Exploration of the Social Representations of Eating Disorders among Social Workers

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ABSTRACT

The feeding behaviour, undoubtedly one of the human's most complex, is the result of a balance between biological, psychological and sociological components. An imbalance within components gives rise to pathologies such anorexia and bulimia. Teams made up of medical and human relations professionals help people living with these conditions. Within these teams, social workers are distinguished by their training focused on the psycho-sociological aspects of issues. The goal of this research was to highlight the workers' social representations of eating disorders. An exploratory study was carried out based on semi-structured interviews with social workers (n = 8) working in psychiatric care in Quebec City and Montréal (Canada). The theory of social representations was used to analyze the results. It appears that among social workers the psychosocial aspects of these disorders are quite significant in the interpretation and representations to the detriment of medical aspects. This research can contribute to reflection and debate on the cultural aspects of a mental health problem.

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EATING DISORDER

Food is a major concern for Western societies. In addition to its biological and psychological aspects, food displays essential sociological features. It is the context and the social environment that will provide the individual the information that will condition, consciously or not, food choices, food preparation, and ingestion. On the other hand, epidemic medicine establishes a direct relation between diet, poor health habits and morbidity (INRA, 2010). Many contemporary ailments such as cancer, hypertension, intestinal disorder and colitis of all kinds, cardiovascular disorders and obesity, were topics of research, and the focus of public health services fight against these modern diseases.

With the industrialization of food and the development of scientific knowledge, food symbolism and its behaviours have evolved (Fischler, 1993), as well as social representations, values and norms relating to food (Baril & Paquette, 2012). It is in this context that new perceptions of the body and health have emerged. The definition of health has evolved from the absence of disease to an ideal of well-being, eventually becoming a norm to be met. It is no longer a question for the individual to fight against the disease, but to remain "healthy" (Pierret, 2008). One of the consequences of this is that the individual is now in charge of his good health and the regulation of his behaviour (Gori & Del Volgo, 2008). The requirement to self-regulate and be healthy is henceforth a characteristic of modern societies (Crawford, 2006) and now necessary to be recognized as a full-fledged citizen. Such requirements create boundaries between normality and deviance (Crawford, 2006). Furthermore, when the individual discredits his/her ability to self-regulate their own behaviours based on group norms, this negative interpretation of the individual's behaviour becomes a source of suffering and illness (Demailly, 2014). Epidemiological medicine and psychiatry observe a set of behaviours, such as smoking, hyperactivity in children, menopause, birth, death, sexuality and all forms of addictions, in order to control and set acceptable boundaries. There is now a threshold, a standard beyond which one is recognized, and one recognizes oneself as mentally ill (Di Vittorio, 2005).

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EATING DISORDER

Toward the end of the 19th century, the inability to maintain adequate eating behaviours was interpreted as a pathology and listed in psychiatric nosographies[1]. These diagnostic entities are today broken down on a continuum whose extremities are anorexia and bulimia. Only merycism and pica (APA, 2004), which usually appear in early childhood, fall outside this continuum. In North America, eating disorders are identified and described in the Diagnostic and Statistical Manual of Mental Disorders (DSM); nosographs in use by mental health practitioners and published by the American Psychiatric Association. (APA). The 5th edition of the DSM (APA, 2013) presents specific eating disorders. The main entities are: Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder (BED), and Eating Disorder Not Otherwise Specified (EDNOS). However, anorexic and bulimic behaviours remain the two mainstays.

For each of these disorders, behavioural, temporal, biological, psychological and social criteria are identified. The symptoms of anorexia are energy restrictions leading to a below-normal weight for sex, age and height, intense fear of gaining weight or becoming fat, impairment of weight and body perception with an influence on self-esteem and denial of the severity of current wasting. Bulimia symptoms can be recurring binges and absorption of huge amounts of food in a limited time. This behaviour is followed by a bad feeling of loss of control. Other symptoms include: presence of compensatory behaviour to prevent weight gain (vomiting, use of laxatives, intense physical activity, etc.), with crises and compensatory behaviours occurring at least once a week over a 3-month period, and self-esteem strongly influenced by body weight and body shape. Eating disorders that do not exactly meet the criteria for anorexia and bulimia are classified as non-specific conduct disorders. Regarding the nosographic descriptions of eating disorders that allow to establish a diagnostic Alarcon (2009) does notice that sociological elements are presented as "cultural mentions" and considered as secondary elements of the diagnosis. Psychiatric medicine neglects this cultural dimension, settling for mere statements about the image of the slim body in the mass media and about race, ethnicity, or language

