

***Doctorate in Professional Educational,
Child and Adolescent Psychology***

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**Doctorate in Professional Educational, Child and
Adolescent Psychology**

Doctoral Thesis

**Looking into the rabbit hole: an exploration of the experiences of
adults who had an eating disorder whilst in school and the role that
teachers and Educational Psychologists may have in offering
support**

WORD COUNT: 35,430

DECLARATION

I confirm that the work presented in my thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

ACKNOWLEDGMENTS

Thank you to my family and supervisors for their unwavering support. Thank you to the women who shared their stories with me, with the hopes of using their past experiences to reach out for the greater good of what the future has in store, for children and young people experiencing eating disorders in schools today.

ABSTRACT

This study aimed to explore the experiences of adults who had an eating disorder whilst in school, focusing on the role that teachers and Educational Psychologists may have in offering support. Using a cross-sectional design, the research used both qualitative and quantitative methods for data collection across two phases. In Phase 1, an online questionnaire was completed by 133 educational professionals working in Greater London, revealing a notable lack of confidence amongst Educational Psychologists and teachers in effectively supporting young people with eating disorders. In Phase 2, semi-structured interviews were conducted with 10 adults, who navigated eating disorders during their schooling. Reflexive Thematic Analysis of interview data identified five overarching themes: 'Academic and Cognitive Functioning at School', 'Social Dynamics and Relationships at School', 'Emotional Wellbeing at School', 'Awareness, Recognition and Education about Eating Disorders', and 'Systemic and Individual Roles in Supporting Eating Disorders'. The study found that the experience of school for individuals who had an eating disorder was varied and multifaceted, with participants sharing diverse perspectives on the impact their eating disorder had on them, whilst in an educational setting. Participants also provided insights into the ways in which educational professionals could better support children and young people with eating disorders at school, based on their own experiences. Overall, this study contributes to bridging the gap between research and practice, by providing valuable understandings into effectively supporting students with eating disorders in educational settings.

IMPACT STATEMENT

The findings of this study represent a distinctive contribution to the field of educational psychology, offering evidence of originality and critical awareness of research. This study marks a pivotal step forward in understanding and addressing the experiences of individuals who navigated school with an eating disorder, and how reflections from the past, can inform support for students currently grappling with eating disorders at school. This research also contributes to the literature accessing the knowledge, understanding and confidence, of both Educational Psychologists and teachers, in supporting children and young people with eating disorders.

By employing a cross-sectional design encompassing both qualitative and quantitative methodologies, this study not only illuminates critical gaps in support systems but also offers tangible pathways for improvement. The Phase 1 findings highlighted a significant lack of confidence among Educational Psychologists and teachers in supporting individuals with eating disorders, which serves as a call for enhanced training and intervention strategies for these school professionals.

Findings from the Phase 2 interviews sheds light on previously unexplored aspects of eating disorders within educational contexts, emphasising how retrospective reflections from adults can offer valuable and unique perspectives, about their past experiences. Accessing this population not only enriches our understanding of the challenges faced by individuals with eating disorders, but has broader implications for future research, as by uncovering these insights, this study opens avenues for further exploration of the intersection between mental health and education, through reflective examination of past experiences.

Through exploring the impact of eating disorders on academic, social and emotional well-being, this research offers a comprehensive understanding of the complexities and the significant impact that eating disorders may have, specifically in a school context. By amplifying the voices of those affected by eating disorders, this

study also fosters a sense of empowerment, in allowing the participants to reclaim their stories and advocate for their needs. It additionally highlights the importance of including individuals with lived experiences of mental health difficulties in decision-making processes, ensuring that policies and interventions are informed by their needs and understanding, contributing to the development of more effective and responsive support systems for individuals with eating disorders and other mental health difficulties.

By delving into the lived experiences of individuals who had eating disorders in educational settings, this study not only deepens our understanding of the challenges they faced, but also provides actionable recommendations for better developing support systems within schools. These suggestions encompassed a range of practical strategies and empathetic approaches aimed at fostering a more supportive environment within educational settings, which have significant implications for shaping the roles of Educational Psychologists and teachers, both at the individual level and within systemic frameworks. It further underscores the importance of ongoing professional development and critical reflection in enhancing support for vulnerable populations within educational settings.

Ultimately, this research contributes to the broader goal of promoting the wellbeing and fostering supportive mental health practices for all students in school settings. By leveraging the expertise, knowledge and insights generated in this study, educational professionals can work collaboratively and creatively work to develop inclusive environments where all students can thrive.

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LIST OF ABBREVIATIONS

AFRID	Avoidant/restrictive food intake disorder
ALSPAC	The Avon Longitudinal Study of Parents and Children
ACT	Acceptance and Commitment Therapy
AN	Anorexia Nervosa
APA	American Psychiatric Associations
BEAT	Beat Eating Disorders (charity)
BED	Binge Eating Disorder
BN	Bulimia Nervosa
BPS	The British Psychological Society
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CBT-E	Cognitive Behavioural Therapy for Eating Disorders
CPD	Continuing Professional Development
CYP	Children and Young People
DBT	Dialectical Behaviour Therapy
DSM	The Diagnostic and Statistical Manual of Mental Disorders
DfE	Department for Education
DfES	Department for Education and Skills
DHSC	Department for Health and Social Care
DoH	Department of Health
ED	Eating Disorder
EDs	Eating Disorders
EDNOS	Eating Disorder Not Otherwise Specified
EP	Educational Psychologist
EPs	Educational Psychologists
FBT	Family-Based Therapy
FE	Further Education
HCPC	The Health and Care Professions Council
IPT	Interpersonal Psychotherapy
MH	Mental Health
MHCYP	Mental Health of Child and Young People Survey

MI	Motivational Interviewing
NHS	The National Health Service
OCD	Obsessive Compulsive Disorder
OFSED	Other Specified Feeding or Eating Disorder
PTSD	Post-Traumatic Stress Disorder
RTA	Reflexive Thematic Analysis
RQ	Research Question
S	Statement
SDT	Self-determination Theory
SES	Socioeconomic Status
ST	Schema Therapy
TEPs	Trainee Educational Psychologists
WHO	The World Health Organisation
YOTs	Youth Offending Teams

1.0 INTRODUCTION

Eating disorders (EDs) are complex mental health (MH) conditions that can profoundly impact individuals' lives, particularly during their formative years in school settings. As a survivor of an eating disorder (ED), the researcher has first-hand experience of the challenges and struggles faced by students grappling with these conditions whilst navigating the demands of education. The researcher's journey through an ED, has instilled a deep-seated passion for understanding and addressing the experiences of students who have faced similar battles whilst in school.

Beat Eating Disorders ([BEAT]; BEAT, 2024), the UK's ED charity, estimate that 1.25 million people in the UK have an ED and the peak age of onset for EDs is typically in adolescence, which coincides with when children are in secondary school (Knightsmith, 2015). Further, EDs have been described as one of the most difficult psychiatric disorders to treat (Halmi et al., 2005) and the average illness duration is about six years (Royal College of Psychiatrists, 2019), which means that a child may have an ED throughout their secondary education. Out of all the mental disorders that emerge in adolescence, EDs, largely Anorexia Nervosa (AN), have the highest rate of mortality and morbidity due to difficulties arising from the ED and also, completed suicide (Arcelus et al., 2011; Berkman, Lohr & Bulik, 2007).

The prevalence of EDs amongst school-aged individuals is a growing concern, with recent data indicating that rates have increased significantly. There was a reported rise in 84% in hospital admissions from 2015/16 to 2020/21, with the admissions of children and young people (CYP) rising by 90%, with a 35.4% rise from 2020/21 alone (NHS, 2021), which some authors suggest is a result of the factors associated with the COVID-19 pandemic (e.g., Devoe et al., 2023; Zipfel, Schmidt & Giel, 2022). Although this is a significant and shocking increase, the rise in EDs has been a consistent trend observed over the last 50 years (Treasure, Duarte & Schmidt, 2020).

A large proportion of literature in this field, focusses on the perspectives of individuals *currently* undergoing treatment for EDs in clinical settings or recounting their journey towards recovery. However, there is a dearth of research concerning adults reflecting on their own experiences of having an ED, whilst in a school setting. This gap presents an opportunity for researchers to delve deeper into the perspectives of this population, which may greatly enrich the understanding of the complexities surrounding EDs in a school environment. Drawing from the researcher's own personal experience, reflections from participants in this study and existing research that highlights the cognitive and behavioural distortions associated with EDs (e.g., Björk & Ahlström, 2008), this study argues that the retrospective insights gleaned from individuals who previously had an ED, offer a more authentic and valid depiction of the challenges faced during schooling, than those currently grappling with the disorder.

Through qualitative exploration and analysis, this research aims to shed light on the unique and nuanced perspectives of adults, as they reflect on their experiences of having an ED while in school. This study seeks to explore the specific challenges they faced and the school support systems they encountered or lacked. Additionally, this study will investigate the perceptions and roles of teachers and EPs in providing support to students with EDs, identifying strategies for improving practice within educational contexts, and also seeking to assess current educational professionals' confidence in supporting CYP with EDs in schools.

By integrating personal reflections alongside empirical research, the current study aims to offer a comprehensive understanding of the complex interplay between EDs and the school environment. It is hoped that this research will contribute to the development of informed and effective strategies for supporting students with EDs, ultimately fostering a more inclusive and supportive educational environment.

2.0 LITERATURE REVIEW

This literature review aims to provide a comprehensive overview of EDs in school settings, covering ED characteristics, the unique school environment and associated risk factors, in addition to the understanding of EDs by educational professionals.

2.1. Overview of eating disorders

2.1.1 Definition and classification of eating disorders

EDs are “characterized by a severe and persistent disturbance in eating behaviour that causes psychosocial and, sometimes, physical impairment” (Murphy et al., 2010, p611). The Diagnostic Statistical Manual 5th Edition ([DSM-5]; American Psychiatric Association [APA], 2013, p329), organises EDs into three main categories: AN, Bulimia Nervosa (BN) and Binge Eating Disorder (BED). According to the DSM-5 (APA, 2013), AN is characterised by extreme weight loss, coupled with severe energy restriction, whilst BN involves recurrent episodes of uncontrollable binge eating, where food intake exceeds typical consumption within a specific timeframe. Compensatory behaviours such as vomiting or laxative use, then follow to avoid weight gain (APA, 2013). BED in contrast, does not involve the compensatory behaviour evident in BN and therefore, BED is often present in individuals with obesity (de Zwaan, 2001). Individuals who do not meet the full criteria for AN, BN or BED may fall into the category of Other Specified Feeding or Eating Disorder (OFSED), which replaced Eating Disorder Not Otherwise Specified (EDNOS) from the DSM-IV (APA, 2000). This includes atypical AN, low frequency or limited duration BN and BED, purging disorder, night-eating syndrome, and additionally any of the symptoms associated with BN, AN and BED can also occur in OFSED. The validity of this as a diagnostic category has been questioned, due to the overlap OFSED has with threshold EDs, challenging its clinical utility (Fairweather-Schmidt & Wade, 2014).

2.1.2 Epidemiology of eating disorders

Estimates from the National Institute for Health and Care Excellence (NICE, 2020) and the Royal College of Psychiatrists (2019) suggest that over 700,000 people in the UK have an ED, 90% of whom are female. In contrast, BEAT (2024), estimate that 1.25 million people in the UK have an ED, the discrepancy believed to be likely because many cases remain undiagnosed. The average illness duration is about six years (Royal College of Psychiatrists, 2019), although this can vary between individuals and specific diagnoses (Schmidt et al., 2016), and the age of onset for EDs is typically between 15-25 (Micali et al., 2013; Schmidt et al., 2016). A significant concern is the lack of access to support and evidence-based treatments for individuals with EDs; for example, it is estimated that only one third of ED cases are detected by healthcare professionals (Keski-Rahkonen & Mustelin, 2016), and further, a substantial proportion of individuals with EDs (34.5% of those with AN, 62.6% of those with BN, and 49% of those with BED) will not seek treatment or support (Coffino, Udo & Grilo, 2019). Note however that Coffino, Udo and Grilo's (2019) research was conducted in a sample of US adults, so the proportion of adults with EDs seeking help may vary cross-culturally and between countries.

The prevailing stereotype that EDs are diseases of affluence (Bruch, 1975), with EDs being elevated in individuals of higher socioeconomic status (SES), has been challenged by recent research. Huryk, Drury and Loeb (2021) found that EDs occur across a range of socioeconomic backgrounds, with no consistent pattern to suggest that AN, BN or BED are linked with a higher SES. This systematic review highlighted that higher SES does however predict the likelihood of seeking treatment, with cost of treatment acting as a significant barrier to getting support for an ED. It is worth noting here that the operationalisation of SES varied among studies, hindering systematic comparison. Additionally, caution needs to be had with the generalisability of these findings to other countries, as studies have shown that rates of EDs in schools do vary cross-culturally (e.g. Almutairi et al., 2023; Morandé, Celada & Casas, 1999). Whilst EDs do occur in different cultures, Western and Eastern ideals of body type vary, which may influence the presentation of EDs, perhaps further confounded by the fact the DSM-5 and research in this field, may be

biased toward Western definitions of EDs (Hoek, 2016). Intersectionality, considering the interplay of factors like SES, race and gender, is crucial in understanding EDs (Kapilashrami & Hankivsky, 2018). Burke et al. (2023) discovered variations in ED prevalence across gender, race and sexual orientation, emphasising the need to address intersectionality in both understanding and treating EDs.

2.1.3 Cause and comorbidities of eating disorders

The etiology of EDs is largely regarded to be multifactorial (Striegel-Moore & Cachelin, 2001; Zanella & Lee, 2022), encompassing risk factors spanning from social-cultural to genetic and neurological influences (Atkinson & Hornby, 2015, p63-64). However, Schmidt (2002, p247-250) critiques this characterisation, stating that the term multifactorial “is so broad as to render it useless without further qualification”. A risk factor can be defined as a factor that is associated with a disorder and may support a causal connection. Schmidt (2002) outlines that for there to be a causal link between the risk factor and disorder there must be the following criteria: The factor must precede the disorder being studied; there should be a repeated appearance of the same risk factor in multiple risk factor studies; the risk factor must be associated with one disorder only; an experimental intervention that eliminates the risk factor also should eliminate the disorder. A major difficulty in the studies of EDs, largely those using cross-sectional designs, is that temporal precedence cannot be inferred, meaning that it cannot be established whether the risk factor or the ED occurred first.

When considering causes of EDs, one must also take into account comorbidity. Comorbidity, in the context of EDs, refers to the simultaneous presence of one or more additional medical or psychological conditions alongside the ED, which may exacerbate ED symptoms, perpetuate certain ED behaviours, and lead to unfavourable treatment outcomes (Hambleton et al., 2022). It is well documented that the most common comorbid disorders are anxiety, depression, substance misuse and post-traumatic stress disorder ([PTSD]; e.g., Hambleton et al., 2022; Swinbourne & Touyz, 2007; Blinder, Cumella & Sanathara, 2006). Comorbidity can occur before the onset of the ED, co-occur or be a result from the ED itself (Van Alsten & Duncan, 2020). Thus, studies that have explored comorbidity in EDs are

challenged by methodological difficulties, as it cannot always be ascertained whether the comorbidity occurs before, during or after the ED.

Self-harm is also common in individuals with EDs (Claes, Vandereycken & Vertommen, 2001) and their cooccurrence was examined in the Avon Longitudinal Study of Parents and Children ([ALSPAC]; Warne et al., 2021). Participants reported on self-harming and disordered eating behaviours at 16 and 24, and high comorbidity was observed with nearly two thirds of 16-year-old females and two in five 24-year-old males. These authors noted that the comorbidity between self-harm and disordered eating may be a result of shared risk factors, such as impulsivity, emotion dysregulation and dissociation, which aligns with previous research (Svirko & Hawton, 2007).

2.1.4 Integrative theories of eating disorders

The “general consensus is that all childhood-onset eating disorders must be considered using a multidimensional model that takes into account physical, psychological, social, and family factors in origin, assessment, and treatment” (Watkins & Lask, 2002, p65), which also allows for an exploration of the complex interplay between various potential risk factors and causes of EDs (Rikani et al., 2013). As such, attention will be turned to more integrative theoretical models of ED development.

Transdiagnostic theory of eating disorders

As noted by Fairburn (2008, p10) what is most striking about EDs is “not what distinguishes them but how similar they are”. The different ED diagnoses all share similar clinical characteristics, including the overevaluation of the importance of shape and weight, and the control of these (Fairburn, Cooper & Shafran, 2003; Fairburn, 2008). Fairburn, Cooper and Shafran (2003) refer to this as the “core psychopathology” of EDs or a dysfunctional system for evaluating self-worth. People with this core psychopathology judge themselves heavily in relation to their eating habits, shape or weight, and their capacity to control them. Other clinical features of EDs can be seen as an extension of this overevaluation, such as restraint, restriction, excessive exercise, laxative use, body checking and preoccupied

thoughts (Fairburn, 1981; Wilson et al., 2002). Thus, Fairburn (2008) suggests that regardless of how the ED presents, all EDs have the same undermining core psychopathology, meaning they can also all have a unified method of treatment. Furthermore, Fairburn highlighted, (2008, p17) putting BED aside, one of the most “striking characteristics of eating disorders is the diagnostic migration”; this refers to how individuals with EDs will often “migrate” between the different ED diagnoses (Milos et al., 2005). Whilst the DSM-5 encourages seeing ED diagnoses as distinct and separate entities (APA, 2013), there be merit in considering the consolidation of EDs into a single diagnosis, due to the shared core psychopathology and potential for diagnostic migration.

Fairburn, Cooper and Shafran (2003) suggested that additional interrelated mechanisms can act alongside the core psychopathology to maintain EDs; namely the impact of severe perfectionism, the influence of enduring low self-esteem, a difficulty with experiencing intense mood states and difficulties in relationships and interpersonal functioning (see Figure 1). These mechanisms don’t need to be present in every case or act simultaneously but are seen as an obstacle to change, and interact with the excess focus on weight, shape and eating, to make recovery more challenging (Cooper & Fairburn, 2011).

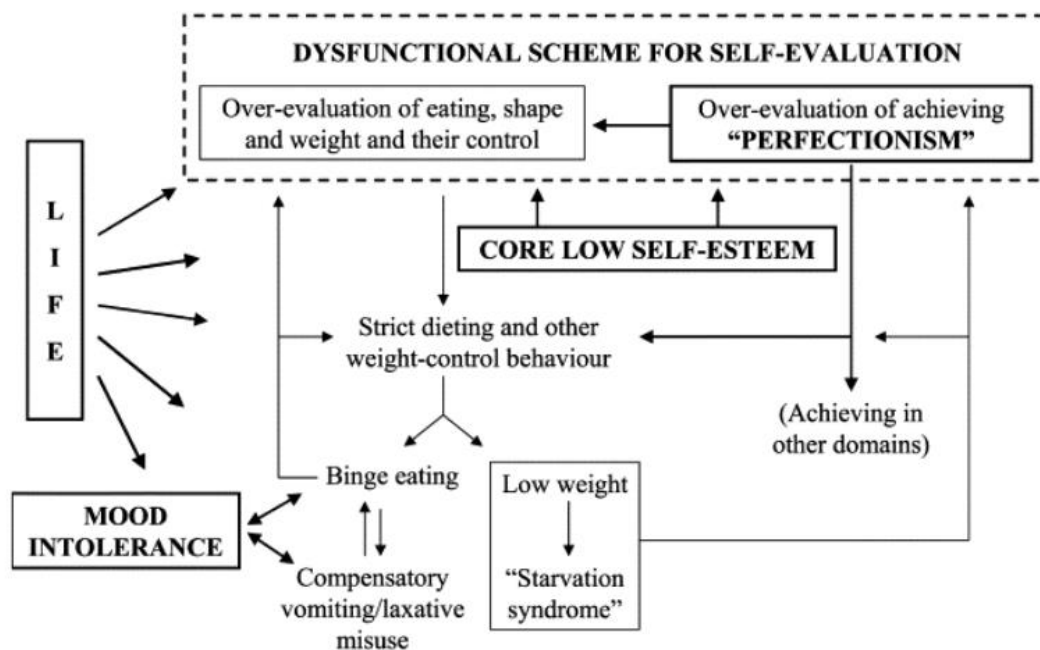


Figure 1: A figure to show the transdiagnostic theory of EDs, taken from Fairburn et al., 2003a. ('Life' is shorthand for interpersonal life).

Although the validity of the transdiagnostic model has been shown in the literature (e.g., Fairburn, Cooper & Shafran, 2003; Hoiles, Egan & Kane., 2012), the theory has received some criticism. For example, Birmingham, Touyz, and Harbottle (2009) used Hill's Criteria of Causation (Hill, 2015), to test the hypothesis that AN and BN are one disorder. Their findings indicated that consistency, specificity, biological gradient, coherence and most experimental evidence, did not meet all of Hill's criteria, suggesting that AN and BN do not share a common cause. The authors also warn against the indiscriminate grouping of all EDs into one diagnosis, as it may homogenise morbidity and mortality, potentially diminishing the perceived seriousness of AN; this could in turn, lead to a reduced allocation of funding for AN treatment.

The cognitive interpersonal model for Anorexia Nervosa

The cognitive interpersonal model for AN (Schmidt & Treasure, 2006) assumes predisposing intrapersonal factors (such as obsessive-compulsive traits, anxious avoidance to close relationships and biological factors) increases an individual's vulnerability to developing an ED. These factors then become entangled with interpersonal relationships, where the behaviours and symptoms associated with the ED cause others to interact with the individual in positive or negative ways (Treasure & Schmidt, 2013). Different factors will have more importance at different stages of the illness. For example, at the start of an ED, intrapersonal factors may more likely influence an individual, such as the positive reinforcement from an improvement in mood/wellbeing by reducing intake, or a biological vulnerability. Interpersonal factors may also change as an ED progresses, such as that initial weight loss may be praised, but further down the line, this weight loss is seen as a concern. This model additionally assumes that the behaviours traditionally associated with AN, such as dietary restriction, may also manifest in other EDs. This broader perspective facilitates for tailored interventions that address common underlying characteristics across EDs, akin to the transdiagnostic model. Also like the transdiagnostic theory, the cognitive interpersonal model focusses on factors that maintain the ED, in addition to characteristics that may be elevated in individuals with EDs; these factors are:

- 1) A thinking style characterised by rigidity, detail focus, and perfectionism.
- 2) Difficulty in the socioemotional domain, such as with emotional expression in close relationships and avoidance of interpersonal experiences.
- 3) Positive beliefs about AN, such as identity becoming associated with AN.
- 4) A response of close others that may inadvertently maintain AN, such as high levels of expressed emotion or through accommodation and enabling behaviours.

2.1.5 Evolution of eating disorders and treatment approaches

The concept of *Otherness* in mental illness, as noted by Jodelet (1991), influences societal perceptions and treatment of MH conditions. Foster (2001) emphasised the need to recognise the distinct characteristics of different mental illnesses for effective treatment. Foster's (2003) ethnographic research of clients in MH services, identified two dimensions of mental illness: namely control and location. EDs are seen as controlling and internal, like an 'internal parasite' (p.648), requiring substantial support for recovery. Indeed, it is consistent across the literature, that individuals with EDs rarely recover without significant support and treatment (e.g. Knightsmith, 2015).

Defining successful treatment and recovery for EDs is complex and often inconsistent. Traditionally measured by symptom remission and weight normalisation, recovery now also includes MH and well-being (Noordenbos & Seubring, 2006). De Vos et al. (2017) found six key criteria for recovery identified by individuals with EDs themselves: positive relationships, self-acceptance, autonomy, personal growth, improved ED behaviours/cognitions, and resilience. The authors noted that 'whether someone is recovered or not remains a question primarily to be answered by the patient her/himself' (p.12), although acknowledging the need for a consistent standard on how to measure criteria for ED recovery amongst researchers and clinicians. This emphasises that ED journeys and their recovery are unique to each individual, and this must be considered when determining what support and treatment may look like.

Early intervention is crucial for ED recovery, leading to higher recovery rates and improved outcomes (Allen et al., 2023; Hart et al., 2011). Treatment for EDs typically involves a multi-disciplinary approach addressing the physical, psychological, and social dimensions of the disorder, and it is thus vital that practitioners understand the multifaceted nature of EDs to provide effective support, foster successful recovery, and inform preventative practices. Stabilising the individual's physical health is a primary goal due to the significant medical complications associated with EDs, such as malnutrition and cardiac issues (Knightsmith, 2015). This often involves medical monitoring, nutritional rehabilitation, and interventions to mitigate immediate health risks.

Psychological treatment focuses on addressing the underlying factors driving disordered eating behaviours. Evidence-based psychotherapeutic approaches, including Cognitive Behavioural Therapy (CBT), Dialectical Behaviour Therapy (DBT), Acceptance and Commitment Therapy (ACT), Schema Therapy (ST), and Interpersonal Psychotherapy (IPT), are commonly used to help individuals challenge distorted thoughts about food and body image (NICE, 2020). These therapies aim to develop healthier coping mechanisms and improve emotional regulation skills, supporting long-term recovery. For young people with EDs, family therapy is often regarded as the leading evidence-based treatment, contrasting with the individual psychotherapeutic approaches more common in adult treatment (e.g. Dalle-Grave et al., 2021).

2.2. Eating disorders in a school setting

2.2.1 National picture of mental health in childhood

The World Health Organisation (WHO) defines MH as “a state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (WHO, 2004). Although it may be difficult to establish the precise prevalence of MH issues due to inconsistent definitions of MH and methods used in surveys (Greig, MacKay & Ginter, 2019), it would seem (regardless of definition) that the prevalence of MH issues is rising. In England’s Mental Health of Children and Young People Survey (MHCYP), rates of probable mental disorder increased from 10.8% in 2017 to 16.0% in 2020 across all sex, age and ethnic groups (Vizard et al., 2020). The picture of the deteriorating MH of CYP is not new (Sellers et al., 2019; Sadler et al., 2018) although health, educational and social outcomes for the MH of CYP, were likely further exacerbated as a result of the pandemic (e.g., Waite et al., 2021).

The awareness of the growing MH concerns in CYP has reached the level of UK legislation resulting in a surge in educational policies including the *Future in Mind* document (Department of Health [DoH], 2015); the Green Paper, *Transforming Children and Young People’s Mental Health Provision* (Department for Education [DfE] & Department for Health and Social Care [DHSC], 2017); and the *State of the Nation* report (DfE, 2019a), highlighting the importance of supporting the MH and wellbeing of CYP, and also addressing that there has been a lack of MH support in UK schools. EDs are “serious mental illnesses” (Klump et al., 2009, p97) although are often not warranted the “same level and breadth of health care coverage as conditions currently categorized in this way” (such as schizophrenia, bipolar disorder, depression, obsessive compulsive disorder [OCD]; Klump et al., 2009, p97). Mond (2014) suggested three reasons why this may be the case: Firstly, that there is a poor awareness and understanding of the spectrum of disordered eating at the population level; secondarily the belief that EDs are either serious but uncommon, or common but trivial; and thirdly, the stigma around EDs (such as that EDs are self-inflicted and a result of being appearance obsessed).

2.2.2. School-based risk factors for eating disorders

Systems thinking assumes that behaviour only has meaning when understood in context; people are complex organisms living within complex systemic contexts, and it is vital to take these systems and interactions into account (Bronfenbrenner, 2005). Bronfenbrenner (1979) arranged these interactions in a set of nested structures, that exert certain pressures and influences, depending on the distance to the individual at the centre. The closer to the individual, the greater influence the level exerts (from Macrosystem to Microsystem), although the systems are interconnected. School and home are identified as the two closest systems to a child and young person. As mentioned, few reliable and consistent biopsychosocial risk factors for EDs have been identified, although it is accepted that EDs are more common amongst females, with the average age of onset occurring in adolescence (Striegel-Moore, 1997). This is especially pertinent in school settings, where CYP spend around six hours a day and over a 1000 hours a year (Ghaziani, 2008). Knightsmith (2015, chapter 5) did however suggest specific factors in the school environment that may put students at risk of EDs, that can be understood within the systemic framework, and will be explored in turn.

Bullying or teasing

Bullying and teasing are forms of aggressive behaviour that can have significant psychological effects on individuals, particularly during the sensitive period of adolescence. Bullying is common in schools, with long-lasting physical and psychological consequences (Wolke et al., 2013). Bullying may affect eating behaviour either directly through teasing about weight or appearance (Thompson et al., 1995), or indirectly by negatively influencing self-esteem, inducing body shame or impacting on anxiety (Duarte, Pinto-Gouveia & Stubbs, 2017; Lee & Valliancourt, 2018). There have been several meta-analyses exploring the impact of bullying on ED onset; although these studies allow for a high statistical power, meta-analyses may be susceptible to publication bias, where studies with statistically significant results are more likely to be published, leading to an overestimation of effect sizes. A meta-analysis and systematic review by Lie, Rø and Bang (2019) highlighted that

compared to healthy controls, individuals with EDs were two to three times more likely to have experienced bullying or teasing (generic or appearance related) prior to ED onset. A later study by these authors, indicated that bullying victimisation is greater linked to EDs marked by binge eating and purging, than those which are restricting (Lie et al., 2021). Interesting the impact of bullying on EDs is not limited to victims; those who bully others are also at an increased risk for symptoms of BN and associated features of EDs (Copeland et al., 2015).

Exam/academic pressure

The detrimental psychological impact of exams on CYP is well documented, leading to increased stress, anxiety, and depression (e.g., Khawaja, 2020; von der Embse et al., 2018), and Knightsmith (2015) highlights that exam pressure is a common trigger for MH issues, including EDs. Whilst Johnson-Sabine et al. (1988) found that stress in schools (academic and social stress) acted as a risk factor for disordered eating, research on the relationship between school stress and EDs remains limited. There have however been several studies indicating the negative impact of academic pressure on eating behaviours amongst *university* students. For example, Costarelli and Patsai, (2012) found that exam stress is associated with increased disordered eating symptoms, anxiety and lower self-esteem in female students at university. Although university students differ from school students in demographics and characteristics, it is reasonable to assume that school-related stress may be significant factor in the development of disordered eating among students. This also is supported by the view of Evans, Rich and Holroyd (2004), that formal education and the pursuit of academic excellence can contribute to the development of EDs in middle class girls, particularly AN, by fostering a culture of performance and perfectionism.

Transition to a new school

The shift to a new school environment may pose a risk for developing EDs, influenced by factors such as sociocultural pressures, adjustment challenges, perceived stress, and the demographic composition of the school (Howard, Romano & Heron, 2020; Derenne, 2018). Research on school transitions, especially

mid-year moves in primary and secondary settings, is limited, with more focus on college transitions. However, as noted in a review by Evans, Borriello and Field (2018), the transition to secondary education can negatively impact psychological wellbeing and academic achievement, exacerbated by stress and early adolescence.

Competitive hobbies

There is a positive correlation between disordered eating and the desire to excel in areas related to appearance, other than academic accomplishments (Burckle et al., 1999); consequently, it can be assumed that competitive hobbies that emphasise appearance may act as a risk factor for EDs. As noted in Knightsmith (2015, p73) although engaging in highly competitive hobbies can be rewarding, it can be accompanied by additional pressure, notably in sports, which can lead to some students feeling anxious or fearing failure. This could result in the development of unhealthy coping mechanisms such as EDs. Indeed, elevated levels of athletic competition correlate with a heightened risk of EDs, especially within sports that prioritise leanness or impose weight restrictions, such as dance, gymnastics or boxing (e.g., Picard, 1999; Garner & Rosen, 1991). Fulkerson et al., (1999) discussed the importance of considering perfectionism in the relationship between athletic competition and EDs, as although perfectionist attitudes may initially benefit sporting success, they may lead to disordered eating behaviours, if unrealistic expectations about performance are acted upon. This also highlights the challenges with relying on correlational studies to explore the relationship between competitive hobbies like sports and EDs, as no cause and affect can be established, but rather only the relationship between two variables explored.

Influence of peers in school

Peer influence, including peer pressure and comparison, is significantly associated with an increased risk of body dissatisfaction and developing an ED, which is often related to perceived likeability associated with the ED (e.g., Meyer & Gast, 2008). Some individuals in school may assume that they will be better liked by their peers by losing weight, with the belief of thinness being important for achieving

satisfying interpersonal relationships (Oliver & Thelen, 1996). Indeed, certain body types can be perceived as having increased social worth (Rich & Evans, 2005), resulting in some students being more popular and accepted by peers (Evans, Rich & Holroyd, 2004). Halse, Honey and Boughtwood (2007) refer to these as “body perfection codes” and if an individual does not comply with them, they may feel likely to receive rejection from peers or weight-related judgement and bullying.

Importantly, adolescents may show heightened vulnerability to the pressure to comply to these codes, as CYP may try to belong to peer groups as part of their social identity (Erikson, 1994), and peer groups will often show similar levels of body image concerns, dietary restraint, and extreme weight loss behaviours (Paxton et al., 1999). Lieberman et al., (2001) found that girls who attributed weight and shape for popularity and dating were more likely to engage in disordered eating, and additionally, girls who were rated as popular by peers were more likely to engage in disordered eating, further having lower body-esteem. This study only recruited females, but interestingly a meta-analysis by Marcos et al. (2013) found that the influence of peers was greater for girls than for boys in dieting behaviour; this difference was related to the subculture that exists in female friendships, where there is exceeding value placed on thinness and frequent discussions about weight loss behaviour (Eisenberg et al., 2005). Additionally, peers may also share information on how to control weight or model disordered eating behaviour and unhealthy coping mechanisms, such as informing others of how to purge (Jones & Crawford, 2006).

2.2.3 Impact of eating disorders on learning and relationships in school

When examining the effects of EDs on various facets of school functioning, it is imperative to address the potential causal relationship, colloquially referred to as the ‘chicken-and-egg’ scenario. Specifically, one must discern whether challenges related to learning or maintaining peer relationships precede the onset of EDs, emerge concurrently with the disorder, or manifest subsequently to its development.

As noted in Schilder et al., (2021) students with EDs may assign significant importance to schoolwork and prefer to engage in a challenging curriculum at school. Students with EDs may also have a strong work ethic (Treasure, 1997) and strive for academic excellence (Crisp, 1995), which can be linked with a desire for perfection

and control (Bardone-Cone et al., 2007). As a result, work at school may be sought to be at a very high standard, which on the face of it could be deemed a positive trait for a pupil to possess; additionally, students with EDs “may be very intelligent, receive high grades, appear motivated to perform well in their academic pursuits, consistently participate in extra-curricular activities and may maintain an active social life” (Hellings & Bowles, 2007, p61).

On the other hand, when EDs become more entrenched, notably AN, there is evidence that cognitive changes may take place including deficits in attention, concentration, impairment of memory and a reduced capacity for new learning (Duchesne et al., 2004; Grau et al., 2019); this would significantly impact on learning at school. Helling and Bowles (2007) note that academic performance and work ethic are likely to decline as a consequence of insufficient nutritional intake, affecting a student’s brain function, cognitive ability, physical health and mood. Additionally, individuals with EDs may experience preoccupations related to food, weight and body image which can interfere with their ability to concentrate on other tasks (e.g., Green et al., 1996; 1998). There is also a significant body of research around certain cognitive functions and executive functioning skills that are impaired in individuals with EDs such as central coherence, decision making and set shifting (Danner et al., 2012; Tchanturia et al., 2012; Duchesne et al., 2004; Smith et al., 2018). Whilst these studies typically involve in-patient samples or experimental methods, their findings regarding the impact of EDs on cognition may offer insights applicable to school settings, albeit with caution due to the potential differences in findings between clinical and educational contexts. In more severe situations, CYP with EDs also sometimes need to defer their education whilst seeking treatment, and subsequently spend time out of school (Hellings & Bowles, 2007). There is extensive research showing the profound negative impact that missing school has on academic achievement in the long and the short term (e.g., Gottfried, 2011; Liu, Lee & Gershenson, 2021).

EDs can have a significant impact on social interactions and relationships, particularly in the school environment, where most CYP will encounter others of their age. Early signs of EDs, notably AN, include increasing isolation and loss of friends (Hogg, 1995), and students with EDs may experience difficulties in their

friendships due to negative attitudes and behaviours related to eating (including anxiety, depression and poor body image), which can lead to alienation and conflict within peer relationships (Schutz & Paxton, 2007). Negative mood and low self-esteem have been suggested as potential mediating factors for the link between difficulties in relationships and EDs (Pelletier Brochu et al., 2018). This aligns with the transdiagnostic model, where problematic interpersonal relationships have been suggested as a core component contributing to the development and maintenance of ED pathology and are interrelated with self-esteem and mood intolerance (Fairburn, Cooper, & Shafran, 2003).

2.3 Understanding and supporting students with eating disorders

2.3.1 Teachers' knowledge and attitudes towards eating disorders

Work by Knightsmith, Treasure and Schmidt (2013; 2014) suggested that teachers have a lack of knowledge and awareness around EDs, and they feel ill-equipped to offer this support. Knightsmith, Treasure and Schmidt (2013) conducted eight focus groups with 63 school staff members, including support staff, teaching staff and principals. 29 schools were represented, a mix of independent, all-girls and coeducational settings. The study revealed that many staff lacked knowledge about EDs, found discussing EDs uncomfortable (as they are often treated as taboo in schools) and desired more practical ideas for support (such as effectively communicating with students about EDs and collaboration with parents). These findings echo previous research indicating limited teacher knowledge and confidence in addressing EDs in schools (Price et al., 1990; Yager & O'Dea, 2005). This study has a number of strengths, notably, two researchers independently categorised the transcripts, resulting in an inter-rater reliability of 87%. However, it is worth mentioning that staff members involved in the study had prior experience in research related to EDs in school, indicating potentially heightened expertise or interest in the subject matter.

