

Title:

The role of pride in anorexia nervosa: A qualitative study

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Abstract

Objective: Theory and clinical literature suggest that pride may play an important role in the maintenance of eating disorders. A grounded theory study explored experiences of, and reflections on, pride among women with a current or past diagnosis of anorexia nervosa.

Design: This is a qualitative study using social constructivist grounded theory.

Method: Semi-structured interviews were conducted with 21 women recruited from an eating disorders unit in England, and from a UK self-help organization. Grounded theory from a social constructivism approach was used. Analysis involved coding, constant comparison and memo-writing.

Results: Pride evolves over the course of anorexia. Two overarching conceptual categories were identified: 'Pride becoming intertwined with anorexia' and 'Pride during the journey towards recovery'. These categories encompassed different forms of pride: 'alluring pride', 'toxic pride', 'pathological pride', 'anorexia pride', 'shameful pride', 'recovery pride' and 'resilient pride'. Initially, pride contributed to self-enhancement and buffered negative emotions. As the condition progressed, pride became a challenge to health and interfered with motivation to change. During recovery, perceptions of pride altered as a healthy approach to living ensued.

Conclusions: The evolving nature of pride plays a central role in development, maintenance, and treatment of anorexia. Understanding of pride and its role in psychotherapeutic work with this client group may increase motivation to change and promote recovery. Future work should investigate if tackling pride in eating disorders increases treatment efficacy and reduces the risk of relapsing.

Keywords: eating disorders; anorexia nervosa; pride; grounded theory; qualitative research.

Practitioners Points

- Pride associated with anorexia appeared to evolve in nature.
- During early stages of the eating disorder, it stopped people from seeking help. Later on, it prevented them from seeing pride in healthy domains of life (outside anorexia). Over time, pride in anorexia became an overwhelming emotion that interfered with motivation to change.
- It is important for practitioners to assess and discuss pride in anorexia and its evolving nature during treatment.
- Understanding of pride and its role in psychotherapeutic work with this client group may increase motivation to change and promote recovery.

The importance of pride in eating disorders was first recognized by Bruch (1973), who highlighted that one of her patients with anorexia nervosa experienced a “sense of glory and pride in the self-denial and feeling hungry” (p. 268). In line with this, Bemis (1986) interviewed women with anorexia nervosa and found that feelings of pride, feeling triumphant, powerful, special, and superior were common experiences linked to weight loss. However, the study of pride was neglected for several decades. There is only one theoretical model including pride as a factor that explains the onset and maintenance of eating disorders and it’s the shame and pride model recently developed by Goss and Gilbert (2002). According to Goss and Gilbert’s model (2002) people with eating disorders experience pride in their ability to control food intake, body weight and shape, and to resist desires or impulses to eat; whilst shame is associated with failure to succeed in these endeavours. Thus, pride linked to restrictive eating becomes both a consequence of, and maintenance factor in eating disorder behaviours (Allan & Goss, 2012; Goss & Allan, 2009, 2014; Goss & Gilbert, 2002).

Research into pride in eating disorders is sparse. Only four qualitative studies alluded to pride being an important theme in the narratives of participants with eating disorders, mostly women with anorexia nervosa. Dignon, Beardsmore, Spain, and Kuan (2006) explored perceptions of the causes of anorexia and found that participants used control over food to cope with unhappiness. Being able to exert this type of control gave individuals a sense of pride, which then prompted them to restrict their eating further. Skarderud (2007) investigated shame and found that participants also reported pride in self-control, pride in appearance, pride in being extraordinary (e.g. being able to restrict food intake when others could not do so), and pride in the use of thinness to signal rebellion and protest. Similar findings were reported by Elsworth (2006), who examined shame in anorexia and bulimia nervosa. Recently, Robinson and colleagues (2015) interviewed individuals living with anorexia for more than 20 years and found that they experienced a sense of pride at their endurance and survival in spite of the

eating disorder. These findings provide initial evidence that pride is an important emotion experienced mainly in women in anorexia nervosa. However, none of these studies focused specifically on the investigation of pride and its function as the illness progresses. Despite the current, emerging interest in the role of pride in eating disorders, systematic research is limited.

This is the first study to explore experiences of, and reflections on, pride in women with a current or past diagnosis of anorexia nervosa. A qualitative approach was chosen for two reasons. First, research in this area is in its early stages and a qualitative approach was considered a fundamental step to collect in-depth data and to develop our theoretical knowledge on the role of pride in anorexia nervosa (Mays & Pope, 1995). Second, to enrich emotional models of eating disorders and inform the continued development of psychological interventions, it is crucial to learn about pride from a service-user oriented perspective.

Method

Design

A constructivist grounded theory approach (Charmaz, 2006) was adopted to develop an integrated explanatory theory of the role of pride in anorexia nervosa.

Recruitment

Purposive sampling was used to recruit a varied sample of women with anorexia nervosa at different stages of the disorder (i.e. inpatients, day care patients, outpatients, and not currently in treatment but with a past experience of the illness). Theoretical sampling was applied to further understand and define theoretical categories emerging from the analysis following principles of grounded theory (e.g. through constant comparison and analysis shaping further data collection).

Participants were recruited through an adult Eating Disorder unit in England, which provides in-patient and day-care services, and a UK charity known as Beat¹ (Beating Eating Disorders). Inclusion criteria were: (1) females over 18 years of age, (2) with a current or past history of anorexia nervosa, and (3) competency in English. Diagnosis of participants from the Eating Disorder service was confirmed by the resident consultant psychiatrist using the International Classification of Diseases-10 (World, Health, & Organization, 1992). Participants recruited from Beat identified that a health professional had formally diagnosed them with anorexia nervosa.

