alcohol use serving as a secondary (coping) process. This was the case regardless of the whether the women presented at the alcohol or eating disorder service. The implication of this is that the primary eating disorder
should be the main focus of treatment and thus has important implications for agreement on referral patterns across services.

This has additional implications for:

1) **Staff training and education.** The main purpose of this would be to increase mental health professionals’ understanding of the notion of ‘dual diagnosis’ and specifically the potential role of the abused substance as a coping strategy for the primary mental health problem. This may take the form of a one-off initial training session, facilitated by a specialist substance misuse professional, with later ongoing refresher sessions and joint case working which could be facilitated by an existing team member, specifically trained in this area.

2) **Consultancy Roles.** The importance of having a trusting relationship between the client and therapist is well known and this was also highlighted in the current research. Rather than encouraging direct co-working with clients, it may be that substance misuse services adopt a consultancy model, whereby they are involved in the assessment of dual diagnosed clients and also in providing an advisory role to mental health professionals with regards the ongoing substance misuse.

Whilst some services may claim to do this ‘in theory’, by having this formally agreed between services, this may prevent the ‘passing on’ of clients from service to service. With respect to eating disorder services, this will mean that clients would receive
specialist help for their eating disorder, with the potential to address their substance abuse with a trusted therapist at a time that they feel is appropriate.

In terms of substance misuse services, who are typically involved in working with clients with concomitant mental health problems such as eating disorders, the current findings imply that an appropriate form of action would be to refer on for key worker responsibility, with the recommendation that the substance misuse service act in a secondary supportive role.

Lastly, the findings have implications for the use of self-help literature for substance misuse problems, which could be used by the client in addition to face to face contact with a mental health professional and/or to support the mental health worker in dealing with a co-morbid substance misuse problem. Recent research indicates that self-help material for alcohol problems are both clinically and cost effective (Humphreys and Moos, 2001) and offer a non-intrusive way of providing an incentive for change (Koski and Cunningham, 2001).

4.3.3 Clinical Implications

As with any mental health problem, mutual exploration between the client and therapist is recommended, in order to fully understand the nature of the difficulties and the clients perceptions of their problems.
The current findings, highlighted in particular, the need to understand the client’s position in terms of self-control. The assertion that clinicians should acknowledge and respect the individual’s need for control within an eating disorder setting is advocated by a number of researchers and indeed is central to the feminist perspective, which proposes that a space is created, in which the woman’s relationship with food can be defined in terms other than weight (Orbach, 1985).

As suggested in this study, there may be no ‘single’ meaning attached to self-control. Attempts should therefore be made to explore these different meanings. This may include exploration of an ‘inbuilt’ notion of control but also what other (perhaps preferred) notions of self-control might be. This may encourage a less rigid approach. It is also important to explore the client’s current perception of self-control (for example in terms of the process model).

The women described relationships in which they assumed the role of a ‘passive victim’, subject to the control of more powerful others. Other qualitative research within the area of anorexia nervosa has concluded a need for the therapist to set time aside to explore the individual experience of the disorder, the meaning of treatment and motivation to change, as a way of sharing responsibility and control between therapist and patient (Payne, 1999). It is suggested here that the very issue of control has an explicit focus for further exploration.
Sesan (1994) has argued for the balancing of power within inpatient eating disorder settings, as clients typically view therapists as the experts which may minimise their own sense of expertise. This study is not conclusive enough to suggest that service philosophies which encourage the patient to 'surrender control' in order to facilitate recovery, are unhelpful. Rather, it is suggested it is the specific nature of the client-therapist relationship that plays a crucial role.

For women with co-morbid alcohol problems, it is likely that there will be heightened sensitivity regarding other people's opinions of their behaviour, derived from societal attitudes towards female drinkers. The therapist's perceived notion of self-control therefore also has important implications.