Similarly, Knightsmith, Treasure and Schmidt (2014) surveyed 826 school staff, from a range of secondary, primary, specialist and further education (FE) settings in the UK. Results indicated widespread uncertainty about how to support students with EDs, inadequate training and policies, discomfort in educating students about EDs and the need for specific support for the reintegration of students following absence. EDs were encountered by most of the school staff in the sample, but 40% did not know how to follow up concerns about students at risk or suffering from an ED. 41% of respondents' schools did not have reference to an ED policy and further, 74% of respondents' schools had not received training on EDs; for those who had, the training had been given to three members of staff or fewer. Additionally, 89% of school staff felt uncomfortable or very uncomfortable teaching their students about ED, with the most common reason being due to a lack of knowledge on the

area. There was also a worry that open discussion of EDs would lead to an increase in cases, a finding which was evident in the authors' earlier study. Teaching students about EDs may seem to increase the incidence of these disorders, but it's primary due to previously undetected cases being identified, rather than unintentionally exacerbating the issue (Knightsmith, 2015, p41). Although this study included the responses from a large number of school staff, the use of an online questionnaire has the potential for response bias, where participants may provide inaccurate or socially desirable responses, due to bias or demand characteristics. Additionally, self-report measures rely on participant's subjective perceptions, which may not always align with their actual behaviours or experiences.

Whilst these studies provide valuable insights, they were conducted before the surge of educational policies around MH in schools, thus findings may differ in today's context. Knightsmith (2015) emphasised the importance of increasing staff confidence in addressing sensitive issues like EDs, and suggests providing comprehensive training, proactive support strategies to students, clear school policies and routine discussions about MH and emotional wellbeing (Knightsmith, 2015, p31-33).

2.3.2 The role of teachers

Teachers are in a unique position to not only detect CYP at risk of EDs, but to also provide within-school support, monitoring and creating nurturing environments to facilitate recovery (Yager & O'Dea, 2005). Anonymous online questionnaires were completed by 511, 11–19-year-old students from 21 UK settings, in research by Knightsmith et al. (2014). 38% of participants reported either currently having an ED or had recovered from one (of which 49% had not received a diagnosis). 53% of the participants reported having a friend who had an ED, and 23% reported not having an ED themselves or a friend who had had one. In addition to exploring student experiences of EDs, the study also examined ways in which schools could support students with EDs and their suggestions for improving the supportive environment within schools. Through content analysis, three themes emerged from pupils' proposed recommendations for school staff, which will be explored in turn.

Picking up the signs: Improving education for staff and students

Identifying EDs at an early stage is critical for promoting positive long-term outcomes (e.g., Treasure & Russell, 2011). School staff have an advantageous vantage point for noticing the physical and behavioural alterations indicative of initial phases of an ED (Shaw, Stice & Becker 2009), and Knightsmith (2015, p78) notes that sports teachers will often notice the physical warning signs early on. Despite school staff being in a unique position to spot ED warning signs that may be hidden at home, action may be limited by the lack of knowledge and confidence around EDs, in terms of support and recognition in students (Yager & O'Dea, 2005).

Encouraging disclosures and providing support

In the study by Knightsmith et al. (2014), only 7% of students said they would talk to a teacher if they were concerned that a friend may have an ED. This hesitance stemmed from concerns that teachers may not treat their disclosure seriously, overreact or fail to maintain confidentiality, by informing parents. Parental involvement can however be supportive when it is approached collaboratively, and a student is informed and invited to agree with what information is shared (Knightsmith et al., 2014).

Supportive characteristics shown by teachers if an individual discloses a MH or wellbeing difficulty, such as showing non-judgemental attitudes and active listening (as outlined by Knightsmith, 2015, p98-103), bear resemblance to the qualities of a trusted adult. Trusted adults are those who CYP are willing to be vulnerable with and whom they will rely upon, due to the belief the adult will prioritise safeguarding their wellbeing and show traits of reliability, competence and openness, irrespective of their level of control over the situation (Mayer, Davis & Schoorman, 1995); additionally, they will show and model empathy by validating the concerns of a child and young person, and accept their feelings (Rhodes, 2005; Hurd et al., 2018). Trusted adults are not the child and young person's parents (Beam, Chen & Greenberger, 2002) and are not formally assigned to a child and young person for a mentoring purpose, but instead are the adults who CYP have sought out and chosen to trust, with whom they have developed rapport with (Dang & Miller, 2013).

Management and integration: Promoting recovery in school

Knightsmith et al., (2014) underscore the importance of fostering a nurturing school environment, to support students with EDs. Schools can also have a role in collaborating with families to support students recovering from EDs, including if they are integrated back into the setting following a period of absence. As noted in Knightsmith (2015), supporting recovery from EDs in school will have the most success when a student is involved in deciding what support is necessary and what this will look like in practice.

Besides research revealing limited staff awareness and understanding of EDs, barriers within the school system may impede teachers' ability to support students with MH difficulties or EDs. Firstly, one has to consider that it may be difficult for staff in schools to identify individuals suffering from an ED, as they are likely to not fall behind academically in school (Lask & Bryant-Waugh, 2013). EDs also can be hard to recognise in adolescents, especially with BN and BED where significant weight may not be lost or gained; alongside this, individuals with EDs may be less inclined to disclose their difficulties, meaning that EDs may persist as a concealed condition if professionals do not intervene or notice the signs. Secondly, although there is an increased expectation of staff to identify MH difficulties and refer students to appropriate services (DfE & DoH, 2017), one has to take into account what is realistic and achievable for teachers in offering MH support. As noted in Finney (2006), school staff may already be overwhelmed in their teaching responsibilities, and efforts concerning supporting the MH of students are likely to be seen to increase the workload rather than alleviate it. In other words, the demands and pressures of teaching may stand in the way for staff to be fully available to support the MH of students, including those with EDs. Indeed, the decline in teachers' MH due to 'burn-out' has been well documented in the literature (e.g. Friedman, 2000; Gluschkoff et al., 2016) and the need for more support for school staff has become a priority for government strategy (DfE, 2019b); increasing the demands on school staff to monitor and support students with various MH difficulties, such as EDs, may further contribute to the stress and responsibilities associated with the teaching role.

2.3.3 Educational Psychologists' knowledge of eating disorders

There is a paucity of research looking at what EPs 'know' about EDs, even though it has been acknowledged that EPs are undertaking more work in supporting MH in schools (Price, 2017). Saying that, a recent study (Elms & Higgins, 2022) found that the EPs believed that their own knowledge base around EDs was inadequate. Reasons for this included the fact that EPs are not specifically trained in supporting those with EDs and it is not common practice for training on EDs to be part of continuing professional development (CPD) post qualification. Elms and Higgins, (2022, p169) concluded that to improve practice, there is a need to "better upskill parents and staff and *indeed themselves [EPs]*". The authors (p168) stated that it is the "responsibility of individuals [EPs] to up-skill themselves on the impact of ED on the lives of young people", although arguably, this 'up-skilling' needs to occur on a service-wide level, as opposed to individual EPs having the impetus to grow their understanding of EDs. As mentioned, EDs are seemingly becoming increasingly common in young people (Royal College of Psychiatrists, 2019) and therefore the schools in which they attend, so gaining an understanding of what EPs know (and the gaps in their knowledge) is vital for supporting individuals with EDs in a school setting. Although EPs would seem well placed in offering support for schools on EDs, it would seem that upskilling EPs' knowledge of EDs is a prerequisite prior to any involvement (Elms & Higgins, 2022).

2.3.4 The Role of Educational Psychologists

Elms and Higgins (2022) suggested that the ways in which EPs could work with schools to support their students with EDs include: Incorporating core EP skills such as the importance of working systemically, the use of consultation, holistic assessments and interventions, the provision of tailored and flexible support for young people, siblings and families, and working to better upskill parents and staff and themselves (see Figure 2). This reflects the five main areas of EP practice namely consultation, assessment, intervention, training and research (Scottish Executive, 2002), which operate across various levels, including: The *individual* (e.g. assessment and intervention with an individual child), the *organisation* (e.g., a school providing training of teachers), and the *system* (e.g. in a Local Education Authority which is developing innovatory,

special or additional education provision; Curran et al., 2003). The role of the EP in supporting individuals with EDs on each of these levels will be briefly explored in turn.

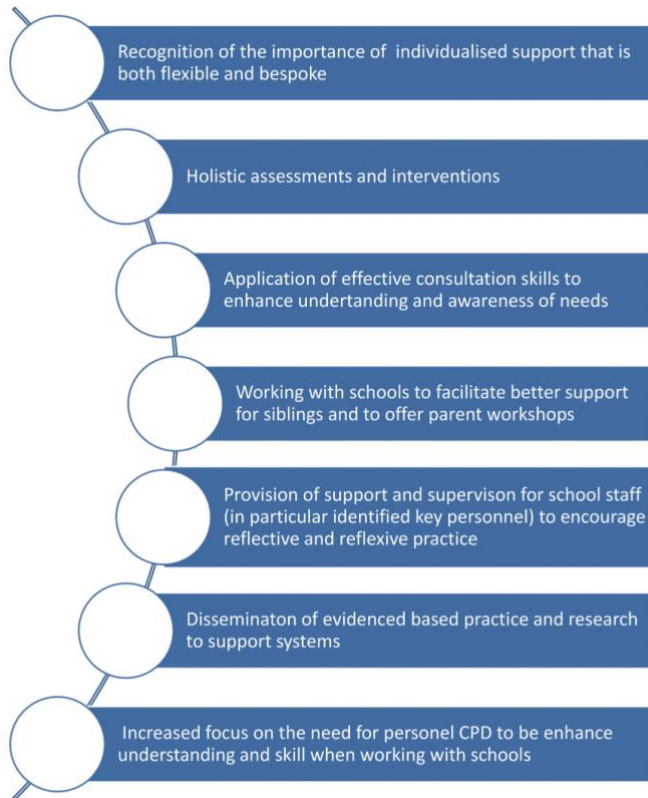


Figure 2: A figure to show ways in which EPs could work with schools to support their students with EDs, as found by Elms and Higgins (2022).

The Individual Level

“EPs are fundamentally scientist-practitioners who utilise, for the benefit of children and young people, psychological skills, knowledge and understanding” (Fallon, Woods & Rooney, 2010, p4). It stands to reason then, that if an EP has the knowledge of the key psychological features of EDs, the understanding of theory around EDs and the skills necessary to support CYP with EDs, they would be better able to identify signs of EDs in assessment and offer the necessary support or intervention (e.g. Treasure, 1997). In accordance with the research explored here, the knowledge, skills and understanding of EPs around EDs would appear to be limited, which may influence how their involvement plays out. EPs are however, legally obligated to respond to MH issues within schools (DfE & DoH, 2015) and

support CYP accordingly (DfE & DoH, 2017) which emphasises the need to understand the unique profile of CYP with EDs in a school setting. It is worth noting here that a child and young person at risk of or having an ED, may appear initially as a model student, not showing any obvious symptoms of anxiety, depression or discomfort (Hellings & Bowles, 2007). This may mean that a referral to an EP is more unlikely, or prioritised even if identified, considering EPs often become involved with supporting CYP when they are not progressing with school or showing clear symptoms of distress. EPs work only with children referred to them, so it may be the responsibility of schools to identify these children. As mentioned, it may be difficult for schools to detect EDs, due to often unaffected school performance and the 'masked', secretive and hidden nature of EDs in general (Fursland & Watson, 2014), which once again emphasises the importance of upskilling teaching professionals in the identification and support of CYP with EDs (Elms & Higgins, 2022).

Mackay (2007) suggests that EPs are a crucial therapeutic resource for CYP in schools. Further, direct therapeutic involvement and interventions with CYP are considered as necessary competencies for the EP role (and included in EP training), by both The Health and Care Professions Council (HCPC) and the British Psychological Society ([BPS], BPS 2023; HCPC, 2023). EPs will often receive training in cognitive behavioural approaches and use this in their practice, meaning elements of the approach can be used to support individuals with EDs (Hoyne and Cunningham, 2019). Cognitive behavioural therapy for eating disorders (CBT-E) is a recommended intervention for young people with AN, and elements of this can be incorporated into interventions for all CYP with EDs. EPs are also able to offer counselling and support for students with EDs, alongside implementing prevention programmes and making referrals when necessary (Bardick et al., 2004).

The Organisational Level

Elms and Higgins (2022, p169) highlighted how "supporting the key systems surrounding these individuals [with ED] could enhance the effectiveness of the outcomes, and that EPs have an important part to play in this". When considering the support EPs can offer at the organisational level, it is important to note the role of EPs in training and upskilling staff in schools on how to support pupils with EDs. This

has been identified as a central strategy schools could implement in supporting young people with EDs, in the literature reviewed for this research (e.g., Knightsmith, 2015).

EDs are their most prevalent in adolescence, when CYP are going through secondary education (Patton et al., 1999; Vilela et al., 2004), and early intervention and support will likely lead to a greater chance of recovery for these CYP in the future (Knightsmith, 2015). As previously mentioned, Knightsmith, Treasure and Schmidt (2014), found that staff feel ill-equipped to support students with EDs. This suggests that there is a need to develop the skills of teachers and their ability to manage situations surrounding EDs that may arise, including improving their basic understanding of EDs and providing them with the tools to recognise the warning signs of EDs (Knightsmith, Treasure & Schmidt, 2013). EPs are in a unique position to offer this support.

Consultation is a central and preferred role in EP practice in the UK (Farouk, 2004), and respectively concerns conversations that help move thinking towards possibilities of change, adopting a strengths-based solution-focussed approach (Wagner, 2000). At an organisational level, EPs can collaborate with schools and families (in a joint school-family consultation [JSFC]) to share perspectives and understandings of what is going well for the young person, and what further support may be needed. Relating this to consultation specifically for CYP with EDs, if EPs have a knowledge of how EDs may develop within school and the potential resources to support CYP within a setting, then they may be able to contribute a unique psychological perspective in discussions and problem solving (Langford, 2021) with both the school and family, and find a way forward with the presenting problem.

The Systems Level

The importance of multi-agency working for the EP within the Children's Services, was emphasised in the Every Child Matters (Department for Education and Skills [DfES], 2003) agenda. Following the agenda, EPs have been placed more centrally within community contexts where schools constitute as only one of the settings in which they work (Farrell et al., 2006), in addition to collaboration with

services such as child and adolescent mental health services (CAMHS) and youth offending teams (YOTs). As noted in Farrell et al's., (2006) review, there is extensive evidence of EPs *effectively* working in multi-agency contexts in all aspects of their work and also having a positive influence in improving EPs feelings of their professional identity (Gaskell & Leadbetter, 2009). Multidisciplinary work by EPs when working with EDs in a school setting is essential and necessary, as it is exceedingly important that CYP have access to physical, nutritional, psychological and psychiatric interventions, in order to achieve full recovery (Murray et al., 2017).

3.0 ACADEMIC, PROFESSIONAL AND PERSONAL RATIONALE

This literature review has sought to provide a comprehensive exploration of EDs, examining the complex interplay between EDs and school environments. Additionally, the review scrutinised the role of teachers and EPs in supporting students with EDs, highlighting the importance of awareness, knowledge and a holistic approach to addressing MH concerns in schools. Through its multifaceted analysis, this review underscores the critical need for effective support mechanisms within educational settings to address the challenges posed by EDs and to promote the wellbeing of students.

A novel aspect of this research is the focus on adults reflecting on their own experience of having an ED whilst at school. They can be deemed experts by experience, as the adults who volunteered to participate in this study have personally lived through EDs at school. Incorporating the perspectives of individuals with lived experience of EDs, has become more evident in the literature in recent years, notably around how recovery is defined and navigated (e.g., Hower et al., 2022; Wetzler et al., 2020; Pettersen & Rosenvinge, 2002). In these samples however, the perspectives of individuals *currently* experiencing EDs are sought, often when as inpatients or in clinical settings. Ethical challenges with this design are evident, notably around participant wellbeing, vulnerability and avoiding harm (e.g., Rance, Moller & Clarke, 2017), although these perspectives have contributed to the development of evidence-based practices and interventions based on the voices of individuals who have experienced EDs.

Individuals reflecting on their past experience of having an ED may give a sense of empowerment, as well as providing rich qualitative data and allowing for knowledge to be shared (Anthony, 1993). This is seen in how recovery stories and memoirs of EDs have become more readily available online in recent years (e.g., Dawson et al., 2018). Additionally, as noted by Vitousek, Daly and Heiser (1991), individuals who have recovered from EDs, often exhibit reduced defensiveness about their ED, making them potentially valuable sources for understanding the nature of EDs first hand. Reflection on MH difficulties in the past, is also relevant to principles of a narrative perspective, where individuals are encouraged to construct

and share personal stories in a way that promotes understanding, empowerment, and facilitates “meaning making” (McAdams, 2006). By sharing past experiences of having an ED at school, adults may engage in a process of storytelling that allows them to make sense of their past and identify patterns and themes in their journey and recovery (e.g., Reed, Josephsson & Alsaker, 2020). Thus, in this study, by revisiting personal journeys of EDs in school, individuals may be able to gain profound insights into their own ED stories, promoting individual healing and contributing to a broader understanding of EDs.

Reflection on a past ED as a recovered adult can bring with it wisdom, and knowledge gained from experience. Ardel (2003) recognises the multidimensional nature of wisdom, which encompasses cognitive, reflective, and affective components. Of particular relevance to this study is the reflective dimension; “a deeper understanding of life is only possible if one can perceive reality as it is without any major distortions” (Ardelt, 2003, p278). This involves engaging in reflexive thinking, considering various perspectives to enhance self-awareness and insight, and through this practice, subjectivity and projections diminish, and insight into the true nature of phenomena, including self-motivation, increases. Literature has shown that distorted thinking is a characteristic of EDs (e.g., Rawal, Park & Williams, 2010; Aspen, Darcy & Lock, 2010), and furthermore, EDs have been associated with a lack of insight, interoception, denial and an impaired self-awareness (Konstantakopoulos et al., 2011; Martin et al., 2019). Collectively, Eaton (2020, p373) refers to this as “tumbling down the rabbit hole” (a reference from Lewis Carroll’s (1865) *Alice in Wonderland*) where there is an “illusory barrier between an individuals’ previous world and the current eating disordered reality” (Eaton, 2020, p373). Whilst some may argue that reflecting on past experiences may bring with it cognitive biases (see Azzopardi, 2021) influencing valid recollection, especially when recalling emotional events (Kensinger & Ford, 2020), this researcher contends that reflecting on a past ED from a recovered, distinct and separated perspective, may offer a much more authentic reflection of the challenges associated with an ED at school, compared to reflection while still immersed in the “rabbit hole” of it. As such, there is a need for further research exploring the experience of adults reflecting on their time as students with EDs within educational settings. By gathering insights from adults who have navigated EDs during their school years, we can gain a deeper

understanding of the challenges they faced, the support they received (or lacked) and the impact of EDs on their academic performance, social interactions, and overall wellbeing.

Additionally, there is a need for a more comprehensive understanding of the roles of teachers and EPs in supporting students with EDs. By examining their knowledge, attitudes and practices related to EDs, as well as the challenges they encounter in providing support, we can identify areas for improvement for educational professionals to enhance their capacity to effectively support students with EDs. Overall, by addressing these gaps in research, we can work towards creating more inclusive and supportive environments for students with EDs in schools.

3.1 Research Questions

Based on the literature the aim of this research is:

To explore of the experiences of adults who had an eating disorder whilst in school and the role that teachers and Educational Psychologists may have in offering support.

This study seeks to answer the following three research questions (RQs):

RQ1) Do educational psychologists and teachers feel confident in supporting young people with eating disorders in terms of theory, interventions and early signs of identification?

RQ2) How was the experience of school influenced by having an eating disorder?

RQ3) What support could professionals in school settings offer children and young people who have an eating disorder whilst in school?

4.0 METHODOLOGY

4.1 Ontological and epistemological positionality

Ontology and epistemology are intrinsically connected to research practice, informing “what is ideal, what is permissible and what doesn’t make sense” (Braun and Clark, 2022a, p166).

Ontology refers to the philosophical study of the nature of being and existence (Guba & Lincoln, 1994). This research will adopt a critical realist ontology which assumes “the truth is out there, but it’s impossible to access truth directly”, as it is influenced by environmental factors such as language and culture (Braun & Clarke, 2022a, p169). This ontology offers a nuanced perspective that navigates between the poles of relativist and realist positions, acknowledging the existence of an external reality, whilst also appreciating the role of human interpretation and social processes in shaping our understanding of that reality (Moon & Blackman, 2014).

Related to ontology is epistemology, which relates to the study of knowledge and how it is created, acquired, and interpreted (Raelin, 2007). This research uses the approach of contextualism, which “views knowledge, and the human beings who created it, as contextually situated, partial and perspectival” (Braun & Clarke, 2022a, p178); it can be positioned between epistemologies of positivism and constructionism (Henwood & Pidgeon, 1994). Contextualism assumes that knowledge and understanding are context-dependent, shaped by specific circumstances, interactions, and environments in which they occur (Van Oers, 1998). By embracing contextualism, this research acknowledges the multifaceted nature of EDs in schools and seeks to explore how various contextual factors in school settings, influence individuals’ perceptions, experiences and behaviours. Therefore, this research hoped to uncover the nuanced and contextually bound meanings and interpretations surrounding EDs in schools (from adults reporting on their experiences), contributing to a richer understanding of this phenomenon within its broader socio-cultural context (namely the confidence of educational professionals in supporting EDs in schools).

4.2 Methodological and research adaptations

No plan survives contact with the enemy, and indeed this thesis has gone through many iterations due to difficulties with sampling, and findings from pilot studies along the way. Initially, this thesis was centred around the experiences of teachers who had an ED whilst teaching, and how teaching practice is influenced by having an ED. This was going to be explored using constructivist grounded research methodology, due to the novelty of the topic (Charmaz, 2006). Due to challenges with recruiting participants, it was decided that an alternative topic should be explored. Interestingly however, out of the 10 participants who volunteered for the present study (see participant information below), four individuals had worked as a teacher either in the past or at present.

4.3 Research design

The research was divided into 2 phases: Phase 1 explored RQ1 (Do EPs and teachers feel confident in supporting young people with EDs in terms of theory, interventions and early signs of identification?) and Phase 2 aimed to answer RQ2 and RQ3 (How was the experience of school influenced by having an ED? And what support could professionals in school settings offer CYP who have an ED whilst in school?). The pattern of qualitative and quantitative methods is shown in Table 1 below. It must be noted that Phase 1 collected both quantitative and qualitative data through online questionnaires, although only the quantitative data was analysed in this thesis, due to its relevance to RQ1.

Phase	RQ	Quantitative	Qualitative
PHASE 1	RQ1	YES	YES
PHASE 2	RQ2	NO	YES
	RQ3	NO	YES

Table 1: The pattern of quantitative and qualitative methods.

This research uses a cross-sectional design with qualitative and quantitative methods for data collection. Through meticulous reading and supervision, the researcher concluded that whilst sharing similarities with mixed and multi-methods research designs (Williams, 2007; Lindsay, 2015; Creswell & Plano Clark, 2011) the

current study does not fully meet the criterion. Some would also contend that a pragmatic epistemological approach should be adopted in this study, as quantitative and qualitative approaches are underpinned by different paradigms (the former aligning more an objectivist epistemology and the latter with a subjectivist epistemology; Creswell, 2014). The chosen epistemology and ontology is believed however to be the most suitable to establish some consistency and generalisability across the data, as well as implications of the study itself. In attempting to understand more about the experiences of having an ED in school, the focus will be on individual experiences, using a framework of contextualism, acknowledging the importance to consider wider perspectives of the phenomenon.

4.4 Recruitment and inclusion criteria

In Phase 1, online questionnaires were completed by EPs and trainee EPs (TEPs) distributed through Twitter, email, word-of-mouth and EP service contacts. Only EPs and TEPs working in Greater London were able to take part, and they had to be currently practicing. Online questionnaires were also sent to qualified teachers, again working in Greater London, distributed through Twitter, email, word-of-mouth and school contacts. There were no criteria about the type of school they were working at, meaning teachers from a range of settings would be able to take part. It was hoped that 50 responses from both teachers and EPs/TEPs would be received, based on a power analysis on similar studies alongside discussions in supervision about what would be feasible.

In Phase 2, information about the research was advertised on Facebook groups for EDs, Twitter and using posters (Appendix A). Also, some of the participants were recruited through snowball sampling, where at the end of the interview, participants were asked to pass on information about the study to other individuals who they knew had had an ED in school. Snowball sampling is often used in studies where the target population is difficult to access but may however introduce bias as participants are more likely to refer individuals who share similar experiences (Naderifar, Goli & Ghaljaie, 2017), and in this case, similar school experience, or even the same school.

Inclusion criteria to take part in the interviews in Phase 2 was to be over 18, to speak English and have had an ED whilst at school in the UK. To qualify as having had an ED, a formal (clinical) diagnosis was not required in order to take part, due to the extensive literature suggesting that many EDs go undiagnosed (e.g., Campbell & Peebles, 2014; Bryant et al., 2022). When considering inclusion criteria, the requirement to be 'recovered' from an ED was not included, as there is a line of reasoning that recovery from EDs is never full realised (for example, if it is related to underlying personality traits and that coping mechanisms evolve over time), and many individuals do not experience full recoveries from EDs (D'Abundo & Chally, 2004; Geller, Williams & Srikameswaran, 2001). The potential ethical concerns associated with not actively seeking out 'recovered individuals' for participation were carefully considered, particularly in relation to the possibility that adults who had experienced EDs during their school years may still be struggling with them. The recruitment strategy aimed to engage participants who felt emotionally ready to talk about their ED and experiences of school (Poyser, 2020) and this readiness was assessed through preliminary discussions by the researcher (in a short conversation), prior to the interview. The study recruitment did not specify the gender of participants, acknowledging that EDs affect individuals of all genders (e.g., Spratt et al., 2022). It was hoped that 10 participants would take part in the interviews, as it was discussed in supervision that this would be sufficient amount to reach data saturation; additionally, 10 participants are seen as suitable for a small research projects by Braun and Clarke (2022b).

4.5 Participants

Information regarding the participants involved in the current study is summarised in the tables 2 and 3:

Participant group Phase 1	Number of participants (n)	Years of experiences of qualified teachers and EPs * % to 1DP
Qualified teachers working in Greater London	78	36% (n28) - 0-5 years 26% (n20) - 6-11 years 23% (n18) - 12-17 years 6% (n5) – 18-23 years 9% (n7) – 23 years plus
EPs and TEPs working in Greater London	20 TEPs, 35 EPs	37% (n13) – 0-5 years 20% (n7)- 6 -11 years 6% (n2) – 12-17 years 14% (n5) – 18-23 years 23% (n8) – 23 years plus

Table 2: Participant information for Phase 1.

Participant group Phase 2	Number of participants (n)	Recruited from/by	Age of participants
Adults who experienced an ED whilst in school	10	20% (n2) – Twitter 20% (n2)– Facebook 30% (n3) –Poster 30% (n3) - Snowball	10% (n1)- 18-23 years 50% (n5) - 24- 29 years 30% (n3) - 30-35 years 10% (n1) - 36 years plus

Table 3: Participant information for Phase 2.

In this research, 70% of participants (n7) attended private schools. Two participants moved school (from private secondary to state college). Participants were given pseudo names in this research. Caroline, Julie and Suki attended private girls' schools; Bethan and Gemma attended private girls boarding schools; Maddie

and Trisha attended mixed private schools; and Charlotte, Dianne and Lesley attended mixed state schools.

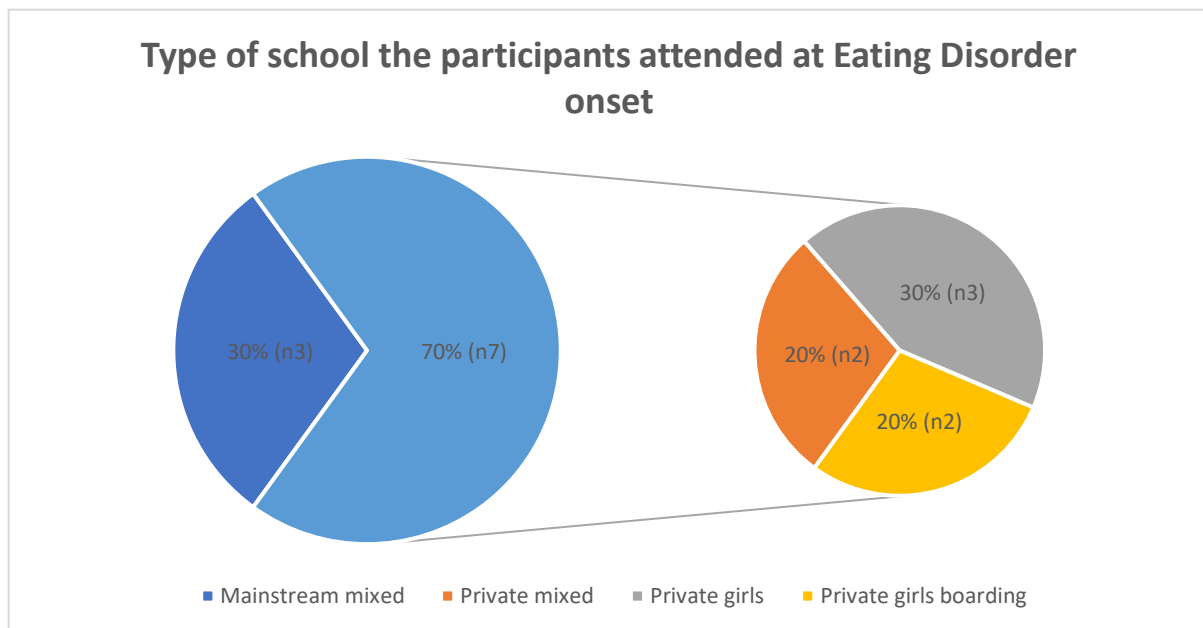


Figure 3: Type of school the participants attended at ED onset

4.6 Measures– questionnaires and interviews

The questions in the questionnaires for Phase 1 (Appendix B and C), were informed in part from the Eating Disorders Experience Survey used in the study by Knightsmith et al. (2014) but largely from BEAT's guide, 'helping a loved one recover from an eating disorder: a guide for families and carers'(n.d.). The questionnaires encompassed both closed-ended questions using Likert scales, and open-ended questions. An open-ended question asking about educational professionals' definitions of EDs was not included in analysis, as although it was interesting, it was not relevant to the RQs. The questionnaires were created in line with the stages outlined by Roopa and Rani (2012; see Figure 4).

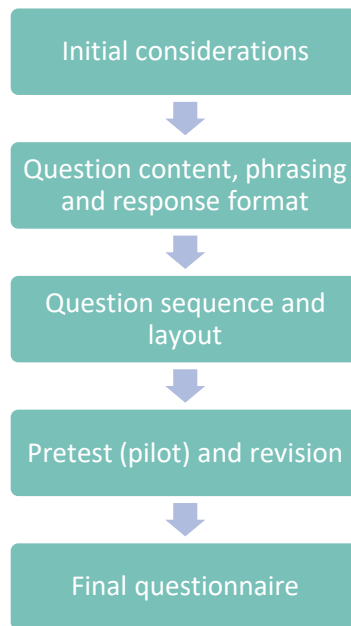


Figure 4: Stages of planning a questionnaire, taken from Roopa and Rani (2012)

In order to formulate the guide for the semi-structured interview (Appendix D), ideas from the literature review were drawn upon, notably in terms of risk and protective factors for EDs that may be present in the school environment, in addition to the potential role for educational professionals in offering support. The guide was shared with the researchers' supervisors, and a collective reflection was had on the questions considering the RQs, to assess both face and content validity. The semi-structured interview guide was created in line with the stages outlined by Kallio et al. (2016; see Figure 5).

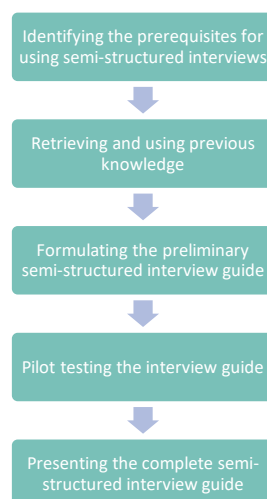


Figure 5: The interrelated phases of the development of a semi-structured interview guide, based on Kallio et al., (2016).

4.7 Pilots

Pilots were carried out for Phase 1 and Phase 2 to investigate whether the methods and measures used were appropriate, and to give early indications of any potential pitfalls in the research (Van Teijlingen & Hundley, 2001). Participants in these pilots were excluded from the final dataset due to subsequent changes in the content and criteria of the methods.

The two online questionnaires to educational professionals (Phase 1) were sent to close contacts of the researcher, involving two teachers, two TEPs and the researcher's two supervisors. The groups felt that the questionnaires contained items relevant to both teachers, and EPs, reflecting their understanding and knowledge of EDs in a school setting, but suggested several modifications including:

- The inclusion of an open-ended question where participants could describe what training they have received, and also about what direct work with a student with an ED entailed.
- Altering some of the phrasing of the questions, to focus on confidence rather than awareness.

Two pilot interviews (Phase 2) were conducted to make sure the interview questions were transparent and easy to answer (Baker, Edwards & Doidge, 2012). One participant in this pilot was known to the researcher prior to the study, and the second involved an individual unknown to the researcher, who had got in contact through a Facebook group. Modifications following the pilot study included:

- The inclusion of researcher's own disclosure of their experience of having an ED at school, aligning with Hesse-Biber (2007, p128) that "the idea of sharing identities and stories with one another is thought to increase reciprocity and rapport in the interview process", allowing participants to be more comfortable in sharing their own experiences.
- The inclusion of more specific prompts to elicit detailed responses regarding the impact of EDs on school experience, drawing on the four areas identified by EPs in statutory assessment.
- Limiting participants to the 18-25 age bracket was reconsidered, as insights into ED experience were deemed valuable across a broader age range.

- A pre-interview conversation was introduced to gauge participants' emotional readiness to discuss their ED experience. Interviews can offer catharsis, self-acknowledgement, a sense of purpose, self-awareness, empowerment, and healing (Hutchinson, Wilson & Wilson, 1994); the researcher concluded that it was important to prioritise that participants benefit from the interviews, beyond purely collecting data, acknowledging the potential therapeutic aspects of sharing experiences.

4.8 Procedure

Distinct and separate procedures were conducted for Phase 1 and 2 (Figure 6 and 7).

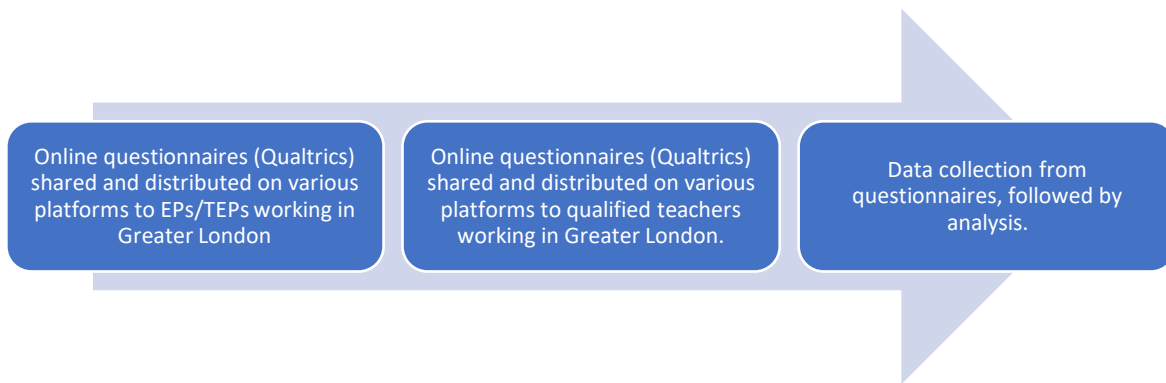


Figure 6: Procedure for Phase 1.

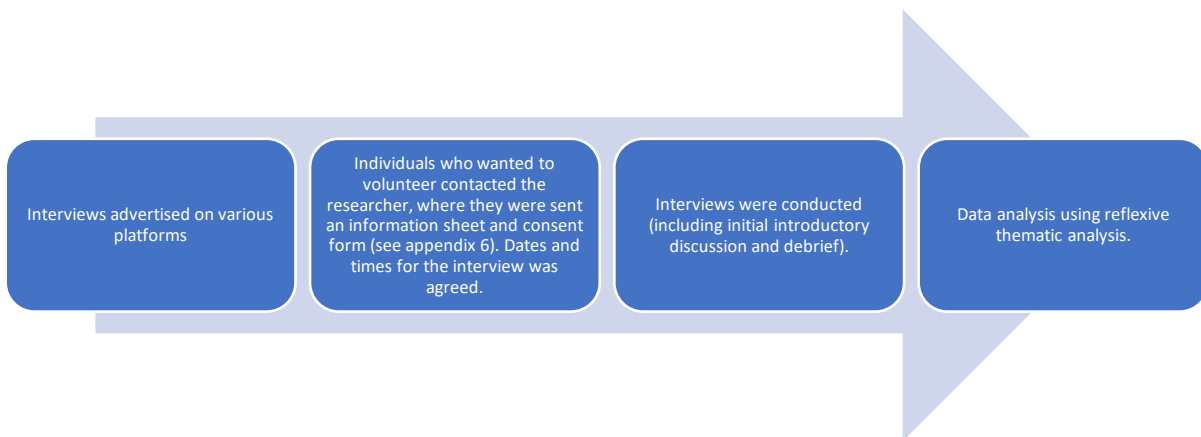


Figure 7: Procedure for Phase 2.

The questionnaires were completed anonymously using the Qualtrics online platform. They were live for approximately two months. Interviews, each lasting approximately for 45-60 minutes (including 15-minute introductory discussion and debrief) were carried out via ZOOM.

