

‘Does meaning matter in the treatment of anorexia nervosa?’

A mixed methods study of the experience and meaning of illness for female children and young people diagnosed with anorexia nervosa and other restrictive eating disorders, and their parents.

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Declaration

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

Signature: Catherine Troupp

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Abstract

Does meaning matter in the treatment of anorexia nervosa?

A mixed methods study of the experience and meaning of illness for female children and young people diagnosed with anorexia nervosa and other restrictive eating disorders, and their parents.

Rationale

This research was prompted by clinical experience and curiosity about the apparent absence of meaning-making in therapeutic conversations with parents and children in the family-based treatment (FBT) model, the current first-line, evidence-based treatment for young people with anorexia, and how this absence might impact treatment outcome and family relationships. A second area of research concerned parents' capacity for 'mentalizing' – that is, imaginatively trying to understand the intentions behind their children's behaviour.

Recruitment

Research subjects were recruited from a Tier 4 outpatient, national service treating young people with a range of eating disorders and their families. Ten families and one pilot family were recruited in 2012-13. All the children and young people in the research cohort were girls.

Design and method

The study was designed as a mixed methods, longitudinal study, based entirely on individual interviews. A total of 35 interviews were analysed. Mothers, fathers, and children were interviewed separately near beginning and after end of treatment in the service. Data analysis was conducted both qualitatively by means of Interpretative Phenomenological Analysis (IPA), and quantitatively with the measure of Reflective Function. The semi-structured interview was designed, and results partly presented, along four main domains, Understanding, Impact, Value and Recovery. Interviews were also designed to probe for mental state thinking and mentalizing about self and other.

Discussion

Results indicated that parents in particular fell into two discrete groups, with common characteristics. One group prioritised understanding and 'mentalizing' their children, while the other group viewed eating disorders as something likely unrelated to family relationships. The emotional impact of their child's eating disorder was markedly different in each group. The discussion includes a psychoanalytic theoretical framework when interpreting findings.

Impact statement

The research presented in this thesis addresses a gap in the clinical and theoretical understanding of children with anorexia nervosa and other restrictive eating disorders, and their parents.

The meaning of the eating disorders symptoms for children and parents alike, from their respective vantage points, is poorly researched and poorly understood. Treatment models favour behavioural family interventions and health and weight focused outcomes. The management and care of a child with an eating disorder represents a family crisis and catastrophic event in many families. Literature exists that attests to its traumatic impact on parents in particular. This thesis argues that for recovery to proceed in all family members, and mental health restored, it is essential that family members be helped to understand the meaning of the symptoms. By this is meant the communications about emotions of distress that lie behind the symptoms, and that children intend to express through their eating disordered behaviour. The results of this research indicate that this distress may concern family relationships and the child's own prospects for development in adolescence.

Thirty-five interviews with all members of families with a child with an eating disorder – mothers, fathers and children – were analysed with mixed qualitative and quantitative methods. The qualitative method searched for themes of meaning in all participants' narratives; the quantitative method assessed participants' capacity for Reflective Functioning, the measure of mentalizing in the context of attachment relationships. Where possible, the themes elicited and the RF values obtained were compared in several different constellations: within and between groups of mothers, fathers and children; and within family groups themselves.

Results indicate relatively low levels of understanding by parents of the intentional communication of their children as expressed through their eating disorder symptomatology. Misunderstanding between couples was also common. In this context, the ground is ripe for the growth of damaging emotions such as anger and blame to flourish alongside the distress and incomprehension. A child's eating disorder can inflict long-term damage on the emotional well being and functioning of the family for many years to come.

In this context, and for the benefit of future treatment for families, it is argued that it is essential that

- a) further research into the 'meaning behind the behaviour' in eating disorders is undertaken specifically in family contexts
- b) means of communicating the findings of such research to the families themselves, are developed
- c) means of enhancing first-line treatments delivered to families are developed so that clinicians feel skilled and equipped to address the misunderstandings and extreme emotions within families, between parents and children, and between couples

Publication of findings:

The researcher intends to publish a short series of articles in journals aimed at eating disorders specialist clinicians, reporting the results of this study for the meaning of the eating disorder for mothers, fathers and children respectively. Though outside the scope of this study, brief recommendations are made for clinical enhancements and innovations that are practicable to be implemented in our existing specialist eating disorders services.

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Chapter 1.Introduction

1.1 The place of meaning in the current treatment landscape for young people with anorexia nervosa, and their parents

The search for the possible meanings contained in the symptoms of an eating disorder in children and young people, is rarely the starting point of clinical treatment in current approaches to treatment for eating disorders in young people. There are several potential reasons for this – clinical, medical and political.

First, militating against a ‘search for meaning’, at first presentation at least, is the high-risk nature of the disorder. Anorexia nervosa (AN) in particular requires immediate symptom amelioration, that is, nutrition and weight gain and the restoration of physical health. Indeed, Freud warned that ‘psychoanalysis should not be attempted when the speedy removal of dangerous symptoms is required as for example, in a case of hysterical anorexia’ (Freud, 1905[1904], p 263).

In children and young people, health restoration is even more urgent since a period of starvation can have a permanent deleterious impact on growth, bone health and even fertility.

Second, in the past twenty or thirty years, the most robustly evidenced treatment for eating disorders in children and young people has become treatment that involves the child’s family in a specific, behavioural eating-focused way. Family Based Treatment (FBT) was originally developed at the Maudsley Hospital in London, where it is called Family Therapy for (FT-AN) and also known as ‘the Maudsley model’. It was subsequently named FBT and manualized (Lock & Le Grange, 2002, 2013, 2nd ed.), and tested in randomized controlled trials by Lock and Le Grange and colleagues in Stanford and Chicago (Lock et al., 2010; Le Grange et al., 2012; Lock 2015, Le Grange et al., 2016). The family-based treatment approach, now further refined into versions where the child is and isn’t present, has accrued the most substantial treatment outcome literature. On the one hand this development is undoubtedly welcome in a field where there was previously something of a free-for-all in terms of clinical approaches and interventions. On the other hand its development has had the consequence of leading practitioners to act as if they believe that other approaches are

therefore disproven, and further, researchers to believe that other approaches are not worth modelling and trialling. So the current prevailing belief in the eating disorders field has come to be that research and treatments where subjective meanings are explored and understood, are actually incompatible with effective treatment and positive treatment outcomes.

FBT is a behavioural form of family therapy where parents are viewed more as co-therapists than clients, and supported by professionals to 'take charge' of their children's eating and re-nourish their child at home. The model is described thus:

"Family Based Treatment (FBT) focuses on encouraging parental control of eating related behaviors in their child and is conducted over three phases. In the first phase, therapy is characterized by attempts to absolve the parents from the responsibility of causing the disorder. Consequently, the therapist will compliment the parents on the positive aspects of their parenting. Parents are encouraged to take steps that will work for their family to help restore the weight of their child with AN thereby improving their sense of efficacy in this arena. In Phase 2, the therapist will support the parents to transition eating and weight control back to the adolescent in an age appropriate manner. The third phase focuses on establishing a healthy adolescent relationship with the parents where the eating disorder is not the idiom of communication. (Le Grange et al., 2012, p86)

As can be inferred from this description, parents' authority and strengths are highlighted and reinforced in FBT. The search for meaning in the symptoms is side-lined in part because of the potential for implied criticism and blame from both the child with the eating disorder herself, and from clinicians, thus potentially also undermining parental authority. What the eating disorder might 'mean', or might be intended to communicate, may be quite briefly attended to in the third and final phase of treatment when physical health has been restored and eating become more normal. In part, the search for meaning is also side-lined because it is seen as a distraction from the primary task of the family based treatment, that is, to promote and support the parents to feed their child. One might say that in this model, understanding their child is not viewed as necessary for parents to feed their child. What is viewed as essential, is understanding AN as a collection of typical symptoms, behaviours and thought patterns. It is often said to parents that although every child is an individual, the eating disorder or 'illness' as it is increasingly referred to in clinical settings, is pretty similar in each sufferer.

There are few alternatives to the FBT approach in the recent clinical research literature, because no other treatment approaches have been systematically researched except for one form of individual therapy called Adolescent Focused Therapy (AFT). This therapy was the control arm in the randomized controlled trials (Lock et al. 2010; Fitzpatrick, Moyer, Hoste, Le Grange & Lock, 2010).

There is a small body of clinical case studies in eating disorders in the psychoanalytic literature, child and adult. Psychoanalysis can surely be described as a treatment approach that prioritizes the search and making of meaning, with the aim and expectation that this process will itself be developmental, therapeutic and curative. Although there is a wide range of theoretical ideas in eating disorders based on individual cases in the literature, there is little information about the outcomes of these individual cases, let alone any larger scale study using a psychoanalytic approach. All accounts of psychoanalytic or psychodynamic treatment of AN appear to concern single case studies (Caparrotta & Khaffari, 2007), including some famous ones documented in the literature such as the case of Ellen West (Akavia, 2008).

Because of the lack of a treatment model, and therefore any outcome research and data, and with the evidence base for FBT expanding both in terms of time and number of studies (though in reality still only a handful of studies), psychoanalytic and psychodynamic oriented therapy for child and adolescent eating disorders, was until recently seen as a misdirected approach, at best useless, at worst actively unhelpful. Psychotherapy posts in child and adolescent eating disorders services mostly disappeared. If a psychotherapist was available, usually borrowed from a neighbouring generic Child and Adolescent Mental Health Service (CAMHS), psychotherapy might be offered to a few young people where everything else had failed or conversely, where the young person was much recovered and actively expressed a wish for therapy.

This seemed to be the situation until the recent publication of the updated NICE Guidelines for Eating Disorders (NICE, 2017), when AFT was also included as an individual therapy that could be considered, a therapy by which psychotherapists may come to play a role in eating disorders treatment in the future.

Otherwise, treatment for young people with AN begins as uniform, evidence-based and NICE guidance concordant, with the FBT the first-line intervention, irrespective of the

possible original precipitants and triggers, or indeed the possible function of the eating disorder.

The mode of family and individual member functioning at the point of presentation is not taken as a representation of family members' 'real' selves, or of the 'real family', but rather, as a representation of a family traumatized and profoundly changed by the appearance of an eating disorder in their midst. The professional stance striven for in dedicated eating disorder teams with regards to aetiology is genuinely agnostic. Agnosticism is not the same as forswearing the search for meaning, and yet the two have become merged. It has been as if the rush to assure parents and families that no one is to blame for the eating disorder, meaning has been jettisoned also.

Later in treatment, care plans may become more guided by specific needs displayed by the family or the young person, usually if first-line intervention is only partially successful. This differentiation may typically appear when weight is beginning to be restored, but the young person is not recovering emotionally or developmentally. It is an encouraging trend that post-weight gain treatment is becoming an important secondary focus for treatment, along with the understanding that adequate dose and appropriate orientation of therapy is potentially important for robust recoveries in eating disorders.

While the 'meaning focused' therapies faded from the field, however, there was an upsurge in qualitative research, seeking information about the subjective thoughts, feelings and experiences of the parents, the young people, and their siblings, on many aspects of the experience of illness. 'Subjective experience' and 'meaning' are potentially but not necessarily overlapping constructs; some of these qualitative studies shed light, or at least hint at, the meanings that various members of the family attribute to the eating disorder while others do less so, and much research seeks to highlight the levels of suffering, in particular the 'carer burden' in a variety of forms.

Meaning of a different kind was at the heart of Minuchin, Rosman and Baker's (1978) and Selvini Palazzoli's (1978) pioneering but now somewhat infamous approach to treating eating disorders in the 1970s and 80s. While their treatment was pioneering in that the family, not the individual, was the unit for therapy, the focus was on the family dynamics as 'cause' of the eating disorder. Families were designated pathogenic, a typology was proposed (an anxious appeasing enmeshed mother, an apparently strict but actually ineffectual father, circular communications where conflict was avoided not

resolved), and inevitably parent blaming and criticism followed. It was in this overheated context that the etiologically agnostic and theoretically bland, but behaviourally apparently more effective, successor to Minuchin's therapy, FBT, was developed (Lock & Le Grange, 2002, 2012). The challenge for the field, as for this study, will be to proceed with the project of making meaning without assuming that meaning necessarily points to causality. "The one seeks to liberate, the other to imprison."

Clinicians are struggling with adapting old therapeutic paradigms to new research findings, and vice versa, researchers too are struggling not to throw out the baby with the bathwater, particularly where biologically based research is concerned. Strober and Johnson (2012) in an article entitled 'The need for complex ideas in anorexia', proposed that it could be the very complexity of AN that has prompted a fashion for monolithic explanations of nature of the disorder. They wrote:

"It is an exciting time for eating disorders research because the opportunities for advancing knowledge are now rich. But ironically, there is also a knowledge chasm that is wide. Simply stated, in spite of a wealth of empirical and experiential knowledge that brings attention to the complexities embedded in AN, a counter-intuitive view now prevails in the minds of many, one that portrays the illness and its treatment in ways that do not suffice as truth. The two main sources of controversy centre on (1) the explanatory role of causal genes and abnormal biology, and (2) whether family-based treatment for weight correction should have primacy in managing younger patients" (Strober & Johnson, 2012, p156).

On the other hand, when appropriately complex formulations about aetiology and treatment needs are proposed, the result may also look something like this abstract for a chapter on the place of psychodynamic psychotherapy in eating disorders (for adults):

"The available research suggests that the aetiology of eating disorders (EDs) is multifactorial and individually variable, with risk conferred from personality pathology, family history, developmental history, sociocultural phenomena, comorbid disorders, and genetic endowment. The treatment of EDs is complicated by characteristic problems in interpersonal relationships, resistance to change in symptomatic behavior, and difficulty in accessing emotional experience. Psychotherapy for EDs must target not only overt symptoms, but also motivation, emotion regulation, insight, and resistance. Among the various forms of "talk therapy," psychodynamic psychotherapy arguably has the most techniques for addressing the complex problems characteristic of individuals with EDs." (Thompson-Brenner, Weingeroff & Westen, 2009, p67)

This proposal is so broad and inclusive that it becomes almost meaningless, a ‘crowd pleaser’ of a summary of factors at play in the development and trajectory of an eating disorder, from which no conclusions can be drawn with implications for effective treatment.

1.2 Why research meaning?

So why ask the question, ‘Does meaning matter in the recovery from anorexia nervosa?’ To whom does it matter whether meaning is part of what is known and written about AN and other eating disorders?

The question grew from clinical experience working with families where a child had been diagnosed with an eating disorder. It grew from concern over the side-lining of meaning at a time when treatment was becoming more evidence-based and more coherent. How could people not seek to make meaning – parents, children and clinicians alike? Was meaning-making a choice, an optional activity or, as the researcher believed, a human need? Philosophers, psychoanalysts, psychologists and writers all in their own ways attest to our need to give meaning to our experience (Frankl, 1946; Bruner, 1993; Fonagy & Target, 1996).

Less loftily, the research question was driven by a more specific curiosity on the part of the psychoanalytically trained researcher about whether behavioural strategies could resolve mental ill health even when their cause or function was not reflected upon, and not understood.

It was challenging to be a psychoanalytic child psychotherapist in a specialist eating disorders team, and a wish to confront this challenge also sparked the desire to carry out this research. Psychoanalytic practitioners proceed on the assumption, and *modus operandi*, that patients are treated by finding the origins of the problem and working through how they manifest in the present. The loss of this old ‘certainty’ in the eating disorders service of the researcher prompted, perhaps, a period of professional confusion and professional loss. Was the work of supporting individuals in making meaning merely an arcane curiosity, or a clinical luxury, or did it have an actual place in the treatment and outcome of eating disorders?

But was the meaning of the eating disorder important not only to the clinician-researcher, but also to the young people themselves, and to their parents?

It is clinically observable that the children and young people themselves often forswear meaning, when they are in the grip of the eating disorder and first come for treatment. Seeking, and valuing, meaninglessness, can be part of the disorder itself. Young people in treatment may explicitly say that they do not want to think about anything, or more specifically, that they are afraid that if they think about anything, the eating disorder will lose its grip over them. In this instance meaninglessness can be invoked for the maintenance of the valued eating disorder.

Clinicians often suspect that this apparent valuing of meaninglessness is a 'cover story', however.¹ It may also be that the meaning is profoundly private and personal and the avowed meaninglessness is a form of protection. Evidence that the meaning matters to children and young people can be drawn from the familiar clinical observation that they very much dislike hearing that the symptoms of AN are much the same in everyone, and that some of the symptomatology can simply be an effect of starvation.

The situation may be the very opposite for parents of young people with eating disorders. They may be quite desperate for a narrative that makes meaning of the developmental blight that, variously, appears to have crept up on their child or come from nowhere in an instant, and to share it with other parents. The researcher had ample experience of this need in nine years running a weekly support group for the parents of the children with eating disorders. The clinical experiences in this Parents' Group were the strongest spark for this study.

For parents, the question 'why and how did this happen to my child and our family?' was sometimes explicit, sometimes implicit, in conversations in the group, but never far from the surface, particularly so when parents shared their feelings with each other. Feelings of guilt were often expressed, often associated with a search for a cause, and often prefaced with a statement along the lines of, 'I know we have been told there is no one specific cause and that eating disorders are not the fault of parents, but...', followed by the expression of a need to understand.

¹ With thanks to Dr Dasha Nicholls for making this connection.

The FBT literature appears uneasy with this parental quest. For example, in the Foreword to the first edition of Treatment Manual for Anorexia Nervosa: a Family-Based Approach by Lock and Le Grange (2002, p.), Gerald Russell wrote, ‘Common difficulties are anticipated, such as the beguiling request by the parents to discover the “underlying causes” of the illness, before tackling their task of refeeding.’ This line had been removed from the foreword to the second edition. Instead Russell wrote (Lock & Le Grange, 2013, p. xii). ‘The basic principles underpinning family-based treatment (FBT) remain the same. The parents are exonerated from blame for their child’s illness through actions erroneously deemed to have caused AN. Certainly, the therapist is urged to adopt an agnostic view regarding the causes of AN.’ The new foreword also acknowledges positively the new emphasis on adolescent developmental process as a focus for later treatment in the second edition of the Manual.

Parents receive psycho-education in the early stages of FBT and will be told that research has shown that the emergence of an eating disorder in a child is the result of multiple factors. The formulation might typically describe a ‘perfect storm’ of the child’s pre-morbid personality traits such as high levels of anxiety or perfectionism, triggering events such as bullying or loss of a friend, academic pressure, and in younger children and in keeping with new research (Tagnau, Micali, Stewart & Nicholls, in preparation), a period of physical illness or infection, often gastroenteritis or something digestion related. Parents are told firmly that searching for individual aetiology is not helpful if it leads them to blame themselves. Therefore parents may almost heroically try to refrain from blaming themselves but at the same time exhibit an inescapable wish to understand what has happened to their child and their family, what has gone wrong, and, inevitably, wonder if there was something they could have done differently?

A final impetus for this study was the hope that one outcome would be some fresh guidance for clinicians as to how to respond properly, robustly, knowledgeably and above all empathically, to this expression of parental need.

1.3 Are all meanings equal?

While parents in the Parents’ Group seemed united in their need to create a narrative and to find meaning in the family crisis that they were living through, it was also observable that parents varied in their interest in, and capacity for, putting themselves in their children’s shoes and imagining what their children were experiencing and struggling with, both before and now. And even further, there was variation in parents’

apparent expectation of how much they could be expected to know of their children's mental life, their thoughts, feelings and subjective experience. Thus the concept of Reflective Functioning (RF, Fonagy, Target, Steele, & Steele, 1998) was proposed as an object of research, alongside a qualitative approach to discerning and defining the meanings that parents and their children gave to the eating disorder.

Finally, and abjuring political correctness in the field, the question was posed as to whether parental capacity for putting themselves in their children's shoes, or mentalizing their children (Fonagy, Gergely, Jurist & Target, 2002) had any bearing on their child's trajectory of treatment and recovery, given the central role of parents as the agents of change in the family based treatment model (Rossouw, 2015).