Sample size was defined by criteria of theoretical sufficiency (Charmaz, 2006; Dey, 1999). The authors concurred that theoretical sufficiency was achieved after 21 interviews. Theoretical sufficiency was indicated by the thoroughness of data collection, as well as the rigor of the analysis; concepts developed from the data were dense, detailed and differentiated to a sufficient extent to generate a robust theory.

Data collection

Participant information sheets (PIS) were provided to patients attending community meetings at the eating disorder unit. Individuals who did not attend community meetings were able to find PIS in the unit and from staff. An advertisement for the study was also placed on Beat's website and in its newsletter. All participants provided written informed consent, were interviewed and were asked to complete two self-report questionnaires, i.e. the Eating Disorder Examination Questionnaire (EDE-Q; Fairburn & Beglin, 1994), and the Clinical Impairment Assessment Questionnaire (CIA; Bohn et al., 2008).

¹ Beat is the UK's leading charity supporting people affected by eating disorders or experiencing difficulties with food, weight and shape (www.b-eat.co.uk).

Fourteen participants were interviewed face-to-face and seven over the phone due to geographical location. Telephone interviews were of comparable length, content and quality to face-to-face interviews. Interviews lasted approximately an hour. All were audio-recorded and transcribed verbatim. Any identifying information (e.g. names, locations) was removed from the transcripts to protect participants' anonymity. Approval was obtained from the North West Preston NHS Research Ethics Committee (Ref Number: 13/NW/0038).

An initial interview schedule was developed through discussion between the research team and reviewed by an expert with experience (i.e. a woman with anorexia) to ensure that questions were clear and posed sensitively. The initial interview schedule included general questions about the eating disorder (e.g. symptoms, number of hospitalizations) and about participants' emotional experience of the condition. Interviewees were then asked to describe the meaning of pride and to think about times when they experienced it, past and present. The initial interview schedule was then refined following analysis to collect further data and gain a deeper understanding on the phenomenon under investigation.

Data analysis

Following the procedures of social constructivist grounded theory (Charmaz, 2006), data collection and analysis occurred simultaneously, with analysis informing further data collection. Initial analysis prompted a refinement of the interview schedule in order to clarify gaps in the data and gain a deeper understanding (see **Table 1**).

Although analysis was on-going and dynamic, it is presented here in a linear way to facilitate understanding. First, data were analysed line-by-line to capture a descriptive picture of each participant to start developing an understanding on the role of pride over the course of the illness. This is known as initial coding (Charmaz, 2006). Second, data were analysed through focused coding, applying a method of constant comparison, meaning that data within

and across participants were compared for similarities and differences, and emerging ideas were tested (Charmaz, 2006). Third, focused codes were grouped into theoretical categories to explain large segments of data, including conceptual definitions, in order to move towards an analytic level of abstraction. Finally, categories were linked to build a theoretical model (Charmaz, 2006).

Throughout data collection and analysis, memos and conceptual diagrams were used to facilitate comparisons between participants and to assist with theoretical integration. Analysis was supported by NVivo-10 software (QSR International Pty Ltd., 2012).

Rigour and efforts to maximize quality

This study followed accepted guidelines to ensure quality, validity and reliability in qualitative research (Elliott, Fischer, & Rennie, 1999; Yardley, 2000). These included: i. addressing authors' theoretical orientations and being reflective about their background, values and assumptions, ii. describing research participants, iii. providing examples through interview quotations to illustrate the analytical procedure and the developed understanding, iv. discussing and checking codes, memos, field notes, theoretical sufficiency, and developing theory in debriefing sessions with the research team (Holloway & Wheller, 2010; Robson, 1993). In addition, initial codes derived from analysis by the first author were assessed by a member of the research team, resulting in 88% agreement. Disagreement on the codes was resolved through discussion.

Reflexivity

The first author is a 32-year old White Italian/Argentinian woman, who has eight years of experience working with people with mood disorders and borderline personality disorders, some of whom had an eating disorder. The first author became particularly interested in this

group because they reported an overwhelming negative state but also positive emotions attached to the eating disorder, and therapy was often less effective for them compared to borderline personality disorders clients without eating disorders.

Other members of the research team had either considerable experience in clinical or research work (quantitative and qualitative methodologies) in eating disorders, and/or mental health.

Results

Participant characteristics

Participants were 21 women aged 18 to 61 ($M = 29.67$, $SD = 12.19$). See **Figure 1** for details about their treatment status. Time since diagnosis ranged from one week to 43 years. Over half of participants ($n = 11$) fell into the weight range to be classed as having anorexia ($BMI \leq 17.5$). The remainder had a BMI ranging from 18.36 to 24.65 ($M = 20.07$; $SD = 2.88$). Scores from the EDE-Q and the CIA are presented in **Table 2** and indicate variance in the sample. Higher scores on the EDE-Q indicate greater levels of eating psychopathology and higher scores on the CIA indicate higher levels of psychosocial impairment due to eating disorder features. All women defined themselves as Caucasian.

Conceptualization of pride

Pride was defined by the participants as an emotion experienced when something valuable to them, or others, was achieved. They related pride to feelings of success, superiority, happiness, confidence, self-worth, self-esteem and self-respect.

During the interviews, after a question including the word ‘pride’, participants used the following expressions: ‘feeling elated’, ‘feeling a buzz’, ‘feeling excited’, ‘feeling fascinated’, ‘feeling ecstatic’, ‘feeling high’, ‘feeling a kick’, ‘feeling on the top of the world’, ‘feeling

superior', 'feeling invincible', 'feeling powerful', 'feeling strong', 'feeling good'. Accordingly, the interviewer interpreted those expressions as related to pride.