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[1] Anorexia was identified as a "disorder" in 1873. Ernest-Charles Lasègue (1816–1883), French psychiatrist and doctor, and Sir William Withey Gull (1816–1890), British doctor, considered the inventors of the diagnosis of anorexia nervosa, have been unable to attribute a physical cause to this state of undernutrition, which will be considered as nervous or mental (Darmon, 2003). It was not until 1979 that the entity bulimia nervosa was described as a different clinical entity from anorexia nervosa and obesity by Russel, an English psychiatrist (Pomerleau, 2001).

(Alarcon, 2009). Also, several researchers, observers of psychiatric environments, note that the organicist aetiology ensures that psychosocial aspects of the disorders are facilitators of pharmacological treatment (Borgeat & Stravynski, 1985; Corin, Poirel, & Rodriguez, 2011; Dutrénit, 1977). Other authors (Austrian, 2005; Kutchins & Kirk, 1995; McQuaide, 1999) have pointed out that the symptomatologic vision offered in nosographs does not allow us to understand the complexity of this condition since side the systemic aspects like "the crucial role of families, small groups, and communities; a growth and development model of human behaviour; client individualization; a sensitivity and commitment to multicultural diversity; the emphasis on client abilities and strengths; concerns about distributive justice; and the focus on the client empowerment model for interventions" (Kutchins et al., 1995).

Strict forms of anorexia are infrequent in the general population, thus, mixed forms of anorexia bulimia, nibbling, craving and dietary obsessions would account for the majority of clinical cases (Fairburn & Bohn, 2005; Vassière, 2004). The development of these atypical forms is believed to be exacerbated by the current social situation that increases the vulnerability of young women aged 15 to 35. These atypical forms of eating disorders affect all strata of society. They are poorly documented (Vassière, 2004) and their incidence is undervalued (Fairburn & Bohn, 2005). Eating disorders are probably the most publicized and known mental disorders in the general population (Casilis et al., 2012 cited in Beck, Maillochon, & Richard 2013). Otherwise, the shocking images of emaciated young women relayed by the mass media (Beck et al., 2013), and on the destructive potential of this condition: the mental disorder with the highest mortality rate (Arcelus et al., 2011), strike the imagination. The medical community agrees that Anorexia and bulimia affect adolescents and young adults in industrialized societies (Douglas, 2015). Young women are mainly suffering on a biological, psychological and social level, with a higher prevalence in groups with competitive exercise, slimming, stress and intensive physical training (Brouwer, Mirable-Sarron, & Pham-Scottez, 2009). The frequency of these problems and their physiological, bodily, psychic and social repercussions would evoke the difficult challenges of adolescence and challenge healthcare workers as well (Wilkins & Meilleur, 1991).

ETIOLOGY

Modern epidemiological medicine in mental health has become more complex and, beyond statistics on pathological cases, has focused on the etiology of mental disorders. Concerning eating disorders researchers (Steiger, Bruce, & Israël, 2003; Striegel-Moore, 1997; Treasure, Claudino, & Zucker, 2010) agree that eating disorders are caused by the entanglement of biological, psychological and social factors. Genetic aspects are also challenged and studied as they are likely to affect the mood, behaviour, basal metabolism, appetite and satiety. Stress caused by the environment is also a leading cause. Severe diets are considered potential triggers by their effects on the expression of certain genes and metabolism. Durand and Barlow (2002) note that compared to other mental disorders, the etiology of eating disorders would be significantly influenced by factors "of a socio-cultural rather than a psychological or biology nature" (Durand & Barlow, 2002, p. 433).