1.4 'Doublethink' in eating disorders research and treatment

There can at times appear to be an internal inconsistency between the approach that states that it is fruitless to search for aetiology in eating disorders and that parents are categorically not responsible for its onset, and yet treat AN by the traditional means of mental health treatment, that is, by talking and behavioural therapies. The usual synthetic response would be that while parents are not the cause, they are the vehicle of recovery. In reality, treatment was rarely so consistent with theory.

Professor Bryan Lask² reported a conversation with a father who aggressively questioned the logic of asserting that eating disorders were not caused by parents yet made family therapy the primary vehicle of treatment. Lask took the position that this father's logic was accurate and that the field should 'put its money where its mouth was' and indeed step back from family treatments. Lask at times claimed to hold the view that eating disorders didn't mean anything at all.³

We may recall the three slogans of the party in Orwell's novel 'Nineteen Eighty-Four' (1949), where the phrase 'doublethink' was coined — "War Is Peace; Freedom Is Slavery; Ignorance Is Strength". Orwell in his novel defined doublethink thus:

² Personal communication.

³ At a research meeting where my research proposal was being presented, Prof Lask said: 'Does meaning matter? I can answer that in one word. No.'

'The power of holding two contradictory beliefs in one's mind simultaneously, and accepting both of them... To tell deliberate lies while genuinely believing in them, to forget any fact that has become inconvenient, and then, when it becomes necessary again, to draw it back from oblivion for just as long as it is needed...'

Sufferers of AN themselves are propagators of doublethink. 'Thin is good', 'I don't need food to live', 'I'm fat and disgusting', 'for every calorie consumed I need to burn two', 'for every sentence I utter in therapy I need to compensate with silence for twice as long' and private mantras of this kind are 'lies', which the sufferer needs to convince herself are truth. In the process, she has to find a way of squaring her own 'beliefs' with the opposing ones, held by her family, her peers (one hopes), and wider society. Many people with AN will simply assert that although other people need food to live, and other people need to be a healthy weight, it is different for her, the anorexic. And as noted, young people with AN often deny that their symptoms, actions and beliefs have any psychic meaning. They are simply pursuing their own personal and fiercely fought for 'truth' in a logical fashion.

Perhaps it is when working clinically with such blind devotion to beliefs, or positions, that bow neither to science nor reason nor logic, that clinicians in the field have developed their own versions of doublethink. This way head-on confrontations of belief systems can be avoided.

Clinicians' beliefs can be felt to be provocative and powerfully coercive to people with eating disorders. They also sweep away any consideration of the potential meaning in the 'beliefs' and meet the absolutism of AN with similar absolutism of mental health. Think, for example, of the assertions that 'the illness' is separate from the person, is holding the sufferer to ransom and that therefore she cannot be held responsible for her actions, which in turn necessitates her parents taking control of her health, in particular her eating, and that any opposition to this plan will result in greater coercion still, such as an admission to an in-patient unit where the ultimate recourse will be nasogastric feeding or in even more extreme cases, PEG (percutaneous endoscopic gastrostomy) feeding, where a feeding tube is inserted into the stomach directly.

To conclude, and to repeat, my interest in the research into the construction of the meaning of their symptoms, by young people, and their parents, and the genesis of this study, sprung from a combination of concern at the absence of meaning from

evidence-based treatment such as FBT, with my interest in parents' accounts in the Parents' Group that I ran for nine years at the service where I worked.

Did meaning matter – to parents, their children, and to their therapists?

Could families as a unit and their individual members recover from the child's eating disorder without developing their own meanings?

Did parents' capacity to mentalize their children matter in their children's recovery?

Crafting a methodology to research these questions, gathering the research data, and finding means of analysing the data, form the mainstay of this doctoral thesis.

Chapter 2. Literature review

2.1 Introduction

This review of several bodies of literature in eating disorders focuses on ways in which writers have understood and made sense of eating disorders, particularly AN. Most of the literature reviewed is scholarly, by either clinical or research professionals, or by those who straddle both. Some popular writers about the cultural contexts of eating disorders, particularly feminist accounts of the construction of femininity, are reviewed, as well as a brief view of trends in the literature produced by those who have suffered from eating disorders themselves, or their families.

Section 2.2 offers a historical overview of the definitions, theories and treatments for AN in particular that have evolved in the last one hundred years or so. Where possible, other bodies of literature have also been approached from a historical and historiographical point of view, for example, the review of psychoanalytic theories about eating disorders in Section 2.3, and the review of treatment trends in Section 2.4. This literature is presented and evaluated particularly in terms of what it tells us about prevailing understandings of eating disorders and AN in the context of cultural and clinical preoccupations and beliefs of the time.

Section 2.3.4 concerns more recent theory and research on eating disorders in the attachment theory framework, and evaluates this perspective in regards to any fresh light it may cast on the question of meaning. Some questions of research methodology are also considered, in particular ones that relate to Chapter 8 in this thesis, where results are analysed using Reflective Function (RF), a measure of analysis developed within attachment theory research.

Section 2.4. presents a chronology of treatment approaches; psychoanalytic, through the case study of Ellen West in the early part of the 20th century, systemic in the 1970s and 80s, and FBT today. Studies relating to treatment outcomes will be evaluated not on the scientific robustness or correctness of their design, methodology or statistical analysis but looked at more from the point of view of what their preoccupations may say about assumptions and theories about eating disorders past and present, and the place of meaning within this.

Section 2.5 reviews current qualitative research and qualitative research methods in eating disorders, a field that is burgeoning and that may justifiably be said to represent the modern approach to meaning. Studies reviewed are divided into sections about the experience of parents, siblings, and young people with eating disorders. The author has found extremely few qualitative studies that replicate one particular aspect of the design of this study, that is, simultaneously researching the experience and perspective of parents and children from the same family. Finally, in preparation for the chapters that follow on study design, research methods, and the analysis of results, literature on qualitative research methods is briefly reviewed.

2.2 Historical overview of definitions, theories and treatments of AN

Habermas (2015) tells us that the term anorexia nervosa (AN) has been in use for the past 140 years (Gull, 1874, 1888); and in fact some writers go as far back as Morton (1694).

Nineteenth century physicians began to note the disorder and put forward theories about its aetiology, both psychological and environmental. Lasègue (1873) coined the term 'anorexie hysterique' referring to it as 'one of the forms of hysteria of the gastric centre', and believed it to be caused by 'the mental disposition of the patient'. He underlined the patient's pathological conviction that food damages the body and thus must be avoided. He also noted other psychological features such as the need for approval and self-doubt as well as the patient's lack of concern.

Gilles de la Tourette (1895) described two subtypes of AN according to whether there was voluntary food refusal or gastric pathology. Janet (1911) also distinguished two groups. In the first type refusal to eat was due to an obsession or phobic anxiety about food and eating. The second type was of a hysterical nature, which in his view was less common.

But long before this, the first full medical description of self-induced starvation leading to severe weight loss is attributed to Richard Morton (1694) who classified this condition as 'nervous consumption' and devoted the very first chapter of his 'Phthisiologia, or, a Treatise of Consumptions' to its description. He distinguished this disorder from other wasting maladies and believed it to be amongst others the product of 'violent passions of the mind'. His two case histories concern a young woman of 18 and a boy of 16. The boy seemed to recover after Morton prescribed a milk diet,

country air, horse riding, and abandonment of his studies. Of the young woman, he writes:

“Mr Duke’s daughter in St. Mary Axe, in the year 1664 and the eighteenth year of her age, in the month of July fell into a total suppression of her monthly courses from a multitude of cares and passions of her mind, but without any symptom of the green sickness following upon it. From which time her appetite began to abate, and her digestion to be bad; her flesh also began to be flaccid and loose, and her looks pale... for that she was wont by her studying at night, and continual poring upon books, to expose herself both day and night to the injuries of the air... I do not remember that I did ever in all my practice see one, that was conversant with the living, so much wasted with the greatest degree of a consumption, (like a skeleton only clad with skin), yet there was no fever... [Morton prescribed a number of stomach tinctures] Upon the use of which she seemed to be much better, but being quickly tired with medicines, she begged that the whole affair might be again committed to nature, whereupon consuming every day more and more, she was after three months taken with a fainting fit, and died.” (Morton, 1694, pp 8-9).

Morton’s overall advice concluded that besides fresh air and a ‘delicious diet’, the physician should ‘Let the patient attempt to divert and make his mind cheerful by exercise, and the conversation of his friends. For this disease, does almost always proceed from sadness, and anxious cares.’ (ibid., p8).

Habermas points out that,

“This designation has been criticized as a misnomer, because the syndrome does not necessarily involve a lack of appetite. Hilde Bruch (1973) suggested that the German term ‘Magersucht’ described better the distinctive psychopathological feature, an ‘addiction’ to extreme thinness, termed variously ‘drive towards emaciation’ (Selvini-Palazzoli, 1963/1974) and ‘relentless pursuit of thinness’ (Bruch, 1965), or, more adequately in stressing fear, ‘l’idée fixe d’obésité’. (Charcot; cited by Janet, 1907), ‘weight phobia’ (Crisp, 1970), or ‘morbid fear of being fat’ (Russell, 1970). These terminological issues reflect how much AN has been disputed in history, and also how much its history is still in dispute.” (Habermas, 2015, p11).

Habermas, points out how over time, insights are made, forgotten, and rediscovered, and how they are governed by cultural constructs of the era. In the particular case of AN, the secrecy of the sufferer about her symptoms, and the absence of diagnostically confirmatory accounts by sufferers themselves, presents an additional challenge in the historical research on definitions and diagnosis.

There is a long history of fasting beginning with records of the 'ascetic-mystic extreme fasting' of pre-reformation, late medieval female saints, such as Catherine of Siena. The Catholic Church actually attempted to repress these fasting women by offering them institutional roles within the Church, the miraculous powers that the capacity to live without eating seemed to bestow, were seen as a challenge to the authority of the Church. The first reported miraculous fasters were Italian, but after the Reformation new cases were reported in Dutch and Germanic medical writings. These cases were not primarily religious in presentation but rather represented secular miracles and the 'sufferers' were said, typically, to be young women of modest background, still often living at home, and who gained some notoriety or fame in their local communities for their 'miraculous' ability to survive without food.

The history of definitions of and theories about AN in the modern area is usually said to begin with the coining of the terms *anorexie hysterique* in 1873 by Charles Lasègue, and *anorexia nervosa* in 1874 by William Gull. "The differences between the French and British traditions already show in these first two reports, inasmuch as Gull reports mostly physical and behavioral aspects, whereas Lasègue pays more attention to the psychological aspects of his patients." (Vandereycken & Abatzi, 1996, pp18-19).

And a glimpse from Charcot's case reports:

"It was a case of psychic AN. The patient systematically and energetically refused all food. ... She weighed 29 kg ... the *idée fixe* not to eat [was] ever present. At times she hid the food in her towel, her pockets, her stockings, sometimes she even tried to keep it in her mouth... She entered the water cure clinic of Passy in a state of great agitation. Her skin was cold and viscous; she was incessantly tormented by the idea of gaining weight. Half a year later, after being treated by water cure and a strict alimentary regimen, the patient was released with a body weight of 40 kg (88 lbs). After returning home, the young woman soon lost weight again. Her mother refused to put her back in the hospital, and the patient died within weeks (Charcot, 1883, p.4).

Different early authors foregrounded different symptoms and features, as the collection of typical features and the range of behaviours coalescing around what are now called 'weight and shape concerns' were not yet systematically collected: weight phobia, fasting, overactivity and restlessness, purging, denial of illness, secretive behaviour, family protectiveness, and so on.

Interestingly to the modern clinician, one of the currently noted key features of AN, the ‘care eliciting’ behaviour, whether intentional or apparently unintentional, can be seen even in early case reports.

From the 1930s, case series of more than 20 patients began to be reported, with a notable clutch of studies of late adolescent and adult patients, published in 1936. Ross (1936) reported on a series of 19 patients over ten years; Ryle (1936), 37 patients in 16 years, and Hurst (1936), 50 patients over 19 years. This last study was remarkable and suspect in equal measure (Scott, 1948) for its report of not a single failure of treatment.

Theoretical writing, less so systematic research, intensified in the 1960s and 70s, when indeed definitions of AN were attempted by Bruch (1973), Crisp (1976), Russell (1970) and others, highlighting new features as they became clinically observable in new treatment settings, often mixing up clinically observable phenomena with hypotheses about aetiology and motivation, i.e. ‘meaning’ of the symptoms. For example, Bruch insisted that a sense of ‘ineffectiveness’ and lack of personal agency was a key diagnostic factor, while Crisp asserted that aversion to sexual maturity was equally central.

The current definition of AN in the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5, 2013) has abandoned definition according to psychological determinants, by stipulating quite minimal diagnostic criteria, and removing all phrasing that might imply intentionality. The criteria are:

- A. “Restriction of energy intake relative to requirements, leading to a significant low body weight in the context of the age, sex, developmental trajectory, and physical health (less than minimally normal/expected).”
- B. Intense fear of gaining weight or becoming fat or persistent behavior that interferes with weight gain.
- C. Disturbed by one’s body weight or shape, self-worth influenced by body weight or shape, or persistent lack of recognition of seriousness of low bodyweight.

The first criterion differs from Diagnostic and Statistical Manual of Mental Disorders 4 Text Revision (DSM-IV-TR, 2000) where it read:

“Refusal to maintain bodyweight at or above minimally normal weight for height/age (less than 85th percentile).”

The second criterion had the rider, ‘even though underweight’ in DSM-IV-TR, which was dropped from DSM-5. The third criterion remained the same, and the fourth criterion in DSM-IV-TR, the absence of three consecutive menstrual cycles, was dropped altogether. The shift signifies, therefore, an explicit recognition that people with AN can have the disorder without being significantly underweight, and an implicit recognition that their psychological motivations are opaque, and varied, and therefore not able to be captured or made essential for the diagnostic criteria.

We can conclude that,

“The history of AN has several lessons to offer. It shows how malleable conceptions of a psychiatric disease are due to professionals’ major convictions about the nature of mental disorders. In the case of AN, ignorance of patients’ subjective point of view and a naturalistic somatic prejudice obscured the understanding and adequate recording of AN in the past, and these factors continue to trouble the field to this day.” (Strober & Johnson, 2012, p22).

2.3 Psychoanalytic theories

Psychoanalysis was an early contender as a treatment for AN, rich as it was with hypotheses and theories of aetiology and meaning of the disorder.

Freud himself had little to say about AN except briefly allying it to melancholia and depression, seemingly in the true sense of the word anorexia, that is, loss of appetite.

A search on the Psychoanalytic Electronic Publishing website PEP-Web, using the single search term ‘anorexia nervosa’, returned 1,877 results. The first 14 of these were by Freud or his contemporaries citing his work, spanning the years 1888 to 1918. In these early writings, AN is only mentioned in passing. The reference that has most captured the attention of subsequent writers is the one from ‘Draft G’ on Melancholia in Freud’s letters to Fliess. The reference is brief, and Freud proposes that,

“The neurosis concerned with eating, parallel to melancholia, is AN. The famous *anorexia nervosa* of young girls seems to me (on careful observation) to be a melancholia where

sexuality is undeveloped. The patient asserted that she had not eaten, simply because she had *no appetite*, and for no other reason. Loss of appetite — in sexual terms, loss of libido.” (Freud, 1894, p99).

Later in the same ‘Draft G’ he links both AN and ‘anaesthesia’, the main topic of his draft, and by which he means to denote lack of sexual libido, linked to disgust. (ibid., p101).

From a historical and sociological point of view, it is interesting to note Freud’s phrasing ‘the famous *anorexia nervosa* of young girls’. This might suggest that ‘pursuit of thinness’ has been a preoccupation of adolescent girls for longer than we thought. As Habermas points out, we are stymied in our attempts to map its past prevalence partly by the lack of historical records, in the form of personal accounts, left by the subjects themselves.

2.3.1 Psychoanalytic theories of AN

Caparrotta and Ghaffari (2006) undertook a literature search with the aim of charting the development and contribution of psychodynamic theory to the understanding of the aetiology of eating disorders. They found no coherent contribution but made the claim that their survey demonstrated the ‘unique contributions of psychodynamic concepts towards a better understanding of the aetiology of eating disorders and how much they have influenced and informed modern thinking on the meaning of these complex conditions.’ They summarized the psychoanalytic search for meaning in eating disorders thus:

“The original contribution from psychoanalytic authors has focused on different ways of understanding the unconscious and symbolic meaning of these disorders and AN in particular. The emphasis on the meaning seems to have shifted from a focus on internal conflicts to object-relations and to family dynamics depending on the prevailing theories and concepts at the time.” (Caparrotta and Ghaffari, 2006, p176).

The first reference on Psychoanalytic Electronic Publishing (PEP-Web) where AN is the main focus of a paper, rather than referred to in passing, is a brief review in 1931, by Marjorie Brierley in the International Journal of Psychoanalysis, of a ‘Medical Pamphlet’ recording a discussion between five doctors about AN:

“While differing on some points, all lay stress on the etiological importance of adverse external environment and agree that the symptoms concerned have the character of protest against authority. Thus Dr. Langdon Brown finds such disorder to be a pathological manifestation of the detachment of the individual from the parental authority, related to the general question of infantilism and having affinity with dementia præcox. Dr. Crookshank regards the symptoms as invariably a protest against parental authority. He considers they may be adequately treated by engaging in the family struggle on the patient's side and helping to secure the measure of independence desired... Dr. Young agrees that is always a reaction to some obstructing authority, while Dr. Gordon is of opinion that 'if there is any single and simple mechanism involved in this condition—probably an unwise assumption—then the mechanism is one of protest against authority', parental or otherwise. On the other hand, Dr. Bevan Brown thinks the reaction against authority, while of the greatest importance in sustaining the symptoms, is really secondary to disappointment in the craving for love.” (Brierley, 1931, pp500-501).

Treatment options proposed included ‘engaging in the family struggle on the patient’s side and helping to secure the measure of independence desired’. Notably, the review quotes one discussant asserting that ‘analysis by the Freudian technique is neither advisable nor required’.

The emphasis on the family dynamic remains up-to-date, although rather than seeing the disorder as *either* a protest against parental authority *or* an expression of ‘infantilism’, modern-day understanding tends to encompass a both-and view and consequently advocates treatment that *both* supports parental authority *and* a young person’s striving for individuation and independence. The road to this synthesis has been fraught with dead-ends, however, as we will see.

A paper by W. Clifford M. Scott (1948) entitled ‘Notes on the psychopathology of anorexia nervosa’ showed that thinking had become both more ‘psychoanalytic’ and more ‘multi-disciplinary’ – the latter again strikingly modern in its call for doctors, dietitians, and psychological workers to collaborate in the treatment of AN. His paper is more of a musing than an argument, traversing topics from cultural beliefs about the benefits and harm of food and diets, the powerful impact of patients with AN on their therapists and physicians, including the tendency for professionals become dogmatic and knowing; and the poor outcomes and high death rates of patients with AN over time. Scott challenged doctors of the time who claimed success with the simple cure of making the patient eat, arguing that cure could not be achieved without examination

and understanding of the emotional problems that lay beneath the symptoms. Scott also presents some now discarded beliefs as 'knowledge', such as that alternating starvation and episodes of binge eating equated to 'manic depression'. At the same time he calls for more understanding of the effects of starvation, both physiological and psychological.

Scott cites a number of contemporary studies on the outcomes of AN ranging from single cases to cohorts of 19 (Ross, 1936), 37 (Ryle, 1936) and 50 (Hurst, 1936). Hurst claims to have cured all 50 patients, a claim which Scott treats with disbelief. He makes the key observation,

"Most of the literature gives the same list of emotional problems as is brought forward to explain any other type of neurosis, and as yet little has been done to try to trace specific connexions between the symptoms and the instinctive life, the imagination and the interpersonal relations." (Scott, 1948, p243).