As suggested in the introduction, the term 'self-control' may be unhelpful in that it may focus too heavily on the role of personal volition with subsequent failure to achieve self control resulting in feelings of failure, inadequacy and anger. Alternatively, a self attribution of addiction may be a way of making sense of past failures to give up and an excuse to continue the behaviour on the grounds that it is not volitional.

The conflicts described by the women may cause problems for the therapist. For example, by adopting the view that the client's behaviour is under her control, the therapist risks alienating the client and encouraging a repetition of criticising relationships and secretive behaviour. On the other hand, by adopting the view that the behaviour is due to factors such as 'personality', the therapist may decrease the client's
confidence regarding change. By openly acknowledging this conflict with clients, therapists may avoid the risks outlined above.

Finally, the study highlighted the need for the therapist to understand the client’s perception of each of the disorders (drinking, eating), for example in terms of the severity and functionality. While this was not evident in the current study, the client may perceive their alcohol problem as being more problematic than the eating disorder, in which case, the substance misuse service may be required to provide a more active role. Alternatively, focusing too heavily on the alcohol use, when this is not perceived as being the most significant problem may further risk alienating clients and encouraging ‘secret’ drinking.

4.4 Critical Evaluation

In this section, the methodology of the study shall be critically evaluated with respect to its validity, reliability and generalisability. Finally, the role of the researcher and the impact that this had on the results shall be discussed.

4.4.1 Validity

The researcher’s attempt to increase the validity of the study is reviewed, with additional consideration given to methods which were not used but which may have offered further validation.
4.4.1.1 Triangulation

Investigator Triangulation

The qualitative group provided a useful forum for discussing issues pertinent to the research and the alternative perspectives enabled different avenues to be explored. Individual supervision sessions throughout the research process had a similar impact. At one stage, it was felt that there might have been a danger of having ‘too many’ conflicting opinions, which may have added confusion when interpreting the data. This was dealt with by setting aside some time to reflect on the data alone, before taking it back to other clinicians to discuss the emerging theory further.

Theory Triangulation

Here, the data are analysed from a variety of theoretical perspectives. Whilst the researcher had some awareness of the relevant theoretical literature prior to the research, a more detailed analysis of its applicability was only conducted after the themes had been clearly defined. This helped to ensure that the research was grounded in the data, whilst enabling integration with existing knowledge and theory.

Member validation

This refers to the process of revisiting participants and asking for their comments on the preliminary findings as identified by the researcher. On the basis of these comments, the interpretations would be revised accordingly. As implicated in social constructionism, all accounts, whether described by participants or researchers, are likely to be subjective.
Hence, it was initially felt that whilst this procedure may have provided additional insights into the data, these insights would be any more valid than the account developed by the researcher. Furthermore, it was felt that the participants may have felt pressured into agreeing with the researcher (Smith, 1996) or have difficulty in understanding some of the concepts.

With hindsight, however, it was felt that contacting the participants in order to ascertain their views on the researchers interpretations would have been helpful.

There are two potential explanations for this change of opinion. Firstly, having been immersed in the data analysis for a considerable length of time, without any subsequent contact with the participants, there was a danger that the specific context may have been ‘lost’, resulting in inaccurate interpretations. It was hoped that listening to the tapes regularly, rather than just focusing on the transcripts would reduce the likelihood of this.

Secondly, whilst it was useful to have other perspectives within the qualitative group forum, this was done as the theory was emerging, with the final account being largely based on the perspective of the researcher. Although this account is believed to be accurate and valid, having this confirmed by the participants would have increased the validity both in the researcher’s and the reader’s eyes. Alternatively, having the interpretations disconfirmed would have prompted further exploration.
Unfortunately, even with this hindsight, member validation was not possible in the time limit available. However, it is hoped that this will be pursued at a later date.

*Theoretical Sampling*

The use of theoretical sampling was described in the original proposal of Grounded Theory (Glaser and Strauss, 1967), as a way of furthering the developing theory and increasing the validity of the results.