Theoretical Model: Overview

The analysis revealed that pride was experienced from two different sources: 'pride in myself' and 'pride through others'. The former included pride linked to achievements that were meaningful to the individual, and the latter to thoughts of what others valued. 'Pride in myself' had a direct, immediate, and long-lasting effect, whereas 'pride through others' was indirect, distant, and transitory. Prior to the onset of anorexia, some participants experienced 'pride through others' (i.e. parents, teachers, coaches) based on their high performance at school/university/work and in sports. However, all women reported a lack of 'pride in myself' before the illness and emphasized that through food restriction, weight loss and thinness, 'pride in myself' (that did not involve others) started to emerge. This suggests that 'pride in myself' is a standalone pride, whereas 'pride through others' is an interdependent pride experienced through achievements that please others more than the individual.

These two sources formed part of a key concept to emerge within the data, which was that pride in anorexia evolves over the course of anorexia nervosa. This notion of evolving pride was underpinned by two overarching categories: i. 'pride becoming intertwined with anorexia' and ii. 'pride during the journey towards recovery'. Seven forms of pride (theoretical codes) were evident within these categories, and they were labelled as follows: 'alluring pride', 'toxic pride', 'pathological pride', 'anorexia pride', 'shameful pride', 'recovery pride' and 'resilient pride'. **Table 3** shows the focused codes that underpin these seven forms of pride. A visual representation of the final theoretical model including the relationship between different codes and categories is presented in **Figure 2**.

Pride becoming intertwined with anorexia

The first overarching category relates to the role of pride in the onset and maintenance of anorexia. At the beginning of this disorder, participants described experiencing a significant amount of negative affect (i.e. sadness, unhappiness, shame and embarrassment towards their body and themselves) and felt highly distressed, overwhelmed, out of control, and vulnerable (i.e. pressure at school/university/work, grieving the death of a loved one,). After changing their diet and losing some weight, an unexpected yet pleasant pride transpired, that had an impact on their self-evaluation and seemed to prompt them to engage in further restrictive eating. This relates to the theoretical concept defined as ‘alluring pride’.

Alluring Pride

This theoretical concept captured participants’ descriptions of pride at the beginning of anorexia. Upholding restrictive eating rules (e.g. not consuming chocolate during the week) and subsequent weight loss affected participants’ perceptions and feelings towards themselves, which increased their ‘pride in myself’. ‘Alluring pride’ was experienced by every interviewee, regardless of age, and was specific to onset of the condition.

‘Alluring pride’ was characterized as being unforeseen and immediate. Women seemed to be lured into anorexia, which explained their rapid adherence to further food restriction and weight loss.

P17: ...if you’d skipped a meal and you’d managed to not give into it (eating) then you felt good, or if you’d weighed yourself and you’d lost weight, then you felt good, so it was just trying to get to that point where you felt proud of yourself, I was just kind of driven.

It became apparent through the analysis that ‘alluring pride’ was a tangible emotion that fostered self-enhancement, thereby commencing ‘pride in myself’. This was reinforced by

social approval through feedback on weight loss and physical appearance, leading to participants also experiencing ‘pride through others’.

Toxic pride

As the eating disorder progressed, ‘alluring pride’ evolved into ‘toxic pride’, with interviewees becoming immersed in anorexia and its rules, meaning that they excluded more foods, began to skip meals regularly, exercised more in order to burn off calories, and some started to use laxatives, diuretics, and occasionally made themselves sick. The term ‘toxic pride’ highlights its immediate, powerful effect and the challenge it posed to individuals’ health. Compared to ‘alluring pride’, ‘toxic pride’ was aggressive and competitive. It centered on participants being in control of their eating and their emotions.

During ‘toxic pride’ interviewees depicted pursuing feelings of pride by continuing to carry out restrictive eating behaviours. ‘Toxic pride’ was constant, reliable, achievable and predictable; characteristics that meant participants overlooked its unhealthy nature.

P20: When you kind of step on the scales, and you’ve lost a little bit more, there’s that sense of pride because you did it again!, but at the same time [...] it doesn’t feel right

Pride experienced through the use of laxatives and self-induced vomiting was less commonly reported. Instead, interviewees discussed feelings of shame and guilt in bingeing, although they did experience pride through a sense of control linked to planning when and where to make themselves sick and not being discovered.

P8: ...if you’ve eaten something that you’re not comfortable with and then you’ve managed to alleviate your body of it, by laxatives or purging, then you feel proud that you’ve managed to do that, to regain the control, but then you still feel the guilt of eating it in the first place.

This seems to suggest that ‘toxic pride’ was a transitory feeling that buffered negative feelings but did not eradicate them.

‘Toxic pride’ involved participants’ ability to ‘*shield*’ (P12) and ‘*protect*’ (P20) their autonomy and independence from others perceived as figures of authority (i.e. parents, coaches). It was related to a perception of actively coping with negative emotions, which led to a sense of control and strength and, consequently, increased ‘pride in myself’.

P12: *The only way I could get some control back was to be like, well I’m not eating that food, [...] it was like me silently but very powerfully, going, fuck off! (laughs)... It’s not pride as people would imagine, like, oh I’m so proud of how I look, it’s pride as in, I need to keep some self-esteem otherwise I’m going to crumble, that kind of pride.*

During ‘toxic pride’, interviewees experienced pride through perceiving themselves as superior to others who were unable to maintain a diet, could not lose weight, and were not as thin as them. This appeared to reinforce interviewees’ personal value, driving them on to engage further in eating disordered behaviours and competitiveness.