4.9 Data collection and analysis

Qualtrics was used to collect data in Phase 1, of which the quantitative data was then analyzed with descriptive statistics.

Reflexive thematic analysis (RTA; Braun & Clarke, 2006) was chosen to analyse the qualitative data in Phase 2. This method was chosen over narrative and phenomenological approaches due to its balance between structure and flexibility, in that it allows for the identification of overarching themes whilst still exploring the depth of individual experiences. RTA also incorporates and prioritises reflexivity into the analytical process (Nowell et al., 2017), which was crucial, due to the emotional investment and connection the researcher had to the research.

RTA is a theoretically versatile method for qualitative research, allowing for identification, analysis and interpretations of patterns or themes within the data. An inductive orientation to the data was taken, where coding and theme development were driven by the content of the data, and a semantic focus of meaning, where the analysis explored meaning at a more surface level (Braun & Clarke, 2022a). The analysis process involved several iterative stages (Braun & Clarke, 2006), the process of which was followed in this analysis. Each stage is briefly outlined, with explanations to illustrate how the present study addressed each step:

1. Familiarisation with the data: Braun & Clarke (2022a, p43) describe how this step “involves both closeness and familiarity (immersion) and distance (critical reflection)”. After completing all 10 interviews, each interview was listened to multiple times and then transcribed the audio-recordings verbatim, again reading over each transcript several times. The researcher’s thoughts, ideas and emotions were documented as journal entries.
2. Generating initial codes: Codes were generated and then refined with a semantic focus, over three occasions of reading all the transcripts. NVivo was used in this research to organise data and categorise codes. The researcher kept the RQs central, as any item of data that may have been useful in addressing the RQ, required coding. Through the iterations of coding, and the

amount of codes that were produced, the researcher engaged in collapsing the codes, in order to make the data more manageable (Byrne, 2022).

3. Searching for themes: All condensed codes were recorded on paper and read multiple times over. The researcher then used post-it notes to display all the codes visually, to help group them together in a more efficient way.
4. Reviewing themes: The researcher reflected on the initial themes and whether they addressed the RQs and represented meaningful interpretations of the data. A thematic map was useful in this step for helping to show how the themes and subthemes related to one another. Themes were also reviewed with the researcher's supervisors to see if they best encapsulated the data.
5. Defining themes: Byrne (2022) highlighted a potential overlap between stages five and six in the analysis process. As such, the themes and subthemes were revisited and revised, to ensure that they accurately expressed the dataset and RQs, exploring data through surface-level illustrative presentation.
6. Write-up: Thematic maps helped guide the how the thematic analysis was presented. Emphasis was placed on integrating diverse perspectives within each theme, and quotes from the transcripts that were most relevant and informative to the RQs were included.

4.10 Ethical considerations

Ethical approval was obtained by the UCL IOE Research Ethics Committee and the Data Protection Office assigned the data protection number Z6364106/2023/03/97. An amendment request form was completed (on 19/10/23) following the change in research title and focus. Individual ethical considerations were considered in Table 4 below.

Ethical consideration	Explanation	
	Phase 1	Phase 2
Confidentiality and anonymity	<ul style="list-style-type: none"> - Participation was voluntary - all participants were over 18 years old. - No personal information was be collected (name, age, gender). 	<ul style="list-style-type: none"> - Participation was voluntary– all participants were over 18 years old. - Participants were informed that their data would be anonymised upon transcription, with pseudonyms being used to identify participants. - Data was stored on a secure, password and fingerprint protected laptop, in an encrypted format. - Audio recordings were deleted once transcribed.
Informed Consent	<ul style="list-style-type: none"> - The questionnaires for teachers and EPs/TEPs featured an introductory box, outlining the research and stating that by completing the questionnaire, consent will be assumed for the use of the participants' anonymous data to be used for analysis 	<ul style="list-style-type: none"> - Consent forms and information sheets about the research (Appendix E), were emailed to the participants, after they expressed an interest in taking part in the study. The information sheet contained all the necessary information about the research to allow participants to make an informed decision on whether to take part or not. If they signed the consent form, it was assumed that the participants understood their rights and chose to participate on their own volition. - At the start of the interview, additional verbal consent was also asked for, with the researcher reiterating what the study would involve and what they were consenting to.
Right to withdraw	<ul style="list-style-type: none"> - Participants could exit the questionnaire at any point, and their data would not be saved. 	<ul style="list-style-type: none"> - It was emphasised at the start of the interview that participants could withdraw their consent and data at any time (up unto the point their data was transcribed and anonymised), did not have to discuss specific questions/topics if they did not want to in the interview, and could leave the interview at any point if they chose to. - It was highlighted that audio recording could be stopped at any time. - If participants were observed appearing in discomfort or distress, they would have been reminded of their right to withdraw from the study, without judgement or pressure; additionally, the researcher would have made the professional judgement of

		<p>whether to terminate the interview, if it appeared that the participant had become significantly distressed, but still chosen to continue with the interview.</p>
Participant well-being	<ul style="list-style-type: none"> - As EDs could potentially be a sensitive subject for certain participants, a short description of the questionnaire was provided in the introductory box. Individuals could leave the questionnaire if they felt uncomfortable answering questions on the topic. 	<ul style="list-style-type: none"> - Beyond 'do no harm', it was hoped that the interviews could be a positive experience for the participants. - As the interviews were semi-structured the researcher was able to empathetically reply to participants in an organic way (McIntosh & Morse, 2015). - Signposting services were outlined on the information form and at the start of the interview, and it was emphasised that if participants found any of the topics covered triggering, they should consolidate the signposting services. - Introductory conversations with the participants were had, with the researcher assessing whether they were emotionally ready to reflect on their experiences of having an ED in school, in a way that was not triggering or caused them unnecessary psychological distress. - Interviews were conducted online, providing participants the flexibility to choose a location where they felt comfortable discussing their experiences.
Debriefing	<ul style="list-style-type: none"> - At the end of the questionnaire, participants were thanked for their involvement and the researchers' contact information was available, should those who completed the questionnaire wish to reach out for any reason. 	<ul style="list-style-type: none"> - At the end of the semi-structured interview, there was a debrief about how participants found the interview, where they had the opportunity to ask and questions or further discuss any areas of the interview. - Links to sign-posting services were made available in the debrief, in addition to giving thanks for participants' involvement, and sharing the researcher's contact information in case they wanted to reach out. - Participants had the option to be sent their audio recording or transcription of the interview.

Dissemination	<ul style="list-style-type: none">- It is hoped that the findings will be reported in an academic research article.- There will not be any identifiable information included about the participants in the report.- Participants' identities will be protected with a pseudonym. Before uploading the transcript, any text which links to the participant's identity will be redacted.
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Table 4: Ethical considerations

4.11 Trustworthiness, validity and reliability

Roopa and Rani's (2012) guidelines were held in mind and adhered to in Phase 1 for this research, to enhance the validity and reliability of the data gathered (see Table 5).

Planning stage	Evidence of consideration
Initial considerations	<ul style="list-style-type: none"> - The comprehensive approach to questionnaire development aimed to capture a range of relevant perspectives related to EDs, thereby enriching the depth and breadth of data collected. - Face and content validity of questionnaires was explored in the pilot study; this was crucial, given the novelty of the questionnaire. This ensured that the questions were clear, relevant and comprehensible to participants, thereby enhancing the overall validity of the instrument. - Questionnaires were sent to educational professionals specifically working in Greater London. This selection aimed to ensure that the sample encompassed a broad spectrum of school settings, thereby enriching the validity and generalisability of the findings to similar urban contexts.
Question content, phrasing and response format	<ul style="list-style-type: none"> - Questions were easily understood, unambiguous and concrete. This enhanced the validity of the data collected by minimising the likelihood of misinterpretation and also, contributes to the reliability of the research by promoting consistency in respondents' understanding and interpretation of the questions. - Both open-ended and closed questions were used, allowing for a comprehensive understanding of participants' perspectives. Open questions allowed for nuanced responses, whereas closed questions allowed for structured responses that could be analysed quantitatively, enhancing the reliability of findings through standard data collection.
Question sequence and layout	<ul style="list-style-type: none"> - Qualtrics offered an intelligibility score and allowed the researcher to preview how the questionnaire would appear on a mobile device. - The refinement of the sequence of questions and their layout underwent a thorough review process, including pilot testing and discussion in supervision. This iterative approach not only ensured the coherence and flow of the questionnaire, but also provided insights into supporting participant engagement and optimising data collection strategies.
Pretest (pilot) and revision	<ul style="list-style-type: none"> - The two online questionnaires (for EPs and teachers) were sent to close contacts of the researcher, to enhance the validity and reliability of the questionnaire. By involving individuals who have direct experience in educational psychology and teaching, this pilot ensured that the feedback was

	grounded in real-world insights and perspectives. Feedback provided valuable insights that facilitated several changes to the questionnaire.
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Table 5: Validity and reliability of the questionnaires in Phase 1

Although qualitative research is the most suitable approach for investigating perspectives and experiences, certain criteria must be fulfilled to ensure that the research remains high quality (Yardley 2000; Yardley & Smith, 2008). This is outlined in Table 6.

Principle	Evidence of consideration
Sensitivity to context	<ul style="list-style-type: none"> - At the start of the interview, the researcher shared their own ED story, seeking to allow the participant to feel more comfortable in sharing their own ED experiences. - Interviews took place online, where participants were able to choose the location of the interview. It was important that interviews occurred in a private and comfortable place for participants, to help them feel at ease and contribute to more authentic responses. - Flexible scheduling options and clear communication about time commitments of the interview, demonstrated sensitivity to participant's time constraints. - The researcher ensured in interviews that they were attuned to the emotional needs of the participants, especially as reflecting on one's own ED, can be a sensitive topic. Participants were given opportunities to take breaks, express their feelings or seek support from signposting services if needed.
Commitment to rigour	<ul style="list-style-type: none"> - The researcher continually engaged in reflexivity by critically examining their own biases, assumptions and beliefs throughout the research process. This promoted transparency and self-awareness, but also ensured the analysis and interpretation of the data was compelling and thoughtful. Supervision and a research journal helped facilitate the researcher's reflections throughout the research. - The framework by Kallio et al., (2016) was used to guide the creation of the semi-structured interview guide, which helped to ensure consistency, clarity and relevance in the interview process, ultimately strengthening the quality of the research. - Qualitative data analysis for Phase 2, was conducted using Braun and Clarke's (2006) approach to RTA. This methodological rigour involved a step-by-step process of data coding, theme identification and interpretation, and was guided by principles of consistency and reflexivity. By adhering to this framework, the reliability of qualitative findings was enhanced, as it provided a systematic and transparent approach to analysing complex and nuanced data.

<p>Transparency and coherence</p>	<ul style="list-style-type: none"> - Methodological transparency was observed, with the researcher outlining methods, including data collection procedures, sampling techniques and information on data analysis. - The researcher's ontological and epistemological positions were deeply considered, and how this would influence the methods and thematic approaches used in the study. - Braun and Clarke's (2006) step-by-step guide to RTA was followed. This approach provided a systematic and transparent process for analysing qualitative data, ensuring coherence and reliability in the interpretation of findings.
<p>Impact and importance</p>	<ul style="list-style-type: none"> - The research aimed to provide an understanding of how EDs intersect with the school environment. By doing so it sought to improve strategies for supporting students with EDs, create a more inclusive and supportive educational setting. - A review of the literature helped identify gaps in current research, notably the lack of research on adults reflecting on their own experience of having an ED in school, and the need for research to access this voice.

Table 6: validity and reliability of the qualitative data collected in Phase 2

4.12 Reflexivity

Reflexivity plays a crucial role in research, not only in relation to RTA, but by encouraging the researcher to critically examine their own assumptions, expectations, choices and actions throughout the research process (Finlay & Gough, 2003). This self-awareness enables researchers to navigate complex ethical and methodological challenges, ensuring transparency and integrity in their research practices. Additionally, it is important to note that in RTA, researcher subjectivity should be treated as a tool for doing analysis, rather than dismissed or avoided (Gough & Madill, 2012); as Braun and Clarke (2021a) highlight, subjectivity is something valuable rather than problematic in RTA. Furthermore, contextualism underscores the necessity for reflexivity on the part of the researcher (Madill, Jordan & Shirley, 2000). This involves a critical examination of the researcher's role in shaping the research process and bringing to light the contextual factors that influence how the data is produced (Braun & Clarke, 2022a).

As the researcher is at the heart of the research with qualitative data (Miles & Huberman, 1994), throughout the research process, deliberate effort was made to

reflect on how factors such as the researcher's background and life experiences, may influence the analysis. Reflections from the researcher have been incorporated into 'reflection boxes' which are written in the first person to emphasise the researcher's active involvement in the research, which is echoed by Pellegrini (2009, p272), who stated "a direct consequence of self-reflexivity is the use of the first person to discuss the author's 'embedded' role in the case study, not as an 'objective' outsider but as a practitioner affecting, and being affected by, the system". Additionally, the researcher's personal experience in the research topic offered insights into the participants' language, thoughts, feelings and the significance they attributed to certain topics or situations (Holloway & Biley, 2011).

The researcher's declaration of having a lived experience of an ED at school, underscores a commitment to understanding and addressing the challenges faced by students who have EDs in educational settings. Throughout the analysis, vigilance was maintained regarding potential biases stemming from personal experiences, that may have influenced the interpretation of the data. Instances arose where the researcher's personal experiences strongly resonated with those of the participants, potentially biasing interpretation towards themes that aligned with the researcher's own journey. When such connections emerged, deliberate efforts were made to seek alternative perspectives and evidence, counter to the researcher's personal experiences, thus challenging preconceptions and ensuring consideration of the diversity of participant experiences. A reflexive approach to this research was adopted, involving continual interrogation of the researcher's assumptions, receipt of feedback from colleagues and supervisors, and engagement in personal reflection. Reflective insights have been documented throughout the research, facilitating tracking of self-awareness and engagement with subjectivity. This transparency enhances the rigour and trustworthiness of findings, by acknowledging the potential influence of personal experience on the research process.

5.0 RESULTS

5.1 Overview of quantitative data

This section presents the findings from Phase 1 of the research, where educational professionals (teachers and EPs) completed an online questionnaire. The analysis uses descriptive statistics to address RQ1: Do EPs and teachers feel confident in supporting young people with EDs in terms of theory, interventions and early signs of identification?

5.1.1 Responses from EPs²

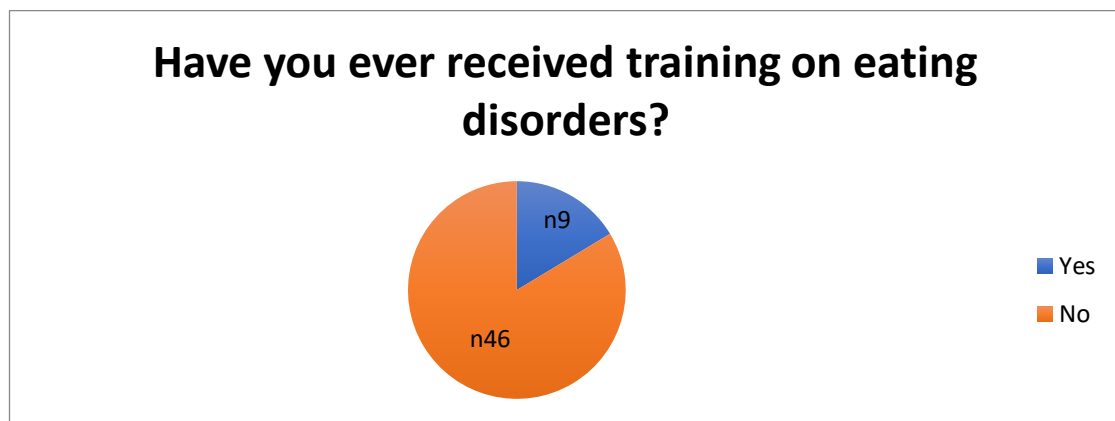


Figure 8: The number of EPs who had received training on EDs.

84% (n46) of EPs reported having not received training on EDs, whereas 16% (n9) of EPs had. The training that EPs had had, included EDs being discussed in wider general training on MH issues, MH first aiding and training as part of an undergraduate degree.

² Note that 'EPs' include both TEPs and EPs in this section.

Have you ever had direct experience of working with individuals with eating disorders?



Figure 9: The number of EPs who had direct experience of working with individuals with EDs.

51% (n28) of EPs had direct experience of working with individuals with EDs, whereas 49%(n27)had not. Of the EPs that had had direct experience, it was largely in the remit of statutory, traded and consultation work, although included giving psychoeducation to CYP and supporting transitions back into school. EPs recounted specific examples of working with students with AN, BN, Prader-Willi, avoidant/restrictive food intake (AFRID) and autism. EPs also reported about direct work with individuals with EDs in previous roles, including teaching and working in

Reflection: I found it interesting that EPs stepped back to consider the inclusion of EDs in their undergraduate training. I also reflected on how EPs may consider EDs, when they relate it to specific diagnoses like Prada-Willi or Autism, and how this may differ from EDs that exist distinctly. The importance of supporting students with the transitions back to school (e.g., from hospital) with an ED, has come up a lot in the research although the precise EP role in this was not fully clear. In future work, it may be useful to explore how EPs supported these students in more depth.

MH services.

The following graphs summarise the responses to the Likert Scale, within the questionnaire. Participants were asked how much they agreed with 11 statements (S), on a scale of 1-5 (1 = Strongly Disagree, 2 = Disagree, 3 = Neither Agree Nor Disagree, 4 = Agree, and 5 = Strongly Agree).

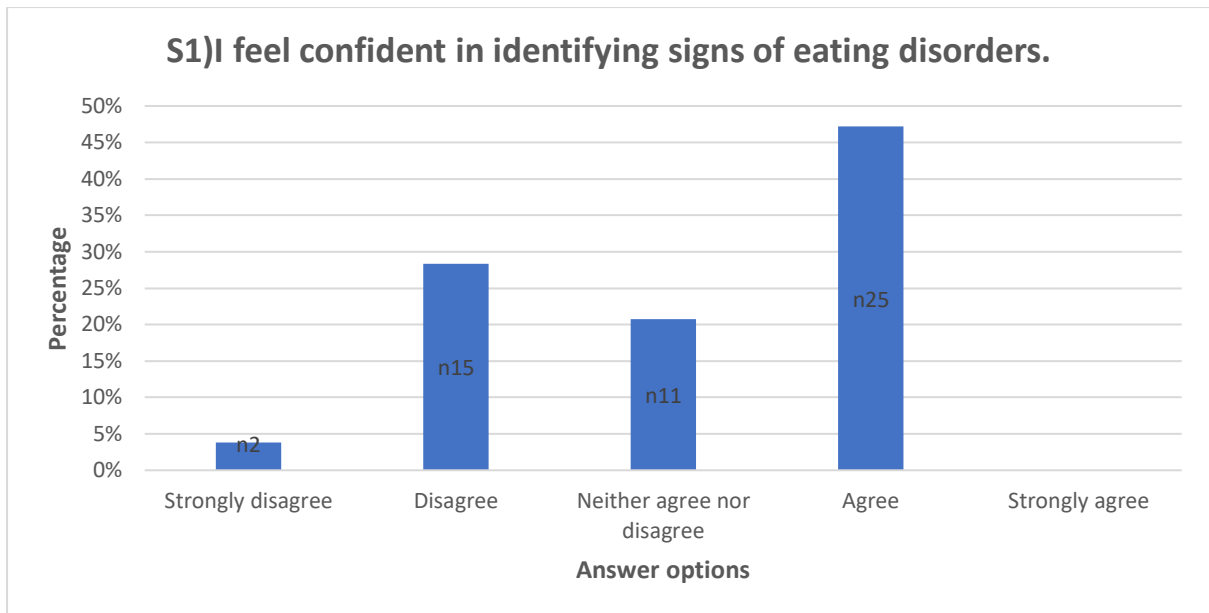


Figure 10: EPs' responses to S1, 'I feel confident in identifying signs of eating disorders'.

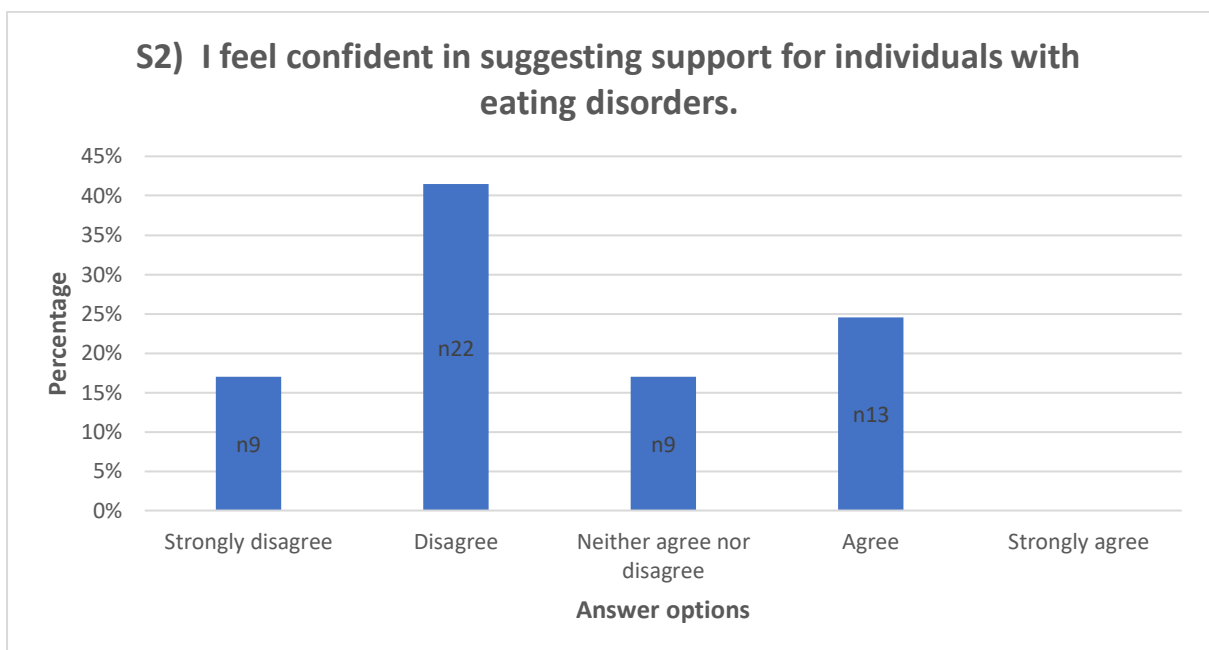


Figure 11: EPs' responses to S2, 'I feel confident in suggesting support for individuals with eating disorders'.

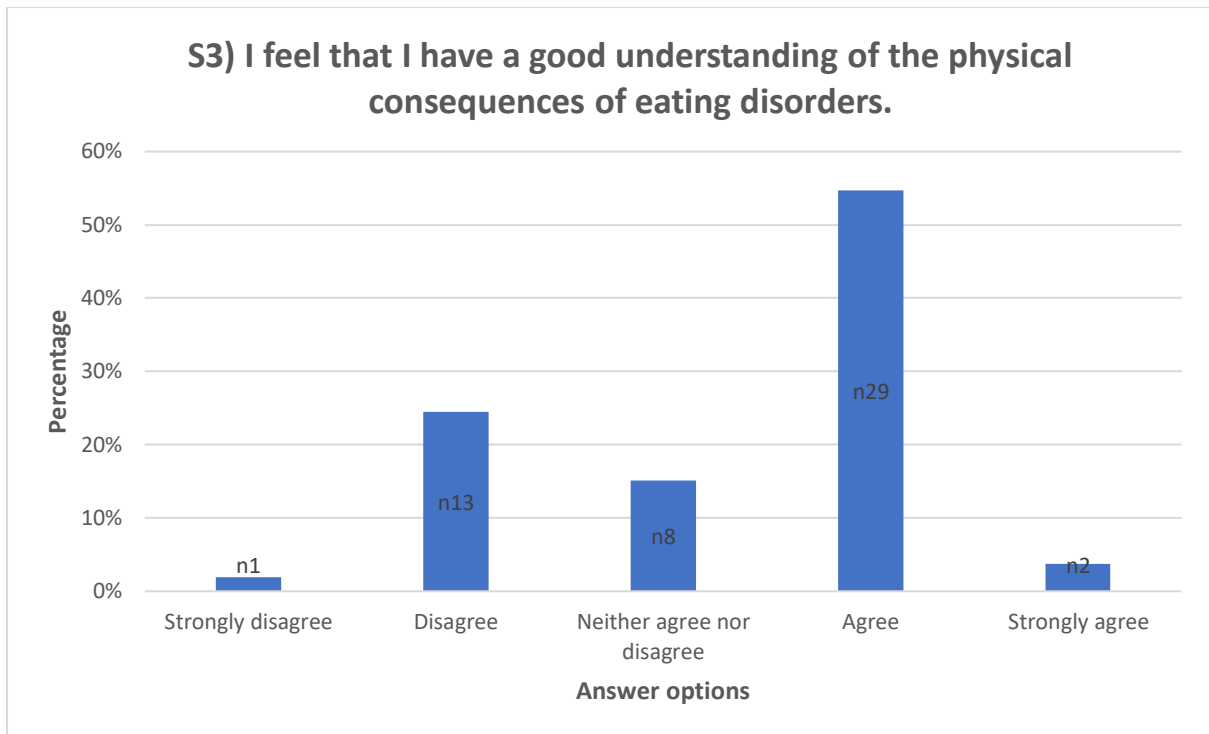


Figure 12: EPs' responses to S3, 'I feel that I have a good understanding of the physical consequences of eating disorders'.

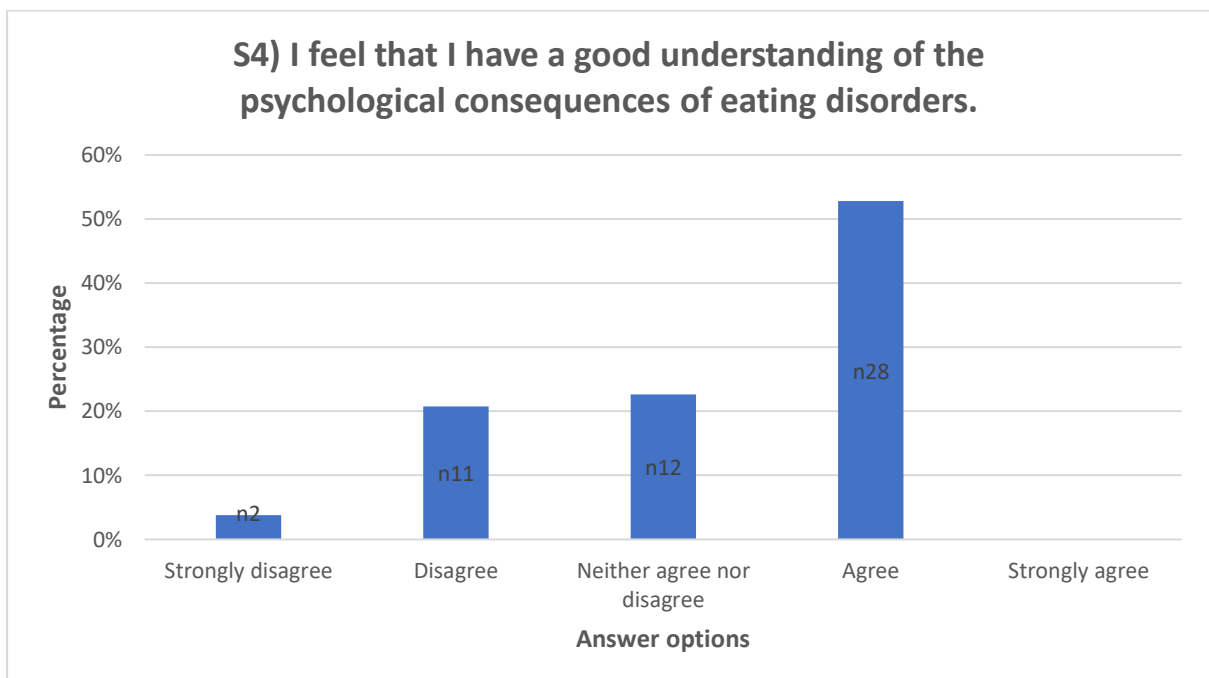


Figure 13: EPs' responses to S4, 'I feel that I have a good understanding of the psychological consequences of eating disorders'.

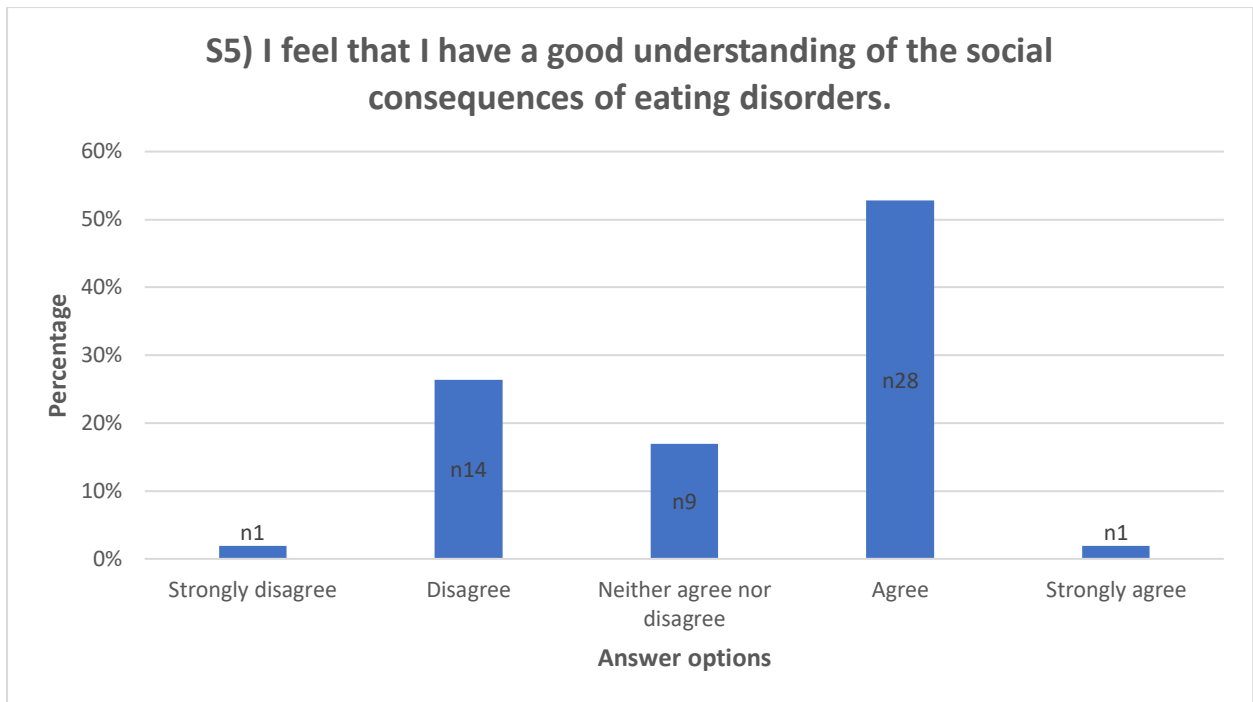


Figure 14: EPs' responses to S5, 'I feel that I have a good understanding of the social consequences of eating disorders'.

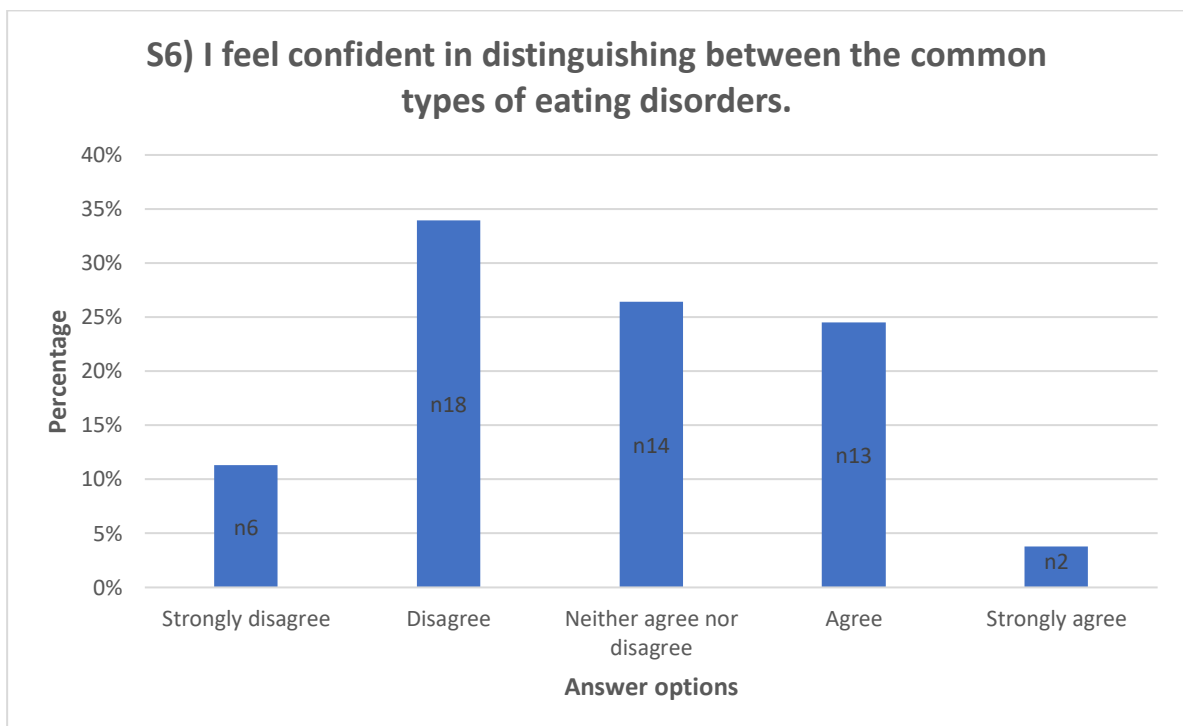


Figure 15: EPs' responses to S6, 'I feel confident in distinguishing between the common types of eating disorders'.

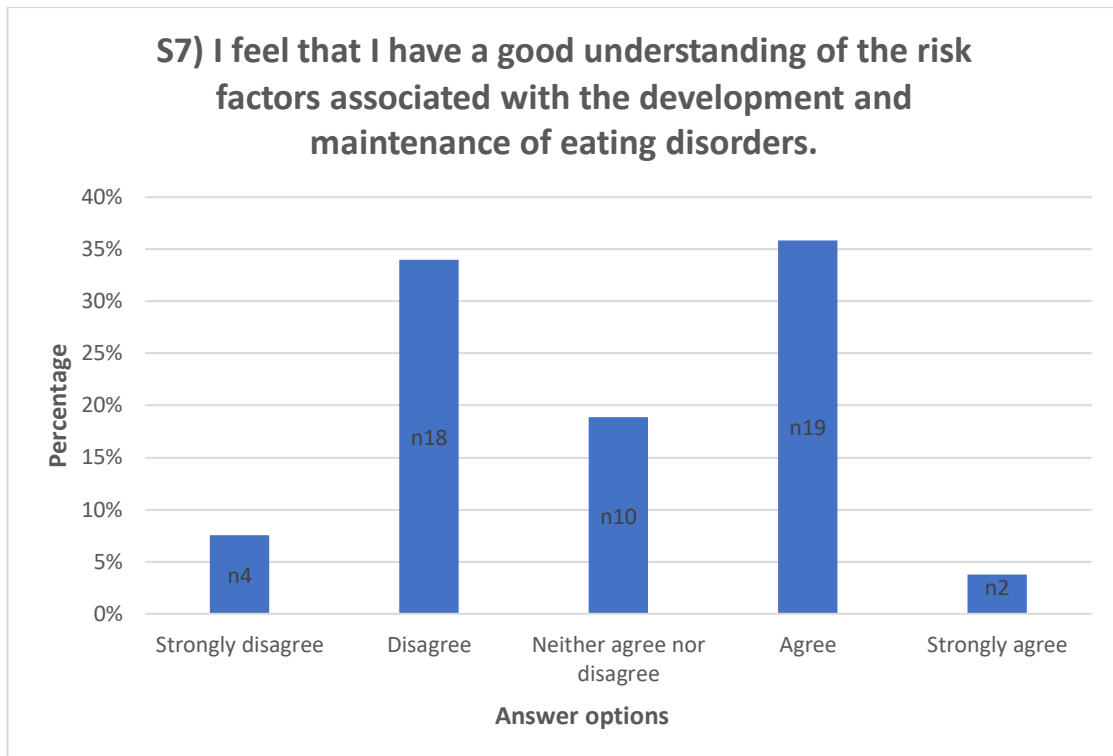


Figure 16: EPs' responses to S7, 'I feel that I have a good understanding of the risk factors associated with the development and maintenance of eating disorders'.