This particular methodological fault line can be seen as the nemesis of psychoanalytic theories in the field, as claims to have isolated specific 'anorexogenic' factors have never stood up when compared with those in other mental health disorders. Today, as we will see in section 2.3.4, the same methodological problem and same findings bedevil attempts to isolate attachment-related factors that might specifically be associated with AN and eating disorders.

Scott goes on to summarise three treatment cases of his own, of adults with AN. In the history of each case, he highlights that the first occasion of AN developed in adolescence after what we today call sexual abuse by a relative. Scott calls the incidents 'sexual episode', 'episode', and 'affair'. In each case he contends that the patient became fearful of possible pregnancy and tried to starve the possible conception out of her body, and that in each case 'unconscious' imaginings of pregnancy remained. He concludes,

"These three patients show some of the relatively superficial interrelations between eating, pregnancy delusions and cessation of menses. Such patients are often used as test tubes for endocrine or vitamin experiments. One wonders how the results can be understood without attempting to study the coincidental psychopathological changes which are occurring." (Scott, 1948, p245).

Shockingly, to the modern reader, Scott makes no remark at all on the possible traumatic effects of child sexual abuse or exploitation, repeated in all three cases. There is no sense at all that the patient in question had suffered an assault, and no mention at all is made of familial circumstances. The modern reader is left with many unanswered questions.

Melanie Klein's influence was particularly marked in Scott's assertion that

"Psycho-analysts have found that eating difficulties, both in young children and adults, are related to some of the earliest anxiety situations of a paranoid type. While feeding is dominated by cannibalistic phantasies, patients equate articles of food with the loved, hated and feared people, parts of people, and objects in their environment. Food, when eaten, is equated with the objects and organs already felt to be in the body and may give rise to fears of being poisoned and destroyed inside, and of losing or having destroyed one's loved inner possessions... In the manic reaction denial of the internal problem, omnipotent control and projection mechanisms are at work." (Scott, 1948, p246).

This interpretation, struggling to bring together the symptoms of AN with the emerging Kleinian orthodoxy, runs counter to Scott's other stated task, to draw connections between the familiar and impersonal symptoms of AN, and the specific emotions and experiences of the individual. The latter remains as unresolved today as 70 years ago. Nevertheless, Scott's proposal to draw connections between the individual and the symptoms of the disorder, and whether or not such an endeavour has viability, goes to the heart of the question in this study.

Going forward another decade or so, in 1960, an article appeared in the British Journal of Medical Psychology, entitled 'Regressive forces in anorexia nervosa' (Jessner & Abse, 1960). The emphasis here was on the difficulty of employing basic psychotherapeutic technique, that is, of having patients convert their actions and behaviour into verbal communication. The implicit 'care eliciting' behaviour and difficulty in converting behaviour into verbal communication remains the therapeutic dilemma until the present day, and gives Jessner and Abse's paper a modern feel.

These authors also situated AN firmly within the developmental challenges of puberty, in keeping with the emergence of 'adolescence' as a discrete developmental phase at this time. Interestingly, they assert (without data) that bulimia (here seeming to mean over-eating rather than the psychiatric syndrome of today) in late childhood or early

puberty often precedes the onset of AN. They describe the 'transference manifestations' of either a wish to be 'harmoniously united' with a mother, or to re-enact an ambivalent alternating union and separation, with resulting conflict. This assertion appears based on the case history, again involving shocking and traumatic family relations and experiences that, as in Scott (1948), are awarded no acknowledgement for their impact on the patient. Rather, Jessner and Abse resort to interpretation about internal motivations and object relations, and in the interpretation, no mention is made of the traumatic external events (in this case, repeated severe beatings by the patient's father, usually for food refusal). On the contrary, the authors contend that the patient 'provoked her father to beatings on her behind' and gained 'masochistic gratification' from these, resulting in her 'renouncing her sexual feelings' for him. Individual, culturally prevalent, female trauma, is recast in these psychoanalytic accounts as representing the individual, intrapsychic psychopathology, straying from empirically observable phenomena in order to remain faithful to, in this case, Freudian theory, or in Scott's account, Kleinian theory. The resultant lack of acknowledgement of the violence done to girls is harrowing to the modern reader.

The account of treatment in Jessner & Abse (1960) is interesting in its own right for the therapeutic milieu that was established on the principle that the patient herself was to be treated as being without the capacity for responsibility – a conceptual foundation for FBT that continues to this day. The interpretations about orality and defences against it, phantasies of pregnancy and defences against it, greed and destructiveness, as well as fear of sexuality and longing for fusion, may hold valency in psychoanalytic theory but, as all such accounts, remain unable to be proven empirically. Each individual case study captures its author's particular interest in one or more areas and in this case it appears to be the intense relationship with the mother and the fear of losing it that has piqued the authors' observations.

The preoccupation with theorizing the symptomatology - in terms at the time fashionably bowing to both Kleinian internal objects theory and Freudian Oedipal theory - has resulted in turning a complete blind eye to the abuse suffered by this particular victim.

Around the same time, before the second wave of feminism, Hilde Bruch (1962) was arguing for a more 'cognitive and perceptual' view of AN on the part of the professional or clinician, and a less interpretative one, in the context of a proliferation of psychoanalytic theories of the time.

She presents a case series of 12 patients over ten years, and argues for the necessity for clear diagnostic criteria, which did not exist at the time. She proposed disturbance of body image and disturbance of perception as the first two criteria, the latter including what has been called 'interoceptive awareness', recently refined into a three-dimensional construct comprising interoceptive accuracy, sensibility and awareness, the latter term now being reserved for a meta-cognitive dimension (Garfinkel et al., 2015). Bruch writes about awareness of hunger, fatigue and pain, but also under this heading, though more briefly, includes awareness of emotions, characteristically apparently absent in AN. Bruch's third proposed diagnostic criterion was 'a sense of ineffectiveness', which she also called 'helplessness', and which she related to an outlook or sense of self discovered through the course of the psychotherapies she conducted with these patients. She observed how her patients were reported to have been 'perfect' and 'model' children in the pre-pubertal years, pleasing their parents with their good behaviour and achievements, and asserted that they developed without a sense of agency or individuality until they hit a developmental wall in adolescence.

Comparing Bruch's three proposed diagnostic definitions with what is currently agreed upon in DSM-5 (given in section 2.1.), we can see that her first two overlap well enough with modern diagnostic criteria but her third, a sense of personal 'ineffectiveness', or indeed any psychological constellation, has been eschewed. To this day, the epistemology of the underlying psychology of AN remains too varied, too enigmatic, too unknown, perhaps, for any diagnostic agreement. In DSM-5, in fact, steps away from cognitive criteria were taken, such that the behavioural symptom in the absence of cognitive acknowledgement was included ('persistent behaviour that interferes with weight gain even though significantly low weight'), allowing for the idea that for some people with AN, awareness of their disorder is not required for the diagnosis to be made.

Bruch (1962) concludes with a view on why psychoanalytic treatment for AN had not proven successful. She says that the patient's lack of active mental life precludes an interpretative approach meaningful to the patient, and rather, 'giving interpretations' only reinforces the sense of ineffectiveness, of being the puppet of an external authority. Instead, she proposed treatment where the therapist properly listens to the concerns of the patient and adjusts their interventions accordingly. She writes:

"I gradually recognized that giving insight to these patients through motivational interpretations

was not only useless but reinforced a basic defect in their personality structure, namely the inability to know what they themselves felt, since it has always been mother who "knew" how they felt." (Bruch, 1962, p194).

2.3.2 Psychoanalysis, feminism, motherhood and AN

Hilde Bruch remains known particularly for her feminist pioneering, socio-psychological formulation summed up in her 1978 book '*The Golden Cage: The Enigma of Anorexia Nervosa*', where she builds on the embryonic views expressed in her earlier publications, namely that AN was a form of protest by girls and young women against the contradictory gender-based expectations imposed on them both by society and their parents (mothers primarily). The link between social expectations of gender and AN remains unproven, even while the biggest risk factor for AN remains being female.

'*The Golden Cage*' was published in the same year as Susie Orbach's seminal clarion call on eating disorders and feminism, '*Fat is a Feminist Issue*', where she argued that eating disorders should be understood in the context of patriarchy with its impossible expectations of girls and women to be seductresses, mothers, ever sexually available (post-1960s sexual revolution) and also guardians of virtue and chastity. Nowadays it is a commonplace to say that the '70s were the most exploitative decade for girls and young women to grow up in. If there is any link between the social expectations of girls, and eating disorders, then the most recent decades have not been any better for girls (Hoek, 2016).

In the psychoanalytic field, Blitzer, Rollins and Blackwell (1961), writing in *Psychosomatic Medicine* at the same time as Bruch, claimed that their case series of 15 children and early adolescents (12 girls and three boys) at Boston Massachusetts Children's Hospital was the largest to date; it may have been the first study of early onset AN where the majority of the girls were pre-menarchal. Blitzer and co-authors were seemingly unaware of Bruch's work as none was referenced, and similarly Bruch appears unaware of the work of Blitzer et al. in her article published in the same journal the following year. Of Bruch's nine references to existing literature, four referred to her own work and two more to historic writers (Gull, 1874 and Morton, 1694). Neither Bruch nor Blitzer referred to the case series by Ryle (1936), Ross (1936) or Hurst (1936) reviewed by Scott (1948), though these were of adolescents and adults mingled together. Neither Bruch nor Blitzer cited Jessner and Abse (1960) writing a year earlier. It is difficult to know if it was absence of communication between different

treatment centres, lack of modern technologies of communication, splits between different branches of psychology, psychiatry and psychoanalysis, or something else that could have been the cause of such limited exchange of ideas and knowledge between professionals interested in AN and other eating disorders.

Blitzer et al. (1961) published data that were curious from several perspectives.

In terms of recovery from AN, they claimed that nine of their 15 cases recovered from AN. One died at the age of 11, apparently discharged against medical advice. They also characterized each child's 'personality' in terms now unfashionable, such as 'hysterical', 'hysterical and depressed', 'schizoid with hysterical and compulsive features', and so on. There were so many combinations of personality factors in this manner that the authors concluded, with refreshing empiricism, that some people had 'weak egos' and some 'relatively strong egos' and that in this, their patients mirrored the general population.

No further details were given in the text about the components of the 'schizoid' presentation. It is interesting to speculate whether 'schizoid' might refer to the clinical picture familiar in the present of children who have 'autistic' features and who may have co-morbid diagnoses of autism spectrum disorder according to current diagnostic guidelines and 'fashions', that is, children who are said always to have had difficulty identifying and expressing their emotions, who have had limited success in the friendships and peer relations, who have a tendency to isolate themselves, to struggle with change and to prefer repetition and rigid rules in their daily lives. For these children who also exhibit eating disorders, a new category was established in DSM-5, named Avoidant Restrictive Food Intake Disorder (ARFID), to denote the restriction without the context, necessarily, of weight and shape and body image concerns. Two of three boys and two of the 12 girls in the series (Blitzer et al., 1961) were described as having 'schizoid' features.

Further, no specific markers for 'improvement' in either AN or personality were given.

Rather, the discussion in Blitzer et al. centred on the 'fantasies' of the patients, as well as some accounts of their family dynamics. The point made by the authors particularly strongly was that besides there being no single personality type, there was also no particular constellation of 'fantasies', or family situations, that could be said to be representative of the context for the development of AN. They wrote at some length

about 'sexual anxiety, particularly related to incestuous fantasies of oral impregnation,' and repeatedly referred to the study by Waller et al. (1940) where it was asserted that fantasies of oral impregnation underlie both AN and the common physically associated symptom of constipation (implying that it was not known that constipation is a common physiological consequence of malnutrition.) The authors also made the astonishing assertion that 'starvation is not the major factor in producing the amenorrhea', implying that psychological not physiological disturbance is the cause of amenorrhea). At the same time they noted that this argument had been challenged in another study (Cobb, 1944 & 1950; Rose, 1943) where it was found that many adolescents have fantasies of 'oral impregnation' without developing AN.

They cited another study (Masserman & Leonard, 1941) that reported

"cases in which the eating disturbance was associated with orally destructive, incorporative wishes. The female patients, in an inverted oedipal attachment, wished to incorporate orally the father's penis, in order thereby to become masculine and to please the mother. Regarded in this light, AN becomes a defence against destructive impulses associated with guilt and, indirectly, an expression of passive wishes for the mother's love and care as in infancy." (Masserman & Leonard, 1941, p372).

Blitzer et al.'s own data do not support this assertion, however, although they express the belief that it should, and they conclude that it could be their own interviewing or parents' reporting that is at fault.

In sum, the study by Blitzer et al. (1961) stands out both as an unusual case series of unusually young sufferers of AN, and one where the authors try to remain true to their own careful clinical observations in the face of psychoanalytic orthodoxy, some of it held by themselves and some questioned, that AN must be related to early mother-child relationship disturbances, to depression, to destructive oedipal fantasies, and so on. They fall to searching for pathological family dynamics and describe one scenario of a father with disturbed ideas about food among their case load, and other instances of regressed and tyrannical behaviour on the part of the child with AN dominating the family, but are also able to consider that such dynamics may be the result, and not the precipitant, of the illness.

Sours (1974) is one of relatively few authors since the time of the 1960s 'pioneers' to have published a wholly psychoanalytically formulated article on AN dealing with the

disorder itself and cohorts of patients, rather than individual cases. His language is characterized by drive theory and hence somewhat impenetrable to modern readers, concealing what is really meant beneath formulaic concepts.

Sours reviews Jessner and Abse and also what was then new work by Selvini (1963). He offers not only his own psychoanalytic formulation, but also his assessment of family dynamics, with great certainty.

“The syndrome reflects ineffective egostructure, instinctual fixation and infantile object dependency. Feminine genital wishes push these girls back to primary object relations and pregenital drive discharge. Marked fear of merger of self with the infantile inner object mobilizes a primitive identification with the omnipotent mother and makes available magic devices to save the self from merger.... So powerful is the ambivalence to the mother that all food must be refused and hunger denied. Aggression is directed toward the self on the basis of identification with the ambivalently loved object.” (Sours, 1974, p569).

Sour goes on to describe a ‘typical’ family consultation:

“The mother usually provides the analyst with an idealized early developmental history. Pregnancy, birth and the early infancy years are typically characterized as blissful and idyllic. The patient as an infant is always remembered as a healthy, chubby, baby responsive to the mother's smiles, gestures and wishes. Eating disturbances are seldom recalled. Frequently, the child's eating patterns are described as ideal.... Often this type of AN patient ... was picked out by the parents as a potential fulfilment of their own aspirations or as a replacement for a dead, defective or disappointing sibling... Throughout the mother's history of the child it is apparent that the mother narcissistically uses the child to maintain her grandiose self, self-esteem and sense of safety.... Historically, the father has a minimal relationship with the daughter. He has invested heavily in his profession or artistic career after having been greatly encouraged by his ambitious narcissistic wife, who then feels abandoned to her failure and isolation.” (Sours, 1974, pp571-572).

The long extracts are offered as a reminder of how, until very recently, this kind of contempt for women, mothers, girls was commonplace, and a warning to our generation to look closely at the assumptions about the all-powerful “mother-daughter relationship” that we continue to make in whatever language of whatever academic field it may be couched.

Three main questions present themselves in relation to the extracts above. First, what data is Sours drawing on, or has he allowed a number of patients to blur into one stereotype in his mind without differentiating, in the predetermined search for a convincing prototype of pathogenic mothers? Second, to what end is this theoretical summary presented, that is, are any treatment guidelines able to be derived from it? And third, it is reasonable to wonder why he describes the mothers of children with AN that he has treated with sarcasm and contempt.

A contemporary, Kramer (1974), did in fact comment on Sours' article in the same journal issue, claiming that he displayed a misunderstanding of Mahler's theory of child development, asserting that even with 'satisfactory mothering', children's own 'constitutional ambivalence' between fusion and a drive to separation could lead to developmental difficulties. She pleaded for the discarding of the 'presently overused concept 'domineering mother'. She also made the key point about the flawed methodology or reasoning that bedevilled psychoanalytic attempts to connect individual psychological features with the presentation of AN.

"Otherwise we are given a too general history which could be appropriate for many psychosomatic patients, for cases of homosexuality, of borderline pathology or of normal pre-adolescence. We are not given sufficient clues as to why the AN syndrome occurs in these patients." (Kramer, 1974, p578).

Feminism in the 1970s produced a large new literary canon, of which psychoanalysis and feminism was one part (Mitchell, 1974,1984). The idea that women and men's roles in society were 'gendered' was not easily accepted in psychoanalysis, which now co-opted developmental psychology (Hamilton, 1982), attachment theory and theories of mother-infant inter-subjectivity into its quest for etiological explanation of mental ill health, on the one hand, but perhaps also into biologically based arguments for the innateness of 'the masculine' and 'the feminine' on the other.

Rose (2018), in her book on the politics of motherhood, which she describes as 'the place in our culture where we lodge, or rather bury, the reality of our own conflicts', asks,

"what version of motherhood would make it possible for a mother to listen to her child? For if Western culture in our times, especially in the US and Europe, has repeatedly conspired to silence the inner life of the mother by laying on mothers the heaviest weight of its own

impossible and most punishing ideals, and if the term 'mothers' is so often a trigger for a willed self-perfection that so often crushes women as mothers before anyone else, then how can they be expected to hear their children's cry – not as wailing babies, which is of course hard enough – but as protest and plaint?" (Rose, 2018, pp120-121).

Mothers, it seemed, were to do little right for the daughters in the coming decades, and AN was just one of the ways in which this failure of mothers manifested itself.

From the 1970s onwards, the idea that an unhealthy and anti-developmental merger, or fusion, between mother and child was a key characteristic of the symptom constellation of AN, dominated psychoanalytic writing and also, in a slightly different language or framework, the new writing on the 'anorexogenic' family described by Selvini Palazzoli (1978) and Minuchin et al. (1978).

In 1989, Birksted-Breen published a single case study of a patient with AN and in her brief overview of psychoanalytic writing on the topic highlighted a clutch of psychoanalytic writers who had focused on "the anorexic's wish for, and fear of, fusion with her mother (Bene, 1973); (Spillius, 1973); (Bruch, 1974); (Boris, 1984); (Sprince, 1984); (Hughes et al., 1985)."

She summarizes:

"From this perspective, AN can be seen as a girl's attempt to have a body separate from her mother's body, and a sense of self separate from her mother, the pathological nature of this attempt arising from the very lack of achievement of such separateness prior to adolescence. The anorexic is caught between the 'terror of aloneness' (Sprince, 1984) and the terror of psychic annihilation. Whereas the wish and fear of fusion with the mother could lead in the boy to sexual perversion (Glasser, 1979), in the girl it could lead to finding a way of having a body different from the mother's body, as if maturing into adulthood is experienced as becoming the mother (Hughes et al., 1985). In the extreme it would mean doing away with her body altogether." (Birksted-Breen, 1989, p30).

The most recent substantial contributor to psychoanalytic theory of AN in young people has been Gianna Williams, a child psychotherapist (1997a and 1997b). Her thesis is that AN represents what she terms a 'no-entry defence', developed to protect against projections by mother in a reversal of Bion's 'container-contained' model (Bion, 1963). This model had great influence on modern psychoanalytic child psychotherapy, to the extent that it can seem that almost every childhood emotional difficulty is traced back to

a Bion-esque 'failure of containment'. Williams's language is less overtly blaming than Sours', but narcissistic mothering (for whatever reason, including mothers' own deprivation and psychopathology) remains at the heart of the interpretation: mothers who could not 'take in' their babies' needs have children who develop mental health disorders. The idea of maternal rejection is quite graphic in the Bion 'container-contained' model. Graphs exist to show the idea that when the 'container' (mother) fails in her task of containment, she becomes a convex shape instead of a concave shape, and the infant's needs (projections) bounce off her hard unyielding surface and return back to the infant, uncontained and unmodified, to persecute, bewilder and disturb emotional development. Bion's concept of 'maternal reverie' has mutated from a description to an imperative, a maternal standard that must be achieved by any good mother, without which, it is presumed, infants and children will be blighted in their future personality development.