P15: *I lived in a hostel that was catered, they’ll give you pizza and chips and I’d feel proud that I could go downstairs and other dancers would be eating that, and I’d think, no, I’m just going to have the salad...although the competition was never explicit... I was imagining in my head that they were in awe of me.*

Pathological pride

Over time, ‘toxic pride’ evolved into ‘pathological pride’. The label ‘pathological pride’ emphasizes that women’s sense of self was overtaken by the illness, as illustrated by phrases such as: ‘*My personality was completely gone... I didn’t have anything of myself left*’ (P1), ‘*I am submerged in the anorexia*’ (P10). Individuals seemed to develop pride in an anorexic identity. Unlike ‘toxic pride’, ‘pathological pride’ was unchallenged and interviewees seemed to give into it in order to maintain ‘pride in myself’. ‘Pathological pride’ revealed feelings of empowerment associated with extreme thinness and focused on being successful in extreme

behaviours (i.e. not eating for days, over exercising) associated with being a ‘*very good anorexic*’ (P6).

‘Pathological pride’ was experienced as an immediate, positive feeling. However, compared to ‘toxic pride’, participants encountered unpleasant feelings related to physical discomfort, which they regarded as a sign of endurance. For instance, P9 described over-exerting her body limits when she was swimming.

P9: ...it just made me feel really powerful...my legs would feel like jelly...but you push yourself to keep going, [...] it's not necessarily pleasant, but it still gives you a buzz, a sense of pride and control.

Analysis highlighted that during ‘pathological pride’, interviewees augmented their ‘pride in myself’ through comparing themselves to others and judging themselves as the best, which led to feelings of grandiosity (in contrast to ‘toxic pride’ where they experienced feelings of superiority). Furthermore, participants’ experiences during ‘pathological pride’ had a particular tone and intensity. For example:

P6: I felt like a sense of pride that I'd managed to get my BMI lower than anybody else in this unit [...] it was like, you'd gone as far as you could go kind of thing, it feels like on top of the world.

Another characteristic of ‘pathological pride’ was that it was followed by a sense of not being good enough. This seemed to have a strong influence on setting new goals to maintain ‘pride in myself’, which appeared to be threatened. ‘Pathological pride’ was experienced after reaching these new targets, but it was instant and fleeting. Over time eating disorder behaviours became more extreme and feelings of pride were increasingly short lived.

During ‘pathological pride’, interviewees recalled receiving comments from other people indicating that extreme thinness was a physical issue to be worried about. This reinforced rather than reduced their pride because it was seen as confirming their success.

P10: *One of the lads in my class who had bullied me just relentlessly about being fat... he turned round to me and said, oh you've lost weight, you're looking good, but I looked horrendous, as by this time I was getting on for six stone, and of course, for someone to start saying you look thin, even if they say it as a negative thing, you think, oh, well it's working, I am succeeding.*

It became apparent through the analysis that 'pathological pride' prevented women from developing pride in achievements outside anorexia. This seemed to be related to an inability to see where the self ended and anorexia started.

P17: *I can feel proud of what I'm doing, but the anorexia does stop me feeling proud when it's bad, just, 'cos it doesn't matter, everything you are proud of is centered around it.*

Pride during the journey towards recovery

The second superordinate category relates to women's experiences of, and reflections on, pride during and after treatment of anorexia. Participants reported that their journey towards recovery started with a moment of clarity, when they realized how ill they were and believed that anorexia was going to lead them to death. During the journey towards recovery, pride changed and resulted in these different forms: 'anorexia pride', 'shameful pride', 'recovery pride', and 'resilient pride'. As individuals entered treatment, they started to acknowledge that 'toxic' and 'pathological' pride were both clearly related to the development of an illness identity and were unhealthy. Over the course of treatment, individuals moved from 'anorexia pride' to 'shameful pride', towards sensing pride in taking a healthy approach to living through experiencing 'recovery' and 'resilient' pride.

Anorexia pride and Shameful pride

Interviewees' descriptions of the concepts labelled as 'anorexia pride' and 'shameful pride' highlighted degrees of differentiation between themselves and the illness. This was in contrast to 'pathological pride', in which participants were completely submerged in anorexia and struggled to separate their sense of self from the illness.

'Anorexia pride' was experienced at the beginning of treatment, when individuals reported lower levels of differentiation from the illness. It appeared to be pleasant, immediate and easily accessible, leading women to feel confused about their desire to recover and influencing negatively their engagement in therapy. Over time, while individuals progressed in treatment, they recognized 'anorexia pride' as a feeling associated with their ill self, but it could still be experienced as rewarding.

P6: I want to gain weight but still when I first get weighed if the number's gone down I get a little like buzz, that's like my sense of pride, like yes! it's come down and so it's like you still get that, it's almost like an anorexic pride...

As the differentiation between the illness and individuals' own self increased, they started to experience what was labelled as 'shameful pride'. The difference between 'anorexia pride' and 'shameful pride' was that the latter involved an immediate sense of satisfaction followed by a negative judgement, whereby pride became heavily mixed with shame. During 'shameful pride', participants started to believe that this form of pride related to the disorder would not be valued from healthy people's perspective.

P14: ...the pride that's sort of related to eating disorders...(sigh) it, it's difficult to explain exactly what it's like because I think that it's become sort of .. it's shameful pride I think, because I know that I am damaging my body and .. it's wrong basically, it's sort of really harmful, self-destructive behaviour.

Analysis highlighted that individuals were more likely to experience ‘shameful pride’ when they were out of hospital, for instance when they went for a walk off the ward. Conversely, in the inpatient unit most interviewees appeared to experience ‘anorexia pride’, as they strove to be the best anorexic.

A more persistent ‘shameful pride’ was recounted by women over 50 years old whose anorexia onset was in their late teens, and by younger participants who were under 20 years. For these interviewees, ‘shameful pride’ was related to a sense of loss and how far they did not enjoy their life due to being ill and/or hospitalized. Women who had achieved a degree, maintained high performance in a job or sport despite being ill, experienced ‘shameful pride’ for a shorter period of time. This suggests that achievements outside the anorexia may positively influence women’s experiences in relation to their sense of loss linked to being ill.