In the early stages of the research, it was assumed that the participants recruited would all meet the criteria described in the method section. However, as the research progressed, it became apparent that the number of eligible (and agreeable) participants was going to be fairly low.

According to Charmaz (1990), by the time theoretical sampling is planned, the researcher would have some hunches or even hypotheses which he or she wishes to check.

In the current research, theoretical sampling was conducted after four of the interviews had been completed. Whilst analysing these interviews, specific findings relating to the women's beliefs about their drinking behaviour, did not seem conducive to the researcher's clinical experience of working with women referred to the Clinical Alcohol Team. For example, whilst in order to meet criteria, the women had to self-define their alcohol use as being problematic (as well as meeting DSM IV criteria for alcohol abuse / dependence and engaging in binge drinking behaviour as defined by the community
alcohol team), further interviewing revealed that they did not seem to see their binge drinking as particularly problematic.

Through the process of theoretical sampling, whereby 2 female binge drinkers were recruited, knowledge about the specific relevance of the eating disorder in relation to binge drinking and perceptions of self-control was strengthened. Had these participants not been included, it would not have been possible to make the same assumptions.

Ideally, more participants with both eating and drinking problems would have been recruited subsequent to theoretical sampling, in order to further ‘test’ the emerging theory. However, this was not possible due to time constraints and availability of eligible clients.

### 4.4.2 Saturation

As there were broadly 3 different strands to the research (reflected in the 3 aims), it was inevitable that some issues were discussed in more depth with certain participants than with others. This was reflected in the sub-categories, which only related to 2 or more of the participants. However, both the main and intermediary level categories related to all of the women with eating and drinking difficulties. With respect to these categories, by the fourth interview, the emerging themes had become repetitive, with no new responses being revealed to the questions asked. The last 2 interviews offered further confirmation for the findings.
As Rennie (2000) points out, articulation of understanding of the phenomenon can go on for months but even then, the resulting understanding is always open to new interpretations. Consequently, it is difficult to know when the analysis is actually over, yet it is necessary to force an ending at some point (Watson, 1999).

With hindsight, it was considered that although factors underpinning the need for self-control were felt to be appropriate to the study, given the extensive existing literature in this area, it may have been more fruitful to focus more attention on questions relating to the meaning of self-control and the relationship between eating and drinking and perceived self-control. These were highlighted as gap areas in the literature. This may have led to a more saturated representation of the data.

4.4.3 Reliability

As highlighted earlier, positivistic notions of reliability may be unhelpful when conducting qualitative research. However, as Lincoln and Guba (1985) pointed out, if the study were to be repeated within a similar context, one would expect a replication of the findings. Qualitative revisions of reliability (for example, see Flicke, 1998) have pointed to the dependability of the data, which are derived from the grounded theory method.

There were two methods which were of particular relevance here: Firstly, the use of the constant comparative method, described in the methodology section and which was central to ensuring the reliability of the findings. Secondly, the precise documentation of
the research process throughout the study (including the research diary and memos) provides a clear account of the steps involved in the research as well as an understanding of how decisions about the direction of the research evolved over time.

4.4.4 Generalisability

As highlighted in Chapter 2, to generate a 'fully fledged' account may be beyond the realms of the grounded theory approach. However, attempts have been made to compare the findings that emerged from the data (based on interviews with women attending two different services) with existing theoretical accounts in the relevant literature. In addition to enabling potential gaps in the current research to be highlighted and new ideas to be tentatively formed, this also encourages a localised theoretical reflection, for example, with respect to the way services may deal with potential dual diagnosis cases involving an eating disorder and substance misuse problem.