AND OTHER WAYS OF UNDERSTANDING

While medicine seeks to discern between what is considered normal and pathological, sociologists, psychologists and anthropologists have integrated a conceptual framework that offers other perspectives of explanation for mental disorders. Indeed, some sociologists consider mental illness as a consequence of a rupture between the individual and society (Dorvil, 2007; Sévigny, 1985). Indeed, imposing social standards leading to the control of some behaviours (diet, healthy weight, ideal thinness, regular physical activity, smoking, etc.) may have harmful effects on some individuals (Mischel, 2015). Demailly (2014) hypothesized that disorders such as anorexia, bulimia, burnout, ADHD, and drug addiction, represent forms of resistance to the institutional discourse on health. Vincent de Gaulejac and Taboada Léonetti (1994) suggest that modalities such as aggressiveness, alcoholism or dropping out of school are behaviours implemented by individuals to manage conflicts with social structures they are facing. The individual is not sick; behaviours deemed inappropriate or classified as pathological by medicine would allow individuals to adapt to a strong and pressing social environment. These behaviours would be the expression of a psychological distress (Hacking, 1998, cited in Faucher, 1999). Other authors (Brossard, 2014; Maltais, 2013) point out that adopting specific deviating behaviours (self-injury, drug abuse, early sexuality, bulimia, anorexia, compulsive shopping, suicidal thoughts) not only allows the individual to express distress, but also to temporarily

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regain control over their life. From a sociology standpoint, these behaviours are "adaptive behaviours" and disappear by themselves when the harmful situation changes.

EATING DISORDER INTERVENTIONS

In Quebec, specialized units in the treatment of eating disorders include professionals from several disciplines who work in teams for the patients. For example, the Douglas Eating Disorders Program is supported by two psychiatrists, one physician, ten nurses, one dietician and three social workers (Douglas, 2015). The public health system offers three levels of care varying in practitioner specialization and care offered, and the intensity and duration of the follow-up required for recovery. The third level treats individuals with only severe clinical criteria. Most of psychiatric institutions offer services like outpatient clinics, which support individuals and families through group therapy, pharmacological and nutritional therapies. Other care options are: day programs with eight-week intensive group follow-up, day hospitals suited for people with severe eating disorders who do not require nighttime monitoring, and inpatient units for people with severe medical and psychological conditions. This mental health intervention puts forward proven approaches that have demonstrated their practical and scientific effectiveness. Thus, nutritional advice, medical follow-up, pharmacological and psychotherapeutic treatments will be offered. Cognitive and behavioural therapies (CBTs) are very popular in institutional settings. Since the 1980s, the interest and use of this type of clinical approach has continued to grow (Forman, 2009). The predominance of this therapy is due in part to the ease with which it is possible to establish statistical corollaries. Its trendiness also explains its popularity among clinicians looking for speed and effectiveness in distress relief (Dalpé, 2014).

SOCIAL WORKERS

In Quebec, social workers are usually part of professional teams involved in mental health, and compared to other stakeholders, they have received a general education that focuses on psycho-sociological issues. They are characterized by their overall perspective of the individual, going beyond symptomatology (Golightley & Goemans, 2017). They are skilled at working in

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community health and social care service centres (CLSC) or for the Director of Youth Protection. Others work in hospitals, rehabilitation centres and, rarely, in the private sector (Stephensen et al., 2000). In addition, the changing and dynamic nature of social work means that these professionals, compared to others, find it difficult to fully invest in a professional niche. Their social representations of social work are multiple and fit poorly in categories as clearly defined as those of other intervention professionals (Aballéa, 1996).

Institutional environments promote the specialization of practitioners and the general training of social workers as well as the diversity of the problems they are likely to intervene with increases the identity issues for the profession (Fortin, 2003). For example, in an institutional setting where teamwork is influenced by the biomedical model, the social worker, theoretically isolated, may tend to identify only with medical values and thus lose some of their professional identification with social work (Gusew, 2011). In this regard, Pelchat, Malenfant, Côté, and Bradette (2005) note that social workers seek to merge with their workplaces and avoid theoretical quarrels, offering little resistance to interference by their colleagues. In hospital context, the lack of a clear role definition of social workers means that they are assigned tasks similar to other professionals, which considerably dilutes the specific contribution that these professionals could make to the understanding of mental disorders (Barth, 2003; Berger & Mizrahi, 2001; Globerman & Bogo, 2002).