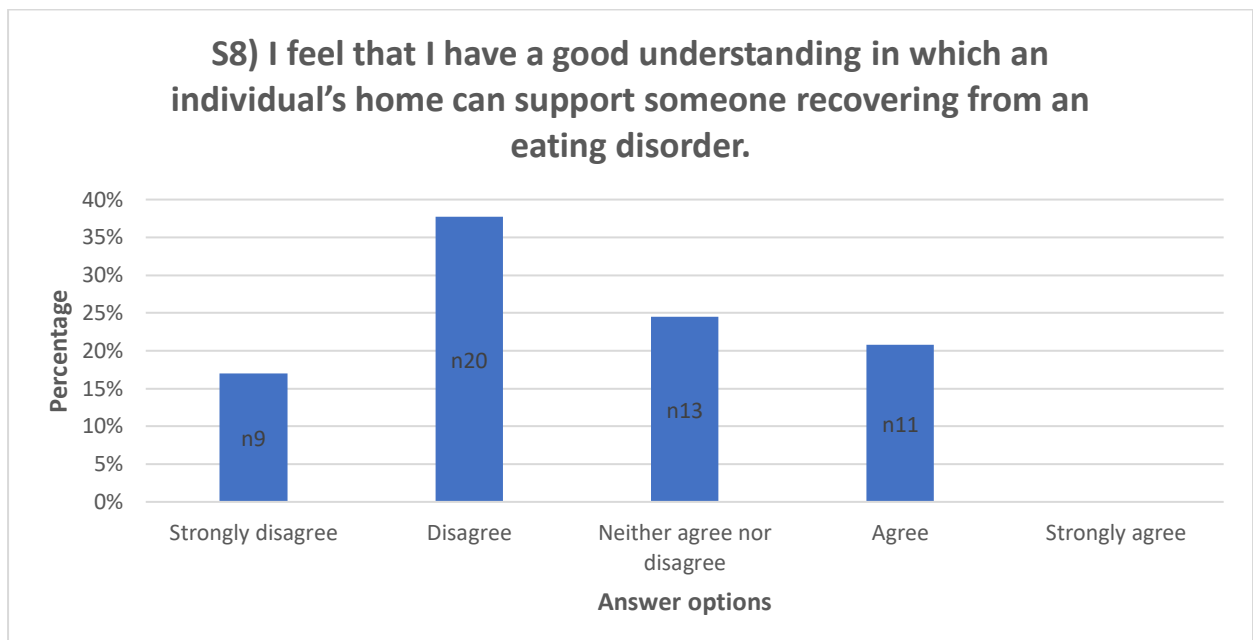


Figure 17: EPs' responses to S8, 'I feel that I have a good understanding in which an individual's home can support someone recovering from an eating disorder'.

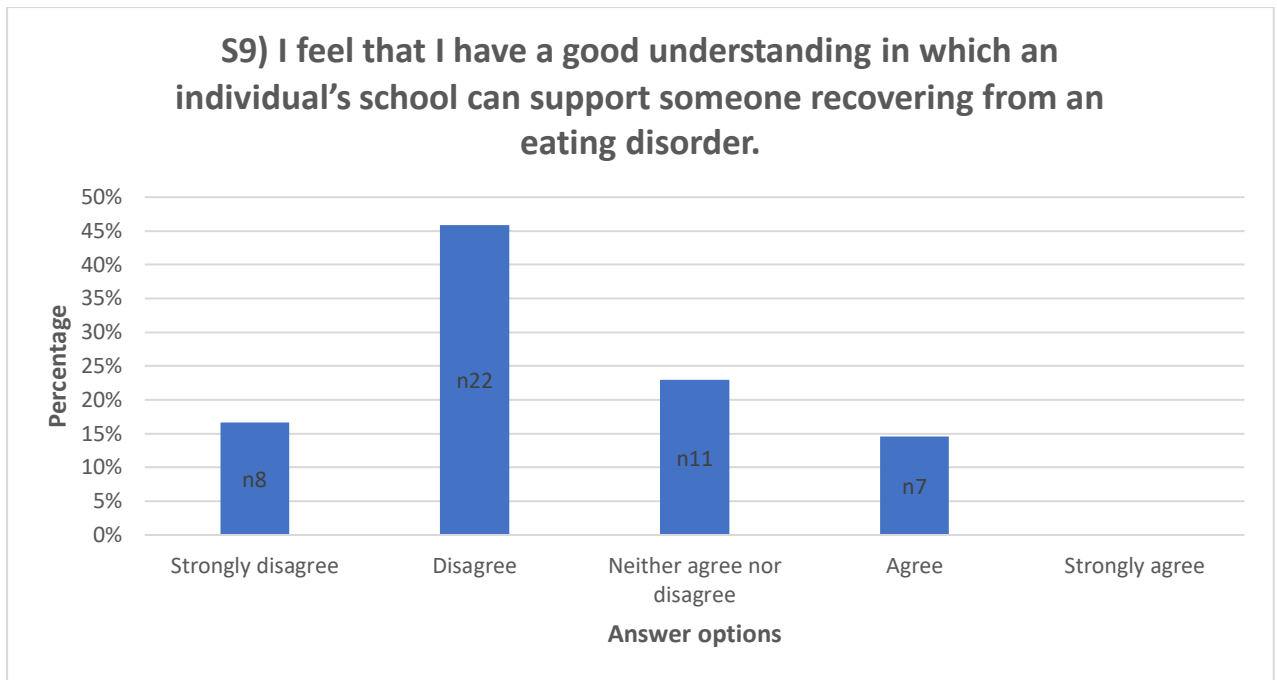


Figure 18: EPs' responses to S9, 'I feel that I have a good understanding in which an individual's school can support someone recovering from an eating disorder'.

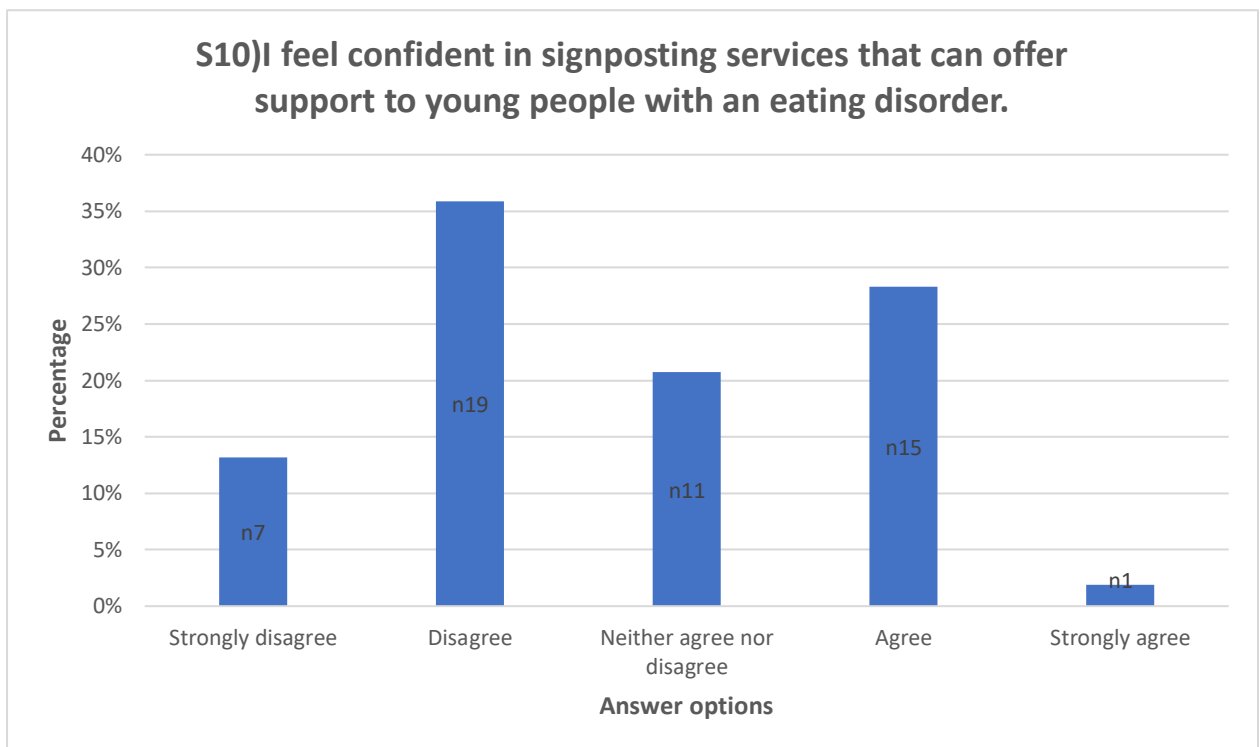


Figure 19: EPs' responses to S10, 'I feel confident in signposting services that can offer support to young people with an eating disorder'.

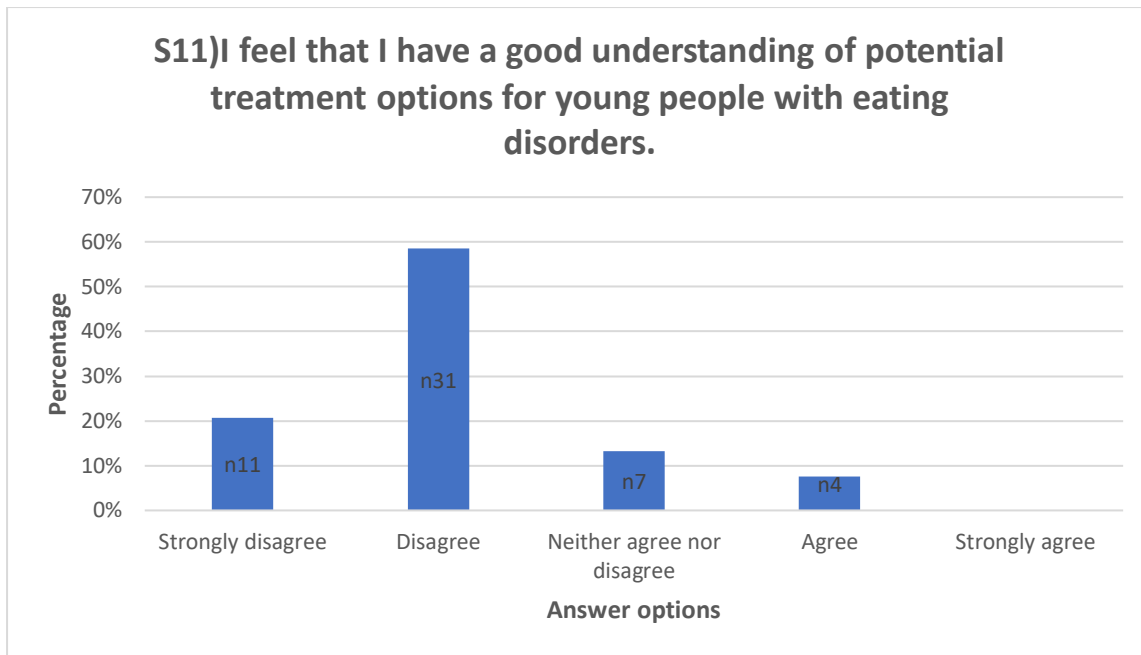


Figure 20: EPs' responses to S11, 'I feel confident in signposting services that can offer support to young people with an eating disorder'.

Key findings: EPs' confidence in supporting young people with EDs in terms of theory, interventions and early signs of identification, as revealed from Likert Scales. ** 2DP and Likert >3, so a response of 4 or 5 assume confident (agree or strongly agree with statement).

1. 47% (n25) of EPs feel confident in identifying signs of eating disorders
2. 25% (n13) of EPs feel confident in suggesting support for individuals with eating disorders.
3. 59% (n31) of EPs feel they have a good understanding of the physical consequences of eating disorders.
4. 53% (n28) of EPs feel they have a good understanding of the psychological consequences of eating disorders.
5. 55%(n29) of EPs feel they have a good understanding of the social consequences of eating disorders.
6. 29% (n15) of EPs feel confident in distinguishing between the common types of eating disorders.
7. 40% (n21) of EPs feel they have a good understanding of the risk factors associated with the development and maintenance of eating disorders.
8. 21% (n11) of EPs feel they have a good understanding in which an individual's home can support someone recovering from an eating disorder
9. 15% (n7) of EPs feel they have a good understanding in which an individual's school can support someone recovering from an eating disorder.
10. 30% (n16) of EPs feel confident in signposting services that can offer support to young people with an eating disorder.
11. 8% (n4) of EPs feel they have a good understanding of potential treatment options for young people with eating disorders.

Figure 21: Key findings from EPs' responses in questionnaire.

Reflection: I was shocked but honestly not surprised with the low confidence reported by EPs in supporting CYP with ED. I found it quite alarming that only 15% of EPs had a good understanding of how an individual's school may support them with recovering from an ED. Again, as this is closed questioning, I was not able to explore things like in what ways do EPs feel they have a good understanding of the psychological consequences of EDs, as it would be interesting to see how they conceptualise these consequences for example (and whether this reflects the literature and lived experiences of participants in this study).

5.1.2. Responses from teachers



Figure 22: Number of teachers who had received training on EDs.

90% (n70) of teachers reported having not received training on EDs, whereas 10% (n8) of teachers had. The training that teachers had received on EDs, was included as part of teacher training, MH first aiding, and self-led training.

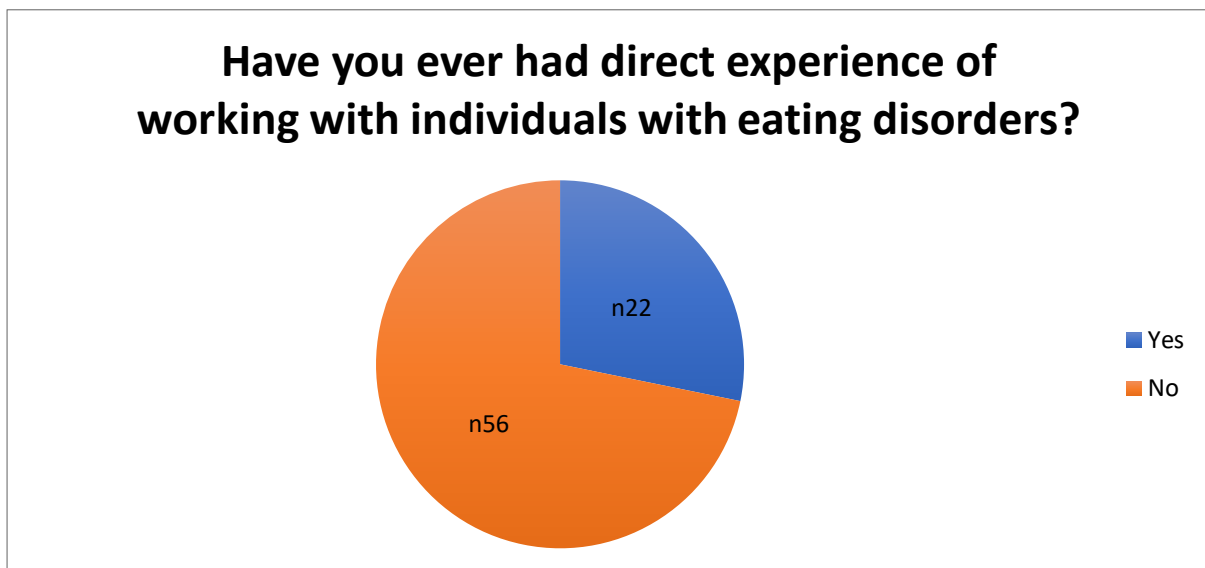


Figure 23: Number of teachers who had direct experience of working with individuals with EDs.

28% (n22) of teachers had direct experience of working with CYP with EDs, whereas 72% (n56) had not. Of the teachers that had had direct experiences, it

included noticing and monitoring symptoms of ED, liaising with CAMHs and healthcare professionals, direct work with CYP with AFRID and dysphagia, and CYP who were restricting their eating. Additionally, teachers reported direct work in supporting staff members and friends/family members with EDs.

Reflection: I was again surprised but not shocked, by the number of teachers who had had training on EDs. I did however expect for there to be a higher percentage of teachers who had direct experience working with students with EDs – I reflected in supervision about whether this may be due to EDs going undetected by school staff (so they may be working with these students but not aware). Additionally, it would have been interesting to know what types of settings the staff were in, who reported working with students with ED (and say if there was a pattern in the type of setting).

The following graphs summarise the responses to the Likert Scale, within the questionnaire. Participants were asked how much they agreed with 11 statements (S), on a scale of 1-5 (1 = Strongly Disagree, 2 = Disagree, 3 = Neither Agree Nor Disagree, 4 = Agree, and 5 = Strongly Agree).

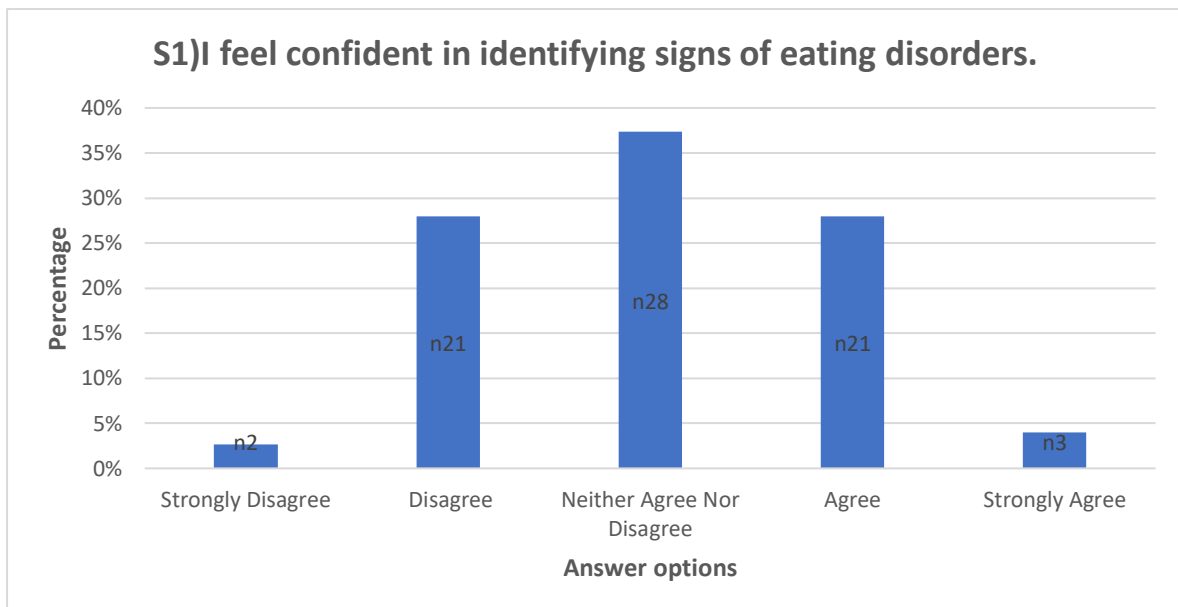


Figure 24: Teachers' responses to S1, 'I feel confident in identifying signs of eating disorders'.

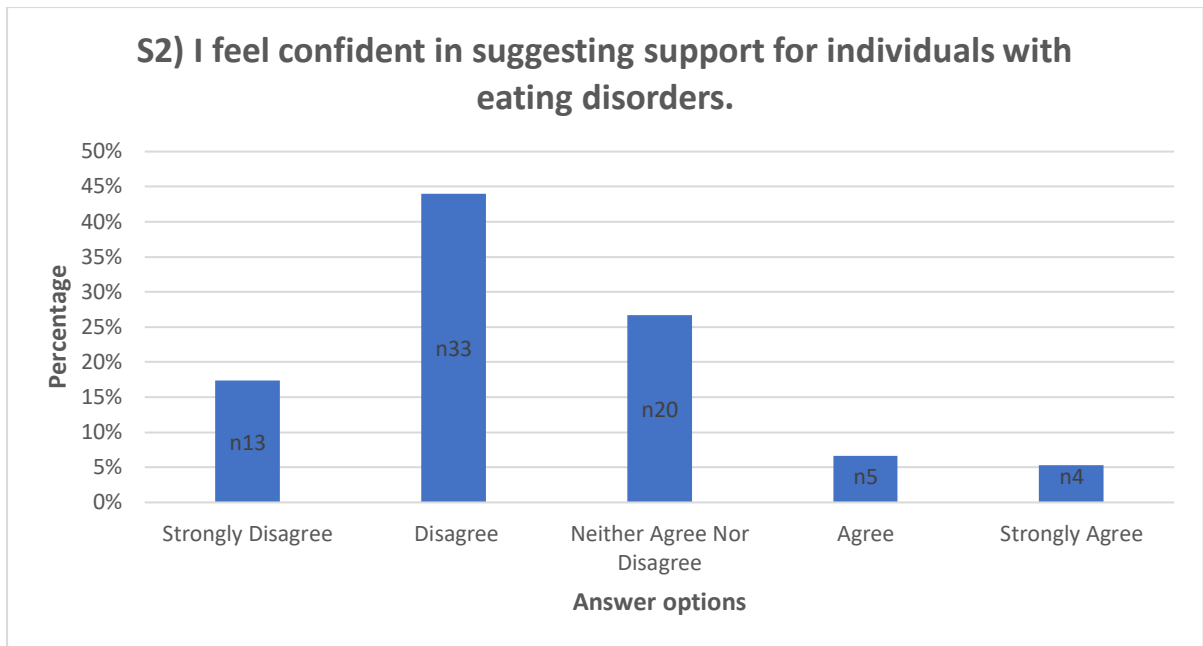


Figure 25: Teachers' responses to S2, 'I feel confident in suggesting support for individuals with eating disorders'.

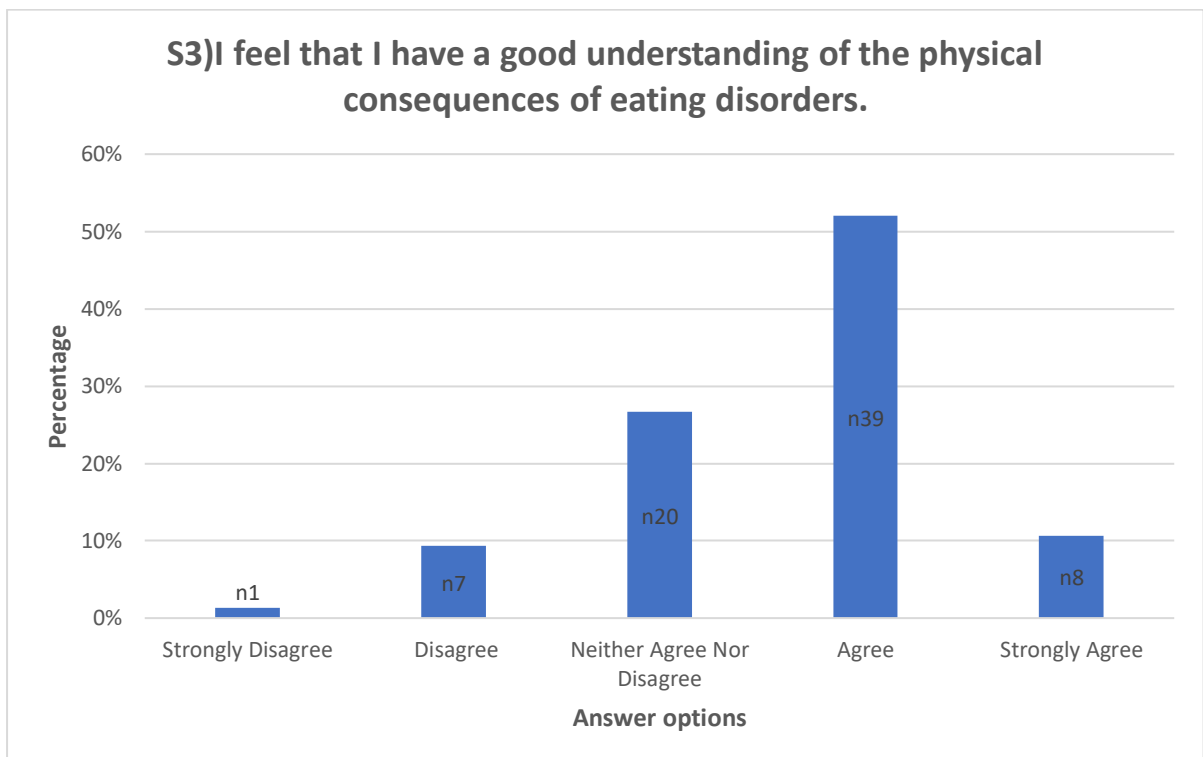


Figure 26: Teachers' responses to S3, 'I feel that I have a good understanding of the physical consequences of eating disorders'.

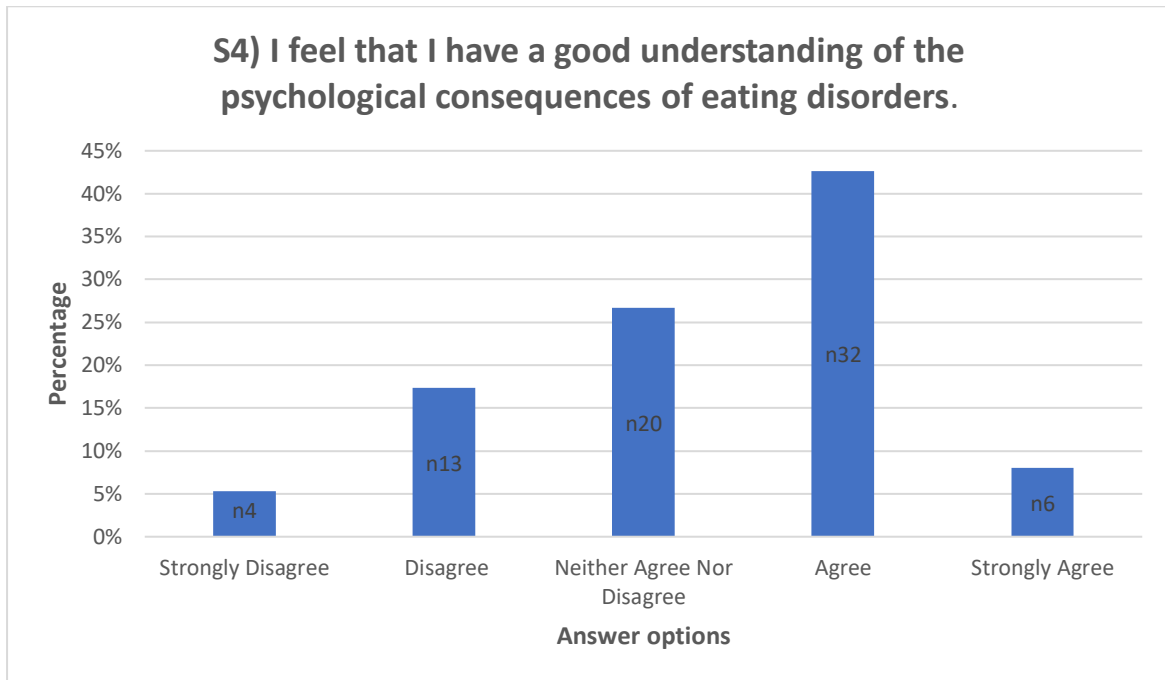


Figure 27: Teachers' responses to S4, 'I feel that I have a good understanding of the psychological consequences of eating disorders'.

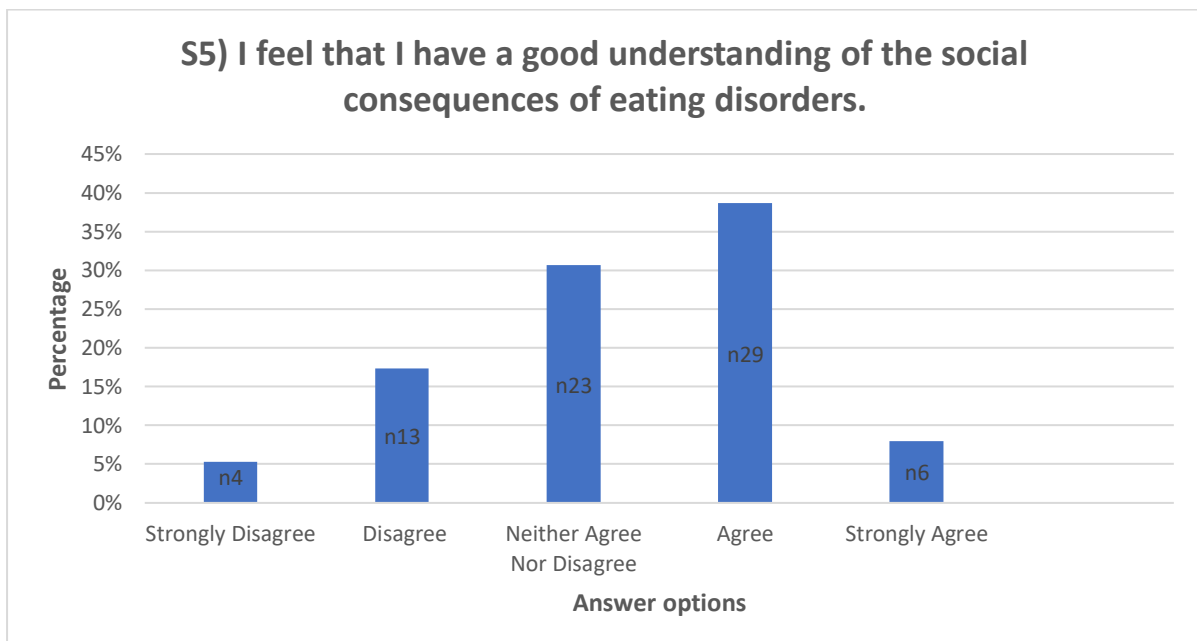


Figure 28: Teachers' responses to S5, 'I feel that I have a good understanding of the social consequences of eating disorders'.

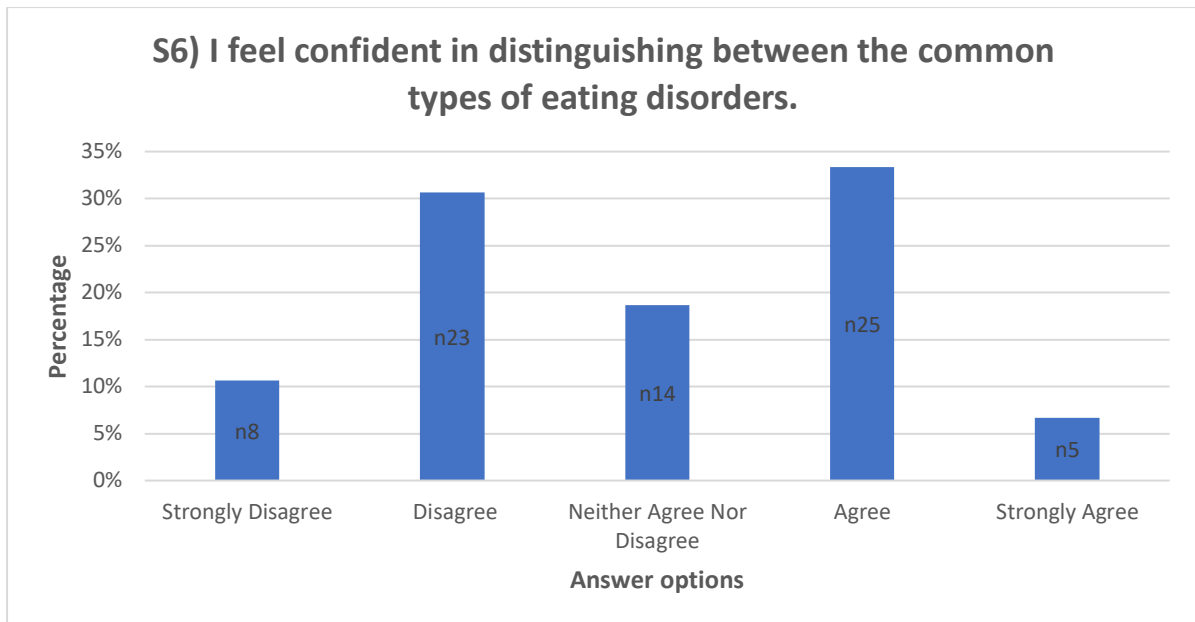


Figure 29: Teachers' responses to S6, 'I feel confident in distinguishing between the common types of eating disorders'.

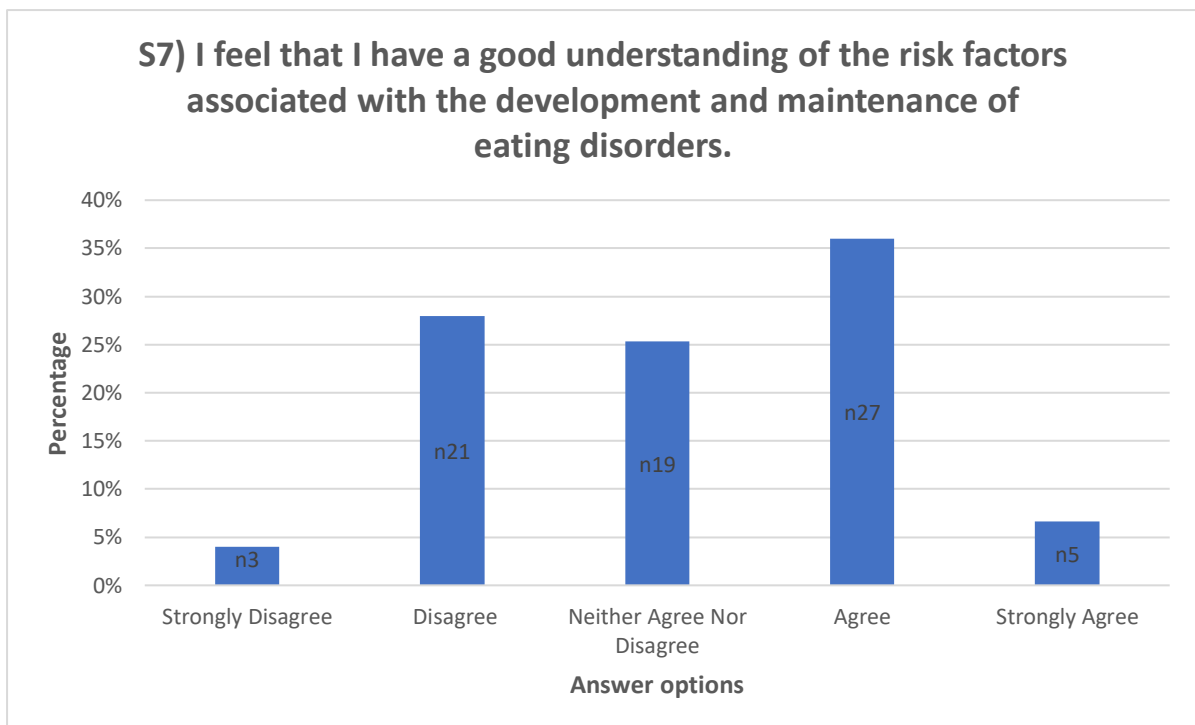


Figure 30: Teachers' responses to S7, 'I feel that I have a good understanding of the risk factors associated with the development and maintenance of eating disorders'.

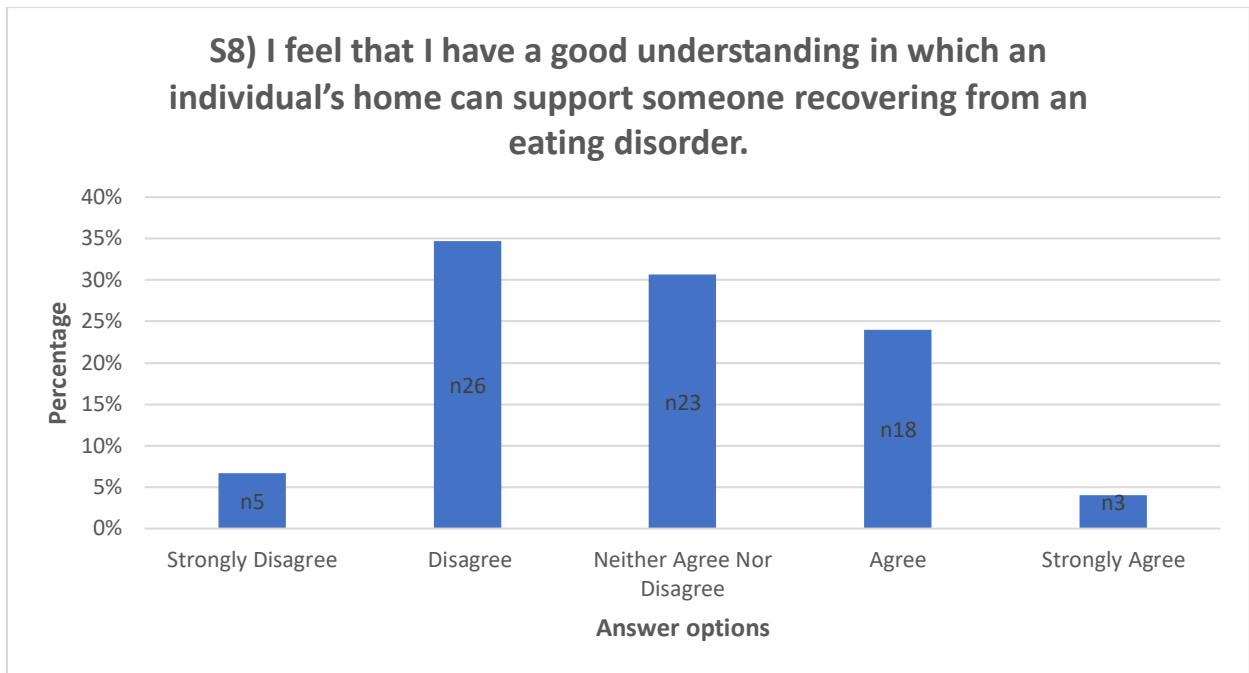


Figure 31: Teachers' responses to S8, 'I feel that I have a good understanding in which an individual's home can support someone recovering from an eating disorder'.