It is acknowledged that the analysis was conducted on a small number of participants. However, the object of the research, was to contribute to the creation of theory that is directly related to the realities of the individuals being studied. Whilst Orford’s (1985; 2001) excessive appetites model of addiction applies to a wide variety of behaviours, the findings described here, within the context of the model, are specific to eating and drinking problems. Further research would be needed to understand the interacting processes involved in the development and maintenance of other combinations of addictive behaviours.
4.4.5 Reflexivity: Personal Experience of the Research

Throughout the study, an attempt was made to remain reflexive to my own personal values, assumptions and biases. These were monitored through the research diary, the qualitative support group and individual supervision.

During the planning stages of the research and having read various texts relating to conducting interviews within a grounded theory framework, I felt a nervous but excited sense of anticipation and was eager to start interviewing as soon as possible. However, notes in my research journal indicated a feeling of disappointment and frustration following interview number 1. Although I had lots of 'interesting' information, this interview had not 'gone as planned', in that it was shorter and more disjointed than I had anticipated and without the detailed descriptions of 'self-control' that I had hoped for.

Reflecting upon this interview, I felt that by focusing too directly on self-control in my questions, there was a risk that the women could have felt that they were being 'judged', particularly given that it was likely that they may see self-control in terms of success or failure. Secondly, whilst I had anticipated that the women would probably make judgements about me, based on the limited information they had about me (appearance, age, job), I was not prepared for any overt comparisons to be made, as was the case in the first interview. Whilst her comment was useful in that it prompted a discussion about social comparisons, this had quite a 'humbling' effect on me, whilst heightening my awareness of the struggle that these women faced.
In terms of the impact on future interviews, I adopted a more open minded stance with respect to how long the interview should be and how much depth should be afforded to particular issues. Interestingly, all subsequent interviews were substantially longer! I also spent more time in conversation prior to each interview and attempted to encourage the notion of the interview as a 2 way, equal process. Discussions within the qualitative group forum have led me to thinking that perhaps this was a naïve assumption.

As the interviews progressed, I was aware that some of my initial interpretations to comments made by the women represented my own assumptions. For example, when they talked about binge eating and getting drunk on the same occasion (as opposed separately), I assumed that the alcohol would reduce their inhibitions and thus encourage them to ‘loosen their control’ over their eating, which would lead to a binge. It was only through the analysis of the data that I realised that the link might be in the opposite direction, which was then tested out in further interviews.

I believe that this research has had a considerable impact on my clinical work. It has encouraged me not to make assumptions about what people are saying without further exploration of their understanding of the meaning or significance. I consider this to be of particular importance with regards to use of common phrases (such as control), which may be used in every day language and perceived as having a generic meaning. I have also become more aware of my use of language in clinical settings and the need to ensure that this is not inadvertently stigmatising. For example, when analysing the transcripts, I
was aware that I frequently used the term 'normal', for example when asking if the women would like their situation to be any different. This could lead these women to assume that I did not think that they were normal, which would fit in with some of their experiences of being stigmatised by society.

This links to the feeling I am left with regarding diagnosis. The inclusion criteria for the study was largely based on DSMIV criteria and yet, as Orford (2001) has pointed out 'excessive appetite' behaviours are normal and there is no point at which normality ends and abnormality begins. I am inclined to agree with him that such diagnoses may be unhelpful. Certainly, I believe that my inclination to use such criteria was a reflection of my perception that this would encourage non qualitative supervisors to see my research as more 'credible'.

Having completed my first qualitative project, my feeling is one of exhaustion but satisfaction that I have made a valid attempt to describe the real experience and meaning from the women's perspectives. Comparing this research to previous projects that I have been involved in, I agree with the assertion made by Gillies and Willig (1997) that quantitative research often strips the data of any context.

My main regret is not having had the time to 'check out' these interpretations with the women within the time scale and I hope to do this at later date.
4.6. Future Research

Based on the findings from the current study, (as well as current gaps in the literature), the following two areas are considered to be of particular interest for future:

- An exploration of the specific secondary amplifying processes (described in Orford’s (1985; 2001) model of excessive appetites), which may influence the interaction between eating and drinking. In particular, research should explore which cognitive processes make such an interaction more or less likely.