SOCIAL REPRESENTATION AS A READING GRID

To explore the interpretations of social workers regarding eating disorders, we chose social representations as a reference theory. In both concepts and theories, the notion of social representation is situated at the interface of psychology and social work and refers to a multitude of realities. Social representation can correspond to ″a person, a thing, a physical, psychic or social event, a natural phenomenon, an idea, a theory, etc.; it can be real, imaginary or mythical″ (Jodelet, 1989, p. 54). A representation is necessarily the representation of an object, and this object is part of an active context. This context is more or less regarded by the group as an extension of its behaviour, attitudes and norms (Jodelet, 1994, p. 188). The context and the group

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are essential to social representations since it is within the group that they are elaborated and shared through a process of objectification and anchoring.

Moscovici described the sequence of phenomena that participate in the formation of social representations within the group in two major phases: objectification and anchoring (Rateau, 2007). The process of objectification allows to synthesize information on a phenomenon or an object which burst in the social environment. These social objects are transformed into concrete explanatory images that can be understood and used in group communication. Anchoring is the process by which the new representation is integrated into the reference system of individuals by building on existing representational elements. Objectification having made the object manipulated by the mind, the experience of the object, by the group, is included through anchoring.

This knowledge of "common sense", "systems of values, notions and practices" (Moscovici, 1990, 1993) will be used to interpret the world, to explain reality, and to guide practices and behaviours. This kind of knowledge, shared within the group, allows individuals to interact with others in the most appropriate way (Tremblay, 2005), which gives social representations an identity function. Within the group, representations are used as a common code that allows individuals to distinguish themselves from other social groups. Otherwise, social representations allow individuals to justify their actions and behaviours and to integrate into the group, while remaining in harmony with its norms and values, time and place of the insertion (Abric, 1994).

SOCIAL REPRESENTATIONS - PROFESSIONAL REPRESENTATIONS

Social representations are essentially formed within the group, they are therefore part of a changing context, society being in perpetual change. They have at the same time a history. They are born, have a life during which they stabilize, transform, and finally disappear (Rateau, 2007). Several generations of social representations can thus succeed and change under the influence of cultural practices. For example, the changing nature of work following industrialization and digitalization means that today it is seen more as a pleasant activity creating social bonds than as a burdensome task of an economic nature (Negura, 2006). In Quebec, even if no research in this direction has been carried out, it may be supposed that social representations of social work have necessarily evolved. As a result of industrialization and urban growth, ecclesiastical philanthropy,

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institutions, workers and values of dedication and charity have become professionalized in concerted social action (Rocher, 1960). Today, the majority of Quebec social workers are public workers (Stephenson, Rondeau, Michaud, & Fiddler, 2001) likely to exert authority and be social regulation and control agents for offending populations (Courtois, 2012).

Bataille (1997) draws a distinction between social representations and professional representations, the latter being social representations dealing specifically with objects belonging to a professional group and shared by the members of this profession (Ibid.). Thus, social workers, psychosocial professionals, acquire through their training practical knowledge needed to exercise their profession. Social worker trainees arrive with representations of their future profession which are reinforced or modified throughout training and professional experiences (interactions with patients/beneficiaries/clients) to finally constitute a specific knowledge (Bataille, 2000) which will be recognized by both peers and society as a whole and cannot be considered either as a job or as a work (Bataille, Blin, Jacquet-Mias, & Piaser, 1997).

Flament (2001) states that representations are transformed through interactions (action and feedback). This observation joins the Aix-en-Provence school's theoretical development of social representation changes through practice influence (Abric, 2003). Thus, it is stated that the transformation of practices, either accidentally (following the evolution of social and cultural models) or intentionally (because of an intervention), has a direct effect on the organization and meanings of social representations (Jodelet, 2013). For Abric, "representations and practices engender each other" (Abric, 2003, p. 230).