The immediate and affirming feelings experienced by ‘anorexia pride’ interfered with individuals’ motivation to change, whilst feelings of ‘shameful pride’ appeared to promote change. The judgement during ‘shameful pride’ of anorexia as a source of unhealthy and wrong pride (even though it was pleasant to some extent), and individuals’ thoughts about how others would view them for drawing positives from being ill, appeared to be crucial for transition into ‘recovery pride’.

Recovery pride and Resilient pride

Individuals began to actively face ‘anorexia pride’ and ‘shameful pride’ when experiencing ‘recovery pride’. Interviewees thought that if they reported their pride in anorexia, clinicians and other people would doubt their willingness to get better. When they did talk about it, they felt there was a lack of understanding from healthcare professionals and suggested it would be helpful to address pride in anorexia during treatment.

P14: *...people that don't have anorexia and my counsellor, my therapist, to a certain extent, they don't understand that feeling of pride [...] so it's very difficult to sort of discuss with anybody that doesn't, or hasn't experienced it.*

Participants described different strategies they used to overcome pride related to anorexia. Some tried to dismiss it by consciously thinking that other people would value the fact that they had put weight on or if they managed to eat a difficult meal. Thus, they started to build up pride linked to recovery achievements, supported and encouraged by their perceptions of others. This relates to 'pride through others', which was boosted by receiving direct positive feedback from relatives and clinicians.

Unlike 'anorexia pride' or 'shameful pride', which were constant and easily accessible, 'recovery pride' was depicted as the consequence of active effort. Specifically, women put a lot of effort into eating a meal and not exercising. They described an immediate sense of shame and guilt after carrying out such behaviours. However, over time they realised that these feelings were not going to last forever and a sense of pride would eventually ensue.

P9: *...the pride in recovery is like a, it's like a hindsight thing, whereas pride for restriction is very in the moment...I absolutely hate that I was made to eat a whole baguette for my lunch, I hate it [...] but let's say, this time tomorrow, I might look back and think, I'm really proud that I got through it.*

'Recovery pride' involved coping with immediate distress for a greater good; feelings of pride were not immediate. This type of pride was perceived by interviewees as fulfilling, meaningful, and genuine; it seemed to be sustainable, approved, and valued, which could be empowering.

P13: *Now, I can sometimes feel proud of myself that I've been able to challenge the illness for a period of time, I think, it's more about being proud and having pride in being healthy and trying to fight the illness.*

In all the previous forms of pride, achievements outside the illness were perceived by individuals as irrelevant. Conversely, during ‘recovery pride’ some participants (mainly those who managed to stay out of hospital for a longer time despite being ill) started to value their previous accomplishments. This suggests that acknowledging pride in anorexia as unhealthy may enable individuals to move towards a healthy sense of pride.

P17: Now I can look back and go, yeah, you did it (university degree), even when you were ill, that’s my pride.

During this journey to recovery, some interviewees who had not engaged in anorexic behaviours for some time discussed feeling pride linked to being a stronger person. This was labelled as ‘resilient pride’ to capture both experiencing anorexia as extremely traumatic and changes in their sense of self that resulted from living through this condition. Analysis highlighted that women experiencing ‘resilient pride’ paid more attention to pleasing themselves and to doing things they valued in order to develop healthy sources of pride.

P5: Now I’m, I feel right chuffed meself, got a lot of pride in meself at minute, I can say what I want to do, what I want to achieve...rather than feeling that I’ve got to please everybody else

‘Resilient pride’ also seemed to include a change in the attitude of interviewees towards themselves. They highlighted the importance of accepting themselves as who they were, with their strengths and weaknesses.

P13: ...going through having an eating disorder has meant that I am now able to accomplish some of the things I want to and be proud of myself and accept myself as I am...

In conclusion, ‘recovery pride’ appeared to be distinct from other types of pride because it took considerable effort from participants and did not provide an immediate gratification/reward. It involved facing pride in anorexia, a lack of pride in the self (outside anorexia), and included learning strategies to cope with negative feelings (e.g. shame, guilt, disgust), which had been masked previously by other forms of pride in eating disorders.

‘Recovery pride’ had to be nurtured to create a healthy inner pride that was experienced as real, sustainable, fulfilling and empowering, which enabled participants to be aware of other areas in life that engendered a feeling of pride, providing them with a ‘resilient pride’.

Discussion

This is the first study examining pride experiences in women with a current or past diagnosis of anorexia nervosa. It found that at the beginning of anorexia, pride is encountered by chance, as a consequence of dieting and weight loss. This starts a positive evaluation towards the self. As the illness progresses, pride evolves as an affective-defensive response that contributes to the development of autonomy and independence, and results in self-enhancement. Within treatment, pride in anorexia becomes difficult to eradicate and interferes with motivation to change. During the journey to recovery, acknowledging anorexia as an unhealthy source of pride reflects ‘shameful pride’. Experiencing this type of pride appeared to be essential to allow for recognition of recovery achievements and to facilitate development of pride in a healthy approach to living. Findings support Goss and Gilbert’s (2002) model which suggests that pride is a factor that contributes to the maintenance of restrictive eating disorder behaviours. In addition, findings are in line with previous studies highlighting pride as an important emotion acknowledged by women mainly with anorexia nervosa (Dignon et al., 2006; Elsworth, 2006; Robinson et al., 2015; Skarderud, 2007).