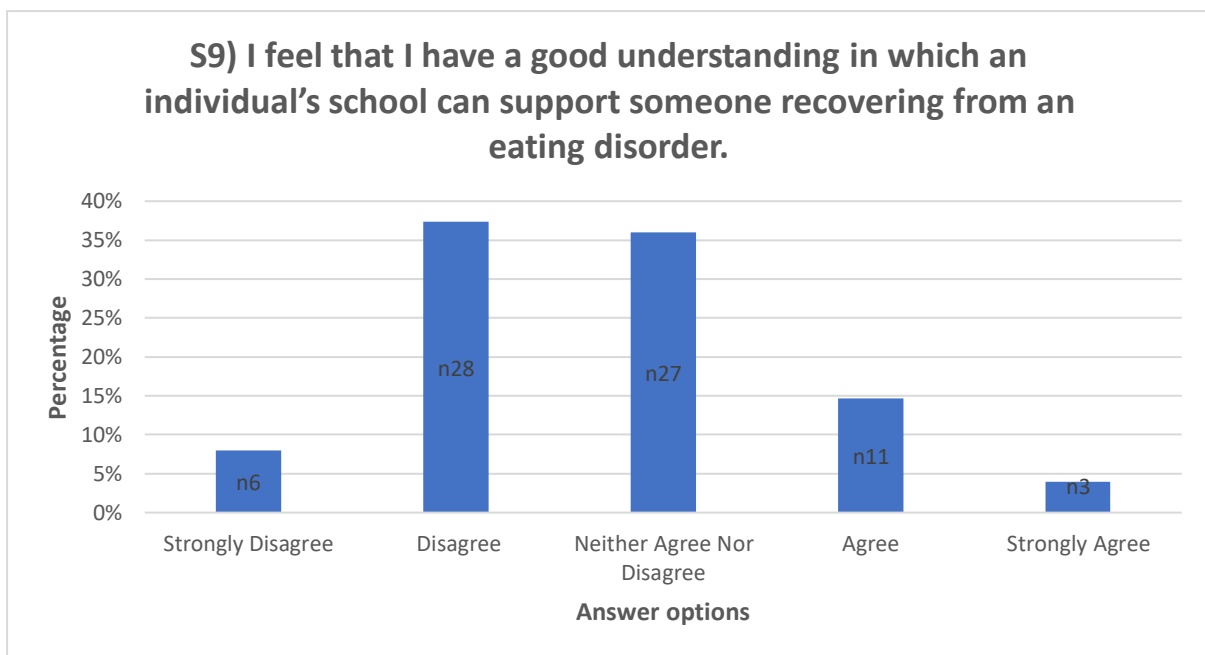


Figure 32: Teachers' responses to S9, 'I feel that I have a good understanding in which an individual's school can support someone recovering from an eating disorder'.

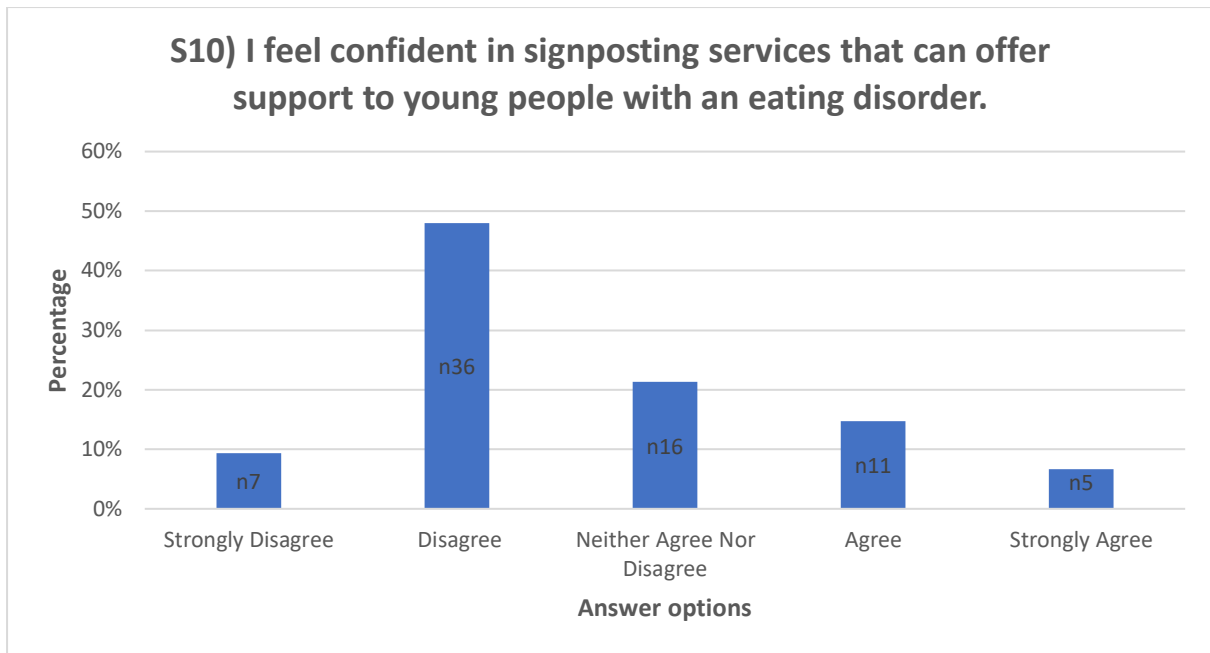


Figure 33: Teachers' responses to S10, 'I feel confident in signposting services that can offer support to young people with an eating disorder'.

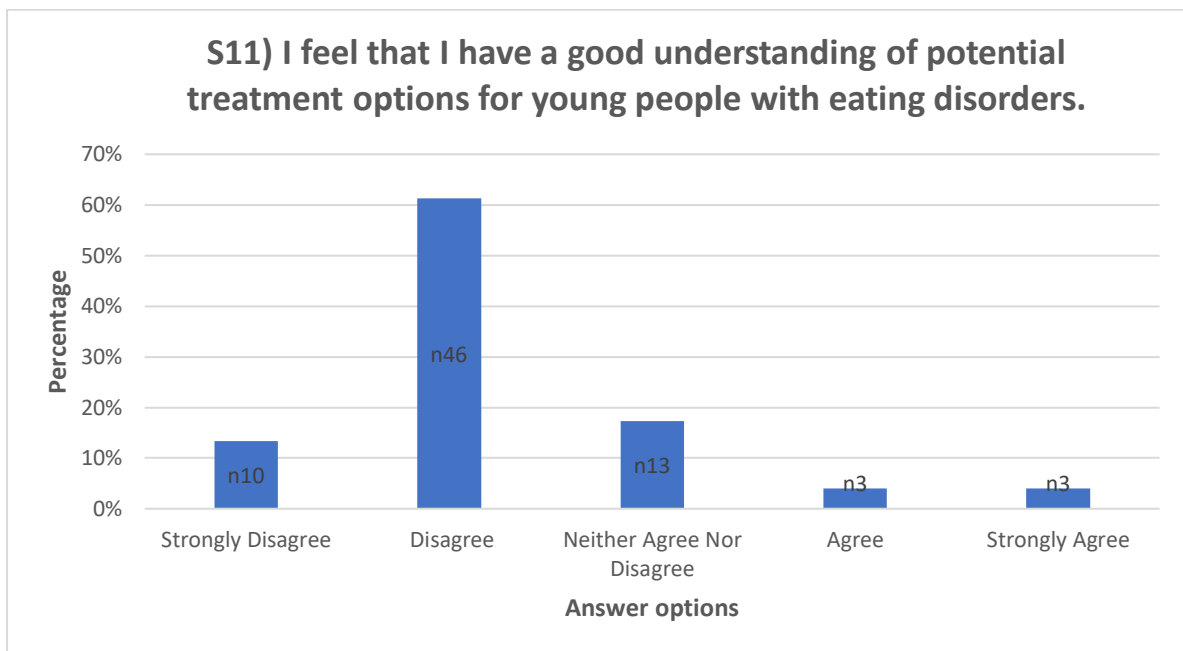


Figure 34: Teachers' responses to S11, 'I feel that I have a good understanding of potential treatment options for young people with eating disorders'.

Key findings: teacher's confidence in supporting young people with eating disorders in terms of theory, interventions and early signs of identification, as revealed from Likert Scales. ** 2DP. Confidence = Likert >3, so a response of 4 or 5 assume confident (agree or strongly agree with statement).

1. 32%(n24) of teachers feel confident in identifying signs of eating disorders
2. 12% (n9) of teachers feel confident in suggesting support for individuals with eating disorders.
3. 63%(n47) of teachers feel they have a good understanding of the physical consequences of eating disorders.
4. 51%(n38) of teachers feel they have a good understanding of the psychological consequences of eating disorders.
5. 47%(n35) of teachers feel they have a good understanding of the social consequences of eating disorders.
6. 40%(n30) of teachers feel confident in distinguishing between the common types of eating disorders.
7. 43%(n32) of teachers feel they have a good understanding of the risk factors associated with the development and maintenance of eating disorders.
8. 28%(n21) of teachers feel they have a good understanding in which an individual's home can support someone recovering from an eating disorder
9. 19%(n14) of teachers feel they have a good understanding in which an individual's school can support someone recovering from an eating disorder.
10. 22%(n16) of teachers feel confident in signposting services that can offer support to young people with an eating disorder.
11. 8%(n6) of teachers feel they have a good understanding of potential treatment options for young people with eating disorders

Figure 35: Key findings from teachers' responses in questionnaire.

Reflection: I feel that although this data is informative and interesting, qualitative studies exploring these questions would be useful in the future, to understand reported confidence in more depth and see if say, the risk factors for EDs, teachers are using are valid and representative of the literature. I also reflected on this data with colleagues and wondered whether the sample may have slightly skewed the data. There were a couple of teachers who reported 'strongly agree' to all the questions, and I thought about whether this may be due to specific training they had or maybe an interest, that was self-led outside the teaching role.

5.1.3 Teachers' and Educational Psychologists' confidence in supporting children and young people with eating disorders

The graph below shows the responses of EPs and teachers in terms of their level of confidence, to statements from the Likert scale in the questionnaire. Confidence was deemed to be a score of 4 or 5 on the Likert scale, equating to 'agree' or 'strongly agree' with the statement. The graph shows the combined percentage of participants who responded 4 and 5 for each statement in the Likert scale.

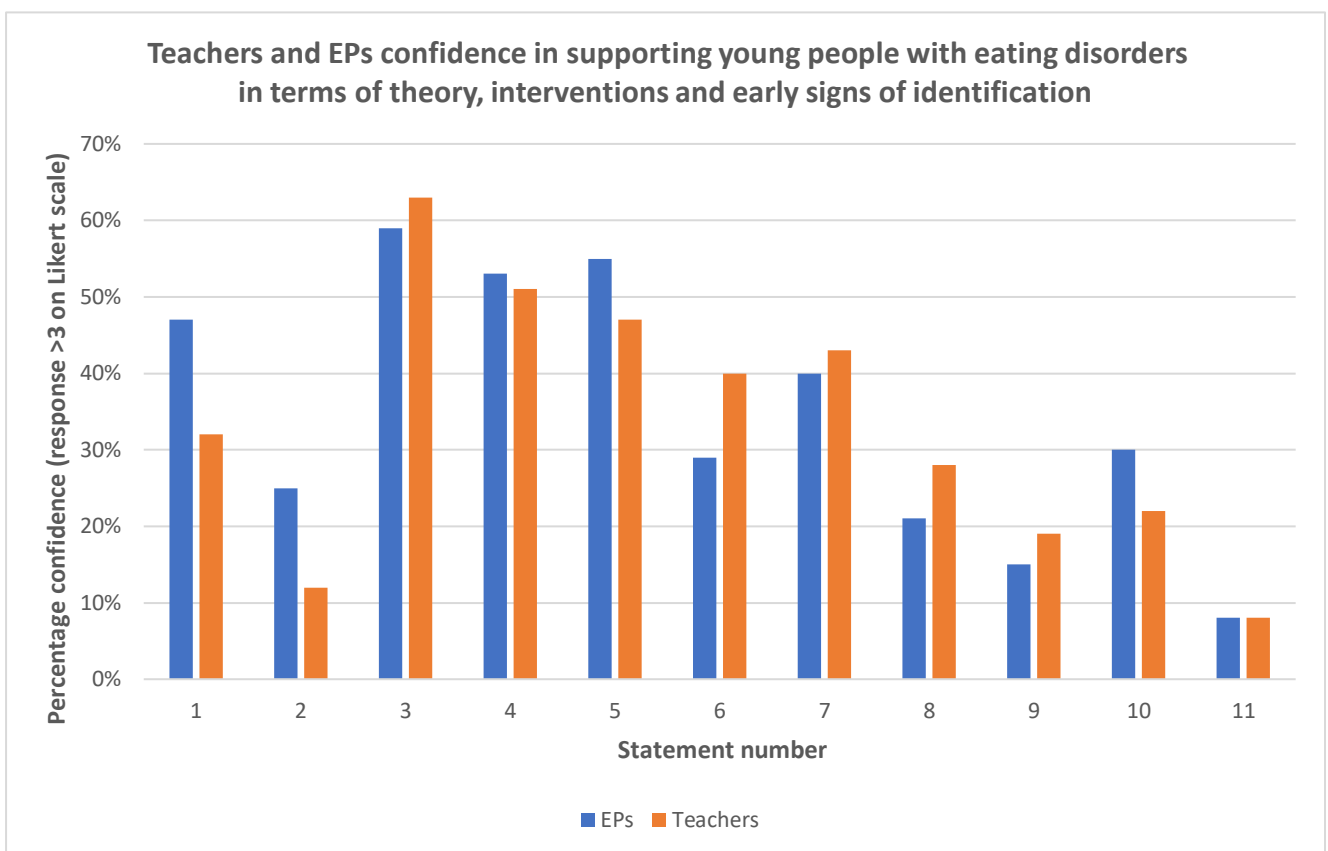


Figure 36: Teachers and EPs confidence in supporting CYP with EDs, in response to the 11 statements presented as Likert scales (confidence = >3 on scale).

5.2 Overview of qualitative data

This section presents the findings of the thematic analysis carried out in Phase 2 of the study, involving semi-structured interviews of adults who had an ED whilst in school.³ The analysis focused on addressing RQ2) how was the experience of school influenced by having an ED? and RQ3) What support could professionals in school settings offer CYP who have an ED while in school?

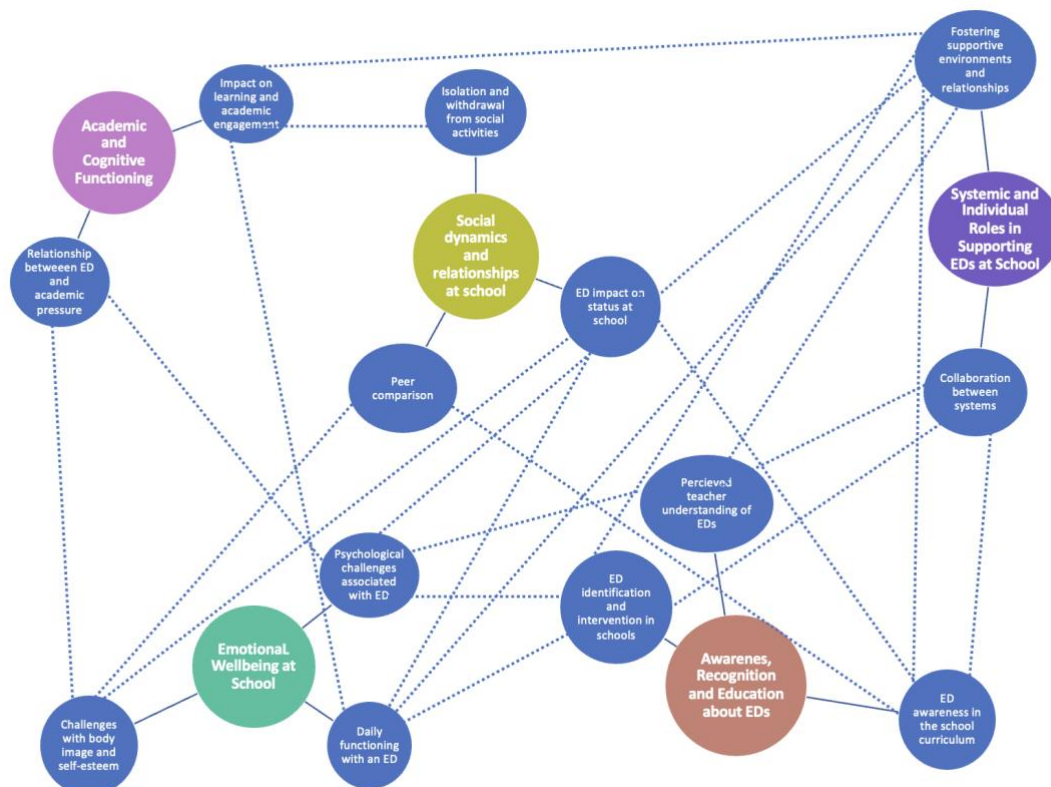


Figure 37: A thematic map showing all the themes and subthemes identified in Phase 2 of the research. The main themes are depicted by coloured circles, with solid lines representing the subthemes within each theme. Dashed lines indicate the interconnections between subthemes across different themes.

Reflection: The more I explored my themes/subthemes, and they evolved and adapted, I came to realise how interconnected they all were. I feel that the themes and subthemes accurately captured the patterns that existed within the data but feel that the impact of EDs in school settings do need to be considered dynamically and holistically, as I tried to show in the thematic map.

³ Participants' quotes are shown in italics.

5.2.1 Theme 1: Academic and Cognitive Functioning at School

This theme explores the profound and multifaceted impact of participants' EDs on their academic journey and cognitive functioning within the school environment.

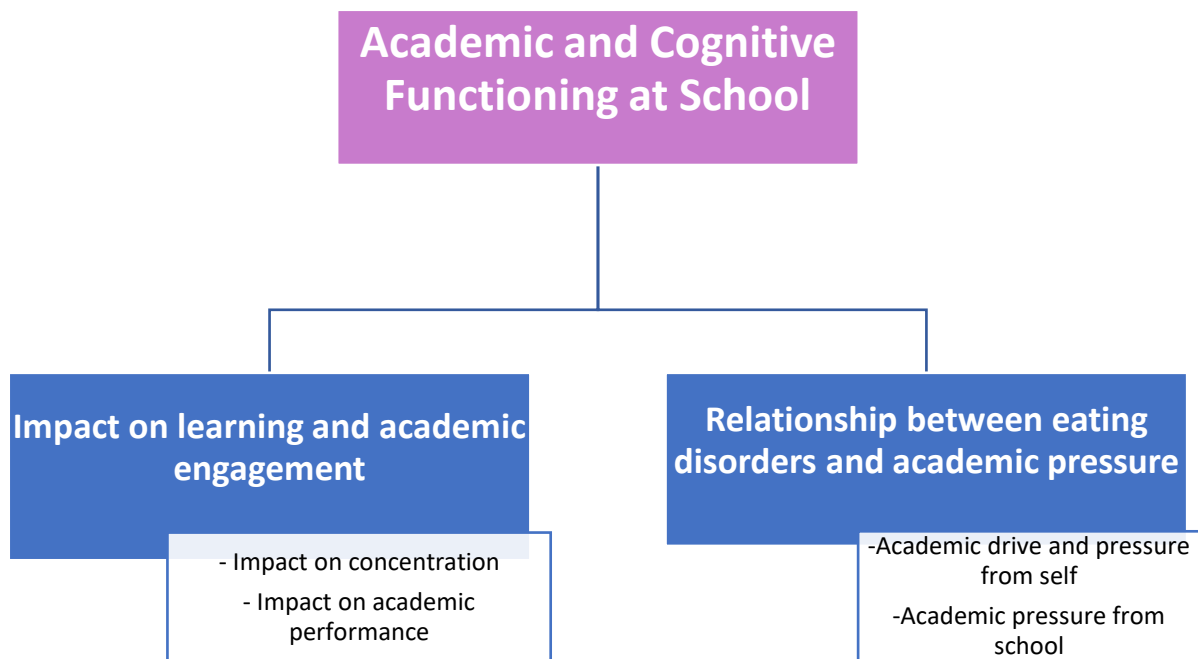


Figure 38: A thematic map depicting theme 1.⁴

Subtheme 1: Impact on learning and academic engagement

This subtheme delves into the effects of EDs on individual learning experiences and academic engagement. Some participants reported experiencing difficulties in concentration and maintaining focus in lessons due to their ED. Charlotte reflected on her preoccupation with her MH which overshadowed her ability to engage fully in academic activities, and Caroline spoke about her drastic concentration 'dip' due to the lack of nutrition, which necessitated taking more rest breaks. Similarly, Lesley depicted moments of mental fog, indicating the disruptive impact of her ED symptoms on her attention. Lesley's metaphorical description also

⁴ In the thematic maps for this section, the subthemes are shown in blue, with the sub sub-themes in white. The main theme is coloured.

illuminated the subjective experience of how her cognitive functioning was impacted by her ED.

Charlotte: You just, you can't concentrate, can you when you're exhausted.

Lesley: I think the only time it sort of hindered me, were those times where I was like, oh I'm spacing out...my brain is sliding off the edge of the cliff.

Conversely, some participants noted a paradoxical increase in concentration and academic engagement. Bethan and Suki articulated feelings of intensified focus, drive and improved cognition, relating it to a refocusing control or a coping mechanism in response to their EDs. Suki also noted how this challenges conventional assumptions about the purely detrimental effects of EDs on academic functioning.

Bethan: I think it really focuses your mind because, like, you need to, you need to have something to kind of channel your, almost like your soul, like yourself into.

Suki: But I, I just remember feeling like uber focused, uber driven just like...boom, boom boom you know.

Reflection: Bethan's reflection really resonated with me, although I acknowledged that there were other contrasting experiences of how EDs affected concentration and learning. Bethan and I reflected in the debrief on how it seemed unusual that our concentration and learning got better, and that we were both unaware that other people may have experienced this 'positive' impact of EDs.

It was also mentioned by a number of participants, that having an ED increased study time at school. Gemma noted an escalation in study time, driven by a desire to avoid meals, whilst Maddie highlighted bingeing as a means of achieving numbness, allowing her to immerse herself in academic pursuits. This highlights the impact of EDs on participants' routines and priorities, as well as the relationship between maladaptive coping strategies and academic performance.

Gemma: And I think I probably spent more time doing like homework because like. It was er...like...it was a good reason not to go to a meal.

Maddie: I'm sure that erm, the reason why I binged for the first time and then carried on doing it was because it gave me a sense of like numbness, that allowed me to then just study and focus on that.

Participants ranged in describing the impact of their ED on learning and grades, largely thought to be a result of their concentration (either a lack thereof or heightened focus). For example, Charlotte outlined the negative impact of her ED on her grades at school due to starvation, impacting her ability to think clearly, showing the detrimental consequences of nutritional deprivation on cognitive functioning. Maddie also spoke about how her fixation on obsessive exercise, shifted her focus away from learning to physical activity.

Charlotte: You can see in my A-level results when I was at my most sick because I just flunked everything and I tried so hard. But, like, my brain just didn't do it. It wouldn't remember anything. It wouldn't read anything.

Conversely, some participants highlighted instances where their ED positively influenced their academic performance, for example, through heightened willpower and focus, and a shift in priorities to from social to academic. Trisha's perspective challenges the prevailing narrative of EDs as solely barriers to academic success, highlighting the potential adaptive function of ED behaviours in certain contexts.

Trisha: And I think that what, obviously losing a lot of weight and changing my priorities happened, was my focus. Was my work. Not my social life...So I would say that at school my grades became better because you just got, like a willpower that's like nothing else.

Reflection: I thought about Trisha's statement in terms of self-determination theory. It also goes at odds with the aspect of relatedness, but perhaps increases autonomy and competence (through study and deciding to study), which could have a significant impact on intrinsic motivation and 'willpower' as she refers to.

Additionally, there were some participants who reported that their ED did not significantly hinder or improve their academic outcomes, for example, during GCSEs.

Dianne: I don't think they [ED] did. I did, at school, I think I was fine.

Subtheme 2: Relationship between eating disorders and academic pressure

Participants recounted their strong academic drive and performance, and their energy invested in schoolwork. Whilst it is difficult to disentangle whether these characteristics were present prior to, or a consequence of the ED, it is clear that these self-driven expectations (associated with the ED) influenced the experience of school for participants. Lesley discussed the channelling of her energy into schoolwork and having academic success despite her ED, which she said may have been a coping mechanism for her ED. Bethan also reflected on her intrinsic motivation to excel academically, which served as a source of confidence and validation, outside of the ED.

Lesley: Did really well at school. Er full marks in all the things, erm. So all of my energy was poured into school work, all of it.

Bethan: I won like, you know every academic prize going and erm I, I was so driven academically. I was so, so driven academically.

Charlotte reflected on how these high academic expectations set for herself could often result in high internalised pressure to succeed in school, but Lesley and Bethan both spoke of their love of learning.

Bethan: I remember I think I always, I still always loved school. I think I, I loved learning. I loved, loved learning.

Several participants outlined the importance of their academic achievement for their identity and self-worth. Bethan discussed the impact of academic achievement on her self-esteem and confidence, saying that it gave her a sense of assuredness

at school. This highlights that academic pursuits offered both a distraction from the ED, but also as a source of personal validation.

Bethan: I don't know how I would have coped, if I hadn't been. If there hadn't been something else. If there hadn't been something that I was really good at, you know...And that's, that was like a great source of kind of pride and like confidence to me.

Reflection: I deeply connected with the reflections of participants about their academic drive, love for learning and how academic achievement was central to their identity at school. I reflected in my journal on how in my own experience, I had always had that drive and wondered about what individual, cultural and also familial factors may have contributed to this. I also thought about how I still do feel this way to an extent – still having an academic drive, love for learning, and that this is a key aspect of my identity. It seems, speaking to other participants, that they have also maintained this perspective, such as being in challenging careers, where self-driven learning is a central element.

Conversely, some participants discussed the negative effects of high academic pressure and expectations (notably around GCSE exams) put on by the school setting and by themselves, leading to feelings of overwhelm, stress or burnout. The emphasis on academic achievement with a lack of emotional support from school, was spoken about by Caroline and Charlotte; other participants also attributed their difficulties in handling academic stress to systemic factors within the education system.

Caroline: I remember crying after getting a B in like a physics mock and nobody said like it doesn't matter, like it's fine, like you'll still be OK, you'll still get to where you want to go. It was just all the onus was on academics and achieving.

Charlotte: There was so much going on in my life and it felt like all my school cared about was whether or not I would sit my exams and get the A's that they wanted me to get. And they weren't really bothered what happened on the way there, as long as I would sit there in that exam room.

Reflection: I was mindful of not attributing blame to the educational system or being critical of how schools may put pressure on students, as my research in the past has focussed on this (namely the damaging psychological impact of schools). I recognise however that these preconceptions may have affected my analysis and interpretation such as the importance I assigned to comments like Charlottes.

5.2.2 Theme 2: Social Dynamics and Relationships at School

This theme explores the complex interplay between EDs and individuals' social interactions within school, as reported by participants.

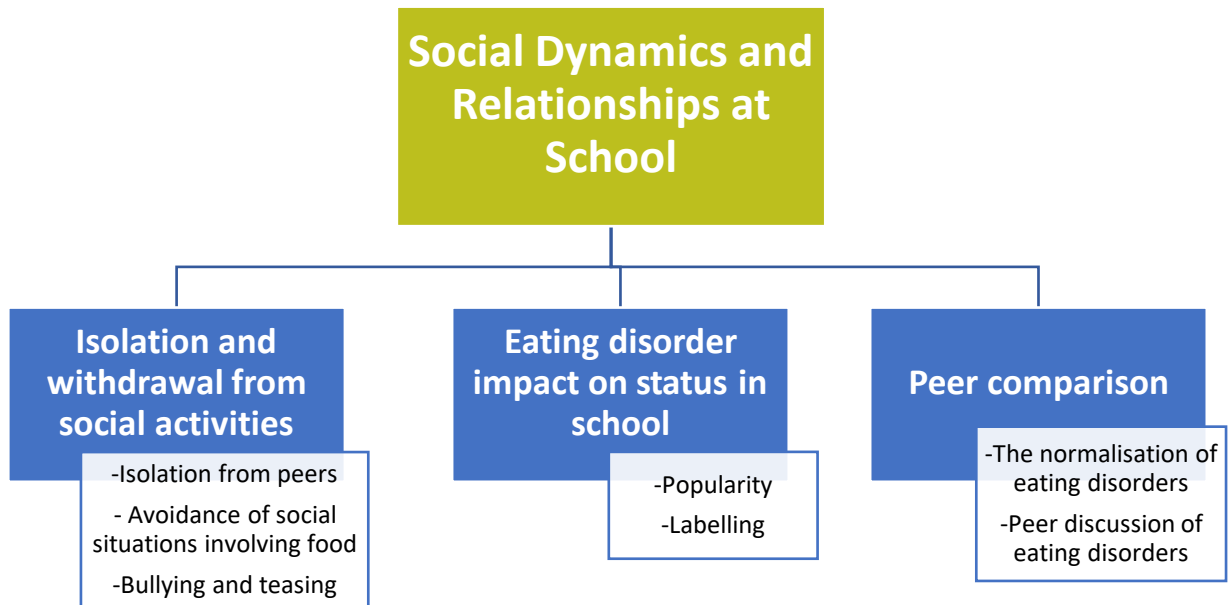


Figure 39: A thematic map depicting theme 2.

Subtheme 1: Isolation and withdrawal from social activities

It was clear from reflections, that many participants experienced loneliness and isolation when having an ED in school, exacerbated by a lack of understanding and support from others. Caroline reflected on the isolating nature of her ED and highlighted the sense of disconnect and longing for empathy, for her past self.

Caroline: Nobody, I just, nobody understood it was such an isolating place to be and I think back and I, I just want to take that 16-year-old me and hug them and, and tell them that they're not alone and explain it to them and I didn't really have anyone that did that for me.

Reflection: I found Caroline's way of speaking about her isolation very emotive, and it was difficult to listen to at times, as I can also relate to her experience. I felt that her comments will resonate with other individuals and felt honoured that she was able to open-up to me in such a transparent way.

Caroline discussed experiencing challenges in communicating with peers, which meant she would not speak to anyone for long periods of times; Gemma reflected on how this shift in communication, towards withdrawal, resulted in her peers at school distancing themselves, leading to her isolation. This was often attributed to the age of the peers at the time (and lack of understanding associated with this), although Trisha also said that the withdrawal of her peers seemed to be in response to her changing personality associated with the ED. Julie however, spoke about her supportive friendship group at school, each with their own trials that meant she did not experience isolation with her ED, as there was a mutual understanding about EDs.

*Trisha: Like suddenly here's this girl who was like really fun to be with and...all vivacious and flirtatious and like alalalala. And then suddenly, she's just a ***** weird mute who - won't, like, doesn't want to hang out with anyone. And like, that was like drop of the hat, see you later.*

Additionally, several participants described actively avoiding social situations that revolved around food due to discomfort or anxiety related to their ED. This contributed to their sense of isolation and disconnection, and Bethan and Gemma discussed the challenges of navigating communal meals. Gemma thought this to be particularly pertinent in a boarding school setting, where social life and free time revolves around meals.

Bethan: You can't go shopping with people or go for pizza or anything, like if there's a risk that you might have to eat, so it was definitely isolating,

Reflection: The act of avoiding food made me reflect more sociologically about how the sharing of food is often considered to be a primary way of bonding and interacting with others. I wonder whether the impact of EDs on this would differ culturally, as I am aware from peers that in some cultures, not eating with family members is considered offensive and there is a greater expectation and pressure to do so.

Bullying was discussed by participants to be a significant risk factor in the onset of an ED but was also a risk factor for exacerbating social withdrawal amongst students with EDs; Gemma reflected on the impact of bullying, leading to ostracisation and isolation from her peer group. Peer teasing was also said to contribute to feelings of low self-worth and esteem by Charlotte, which made it more difficult to engage in social situations, further compounding the challenges of navigating school and adolescence, whilst struggling with an ED.

Gemma: And I just didn't want to, like, eat with those people particularly, because I always felt quite uncomfortable...It wasn't at that point anything to do with not having food. It was just I didn't want to be around that group.

Subtheme 2: Eating disorder impact on status in school

This subtheme delves into the ways in which EDs influenced participants' relationships with their peers, in terms of their status in school. Suki noted a perceived association between losing weight and increased popularity among peers, possibly due to societal beauty standards and peer dynamics within adolescent social hierarchies.

Suki: If you're attractive and you want to stay slim and you want to be one of the popular girls, then that was that. We took laxatives or threw up or you know, stopped ourselves from eating...It didn't cost. We all did well at school.

In contrast, Maddie spoke about the self-confidence she associated with her ED, and how this helped her to develop social and interpersonal skills, encouraging continued social participation.

Maddie: Being pretty and being thin had given me the confidence to develop those other social tools that I needed. And then when I went to university, I had those social tools so...I could do what the eating disorder...had like, allowed me to do.

Lesley and Caroline recounted the stigma and social labelling associated with their EDs at school, which influenced their peer relationships but also feelings of marginalisation and alienation. This stigma not only undermined self-esteem in these participants, but also perpetuated harmful stereotypes.

Lesley: It became part of my erm, yeah, personality to people. Yeah, skinny weird.

Caroline: There was always the like, the like token eating disorder girl of every year was definitely like the thing...I was that person you like a brand, like tarnished with that brush of being the token person with the eating disorder.

Reflection: These accounts by Lesley and Caroline resonated deeply with my own experiences, evoking feelings of empathy as I reflected on the shared struggles of navigating social stigmas with my ED. I was also surprised by Caroline's reflection of the 'token ED girl' – if this is a known thing amongst students, how has it not been followed up by adults supporting students?

Subtheme 3: Peer comparison

Caroline and Dianne reflected on how social comparison and scrutiny with peers was typical in peer groups, leading to feelings of inadequacy and insecurity, and exacerbating ED related anxieties and behaviours.

Caroline: I remember looking round and being, seeing people kind of smaller than me and kind of slimmer than me and being really conscious of how I looked.

Dianne: My eating disorder made me compare myself to every single other girl that I was at school with, so I tended to stay away from them.

Maddie and Lesley also described how school offered unique opportunities to compare eating habits and body image with peers, such as at lunchtime.

Maddie: And there was a girl, XXX, in the year below, who like, you know, wasn't eating at lunch or was skipping lunch and I, I, became very like hyper focused on what these people were up to...it became like a bit of a, a mystery, murder mystery to me.

Several participants discussed the prevalence of EDs amongst their peers and how this influenced their interactions and self-perceptions of their own ED. EDs were also normalised in school settings, which was thought by participants to be especially evident in all-girls schools and boarding schools, with Maddie discussing how boarding schools were a breeding ground for EDs. Dianne also spoke about how every one of her female friends in adulthood had participated in disordered eating, and Lesley and Gemma further mentioned how many of their friends will engage in disordered eating, notably during times of stress, and that their ED has endured into adulthood from onset in school.

Suki: I can say around 50% of my class were always making themselves...It was a known thing to make ourselves sick.

Julie: It was so normalised that every single person, every single like student in our year, in our school, had some form of issue with their body.

Participants discussed how the prevalence of disordered eating and body image concerns in their school, meant that peer discussions about weight or eating were frequent and normalised. This normalisation and discussion of ED-related behaviours was said to foster a sense of camaraderie and belonging by Gemma and Maddie, but also perpetuate harmful beliefs and practices, through information exchange.

Suki: A very bizarre, now I reflect, that very weird conversations [around exchanging information for purging] to be having as if they're normal.

Reflection: Surely this, the normalisation and prevalence of EDs, highlights the urgent need for proactive support and the acknowledgement of the seriousness of EDs in schools? Whilst this does not align with my own experience of having an ED at school (where I was not actually aware of others with EDs) in my professional role now and speaking with colleagues, EDs are 'in' every school and appear to be becoming increasingly apparent. Various participants reflecting on the prevalence of EDs in schools made me quite frustrated in recognition of the systemic failures in addressing MH issues in educational settings and I recognise that this may have made me more biased in interpreting this data. However, I aimed to set aside personal frustration to approach the analysis in a way that understands the complexities of the participants' experiences without allowing my own emotions to unduly influence the interpretation of their reflections.

5.2.3 Theme 3: Emotional Wellbeing at School

This theme explores the intricate relationship between emotional wellbeing and EDs, as recounted by participants, highlighting the significant impact of EDs on the individuals' psychological states in school.

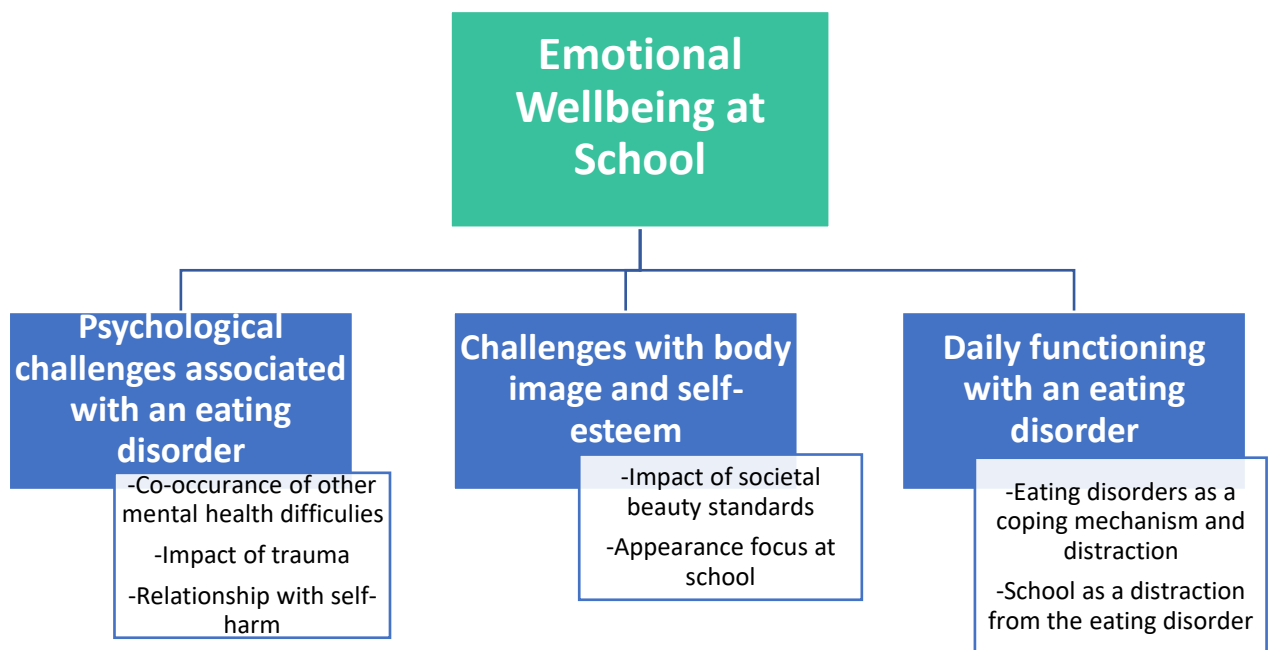


Figure 40: A thematic map depicting theme 3.