Boutanquoi (2008), meanwhile, draws attention to the fact that "if the practices are related to representations, they are necessarily part of institutional, organizational, collective, in contexts that are not without weight on their orientation; they are implemented by subjects that cannot be reduced to the representations they share with others" (Boutanquoi, 2008, p. 127). Thus, in their interventions social workers bring into play not a single representation, but a complex cognitive system that constitutes their "symbolic and social environment" (Abric, 2001, p.98). The emergent context, the symbolic environment, includes, in addition to social representations, other tools that determine attitudes and actions, such as ideologies and beliefs.

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RESEARCH GOALS

Considering the genesis of social representations and the fact of the specificity of the training of social workers and their inclusion in professional teams of biomedical theoretical allegiance, we wanted to know the nature of the social representations of social workers about the disorder and how they articulated these in their perception and understanding of this mental health problem.

This exploration is not intended to invalidate or confirm hypotheses, but to collect specific information that has allowed us to identify social representations through the speakers' speeches. Our approach was inductive and it is from the raw material that emerged the questions and findings (Dépelteau, 1998, p. 56).

METHODS

The sample

Before recruiting participants, we first conducted a survey of practice settings that offered curative services to people with "eating disorders". To this end, the *Anorexie boulimie Québec* (ANEB) website and the directory of the *Centre de référence du grand Montréal* were particularly useful. Once this list was established, we contacted these organizations to list candidates who met our inclusion criteria. Our "practitioner" population consists of one man and seven women, all with social work training, including one technician and seven academics. Five of our participants were under 40 years old. All had been working directly with people with eating disorders for more than 12 months.

Data Collection Instruments

Despite the fact that the study of social representations generally requires the use of more than one collection instrument (de Rosa, 1988), it is possible to obtain relevant results with the use of a qualitative method. We opted for open-ended semi-directed interview as the method of data collection. This structured verbal technique provides access to elements further removed from the essential contents of social representation (de Rosa, 1988). In addition, this method is particularly interesting to understand the workers experience. It respects their perspective of the problematic,

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as well as the meaning they place on their actions (Poupart, 1997). The semi-structured interview grid addressed five themes: academic and professional experiences; comments and opinions regarding the concept of eating disorders; and finally, participants' perceptions of social work and their specific role as a mental health professional.

Data Analysis

We proceeded with content analysis to analyze the entire body of data obtained during the semi-structured interviews. Negura (2006) points out that the theory of social representations originated from content analysis, with Moscovici having made extensive use of this tool in his study of psychoanalysis (Moscovici, 1961). Discourse and communication form the basis of the process of formation of social representations and the analysis of these interactions makes it possible to grasp their functioning (Negura, 2006).

The analysis of the interviews was done continuously. That is to say, we constructed a thematic tree as the analysis of all the speeches was analyzed. Thus, during this process, a theme tree was created which pooled together all the comments of the interviewed social workers. This tree includes five branches: academic training, work experience, social representations related to the concept of "eating disorder", social representations concerning the professional practice of social workers and finally the intervention to people with eating disorders.

RESULTS AND INTERPRETATION

Definition and interpretation of eating disorders

For social workers, an eating disorder develops when the individual does not feel free to be themselves. Loss of control of one's inner environment (behaviour) or external environment (family, social environment, etc.) generates stress. The impression of loss of control likely precipitates a biological and/or social dysfunction. For social workers, the severe and recurring aspect of suffering defines the notion of the disorder: "[…] *I think that a disorder is to lose the freedom of your mind.* […] *restrictions preventing us from being comfortable in our skin, to enjoy life, that prevents me from doing what I want.* […] *A disorder also brings suffering* […] *because if I have no problem, I will enjoy eating, whatever I happen to be eating.*" (6th interview). An eating disorder is not just about suffering. It is a complex problem where

biological, psychological and sociological aspects are intertwined: "*It is a complex psychiatric disorder. There are several factors that come into play. There's a biological aspect to it, clearly, according to research, and also more in more in those with a psychological vulnerability and social pressure.* […]". (2nd interview). Social workers interpret eating disorders as a form of adaptation to an environment generating stress or negative emotions. In addition, an eating disorder often results in teenage rupture with the social environment: "[…] *Eating is a symptom, after all.* […]*, a symptom of something that is not right. I say something, but it can also have to do with problems dealing with emotions or lack of love for oneself [...] you know, without belittling or being in denial, it's not someone's fault, it's because of society…"* (4th interview).