- A comparison of the meaning attributed to self-control between women with different types of eating disorders as well as women with other forms of addictive disorders. Attempts should be made to explore if and how the meaning changes, according to different stages of the disorder (for example, abstinence versus bingeing).

Both studies would add to existing knowledge about self-control in addictive behaviours – a knowledge that could then be incorporated into existing models and used to inform treatment protocols.
CONCLUSION

Chapter 1 reviewed the literature pertaining to control, eating disorders and drinking disorders in women. It was highlighted that the meaning of self-control and its relation to eating and drinking disorders merited further exploration and therefore this study endeavoured to do this by using a grounded theory approach.

In summary, the meaning of self-control to the women is unclear and fuelled by a number of contradictions. The notion of self-control is described as an ‘Illusion’, in that it appears to reflect a false impression of control at various stages of the women’s disorder(s).

A process model of self-control is described, to account for the development from having a perceived need for self-control to a continued struggle for self-control. As described in this model, there appears to be a specific interaction between binge eating and binge drinking.

The findings have been described in terms of existing literature, with Orford’s (1985, 2000) excessive appetites model of addiction and Fairburn et al’s (1999) cognitive behavioural model of eating disorders, being particularly applicable to the current study. However, these models do not fully account for the findings, and suggestions for future research have been highlighted to further theoretical understanding in this area.
It appears that self-control is not a static concept but rather has different meanings for the women studied. Whilst models of eating disorders and addictive behaviours such as alcohol use, rightly emphasise the importance of self-control in terms of the onset, maintenance and recovery process, it is concluded that the actual meaning (or indeed meanings) of self-control is poorly understood.
REFERENCES


196


202


Dear Lynne

Re: “Perceived self-control in females with Bulimia Nervosa and alcohol dependency characterised by binge drinking.”

Please find enclosed a copy of the outcome of the deliberations of the Leicestershire Research Ethics Committee in respect of your submission. This has been given the reference code 6036, which should be included in any communications with the Ethics Committee and the Research Office (the project has also been assigned an internal Trust Code).

Then enclosed letter indicates that you have been given approval to begin the study, subject to minor modifications. These are clearly described in the enclosed letter and should be sent directly to the Ethics Committee marked for “Chair’s Approval”, and copied to the Research Office.

This letter also confirms that you have full Trust Approval to undertake the work, subject to the consent of the Services involved. Please remember that at the conclusion of the study you need to send a report to the Ethics Committee via the Research Office. It would also be of great use if any publications, or a summary of the main findings are submittted to the Research Office.

If I can be of any assistance, please do not hesitate to get in touch.

Regards,

Dave Clarke
[R&D Manager]
04 December 2000

Dear [Name],

Re: Research Study: Self-control in women who have problems with alcohol and food

I am writing to you to enquire whether you may be prepared to help in the above research project which is being conducted in conjunction with the Eating Disorders Service and the Trust’s Community Alcohol Team by Lynne Battersby, who is a trainee clinical psychologist at the University of Leicester.

Details of the study are outlined in the enclosed patient information sheet. We hope that you may be interested in participating as we regard this as an important study which will help increase understanding about problems relating to food and alcohol. It is entirely your choice, however, as to whether you participate and your decision will have no influence over your treatment within this Service.

If you need further clarification, may I suggest you contact Lynne Battersby on Leicester (0116) 225 6350. If you are agreeable to taking part please return the slip below in the enclosed pre-paid envelope and Lynne will contact you to arrange an appointment.

Many thanks.