Subtheme 1: Psychological challenges associated with an eating disorder

Participants reflected on psychological challenges associated with the ED, which was seen to significantly impact their overall wellbeing at school. Several participants shared how their ED intersected with their experiences of depression and anxiety, offering different perspectives on whether these MH challenges preceded, co-occurred with, or emerged because of their ED. Caroline spoke about the comorbid nature of depression and anxiety alongside her ED, and the benefit of treating depression with medication; Gemma in contrast discussed how depression

or anxiety may make someone less likely to eat appropriately. Trisha on the other hand, reflected on how her depression was a result of her ED and metaphorically described how her ED obscured the recognition of her other MH difficulties.

Trisha: You get depression as a consequence of anorexia and not eating. But I think that the...the stem of it, is some sort of unresolved, erm, unacknowledged thing inside you which. Anorexia unfortunate, unfortunately just sort of shadows and puts like a cast, cloud, grey cloud over the issue itself.

Reflection: Trisha's metaphorical description of her ED, and other metaphors throughout the interviews, reminded me of Lakoff & Johnson's 'metaphors we live by' and Juliette Foster's work around how MH can be described metaphorically to assign meaning and comprehend the ED, such as a pit, a hole or blackness.

Gemma also discussed how her depression and anxiety were treated rather than her ED by CAMHS, and Maddie reflected that school support from a counsellor was related to stress, rather than her ED.

Gemma: I said, I want help with this eating. I don't know what to do anymore, like I'm at my wits end. It's making me so depressed and they're like no, you're, you are just depressed. So we're going to treat you for depression and anxiety, because that's the issue here.

Many adults in the interview, reflected on the intense feelings of sadness intertwined with their experiences of having an ED at school. Interestingly, this sadness was associated by Trisha, Caroline, Maddie and Lesley as leading to memory fragmentation, where periods of school whilst having the ED, were forgotten.

Dianne: I don't think I'll ever look at those photos and not have the first thought as god, I was so sad then...And not just in like, in a angsty teen kind of way. Like it was real sadness that a child shouldn't have to experience.

Reflection: Hearing the intense sadness participants made it difficult for me to be anything but empathetic and understanding (neutral was not possible); also, the vulnerability with disclosing these past feelings, built rapport between participants and myself as a consequence. This emotional connection facilitated a deeper engagement with the data, although I am mindful of the need to balance empathy with analytical rigour, to ensure the integrity of these findings. I ensured that I was in a 'good headspace' to speak with participants from the start of the interviews, as I knew that it may be quite intense and emotive. I monitored my wellbeing through this research, and although I was ok, knew I had my supervisors to reach out to if necessary.

Participants discussed how past traumatic events, such as sexual abuse, physical health difficulties, abusive relationships, the death of a parent, death of a friend and emotional neglect, significantly impacted their emotional wellbeing and interactions within the school environment. Charlotte, Trisha and Suki outlined how traumatic events were the causes of their EDs, that had a subsequent impact on their emotional wellbeing at school, including withdrawal from school and the development of other MH difficulties. These individuals also expressed frustration and disappointment of the lack of acknowledgement by others, of the impact of trauma on their MH and ED development.

Trisha: No one diagnosed me for grief. And no one thought to think of the whole picture. They just saw this girl with a vanity disease called anorexia. And that's exactly how, you know, I was treated.

Reflection: It was poignant to learn about one participant's experience of sexual assault in school. Whilst I am grateful for their trust in sharing such a sensitive story with me, it prompted my own reflection on the emotional toll of trauma and the subsequent lack of support from the school system. This disclosure evoked a mix of empathy, frustration, and a renewed sense of responsibility to amplify the voices of those who may have been failed by educational support structures, as well as emphasise the link between trauma and EDs.

Additionally, several participants also discussed engaging in self-harm whilst experiencing their ED at school. Gemma reflected on her transition from an ED to self-harm as a coping mechanism, whilst Dianne spoke about using self-harm as a form of punishment, and its interconnected relationship with her ED. This underscores the diverse manifestations of self-harm within the context of EDs, whether preceding, cooccurring with or arising as a consequence of the ED.

Participants also ranged in their perspectives of seeing an ED as a form of self-harm; Dianne spoke about how her perspective on this changed over time (from not viewing an ED as self-harm, to viewing it as a form of self-harm) whilst Suki felt that EDs were a form of self-harm.

Gemma: I think things just changed for me more than necessarily getting better. I think I moved on to just self-harming.

Reflection: Although the link between self-harm and EDs is well established, should it be included within Fairburn's transdiagnostic model, in terms of the fluidity and interconnectedness of diagnoses? My own experience, where my ED evolved into self-harm over time, underscores the personal relevance of this consideration, but does make me reflect on the potential challenges of incorporating self-harm into the model, in terms of classification and treatment.

Subtheme 2: Challenges with body image and self-esteem

This subtheme explores the complexities the participants faced regarding their body image and self-esteem within the school environment, and how factors in the school environment may amplify these difficulties. Caroline described how her ED largely affected her self-esteem and confidence, leading to struggles with self-worth and expression.

Caroline: No one really wants to know what you say. No one really cares about what, what you say and, and I think it definitely made me less confident in what I was saying.

Additionally, EDs were discussed in relation to the development of body image insecurities at school, notably during puberty, and Gemma spoke about how the pressure to conform to societal ideals of slimness clashed with the desire to developed sexualised features.

Bethan: I felt like I had quite small breasts. So I felt really insecure about that. I, I can't eat and I want to be thin, but oh my god, like, I'm not like, I'm not like a woman, you know, I'm so tiny.

Engagement in sports like ballet, gymnastics and swimming heightened participants' awareness of their bodies, leading to body image insecurities. Julie linked this to gender identity and the damaging impact of the sexualisation of young women from an early age.

Julie: Yeah. It's just you're, you're so aware of your flesh...in those leotards from the age of four, wanting to kind of pull it down.

Participants reflected on the significant impact of societal beauty standards, especially during adolescence, shaping their perceptions of themselves and their bodies. Maddie and Suki spoke about how the pressure to conform to these standards often led to feelings of inadequacy and the belief that being thin equated to being desirable or worthy, particularly within the school context. Julie spoke about the difficulty in escaping these beauty standards at school and also when going online.

Julie: There was a standard for young women and girls to look a certain way or to not look another way...Like, I can't remember an age where I wasn't aware of my own body as something that was needing to be changed.'

Reflection: Participants' reflections on societal beauty standards struck a chord with me, reflecting on my own struggles and the pervasive pressure to 'be beautiful', notably in adolescence. I also feel that this intersects with feminist theory, showing the oppressive nature of gendered expectations. But in the light of this I do a) wonder how things have changed since the participants and myself were at school (largely in terms of body-inclusive media) and b) how this impacts males, as EDs have since been recognised and acknowledge as affecting both genders. Nevertheless, this reinforces the need for feminist perspectives in understanding why many may associate thinness with worth, which I do still think is a common belief in the present day.

The hypocrisy and invalidity of these beauty standards was mentioned, with the potential for them to have a damaging impact on wellbeing and influence the development of EDs. Julie discussed how achieving thinness did not guarantee fulfilment of other societal expectations of attractiveness, which in turn, contributed to frustration and intensified restrictive behaviours, for personal motivations rather than a desire to conform to beauty standards.

*Dianne: And then this, all of this beauty, vanity, nothing tastes as good as skinny feels *****. Is, is the straw that broke the camel's back.*

Reflection: Dianne and Charlotte both used the phrase 'the straw that broke the camel's back', when discussing the risk factors that may have been associated with their EDs. This made me reflect on the cumulative impact of various stressors and triggers for EDs. The metaphor highlights the complexity and multitude of factors involved in the development of EDs, showing the need for comprehensive support systems to address different triggers effectively

Participants also discussed the appearance expectations in the school environment, highlighting the significant social pressure placed on one's physical appearance. This pressure centred around being slim and attractive. Julie mentioned the reinforcing influence of popular culture, such as the thigh gap during secondary school, and Dianne also spoke about the prevalence of fashion crazes at school, and her own difficulty with keeping up with them due to financial constraints.

Suki: I think everyone was so obsessed with being skinny...we were all expected to be clever and do well...but it was that thing about you also had to look perfect...nothing about personality.

Participants described how their EDs were often driven by internal pressures on appearance, and Maddie reflected on the value she assigned to beauty at school, and how her self-worth and esteem was largely dictated by her appearance. Julie also spoke about this in relation to her motivation for swimming, with the value she assigned to male attention and the desire to train harder, as internal drivers to succeed and reach self-defined physical and beauty goals.

Maddie: Like pressures from, from, on myself, that I put on myself to, like fear of losing my boyfriend, fear of losing friends. And I just thought that being pretty and thin was like the solution to that.

Subtheme 3: Daily functioning with an eating disorder at school

Several participants described how their EDs acted as coping mechanisms to manage emotional distress, feelings of a lack of control or other MH difficulties. These insights offered perspectives on the adaptive functioning of EDs within the school context. Lesley described how her ED served as a coping mechanism amid her difficult homelife, caring responsibilities and abusive relationship, where she felt overwhelmed. For Lesley, controlling her eating was a method to regain some stability when other aspects of her life were out of control.

Charlotte: I think, whatever, whether it's eating too much, not enough, throwing up, exercising, I think whatever it is, it all comes back to...people who can't manage whatever is going on in their life.

Reflection: It was difficult at times emotionally, to hear about Lesley's challenges at home, and I was aware of not attributing any blame to or being critical about her parents. It also made me think about the value of almost, having an ED, an unhealthy coping mechanism, but a coping mechanism all the same, if there are so many other factors that are negatively influencing someone's psychological wellbeing. I did also reflect on my own experience of this, and how I did not have a difficult home situation or significant stress in other areas of life, although still developed an ED, which perhaps shows the relationship between individual vulnerability factors and external stressors in the development of EDs. Truthfully, I couldn't shake a sense of selfishness, feeling conflicted about my own experience without tumultuous factors in my life, yet still developing an ED.

It was also discussed by Julie and Bethan how feelings of hunger in school and a focus on food, allowed for a distraction from personal difficulties, and Gemma, and Julie reflected on how the physical feeling of hunger could also actually feel positive and rewarding. Lesley found the physical sensation of hunger as a comforting distraction from her challenging homelife; she spoke about how the physical pain of hunger was easier to deal with than the emotional pain that she was experiencing at home.

Lesley: And if I was, if I was hungry, I'd be thinking, oh my tummy hurts...but I wouldn't be thinking about, whether dad's gonna kick off when I get in, whether mum's drunk, whether she's alive.

In relation to this, school was often seen as a distraction away from the ED, making it an experience that was positive and full of relief for some participants. School was described in the interviews as a safe place away from the ED by Bethan, where she could briefly escape her constant ED thoughts and focus on structured learning, using academic pursuits as a distraction.

Maddie: Lessons were the dream because you could go in. Like, no one thinks or talks about food. You don't have to think or talk about food. You're being kept busy until, like, from, from you know 9 until 1. Literally ideal.

Maddie did however reflect that as school offered her respite away from her ED, it made it difficult to identify the role that school had in supporting students with EDs, as it was inadvertently doing so; she felt that teachers couldn't do much in the light of this.

Maddie: Like the lessons thing, like is when I would say eating disorders are less, or the least obvious because they're when most people would have their kind of space away from, away from the eating disorder.

Reflection: If schools offer a respite from EDs, should schools do anything differently?

5.2.4 Theme 4: Awareness, Recognition and Education about Eating Disorders

Participants' reflections shared in interviews, whether stemming from experiences of receiving support, encountering its absence, or informed by their idealised vision of school-based support, provided valuable insights. These insights encompassed the awareness and recognition of EDs in school settings and ideas regarding the characteristics of effective support.

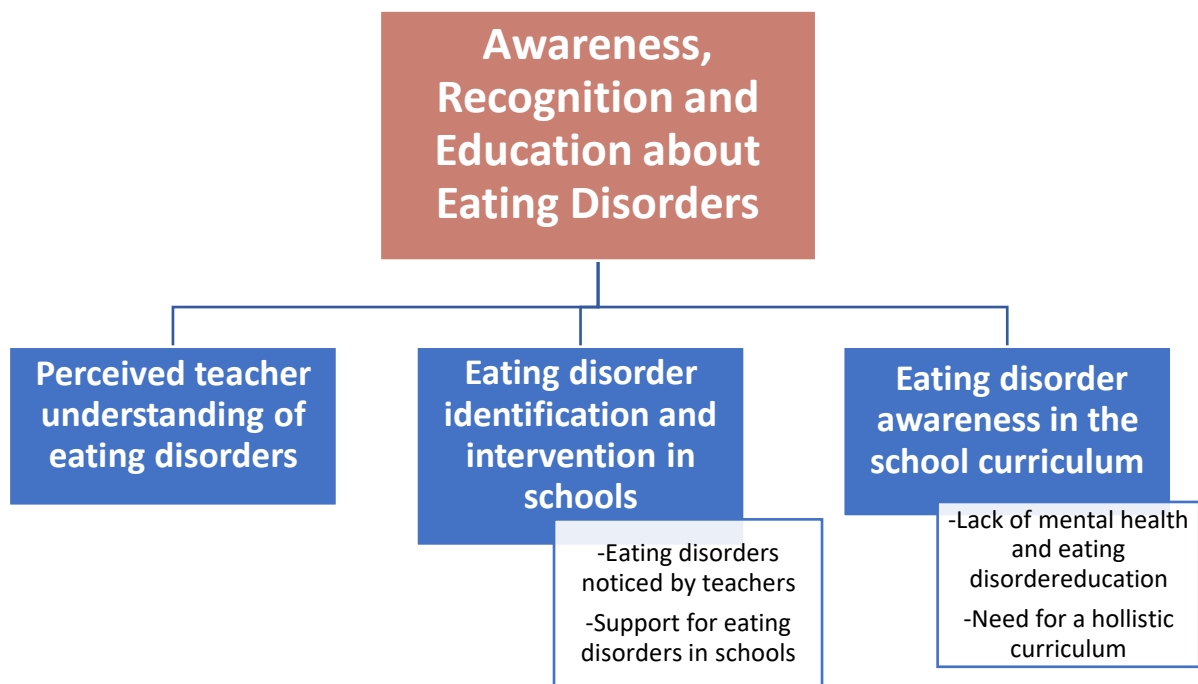


Figure 41: A thematic map depicting theme 4.

Subtheme 1: Perceived teacher understanding of eating disorders

Many participants reflected on the lack of understanding from school staff about EDs, which was thought to influence the support they received. Dianne discussed an incident where a teacher sanctioned her for not taking her coat off, whilst experiencing intense feelings of coldness due to starvation associated with her ED; Trisha additionally discussed her frustration with the lack of recognition from school staff, of the severity of her ED, with blame being put on her for choosing not to eat.

Trisha: There was no kind of understanding that this was bigger than me. And more powerful than the tools that I had to try and combat it.

Moreover, Charlotte recounted the lack of understanding by a school counsellor, which hindered the effectiveness of the therapeutic sessions. Charlotte also spoke about situations where other people assumed that AN was similar to a diet, which made her feel that the severity of her ED was not being taken seriously. She did however believe that school staff do not need a lived experience of an ED to provide support, but it is important for them to acknowledge their limitations in understanding EDs.

Charlotte: She said to me in the first session... Oh well, I, I totally get anorexia because I really like fasting. I was like. Never going back there again.

Additionally, Maddie, Gemma and Lesley reflected on their own lack of awareness and understanding of their EDs during their school years. Lesley noted her challenges in discussing her ED with teachers due to this lack of awareness; she expressed a preference for teachers to initiate dialogue with her, rather than her independently seeking support.

Lesley: I wasn't aware that I had disordered eating until I started therapy a couple of years ago.

Reflection: I was initially surprised at participants disclosing they had no awareness of their EDs. I found myself however questioning my level of awareness of my ED in my school years. In the present day, it is clear I had an ED, and I am fully aware of it, but I wondered if I lacked the awareness of my own struggles, due to denial or if I consciously chose to ignore the ED. Again, this is tied up with my memory of having an ED at school, which is fragmented and cloudy at times. This shows though the importance of promoting open dialogue and MH education in schools to support early recognition and intervention for CYP facing similar challenges.

However, some participants discussed the positive impact and support given by specific teachers who did have an understanding of EDs. Charlotte reflected on

her experience of a teacher who shared with her that he had also had an ED at school, and as a result, was able to understand what she was going through.

Caroline: So she really understood it and got it and I think without her, I think my school experience would have been absolutely horrific and I probably wouldn't have made it into school at all.

Participants stressed the importance of enhancing teachers' understanding of EDs to better equip them in providing effective support to students. The role of training was identified by Trisha, notably in terms of educating teachers about the causes of EDs.

Trisha: But I think in general, all teachers need to be talked to and trained as much as possible, as to like understanding.

Subtheme 2: ED identification and intervention in schools

The majority of participants spoke about how their EDs went unnoticed by teachers at school. Despite intentional efforts to conceal their struggles, some participants expressed a hope that school staff would recognise their difficulties.

Gemma: If they had noticed they hadn't done anything, I think became a really big driver of like self-critical thoughts and like feelings of worthlessness for me. It felt really, like despite the fact I was trying to hide it and I knew that. It felt like if someone cared enough, they would have noticed.

Participants did acknowledge however, the difficulty of detecting EDs due the ease of hiding it in school settings, allowing it to remain undetected by school staff. Maddie, Lesley and Gemma discussed how it is almost impossible for schools, notably secondary and boarding schools, to monitor the eating behaviour of students throughout the day, making it difficult to see if students are showing any signs of disordered eating.

Maddie: I think that everything was very erm, like undetected. Like even, even un, undetectable even, like it was erm. No one would think that I had an eating disorder unless you were spending, you know, all the time with me.

Several participants reported on their shy and quiet disposition at school, which persisted both before and after the onset of their EDs, and Lesley highlighted that her introversion may have influenced whether her ED was detected.

Charlotte: There's always that dynamic that erm, quiet girls who internalise and aren't too difficult...they just get missed, don't they? And nobody sees those children as, as children who might be having difficulties, or who might be on the edge.

Reflection: The observation that shy and quiet CYP may go unnoticed resonated deeply with me, notably in my current position as a TEP. Overlooking the silent struggles of more introverted individuals may be commonplace in schools, and result in a lack of detection and support for those in need. Practically speaking, EPs generally only get involved when students are referred to them, which may mean that certain students (with a variety of MH needs) are missed in schools due to their disposition – largely if they are not causing behavioural concerns and going under the radar.

Participants also discussed missed opportunities for EDs to be detected in school. For example, Lesley spoke about instances of peer-teasing about her thinness that went unnoticed by teachers, which she believed could have provided an opening for her to discuss her ED. Maddie also discussed how tutor group meetings may have been a good opportunity for teachers to see students and observe their behaviour, intervening if they felt concerned about an aspect of their MH.

Maddie: There was a girl...who would come in every single day thinner than the last...that is something that could have easily been picked up by Mr XXX.

In contrast, although some participants reported instances where their EDs were noticed by school staff, some felt that it was not followed up with appropriate intervention or support. Gemma discussed how upon her ED being noticed by her house mistress, she later found out (years later) that her parents had been told about it, but it had not been spoken about or followed up with her at school.

*Gemma: I think that really impacted me as well...in terms of feeling like it was like, oh ****, no, someone has noticed. They still weren't bothered to come to me about it though.*

Many participants felt there was a need to train school professionals in identifying and supporting students with EDs, notably around recognising signs and symptoms of EDs and other MH difficulties. Gemma felt that this was especially important in boarding school settings, as school staff have such a holistic view of the lives of CYP.

Gemma: [Training] in like knowing what the signs are, in like a more holistic way than either just like appearance or just classroom behaviour.

Bethan and Maddie expressed ambiguity in suggesting a role for school in intervention/support, as most support for EDs, if it was had, was external to the school setting. Bethan reflected that being taken out of class to see a counsellor or having a staged intervention in school, such as having a teacher eat lunch with her, may have made her ED worse; saying that she identified the potential valuable role of weekly support from a trusted teacher.

Bethan: Someone, someone to kind of like check on you could be really useful. Erm, if it can be done sort of discretely.

Many participants reported that they had no support or intervention for their ED at school, although Caroline reflected on the benefit of the accommodations made by her school to support her; this included key adults to talk to, curriculum adaptations and access to resources. Caroline acknowledged however that this support was uncommon, saying that it should be more widespread to support students with EDs. Gemma also reflected on how attending therapy in the middle of the school day was a four-hour endeavour, causing her to miss a lot of her lessons, so in-house support in school would have allowed her to spend more time learning.

Julie: Erm there was no support at school that is one of the things. They didn't, they didn't want to know about anything.

Caroline: They made a lot of kind of adaptations I suppose, to make it so that I could do the best that I could. Erm. So that's probably why I ended up actually doing OK.

Reflection: The contrast in experiences regarding support for EDs stood out to me and shows the critical role of educational settings in giving support to students facing similar challenges. It also made me reflect on the inconsistency in approaches to EDs in schools, highlighting the potential disparity for CYP in opportunities for recovery, with a student possibly having a greater chance at recovery if they attend a school that provides adequate support for EDs, compared to one that doesn't. Surely there needs to be standardised and comprehensive support systems in schools to ensure equitable access to resources and support for all students struggling with EDs?

In contrast, there were instances where interventions or accommodations at school had negative consequences, which were thought by Charlotte to stem from a lack of understanding amongst school staff. Additionally, Trisha discussed how she was banned from sports lessons, which made her feel ostracised and unsupported. Trisha also reflected on how her setting attempted to expel her from school, because of her ED, rather than consider that she needed help and support.

Charlotte: There was more than one occasion where my form tutor or head of year would decide that I needed supervised meals or they needed to check my Bike account...It never lasted very long. But I remember those occasions as being really, really stressful.

Subtheme 3: Eating disorder awareness in the school curriculum

Participants expressed the need for a dedicated and holistic curriculum, involving the inclusion of ED awareness alongside broader MH education. Several participants reflected on the lack of MH education, particularly regarding EDs, in their school experiences. Gemma spoke about how some general health advice was given, such as eating enough fruit and vegetables, but nothing specific to EDs. Caroline also identified the potential role of EPs in talking to students about EDs, from a young age to fill this gap, and give EDs a bigger focus in schools. Further, Dianne reflected on the disparity between education on physical difficulties like

diabetes, and education on MH issues like EDs, highlighting the need for a more comprehensive MH education.

Caroline: I mean, we had it in, like PSHE lessons, but not a lot. I mean, back then, there was no mental health side of it, really. Kind of maybe one lesson.

Dianne: So we had one lesson out of like humanities or something. It was replaced with a lesson, teaching us all about diabetes. You wouldn't get that with a mental health issue, would you?

Maddie and Lesley suggested that school assemblies and whole-school talks from EPs may be useful to incorporate ED awareness into the curriculum and increase understanding amongst students; Maddie additionally felt this would be useful to develop parents' understanding of EDs. Dianne further mentioned that MH education should receive the same attention and resources as sex education, given its relevance to students' wellbeing and feasibility for schools to put into action.

Maddie: In schools like you know when there's sex, people come in to be like here's a condom on a banana. And I feel like there could be basically the same.

*Dianne: We're having education on substances, drugs, alcohol, sex. But we're not having the conversations about things that are affecting our children...No one was having sex at like 11 years old...That's when, that's when kids start developing eating disorders...that's when that **** happens.*

Reflection: I wonder how teachers would react to this, considering there is a fear that teaching students about EDs could result in 'contagion' and an increase in cases. However, I do personally feel that there is a need to raise awareness and provide resources for students and their families, to address EDs effectively. I do also think there are broader societal, contextual, and structural barriers that may hinder the implementation of comprehensive MH education programmes in schools, including EDs.

Maddie discussed how providing accessible information to students about EDs is important, recounting how she would read leaflets on sexual health information whilst waiting for the nurse.

Maddie: I just feel like there could be, you know, a whole section of stuff about eating disorders and, people to speak to, and what you know, signs are. ...and you know, the fact that these are a real, you know.

As alluded to already, participants discussed the lack of peer awareness and understanding of EDs, and incorporating it into education, was thought to potentially reduce taboo and increase the awareness of EDs amongst students. Caroline spoke about how she had been relied on to explain her difficulties to her peers, which was not ideal when she did not have a full understanding of her ED herself, and advocated for broader education on EDs in schools.

Caroline: And I do think a lot of people were really kind of like what is going on at that point. Erm. So there was definitely a lot of shame around that, which I don't think helped. And there was nothing done, I suppose, to try and educate anybody.

Reflection: I reflected on how some individuals with EDs, may have a preference to explain their difficulties to peers. Although I connected with Caroline's perspective, I considered the interplay between individual coping and the societal pressures to disclose perhaps, reflecting on how different people may navigate this in their own unique ways. Recognising and respecting individual preferences and boundaries is vital I feel, to allow for an inclusive and empathetic approach to support.

Furthermore, it was reflected that some form of education on EDs may also help to develop understanding of individuals' own EDs, as several participants reflected that they were not aware they had an ED at school when they were experiencing it. Caroline expressed a desire for someone to have provided her with information about EDs, believing that access to such information may have helped her better understand her ED and seek support sooner. Lesley spoke about the value of a MH or ED assembly, that may have helped her to recognise her own ED.

Lesley: I would have gone oh wait, that's what I'm doing... You know, not being a hidden thing er you know. Increasing awareness, 'cause I didn't even know I was doing it.

Caroline reflected that even if she had been given information about EDs at school, she may not have taken in that information due to the severity of her ED.

This was reiterated by Suki, who felt that a supportive adult who did not make any judgments may have been better received, rather than having an ED explained to her.

Caroline: I don't think I was in a place to really take in that information...I think things would definitely hit the surface.

Reflection: This made me think about the importance of considering individual readiness and receptivity to ED education, emphasising how vital it is to consider timing and approach, that recognises the autonomy of CYP in their recovery journey. I reflected on how this shares parallels with my own experience, as I too only became receptive to information about EDs when I was ready to recover. This reminded me to approach the analysis with sensitivity to the diverse experiences of participants, and I sought to ensure my interpretations were grounded in the participants' perspectives, and not overly influenced by my own experiences of having an ED.

Furthermore, some participants outlined the need for a holistic curriculum, where conversations about EDs are integrated into lessons in school. Julie advocated that this would be an effective way to normalise MH discussions across the curriculum, and reduce taboo about EDs; Julie also outlined the ease in which EDs could be incorporated into the school curriculum.

Julie: This idea that social, you know, subjects can come up in your lesson about biology...to make it normal that we are being open and having these critical discussions.

Julie: Teachers teach us about like periods and, like, the physical cycle...And then when you're there being like, A) I've not gone through my period or, like physically, I'm physically not as developed. It, it's a conversation to have that could be very easily be brought up.

However, the challenges of incorporating MH education into the curriculum was acknowledged. Suki noted the need to make MH education relatable and feasible within the constraints of the school day, considering that there is no dedicated time allocated for it.

Suki: They either teach it and they traumatise you...I think what's missing is making it human. Having that professional who you can just talk to, who makes you feel human and normal regardless of what's going on in your life, that's what everyone needs.

5.2.5 Theme 5: Systemic and Individual Roles in Supporting Eating Disorders at School

This theme explores the multifaceted roles played by both systemic structures and individual interactions in supporting individuals with EDs at school. Participants reflected on the support available for them when they were at school, using this to inform their suggestions of how this support could be changed and improved for students currently with EDs at schools.

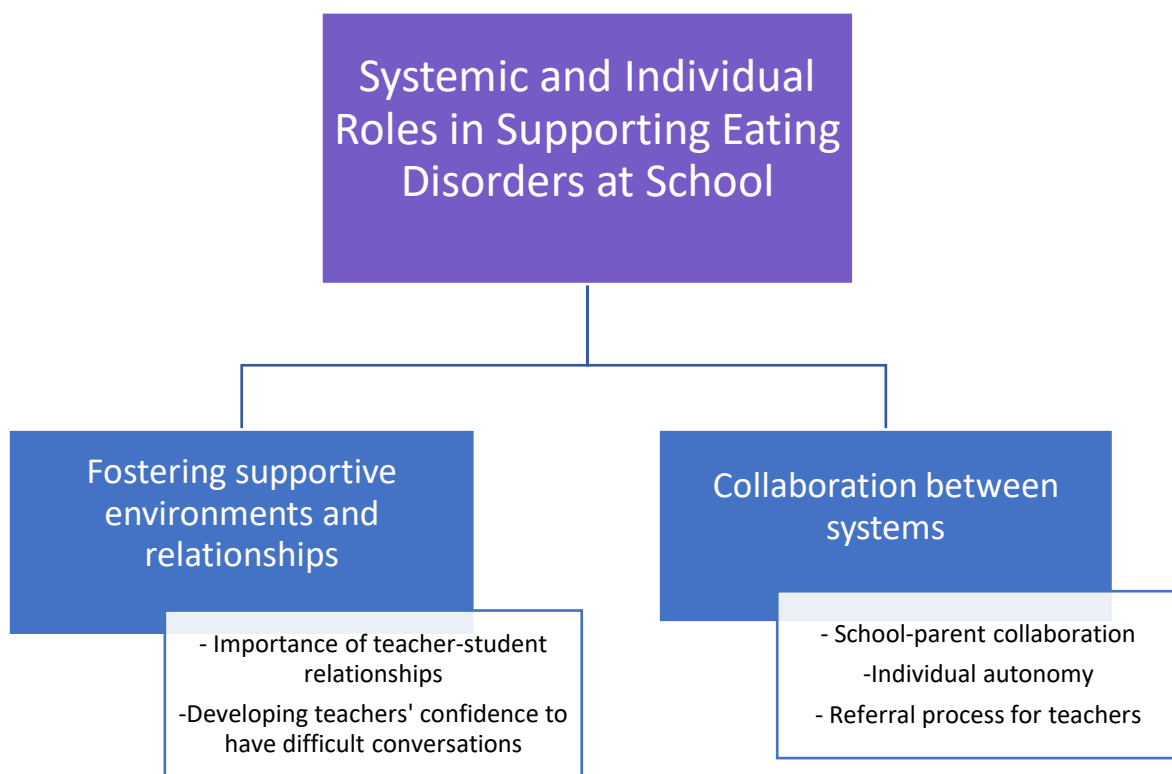


Figure 42: A thematic map depicting theme 5.

Subtheme 1: Fostering supportive environments and relationships

Trisha and Lesley highlighted the pivotal role of positive teacher-student relationships, as they have the opportunity to offer understanding and compassionate support. Lesley spoke about the importance of feeling safe and comfortable with a teacher, as a prerequisite for opening up about personal matters.

Trisha: It would have made sense to me if, you know, the person doesn't become your counsellor, nothing like that. I mean, more the person just is able to speak... they can raise the fact that they're aware, that they might not be OK and if they need to speak to them, they're here.

Additionally, Caroline and Bethan stressed the value of having a trusted adult to confide in, who shows genuine care and interest in the student's wellbeing, who is not a parent. Caroline emphasised that teachers are in a unique position for offering support to students, due to relationships and rapport they have already developed with them.

Bethan: I think it makes a big difference for young people if you have an adult who is interested in you...I think that can make you feel really special...especially someone who like, someone you respect...Because you don't always want to talk to your parents about these things as well.

Many participants discussed how trusted teachers were sought for support, rather than formally assigned, largely due to the relationship and rapport they had already developed. Julie highlighted however that this meant that there was no formal system in school to support MH difficulties, but rather on the student's own volition to seek out support from adults they trusted.

Trisha: So like, you know obviously it would be quite random if the physics teacher who I never saw, was the one giving me sort of support.

Reflection: Reflecting on my position as a TEP, I wonder how this may work with current structures and policies in the school system, as it relies on the students' own volition to seek support out from trusted adults; additionally, that trusted adult may have other responsibilities which limit the capacity for full support and perhaps there may also be lack of emotional support from the school itself (say if they do deal with the MH difficulties of students). Whilst the reliance on trusted relationships can offer a sense of safety and support for students, it may also result in uneven access to resources and support – this made me think back to the comment that those with shy and quiet dispositions get missed. I do wonder the feasibility and effectiveness of informal support systems in schools and think perhaps there is a need for more systematic approaches to addressing MH difficulties in students. There should almost be a formal-informal support system!

Trisha, described characteristics of supportive teachers, as being non-judgemental, understanding, compassionate, and the ability to provide a safe space for students to share their struggles, without fear of criticism. This was reiterated by Charlotte, who felt that schools can't fix EDs, but trusted adults and key relationships with staff have an important role in supporting students with EDs. Trisha did not receive this input at school, but Charlotte did; the consistency in their responses suggests that these characteristics in teachers are not only sought after, but also effective in making students feel valued and supported.

Charlotte: You're not going to be judged. You know, there's somebody to talk to who isn't going to say something obnoxious and awful to you.

Reflection: I thought about how this isn't a tall order to ask for. But then, considering the pressures faced by schools as systems, and the staff within it, it may be easier said than done.

Participants also reflected on the importance of building teacher confidence in addressing students' MH needs in schools. Trisha suggested that training was one way to equip teachers with the tools and confidence needed to handle difficult conversations about MH (including EDs) with students.

Caroline: It's probably quite scary for them to have to, you know, it's a big, I suppose I, it's not even an accusation like, question that you're asking them. Erm, so I think just helping them to feel more confident from a teaching perspective.

Additionally, professional supervision was suggested by Charlotte and Julie, as a way for teachers to express their concerns, including those related to student disclosures of MH difficulties. Charlotte spoke about how this supervision for school staff may largely be about containing their anxiety in these situations. Julie further discussed the potential roles of EPs in helping to redistribute the pressure on teachers when dealing with student disclosures around MH and supporting staff by encouraging a more compassionate and human response, beyond the formalities of confidentiality and procedural aspects of handling disclosures.

Julie: So I think that needs to be more kind of, time and support for teachers to kind of know what to say in that moment ...and how to tailor that to their own kind of, you know, comforts and sensibilities as well.

Participants advocated for a more systemic approach to supporting students with EDs and other MH difficulties. For example, Gemma emphasised the importance of investing money and resources into the well-being and MH of students and providing training for school professionals, to identify and support those in need.

Caroline: I would like to think that every school could have an educational psychologist. That would be the dream, and then they can help support the young people and the staff in the kind of the system.

Subtheme 2: Collaboration between systems

Caroline emphasised the need for complete collaboration between various systems, involving the school, the EP, the family and the child and young person with an ED, in order to develop a comprehensive support plan for each student with an ED.

Caroline: It would be so good to kind of get them in a room, I think. How can we support each other? What support does this young person sat in front of us need?

Reflection: In my role as a TEP, this immediately connects to a joint-school family consultation (JSFC). From my experience, this is a way to share perspectives and collaborate with the CYP about ways to move forward. It would be interesting in future research to explore how JSFCs have been used to support students with EDs.

Parent-school collaboration was seen as essential by several participants. Lesley emphasised the necessity of school professionals in offering support to the student and family, particularly in cases where home environments may not be conducive to open communication or support. Bethan also highlighted the need for school-parent collaboration especially in boarding school environments, where

communication between the two systems is crucial for providing support, due to the extended periods of time CYP spend away from their homes.

Lesley: Where the home context...is not providing a safe space, for, the young person to talk. Erm, where there are perhaps caring responsibilities, that are known. Then I think absolutely there is a place for professionals within school to offer support.

As previously mentioned, Gemma discussed how although ED concerns were noticed by school, they were not directly raised with her but rather relayed to her parents instead. She also acknowledged the difficulty in ensuring confidentiality with students disclosing their needs (e.g., telling parents), due to school policies about safety, although she felt making this evident in discussions with students is vital.

Gemma: [School] Didn't really offer anything regarding like what they should do. Was just like, you need to keep an eye on it and sort it out. My parents never brought it up to me. Erm 'cause they didn't think it was that serious.

Reflection: Gemma's experienced emphasised to me the importance of including CYP in discussions about their own needs and concerns, rather than solely relying on parental involvement. This made me reflect on the need for greater transparency and communication between schools, parents and students when addressing MH difficulties like EDs. As a researcher though, I also acknowledge that my firm belief in including CYP in conversations about their needs and experiences may introduce bias into my interpretation of the data, potentially leading me to prioritise perspectives that align with this viewpoint. Whilst I feel that subjectivity in RTA is not a hinderance, I do accept the need to critically examine the broader context, challenge my own assumptions, and remain open to perspectives that differ from my own.

Other participants highlighted the importance of promoting student autonomy and involving CYP in the development of appropriate support systems. Dianne reflected on her frustration about not being consulted about attending therapy sessions in school, underscoring the importance of respecting the agency of CYP in schools; this made her reluctant to open-up in the sessions and resistant to further intervention or support from school. Additionally, Caroline and Charlotte discussed how they were excluded in school-parent meetings, being spoken about rather than

directly included in conversations. This experience left them feeling uncomfortable and disempowered.