Williams's theory is seemingly theoretically unique, in the history of psychoanalytic accounts of eating disorders, in that no previous psychoanalytic writer had employed Bion's theories to explicate aspects of AN, in particular, aetiology. Williams seemed to conceive her idea in a vacuum, isolated from other, previous psychoanalytic writers, let alone in other fields, judging by her references, which are extremely brief and none refer to previous publications specifically about AN or eating disorders.

Again, Williams's thesis is based on individual cases histories and suffers from lack of specificity, that is, children and adolescents with all sorts of mental health disorders, as well as adolescents without mental health problems, may arguably have served as containers for their parents' projections. There is no empirical way of proving that this type of relationship took place or that it was pathogenic, in either individual cases or a cohort. An interesting recent attempt at empirical research in this field is nevertheless found in Pozzi-Monzo, Lee and Likierman (2012), drawing on observations of mother-toddler relationships in a child mental health setting, using a theoretical framework based on Bion's model.

Lawrence (2001) and Farrell (2000) built on, or independently took, the post-Kleinian direction also by focusing their respective books on psychoanalytic understanding of eating disorders, on object relations, particularly in the case of Lawrence, and actual mother-infant relations, in the case of Farrell. Giambrini (2001), reviewing Farrell, described the heart of the book as, 'a particularly thought-provoking study of the

narcissistic mother's pathology, her body, her conscious and unconscious fantasies of her baby both before and after birth, and her narcissistic and pathological use of her baby in order to function.' Lawrence hypothesises that AN and BN are both attempts to control the internal parental couple, and in the case of BN, to attack it.

In sum, the mother-daughter relationship and its failings, or rather the mother's failings, primary among them narcissism, have been placed centre-stage in a default etiological theoretical approach to AN in the psychoanalytic literature. The landscape that results is summed up neatly, albeit uncritically, in a study by Bers, Harpaz-Rotem, Besser and Blatt (2013):

"Extensive clinical observations of Anorexia Nervosa (AN) indicate that disruptive early experiences with parents, especially the mother, have a significant role in this debilitating, dangerous, and often treatment-resistant disorder (Canetti, Kanyas, Lerer, Latzer, & Bachar, 2008). Problematic early parent-child relationships appear to result in a limited capacity for mature interpersonal relatedness and in a distorted sense of self. Disruption in mother-child relations appears central in AN. Ritvo (1976) suggests that AN is an expression of a daughter's rage and aggression toward her mother that derives from the reactivation of earlier conflicts. Selvini Palazzoli (1974) also views AN as stemming from a daughter's experience of her mother as overprotective and unable to allow her to become a separate person, with the result that the daughter feels ineffective. Sours (1974) proposes that the mother is perceived as imposing her wishes upon her daughter, dominating and controlling her to attain submission and perfection from her, forcing her into passive submission and creating a sense of fusion. Hamburg (1999) asserts that the AN daughter feels surrounded by her mother's "all-consuming, insatiable demand to be absolutely needed." (Bers et al., 2013, p189).

It is questionable whether 'extensive clinical observations' furnishes enough evidence for these assertions. As ever, evidence that this particular pathology led directly and specifically to eating disorders, is lacking. Despite this methodological fault-line, the topic in psychoanalysis remained firmly the attempt to find the cause, developmental and relational, for AN, with the theme '*cherchez la mère*' (to paraphrase the French expression). In many ways, the arguments remained much the same as those mounted from 1931 onwards (Brierley, 1931), with AN seen as an ambivalent and often doomed attempt by an adolescent girl to break free from the constraining social expectations and contradictory messages about autonomy and dependence, mediated by the potent, pathogenic relationship with a narcissistic and frustrated mother.

Two final references will show how firmly this belief took hold.

In the early 2000s there was a relatively brief upsurge of interest in the concept of alexithymia as part of the symptoms of AN (Petterson, 2004). Again, however, this presentation – the inability to recognise internal emotional experience and to give it words – was assumed to be associated with misattuned mothering.

Alexithymia has now become accepted as part of eating disorders presentation and, furthermore, related to autism spectrum disorder – a developmental deficit increasingly seen to be a predisposing factor for eating disorders and these days, one for which deficient mothering is no longer blamed (even if the mother’s physiology may be held accountable, Cherskov et al. 2018).

Likierman (1997), basing her idea on a case study, is of the view that a ‘determinant’ of AN is a fear of assuming the maternal capacities for containment and ‘reverie’. She posits a theory, that in adolescence, long before maternity, girls ‘stretch’ and ‘expand’ emotionally to be sensitive to their own infantile selves in preparation for containing their future babies.

“Her reverie and containing capacities begin to stretch and expand, much as her body will in due course when it accommodates a growing foetus. This psychic expansion happens through a gradual sensitization to the needs and also anxieties of her own baby self or infantile aspect, powerfully stirred up in adolescence. In optimal development there are positive factors that enable a girl to acknowledge and contain these in herself. She learns to know the infant in her and to hold it internally with maternal sympathy... The external factors that I examine are bound up with what has already been widely documented about the overwhelming, intrusive quality of the mother of the anorectic girl.”

(p65)

Likierman gives only one reference for this ‘widely documented’ phenomenon, and displays a lack of familiarity with family treatment for eating disorders that at the time was already gaining ground.

It appears that the idea that controlling, intrusive, domineering mothers more or less caused AN in their daughters had taken root in the psychoanalytic community almost as a fact, without evidence of any empirical nature, only clinical anecdote as demonstrated in this review.

The literature search for psychoanalytic writing about AN yielded no results specifically involving the role of fathers.

2.3.3 Psychoanalysis and treatment for AN

There is a notable juxtaposition in the psychoanalytic literature between the sheer range of theoretical propositions about the nature and aetiology of AN, and the lack of accounts of effective treatment.

Sours (1974) was optimistic that the prospects for the psychoanalytic treatment of AN were positive. A book review (Spielman, 1982) of a book by Sours (1980) concludes:

“We get the impression that analysts have not been in the vanguard of active research and treatment of nervosa. Dr Sours is an exception. Family therapists appear to have great influence and may indeed see the largest number of patients outside the hospital. Sours writes of Minuchin's claim that 'there is no other treatment beyond family treatment' and his reported 86% success rate 'regardless of age, symptomatology, and character structure' (p. 369). ... The weakness of the book—really the weakness of our knowledge and experience—becomes evident in the consideration of dynamics and treatment. There is more theory and conjecture, it appears, than documented clinical reports of the treatment of AN and other eating disorders.” (Spielman, 1980, p264).

Nine years later, however, Birksted-Breen (1989) wrote:

“There is a general feeling of reluctance and pessimism about the possibility of treating anorexics with psychoanalysis, because anorexics do not see AN as a problem, hence there is difficulty in forming a therapeutic alliance, and because of the repetitive and deeply suicidal nature of the pathology. On the whole, anorexics arouse powerful reactions of anger and disappointment, sometimes in the wake of rescuing phantasies, in those closely involved in their treatment.” (Birksted-Breen, 1989, 29-30).

From the late 1970s through the '80s and '90s and into this century, the number of psychoanalytic accounts of treatment increased, but mostly as individual case studies, as family treatment became the dominant mode and the treatment setting became more specialized combining psychiatric and medical co-specialisation. In the U.S., the

trend for treating children became primarily paediatric, and it remains the case that in the U.S., children are hospitalized at higher weights and psychological treatment often does not commence until weight is restored.

The influence of changing views of society, and the place of adolescence in society, can also be seen in some accounts of eating disorders. This broader socio-cultural view tempers the language of clinical case accounts but introduces other curious perspectives, such as an account from 1980 by Mogul, on the potentially positive relationship between AN and adolescent asceticism:

“The progress from childhood to psychological adulthood is long, complicated, and variable. ... Self-discipline, frequently extending to ascetic discomfort and self-denial, is a vital adaptive resource which the adolescent needs, not only to defend against the danger of drive excess, but also in establishing the capacity to survive independently and in mastering the requirements and skills for life, especially the creative life.” (Mogul, 1980, p170).

Onto this treatment landscape of highly interpretative and increasingly imaginative analyses, both clinical and intellectual, of AN, burst Minuchin, Rosman and Baker’s ‘Psychosomatic Families’ in 1978. Its dominant ideas were based on systems theory, that is, that it is the interactions within a family that are pathogenic, rather than that one individual within the family is ‘ill’. They found families of anorexics to be over-close (enmeshed), conflict avoidant, and resistant to change, such as the changes associated with the growing up of children. The treatment style was challenging to the point of aggressive. Treatment itself began with a family meal where therapists provoked conflict and claimed that the child with AN usually began to eat immediately afterwards, so that with the symptom gone, family therapy could begin (Macdiarmid, 1980).

Gabbard’s (2000) summary of current psychoanalytic understandings of eating disorders list the following ideas about the unconscious or symbolic meaning:

1. a desperate attempt to be special
2. an attack on the false sense of self fostered by parental expectations
3. an assertion of a nascent true self
4. an attack on a hostile maternal introjects viewed as equivalent to the body
5. a defence against greed and desire

6. an effort to make others – rather than the patient – feel greedy and helpless
7. a defensive attempt to prevent unmetabolized projections from the parents from entering the patient
8. an escalating cry for help to shake the parents out of their self-absorption and make them aware of the child's suffering

To this we can add a range of meanings collect by Birksted-Breen (1989) from psychoanalytic literature:

1. a defence against greed
2. a defence against the desire for oral impregnation
3. a paranoid fear of being poisoned connected with the mother's projection of her own wishes into her daughter
4. depressive fear of damaging good internal objects
5. connection with autism and turning away from the extreme emotions such as the ecstasy of food, and the rage when food is not there
6. 'dying of pleasure' in a perverse and masochistic sense
7. the essentially frustrating mother-daughter relationship
8. male AN as a feminine identification
9. regressive solution to resurgence of feminine oedipal wishes in adolescence
10. structural ego defects resulting from early failure of separation

As already noted Birksted-Breen herself concentrated on the wish for and fear of fusion with the mother and those writers who have addressed this aspect.

What remains unexplored in psychoanalytic thinking is, what if there is no one cause or even set of causes? What if the pathway to AN were genuinely as multi-factorial as the psychiatric literature suggests? What if the search for etiological factors is skewed, from the start, by the assumption that prevails in psychoanalysis, that if we can find the cause we can find the cure? What if, as the psychiatric literature suggests, children of all sorts of mothers can develop AN?

And further, what if the symptom were not so much meaningful as meaning-denying, less a communication than an anti-communication?

The wealth of psychoanalytic ideas, hypotheses and conceptualisations share the same methodological weakness, that is, they fail to account for all those children who may share the same developmental environments, vicissitudes, misfortunes of various kinds and yet who do not develop AN.

Linking the patient's symptoms to a particular 'psychic constellation' or 'neurosis' or 'unconscious conflict' in psychoanalysis appears not to have led to recorded change in anorexic behaviour or symptomatic improvement. Presumably this is the reason why already in the mid-twentieth century, writers on the subject who were both psychiatrists and psychoanalysts tended to assert that at least interpretative psychoanalysis was ineffective as a treatment (e.g. Bruch, 1962, who asserted that interpretative psychotherapy actually reinforced the patients' symptoms of helplessness).

In the last 20 years or so, psychoanalytic treatment of adolescents with AN became relegated to the shadows of private consulting rooms while family treatments began to dominate publicly funded treatment centres. Psychoanalytic writings in English dwindled to individual case histories reported mainly by child psychotherapists in the few existing child psychotherapy journals. This situation for psychoanalytic research and publication on the topic of AN obtains to the present.

Many of the items on Gabbard's list would be compatible with the understanding and beliefs of non-psychoanalytic clinicians and qualitative researchers in the field of eating disorders (for example, Koruth, Nevison & Schwannauer, 2012; Nordbø, Espeset, Gulliksen, Skårderud & Holte, 2006; Serpell, Treasure, Teasdale & Sullivan, 1999), although different language would most likely be employed to describe similar clinical observations or thematic constructs. The only item that is not familiar in common clinical practice is 'an attack on a hostile maternal introject viewed as equivalent to the body'. Problematic relationships with mothers do not often find their way into qualitative thematic analyses, which could suggest that this topic is not easily proposed for research, or that patients themselves rarely mention them or at least advance them as descriptive or explanatory factors in their eating disorder.

Thus the themes of feeling protected and looked after, gaining feelings of security, and avoiding negative feelings recur across several qualitative studies. They fit with one key psychoanalytic theoretical conceptualization regarding eating disorders, namely the idea that the person with the eating disorder has sworn loyalty to an 'internal gang'

in return for protection against intolerable mental states. The concept 'internal gang' is drawn from Rosenfeld's writings on what he terms 'destructive narcissism' (1971/1987), which he describes in terms of clinical situations that arise with patients who cannot tolerate dependency. His ideas were applied to AN particularly by Williams (1997a, 1997b) and other modern psychoanalytic writers.

Williams and Rosenfeld point towards the possibility that children with eating disorders may not have felt safe to depend on their parents for containment and understanding. There is a strand of research in the attachment field concerned with the attachment status of young adults with eating disorders where the findings seem to be, in common with many mental health disorders, that the prevalence of insecure-preoccupied attachment is much higher than in the general population (O'Shaughnessy & Dallos, 2009; Ringer & Crittenden, 2007; Zachrisson & Skårderud, 2010). We turn now to consider this body of literature.

2.3.4 Attachment based research into eating disorders

In the last 15 years, the concern and preoccupation with maternal-child relationships and mental health and ill health has shifted to the field of attachment and mentalization (Fonagy, Gergely, Jurist & Target, 2002). The attachment theory and research literature uses less overtly pathologising and blaming language concerning illness, health, patient and families, and strives for scientific, systematic and replicable research methods, and objective (as far as is possible for subjective phenomena such as human interactions) and validated measures. Nevertheless, with the focus on the nature of attachment in families, between parents and children, mothers and children, and especially mothers and infants, the holy grail often remains the same, that is, what is it that mothers do, or not do, that helps to make their children securely or insecurely attached, and hence develop optimally or sub-optimally? Secure attachment is associated with mental health and good child development (Fonagy, Steele, Steele, Moran & Higgitt, 1991; Fonagy, Steele, Steele & Holder, 1997; Belsky & Fearon, 2002), while the varieties of insecure attachment are associated with mental ill health, including eating disorders (Fonagy et al., 1996; Cortés-García, Takkouche, Seoane & Senra, 2019), and given that insecure attachment is in large part thought to be the result of specific types of mothering, or parenting, it is but a short step to the same assertion as becomes apparent in clinical psychoanalytic literature, that the quality of mothering is to blame for children's mental health difficulties. Nevertheless, with the

impressionistic, idiosyncratic, sweeping assertions of the previous generation of mental health professionals based on clinical consultations, gone, attachment based research provides a nuanced, wide-armed theoretical framework :

“Fonagy and Target (1996) have elaborated a developmental model of mentalization and RF based on an integration of findings from research on attachment, Theory of Mind (ToM), social cognition, and emotional understanding. In this model, the early sense of self crystalizes around the experience of being treated by a caregiver as a psychological being with a mind, with the child developing a coherent sense of self and identity through interactions with a caregiver that reflects on his mind (Fonagy, Gergely, & Target, 2007; Fonagy & Target, 2006). As Fonagy and Target (2006) observed, it is also difficult to develop the capacity to imagine the minds of others and to mentalize in relation to others without the experience of having been treated as someone with a mind.” (Ensink, Normandin, Fonagy, Target, Sabourin et al., 2014, p2).

Where psychoanalytic conceptions of the mother-child relationship and its impact on the child’s developing mind appear both linear and confused in relation to inner and outer world phenomena, mentalizing and attachment research is grounded in empirical observation while always maintaining a belief in inner-world phenomena. In time, perhaps, we may be able to research as living, changing entities, using sufficiently complex multi-factorial models comprising factors, variously, concerned with developmental stages, life events, economic and educational factors, parental relationship, parental personality and mental states, and child factors of cognition, emotion, affect regulation, and genetics. Then perhaps we would finally get some answers to why some children develop well and others not, all things being equal, and the microscope may – perhaps – slide off mothers alone.

There are some methodological issues and questions about the various relationships between the associated constructs of attachment, mentalizing and reflective function, lucidly elaborated by Katznelson (2014) in her lucid review of RF. It has been established that attachment security is transmissible between parents and children (Fonagy, Steele & Steele, 1991; Ainsworth & Eichberg, 1991), but how could the ‘hunch’ that the mechanism for transmission, the ‘transmission gap’, was mentalizing or RF be proven? (Fonagy & Target, 2005; Slade, Grienenberger, Bernbach, Levy & Locker, 2005b). Although there are now well-established and validated methods for the assessment and measurement of attachment status in adults (Adult Attachment

Interview (AAI), George, Kaplan & Main, 1985), and children (Child Attachment Interview, (CAI), Shmueli-Goetz, Fonagy, Target & Datta, 2008), how do these relate to a range of potentially interesting phenomena, ranging from the capacity for mentalizing and RF, to mental health, for example? RF in parents when talking about their children can be assessed through the Parent Development Interview (PDI) (Slade, Aber, Bresgi, Berger & Kaplan, 2004; Slade, 2005a; Slade, Bernbach Grienberger, Levy & Locker, 2004; Slade et al., 2005b), and more recently, a children's RF scale, the Child Reflective Function Scale (CRFS, Ensink, Target & Oandason, 2013) has been developed and validated (Ensink et al., 2014) and put to use researching the relationship between mothers' and children's RF in a cohort of children who had suffered child sexual abuse (CSA), compared with a normal cohort. However, "data on the relationship between parental RF and that of children are still lacking" (Ensink et al., 2014). How do researchers in the attachment and mentalization field attempt to relate attachment status, mentalizing capacity and RF to the thorny question of whether there is a relationship between parents' attachment security and mentalizing, and their children's mental health?

2.3.4.1. Measuring mentalizing

One of the main scales to have grown out of attachment theory is Reflective Function (RF), with an RF scoring manual (Fonagy, Target, Steele and Steele, 1998) developed for use with the AAI (George et al., 1985) and a parallel scoring manual for use with children (Ensink, Target and Oandasan, 2013; Ensink et al., 2014) on the CAI (Shmueli-Goetz et al., 2008). RF is a construct whose origins Katznelson (2014) describes thus:

"While reading transcripts from the Adult Attachment Interviews (AAI; Main & Goldwyn, 1990) collected as part of the London Parent– child Project, Fonagy et al. (1991) noticed a great variation in the extent to which participants' responses included attempts to understand the behaviour of themselves and others in terms of mental states (Steele & Steele, 2008)... their work soon led to the development of a separate scale originally termed the Reflective Self, and later renamed as the Reflective Function scale (RF) (Fonagy et al., 1998).

Fonagy and Target (2005) proposed that RF might be the missing link in the transmission of attachment security between parents and children, explored further by

Slade et al. (2005a, 2005b) and Grienberger, Kelly and Slade (2005) in a sample of 40 mothers, who found that

“autonomous mothers had significantly higher RF scores compared to dismissing preoccupied and unresolved mothers, suggesting that maternal attachment status measured during pregnancy could reliably predict mothers’ RF, when the baby was 10 months old. Regarding maternal RF and the quality of infant attachment, researchers found a strong significant relationship ($ES=.81$) between the two measures demonstrating that maternal RF was significantly different for mothers of securely and insecurely attached infants. Furthermore, results revealed that RF did play a mediating role between maternal and infant attachment, which seemed to suggest that RF, indeed, plays a central role in the transmission of attachment from one generation to the next.” (Katznelson, 2014, p209-210).

2.3.4.2 RF and psychopathology

Parental mentalization and RF studies have more usually studied the relationship between parents’ behaviour and infant security, for example, showing that ‘maternal sensitivity’, a related concept to RF, and mothers’ mental state thinking about infants at six months predicts attachment security at 12 months and Theory of Mind (ToM) at 4-5 years ability mind-mindedness predicting good child development (Meins, Fernyhough, Fradley & Tuckey, 2001; Meins, et al., 2002), and more recently, that Parental Embodied Mentalizing (PEM) also contributed to predicting infant security at 15 months (Meins & Shai, 2018).