Triggers of Eating Disorders

In response to the question: "In your opinion, what are the triggers and/or causes of these behaviours?" social workers have provided answers that can be grouped according to their sociological, psychological and biological aspects. We present them according to their importance in the answers of the participants.

Sociological Aspects

The sociological aspects of eating disorders were frequently mentioned as important triggers of the illness. Thus, the media and nutrition and health messages are seen as catalysts for food disorders. The sometimes-contradictory mass of information about nutrition is likely to be anxiogenic. Some people interpret this nutritional information as a standard that must be rigidly observed: "[…] *nutrition is a whole different kettle of fish, because we are bombarded with information. What is true, what is now. And we have another eating disorder focusing on healthy eating* […]". (5th interview). Another important component of the sociological aspect is the unrealistic thinness broadcast by the media and the way young women attempt to match those images. On the other hand, information circulating on the Web about eating disorders is suspected of "contaminating" people and through self-diagnosis can actually lead to an eating disorder.

The social workers mentioned certain social developments favourable to the development of eating disorders: the increase of women's responsibilities, the dual task of mothers and professional: "*Performance, yes, on top of the role of the woman with a big career and salary to boot […]*" (5th interview); "*This happened alongside feminism, and I ask myself whether this could have also led to the model of the very pretty, efficient woman. Something we never had before even in my time, when we never heard about anorexia*" (6th interview). Also the techno-scientific evolution has changed the way food is produced and distributed, the effectiveness and accessibility of health care have encouraged the emergence of new perceptions of the body and health, some of our behaviors have been medicalized with the effect of increasing pressure on individuals to comply with new health standards.

According to interviewees, the new values of performance and responsibility circulating in society have an important role in the development of eating disorders. It is creating psychological distress, especially among those who feel that they are not able to meet certain standards. "[…] *Whenever I have people, whether anorexia or bulimia, […] it feels like, I know it sounds cliché, but centred around perfection, performance, results, righteousness, rigour, and all. ''* (3rd interview). The ideal body, the cult of thinness projected by the mass media, is perceived by practitioners as an aspect of performance that is now demanded from women.

Family is identified as a learning place where the individual learns to take care of themselves and to objectively self-assess oneself. However, this environment can also be a source of disarray and discomfort. […] *The family environment is not the only environment you are around as a kid. It is not the sole criterion for this. But then again, it is the environment where you spend most of critical moments, so I think we take away a lot from this, when we see parents self-deprecating, being overly critical against themselves or their children or others such as their brother. The family environment has a large role to play in their learning of this.* […]. (3rd interview). In some circumstances, excessive control over body appearance and diet is the only way to regain some control over one's life. This impression of control calms the individual, who sometimes feels stuck by the injunctions of the family environment.

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Psychological Aspects

Traits of character like anxiety, obsession, and control amplify the intensity or persistence of eating disorders. These traits are not necessarily considered triggers. Thus, anxious personalities tend to develop irrational fears in relation to weight or to certain foods. Some develop obsessions related to body appearance or diet. The sensation of control is essential in eating disorders. The gain or loss of control is specific to anorexic behaviours (hyper control) and bulimic behaviours (loss of control).

Emotions and the superego are also psychological aspects noted by interviewees. The inability to withstand the discomfort that accompanies certain emotions leads individuals to implement avoidance strategies in certain situations or to use food as an anesthetic. The superego is pointed out as the critical part of the psyche, and the excessive development of this normative inner discourse causes distress. "[People living with an eating disorder] *people who are very strict and self-critical, while being very sympathetic toward others. I am generalizing here. It isn't always so, but, yeah, very critical and strict against themselves."* (3rd interview).