Caroline: I wish someone yeah pointedly asked me questions. Around what, what do you need? What do you want? What are you struggling with? Erm. And what can we do in the school to help you?

Charlotte: I would often be in those meetings, which I hated because everyone would just talk about me like I wasn't there but I'm sure they got to tick a box saying we gained the child's voice.

In contrast however, Caroline acknowledged the benefits of collaborative decision-making between home and school, and her own lack of autonomy, when she was not in the position to make decisions on her wellbeing herself. This was also alluded to by Gemma, who described how when she had her ED, she did not actively seek out support, even if perhaps it was needed.

Caroline: Sometimes I was really grateful for that, like when my parents did and the people I trusted made decisions. Because I knew they had my best interests at heart.

This also emphasises the centrality of an individual's autonomy and decision-making in the recovery process, which was spoken about by Bethan and Dianne. Dianne described experiencing a pivotal moment where she woke up one day and recognised that there was more to life than her ED. This realisation prompted her to make a deliberate choice to move forward from her ED. She expressed frustration at how easily this decision seemed to dismiss her struggles with her ED.

Dianne: If I can fix myself, was I ever sick enough?

Bethan: Obviously you need a lot of support in getting, getting over an eating disorder, but my experience anyway, was that like I only got better when I wanted to. When I really decided like I can't do this anymore, like I need to for myself get better.

Reflection: I connect with this completely. Recovery, from my perspective, involves both internal determination and motivation, as well as external support. Recognising the significance of individual agency and the pivotal role of personal decision-making in recovery resonates with my own experiences. However, it also reminds me to remain vigilant against any of my own biases from personal experience, that may affect my interpretation of the data. By remaining open to alternative viewpoints, I am actively engaging in reflexivity and as mentioned, aim to ensure that my interpretation is grounded in the participants voices rather than from my own experience and perspective.

Participants discussed that there needs to be clear teacher-led referral processes in schools, to ensure that students are directed to appropriate support pathways. Lesley emphasised the importance of providing teachers with clear routes for passing concerns on to qualified professionals, to help alleviate some of the burden that teachers have to handle and also, the demands of managing adolescents' MH difficulties. She also emphasised however, the role of teachers in providing a listening ear prior to passing concerns on.

Julie: Because when you have that, you can feel that you're not just passing the responsibility of the child on to another person. You are actually redirecting the student to someone who is a professional, who can help them. So you don't feel like you are listening to the student, you're, you're, you're hearing them.

6.0 Discussion

6.1 Overview

EDs are becoming increasingly prevalent in CYP (NHS, 2023), and understanding their impact specifically in schools is important in order to ascertain the most effective way of providing appropriate support in educational settings. This study sought to explore the confidence of educational professionals in addressing EDs in school settings (Phase 1), unravelling the intricacies of the influence of EDs on school experience and devising strategies to enhance support in school settings (Phase 2). The discussion will explore each RQ individually, drawing on existing literature and interpretations of the findings. The implications of this research for EPs and teachers will also be discussed, in addition to the strengths and limitations of the study, and recommendations for future research.

6.2 Do Educational Psychologists and teachers feel confident in supporting young people with eating disorders in terms of theory, interventions and early signs of identification?

The data suggests EPs and teachers largely do not feel confident in supporting CYP with EDs in school settings. The findings from this research do however highlight a diverse landscape of confidence and knowledge amongst these educational professionals. This diversity has significant implications for the support offered to individuals with EDs and underscores the need for tailored avenues to help professionals develop their confidence in providing consistent support. Although Phase 2 of the research (interviews with adults who had an experience of being at school with an ED) was not intended to inform RQ1, some quotes from participants illustrated and expanded on patterns from the Phase 1 data (questionnaires sent to educational professionals to ascertain their confidence in offering support) and have been included.⁵

⁵ Quotes from participants in Phase 2 of the research, have been integrated into the text in *italics*.

MH training for staff in schools has been shown to be associated with increased knowledge, identification and confidence in helping students with MH difficulties (e.g., Morgan et al., 2018). The present study found 90% of teachers had not received training on EDs, which is a higher percentage compared to the findings (74% and 60%) of Knightsmith, Treasure and Schmidt (2014) and Elms and Higgins (2022). Only 28% of teachers reported having direct experience of working with individuals with EDs. Considering 12.5% of 17–19-year-olds and 2.6% of 11-16 year-olds are reported to have EDs (NHS, 2023), the proportion of teachers having experience of working with students with EDs, arguably could be expected. However, the significant number of undetected and undiagnosed EDs (e.g., Campbell & Peebles, 2014) would suggest that the prevalence of EDs in school settings could be much greater, but these students are not identified as needing support for an ED. This was mentioned by Maddie in her interview, saying that EDs in schools are *undetected...undetectable even*.

In contrast, 84% of EPs reported not having received training on EDs. Whilst Knightsmith, Treasure and Schmidt's (2014) work showed that this training was needed for teachers and provides tools for schools, and Elms and Higgins (2022) outlined how EPs do not typically receive training on EDs, this research represents an initial endeavour to investigate the prevalence of ED training amongst EPs. As discussed previously, the five main areas of EP practice are consultation, assessment, intervention, training and research (Scottish Executive, 2002) and in regard to the changing socio-political context, one must consider whether training *for* EPs (rather than training given *by* EPs) and CPD should also be included as a central component of EP practice. A concern lies therefore in the expectation for EPs to offer support to school staff on EDs, despite their potential lack of knowledge or confidence in this area. 51% of EPs reported having had direct experience of working with CYP with EDs, in statutory, traded and consultation contexts, which is significantly higher than that which is reported by teachers. This finding underscores the unique positions of EPs in addressing the needs of students and highlights the potential impact of their specialised training and roles within school settings; furthermore, it highlights the need for EPs to feel confident in effectively supporting CYP with EDs, due to their frequent exposure and involvement with these complex cases.

EPs and teachers expressed varying levels of confidence in identifying early signs of EDs. In this study 47% of EPs felt confident identifying signs of EDs, whilst 32% of teachers reported the same, highlighting that both groups demonstrated limited confidence. Given that school staff are in a unique position to detect and identify symptoms of EDs, the limited confidence of teachers in the identification of EDs may act as a significant barrier, especially if they do not have the basic understanding of EDs (Knightsmith, Treasure & Schmidt, 2013), perhaps due to a lack of training. In Maddie's interview, she reflected on how identification of EDs in schools by teachers, may rely (and have no option to) on physical characteristics such as changes in weight or height (Treasure, 1997), which neglects a holistic consideration of the other psychological factors associated with EDs; *it's so hard to get away from, from, like an appearance-based thing, when you're talking like in terms of teachers picking things up*. Identification of the needs of CYP by staff in school settings (MH and EDs) will also influence the involvement of other professionals, notably EPs, who tend to work in a peripatetic manner, only getting involved with CYP who have been referred to them (Gutkin, 2012). The finding that only 47% of EPs felt confident in identifying signs of EDs is surprising considering the role of school psychologists in identifying EDs and helping to facilitate access to interventions (Hellings & Bowles, 2007) and also that EPs are legally obligated to respond to mental-health issues (DfE & DoH, 2015).

EPs and teachers also ranged in their levels of confidence in understanding the physical, psychological and social consequences of EDs. Whilst EPs and teachers felt more confident in understanding the physical consequences of EDs (59% of EPs and 51% of teachers), their confidence concerning the psychological and social consequences of EDs was lower. This indicates potential gaps in their awareness and understanding of EDs, perhaps by not viewing it more than a weight-based disorder. Psychological, social and physical understandings of EDs are all integral to the holistic understanding, support and recovery of individuals with EDs (de Vos et al., 2017). As Trisha commented, in schools, *it's thought that if you put on weight, you're going to be fine*. This highlights the societal misconceptions that EDs primarily affect physical aspects of an individual and fixing this (e.g. weight gain or loss) will lead to recovery, neglecting the co-occurring complex internal social and emotional struggles (Rich & Evans, 2005). This can be further related to the finding

that only 8% of teachers and EPs felt that they had a good understanding of the treatment options for CYP with EDs. Although the questionnaire did not allow for expansion, one could wonder whether treatment was primarily viewed as the normalisation of weight and eating, with other potential treatment options being less understood or known by educational professionals. On the other hand, it could be that ED treatment is not seen in the remit of the role by school professionals, as treatment will often occur external to a school setting, with responsibility for treatment had by clinical professionals and CAMHS. Furthermore, it may be that school professionals are concerned about their involvement in the treatment for students with EDs without the necessary knowledge and skills to support them, notably if they are relied upon in the absence of external treatment. As noted in Rothi and Leavey (2006, p35) there is a “large wall” separating educational and health systems, with CAMHS referral often resulting in school involvement being discontinued, with CYP being handed onto more “qualified” MH professionals. Whilst teachers may be seeking a more collaborative working relationship with external health professionals (Rothi & Leavey, 2006), it could be assumed that the separation of healthcare and education systems means that responsibility for ED treatment, is given to clinical professionals, meaning that there is less awareness about potential treatment options. Additionally, EPs and teachers showed limited confidence in suggesting interventions for individuals with EDs, highlighting the need for developing professional awareness in this area (25% of EPs and 12% of teachers). Furthermore, a small proportion of EPs and teachers felt confident in signposting support to CYP with EDs (30% of EPs and 22% of teachers), highlighting the need for further training and professional development in these areas.

29% of EPs and 40% of teachers reported feeling confident in distinguishing between the different types of EDs. Again, it would have been interesting to explore *how* the different types of EDs are distinguished, and whether that is on a basis of physical weight and appearance, or whether emotional factors are also taken into account. One must consider however, whether it is necessary for EPs and teachers to distinguish between the different types of EDs. In line with the transdiagnostic model (Fairburn, Cooper & Shafran, 2003), the similarities between EDs and the likelihood of diagnostic migration led Fairburn (2008) to propose that regardless of their presentation, EDs share a consistent underlying core psychopathology,

indicating the potential value in a unified ED diagnosis. This was alluded to by Charlotte in her interview; *the diagnosis had changed to anorexia...I don't think anything behaviourally had really changed*. Whilst this research does show that a proportion of educational professionals are confident in differentiating between EDs, the advantages of categorising EDs separately must be weighed against the practical implications and varying support or treatments in school settings, that may arise from each distinct diagnosis. Furthermore, it is crucial to reflect on how the different ED diagnoses are perceived, utilised and conceptualised by professionals in school settings, when assessing their confidence in distinguishing between different types of EDs. There is a danger of labelling students with ED classifications, and there may also exist biases in how EDs are evaluated and framed in a hierarchy (Fixsen et al., 2023).

40% of EPs and 43% of teachers felt they had a good understanding of the risk factors associated with the development of EDs. The questionnaire didn't investigate educational professionals' views on what the risk factors were, but future research could delve into what is considered important for ED development in school settings. As discussed in the literature review, a number of school-based factors may put a child and young person at an elevated risk for an ED, such as bullying or teasing, exam pressure, transition to a new school, competitive hobbies and the influence of peers. Whether educational professionals can accurately identify risk factors for EDs in students, is beyond the scope of this study, although research has suggested how factors like bullying may be perceived and identified differently by different teachers (e.g., van Aalst, Huitsing, & Veenstra, 2022). This was echoed by Lesley in her interview; *teachers can be very, very bad at picking up on sort of bullying or low-level teasing that might actually mean quite a lot to the individual*. Knight-Smith, Treasure and Schmidt (2013) noted that in order to improve the understanding and confidence of teachers in supporting CYP with EDs, training programmes need to include understanding risk factors and warning signs for EDs, amongst other elements. School psychologists consequently require knowledge of risk factors, screening tools and referral options for EDs, which is likely best delivered through training rather than self-directed learning (Cook-Cottone & Lampard, 2017).

Disconcertingly, 15% of EPs and 19% of teachers felt they had a good understanding in how an individual's school could support someone with an ED; furthermore, both EPs and teachers felt they had a greater understanding (21% and 28%) of how an individual's home could support someone with an ED. This difference in confidence levels may stem from several factors. One potential reason is the historical belief that the primary responsibility for ED support lies within the home environment rather than the school setting, and also that the home environment may have a more significant role in providing support. This perception may have been influenced by past notions associating ED causes primarily with family factors (Polivy & Herman, 2002), as well as the prominence of Family-based therapy (FBT) as a leading treatment for EDs (Couturier, Kimber & Szatmari, 2013). Additionally, societal attitudes may contribute to the prioritisation of academic achievement over addressing MH concerns within school environments, despite legislation mandating schools to promote student well-being and an offer holistic education (DfE, 2021). Resource constraints and competing priorities in schools, such as the lack of staff, funding or training opportunities, may also limit schools' capacity to effectively support students with EDs (e.g., Sonesson et al., 2020). Moreover, the lack of training for educational professionals about EDs, could result in limited awareness or understanding concerning the role that schools may have in supporting students with EDs. Bronfenbrenner's ecological systems theory (Bronfenbrenner, 2005) highlights the significance of a child and young person's home and school environments in shaping their development and wellbeing. This emphasises the importance of accessible support in both contexts. While schools can offer support and care, it's essential to recognise that they may not necessarily serve the treating team. In this study, participants reported that this was especially important in boarding school environments, where the school setting often blurs the distinction between home and school.

6.3 How was the experience of school influenced by having an eating disorder?

RQ2 and RQ3 will focus on data from Phase 2 of this research, which delved into the lived experiences of individuals who had EDs whilst in the school environment. It must be emphasised, that although patterns were extracted from the data, participants had greatly different reflections on how their experience of school was influenced by having an ED. Through RTA, several key themes emerged about how the experience of school was impacted by having an ED, revealing the intricate interplay between EDs and the school context. These themes will be discussed respectively.

Theme 1: Academic and Cognitive Functioning.

Participants shared insights about how their EDs influenced their academic journey and cognitive functioning. The impact ranged from difficulties in concentration and academic engagement to paradoxical increases in focus and drive, or little impact at all. The findings that some participants experienced a difficulty in concentration, attention and a reduced capacity for learning aligns with previous literature (Duchesne et al., 2004; Grau et al., 2019), that academic success and cognitive functions may be negatively impacted by having an ED; *you can't think clearly when you're starving (Charlotte)*. Lesley reflected on a mental fog that would interfere with her concentration in lessons, which was attributed by Charlotte being a result of nutritional deprivation (Helling & Bowles, 2007) and led to poorer grades than she had hoped for. Additionally, several participants reflected on their difficulty with concentrating in class, due to being preoccupied or distracted by the symptoms of their ED (e.g. Green et al., 1996; 1998). This also aligns with the core psychopathology of EDs outlined by Fairburn, Cooper and Shafran (2003), with features such as preoccupied thoughts being an extension of the overevaluation of shape, weight and control.

The increase in concentration was seen by some participants to be a refocus of control or a coping mechanism for their ED, which also led to increased study time by some participants. Focus and engagement in lessons and academic

achievement, have been associated with each other, in students without MH difficulties (e.g., Johnson, McGue, & Iacono, 2006). Indeed, some participants discussed how their ED led to improved grades and exam results, which Trisha and Bethan felt was a result of a change in perspective on the importance assigned to social and academic activities; *changing my priorities happened, was my focus. Was my work. Not my social life (Trisha)*. The increased focus on academic pursuits could be interpreted as an adaptive response to perceived environmental demands. From an evolutionary perspective, the drive to gain knowledge and success (in school) could be viewed as adaptive, as it increases individuals' ability to navigate or thrive in their present or future environments. Perhaps, hypothetically, the increase in concentration associated with EDs for some participants, may serve as an adaptive mechanism, aiding them in achieving educational success and greater fitness for the modern environment.

Participants in this research discussed their strong academic drive and performance, and high standards and expectations set on themselves. This is a common theme in the literature in this field, that students with EDs may have a strong work ethic (Treasure, 1997) and strive for academic excellence (Crisp, 1995). Bardone-Cone et al. (2007) linked this to perfectionism and a need for control, although Bethan and Lesley, spoke about how this academic success provided a source of confidence and validation, separate to their EDs, and that learning came from a place of enjoyment and passion; *I don't know how I would have coped, if I hadn't been. If there hadn't been something else. If there hadn't been something that I was really good at (Bethan)*. This does however contrast with Fairburn, Cooper and Shafran's (2003) core psychopathology of EDs, as participants judged and evaluated themselves heavily in relation to their academic performance in addition to their eating habits (and capacity to control them). Furthermore, these reflections, in addition to the findings that academic pursuits were prioritised over social interactions by some participants, is at odds with the theory of psychosocial development (Erikson, 1994), which highlights the importance of adolescence as a crucial time for identity development, with peers playing a vital role. Social interactions help adolescents explore their identities, learn social norms and develop interpersonal skills, and the consequence of not engaging in these interactions and diverting focus to academics, may lead to identity confusion and low-self-esteem in

individuals with EDs. This lends credence to the notion that the identity of CYP with EDs may become focussed on academic success, as this may be viewed as central to self-concept and value, and also overlaps with perfectionism which has been shown to be elevated amongst people with EDs (Bardone-Cone et al., 2007).

In this study, EDs were found to be intertwined with perceived academic pressure, and participants varied in their perspectives of the impact of external pressure put on by the school and internal pressures put on by themselves – with some finding this comforting, whilst in other cases, it leading to feelings of overwhelm or burnout. Systemically, this highlights the interaction between the self-pressure put on by individuals, with wider school-based pressure put on by the settings. The differential influence this has, can be succinctly accounted for by Lewin's formula (1935), that $B = f(P, E)$; behaviour (B) is a function (f) of the person (P) and their environment (E). It also needs to be considered, that a large number of participants in this sample attended private school settings. The pressure experienced by CYP in private fee-paying schools may be different compared to those in other educational settings; fee-paying schools may emphasise academic excellence, and may have more rigorous expectations, creating pressure to perform academically (e.g., Ndaji, Little & Coe, 2016; Ball., 1997). This was discussed by Caroline, as she reflected on her move from a private setting to a state setting for college; *the all-girls school was private, so the pressure from the school as a system and that expectation, kind of academically, extra-curricularly was so high compared to the state school*. Neoliberal policies often prioritise competition, individualism and market-driven approaches, which can lead to increased pressure on students to excel academically and socially. Whilst this is arguably more historically and culturally prevalent in private educational settings, with the changing political climate, this neoliberalist agenda has perhaps percolated into both state-run and independent settings in the present day (Sinha, 2022), increasing pressure on students across all educational establishments.

Theme 2: Social Dynamics and Relationships at School

Participants spoke about the complex social dynamics influenced by EDs within the school setting. EDs often resulted in isolation and avoidance of social

engagements, especially involving food, intensifying feelings of loneliness and detachment; *it was such an isolating place to be (Caroline)*. This also aligns with the Social Interpersonal Model of AN (Schmidt & Treasure, 2006) where a difficulty in the socioemotional domain, such as with emotional expression in close relationships and avoidance of interpersonal experiences, may maintain an ED in an individual. As mentioned earlier, Erikson (1994) emphasised the role of peers in identity formation in adolescence and social support has also been identified as a key protective factor in the recovery and support of individuals with EDs (Fairburn, 2008). Fairburn, Cooper and Shafran (2003) outlined that difficulties in relationships and interpersonal functioning could be considered as a maintaining mechanism of EDs, acting alongside the core psychopathology. In this study, challenges in managing relationships with peers, were related to difficulties with communication, where participants would become more withdrawn and also retreat from peers, due to the lack of their understanding of their EDs. Additionally, participants also highlighted that the personality change associated with their ED, made it challenging for peers to adjust their expectations of the relationship (Hellings & Bowles, 2007). This suggests that these interpersonal difficulties cannot necessarily be seen as a risk factor prior to the ED, but rather occur as a consequence of it.

Moreover, the labels attached to EDs affected how participants interacted with peers and their perceived social standing in school. In this study, some participants noted the increase in popularity and self-confidence associated with their ED, notably weight loss, highlighting the influence and impact of societal beauty standards in governing popularity and rank. This lends support to the notion that some individuals believe they will be liked and accepted by their peers by losing weight (Oliver & Thelen, 1996) and moreover, that they are more accepted and gain popularity as a result (Evans, Rich & Holroyd, 2004). Maddie also explained how her ED actually equipped her with the social skills needed to thrive at university, although acknowledging that her self-confidence was built on the insufficient backbone of appearance. In contrast, Lesley and Caroline discussed the stigma associated with their EDs, with it becoming an aspect of their identity, which aligns with and perhaps further develops the Cognitive interpersonal Model for AN (Schmidt & Treasure, 2006), as it provides a new example of the valued nature of the ED in some contexts.

The widespread presence of disordered eating behaviours among peers was reported by participants to normalise certain ED-related actions, creating both a sense of belonging and also perpetuating harmful beliefs. The commonality of EDs in the school population described in this study, were additionally said to have continued beyond school and into adulthood; *I don't have a single female friend that hasn't participated in disordered eating habits (Dianne)*. The prevalence of EDs reported by participants in school settings was surprising and shocking, and really emphasised the importance of supporting CYP at risk or with EDs, as well as the need for educational professionals to consider this as a significant priority and area of concern in schools. Peer comparison and scrutiny (e.g., of eating or body image) was reported to also be common amongst participants, with peers sharing and comparing information on how to control weight or model disordered eating behaviour and unhealthy coping mechanisms, such as such as informing others of how to purge (Jones & Crawford, 2006). Indeed, this was echoed by Suki; *it's about exchanging ways of how to best throw up. Drinking Diet Coke...and making sure that you were. If you've drunk...water or if you eat that will help you throw up*. This can be linked to broader developmental experiences of vicarious learning in adolescence; CYP will observe and emulate various social skills from each other, extending beyond specific behaviours like purging, to a broader scope of learned behaviours, encompassing both positive and negative aspects (e.g., Bandura, Ross & Ross, 1963).

Several participants in this research felt that being at a boarding or all-girls school elevated the risk of the maintenance and development of their ED. Priestner et al. (2024) discussed the psychological impact of boarding schools, interviewing 17 women. Pre-existing factors like negative family body scripts and the need for weight control may be compounded by elements of a boarding school setting, such as feelings of abandonment, scrutiny and a competitive environment. They also note that the control of food can become a way to gain status and popularity. Additionally, although a dated study, Stewart et al. (1994) found that 68% of school matrons in boarding schools (n114) reported encountering a student with AN or BN. This corroborates with Maddie's comment that boarding schools were a *breeding ground* for EDs, and interestingly, Trisha and Gemma discussed how it was easier to avoid

interaction and detection of EDs in their boarding school, compared to their home environments. This suggests that these settings may need tailored and additional ED support. Furthermore, these findings align with the research that has suggested that settings with higher proportions of females have an elevated risk for EDs (Bould et al., 2016; Bould et al., 2018), where perhaps there are heightened body perfection codes, and a greater pressure to comply to them (Halse, Honey & Boughtwood, 2007).

Theme 3: Emotional Wellbeing at School

Emotional wellbeing emerged as a central theme in this research, highlighting the profound psychological challenges associated with EDs whilst at school. Participants shared experiences of the comorbidity of depression, anxiety and self-harm with their EDs, emphasising the complex interplay between MH difficulties and EDs. This aligns with previous literature, as explored in the literature review, suggesting the high comorbidity of other psychological difficulties (Hambleton et al., 2022; Claes, Vandereycken & Vertommen, 2001). As outlined in the results of this research, participants varied in their perspectives of whether their MH difficulties preceded, occurred with, or were as a consequence of their ED; this echoes the sentiments of NICE, in that it can be challenging to establish cause and effect of different psychiatric comorbidities in EDs, which can make it difficult for the appropriate support and treatment to be given (NICE, 2020). Gemma discussed how her depression and anxiety were treated rather than her ED, and caused frustration and prolonged her ED recovery; *we're going to treat you for depression and anxiety, because that's the issue here (Gemma)*.

In this study, trauma was identified by several participants as a factor that contributed to the development of their EDs whilst at school. This echoes research that has shown traumatic events can be precursors to EDs, with PTSD being a frequent comorbidity of EDs (Dalle-Grave, 2011; Brewerton, 2007), and that following trauma, EDs may emerge as a coping mechanism, to gain feelings of control, or attempts to punish or separate from the body (Mitchell et al., 2021). The lack of acknowledgement in school settings of the impact of trauma on the development of participants' EDs was met with frustration, and it was reflected on

how the cause of the ED was not being treated (trauma), but instead the symptoms of trauma (the ED): *They just saw this girl with a vanity disease called anorexia. And that's exactly how, you know, I was treated (Trisha)*. Brewerton (2019) emphasised the need to move from sequential treatments to integrated treatment protocols, that address both trauma and ED symptoms; this is not always achieved in clinical practice, despite the well-documented association between EDs and trauma. It also then may be necessary for school settings to understand in greater depth the relationship between trauma and EDs, and how this may influence students' experiences at school. Trauma-informed practice may be helpful to support students with EDs, in addition to incorporating EDs within trauma-informed frameworks in schools. Training teachers in general trauma-informed practice, may support students with a range of difficulties resulting from trauma, EDs being included (Brewerton, Alexander & Schafer, 2019).

In this study, participants reflected on their low self-esteem and self-worth, with factors in the school environment amplifying these feelings, such as exam stress (Costarelli & Patsai, 2012), bullying (Lee & Valliancourt, 2018) and peer influence (Lieberman et al., 2001). The impact of consistent and enduring low self-esteem was included by Fairburn, Cooper and Shafran, (2003) as a maintaining mechanism of EDs, and additionally, this research supported the notion that negative mood and low self-esteem may act as a potential mediating factor between difficulties in relationships and EDs (Pelletier Brochu et al., 2018). Caroline spoke about how her low self-esteem made it more challenging to interact with others, and other participants reflected on how isolation and solitude was deliberately sought out. The pressure to conform to societal ideals of beauty and slimness, particularly during puberty were mentioned by several participants (Rich & Evans, 2005; Evans, Rich & Holroyd, 2004); moreover, the clash of this with the desire to develop sexualised features and seek validation from the 'male gaze' was also explored in the interviews and articulated by Julie; *it's like I'm really thin. But I don't have all these other things that you are now sexualizing and seeing as attractive. So I can't win.*

Heightened body image insecurities in EDs was thought to be compounded by the pervasive influence of societal standards of beauty, which often equated thinness with desirability and worthiness, especially within school settings (e.g.,

Piran & Cornier, 2005). The pressure to meet these standards was said by Maddie and Julie to lead to feelings of inadequacy and a relentless pursuit of physical perfection. Participants also reflected on how the school environment could reinforce the idea that one's value is intrinsically related to attractiveness, emphasising outward appearance over other aspects of an individual's identity, contributing to a distorted sense of self-worth; *it was that thing about you also had to look perfect...nothing about personality (Suki)*. Additionally, participation in sports that had an emphasis on physicality, was described by participants to further intensify body image insecurities. This aligns with literature suggesting elevated levels of athletic competition, especially within sports that prioritise leanness, can act as risk factors to the development of EDs (e.g., Palermo, & Rancourt, 2019; Garner & Rosen, 1991). Furthermore, this relates to the notion that EDs may be higher in certain groups in society (e.g., models, ballet dancers), as a result of socio-cultural factors that increase risk for EDs, such as the pressure to be thin or achieve (Garner & Garfinkel, 1980).

Daily functioning within the school environment was also influenced by EDs, with several participants seeing their EDs as coping mechanisms to manage emotional distress or regain a sense of control. This echoes Knight-Smith (2015, p17) who highlighted that individuals with EDs may use "their food intake, their weight, or their shape as a way of coping with their life day to day". Whilst EDs were considered by some participants to be a distraction away from other emotional turmoil, school was seen as a distraction away from the ED. Schools were said by Maddie to be a *safe haven* and by Gemma as a *safe place*, where respite from the ED could be had. To the researchers' knowledge, this has not been directly investigated in other research in this area, and this perspective offers a nuanced understanding of how individuals with EDs may navigate their school environments, highlighting the need for further exploration.

6.4 What support could professionals in school settings offer children and young people who have an eating disorder whilst in school?

In this research, the experiences and reflections of individuals who had EDs at school, sheds light on the ways in which professionals in school settings could offer support for CYP who currently have EDs in school. Like RQ2, this was informed by qualitative interviews in Phase 2 of the research. This part of the discussion will explore specifically *what* support could be offered, on a basis of the discussions and suggestions from participants.

Theme 4: Awareness, Recognition and Education about Eating Disorders

The barrier of the lack of perceived teacher understanding of EDs was identified by many participants in this research. This aligns with other studies suggesting that the limited teacher knowledge and understanding of EDs may impact the effectiveness of support, that staff can offer for students with EDs in schools (Knightsmith, Treasure & Schmidt, 2013; Yager & O’Dea, 2005). Participants highlighted instances where teachers lacked awareness and sensitivity, leading to ineffective support or even the exacerbation of students’ struggles. Thus, in order for educational professionals to support students with EDs, they also need support in improving their own understanding and awareness of EDs. Caroline identified the positive impact of her teacher, showing that understanding of EDs in schools can go a long way to offering effective support to students, underscoring the need for this consistent understanding across staff: *She really understood it and got it and I think without her, I think my school experience would have been absolutely horrific (Caroline)*. The importance of teachers’ understanding of EDs in school settings was also highlighted by Maddie, Gemma and Lesley, who lacked awareness of their own EDs whilst in school (Vitousek, Watson & Wilson, 1998; Konstantakopoulos et al., 2011). This emphasises the role that teachers could have in supporting students with EDs, by developing their own understanding of EDs, especially when students may not recognise and comprehend their difficulties themselves.

Developing teachers’ understanding of EDs may require comprehensive training on EDs for school staff (Knightsmith, Treasure & Schmidt, 2013). Trisha

emphasised the importance of training to enhance teachers' understanding of EDs and improve their ability to support students effectively; *all teachers need to be talked to and trained as much as possible, as to like understanding (Trisha)*. Knightsmith (2015) identified the value of whole staff training about EDs, in supporting teachers to develop their confidence when discussing topics like EDs and working with students with EDs. As seen in RQ1, educational professionals largely do not feel confident in supporting CYP with EDs, in terms of theory, interventions and early signs of identification. The researcher believes that developing teachers' understanding of EDs and confidence in supporting CYP with EDs, will go hand-in-hand. Elms and Higgins (2022) suggested that it is important to consider the role of EPs in the training and upskilling of staff in schools on how to support students with EDs, and they may be in a good position to offer this support. Again though, as discussed in RQ1, EPs may themselves not feel confident or have a strong understanding of EDs to effectively support teachers with developing their own understanding; upskilling EPs in their knowledge of EDs should be a prerequisite prior to any other involvement (Elms & Higgins, 2022).

Educational professionals can play a crucial role in early identification and intervention of EDs in students at school. The need to develop teachers' ability and capacity to do so effectively, was identified by participants in this research. As previously explored, teachers' ability to identify and intervene with EDs, may be constrained by insufficient knowledge and confidence regarding EDs in students (Yager & O'Dea, 2005); it could be reasoned that developing this understanding, may also develop teachers' ability to detect and identify EDs in schools. Most participants in this research spoke about how their EDs went unnoticed by teachers at school, although acknowledging that detection of EDs can be difficult for schools, due to the masked, secretive and hidden nature of EDs in general (Fursland & Watson, 2014). This again highlights the importance of upskilling teaching professionals in the identification and support of CYP with EDs (Elms & Higgins, 2022). Participants reflected on the missed opportunities for the detection of EDs, such as in form time or noticing appearance-based teasing, and additionally, common warning signs (Knightsmith, 2015, p98-103) were not noticed or followed-up by staff in school settings. For example, Maddie and Julie reflected on how they would consistently schedule extracurricular activities during lunchtimes and Lesley

spoke about how she would wear certain clothing to hide her ED; *I was wearing baggy clothes all the time so nobody could see that I was really skinny. You know, so nobody sort of picked up on it (Lesley)*. Once again, training was identified by several participants as a way to develop educational professionals' capacity to identify the signs and symptoms of EDs and adopt appropriate approaches to support students with EDs effectively (Knightsmith, 2013).

The role of school professionals in offering direct support or interventions for students with EDs, was variably perceived by participants. Some participants reflected on the value of having accommodations like key adults and curriculum adaptations, whilst others discussed how interventions made by school, such as supervised meals, had a negative impact. Furthermore, most participants spoke about how they had no support for their ED at all in school. This highlights that there was a lack of support in school, which may have not only have exacerbated participants' EDs but underscored the existence of systemic gaps in addressing MH concerns within their educational settings. The researcher believes that this is still the case in the present day, and the reflections of the adults in this study mirror the experiences of CYP with EDs at school today. This suggests there is still an urgent need for comprehensive support systems and proactive intervention strategies to be integrated into school settings, as well as fostering nurturing school environments and facilitating whole-school strategies to promote ED recovery (Knightsmith, 2015, p144-150). Saying that, a common theme running through this research is that each individual had a different experience and journey in their ED; when asking what support could professionals in school settings offer CYP who had an ED whilst in school, it needs to be taken on a case-by-case basis. Some CYP may want support for their EDs from schools, whilst others won't (such as favouring support external to school), as seen in the contrasting perspectives of participants in the interviews.

Professionals in schools can contribute to ED support by integrating ED awareness and teaching, into the school curriculum. Many participants in this research experienced a lack of MH education, particularly regarding EDs, during their time at school; this was met with some frustration, due to the perceived prioritisation of educating students on sex, but not MH. It must be considered that the participants in this study attended school before the shifting focus on MH literacy in

school settings and students currently in school, may have more regular access to MH education. Incorporating ED awareness into the curriculum was envisioned by participants as a way to reduce stigma, increase peer and self-understanding and empower students to seek support; *to make it normal that we are being open and having these critical discussions (Julie)*. This aligns with other research about managing EDs within school settings (Dalle Grave., 2003). Additionally, participants highlighted the potential role of EPs in educating students about EDs within schools. As noted earlier in this study however, teachers may hold a prominent and inaccurate belief, that teaching students about EDs will make students more likely to develop them (Knightsmith, Treasure & Schmidt, 2014). This belief may hold true for EPs, although to the researchers' knowledge, there are no studies on EPs' beliefs around specifically teaching students about EDs. Dispelling this fallacy may be an important systemic and organisational role for professionals working in the school system.

Whilst schools may play a crucial role in supporting young people with EDs, this support must be managed carefully to avoid challenges such as over-identification, self-labelling, social contagion, and iatrogenic harm, which will be briefly explored below. Effective support requires informed, well-trained staff and balanced interventions, ensuring that the school workforce has a deep and nuanced understanding of EDs, perhaps achieved best through comprehensive training by professionals aware of challenges and complexities of developing recognition, identification, and knowledge of EDs in school settings. Over-identification and self-labelling can occur when awareness programs inadvertently lead to students misidentifying normal variations in eating behaviour as pathological. To mitigate this, schools should adopt balanced education programs that provide accurate information about EDs without causing undue alarm. As noted by Puhl and Suh (2015), it is vital to present ED information in a way that normalises seeking help while avoiding stigmatisation or self-diagnosis. Social contagion, where behaviours and symptoms spread within peer groups, is a significant concern in school settings; peer support programs should be carefully monitored to ensure they promote positive behaviours and do not inadvertently glorify or spread disordered eating habits. Iatrogenic harm can result from well-meaning but poorly executed interventions, and thus, educational professionals should collaborate with healthcare

professionals to design interventions that are evidence-based and age-appropriate. Lock and Le Grange (2013) advocate for the involvement of clinical experts in training school staff to ensure that support strategies are effective and safe. Thus, it will be important for educational professionals carrying out training to balance awareness and intervention programmes, with careful consideration of potential negative effects.

Theme 5: Systemic and Individual Roles in Supporting Eating Disorders at School

Creating supportive environments and nurturing relationships within school was seen as essential for supporting students with EDs. Participants emphasised the significance of positive teacher-student relationships, where students feel understood, valued and safe to disclose their struggles; professionals can foster these nurturing environments by cultivating these positive relationships, characterised by trust, empathy and understanding. Participants described the characteristics of supportive teachers, including offering a listening ear, no judgement, emotional support, and a safe space, which allowed/may have allowed them to feel more valued and empowered to seek help. Trisha, Caroline and Bethan also spoke about how these adults were not parents and also not formally assigned adults by schools, but rather chosen by the student as a result of the relationship and rapport they had developed with them. Taken together, this reflects what can be considered as a 'trusted adult', which YoungMinds define as an adult "chosen by the young person as a safe figure that listens without judgement, agenda or expectations, but with the sole purpose of supporting and engineering positively within a young person's life"(YoungMinds, 2024). Trusted adults are those who CYP have independently chosen to trust, and although YoungMinds notes that generally teachers are not seen as trusted adults (due to the structures and expectations of education limiting the ability to form these relationships), participants in the present study seemed to have described these characteristics in teachers. Knightsmith (2015, p148-149) noted that it is common for pupils to develop relationships with trusted adults, and that regular access to a trusted adult for students with EDs is both helpful and reassuring. Considering that a trusted adult is typically chosen autonomously by the student and is based on existing student-teacher relationships rather than formal assignment by a setting (Dang & Miller, 2013; Beam, Chen &

Greenberger, 2002), it may seem disingenuous and unethical to 'teach' school staff how to form trusting relationships, if it lacks genuine care. As Lesley highlighted in her interview, *it's all about relationships*, which are built on empathy, understanding and established rapport and connection. Saying that, training all staff to support students facing difficulties in school (MH or otherwise) could be beneficial, as both supportive and trusted adults share similar qualities. However, it is crucial to acknowledge and respect student autonomy in seeking out specific adults they trust and feel comfortable confiding in.