However, research has mostly been with normal/high-functioning parents, focused on ordinary development not pathology. Exceptions include recent work on the relationship between maternal and child RF in dyads where the child had been sexually abused (Ensink, et al., 2014; Ensink, Bégin, Normandin & Fonagy, 2016), and on parents’ capacity for mentalizing about their child in the context of high parental conflict after separation and divorce (Hertzmman et al., 2017; Target, Hertzmman, Midgley, Casey & Lassri, 2017). There is another body literature not concerned with psychopathology but normal relationships, for example, on the relationship between attachment status and romantic couple relationships, that has sprung from Hazan & Shaver’s work (Hazan & Shaver, 1987), and other new offshoots such as attachment status in therapeutic relationships (Risq & Target, 2010).

Ensink et al. (2016) set out to examine the relationship between child and maternal RF and child depression and externalizing difficulties, in a sample of 74 mother-child dyads where the child had experienced child sexual abuse (CSA). They also examined the potential relationship between child RF and psychopathology. They found that child RF significantly predicted child depression or externalizing difficulties. They found that maternal RF independently predicted child externalizing difficulties, with higher maternal RF associated with lower problematic behaviour in their children. The authors point out the lack of data hitherto linking parental RF and child psychopathology, affect regulation, resilience and other constructs relating to children's emotional and behavioural development and well-being.

In terms of studies relating RF and psychopathology in mothers, and their capacity in this context to think about their child in mental state terms, there have been a few studies of RF in mothers with mental health problems such as PTSD (Schechter, et al., 2005) substance abuse (Suchman et al., 2010) and depression (Toth, Rogosch & Cicchetti, 2008) cautiously demonstrating results such as modest rises in RF after therapeutic interventions.

2.3.4.3 Attachment, RF and eating disorders

As described in 1.3, the present study was sparked by observations in a clinical setting of the variation in parents' apparent capacity or inclination for mental state thinking about their children, before the author became aware of the body of research into this phenomenon or the measures of RF for adults, parents or children.

The observations occurred in a support group for parents of children with eating disorders. Some parents seemed to make an assumption that they would have ideas about the mental activity of their children, even if not verbally expressed but demonstrated through behaviour, such as through eating difficulties. Others displayed less or no such assumption and professed ignorance about what their children might be thinking and feeling that might lead them to behave in an eating disordered way. Initially this variation was conceptualized as a variation in parental expectation of how well or how much they might understand their child, or how deeply they would expect to be in touch with what was going on in their child's mind. The idea of there being an expectation may have implied a conscious attitude on the part of the parents, but the

intention was to capture an attitude that could be conscious, but more likely would be sub-conscious or unconscious.

RF seemed to lend itself as a possible measure of this variation and hence was included in the research design and analysis. This section now reviews the relevant literature around attachment theory, RF and studies relating these to eating disorders.

The idea that families with a child (occasionally several children) with an eating disorder might have some factors in common is very sensitive, sailing close to the wind for parent blame. A primary reason is that previous generations of therapists, particularly family therapists (Minuchin, Rosman & Baker, 1978; Selvini-Palazzoli, 1978) drew typologies of 'anorexogenic' families, based on clinical experience but without considering issues of cause and effect and comparisons with both other clinical populations and non-clinical populations, that is, without consideration for scientific evaluation. The result led to a tendency towards parent blaming in the treatment of eating disorders in the family therapy field as well as the psychoanalytic field. Indeed, given the prevailing belief throughout the nineteenth and twentieth centuries that parents were unhelpful in the management and treatment of AN, it would not be surprising if parent blaming were a pre-existing feature in the thinking of these family therapists. We may remember the proposal by one of the 'five doctors' whose presentation was reported on by Brierley (1931), namely, that the treating clinician should ally himself with the anorexic in support of her right to independence and in opposition to her supposedly controlling parents.

Clinical observation of the attitudes of parents in the support group to their children's minds, that sparked this project, undoubtedly falls into the unscientific category. Nevertheless, the justification would be that research projects in mental health do begin with clinical hunches and observations, especially where there appear to be unspoken taboos or unsayable thoughts. Sometimes they may lead nowhere, or nowhere for some time. In the discussion in Chapter 9, it will be possible to evaluate if this research project has been a worthwhile following up of a clinical curiosity.

Dallos (2004) grappled with the ambition of integrating ideas about narrative therapy with attachment theory, and further, with systemic family therapy for eating disorders. He speculated about the paucity of the narratives of families where a member had an

eating disorder, linking it to the idea from research using the Adult Attachment Interview (Main et al., 1985) that narrative coherence is a marker of attachment security. He then went on to ask the questions about the attachment status, or even mutual attachment status, between daughters with an eating disorder and their mothers. He attempted to link insecurity of attachment to low self-esteem and a denial of one's own needs as a self-protective mechanism in the face of unavailable or inconsistent care-giving. He asks what he calls some 'awkward' questions:

'Is it possible that there is some commonality in families with AN?

'Is it possible that part of this is that they are more unwilling or anxious about engaging in such conversations than other families?

'Is it possible that they have some difficulty, possibly a cognitive one, in engaging in such conversations?' (Dallos, 2004, p42).

Dallos seems to have been grasping for the concept of mentalizing, not yet such a familiar term in common psychology language in 2004, when trying to theorise clinical observation of a 'missing ingredient' between parents and their child with an eating disorder. He is careful to point out – albeit briefly – that the high level of distress of families coming for treatment for eating disorders may muddle up what clinicians perceive as cause and effect and that what we might now cause the 'non-mentalizing' observed in some families with a child with an eating disorder may, at least in part, be attributable to parental trauma consequent on seeing their child change into someone unreachable and unrecognizable.

The theory of mentalizing is said to hold that extreme emotional arousal, such as anxiety or distress, and therefore threatened attachment security, undermines the capacity for mentalizing, that is, for considering one's own and other people's intentional mental states from many points of view or multiple perspectives. In fact, this theory remains a theory and has not been supported as yet with empirical study. Indeed, there is also a more nuanced view (Target, 2008) that a degree of affective arousal is necessary as a prompt for the activity of mentalizing, and that therefore RF or mentalizing is more likely to be activated in situations where understanding problematic emotional states in those closest to us, and on whom our well-being and attachment security depends:

“We care what our loved ones are feeling, and if they are upset we very much want to know why. It would be easy to test this prediction, that mentalization would be more strongly activated the closer the relationship, and increasingly so where there is a problem or puzzle about these feelings. This would be consistent with my experience of coding RF in the attachment interviews of adults and children, that mentalization is strongest in relation to conflict, distress, and confusing behaviour in emotionally important relationships.” (Target, 2008, pp265-6).

Target further elaborates that ‘earned’ secure adults on AAI – that is, adults who have suffered attachment disruption or trauma in childhood and actively worked to recover psychologically – have very high RF, while other secure adults with ‘good enough’ childhoods have fairly low to moderate RF. Target hypothesis therefore that the relationship between affective arousal and RF is in the shape of an inverted U-curve: absence of arousal and high arousal both result in poor or low mentalizing, whereas “high concern and puzzlement, coupled with levels of distress being under control in the moment, can produce very high mentalizing.”⁴

As will be shown in Chapter 8., some of the interview subjects in this research, seemed to bear out Target’s reasoning and to increase their mentalizing, or RF, temporarily in response to the mental health crisis of the eating disorder, and to reduce it when the child recovered and things in the family began to return to normal. This could be seen to occur in both children and parents and particularly where a need to understand the other’s behaviour was acute. This discussion will be returned to in Chapters 8 and 10.

Attachment theory and eating disorders were relatively new research companions in 2004. A small study (Ward et al., 2001) assessed the attachment classification of adult sufferers of AN (n=20) and some of their mothers (n=12), using the AAI (George et al., 1985). Nineteen of the patients and 10 of the mothers were rated insecure, 14 and 7 respectively as ‘dismissive’, although there was no significant association found between patients’ and mothers’ attachment classifications. Other findings included high rates of unresolved loss among the mothers (8) and low RF in both groups. But as the authors said themselves, their study lacked a control arm of another psychiatric classification and therefore high incidence of insecure attachment could apply to any or all mental health disorders, as demonstrated by Fonagy et al. (1996).

⁴ Personal communication

Ward et al.'s study (2001) further did not entertain the possibility that a family member having AN represents a traumatic rupture in the life of the family and undermines security of attachment. At the time of the Ward et al. study, attachment security was probably still viewed as a stable trait across the lifespan, but newer research increasingly posits it as a state that can change depending on life events, the vagaries of relationships within the family, and also specific to certain relationships (Pinquart, Feussner & Ahnert, 2013).

The authors described the finding on the AAI of high rates of unresolved losses in the mothers as striking and unexpected. They compared this finding with other literature, for example, Shoebridge and Gowers (2000) who found high rates of 'severe obstetric loss prior to the daughter's birth' in mothers of girls with AN. Shoebridge and Gowers reported high levels of parental concern in the parents of later anorexic adolescents and suggested that this may derive, in part, from abnormal grief reactions. Ward et al. asserted that "a theme of unresolved loss would be consistent with the older clinical literature, which emphasizes early separation difficulties in the aetiology of AN." (Ward et al., 2001, pp503-4).

More recently, Cortés-García et al. (2019) conducted a meta-analysis of literature connecting insecure attachment to eating 'symptoms' and concluded that the mediators between these two constructs with the highest effect sizes were emotional dysregulation and depressive symptoms, with lower effect sizes for body dissatisfaction, perfectionism and neuroticism.

An interesting source of potential support both for the association between eating disorders and other mental health disorders, and attachment insecurity, dates back to the famous 'Minnesota Study' or 'Minnesota Semi-Starvation Experiment.' (Keys, Brozek, Henschel, Mickelson & Taylor, 1950).

'The Minnesota Experiment on the Biology of Human Starvation' was carried out at the University of Minnesota in 1944/45. It remains the most systematic, ethically justified study of experimental semi-starvation to date. The study was designed to monitor the physiological and psychological effects of severe and prolonged food restriction in 36 healthy young volunteer males, recruited from conscientious objectors during World War II. The experiment involved a three-month baseline control period, six months of semi-starvation, and three months of controlled nutritional rehabilitation. (Eckert, Gottesman, Swigart & Casper, 2018, p2).

The psychological measure used in the Minnesota Study was called the Minnesota Multiphasic Personality Inventory (MMPI), independently developed at the University of Minnesota a few years earlier. All the subjects in the study were assessed as mentally healthy on this scale at the start of the study. Nevertheless, all the subjects suffered psychological ill effects, primarily depression. Their symptoms, known as the “semi-starvation neurosis”, were characterized by significantly increased scores on the first three MMPI scales of Hypochondriasis (Hs), Depression (D), and Hysteria (Hy). Eckert et al. (1950), conducting a follow-up study some 70 years later, speculated that participants in the study with pre-existing personality difficulties may have suffered greater difficulty both in coping with the strictures of the study and in normalizing their eating behaviour after the end of the study. A few participants had to drop out because of mental ill health, and they were found to have pre-existing mental health difficulties. However, the numbers are too small to attain any statistical validity.

“The Keys researchers recognized that the emergence of individual differences in basic personality make-up was associated with the response to semi-starvation. They remarked that “ex post facto” it appeared that men with a more stable personality makeup showed minimal deterioration while those with latent personality weaknesses developed more severe symptoms.” (Eckert et al., 2018, p15).

Jewell et al. (2016) conducted a literature review of published work associating eating disorders with difficulties in attachment and mentalizing in children and young people, and reported, “in the 15 studies investigating attachment, an association with eating pathology was found in all studies. Mentalizing difficulties and eating pathology were found to be correlated in the seven studies which examined their association.” (Jewell et al., 2016, p354).

As Jewell et al. (2016) were careful to point out, the body of literature on attachment and mentalizing is currently much larger for adults with eating disorders, where there is the consistent finding that adults with eating disorders have higher rates of insecure attachment as reported on the AAI compared with community samples. These studies have not consistently controlled for: the association between other mental health disorders and attachment (in)security; the possible impact of the illness itself on attachment security and mentalizing; and the impact of recovery from the eating disorder on attachment security and mentalizing. Thus there are many unknowns in this field.

When it comes to researching the relationship between attachment security and eating disorders in children and young people, the unknowns remain similar to the adult field, though still live in the present of the children: questions about whether, and how, attachment security may predict the onset of an eating disorder, whether there are differentials between attachment to mothers and fathers that have an impact, whether attachment security changes through the course of an eating disorder, what the impact of starvation may be on the capacity for mentalizing, and to what extent it may resume after recovery, or perhaps even be improved as a result of therapy through the course of an eating disorder.

However, two recently published studies have given attachment research in the child and adolescent field a welcome jumpstart.

A longitudinal study by Cortés-García, Hoffmann, Warschburger & Senra (2019), extends previous findings that attachment predicts later eating pathology and also considers reciprocal influence – that is, that insecure attachment both predicts, and results from, disordered eating. The authors followed a cohort of 904 adolescent girls over four time points, starting at a median age of 10.8 years. The children were initially recruited from 15 primary schools in Galicia, Spain. Attachment perceptions of mothers, fathers and peers were examined. Their results are summarized as follows:

“Better attachment to the mother led to less pronounced disturbed eating in girls across the entire age range and in boys across two time periods. In girls, more pronounced disordered eating at T3 predicted worse attachment to the mother at T4 and better attachment to the father at T1 predicted less disturbed eating at T2. In boys, disordered eating at T1 predicted better attachment to the father at T2. Concerning peer attachment, better attachment at T1 predicted disordered eating at T2, in boys only. No other significant cross-lagged effects emerged.”(Cortés-García et al., 2019, p924).

These could be striking findings, although the absence of covariates, for example, depression or other co-morbid conditions or adverse life events, make the findings hard to interpret. As the study is part of a larger study on mental health in adolescence overall, this may be rectified in future publications and also give a new fillip to the feasibility of undertaking attachment research in children’s eating disorders.

The literature on attachment and mentalizing in children and young people with eating

disorders has suffered from a dearth of 'gold standard' assessment measures. Unlike in the adult attachment research field, where the AAI (George et al., 1985) is by now a well established and much used tool for assessing attachment status in adults, the CAI (Shmueli-Goetz et al., 2008) is more recently validated and as yet not in as widespread use (for other associated references see Section 2.3.4.1). Jewell et al. (2019) published a systematic review of attachment measures in middle childhood and adolescence and concluded that the CAI had the strongest psychometric properties for interview and projective measures, along with the Inventory of Parent and Peer Attachment (IPPA, Armsden & Greenberg, 1987) for self-report measures.

The future for research in attachment related constructs and eating disorders in children and young people therefore looks promising.

2.4 Chronology of treatment approaches

2.4.1 The case of Ellen West: a psychoanalytic approach

Ellen West (1897-1921) has become one of the best known cases of AN in the twentieth century, thanks to the writings of her psychiatrist and '*dasein*' (existential) psychoanalyst Louis Binswanger. Her case contributed both to the establishment of diagnostic criteria and definition, and to the image of the illness as one that defeats and divides professionals. In the course of just a couple of years she was variously diagnosed, by a succession of psychiatrists, with 'neurasthenia', schizophrenia, melancholia, obsessional neurosis with manic-depressive swings, but a primary diagnosis of AN was not yet something considered in psychiatry of the day. What is well known about her is that she committed suicide the day after being released from Binswanger's sanatorium Bellevue, and after eating a healthy meal. Her suicide, it is now thought, was aided by her husband Karl West. The onset of her AN at 21 is described as being triggered by being mocked by friends after gaining weight on a trip to Sicily (Binswanger, 1944, cited on the website BIAPSY – Biographical Archives in Psychiatry, Hochschule Niederrhein, University of Applied Sciences, Krefeld, Germany). There are many other features of Ellen West's case, as reported, that fit with our present day knowledge of typical clinical features of eating disorders. Her suicide the day after release from hospital and after eating a large meal might be ascribed, these days, to overwhelming guilt and self-loathing, for example.

Binswanger's presentation of her case has been reviewed and critiqued from many perspectives: the role of family members (Lester, 1971), the tendency towards over-identification with the patient (Akavia, 2008), the release from treatment and the diagnosis of schizophrenia. Binswanger was also criticised for giving an incomplete picture of the case and for not acknowledging his own responsibility. Carl Rogers (1961) highlighted Ellen West's fundamental loneliness and her status as an object in the hands of helpless therapists. Minuchin (1984) even wrote a stage play based on her story.

The question of diagnosis, and its inconclusiveness, is a major theme in all reports both primary and secondary. Psychiatrists sought explanations through melancholia, manic depression, obsessional neurosis, manic-depression, and schizophrenia, but the anorexic component of these was described as an *idée fixe*, a delusional belief that she was fat and a devotion to actions (food intake restriction, abuse of laxatives) to become thin.

In 2001, the descendants of Ellen West's husband donated further material from her medical file in Bellevue to historical archives in Tübingen University, said to be both quantitatively and qualitatively rich, and further light was shed on the process of her treatment and her own point of view. Akavia (2008) says that the parallel narrative of patient and therapist thus allowed is 'extremely rare', and considers the many perspectives woven into her story – psychiatrist Binswanger, her own family, her husband's family, other psychiatrists and psychoanalysts who tried to cure her, most in the tradition of existential psychoanalysis, a new theoretical model of psychotherapy/psychoanalysis at the time, drawing on the phenomenological writings of Heidegger (1927) and Husserl (1931).

'Eating disorder' is mentioned by West's husband in 1923 in a letter to Binswanger as something he had deliberately left out of her scrapbook of diary pages, letters, poems and so on, because he wanted to collect memorabilia of the real person, not a case history of illness.

What can we learn today from the case of Ellen West? Certainly its illustration of the way in which AN confounds family and professionals alike, with sufferers rejecting help offered and maintaining irrational beliefs, is an illuminating reminder of how far we have come with accepting AN and eating disorders as 'a thing', a diagnosis in their own

right. It seemed that all Ellen West's entourage struggled to find the key to her disorder, the right diagnosis that would unlock the right treatment.

2.4.2 'The anorexic family'

In his Foreword to the first edition of 'Treatment Manual for Anorexia Nervosa: A Family-Based Approach' (Lock & Le Grange, 2002), Professor Gerald Russell describes the family-based model as 'a radical break with the traditional treatment of the illness'. This was not because family treatment for AN was new, but rather, the philosophy underpinning the family therapy had, in a sense, been stood on its head. Where families had been seen as pathogenic, and family interactions and relationship patterns seen, *a priori*, as promoting or maintaining the identified patient's eating disorder, families and parents in particular were now posited as the primary treatment resource. In this model, the linear model of treatment, where the cause of the problem is searched for first and the treatment second, was abandoned.

The search for causes via the exploration of assumed unhelpful family dynamics was no longer the focus of therapy, although such dynamics might become the focus at times in the final phases of therapy when the patient was restored in health and weight and the focus was on the young person resuming their developmental track. Any search for a cause of the eating disorder was abandoned or briefly described as multi-factorial, and parents were placed at the centre of the treatment team, with expectations that they would use their parental authority to enforce their child's health and weight restoration plan. The role of the treatment team was conceived as supportive and guiding, consultative rather than directly therapeutic.

The pioneers in the family treatment of eating disorders took what we would now consider a more traditional approach, with the 'cause' searched for in the family, often in the domain of 'enmeshment' between the generations, the 'treatment' then being targeted at separation between the generations and promotion of independence on the part of the adolescent. The pioneers were Salvador Minuchin and his team at Philadelphia Children's Hospital, and Mara Selvini Palazzoli, both active in clinical work and writing their seminal works in the 1970s. Selvini Palazzoli's book 'Self-starvation: From individual to family therapy in the treatment of anorexia nervosa' (1978) has fallen out of print, as has Minuchin, Rosman and Baker's book 'Psychosomatic families: Anorexia nervosa in context' (1978); one might wonder if the turning of the tide of clinical opinion in the last twenty years has something to do with this.