Results from the present study provide further understanding on pride. Specifically, two broad sources of pride were identified within the data that interplay over time -namely ‘pride in myself’ and ‘pride through others’. The former was characterized as an independent pride and was linked to the onset of anorexia. The other was an interdependent pride, involving other people in order to experience rewarding feelings, and occurring mostly prior to onset and during recovery. These pride aspects could be linked to the conceptualization of internal and

external pride. Internal pride was defined by Mascolo and Fisher (1995) as beliefs about one's view of the self and a feeling of success in one's own attributes, qualities, and talents. External pride was conceptualized by Goss and Allan (2009) as one's beliefs that attributes, qualities, and talents of the self are valued, approved or admired by others.

In addition, findings help with establishing a comprehensive emotional model of anorexia, in which pride is evolving and takes different forms: 'alluring pride', 'toxic pride', 'pathological pride', 'anorexia pride', 'shameful pride', 'recovery pride', and 'resilient pride'. These different forms of pride appeared to interplay with negative emotions, highlighting how pride functions as an antidote to emotions such as shame, guilt, disgust and anger. However, most forms of pride were transitory, buffering against negative emotions but not eradicating them, and preventing women from enjoying success in achievements unrelated to eating disorder behaviours (e.g. a graduate degree, getting a promotion at work). Evidence from this study suggests that women with anorexia may engage in eating disorder behaviours to facilitate the experience of pride and not only to cope with their negative affect (e.g. shame) (Burney & Irwin, 2000; Gupta et al., 2008; Troop & Redshaw, 2012).

Pride and its evolving nature may help with understanding the well-documented evidence surrounding ambivalence about treatment engagement among people with anorexia (Steinhausen, 2002; Vitousek, Watson, & Wilson, 1998; Williams & Reid, 2010). Findings from this research suggest that acknowledging pride in anorexia as unhealthy may promote motivation to change and enable individuals to feel pride towards healthy and functional domains.

Finally, 'alluring pride', 'toxic pride', 'pathological pride' and 'anorexia pride', shared a competitive element. This relates to the conceptualization of pride suggested by Gilbert (1998), who defined pride as the feeling that one is outperforming others or winning a competition.

Interestingly, this social comparison was not found in ‘recovery’ and ‘resilient’ pride, forms of pride which could be related to a compassionate approach to the self and towards others.

Clinical implications

Findings from the present study have several clinical implications. First, they suggest it is important for clinicians to assess and discuss pride in anorexia and its evolving nature during treatment. Second, it is essential to acknowledge that at the beginning of the condition people with restrictive eating may be experiencing pride, which may prevent them from seeking help at an early stage of the illness, and later stop them from seeing pride in healthy domains (outside anorexia). Thus, early interventions tackling ‘alluring’ and ‘toxic’ pride could prove fruitful in preventing people from becoming embedded within the illness and it taking a chronic course. Third, targeting ‘anorexia’ and ‘shameful’ pride in the course of treatment could contribute to improve motivation to change. Fourth, treatments should focus on healthy pride sources to develop ‘resilient pride’, which may reduce the risk of relapse. Promoting compassion towards the self and others, through compassion focused therapy (Gale, Gilbert, Read, & Goss, 2014; Goss & Allan, 2014), may also be helpful in this respect.

Limitations and strengths

Participants were self-selected and, therefore, it is assumed that those who were able to recognise and label their emotions and also identified with pride in anorexia were more likely to take part. All interviewees had received psychological support, which may have influenced the way they perceived their emotions and the illness. Furthermore, all were Caucasian women, and most reported several hospitalizations.

The current study has three key strengths. First, it was conducted using a clinical sample, with a variety of participants at different stages of their illness and from a wide range of age.

This allowed for a broad investigation of pride experiences in anorexia. Second, including participants who had lived with anorexia for varying lengths of time provided the framework to ground a theory from a developmental perspective. Third, the use of a qualitative design contributed to an understanding of pride from participants' perspectives and allowed for the development of a comprehensive model of pride in anorexia.

Future research

Future work on pride and eating disorders should focus on: i. assessing pride over the course of anorexia and its impact on motivation to change, ii. examining pride in people with eating disordered symptoms who have never received treatment in order to clarify the role of 'alluring pride' in the moment of onset of the disorder, iii. exploring the views of women who started treatment against their wish to contribute to the understanding of 'pathological pride', iv. studying how pride in eating disorders manifests in different populations (e.g. males, ethnic minority groups, those with bulimia).

Conclusion

Pride appeared to play a key role in development, maintenance, and recovery of the disorder. In early stages of the condition, it seemed to enhance the active pursuit of eating disorder behaviours. As the illness progressed, pride appeared to develop and increase positive self-evaluation. Pride was portrayed as maintaining the illness and interfered with motivation to change. Acknowledgement of pride in anorexia seemed to promote recovery and enabled the development of this emotion towards a healthy and resilient approach to living. Findings from the present study represent a promising contribution to the development of more comprehensive emotion models in anorexia, which may impact the conceptualization of treatments.

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Table 1. *Interview schedule refinement*

After interviewee number	Questions included
3	Can you think about pride experiences before being diagnosed with anorexia nervosa? If yes, can you describe those experiences in more detail? Can you tell me what happened to the pride you experienced prior to the eating disorder as the illness progressed?
5	<p>The clinical vignette that was part of the interview schedule was no longer used because information provided by participants after reading it was, in most cases, not generating further introspective accounts of the individual's emotional experience. In addition, there were new leads to follow.</p> <p>What can you tell me about your feelings of pride, from your childhood until now?</p> <p>When you came to the hospital, what were your feelings in relation to yourself and to anorexia nervosa?</p>
8	<p>How do you perceive pride in eating disorders (e.g. positive, negative attributes, both)? What can you tell me about your experiences of pride associated with the eating disorder over the course of the illness (e.g. prior to, during and after treatment)?</p> <p>What happens to your feelings of pride related to anorexia nervosa when you are out of the hospital?</p>
12	<p>If I ask you to compare pride associated with the eating disorder and other experiences of pride in your life, what can you tell me about it (e.g. similarities, differences)? Can you describe in more detail both experiences of pride?</p> <p>If you think about other people, what do you think they might think about pride in anorexia nervosa? Other people could be people with the illness you might know or people without the illness (family, friends).</p>
17	Can you think about any strategies you might have used to overcome this pride in your eating disorder during and after your hospitalization/treatment?
19	What happens with pride related to anorexia nervosa when you are close to the time of discharge? And what happens after, when you are no longer receiving treatment?