Biological Aspects

Biological aspects were not mentioned by the social workers. In their interpretation, genetics may predispose the individual, but the environment plays a major role in the activation of those specific genes: "[…] *Obviously, there's a gene-environment interaction, a lot of can be predisposed* […]. *Well, I think we are more at risk if we have family factors leading to food phobia, and if we are genetically anxious, obsessive and all, and avoiding* […]" (2nd interview). "[…] *At the end of the day, biomedical is not the only factor of eating disorders. We talk about the physical, behavioural, environmental aspect, but not so much about the social aspect. We don't talk about the social aspect, family a bit, but that's still a lot missing for a disorder that is so medical-focused.* […]" (3rd interview).

Intervention

To emphasize the theoretical and professional influences on the construction of our participants social representations of eating disorder, we asked them to tell us about their practice by describing a typical intervention.

Building blocks of the intervention

Regarding the intervention offered to people living with an eating disorder, the social workers we met were aware of medical interpretation developments. This interpretation will therefore have an impact on the form of assistance provided and on recovery. They understand that behaviour identified as problematic is a symptom of inner turmoil. Therefore, in their practice, they do not systematically address symptom reversal. Behind symptoms and problematic behaviour, they see a human being who will have to be welcomed as a whole.

For them, intervention is a long and painstaking process. The course of the intervention should not be abrupt and every little progress made by the patient is underlined. In this process, it is the person who remains in control of the situation and the worker must be flexible throughout the process. "[…] *I will offer a bunch of tools and objectives, but at the end of the day, the individual is the one making the decision. They're the ones leading the way in all of this, with all my tools and objectives, they steer the ship."* (4th interview).

Approaches and Intervention

The practitioners who participated in our research described different approaches: biomedical, nutritional, solution-centred, family-based, individual, behavioural cognitive and psycho-educational. We present here the comments concerning the biomedical approach.

About Biomedical and Nutritional Approaches

Biomedical and nutritional therapeutic approaches are ubiquitous in the health care system and cause discomfort for some workers. These notes that prescribing a pharmaceutical therapy sometimes scares the person in pain and his family. "*Because it is an important decision and it is also scary, to have to take a psychiatric drug, I think people are, indeed, somewhat scared*

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[inaudible, 0:40:23] There can be side effects or, but you know that is not my field, but certain drugs take 30 to 90 days to have an effect on the body and to see changes." (7th interview).

For most interviewees, the biomedical approach is considered interesting and complementary and should not be rejected as a whole. The place of the medication in the therapeutic process is therefore not in question, any more than the biological aspects of the eating disorder. On the other hand, they consider focusing only on the biological aspect as being restrictive and makes the "disorder" very medical-centred. The cultural and social aspects of the "eating disorder" do not put forward and therefore not very present in official descriptions, scientific literature generally restricting "eating disorder" in terms of health and ideal weight. "*Yes, but in hospital, I'm not saying it's not … it's necessary, it's complementing. There's progress. That approach is only scratching the surface, though. Not really going there.*" (5th interview). "[…] *Actually, biomedical isn't the be all end all. for eating disorders. We talk about behaviour and body. Not much so about social factors and only slightly about the family. A lot is lacking. It's very medical-centred.* […]" (3rd interview).

Because of the widespread use of this approach in hospital institutions, it is essential for practitioners to know the language in order to facilitate communication within the multidisciplinary team. "[…] *Yes and no. Yes, in the sense where it's interesting. I mean, medical terms are interesting and all, no problem with that. So, yes, yes, I'm comfortable with that. It's important to speak the same language and know it well.* […]" (3rd interview).

DISCUSSION

From the analysis of the data gathered, we can argue that social workers represent and define the notion of "eating disorders" as psychological suffering that emerges from difficulties in adaptation to one's surrounding environment. It is a complex experience, and involves the interaction of social, psychological and biological parameters. "Avoidance," "performance" and "control" behaviours lie at the heart of the disorder. The disorder has a significant impact on self-esteem. The disorder sufferer lives in shame and experiences moments of loss of control (experienced or perceived), which can cause major anxiety. For individuals, biological

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components, such as genetics, undernutrition, and hypoglycemia, intervene and interact with psychological and sociological factors and may be associated with the cause and effect experienced social difficulties.