Despite the innovation of involving the whole family in the treatment of their child's eating disorder, the philosophy or beliefs beneath the treatment, that is, that something in the family was causing or maintaining the disorder, propelled interventions towards separating parents and children rather than bringing them together. Another strand towards this tendency was the belief that the young person's adolescent drive towards separation and independence needed to be supported by the therapist, in opposition to the family's tendency towards 'enmeshment' and not allowing their children to grow up.

The belief that family members were a hindrance in the treatment of eating disorders has antecedents long pre-dating the 1970s. The nineteenth-century pioneering physicians mentioned in Section 2.2 also had their views on effective treatment.

In training courses for FBT, it is popular to quote Gull (1874):

"The patients should be fed at regular intervals, and surrounded by persons who would have moral control over them; relations and friends being generally the worst attendants." (Gull, 1874, p23).

Charcot (1882-85) at the Salpêtrière Hospital prescribed isolation and asserted his belief that the presents of parents would effectively hamper all treatment.

Even the very first recorded full medical description of self-induced starvation leading to severe weight loss, attributed to Morton (1694), contained observations of the "psychopathological process between the patient and the family, and advocated the removal of the patient from the family." (Caparrotta & Khaffari, 2006).

It would be interesting to know what clinical observations and experiences led these physicians to comment in this negative way on parent and family involvement.

Clinical experience today often yields a picture, at the point of first presentation, where the young person with AN has managed to co-opt her parents into her behavioural system. Parents will describe how they will 'do anything' to get their child to eat. Stories abound of the lengths to which parents will go to accommodate their child's rules and requirements to ensure that they take in some nutrition. Midnight drives for miles to the nearest supermarket for the only food item the young person will accept, family meals consisting only of vegetables, or cakes baked by the young person and insistently fed to the family while not eating any herself, as well as accounts of violent

outbursts and actual physical assaults on parents, are tales that bond parents in their confusion about how to act when the eating disorder first emerges.

Parents' initial and intuitive reaction to the onset of the eating disorder is, understandably, to try to feed their child without risking their relationship with their child. The young person will present her participation in family relationships as contingent on the extent to which parents and siblings accommodate her eating requirements. It strikes one that the writers from both the nineteenth century and the systemic family pioneers of the last century showed a surprising lack of empathic imagination for this aspect of parental experience.

The observation that families were intensely involved and tended to accommodate to their beloved child without realizing that they were simultaneously accommodating their child's mental illness, was one made in various guises throughout the documented history of the treatment of AN. There is the parallel observation that children and young people with AN tend to regress in terms of their attachment to their parents, or perhaps the other way around, their attachment strategies are activated because of the high level of emotional arousal associated with the anxiety that suffuses all aspects of the eating disorder. Viewing this intense, anxious attachment between parents and their child with AN as a resource, rather than a hindrance to treatment, was the imaginative leap taken by family therapists of the 1970s, which also underpins the efficacy of FBT today. At its root is a view, whether explicit or implicit, of adolescence, not so much as a period dominated by independence strivings as a period of uncertainty and ambivalence about independence. Developmental pushes may be followed by rapid regression and the path towards independence is fragile and easily shattered. There are many accounts of adolescence, psychoanalytic, cultural, developmental, and all emphasise different aspects of this process. Laufer (1981) reminds us that one essential aspect for a girl is her view of her mother, and her mother's body – does she want to emulate her? Can she accept, mentally, the genes that she has inherited from her mother? If not, how should she cope with her guilt, and anxiety, about rejecting her mother? Retreating into dependency puts a halt on such unresolvable conflicts.

The idea that 'normal' adolescence might not involve a straight path to independence, and that the attachment between parents and children would lead parents to be intensely involved in trying to feed and manage their children, primarily daughters, with eating disorders, might have been somewhat lacking, therefore, when Minuchin

proposed the 'psychosomatic family' model. In this model, the eating disorder was seen as an expression of interpersonal conflict in the family (Minuchin et al. 1975; Minuchin et al. 1978; Rosman et al. 1975). The key characteristics of the 'psychosomatic family' were identified as, first, the child's physiological vulnerability, as well as enmeshment, overprotectiveness, rigidity, and lack of conflict resolution.

Ultimately, a model that pathologised family functioning to such a degree and directed treatment towards changing the family dynamic, contained within it the seeds of its own demise. For some decades, 'the family systems model' in eating disorders became a by-word for excesses of hierarchical, expert, bullying and humiliating therapy, and its insights were lost to the next generation. It also foundered on its lack of definitional rigour and systematic research programmes. Eisler (2009) sums up its legacy thus:

"The first clearly explicated notion of family relationships playing an etiological role in the development of AN comes from Bruch (1973) describing a particular mother–infant relationship, in which the mother's constant anticipation of the child's needs prevents the development of appropriate internal responses and leads to a pervasive sense of ineffectiveness, a lack of identity, and the need for control. More complex accounts of the family role come from family systems descriptions of AN (Minuchin, Rosman, & Baker, 1978; Selvini-Palazzoli, 1974; Stierlin & Weber, 1989) which generally stress over-close family relationships, blurred intergenerational boundaries, difficulties in dealing with conflict, and rigid interactional patterns as central to the understanding of AN. (Eisler, 2009, p551).

Eisler (2009) stated firmly the view that to search for common factors in the families of children with eating disorders is futile given the current state of our knowledge.

"Overall, one has to conclude that the empirical evidence in support of a particular type of family functioning in AN is unconvincing, and at best that while there may be some family risk factors, these do not have the force of an explanatory mechanism identifying necessary conditions for the development of the disorder. Moreover, if such risk factors exist they are probably non-specific, increasing the risk of developing a range of disorders rather than being specific to AN." (Eisler, 2009, p553).

As we saw in Section 2.3.2, there were in fact psychoanalytic accounts attributing aetiology of eating disorders to the mother-child relationship predating Bruch, although not gathered systematically but rather comprising generalisation and assertion based on case reports.

A final comment on the systemic family therapy model, AN and the place, implied or explicit, of mothers in their daughters' eating disorders.

O'Shaughnessy & Dallos (2009) report,

"Interestingly Palazzoli also considered a gendered perspective in noting the shift for the mothers of young women with AN from a rural tradition, comfortable with healthy, generous eating and clear maternal roles of carer, provider of meals and homemaker to life in urban settings with less emphasis on these values and more on appearance, presentation and status through outside work. In effect, Palazzoli saw the daughters with AN as expressing through their bodies the conflict that their mothers felt about being caught between a traditional and more modern role." (O'Shaughnessy & Dallos, p560).

Palazzoli's linking of girls' eating disorders with the changing social roles of mothers in the context of urbanisation in Italy, has something in common with Bruch's understanding of AN as the consequences of deficits in self-development, which she then linked with the changing role of middle-class women in post-war U.S. society, with mothers giving their daughters' the contradictory message to be both replicas of restrictive femininity in their own mould, and pioneers of female professional achievement in the new emancipated mould.

But the socio-cultural situation of women was hardly different a generation later. A collection of essays entitled 'Fed Up and Hungry: Women, Oppression and Food' (Ed. Lawrence, 1987) contains this linking of AN and the conflicted 'role of women':

"Girls have to deal with the contradictory expectations of being successful but not so successful that it is challenging to men... For women, anxiety about being successful is based on a fear that they will be punished by men. Success and femininity are mutually exclusive goals. An article in *Company* magazine (Oct 1984) bears out the dilemmas facing a successful woman. The chief one appears to be the goal that every girl is socialized for, motherhood and the family, appears to remain outside her grasp. 'One of the unpalatable truths is that successful, well-educated, high-earning women are not hot property on the open marriage market. In all western countries the tendency still is for men to marry women who are younger than them, less well-educated and who earn less.'" (Pennycook, 1987, pp 76-77).

These are tempting narratives that make powerful social and political meaning of eating disorders. Perhaps they also speak of the conflicts experienced by their originators, Palazzoli and Bruch, both being pioneers as women medical professionals,

and maybe even of the later generation of feminist psychologists contributors to 'Fed Up and Hungry' in the late '70s and early '80s. But will eating disorders wither away when 'the role of women' – the idea that women have a specific role - ceases to mean anything to coming generations? What will happen to motherhood then as 'the place in our culture where we lodge, or rather bury, the reality of our own conflicts' (Rose, 2018)? More specifically, would FBT finally lift the blame for eating disorders from the mothers?

2.4.3 FBT

FBT also recognizes the difficulty when parents are allied with their child's eating disorder in order not to lose their child, and addresses the problem of parental 'collusion' indirectly by means of the technique known as 'externalising'. Therapists label the eating disorders as an external force taking over the young person's life and which they are unable to resist on their own, while parents are invited to join the therapist in 'fighting' AN. Therapists are careful to consistently label AN as separate from the child or young person herself.

According to Lock and Le Grange (2015), one way of understanding the task of early engagement with families is to help parents to detach from the AN while retaining their relationship with their child. At the same time, parents may need to change the nature of their relationship with their child. They will need to ally themselves with the treating clinicians against AN which, at first, may feel like deserting their own child. Indeed, young people with AN often try to censor what their parents may tell the clinician and will beg their parents not to enter into treatment. These issues form part and parcel of the FBT model that has held sway for the past decade at least.

There are a few key papers that set the scene for the dominance of FBT for children and young people with AN, in a landscape where controlled trials have been and still are scarce. In fact, the only body of controlled trials in child and adolescent eating disorders comes from Stanford University under the leadership of Professor James Lock, in collaboration with his long-time research partner Daniel Le Grange at Chicago University. Although in England, the Maudsley team offers training in its own version of family based treatment, known as FT-AN, it has not yet published its manual nor conducted a randomized controlled trial.

The key randomized controlled trial (Lock et al., 2010), with 121 subjects, comparing

manualized FBT with an individual therapy arm, known as Adolescent Focused Therapy (AFT). The FBT manual was already published (Lock & Le Grange, 2002) but AFT was based on an unpublished and somewhat perfunctory manual originally written (Moye & Koepke, unpublished, unknown date) for a previous trial (Robin, et al., 1999), where it was known as Ego-Oriented Individual Therapy (EOIT). This manual is currently being re-written and expanded for publication (Lock, in preparation).

The outcomes of the 2010 RCT were well known for being rather hard to interpret and for not fully supporting the subsequent pre-eminence of FBT over AFT, although the higher rates of hospitalization and associated higher costs weighed heavily.

“Both treatments led to considerable improvements with no difference on the primary outcome variable, full remission, at EOT, though the moderate NNT (5) suggests that the failure to detect a statistical superiority for FBT may have been due to limited power. There were also no differences between the 2 groups on treatment dropout, average amount of treatment received, or use of treatment after EOT. During the follow-up period, however, FBT became statistically superior to AFT. This may have been due in part to differences in relapse from full remission, 10% for FBT and 40% for AFT, as well as more subjects reaching full-remission thresholds in FBT. Weight gain appeared faster for FBT as assessed by age- and sex-adjusted BMI percentile, though this effect was no longer found at follow-up. Participants in FBT were also hospitalized significantly less often.” (Lock et al., 2010, p1030).

In 2015, Lock reviewed the state of the evidence base for treatments for eating disorders in children and adolescents (Lock, 2015). He reviewed 98 publications covering family therapy, individual therapy, cognitive behavioral therapy, dialectical behaviour psychotherapy, cognitive training, and interpersonal therapy. He concluded that

- Family treatment–behavior (FT-B) is the only well-established treatment for adolescents with AN.
- Family treatment–systemic (FT-S) and insight oriented individual psychotherapy are probably efficacious treatments for adolescents with AN.

In 2016 publication of a trial comparing FBT with Parent Focused Therapy (PFT), a therapy without the young person herself present in the family session, but weight monitored and receiving a brief supportive conversation alongside, became something of a potential game-changer when the results showed that remission at end of treatment was higher in the parent-only therapy arm (43% versus 22%), although there

were no statistical differences at longer-term follow-up. (Le Grange et al., 2016).

Despite FBT being the 'winner' of the treatment trials on most measures, that is rates of remission at end of treatment, at six and twelve month follow-up, with lowest rates of hospitalization and therefore lowest cost, the rates of remission remained relatively low overall. In the study comparing FBT and AFT (Lock, 2010), significantly less than half of all patients in the FBT arm were fully remitted (at 95% median Body Mass Index, mBMI) at any time point, whether at end of treatment or six and twelve-month follow-up. In 2018, Lock and Le Grange again reviewed the outcomes for FBT in an article entitled: 'Where are we and where should we be going to improve recovery in child and adolescent eating disorders?', citing disappointing full remission rates of between 29 and 40% across different studies.

Therefore there have been some recent studies attempting to parse out potential mediators and moderators of treatment, mostly targeting 'patient factors' rather than 'therapist factors' that might help or hinder response to treatment.

Keel & Haedt (2008) compared treatment 'dose', that is number of FBT sessions, in an earlier Lock study (Lock et al., 2005), comparing patients treated with 10 sessions (six months) and patients treated with 20 sessions (12 months). Overall there were no differences in outcome but two moderators of treatment were identified. The presence of obsessional thinking and obsessive compulsive features required a higher number of sessions to achieve the necessary weight gain, and similarly children from single-parent or divorced families required a higher number of sessions for improvements in eating related psychopathology as measured by the Eating Disorders Examination (EDE).

Mediators were found in the form of youth and illness duration, with younger patients and those with a shorter duration of illness gained more weight, and in intact families and presentations of AN without bingeing and purging (Agras et al., 2014).

Lock (2015) concluded that for those with obsessive-compulsive features, FT-S might be the preferred treatment.

Two RCTs have examined the role, and cost, of hospitalization for adolescent AN. Gowers and colleagues randomized 167 adolescents aged 12–18 with AN to a specialized eating disorder inpatient treatment programme, outpatient CBT, or TAU at

the local mental health outpatient program (Gowers et al., 2007). At the end of treatment and at one-year follow-up, there were no differences in outcome among the participants by treatment assignment. The authors concluded that there was no advantage to utilizing a specialized inpatient eating disorder treatment programme compared to outpatient treatment for adolescents with AN, but outpatient treatment using CBT was more cost-effective (Byford et al., 2007). In another study, 82 medically unstable adolescents with AN were randomized to two different hospitalization protocols; one aimed to keep the patient in hospital to restore the patient's weight to 90% mBMI; the other to keep the patient in hospital only until vital signs were stable (Madden et al., 2015). Both inpatient protocols were followed by FT-B regardless of the participant's discharge weight. There were no clinical differences in weight, eating related cognitions, re-hospitalization rates, or utilization of other treatments during follow-up between the groups. The authors concluded that hospitalization for the purpose of weight restoration was not systematically beneficial for adolescents with AN when hospitalization was followed by FT-B. These two studies suggest that the use of hospitalization for adolescent AN, especially for the purpose of weight restoration alone, may not be useful for the majority of adolescents with AN.

In part prompted by the study by Gowers et al., (2007), in part other political drivers, the U.K. government in 2015 committed £30 million to the development of community outpatient eating disorders teams across England, in a move to try to reduce the use of in-patient beds and associated costs, given that the majority of in-patient beds in England were occupied by young people with AN. New teams were established and existing teams expanded, and a development plan entitled the Access and Waiting Times Standard published in 2015, with ambitious targets for waiting times and referral rates by 2020. The National Training in Eating Disorders funded by Health Education England was delivered to all 75 dedicated Community Eating Disorder teams in the country as part of this initiative.⁵

⁵ Health Education England (HEE) recently funded a national training for all clinicians from all disciplines working in dedicated community eating disorders services (CEDs), many of these newly commissioned as a result of the government's commitment of £30m to the development of eating disorders services for young people across the country (see <https://www.england.nhs.uk/mental-health/cyp/eating-disorders/>). This training in turn was prompted by and promised in the publication of the Access and Waiting Time Standard for Children and Young People with an Eating Disorders, 2015 (<https://www.england.nhs.uk/wp-content/uploads/2015/07/cyp-eating-disorders-access-waiting-time-standard-comm-guid.pdf>).

In summary, we might conclude that the position of FBT in the field varies, depending on one's perspective being primarily that of a clinician or researcher. Furthermore, there appears a shift currently taking place. Where ten years ago, family therapy approaches were hailed as the most promising path towards recovery for young people with AN, subsequent quantitative and qualitative research has cast a shadow over this expectation.

In 2010, Le Grange, Lock, Loeb & Nicholls stated in the Academy of Eating Disorders position paper on the role of the family in eating disorders, that "it is our position that families should be involved routinely in the treatment of most young people with an eating disorder" (p4), and this position is reflected in the NICE (2017) Guidance that family therapy for adolescent AN is the first-line recommended treatment. Nevertheless, outcome studies in the interim have demonstrated full remission rates of between 29 and 40 per cent (Lock & Le Grange, 2018) and reported new efforts to augment or adapt family interventions to achieve better outcomes. The Cochrane systematic review (Fisher, Skocic, Rutherford & Hetrick, 2019) of 25 studies compared 'family therapy approaches' to three alternative arms, viz., standard care, educational approaches, and other psychological therapies. It found the evidence in favour of family therapy approaches to be very weak, owing to small numbers, poor reporting of methods, and high risks of bias. In addition, some qualitative studies are beginning to evidence high levels of parental distress or dissatisfaction after FBT (Wufong et al., 2019; Aradas, Sales, Rhodes & Conti, 2019). Conversely, clinical argument in favour of family therapy approaches is also presented, for example, Lock & Nicholls (2020) attempted to demonstrate that FBT, when practised with 'fidelity and skill', is able to address not only eating disorders symptomatology but also the associated psychopathology and developmental needs of adolescents themselves. There is a growing focus on the long-term therapeutic needs of recovered young people and recognition that relapse prevention may require several sequential interventions or other supports.

2.4.4 AFT

At the same time as this unique expansion of both services and treatment standards, the new NICE Guidance for Eating Disorders was published. (NICE Guidelines: Eating Disorders: Recognition and Treatment, 2017). In this document, Adolescent Focused Therapy (AFT) appeared as a 'consider' level therapy alongside FBT, to surprise, delight and occasionally consternation, in the eating disorders world.

AFT is a psychodynamically derived therapy, characterised by its authors (Fitzpatrick, Moye, Hoste, Le Grange & Lock, 2010; Robin et al., 1999; Robin, Siegal, Koepke, Moye, & Tice, 1994) as based on self-psychology. As in FBT, a key aim and focus is weight restoration. Unlike FBT, the other key aim and focus is to support and promote the individual young person's developmental trajectory through adolescence. This task is conducted through collaborative therapy where the therapeutic relationship is viewed as an important agent of change, as in psychoanalytic psychotherapy. All topics relating to an adolescent's development are food for the content of the treatment, especially emotional self-awareness and regulation, and relationships with peers and family, as well as plans for the future. Finding meaning in behaviour, or mentalizing self and others, is at the heart of this therapy:

"Adolescents with AN are viewed as using food and weight to avoid negative affective states associated with adolescent developmental issues that they perceive as intolerable. To develop a more constructive coping style and improve self-efficacy, adolescent patients need to first learn to identify and define their emotions, and later, to tolerate emotions, particularly negative ones. In withdrawing from the environment and situations that provoke distress through self-starvation and preoccupations with food and weight, emotional and psychological development is arrested. Learning to identify and cope adaptively with emotions and developmental challenges presented by the environment form the key therapeutic targets of treatment." (Fitzpatrick et al., 2010, p31).

AFT had a precursor in a previous trial (Robin et al., 1994 & 1999), where it performed almost as well as family therapy. At this time, AFT was called 'Ego Oriented Individual Therapy (EOIT)' and the family therapy arm 'Behavioural Family Systems Therapy (BFST)'. It was the outcome of the Robin studies that lay behind the promotion of AFT from unknown outsider to contender in the NICE Guidance (2017).