Yours sincerely,

Dr Eric Button
Consultant Clinical Psychologist

Please return to: Lynne Battersby, Community Alcohol Team, Drury House, 50 Leicester Road, Narborough, Leicester LE9 5DF

Your Name

Address

Tel: No.
PATIENT INFORMATION SHEET

Study Title: Self-control in women who have problems with alcohol and food

You are being invited to take part in a Research Study. Before, you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends and relatives if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

We know that many women have problems with both alcohol and food. Several researchers have attempted to investigate this link and have shown that the notion of self-control is highly relevant. Much of the research has involved filling in questionnaires, which measure things like self-control, self-esteem and mood – you have probably filled in some of these yourself as part of your existing care within the Service. These are very helpful measures and may be used in the present study. However, we are particularly interested in understanding your experience in your own words and aim to do this by conducting an in depth interview.

This will take about 60-90 minutes and will involve questions about your own personal situation and how this relates to self-control as you see it. There are no right and wrong responses – we are interested in how your situation is related to self-control and how this might be connected to your eating and drinking habits – either positively or negatively.

Why have I been chosen?

You have been selected from all women who are in contact either with the Eating Disorder or Alcohol Service and who we know may have some problems with both
eating and drinking. This knowledge is based on previous information which you have shared with us in the Service. We aim to interview between 5 and 10 women in all.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. **You will still be free to withdraw at any time and without giving a reason.** This will not affect the standard of care you receive.

What will happen to me if I take part?

An appointment will be set up with the main Researcher for the study. This will be a good opportunity for you to bring up any queries you might have that are not covered in this information sheet. If you are still agreeable to take part in the study, we will proceed with the main interview. This meeting will probably take place within the Service you are currently attached to – either the Eating Disorder or Alcohol Service. The interview will last between 60 and 90 minutes and will be audio taped. This is solely for the purpose of the analysis as it is important that the Researcher does not miss any information which you share. You are welcome to have a copy of this tape should you require. All information received will remain confidential (see below).

What are the possible disadvantages or risks of taking part?

We do not anticipate any risks to you as a result of taking part in this study. Talking through difficult issues, however, can be quite painful and may make you feel distressed. You will be offered an opportunity to talk through any concerns you may have in relation to the Interview afterwards.

What are the possible benefits of taking part?

We hope that having an opportunity to talk through some of your experiences will be helpful for you. The information we get from this study may help us to understand and treat future women who struggle with eating and drinking problems better.

What happens when the research study stops?

This study in no way affects the existing care you are receiving within the Service. This will continue as usual throughout the duration of the study and thereafter.

What if something goes wrong?

All information which is collected about you during the course of this research will be kept strictly confidential. Your name and address will be removed from any documents so that you cannot be recognised. The audiotapes will be kept in a locked cupboard and you are welcome to have a copy of the tape yourself. All information will be stored on a home computer but will only be accessible with a password and will not be identifiable by name.
What will happen to the results of the research study?

The results of this research will be written up as part of a Doctoral Clinical Psychology Thesis and are likely to be published in a clinical journal. You, of course, will not be identified in any report or publication. You will be given the option to read through the final report should you require.

Who is organising and funding the research?

This research is funded by the National Health Services in conjunction with
- The University of Leicester, Centre of Applied Psychology, Clinical Section
- The Eating Disorder Service, Leicestershire and Rutland Healthcare NHS Trust
- Leicestershire NHS Drug and Alcohol Services – Operational and Developmental Group of Leicestershire and Rutland Healthcare NHS Trust

Who has reviewed the study?

This research has been reviewed by the Research and Development Operational Group of Leicestershire and Rutland Healthcare NHS Trust

Contact for further information

If you have any further queries regarding this study, please do not hesitate to contact Lynne Battersby – Trainee Clinical Psychologist and main Researcher for this study – at Leicestershire Alcohol Service on: 0116 2256350

Thank you for taking part in this study.

Lynne Battersby
Trainee Clinical Psychologist
PARTICIPANT CONSENT FORM

Perceived Self-Control In Women With Eating and Drinking Problems

I agree to take part in the above study as described in the Information Sheet.

I understand that I may withdraw from the study at any time without justifying my decision and without affecting my normal care and management.