The comments we have heard from social workers speak to the complexity of eating disorders. By highlighting the impact of the civilizational movements and the system of values and norms in our western society, especially on adolescents and young adults, social workers have established the psychological and social components of eating disorders. The words "suffering," "perfectionism", and "loneliness", often repeated in conversations, reflect in many respects the psychosocial nature of their interpretations of eating disorders. Suffering originates in the intimate experience of an image of oneself, or of an identity perceived as unsatisfactory by the social group of belonging. This suffering can, therefore, be interpreted as an individual experience rooted in the relationship with the other. This interpretation is in line with that of the sociologist Sévigny (1985) on mental illness.

For the majority of social workers interviewed, eating disorders are perceived as a symptom of social maladjustment, inability to cope with social life or a specific form of social life, and a difficulty in functioning with what is demanded of these individuals by society. In this perspective, the "eating disorder" turns out to be a symptom rather than a pathology. This interpretation, however, obviously does not fit the biomedical doctrine of psychiatric care.

This "symptomatic" interpretation of the eating disorder could be related to the philosopher Ian Hacking, who created the concept of transient mental illnesses as an unconscious expression of psychological distress, or to the sociologists de Gaulejac (1994) and Demailly (2014) who interpret certain behaviours not as pathologies, but as symptoms of the oppression imposed by social structures.

Some social workers have described eating disorders not as a symptom, but as a form of regaining power or control over the lives of patients. This behaviour is believed to restore some interior comfort. This utilitarian aspect of eating disorders is in consonance with current research that explores mental health as a form of adaptation of the individual to the in-situ environment. These approaches have also been explored by sociologists Brossard (2014) and Maltais (2013)

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who consider a range of behaviours, otherwise considered pathological, as adaptive behaviours that resolve themselves when the harmful situation changes.

In addition, none of them were uncomfortable with the intervention model in their practice setting. The criticisms made by the social workers concerned mainly the lack of financial resources which restricts the number of people who can be accommodated in their department, and also restricts the time devoted to follow up therapy. They therefore proposed launching prevention campaigns advocating self-esteem and body diversity and image.

With their comprehensive concept of mental health, which integrates the adaptation of a person to their environment, well-being and the actualization of oneself, we can qualify this concept as a holistic vision. This allows the social worker to focus on the individual rather than the disease. During our interviews, the social workers emphasized their specific perspective, which is at the heart of their practice, and which sets them apart from other practitioners.

CONCLUSION

To our knowledge, there is no research on eating disorders based on social representation theory. This research inevitably contains biases and limitations related to the methodology used and to our subjectivity. In this regard, it must be acknowledged that the research remains limited in its purpose and its elements of demonstration and do not allow us to extend our conclusions to all social workers.

Our results revealed the sociological, psychological and biological complexity of eating disorders, as well as the impact of societal movements, the pressure exerted by social structures on the disorganization of human behaviour. For social workers, eating disorders are perceived as a symptom and/or a form of adaptation to an environment that, for some, proves to be hostile. From this perspective, the forms of intervention, where individuals and their self-determination left to their own devices, would no longer focus on symptom resolution, but rather on an awareness, in our opinion beneficial, of the relentless negotiation of individuals with their environment and the suffering that this environment can generate. It is by reinterpreting and

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objectifying one's difficulties by the "symbolic work of producing meaning" (Chouinard, 2013, p. 174) that individuals regain a certain comfort, both inner and guided toward society and institutions.

Our study also raises issues concerning social work in psychiatric settings. One of these issues is highlighting the sociological aspects of the interpretation of behavioural "dysfunctions" in a social context increasingly marked by the medicalization of social problems. To achieve this, it is necessary to understand the articulation of the psychological, biological and sociological elements within a person. It is therefore necessary to possess some psychological and biological knowledge pertaining to these problems in order to determine the influence of the biopsychosocial paradigm components. Those are decisive in the way the individual fits into their environment.

The professional body responsible for regulating the practice of social workers (OTSTCFQ) is drawing attention to the social determinants of mental health. In this perspective, our research can contribute to reflections and debates on cultural aspects of a mental health problem that affects young people. It can also provide a foundation to questioning and exploring interventions.

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