The inclusion of AFT in the 2017 NICE Guidance, being as it is a 'meaning focused' therapy, is an exciting development for the field of eating disorders, and also the field of psychotherapy. It may mark a new chapter of confluence and integration of the two. From the point of view of this study, the appearance of AFT in the NICE Guidance is timely and an encouraging sign that in both the evidence base, and the developing body of clinical experience and interest among English eating disorders specialists, 'meaning-making' therapy may be enjoying a renaissance. Early discussions in the pioneer peer group of AFT-trained therapists, led by this author, centre around where,

rather than if, AFT may fit in the care pathway of a young person with AN. Pathways composed of consecutive therapies are proposed, for example, a period of FBT for weight restoration and family management, followed by AFT as an individual therapy for the young person to support their adolescent and personal development which, it is hoped among other benefits, will be an important factor in preventing relapse.

At the core of AFT is the formulation that AN is a 'maladaptive' response to the problem of adolescent development. Many in the field find this an uncontentious assertion as many subscribe to the view that AN can be understood, broadly, as a solution to a problem that the young person cannot find the solution to and, further, cannot ask for help with from within her family. For others, this is already too specific a focus and too great an assumption. So one of the key questions as AFT gains momentum from now, will be whether it is suitable only for one type of adolescent with an eating disorder, that is, adolescent's facing problems with the developmental tasks of their age and stage. What is indisputable is that developing an eating disorder inhibits development, but we should beware of confusing this consequence with intention.

The developmental formulation provides us with a neat framework for explorations of individual meaning and narratives in this study. First we make a detour to look at the kinds of meaning that have been posited for eating disorders historically in psychiatry.

2.4.5 Beyond FBT

A decade after the publication of the seminal RCT results (Lock et al., 2010), a small growth of papers in the field of augmenting FBT has begun and a systematic review published in 2018 (Richards, Subar, Touyz & Rhodes, 2018). With full recovery rates reported variously, depending on criteria used, but only around 40 per cent where eating disorder cognitions are taken into account (Lock, 2015) the outcomes may not be sufficient to warrant leaving FBT untouched and additions have been proposed, for example attachment-based elements (Wagner, Diamond, Levy, Russon & Litster, 2016); or more advanced interventions requiring therapist skill (Forsberg, Lock & Le Grange, 2018). In addition, the impact on the family and in particular parental suffering, in part as a result of the commitment required by FBT, is sometimes felt to be too great (Wufong, Rhodes & Conti, 2019).

Parents in the midst of treating their child's eating disorder will variously describe themselves as 'mere feeders', or worse, 'prison wardens', meaning the degree of surveillance and mistrust that they need to maintain in relation to their child's eating, and their awareness of 'tricks' that their child may play in order to eat less. Parents often speak about how shocked they are to find they cannot 'trust' their child and feel they 'no longer know' their own child. The experience of parents looking after a child with an eating disorder furnishes a field of literature in its own right and also forms a substantial component of this study.

2.4.6 The New Maudsley Collaborative Care Model

The New Maudsley Collaborative Care approach (Treasure, Rhind, Macdonald et al., 2015), originally developed for parents and carers of young adults with AN still living at home and based on a theoretical conceptualization of family dynamics around a child's eating disorders known as the 'cognitive-interpersonal maintenance model' (Treasure & Schmidt, 2006; Treasure, Smith & Crane, 2007). This theoretical and clinical model takes an agnostic stance as to aetiology but holds that families arrange themselves around the illness in ways that may inadvertently maintain the eating disorder in their child through their typical interactions. Treasure and colleagues have particularly placed at the centre of their model the notion of 'accommodation and enabling' behaviours, and high expressed emotion on the part of parents, as maintaining factors that draw them and their child with AN into an 'enmeshed' relationship. This model focuses on teaching and coaching parents in 'skills-based' caring approaches that support their child's independence and development. Evidence is emerging for its efficacy for adolescents also, as a follow-on treatment either after FBT or for a period when an older adolescent transitions into adulthood and, possibly, longer-term illness (Salerno et al. 2016). Results included the finding that mothers' skills were more important for outcome than fathers'. It is a model that maintains the no-blame stance regarding family aetiology while providing a treatment that encourages parental self-awareness and self-reflection.

2.5 Qualitative research into subjective experiences of illness

Before this century, qualitative research in the field of eating disorders, especially child and adolescent eating disorders, was scarce (Tozzi, Sullivan, Fear, McKenzie & Bulik, 2003). Since then a small but fast growing body of literature has built up, with common

topics being the patient experience of treatment, particularly in-patient treatment and, more recently, family-based treatment; patients' views of the causes of their eating disorder and the factors that fostered recovery; patients' views of what constitutes recovery; parents' and siblings' experience of having a child/sibling with an eating disorder and AN in particular.

A very few studies have attempted to address a topic similar to the one at the core of this research, viz. the personal meanings attributed by children and young people, and parents, to the eating disorder (Serpell et al., 1999, Nordbø et al., 2006).

2.5.1 Parents' experience of a child with an eating disorder

"Parents describe it best: a transformation of their child's manner seemingly out of nowhere, as mystifying as it is frightening, often leaving them exhausted, in despair, and resentful. AN can not be explained simply, nor is the remedy predictable, because so many of its features—the suddenness of its onset, the rapidly peaking intensity, its ego-syntonic character—are inaccessible to single-focused ideas." (Strober and Johnson, 2012, p158).

As the focus of treatment shifts decisively from hospital or in-patient unit to the home and the family, the burden on and expectation of parents continues to grow. Cottee-Lane, Pistrang & Bryant-Waugh (2004), in their seminal study cited by many researchers in the field of parents' experience of a child with AN, pointed out that at the time there was little systematic research into parents' experience of living with and parenting a child with AN. At the time of their small (n=11) qualitative study, they said that most reports of parents' experience came from parents groups (Nicholls & Magagna, 1997) or anecdotal accounts, but that systematic research was lacking.

Since that time, in keeping with both the changes in treatment research and best practice recommendations, and the digital revolution, there has been both a swathe of qualitative studies on parents' experience, a growth in resources for parents provided by professionals, and an explosion of online and social media resources and fora for and by parents communicating directly with each other. There is beginning to be, if not a mountain, then a mound, of qualitative material about parents' experience of having a child with AN. Parents' voices, only dimly heard at the turn of the millennium, are now louder and clearer, parents are better informed, and therefore – among other things - more able to seek peer support, and to evaluate the treatment options given to their children. It will be interesting to see in what direction this geological shift prompts

future academic research, as well as future service and treatment developments, given that parents' needs for support, wishes for treatment, and expectations of their child's recovery, are by no means always in line with clinicians'. Parents have more opportunities than before to educate clinicians in these domains and in this way may prompt new directions for both research and treatment.

Since Cottee-Lane et al. (2004), there has also been a flowering of mostly small (in terms of participant numbers) qualitative studies researching parents' experience of having and caring for a child with AN. Many studies focus on the experience, with particular emphasis on burden, and stress and distress levels, of parents of young adults with AN, as well as impact on family relationships and family functioning. Professor Janet Treasure, colleagues and collaborators at the Maudsley Hospital in particular have produced a body of research that has become a staple of both clinicians and parents themselves, disseminated via carers' workshops.

For example, Whitney et al. (2005), researching the experience of parents of both adolescents and adults with AN, highlighted the high levels of distress experienced by parents and drew attention to parents' 'illness perception' that might contribute to the maintenance of the illness, that is, beliefs such as that they were helpless in the face of their childless AN, and that only the sufferer herself had the power to bring about change. Parents were also found to suffer high levels of guilt and self-blame, based on the belief that their parenting had contributed to the development of the illness. Significant differences between mothers and fathers' ways of coping were found, with mothers highly emotionally aroused while fathers were more likely to distance themselves both geographically (staying away from home) and emotionally (expressing resignation). These findings have prompted the well-known 'skills based workshops for carers' that are now a staple of resources available to parents, the curriculum of which challenges many of the beliefs uncovered in this seminal study.

This group of 20 parent carers was a sub-group of a previous study (Treasure et al., 2001) of 71 carers (parents, partners, siblings) who filled in questionnaires (General Health Questionnaire and Experience of Caregiving Inventory) to ascertain the caring burden and distress of carers for adolescents and adults with AN. The results were compared with 68 carers of people with a psychotic illness. Results indicated the burden of caring for someone with AN to be significantly higher, with the added emotional dimensions of guilt and shame. This study concluded that carers of people with AN, whether adolescent or young adult, had high levels of unmet need and that

meeting these needs through, for example, carer support groups and family work, might improve the outcome of AN – providing the springboard for the significant developments in this field since that time.

The authors (Treasure et al., 2001) note that high emotional involvement of carers could actually function as a maintaining factor in the illness. Carers' workshops and indeed the development of family based therapy as a whole, has had as an axiom that the emotional investment needs to be hidden from view from the young person, been shown to be invested in health not illness, and that AN must not act as a magnet for the whole family's emotional functioning.

Zabala et al. (2009) conducted a systematic review of research in carers' experience of caring for people (adults) with eating disorders, where studies had to include specifically quantitative measures of distress, burden and/or EE. They reviewed 20 papers (nearly half from the same institution, viz. the authors' own Institute of Psychiatry), confirming, firstly, high levels of depression, anxiety and burden – higher than in one comparison study of carers of people with psychosis. Second, they confirmed high levels of EE, and pointed out “a tendency across all measures for high EE scores to be found in older patients with a long duration of illness.” The authors said that they could not comment on any correlation between high EE and duration of illness.

Within the field of qualitative experience of families of children and young people with AN, there has been a flow of new qualitative studies from Sweden and Australia, in particular. The focus of the studies ranges from open ones on parents' 'lived experience' (Svensson, Nilsson, Levi & Carballeira Suarez, 2013,) to 'coping mechanisms' (Honey & Halse, 2006), to specific experiences of treatment such as multi-family therapy (Engman-Bredvik, Carballeira Suarez, Nilsson & Levi, 2016).

The experiences researched and described appear overwhelmingly negative. Honey & Halse (2006) found that existing quantitative measures of parental coping used for research into the impact on parents of severe or chronic health problems in their children, correlated very poorly with their own complex, qualitative findings about what 'coping' might actually mean in practice for parents of children with AN. They identified a vast range of activities which they named 'explanatory work', 'thinking work' and 'capacity work', and beneath these titles they delineated activities such as seeking information and advice, finding out about their daughter, evaluating past strategies,

comparing and integrating information, separating AN, thinking positively, maintaining a helpful focus, staying realistic, managing other activities, learning new skills, working together, self-care, using social supports, and setting boundaries.

Svensson et al. (2013) identified experiences of social isolation, strained spousal relations, impact on family functioning with everything centred on mealtime management if at home, or time spent at hospital, and negative impact on siblings. Emotional stress and distress was described in terms of emotions such as anxiety and worry, guilt and self-blame, frustration, helplessness, and anger. These findings map well onto previous studies such as those of Cottee-Lane et al. (2004) for parents of young people, and Whitney et al. (2005) for carers of young adults with AN.

Bezance and Holliday (2014) carried out a small qualitative study with nine participant mothers caring for their daughters with AN at home as part of 'home treatment' (HT), a new and as yet un-manualized and un-trialled treatment modality attempting to offer intensive outreach as an alternative to in-patient treatment where weekly CAMHS family based treatment is not intensive enough. Few community eating disorders offered this as yet and the study drew its participants from one service alone, in Oxford and Buckinghamshire. The analysis of the data using Interpretative Phenomenological Analysis (IPA) yielded some startling qualitative data, organised by the researchers into three domains headlined 'becoming enmeshed', 'reaching rock bottom' and 'experiences of help'. Mothers described losing themselves, not caring for themselves, becoming distant from other family members, becoming completely taken over by the task of feeding and overwhelmed by worry and anxiety. Mothers' own mental health became precarious and they suffered feelings of helplessness and failure, as well as social isolation – experiences familiar from other studies on parents' experience. In terms of actual treatment outcomes, furthermore, five of the nine participants' daughters had to be hospitalized after the home treatment failed to prevent deterioration.

A notable gap in the qualitative literature on parents' and carers' experience is that of the meanings that carers may attribute to their child's (occasionally adult sibling's) eating disorder. The literature appears to home in exclusively on experience, as described, and exclusively negatively framed.

The literature that focuses on treatment experience is more nuanced, with positive experiences of treatment described alongside the care burden and emotional distress

and mental strain. In particular, a new trickle of research is appearing, concerned with the impact on families who have undergone family-based treatment for AN but whose child either did not become weight restored or who did become weight restored but continued to exhibit symptoms of psychological distress. For example, in a recently published qualitative study, Wufong et al. (2019) interviewed 13 parents of such children, and drew the conclusions that in these cases, FBT had

“(1) provided a map for therapy that initially relieved parents’ anxieties for their child and facilitated improvements in family functioning;

(2) inadequately addressed parental guilt and blame with a form of externalisation of the illness;

(3) perpetuated parental guilt by raising anxiety about AN and allocating responsibility for refeeding their child in phase 1 of the treatment; and

(4) when ceased, left these parents struggling with an uncertain future, and fears for the wellbeing of their children.” (Wufong et al., 2019, p1).

As will be shown, the research in the present study on the meanings placed by parents on their child’s eating disorders also results in more nuanced experiential descriptions with the outcome occasionally being described as transformative of family dynamics, ‘a blessing in a strange sort of way’, and interestingly, bringing positive outcomes for mothers personally.

As part of the National Training in Community Eating Disorders for whole teams (see footnote 1) a short film was produced with interviews from five parents (all mothers) about their experience of their child’s illness, onset, treatment and recovery. The film was shown to National Training participants with the intention of helping clinicians put themselves in the shoes of parents and the extremes of emotion, stress and distress, that they suffer, usually for years, as a consequence of their child’s eating disorder.

2.5.2 Siblings’ experience

There is very little qualitative research on siblings’ experience of having a sibling with a mental health disorder, let alone an eating disorder. Honey & Halse (2007) summarise the existing qualitative research on siblings of ill siblings in general thus:

“In qualitative studies, well siblings report that negative experiences have resulted from their parents’ responses to their sibling’s illness. These experiences include: physical separation from parents owing to an ill child’s hospitalization; emotional unavailability of parents because of their own distress; emotional realignments within the family; disruption of siblings’ routines;

parental expectations that the well sibling be tolerant and understanding; and differential treatment of the siblings within the family in terms of parental attention, priority of needs, discipline and tolerance.” (Honey & Halse, 2007, p52).

These findings chime well with clinical experience of parental concerns for their other children and suggest that parents are likely not only to be aware of the risks posed to their well children by having an ill sibling, but also see themselves as having a central role protecting their well children. Honey & Halse’s study focuses on parents’ own understanding of this role. In particular, they found that parents made conscious and deliberate efforts to maintain normality, compensate for changes to routines, protect their well children, provide emotional support, and manage the consequences.

Withers et al. (2014) interviewed 20 12-18-year-old siblings of adolescents currently receiving treatment for AN, investigating both the impact on them of their sibling’s illness, how they coped, and the impact of participation in family-based treatment (FBT). The latter component of the research was added iteratively as it emerged that interviewees wanted to speak about their participation in their sibling’s treatment as well.

Withers et al. found that siblings reported being helped to cope by, for example, knowing more about the illness. Siblings also reported the need for regular ‘time out’ from stressful family events and interactions. They also said that close relationships within the family helped. In terms of the impact on the relationship between the well sibling and the sibling with AN, this study found that well older siblings fared better in terms of maintaining a relationship with their ill sibling, whereas younger siblings often found themselves shut out and helpless to find ways of rebuilding the relationship to their ill sibling.

Siblings who had participated in FBT (14 out of 20) all fared better on the domains above and reported more knowledge about the illness, greater understanding of how to help, better communication within the family and closer and more supportive relationships with parents. Siblings who did not participate in FBT were more likely to prioritise ‘time out’ from family. However, results were further differentiated according to whether or not the FBT has been successful in bringing about recovery for the ill sibling. For those families where FBT had not been successful, reports by siblings of feelings of guilt and anger, and a deterioration in sibling relationships, predominated.

The limited available evidence suggests that siblings' involvement in family treatment for AN does not impact the outcome of the treatment itself, but may have benefits for the sibling's well-being or family well-being as a whole (van Langenberg et al., 2018). This qualitative study also addressed the involvement, or lack of involvement, of siblings in two forms of family therapy: family-based treatment where the whole family attends sessions according to the manual, and parent-focused treatment where the parents and the adolescent with AN attend separate sessions. A recent study (Le Grange et al., 2016) found that remission rates at end of treatment were higher for the separated sessions, although without significant differences at follow-up. Van Langenberg et al. (2018) caution that siblings were strongly emotionally affected by parental preoccupation with their ill sibling; by practical tasks such as baby-sitting and housework while parents were busy with their ill sibling, for example, attending therapy appointments or sitting with the anorexic adolescent at mealtimes; and by offering emotional support both to parents and ill sibling, and mediating in family conflicts; and finally, that siblings provide mealtime supervision for their ill sibling contrary to treatment guidelines. The conclusion is that the burden on siblings, and the long-term effects, have yet to be properly explored, documented and understood.

2.5.3 Young people's experience

The qualitative literature on the experiences of eating disorders sufferers themselves remains small. There are many reasons for this. One, oft cited, is that the nature of the illness interferes both with the very means of communication itself, and further, the veracity of communication, or at least, subjects' capacity for a form of self-reflection that would lead to honest communication.

Vitousek, Daly & Heiser wrote in 1991:

"The challenge of getting eating disorder clients to tell us what they think and feel – and the difficulty of trusting them when they do – have long figured prominently among the concerns of clinicians and researchers who work with this population. Anorexics in particular are notoriously protective of their private experience." (Vitousek et al., 1991, p647).

Vitousek and colleagues went on to address the phenomenon of 'denial' in eating disorders and AN in particular, and its implications for research findings in the field, particularly when based on self-report. 'Denial' is defined broadly as both conscious

and deliberate, and unconscious and inadvertent, a cousin of the characteristic of 'over-compliance' where subjects will agree with therapists' interpretations or researchers' suggestions in order to please. They made a plea for research methods that do not rely on clinician intuition or report. In particular they took issue with the theory, more prevalent at the time that they were writing, that AN represented a wish to retreat from the sexual and psychological maturity of adulthood. They proposed a number of methodologies for obtaining 'true' self-report of thoughts and feelings of sufferers of AN, within the context of the time, discernable through the writing, where confrontation and challenge appeared to have been more prevalent techniques in treatment methods, and conflating patterns of functioning in families with an anorexic member with cause of illness, without looking at control groups both within normal populations and populations with other mental health disorders.

The qualitative literature about child and adolescent sufferers of AN is, as ever, even smaller than that for adults with the disorder. If the qualitative literature about adult eating disorders' patients experience – of illness, treatment, recovery, and so on – can to some degree guide us in the absence of a substantial qualitative literature on children and young people's experience, there must nevertheless be a range of perspectives missing, in that the accounts of children and adolescents would be expected include the key platform of development. What the nature of the relationship between the vicissitudes of later childhood and adolescent development, and eating disorders, might be, remains a key interest of clinicians, and clinical therapeutic work could be sharply enhanced by qualitative studies illuminating this relationship.

2.5.3.1 Personal meaning

Few studies have attempted to address a topic similar to the one at the core of this research, viz. the personal meanings attributed by children and young people, and parents, to the eating disorder.

Some studies have come at the question of personal meaning through questions about the personal value of the eating disorder, and also the personal cost. An early, widely disseminated study of young adults' (median age 24.1, median age of onset, 18) experience of AN was by Serpell et al. (1999) with the catchy title 'Anorexia: Friend or Foe?' A simple research objective, to examine anorexics' attitudes to AN, and a neat study design, yielded rich qualitative data.

“Anorexic patients were asked to write two letters to their AN, one addressing it as a friend and the other addressing it as an enemy. A coding scheme was developed using a “Grounded Theory” methodology to group recurrent themes... Commonly expressed benefits of AN included feeling looked after or protected, gaining a sense of control, and feeling special. Perceived costs of the disorder included constant thoughts about food, feeling taken over, and the damage done to personal relationships.” (Serpell et al., 199, p177).