I understand that members of the Research Team may wish to view relevant sections of my medical records but that all information will be treated as confidential.

I understand that medical research is covered for mishaps in the same way as for patients undergoing treatment in the NHS – i.e. compensation is only available if negligence occurs.

I have read the Information leaflet on the above study and have had the opportunity to discuss the details with Lynne Battersby and ask any question. The nature of the study has been explained to me and I understand what my taking part involves.

Signature of participant....................................................... Date............................... 

I confirm I have explained the nature of the study as detailed in the Information leaflet, in terms, which in my judgement are suited to the understanding of the participant.

Signature of researcher....................................................... Date...............................
General Statement—Given the qualitative nature of the study, it is important that the questions are open ended, allowing participants to express their own opinions in relation to each of the objectives to be covered. Below is a list of the objectives with examples of opening questions from which to base the Interview.

Objective One:

To identify what self-control means to the population being studied

- Lots of doctors and researchers talk about the notion of self-control as being important for people with eating and drinking problems — what does self-control mean to you?

- Is self-control something that you either ‘have or do not have’ – or is it something that you can ‘decide to have’?

- Is self-control more about the way you think and feel or is it more about what you actually do?

Objective Two:

To identify factors underlying the need for self-control

- Can you identify any situations or experiences in your life which have threatened your sense of self-control?

- Can you think of any examples in your life when you felt scared that you were not in control?

Prompts if necessary: work/study; relationships; self-esteem; media; family; need for perfectionism; compliance

Objective Three

To identify how eating and drinking habits affect perceived self-control

- There seems to be 3 phases involved in Bulimia Nervosa – a desire to restrict food; a desire to binge on food and a desire to get rid of the food, for example through purging. How does this affect your perception of self-control. Let’s start with the desire to restrict ........... does this increase your sense of self-control? What about when you binge .................?

- Similarly with binge drinking, there seems to be a desire to both restrict alcohol and then drink to excess. How do these two experiences affect your perceived self-control?
- Some people plan binges in advance. Do you do this with food and/or drink? How does this affect your sense of self-control?

- Do you think that your eating and drinking habits are related? If so in what way?

- Do you think that you use your eating and drinking to regulate your self-control?

**Objective Four:**

*To identify how self-control via eating and drinking affects those factors underpinning the need for self-control.*

- Earlier, we talked about specific experiences in your life which have threatened your self-control. Do your eating and drinking habits make any difference to these experiences?

*(For example, you said before that you have a stressful job which can often make you feel incompetent and out of control – do your eating/drinking habits make you feel any less incompetent – in what way?)*
360. go one way or the other can’t I – I can either just think oh sod it I’ve
361. catastrophising ‘all or nothing’ leave up to fate
362. lost everything I might as well carry on the drink and you know, what
363. happens happens or I can right okay well I’ve screwed up a bit but I’ve
364. been given another chance if you like, this time next year I could have
365. my licence back I could have a new job, I could have somewhere of my
366. own to live you know, and I don’t know, that’s what I want, that’s
367. what I’m aiming for but I’m trying to sort of be - you know – take each
368. day as it comes, I suppose and say right
369. another binge?

R 370. Yeah, that makes sense. What sorts of things would be likely to trigger
371. another binge?

P 372. I don’t know really- I mean I got stressed out today because I get on
373. my mum okay sometimes she’s very much like she wants to control
374. it’s like oh I think you should do this think you should do that and I
375. feel myself thinking inside mother, you know , I’m 33 not 3, don’t –
376. now and I know she means well but I sometimes feel myself getting
377. That’s interesting – do you find that when people try and control what
378. you do it makes you more likely

R 379. Yeah, I mean, they all mean well and I know they all think they’re
380. doing it to help me which they are helping me at the minute but I don’t
381. like to feel controlled because my husband was a very much, you
382. know, he liked to be in control ‘cause my mum said to me once I