Finney (2006) highlighted that school staff may already be busy and overwhelmed with their teaching duties and trying to support students' MH may just add to their workload. This perhaps has implications for the capacity of teachers to be trusted adults, but also as mentioned by participants in this research, emphasises the need for professional supervision and support for teachers, potentially from EPs. This may involve containing staff anxiety around ED or MH disclosures, as well as offering support about how to have difficult conversations in the moment. EPs are qualified to offer teachers therapeutic support, training, and guidance through consultation and supervision (Hoyne & Cunningham, 2019). Despite the highly debated perception of the EP role, there is a responsibility for the EP to work across individual, group, and systemic levels, of which the supervision of teachers can be included (Kelly, 2008; O'Donnell, Reeve & Smith, 2011). The support of teachers by EPs in schools, could indirectly enhance the effectiveness of teachers to support CYP with EDs. However, it's important to note, as highlighted by the findings from RQ1, that EPs themselves are not fully confident in supporting CYP with EDs in terms of theory, interventions and early signs of identification.

In this study, Caroline and Trisha proposed that supporting the MH of students, including those with EDs, would be enhanced if every school had an in-house EP. The feasibility of this is a matter of debate, as whilst having direct and in-house access to an EP in a school setting may be beneficial to the MH needs of students, practical factors such as budget constraints, the traded and statutory duties of a service, and the availability of qualified EPs will likely restrict the chances of this happening (Ashton & Roberts, 2006; Lee & Woods, 2017). Taking a systemic perspective, the EP role is evolving, and can be seen as passing through a period of

professional uncertainty in terms of its role, function, status and training (Cameron & Monsen, 2005; Hill, 2013), and responding to the role demands, knowledge and skill development within the profession (Leadbetter, 2000). Perhaps then, EPs may have a more in-house role in schools in the future, especially as EPs are increasingly working around supporting the MH of CYP, due to the awareness and prevalence of MH difficulties in schools (Price, 2017).

Educational professionals can facilitate collaboration between systems, including schools, parents, and MH professionals, which was discussed in interviews as a critical aspect of supporting students with EDs. This may be where EPs could have a unique role in supporting students with EDs, as multidisciplinary work by EPs in general is seen as needed and vital (Gaskell & Leadbetter, 2009), and it is reasonable to assume that multidisciplinary work is also necessary and applicable for CYP with EDs (Monteleone, Fernandez-Aranda & Volderholzer, 2019). Lesley and Julie spoke about the need for clear referral processes for teachers in schools, to pass on concerns to other professionals, such as EPs or CAMHS. This underscores the importance of ED policies and guidelines regarding the referral process for EDs within school settings, so staff can follow-up ED concerns, share information with the necessary professionals and act appropriately if a student discloses or is identified as having an ED (Knightsmith, Treasure & Schmidt, 2013).

Participants also emphasised the need for comprehensive collaboration involving all stakeholders to develop individualised support plans for students with EDs. The importance of thoughtful discussions between home and school settings of CYP was discussed by participants, again highlighting the significance of a child and young person's home and school environments in influencing and supporting their wellbeing (Bronfenbrenner, 2005). However, Gemma reflected on how concerns about her ED were shared with her parents, but not with herself, which led to feelings of distrust towards both school and home; this aligns with other participants, who spoke about the need for school professionals to respect student autonomy, including in parent-school meetings, in order for successful collaboration. Self-determination theory (SDT)⁶ suggests that there is a need for an individual to have

⁶ SDT interestingly additionally advocates, that alongside autonomy, people have a need for competence and connection; without reaching these needs, individuals will not be fulfilled nor

autonomy in decisions made about them (Ryan & Deci, 2000); in particular, CYP need a sense of control over their actions, and to have control in decisions that will impact their future (Deci & Ryan, 1985). This seems at odds with accounts of how participants were included in collaboration attempts between home and school, as reflected on upon by Charlotte; *I would often be in those meetings, which I hated because everyone would just talk about me like I wasn't there (Charlotte)*. When a student is informed and invited to agree with what information is shared, parental support can be supportive (Knightsmith et al., 2014). This highlights the need for students to be included in home-school collaboration, and also the need to include students in deciding what individual support is necessary in schools, to facilitate their recovery.

In line with this, the importance of individual autonomy and decision making in the recovery process from an ED was mentioned by several participants, which is seen in other research in this area (e.g., Patching & Lawler, 2009; Pettersen & Rosenvinge, 2002). This suggests that there may be the need for approaches like motivational interviewing (MI) in school settings, where the empowerment of students to make informed choices about their health and wellbeing can be instrumental in fostering positive outcomes (Miller & Rollnick, 2012; Snape & Atkinson, 2016). MI could provide CYP with the tools and support necessary to explore their own motivations and goals for recovery, whilst respecting their autonomy and agency in the process, and indeed, MI has shown promise in increasing readiness and motivation for change in ED treatment (Macdonald et al., 2013). Additionally, based on the researcher's personal experience volunteering for BEAT, the charity employs MI techniques on helplines to support individuals struggling with EDs, which was felt to be effective. Professionals in school settings may be in a unique position to offer support to CYP struggling with EDs, through a process such as MI.

motivated to grow psychologically. As discussed thus far, and according to RQ3, professionals in school settings could support CYP with EDs in school settings by fostering autonomy (choice in decisions made about them), competence (success and achievement outside appearance) and connection (trusted adults and peers).

As mentioned, a key theme that emerged from this study is the significance of autonomy and incorporating young people's voices in ED treatment and recovery. Empowering young people with EDs to actively participate in their treatment could enhance recovery outcomes, suggesting that practitioners should adopt patient-centred perspectives. The importance of patient-centred care in ED treatment was highlighted in a review by Westwood and Kendal (2012), who found that involving CYP in decision-making processes significantly improved their engagement and treatment adherence. This approach contrasts with traditional perceptions of EDs as conditions that require treatment *done* to an individual, rather than *with* an individual (Foster, 2003). Schmidt, Wade and Treasure (2013) suggested that collaborative care models, which prioritise patient input and are reflective and responsive, lead to better health outcomes and lower relapse rates. This underscores the need for a shift from traditional authoritative approaches to more collaborative and empowering practices.

6.5 Implications for Practice

The findings from this study offer insights for immediate practice and further research, which will be explored in relation to Bronfenbrenner's ecological systems theory (Bronfenbrenner, 1997; 2005). On the microsystem level, the research highlights the critical need for individualised support and early intervention strategies tailored to students experiencing EDs. Whether this should occur within the school setting or externally is a matter of debate and warrants more research. At the mesosystem level, fostering better communication and collaboration between educational professionals, parents, and healthcare professionals is essential for creating a supportive network for young people. Additionally, establishing clear protocols for identifying and managing EDs, and involving families and individuals themselves with EDs in treatment plans, may enhance the overall effectiveness of intervention efforts. On the exosystem level, there needs to be advocacy for systemic changes, such as improved training for staff and access to specialised resources in schools, to better address and manage EDs effectively and safely. At the macrosystem level, addressing societal attitudes around body image and MH, through awareness campaigns and policy changes could help reduce stigma and promote a healthier environment for students. Additionally, understanding how

cultural and contextual factors influence the prevalence and management of EDs in schools can provide a more nuanced approach to tackling this issue. Lastly, it is important to consider the chronosystem; it is vital to recognise how societal, political and social trends will shift over time, such as the rise of social media, changing beauty standards and even the introduction of MHSTs. Practice will need to adapt, revise and reflect in the light of the changing influences and experience of EDs in schools, and consequently ongoing and further research is crucial in this area.

6.6 Implications for Educational Psychologists

The present study contributes significantly to the field of educational psychology by highlighting the pressing need for better support systems for CYP with EDs within school environments. In addressing RQ3, participants delved extensively into the implications for educational professionals in offering support for CYP with EDs. However, their discussions predominantly centred around the support that teachers could offer, possibly influenced by their familiarity with the teaching role, compared to that of EPs. Consequently, based on a thorough review of both data and existing literature, and the knowledge of the EP role, the researcher proposes implications for EPs across individual, organisational and systems levels. To engage effectively at all levels, EPs must develop their own understanding and confidence in supporting both students with EDs and the teachers who work with them. This underscores the importance of integrating such training on EDs into the professional development of EPs.

At the individual level, EPs could play a therapeutic role in supporting CYP with EDs, focusing on nurturing their emotional wellbeing by providing a space to talk if the student seeks it (e.g., Simpson & Atkinson, 2021). Due to the peripatetic way that EPs work in school settings, they perhaps may not be best placed as a 'trusted adult', due to the rapport-building process requiring time and consistency. The researcher contends that the most significant implications for EPs emerge at the organisational level. EPs could have a role in supporting teachers to support students with EDs, as discussed by participants in the interviews, by offering training and supervision, to develop their understanding and confidence in supporting CYP with EDs (Knightsmith, 2015). Furthermore, collaborative efforts between EPs,

students' homes, and schools, facilitated through consultation, can prove highly effective. EPs have the unique skills to facilitate shared problem-solving that empowers CYP and incorporates their voices into decision-making. On a systems level, EPs can contribute to policy development aimed at integrating MH education into the curriculum consistently, ensuring that students receive comprehensive education about EDs and other MH difficulties. Additionally, as mentioned by participants, schools and therefore EPs, may not have a role in 'fixing' EDs, but they are instrumental in advocating for and facilitating access to adequate resources to support students' MH needs (Smillie & Newton, 2020). Effective communication and information-sharing between clinical and educational settings are also essential to ensure that the support provided to students with EDs is both effective and tailored to their individual needs (Farrell et al., 2006; Murray et al., 2017).

6.7 Evaluation of study

The researcher has maintained awareness of both the merits and shortcomings present within the study's methodology and processes, the most pertinent of which will be explored respectively, attempting to bolster this research's credibility whilst openly addressing aspects that may impact generalisability and reliability.

In this study, seven out of the 10 participants attended private schools; of those who attended private schools, five participants were at an all-girls school, and two were at all-girls' boarding schools.⁷ This skewed distribution raises concerns regarding the generalisability of the findings to all schools, as the experiences and perspectives of individuals from private, single-sex and boarding school settings may not accurately represent the broader population of students with EDs in other contexts. This overrepresentation of participants from private schools may also introduce bias in the demographic makeup of the sample. On the other hand, whilst the sample composition may challenge the generalisability of findings, it also can be considered a strength, presenting the opportunity to delve deeper into the nuances of the experiences of individuals from these settings. This also relates to the

⁷ Note, these participants did volunteer for the study, rather than being recruited by the researcher

epistemological positioning of contextualism, assuming that knowledge and understanding are context-dependent, shaped by specific circumstances, interactions, and environments in which they occur (Van Oers, 1998). This research then can be seen to gain insight into how factors such as culture, pressure and social dynamics in private settings may intersect with the development and management of EDs.

Participants in Phase 2 of the research ranged in age, reflecting different time periods of their school experience. Whilst it initially seemed important to gather perspectives from young adults aged 21-25, who had attended school more recently, after a pilot study the researcher found this cut-off arbitrary, recognising that individuals older than the specified bracket may possess valuable insights stemming from their lived experiences. The focus on MH in UK schools has grown significantly over the past decade, driven by factors including awareness of MH issues and government initiatives, such as the 2017 government announcement to invest in MH services for schools (DfE & DHSC, 2017). This has, for example, led to the establishment of Mental Health Support Teams (MHSTs) in schools and a greater emphasis on MH and wellbeing education and resources for pupils, parents and teachers (DfE, 2021). Consequently, one could question whether the experiences of the adults in this study, truly reflect the experiences of CYP with EDs in school in the present day, as there has perhaps been a shift in the role, awareness and input that schools have in supporting the MH of CYP today (Burstow et al., 2018). Additionally, it could be argued that the adults in this research do not fully understand the pressures faced by CYP in schools at present, and experiences of EDs in schools may have evolved over time. This emphasises the importance of including the voices of CYP currently experiencing EDs in school, to give a holistic perspective of how EDs impact the experience of school (e.g. Atkinson et al., 2019; Aldridge, 2016). However, from the researcher's own experience, their professional role in schools and the literature, EDs do appear to still be prevalent and perhaps unidentified, despite the changing MH policies, and as explored in RQ1, professional confidence in supporting EDs is still limited. Thus, the researcher contends that the experiences shared by participants in the interviews will likely resonate with those of CYP currently managing EDs in school environments.

Additionally, it must be considered that whilst the interviews in Phase 2, focussed on the reflections of adult participants on their experience of having an ED in school, this retrospective lens may introduce bias. Participants may have, for example, filtered their memories of having an ED in school through their current knowledge, emotions and beliefs, possibly distorting the reality of their true experience (Hertel & Mathews, 2011). Additionally, as mentioned, societal attitudes and awareness of MH have evolved over time, which could also influence how the participants in this study interpreted and remembered their past experiences of EDs at school. Whilst these reflections from Phase 2 do offer valuable insights and inform this study, it is necessary to approach these accounts with caution, recognising the possibility of biases shaping participants' recall.

It is acknowledged that the researcher's personal investment and emotional connection to the topic may have influenced interpretations, and also affected the semi-structured interview content and thematic analysis. However, researcher bias can play a constructive role in RTA, when embraced within a reflexive framework. Researchers' preconceptions and biases can contribute to a deeper understanding of the data, by guiding the interpretation process, although it is crucial for the researcher to be self-aware of their own biases and perspectives, enhancing the rigor and validity of the analysis (Braun & Clarke, 2021b; Braun & Clarke, 2023). As a result, a concerted effort was made to maintain transparency and openly reflect on the researcher's potential influence on the research throughout.

Strengths	Limitations
<p>The educational professionals involved in Phase 1, ranged in experience and years in their positions. The range of experience in a teaching or EP role, allowed for participants to provide diverse insights and perspectives on their confidence of supporting students with EDs, enriching the depth of understanding gained for RQ1.</p>	<p>In Phase 1, educational professionals from London only completed the questionnaire (this was an artefact from the previous research design). This affects the generalisability of the data (RQ1) to the whole of the UK.</p>

<p>Pilot studies and focus groups were conducted to validate and refine the questionnaire given to educational professionals in Phase 1, ensuring its reliability and validity. The questionnaire represented a novel approach to evaluating confidence levels in educational professionals, and may be a valuable tool for future research in this area.</p>	<p>In Phase 1, teachers were not required to name type of setting they worked (e.g. secondary, primary, grammar, academy, private). Whilst it could be assumed that school staff worked in a range of settings, this cannot be directly drawn from the data. This could mean that some types of schools were over or under-represented, influencing the generalisability of the research to all educational settings.</p>
<p>A notable strength of the interviews in Phase 2, was the emphasis on the emotional wellbeing of participants, with each interview prioritising the participants psychological comfort and giving a safe space for expression. Following the interviews, participants report feeling that the experience was valuable, therapeutic and even enjoyable, highlighting the potential for interviews in research to foster healing and positive emotional outcomes (Appendix F).</p>	<p>Self-reported measures of confidence in theory, intervention and support for students with EDs by EPs and teachers in phase 1, may not translate directly to actual confidence shown in practice. Additionally, confidence was seen as responding >3 on the Likert Scale, which may be seen as subjective cut-off point. Self-reported responses may also have been influenced by the Hawthorne effect (McCambridge, Witton & Elbourne, 2014) where individuals may modify their responses, giving answers that they believe align with what is expected or wanted by the researchers, rather than reflecting on their true feelings.</p>
<p>Participants in Phase 2, were recruited through diverse channels, including posters, Facebook, twitter and snowball sampling. This multifaceted approach to recruitment ensured a broad reach, and allowed for inclusion of individuals from varied backgrounds.</p>	<p>Snowball sampling was used during Phase 2. Whilst this method facilitated inclusion of individuals with relevant insights, it also posed the risk of potential bias or homogeneity within the participant pool, as participants are more likely to refer individuals who share similar experiences (Naderifar, Goli & Ghaljaie, 2017).</p>
<p>Ten participants completed interviews for Phase 2, which is deemed suitable for a small research project (Braun & Clarke, 2013). This contributes to the reliability and credibility of the findings, exploring RQ2 and RQ3.</p>	<p>Only females volunteered and took part in the interviews in Phase 2, which limits the research in terms of its generalisability and diversity of perspectives. Furthermore, it raises questions about the inclusivity of the research process and the potential for overlooking voices from under-represented genders, perhaps necessitating the need for actively seeking males to ensure inclusivity in the study's recruitment.</p>
<p>Extensive time was taken in conducting RTA, involving many iterations of coding,</p>	<p>RTA is still a relatively new research method for the researcher, leading to instances of 'over coding' during</p>

<p>familiarisation and refinement of themes, ensuring thoroughness and rigor in the analysis process. This meticulous approach enhanced the depth of understanding of the data, but also bolstered the validity of findings.</p>	<p>the analysis phase. However, recognising this challenge, efforts were made to mitigate potential biases through extensive review and refinement of the coding process.</p>
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Table 7: Other strengths and limitations identified in this research

6.8 Future research

Future research may benefit from expanding upon the present study, recruiting a broader range of participants (e.g., males and a larger proportion of participants with experience of state education). The researcher believes that future research should continue to seek the perspectives of adults who had EDs in school, as this can offer nuanced, insightful and useful perspectives to help understand the challenges faced by CYP currently with EDs. As discussed thus far, perspectives of emotionally ready individuals retrospectively reflecting on their EDs, may mean that accounts of their experiences at school will be as valid, or more so, than experiences outlined by individuals currently suffering from EDs,

6.9 Conclusion

The findings from this research outline the significant challenges surrounding the support for CYP with EDs in school settings. The present study additionally indicates that both EPs and teachers do not feel adequately confident in their ability to support these individuals, in terms of theoretical understanding, intervention strategies and early signs of identification. Furthermore, the experience of school for individuals who had an ED was varied and multifaceted, affecting aspects of their educational journey including social interactions and academic performance, for the better and for the worse. Lastly, this research highlights the crucial role that school professionals can have in supporting CYP with EDs, with participants reflecting on their general lack of school-based support and offering suggestions toward developing the effectiveness of school-based support.

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APPENDIX A: Information advertising research

Institute of Education



SEEKING ADULTS WHO HAD AN EATING DISORDER WHILST AT SCHOOL FOR IMPORTANT RESEARCH

Are you aged 18+ and had an eating disorder whilst at school in the UK? * This can have been for any period of time in school and does not need to have been formally diagnosed.

Would you be able to take part in a short online interview about your experiences of having an eating disorder whilst at school?



I am Meg Fairclough, an Educational Psychologist in training at the UCL Institute of Education. I am carrying out research to help support children currently in schools with eating disorders, by reflecting with individuals who have gone through the school system with an eating disorder and are able to discuss their experiences during this time.

What will the research involve?

Participation in an online semi-structured interview for 30-45 minutes, which asks individuals to reflect on their experience of having an eating disorder at school. Interviews will draw on 'risk' and 'protective' factors and whether Educational Psychologists and teachers have a role in offering support. Participant information and interviews will be kept anonymous.

We would like to work together with people with lived experience of eating disorders and those supporting them, to better understand the relevance of our resources and to learn about any new content we might need to develop.

If you are interested in taking part in this research or would like more information, please email meg.fairclough.21@ucl.ac.uk.

ARE YOU AN ADULT WHO HAD AN EATING DISORDER WHILST IN SCHOOL ?

WOULD YOU BE HAPPY TO REFLECT ON YOUR EXPERIENCES IN A SHORT ONLINE INTERVIEW?

Please get in touch with meg.fairclough.21@ucl.ac.uk for more information about the research and to be part of the study.

APPENDIX B: Online questionnaire for Educational Psychologists

Educational Psychologists and Understanding Eating Disorders

Introduction This online questionnaire is being sent to Educational Psychologists (and Educational Psychologists in training) in boroughs across Greater London to ascertain whether Educational Psychologists feel confident in supporting those with eating disorders (staff or student), in terms of theory, interventions and early signs of identification.

Thank you for your time completing this questionnaire - please submit your answers by 8th July, 2023. All responses are kept anonymous, although by completing the questionnaire you will be consenting to your anonymous data being used for analysis. Any questions, please email XXXXX

Q1 What is your current position?

- Educational Psychologist (EP) (1)
- Trainee Educational Psychologist (TEP) (2)

Q2 If you are a qualified Educational Psychologist, how long have you been qualified for?

- 0-5 years (1)
- 6-11 years (2)
- 12-17 years (3)
- 18-23 years (4)
- 23 years plus (5)

Q3 How do you conceptualise eating disorders? (please write a sentence or two about how you define eating disorders and understand them in terms of mental health).

Q4 Have you ever received training on eating disorders?

- Yes (1)
- No (2)

Q5 If you have received training on eating disorders, please may you briefly describe what the training included and whether this training was in isolation, or looking at mental health in schools more broadly? (note this training can be prior to EP training or in a previous role)

Q6 Have you ever had direct experience of working with individuals with eating disorders?

- Yes (1)
- No (2)

Q7 If you have had experience of working with individuals with eating disorders, please may you briefly outline what this work entailed? (for example, statutory, traded, intervention groups, consultation).

Q8 For the following questions, check the response that best characterises how you feel about the statement, where: 1 = Strongly Disagree, 2 = Disagree, 3 = Neither Agree Nor Disagree, 4 = Agree, and 5 = Strongly Agree

	Strongly disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Strongly agree (5)
I feel confident in identifying signs of eating disorders. (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel confident in suggesting support for individuals with eating disorders. (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel that I have a good understanding of the physical consequences of eating disorders. (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel that I have a good understanding of the psychological consequences of eating disorders. (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel that I have a good understanding of the social consequences of eating disorders. (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel confident in distinguishing between the common types of eating disorders. (6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I feel that I have a good understanding of the risk factors associated with the development and maintenance of eating disorders. (7)

I feel that I have a good understanding in which an individual's home can support someone recovering from an eating disorder. (8)

I feel that I have a good understanding in which an individual's school can support someone recovering from an eating disorder. (11)

I feel confident in signposting services that can offer support to young people with an eating disorder. (9)

I feel that I have a good understanding of potential treatment options for young people with eating disorders. (10)

I feel confident in signposting services that can offer support to school staff with an eating disorder. (12)

I feel that I have a good understanding of potential treatment options for school staff with eating disorders. (13)

APPENDIX C: Online questionnaire for teachers

Teachers and Understanding Eating Disorders

Q13 This online questionnaire is being sent to qualified teachers in boroughs across Greater London to ascertain whether teachers feel confident in supporting pupils with eating disorders, in terms of theory, interventions and early signs of identification.

Thank you for your time completing this questionnaire - please submit your answers by 30th November 2023. All responses are kept anonymous, although by completing the questionnaire you will be consenting to your anonymous data being used for analysis. Any questions, please email XXXX

Q1 Please confirm you are a qualified teacher working in Greater London.

Yes I am (1)

Q2 How long have you been a qualified teacher for ?

- 0-5 years (1)
- 6-11 years (2)
- 12-17 years (3)
- 18-23 years (4)
- 23 years plus (5)

Q3 How do you conceptualise eating disorders? (please write a sentence or two about how you define eating disorders and understand them in terms of mental health).

Q4 Have you ever received training on eating disorders?

Yes (1)

No (2)

Q5 If you have received training on eating disorders, please may you briefly describe what the training included and whether this training was in isolation, or looking at mental health in

schools more broadly? (note this training can be prior to teacher training or in a previous role)

Q6 Have you ever had direct experience of working with individuals with eating disorders?

Yes (1)

No (2)

Q7 If you have had experience of teaching or working with individuals with eating disorders, please may you briefly outline what this entailed?

Q8 For the following questions, check the response that best characterises how you feel about the statement, where: 1 = Strongly Disagree, 2 = Disagree, 3 = Neither Agree Nor Disagree, 4 = Agree, and 5 = Strongly Agree

	1 - Strongly Disagree (1)	2 - Disagree (2)	3 - Neither Agree Nor Disagree (3)	4 - Agree (4)	5 - Strongly Agree (5)
I feel confident in identifying signs of eating disorders. (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel confident in suggesting support for individuals with eating disorders. (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel that I have a good understanding of the physical consequences of eating disorders. (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel that I have a good understanding of the psychological consequences of eating disorders. (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel that I have a good understanding of the social consequences of eating disorders. (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel confident in distinguishing between the common types of eating disorders. (6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I feel that I have a good understanding of the risk factors associated with the development and maintenance of eating disorders. (7)

I feel that I have a good understanding in which an individual's home can support someone recovering from an eating disorder. (8)

I feel that I have a good understanding in which an individual's school can support someone recovering from an eating disorder. (9)

I feel confident in signposting services that can offer support to young people with an eating disorder. (10)

I feel that I have a good understanding of potential treatment options for young people with eating disorders. (11)

APPENDIX D: Semi-structured interview guide

45 minutes total (excl. pre)

Pre:

- *Thank participant for agreeing to take part.*
- *Reminder of right to withdraw at any point.*
- *Confirmation of age, gender and that they have a lived experience of having had an eating disorder.*
- *Reminder of purpose of the study, and emphasis on the perspective of the participant.*
- *Clarify that questions can be asked at any point in the process.*
- *Check that audio recording is acceptable, and participant is happy to continue*
- *Outline summary of own ED experience*

Please may you tell me a little bit about yourself and your current occupation/position/role?

- Age
- Location
- Current occupation

Thank you for that. Could you share now with me a little about your experiences of being at school whilst having an eating disorder?

- What diagnosis, how long for.
- Positives, negatives
- Are there any examples that spring to mind?

How do you think your ED influenced you at school?

- communication and interaction
- cognition and learning
- social, emotional and mental health
- sensory/physical.
-

Can you identify any factors in the school environment that acted as 'risk' factors, or you found particularly difficult to deal with?

- Events
- Peers
- Subjects
- Stressful environments
- Pressure to perform
- Unpredictable work schedule
- Any examples spring to mind?

Can you identify any factors in the school environment that acted as 'protective' factors, or that you found supported eating disorder recovery or generally helped?

- anecdotes
- school aware
- Peers aware

Did you ever receive support for your eating disorder whilst you were at school?

- Formal support/informal support
- Treatment psychologically or medically
- Why did you decide to get treatment
- Why did you decide to not get treatment

Do you feel there is a role for school professionals (educational psychologists or teachers), in offering support for pupils with eating disorders? (clarify what EPs are if unknown)

- What school/educational professionals should know about how to support teaching staff with EDs?
- How would this differ from ways to support individuals with EDs in schools?
- How do you think other individuals with EDs (in schools) would react to this?
- What skills/attributes do you think the professionals delivering the toolkit/support will need?
- How would these individuals with EDs be monitored over the school year?

Ending (5 minutes)

Is there anything you feel we should have discussed that we haven't?

APPENDIX E: Information sheet and consent form for interviews

An exploration of the experiences of adults who had an eating disorder whilst in school and the role that teachers and Educational Psychologists may have in offering support.

Participant Information Sheet

XXXXX

I am inviting you to participate in a semi-structured interview which is asking for young people aged 18-25 to reflect on their past experience of having an eating disorder at school. Interviews will draw on 'risk' and 'protective' factors and whether Educational Psychologists and teachers have a role in offering support. We want to better understand the relevance of our resources and to learn about any new content we might need to develop.

Thank you for reading this information sheet. Please let us know if you have any questions at any point by contacting me at XXXX

If you would like to be involved, please respond to this email with the completed consent form and if you could give me three potential dates/times of when is convenient to carry out the interview. I will try and organise an interview for one of your options (which can include weekends). I will be in touch after that with a Zoom link and confirmation email.

This project has been reviewed and approved by the UCL Institute of Education Research Ethics Committee.

Why are we doing this research?

The value of this research lies in its potential to help support children currently in schools with eating disorders, by reflecting with individuals who have gone through the school system and are able to discuss their experiences.

We would like to work together with people with lived experience of eating disorders, those supporting them professionally and non-professionally to learn more about the unique group and to collaborate on developing new tools that are relevant to a wider group of people.

Why am I being invited to take part?

We are asking you to take part because you are a key stakeholder in this content. These interviews are seeking the voice of this population.

What will happen if I choose to take part?

We will ask you to provide consent prior to participation.

In the semi-structured interview, I will ask you a number of questions that are open-ended in nature. I will ask a little about your experience of being at school whilst having an eating disorder, and also what supported you/did not. The questions we will ask you will, for example be “Can you identify any factors in the school environment that you found particularly difficult to deal with?”

The interview will be accessed through a personal invite on Zoom and only those who have consented to take part will receive this email. The interview will be audio-recorded to help with data analysis. After the interview we will transcribe the interview and use a pseudonym to protect your identity. We will use quotations from the interviews to support the findings, but we will not use any quotations that reveal your identity or contain personal information.

If you are happy to participate in this study, please complete the attached consent form.

Could there be problems for me if I take part?

It could be a bit tiring to sit through a 45-minute interview. Feel free to take breaks and turn your camera off if this helps.

It might feel daunting to speak about your experiences. Please feel free to leave the interview at any point if you feel uncomfortable – your participation is entirely voluntary. A facilitator will offer you support and signposting services.

Do I have to take part?

It is entirely up to you whether or not you choose to take part. We hope that if you do choose to be involved then you will find it a valuable experience.

What will happen to the results of the research?

We will hopefully report the findings in an academic research article. Please let us know if you would like to receive a copy. We will not include any identifiable information about you in this report. We will upload the anonymised transcripts of the interviews to the UCL data repository which could be accessed by other researchers. For example, they might want to combine these data with those from other studies to review the provision of support for adults with eating disorders. Your identity will be protected with a pseudonym. Before uploading the transcript, any text which links back to your identity will be redacted. For example, if you mention your workplace or a hospital where you have received treatment, we would remove this information.

Data Protection Privacy Notice

The controller for this project will be University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk This 'local' privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information from research studies can be found in our 'general' privacy notice for participants in research studies here. The information that is required to be provided to

participants under data protection legislation (GDPR and DPA 2018) is provided across both the 'local' and 'general' privacy notices. The lawful basis that will be used to process any personal data is: 'Public task' for personal data and 'Research purposes' for special category data. We will be collecting personal data such as your age, gender, ethnicity, eating disorder experience (e.g. whether you are a person with personal experience, a supporter or a health professional) and your thoughts and ideas on the materials we have designed. Your personal data will be processed so long as it is required for the research project. If we are able to anonymise or pseudonymise the personal data you provide we will undertake this, and will endeavour to minimise the processing of personal data wherever possible. If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at dataprotection@ucl.ac.uk.

Contact for further information:

XXXXX

If you would like further support or information on eating disorders, please look at the resources provided by Beat, the UK's largest eating disorder charity:

<https://www.beateatingdisorders.org.uk/>

If you need immediate assistance for your eating disorder or for a loved one's eating disorder, then please call 999, present at your local accident and emergency department or contact a health professional.

This study has been approved by the UCL Institute of Education Research Ethics Committee.

An exploration of the experiences of adults who had an eating disorder whilst in school and the role that teachers and Educational Psychologists may have in offering support.

Consent Form

If you are happy to participate in this study, please complete this consent form below.

Yes

I have read and understood the information sheet about the research.

I understand that if any of my words are used in reports or presentations, they will not be attributed to me and my data will be anonymised/pseudonymised.

I understand that up until data analysis, I will be able to withdraw my participation without explanation following the study.

I understand that I can contact XXX at any time following the study and request for my data to be removed from the project database.

I consent to being audio-recorded during the interview (to enable transcription).

I understand that other genuine researchers may use my words in publications, reports, web pages, further work and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form.

Name: _____

Signed: _____

Date: _____

XXXX

UCL Institute of Education

20 Bedford Way, London, WC1H 0AL

Potential date and time of interview:

1)

2)

3)

Signposting services

BEAT

<https://www.beateatingdisorders.org.uk/>

<https://www.beateatingdisorders.org.uk/get-information-and-support/get-help-for-myself/i-need-support-now/helplines/>

Groups available @ BEAT:

Enter ALL service user info and any/no preferred support types in blue cells. Appropriate service options will show highlighted in green. Tip: Click the service name at the top for further info/link to website page.		BED Guided Self Help	Nexus	Solace	Raising Resilience	Bolster	Echo	Beat Scotland	Swan	Kingfisher	Nightingale	Aviary	Sanctuary	Message Boards
Service availability		FULL	FULL	Available	Available	FULL	Available	Available	Available	Available	Available	Available	Available	Available
Service User (required)		BED	Cares (parent, sibling 16+, partner- not suitable for ARFID, ED <5 years.	Cares	Cares, ED <5 years.	Bulimia, BED	Cares (parent, sibling 16+, partner)	Any ED	Anorexia	Bulimia	BED	Cares	Any ED	Any ED
Location (required)		London	Anywhere	Anywhere	Anywhere	Anywhere	Essex, Sussex, Scotland	Scotland	Anywhere	Anywhere	Anywhere	Anywhere	Anywhere	Anywhere
Age (required)		18+	Any	Any	Any	16+	Any	12-25	Any	Any	Any	Any	Any	Any
Formal (leave blank for any)		Weekly telephone calls	Weekly 40 min telephone calls	Weekly 90 min video calls	Weekly 90 min video calls	Weekly 40 min telephone calls	Weekly telephone calls	1-3 emails per week	Online Group- Mon & Thu 18:45-20:00	Online Group- Wed & Sat 18:45-20:00	Online Group- Tue & Fri 18:45-20:00	Online Group- Sun/Tue 18:45-20:00	Online Group- Daily 09:00-20:00 Mon-Fri, 16:00-20:00 Sat-Sun	Message Boards- with messages anytime, which are moderated 09:00-00:00.
Supported By (leave blank for any)		Facilitated by Beat Specialist Support Officers	Facilitated by Beat advisor	Peer support, facilitated by Beat Clinicians	Structured support with peers, facilitated by Beat clinicians	Facilitated by Beat advisor	Support from Echo Coaches (cares of loved ones now recovered from ED)	Support from befriended now recovered from ED	Peer support, facilitated by Beat Advisors	Peer support, facilitated by Beat Advisors	Peer support, facilitated by Beat Advisors	Peer support, facilitated by Beat Advisors	Peer support, facilitated by Beat Advisors	Peer support, facilitated by Beat Advisors
What's involved:		8 calls over 12 weeks, 10 places available	Similar to Echo, 12 calls over 3 months. Based on Janet Treasure book. Loved one up to 5 years with ED.	Based on Janet Treasure book. Over 6 months.	Expansion of Developing Dolphins- focussed on communication and motivational skills. Loved one up to 5 years with ED.	Similar to BED Guided Self Help- support, coaching, advice. Up to 24 calls.	24 calls over 6 months	Support for up to 1 year	Facilitated weekly themes	Facilitated weekly themes	Facilitated weekly themes	Open chat plus regular Q&As from Ambassadors/Clinicians	Hourly facilitated themes plus regular Q&As from Ambassadors/Clinicians	Available for anyone with an ED themselves or caring, Young person and Adult boards available.
How to refer/signpost service user:		Go through the screening questions in BED Guided Self Help tab (Click here), take name, phone number, email address and Oracle ref to pass to supervisor.	Email/give this link to the carer to complete the form or complete it with them over the phone. Click the link	Direct user to register/book on website: Services@m Someone@Solace. Click for link .	Direct user to register/book on website: Services@m Supporting Someone@Raising Resilience. Click for link .	Direct user to email bolster@beateatingdisorders.org.uk	Direct user to register on website: Support Services@My Area@Echo Peer Coaching. Click for link .	Direct user to register on website: Support Services@My Area@SHARED. Click for link .	Direct user to register on website: Support Services@Support For Myself@Online Support-Chat Support. Click for link .	Direct user to register on website: Support Services@Support For Myself@Online Support-Chat Support. Click for link .	Direct user to register on website: Support Services@Support For Myself@Online Support-Chat Support. Click for link .	Direct user to register on website: Support Services@Support For Myself@Online Support-Chat Support. Click for link .	Direct user to register on website: Support Services@Online Support Groups. Click for link .	Direct user to register on website: Support Services@Message Boards. Click for link .

SEED CHARITY - <https://seed.charity/>

TALK-ED - <https://www.talk-ed.org.uk/>

PEDS - <https://www.pedsupport.co.uk/>

NHS advice - <https://www.nhs.uk/mental-health/feelings-symptoms-behaviours/behaviours/eating-disorders/overview/>

Caraline - <https://caraline.com/>

Hector's House - <https://hectorshouse.org.uk/about/our-work/>

Mind - <https://www.mind.org.uk/information-support/types-of-mental-health-problems/eating-problems/for-friends-family/>

APPENDIX F: Feedback from participants post interview

Caroline	<i>Honestly it has been such, what you said earlier, of like saying I hope it has been a powerful experience. That was the exactly the kind of word that came to mind was. It has been so nice to have a space to talk about this because obviously it goes to your head and it's, it's hard to find people who really understand and kind of ask the right questions to be able to give you that space. So thank you, to you as well for kind of doing this research. And I am so happy that I was able to kind of contribute a little bit to it.</i>
Bethan	<i>It's made me think about a lot of things I hadn't really thought about before and just think about them in a different way.</i>
Maddie	<i>It was good to talk about. You get it and so I felt I was able to like also think about it properly and not feel like embarrassed or anything.</i>
Trisha	<i>That was so interesting. [MF – I hope that was a useful space for you]. Absolutely. Would you be happy to send me through the recording? There were certain things in there where I was like oh I hadn't thought about it like that before. [Trisha is writing a novel].</i>
Gemma	<i>It was cathartic and I actually enjoyed it. I feel good.</i>
Dianne	<i>I've never gotten to talk about it before. I've never had treatment for it. [MF: How does it feel? You ok?] It feels, yeah it feels incredible. I've got friends that I have met online through eating disorder forums and stuff who I can talk to, talk to about this, but like having an actual almost face to face conversation, it's like, especially with our parallels as well.</i>
Lesley	<i>Thank you so much. Thank you. As I say, I have been working on it myself for year now erm., and when I saw your poster I was like (pause) this thing that I went through, I don't want children and young people to go through that. It's absolute ****. And I passed under the radar so easily, so easily you know.</i>