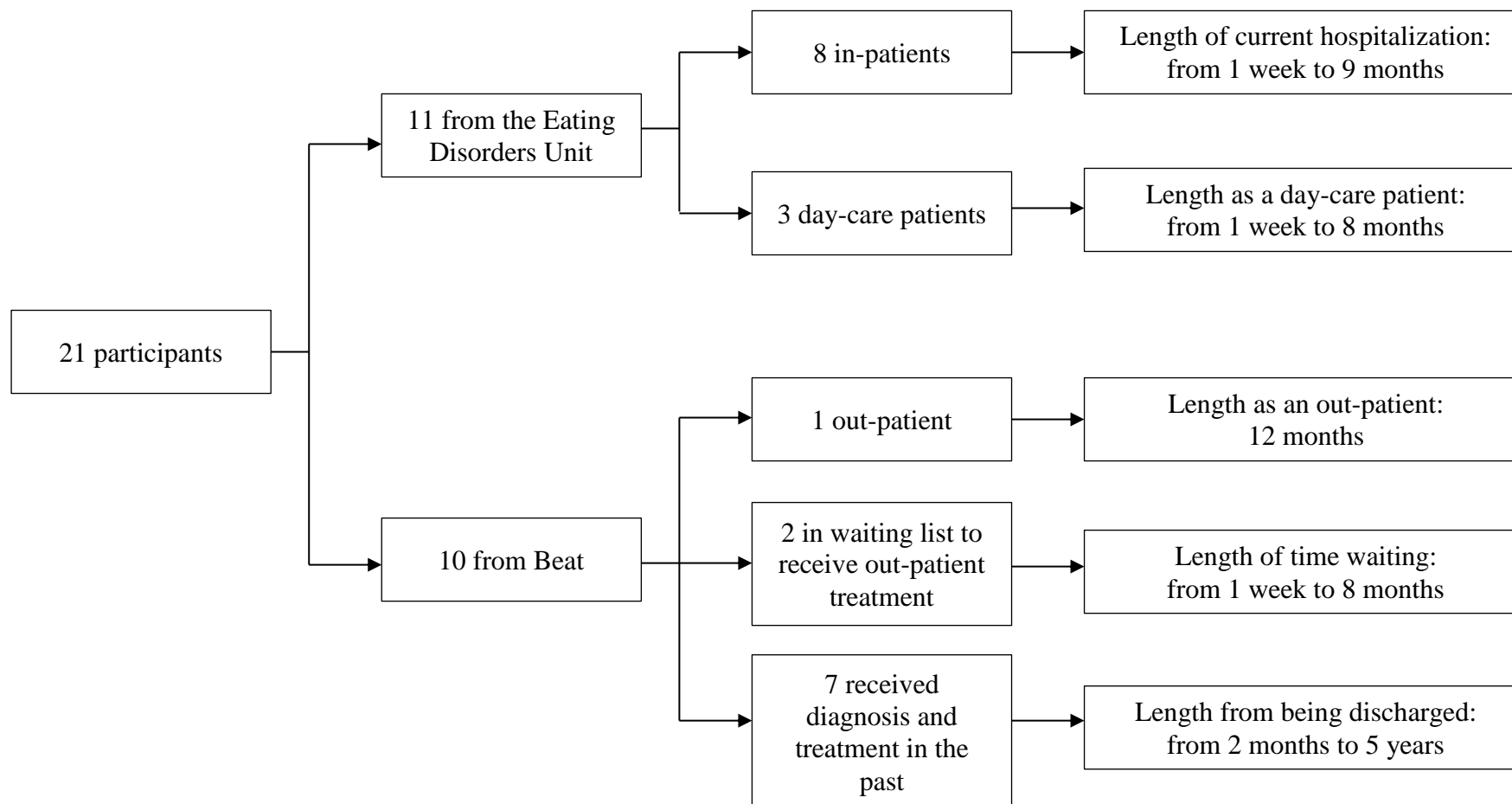
Table 2. *Eating Disorder Examination Questionnaire (EDE-Q) scores and Clinical Impairment Assessment (CIA) scores per participant*

Participant number	EDE-Q Global	CIA
1	4.66	30
2	5.35	48
3	0.20	1
4	0.88	6
5	3.33	18
6	2.94	35
7	0.08	9
8	4.14	46
9	4.27	38
10	0.85	6
11	1.21	15
12	0.86	18
13	3.38	41
14	5.16	37
15	1.95	13
16	4.81	46
17	4.11	41
18	5.70	48
19	3.50	20
20	2.61	22
21	2.80	5

Table 3. *Theoretical codes and how they were informed by focused codes*

Focused codes	Theoretical Codes
<ul style="list-style-type: none"> • Feeling pride through initial weight loss • Feeling pride through avoiding eating a few ‘prohibited’ foods for a limited period of time • Feeling pride when resisting food and others cannot • Feeling pride through reducing my clothing size • Feeling pride through receiving compliments about my weight loss • Developing pride in myself independently from others 	Alluring Pride
<ul style="list-style-type: none"> • Pride through feeling in control • Pride in being superior to others who cannot limit their calories intake • Pride through feeling special • Pride in setting my own rules • Pride in thinness • Feeling pride in continuously and consistently losing weight • Pride in restricting several foods over several days 	Toxic Pride
<ul style="list-style-type: none"> • Losing my own self and developing an anorexic self • Being overtaken by the anorexia self • Feeling pride through extreme thinness • Feeling empowered through not eating • Feeling pride by overexerting my body limits • Pride in being severely ill 	Pathological Pride
<ul style="list-style-type: none"> • Discriminating between my own self and the anorexia self • Differentiating between my pride and anorexia pride • Feeling pride as a spontaneous reaction to anorexic symptoms 	Anorexia Pride
<ul style="list-style-type: none"> • Feeling ashamed of feeling pride in anorexic behaviours and attitudes • Feeling ashamed of putting on weight but later feeling proud about it • Feeling that pride in anorexia nervosa is deceitful • Challenging a lifetime pride (associated to anorexia) 	Shameful pride
<ul style="list-style-type: none"> • Feeling pride while trying to get better requires a lot of effort • Feeling pride when others value my effort to get better • Pride in winning some fights against the illness • Being able to recognise pride in previous healthy achievements • Experiencing genuine pride in myself through recovery 	Recovery Pride
<ul style="list-style-type: none"> • Feeling pride through overcoming the illness • Developing and maintaining healthy sources of pride that are relevant for me • Prioritising and pleasing myself • Going through anorexia made me a stronger person 	Resilient pride

Figure 1. *Data about participants' treatment status at the time of the interview*



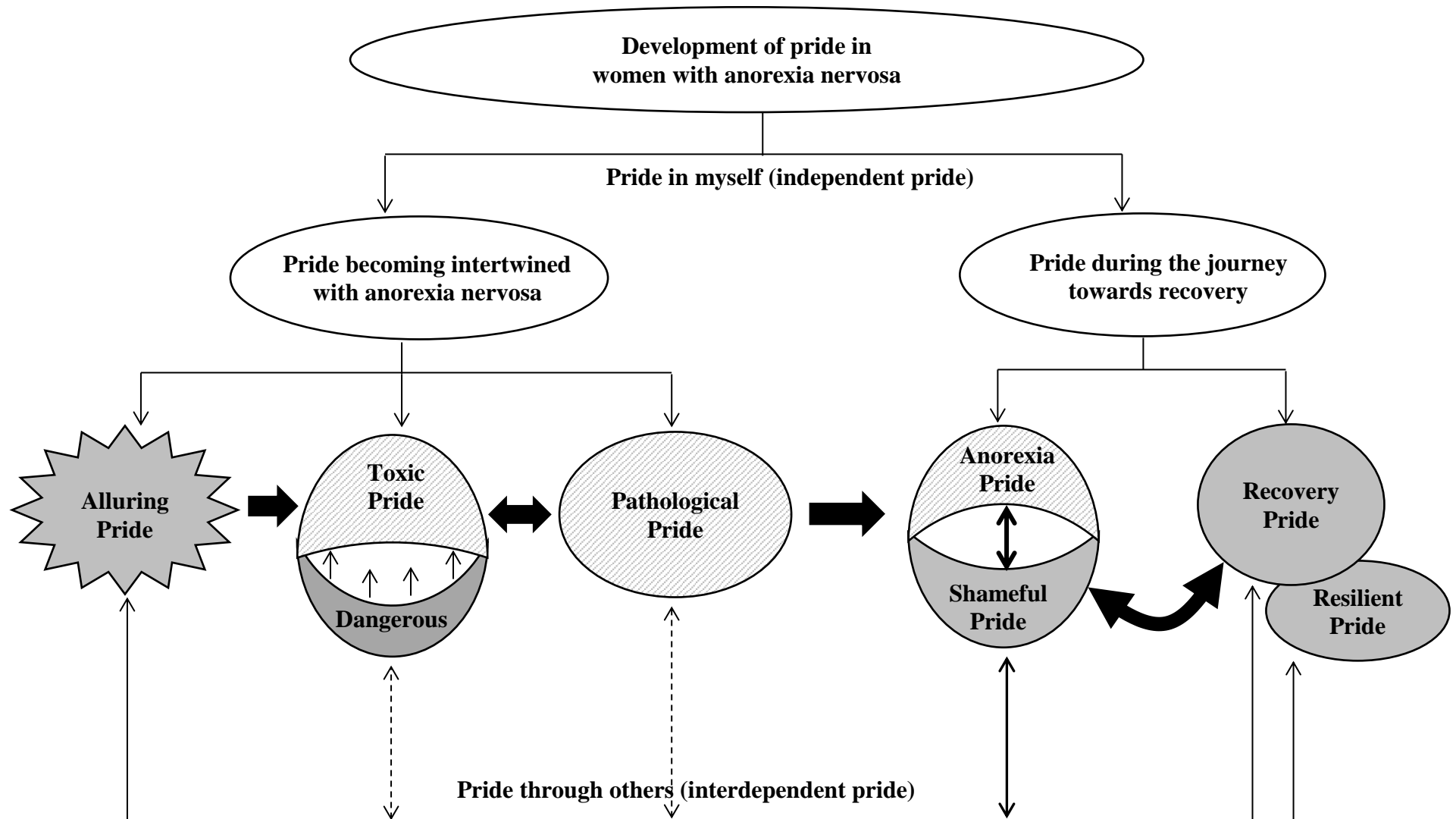


Figure 2. Grounded theory model for the development of pride in anorexia nervosa (thicker arrows in the middle of the figure reflect the key elements of the model; the dashed lines indicate when 'pride through others' is less relevant; the thicker line linking 'shameful' and 'anorexia' pride highlights that 'pride through others' is more important at this point). The grey filled pattern represents the individual's self and the line pattern reflects a sense of self related to anorexia nervosa.