The authors highlight that the ‘ego syntonic’ nature of AN, that is, the positive beliefs and feelings that ‘sufferers’ hold about their condition, is a feature that seemingly sets it apart from other mental health disorders, and contributes to patients’ ambivalent attitudes to treatment and recovery, where the explicit aim is the loss of eating disorder symptomatology. The authors assert that surprisingly little attention in the research literature had (twenty years ago) been given to the ‘reinforcers’, the gains, of the eating disorder. This study contributed significantly to clinicians’ awareness and enabled clinical conversations around the perceived positive consequence of AN for patients themselves. The stigma around sufferers of AN feeling and acting aloof and resistant to treatment, and seeming essentially pleased with their disorder, was reduced when clinicians could point to a research study that normalized such feelings and consequent behaviour, by the finding that they were shared among many. Clinicians and researchers were also been able to deduce the prevalence of co-morbid anxiety in AN, through the finding that the overall most prominent theme of guardianship, of feeling protected and looked after, combined with the second-most prominent theme of feeling ‘in control’.

Nordbø et al. (2006) built on Serpell et al. (1999) with a qualitative study of 18 young adults (saturation of themes was reached after 18) aged 18-34, using interviews and a ‘phenomenological’ analysis. The authors concluded that, with one exception, those interviewed perceived their eating disorder as ‘psychologically meaningful’, as reported both through accounts of their everyday life with AN, and their difficulties in recovering.

The Nordbø et al. (2006) study yielded eight themes that in many ways replicate the findings of Serpell et al. (1999), viz. security, avoidance of unpleasant emotions, inner sense of mastery, self-confidence, identity, care eliciting, communication, and a wish to die. Interestingly, in the Nordbø et al. study interview subjects were not directed to find both positives and negatives but were interviewed in a semi-structured format with the apparent result that the positive aspects of AN dominated the discourse. The only negative theme was the wish to die, which emerged in only two subjects’ narratives.

The authors point out that the meaning of the AN, as derived from interviews, could be perceived at the beginning of the illness, and/or to accrue to it as the illness progressed. In other words, the meaning of the illness was not to be confused with causative factors. However, a close reading of the eight themes shows that often AN was found to act as a solution to pre-existing, co-morbid, emotional and developmental problems, such as low self-esteem or lack of self-confidence, or anxiety and uncertainty.

Pre-existing research, and ideas and beliefs prompting research have, naturally, influenced the kinds of questions researchers asked in qualitative studies. In the earlier studies, qualitative research methodology and philosophical underpinnings were often opaque (Bezance & Holliday, 2013). For example, Tozzi et al. (2003) interviewed 69 women with 'lifetime AN' in New Zealand, a very large cohort for a qualitative study, as part of a case control study. While emphasizing the rigour of their case selection according to DSM-III-R diagnostic criteria, they merely describe the interview protocol as having a component devoted to question about participants' perceptions of the causes of their AN, and the analysis method was merely described as a 'review' of responses. However, this lack of rigour may be less surprising when we consider that at the time of the research, Tozzi et al. had identified only three previous qualitative studies of patient experience:

"Little attention has been paid to the personal perspective of patients on the causes of their eating disorder as well as the factors that contribute to recovery. To our knowledge, only three studies (Beresin, Gordon, & Herzog, 1989; Hsu, Crisp, & Callender, 1992; Rorty, Yager, & Rossotto, 1993) have considered patients' opinions about their eating disorders. These studies consist of small samples." (Tozzi et al., 2003, p145).

Tozzi et al. were in fact interviewing women who had been diagnosed on average 15 years earlier, i.e. 1982-84 inclusive. Their chief findings were that

"More than one-third of patients highlighted family dysfunction as a contributing factor to the development of their eating disorder. This category included family features such as poor parental care/childhood deprivation, parental overcontrol, poor relationship with parents, pervasive family tension/fights, and emotional abuse. The next most commonly perceived causes were weight loss/dieting and stress and frustration" (Tozzi et al., p148).

It would be difficult to achieve similar results today with regards to 'family dysfunction', because of the tendency to pathologise families of anorexics in the seventies and

eighties, and the tendency to abjure causal explanations originating in the family today. Additionally, research since the eighties has demonstrated that although family factors can correlate with a number of mental health disorders, no specific ones have been able to be isolated to account for eating disorders exclusively or specifically.

Tan, Hope & Stewart (2003) investigated the legal concepts of capacity and competence, and their definitional difference, in relation to compulsory treatment, through interviews with 10 subjects aged 10-22. By asking 'who' AN was for each individual, they found that many subjects considered AN to be an essential part of their identity, and feared that treatment would remove this part of their identity, leaving them at loss and depleted, in contradiction to the supposed benefits of health restored. The authors hypothesized that the anorexic identity, with its primary, prized qualities of "perfectionism, compliance, self-esteem, and self-control", grows up in a context where an adolescent is struggling with, but turning away from, the troubled search for an post-childhood identity. In this study, again, no particular qualitative methodology was described. As in the research by Tozzi et al. (2003), credibility was given by emphasising standardized measures (in this case the MacCAT-T test of competence).

A study of a small group of 13-17-year-olds about their experiences of the onset of AN, was designed according to the qualitative method of grounded theory. In this study the research process was described overtly and consistently. Koruth et al. (2012) found that overwhelming and unmanageable negative feelings characterized the time when the eating disorder began. Emotions named were frustration, guilt, loneliness, low mood, fear, worry, and shame. This was also one of the themes found in the qualitative analysis of Nordbø et al. (2006), relating to adults. Other themes that emerged were that a subjective awareness of the AN develops over time, and that interpersonal relationships are impeded. A meaningful, dynamic depiction of how AN may develop, or creep up on a young person, in the context of emotional turmoil is produced in this study, the dynamism being a quality often absent from other accounts.

2.5.3.2 Experiences of treatment and/or recovery

Using Interpretative Phenomenological Analysis (IPA), somewhat new at the time, Colton and Pistrang (2004) made a qualitative study of adolescents' experience of treatment on two in-patient units (n=19). They highlighted the subjects' ambivalence and conflict around getting well and 'giving up' the eating disorder, focusing particularly on patients' views that 'readiness to change' was key in recovery, as well as patients'

emphasis on psychological therapies and an empathic attitude by staff being key therapeutic factors. The authors pointed out that their concern was to convey the complex and often internally contradictory views of patients, in keeping with the 'lived experience' purpose of the IPA method of interviewing and analysing data.

Offord, Turner & Cooper (2006) built on Colton and Pistrang's study (2004) with another, small, IPA study of the in-patient treatment experiences of a cohort of discharged young adults who had been treated in a general adolescent unit, as opposed to specialist eating disorders facility. Subjects (n=7) were aged 16-23 and had had a period of time between discharge and being interviewed. The themes generated were rich and varied and, as before, internally contradictory, reflecting the nature of the eating disorder itself. The authors made recommendations drawn from the interviews for improvement of programmes in in-patient facilities, including making more provision for individual therapies for patients, and encouraging more contact with home and peers during admission to reduce the difficulties of transfer to the community. Themes were organized as per IPA methodology as super-ordinate and subordinate.

Tierney's (2008) study using thematic analysis, again small (n=10), drawn from both outpatient and inpatient cohorts, consolidated some of the themes discerned in the studies cited above, particularly the value that young patients placed on non-judgmental individual therapies, but also on parents' support, and expertise among staff. The theme of difficulties with reintegration into a peer group, and social relationship with peers more broadly, also recurred. Again, the ambivalent views and feelings of interviewees were evident in responses, reflecting the nature of the eating disorder itself.

Haynes, Eivors and Crossley (2011) researched the subjective experiences of 10 adolescents on two generic adolescent psychiatric wards, male and female, with a range of psychiatric diagnoses. Their experiences seemed to differ quite markedly from those of the eating disorders specific studies. The wards were described as quite volatile and violent places where emotions of fear and confusion might be engendered. The dominant theme emerging from the grounded theory analysis was that of 'living in an alternative reality', referring to the disconnection from the world outside, from the peer group, and by extension, from the adolescent developmental process itself, including identity formation. Nevertheless, the participants seemed to strive to stay connected to the adolescent process and peer group and to feel their loss keenly, and

this theme was less prominent in the studies focusing on purely eating disorders cohorts. This would be concordant with the specific preoccupations of eating disorders patients and even with the characteristic withdrawal from, or de-prioritising of, adolescent development.

The authors cited above refer to the small body of qualitative research on patient experience and patient views, especially in the child and adolescent population. The studies cited are limited in both participant numbers and scope of investigation, with results illuminating just a shard of an individual's experience of having an eating disorder, be it experience of in-patient treatment, or opinions on factors promoting recovery, or even recollections of emotions preceding the onset of the eating disorder. Single occasion interviews can only give a limited amount of information and seem to be more or less dependent on the subjects' capacity for coherent narrative, and pre-existing reflective ability. They are also not triangulated for comparison with the accounts of other observers such as parents, or staff.

Noordenbos has produced a body of qualitative research on adult sufferers' experience throughout their illness and treatment and post-treatment journeys. Recent qualitative research in both adult and adolescent fields has focused on experience of treatment and criteria for recovery. In the latter, studies compare patients' and therapists' criteria for recovery (in the absence of any objectively agreed criteria in the field). Patients and therapists largely agreed on a wide remit of criteria spanning 'eating and drinking behaviour; physical activity and exercising; attitude towards food and weight; body evaluation; relaxation; physical recovery; psychological recovery; emotion regulation; social relations; sexual attitude; and comorbidity'. (Noordenbos, 2011, p447).

Noordenbos also points out that previous research has showed that although treatments aiming solely at improving food intake and weight could be completed in a short amount of time, they were often followed by relapse. On the other hand, treatments which required meeting "psychological, emotional, and social criteria for recovery took longer to complete, but reduced the risk of relapse in a substantial way." (Noordenbos, 2011, p442)

Within the research domain of psychological and emotional recovery, the reach is also wide. Psychological and emotional recovery is deemed to span the following areas:

“6. Psychological recovery: has developed a “sense of self”; has self-esteem and a positive evaluation of her self; has enough self-respect; has a positive attitude of herself; self-esteem is not dependent on weight or food intake; has a positive feeling of identity; is assertive enough to express her own opinions; is no longer overly dependent on the opinion of others; has a feeling of autonomy; is able to concentrate; has no maladaptive cognitions about food, weight, herself, her body, or others; is not overly perfectionistic; has no extreme fears of failure; has a realistic self-image.

7. Emotion regulation: no longer avoids or suppresses her emotions, feelings or needs; is able to recognise and express her emotions and needs; is able to cope with negative and positive emotions; is able to cope with conflicts instead of avoiding them; has a positive attitude towards spontaneity and pleasure.

8. Relaxation: has no feelings of extreme restlessness or inner tension; is able to relax her body; can cope with psychological stress without binges; has a relaxed attitude towards her life; and is not rigid or obsessive-compulsive.

9. Social relations: participates in social activities; is able to establish social contacts and to make friends; feels comfortable in contacts with others; is no longer socially isolated.

10. Sexuality (dependent on the age of the person): is no longer afraid of intimacy, erotic situations, or sexual behaviour; is able to express her own wishes about sexuality; is no longer afraid to lose her identity in intimate relations; enjoys intimacy and sexuality.

11. Comorbidity: has no other psychiatric disorders that are related to ED, such as anxiety disorders, depression, self-injury, obsessive-compulsive behaviour, or post-traumatic stress disorder.” (Noordenbos, 2011, pp443-444).

These ideas come from both eating disorders patients themselves and from therapists, highlighting, were it needed, that eating disorders not only result in a destruction of the capacity for enjoyment of eating, but also for relating to others, and enjoying life itself.

Chapter 3. Design and review of alternative methods for the study

3.1. Introduction

This chapter describes the aims of the research, the design and methods chosen for different parts of the project, and considers the dilemmas and the rationale for the choices made.

Section 3.2 summarizes the aims of the study and the main research questions.

Section 3.3 describes the study design, including the process of recruitment of research participants, the method of data gathering, the design and execution of the research interviews, and the time points.

Section 3.4 describes the process of data analysis and presentation of results

Section 3.5 presents a review of the research methods that were available to the researcher, including a review of associated literature, and evaluates their strengths and weakness in relation to the aims of the research.

3.1.1. P.I.C.O.

The P.I.C.O. model for framing clinical questions is a useful way of introducing the study, as follows:

Patient, Population or Problem

The problem concerned the question of what meanings parents and children ascribe to the eating disorder, an aspect of research and practice that has become side-lined as a result of recent advances in evidence based treatments that focus on behavioural parental management. The question of how people make meaning of their experiences is central to psychoanalysis, the theoretical framework underpinning the impetus for this research.

The population researched was a naturalistic cohort of families with a child with a restrictive eating disorder, referred to the researcher's national specialist outpatient service. It was a diverse treatment cohort in all respects, particularly in terms of treatment history, as the national centre served families where local treatments had failed to meet their need. The service also focused primarily but not exclusively on a younger age group.

Intervention

The intervention was a semi-structured, qualitative research interview undertaken at beginning and after end of treatment, with all members attending treatment, usually mother, father and child. It was hoped that the interviews would capture participants original, personal thinking on the subject of meaning, distinct from the prevailing philosophies of treatment, which participants might have had communicated to them to a greater or lesser degree through their therapists. The literature on evidence-based treatment for eating disorders constituted the larger context of the study.

Interviews were crafted to allow for both a qualitative analysis with IPA, and an evaluation for RF. This was intended to approach the data from different standpoints to allow for a richer, more nuanced and layered analysis of the data.

Comparison

There was no comparison or control arm, as it was not a clinical intervention. Nevertheless, comparative data were able to be built up within families, within and between sub-groups of mothers, fathers and children, and between time points. Results were also compared with the fields of literature in which the study was situated.

Outcome

The desired outcome was an answer to the central question, 'Does meaning matter in the treatment of anorexia nervosa?', specifically whether meaning was valued by parents and children alike, and whether it was seen either subjectively or objectively to have any association with recovery.

A second hoped for outcome was to discover whether participants' constructions of meaning would change during the course of treatment, under the impact of treatment.

Finally, there was curiosity about whether young people, and their parents, harboured thoughts about the meaning of the eating disorder that were unsayable in treatment, because they diverged too far from accepted constructions of aetiology and received wisdom.

The type of question being asked was primarily one that could inform future developments in treatment.

The type of study proposed was qualitative, using methods drawn from qualitative health psychology, with a quantitative component drawn from research methods from the field of attachment and mentalizing theory.

3.2 Aims of the study

This study examines the meanings that children and young people with eating disorders, and their parents, ascribe to the eating disorder. The research questions can be summarized under two broad headings, with three subsidiary questions.

1. The first broad aim was to uncover how parents and children understand, and make sense, of what is happening to them, when a child in the family develops an eating disorder. The emphasis on 'making meaning' is in part phenomenological in nature, that is, concerned with research participants' 'personal lived experience'.

This philosophical and phenomenological approach to meaning traces its roots back to the phenomenological philosophy of Husserl (1931), which more recently has been revived as the theoretical foundation for Interpretative Phenomenological Analysis (IPA) (Smith, 1996; Smith 2004; Smith, Flowers & Larkin, 2009), used in many qualitative studies in the fields of psychology and health in the last 20 years. IPA was

chosen as the method guiding the design and analysis of this part of the study also. The rationale for this choice is discussed in Section 3.5. and the Results presented in Chapters 4-6 and Chapter 8.

1a. The first subsidiary question concerned the extent to which meanings might diverge, or converge, depending on who in the family was speaking. So, for example, there was a wish to ascertain the extent to which the different members of one family might have similar or different ways of attributing meaning.

1b. Further, would a comparison of narratives of sub-groups yield data in a new light? For example, might a comparison of the accounts of the sub-group of mothers, fathers, and children, yield a different thematic perspective?

In order to address both these subsidiary questions concerning cross-group comparison of data, it was decided that interviews would be conducted with individuals, mothers, fathers and children separately.

2. The second aim, distinct from the first, was to examine whether any association could be found between the extent of meaning-making in parents and children, and the process of recovery from the eating disorder. This question was at the root of the first conception of the study. This question is somewhat different from the meanings that participants themselves attribute to the eating disorder. To answer it, first, a more objective, or standardized, definition of 'meaning' was required. Second, a comparison of 'meaning' and data about the children's recovery was required.

This part of the study was conducted using the concept of mentalizing and its associated measure, the operationalization Reflective Function or RF. The rationale for this choice is also considered in Section 3.5.4 and the Results presented in Chapter 8.

2a. The subsidiary question here concerned the question of whether meaning-making would change over time, and indeed whether the very capacity for meaning-making might change over time and under the impact of treatment. In order to address this question, it was decided to undertake two interviews, one at the beginning of treatment and one at the end or after the end of treatment.

In short, to summarise, these were the research questions:

1. What personal meanings do children and parents ascribe to the eating disorder?
 - 1a. How do meanings differ or converge between family members?
 - 1b. How do meanings differ or converge across sub-groups, such as all mothers, all fathers and all children?
2. Does the capacity for and extent of meaning-making, defined as 'mentalizing', have any relationship with a child's recovery?
 - 2a. Does the capacity for and extent of meaning-making change between the beginning and end of treatment?

3.3 Study design

Ten families in a dedicated eating disorders service were recruited sequentially as they were referred, and as long as they met inclusion criteria. It was considered that ten families would furnish data sufficient for the requirements of a substantial study such as a doctoral thesis. Each family comprised a mother, father and child; had all potential interviewees participated at both time points, a total of 60 interviews would have been gathered. This number was considered very substantial and therefore allowed for drop-out to occur without jeopardizing the study's value (even though of course the impact of lost cases might be systematic, e.g. cases with worse outcome might refuse interview, and this could be considered among the potential limitations in due course).

Exclusion criteria were young people with difficulties of expressive language including those that might be part of autism spectrum disorder, where such a diagnosis was made, and also those families whose spoken English was poor. These exclusion criteria were set because it was considered that developmental or linguistic difficulties with communication would hamper the effort to obtain rich data where the only method of data gathering was through a face-to-face interview strongly focused on verbal content.

The research was conducted by means of semi-structured interviews of approximately one hour's length, conducted individually with all members of each recruited family. The same interview protocol was followed at both time points, at the start of treatment and at, or after, the end of treatment. A minimum of one year was allowed between interviews at Time 1 (T1) and Time 2 (T2). Interviews were audio recorded and transcribed. Interviews were analysed in two different ways, according to the methodology of IPA and RF.

Results are presented as follows:

IPA Results for Mothers, Time 1 and Time 2 presented separately

IPA Results for Fathers, Time 1 and Time 2 presented together

IPA Results for Children, Time 1 and Time 2 presented together

IPA Results: comparisons between parents and children

RF Results for Parents

RF Results for Children

RF Results: comparisons between parents and children

Interviews were analysed and annotated thematically using IPA, and with a numerical value denoting RF, with accompanying annotations.

Further, as will be seen, a discrete interpretative component concerning the types of emotions expressed by interview participants, was developed, drawing loosely on the embryonic literature concerning psychoanalytic approaches in qualitative interviewing, data gathering and data analysis. This literature, and its potential application to this study, is discussed further in Section 3.5.6.

All interviews but one were conducted by the principal investigator (PI). The PI was also a member of the clinical team, and in particular had a role as the facilitator of the parents' support group.

A discussion of the ethical considerations, advantages and disadvantages, in this overlap between the PI's clinical and research roles, follows below.

3.3.1. Ethical approval

Final ethics approval was received from the NHS Health Research Authority NRES Committee East of England on 19 December 2012 (Appendix 1b). Prior to this, provisional approval was received on 20 August 2012 subject to some procedural revisions (Appendix 1a). The PI attended an ethics hearing on 10 August 2012 in Cambridge and Appendix 1a shows in detail the questions put by the NRES Committee and the PI's replies. The Committee asked questions about whether:

- participants may feel coerced into taking part

- boundaries between treatment and research could become blurred
- how the PI's role as a therapist in the department would affect the recruitment of the participants
- the PI would be able to cope if the participants or their parents become distressed whilst discussing the subject of eating disorders which can be upsetting
- whether the child would describe themselves as having an eating disorder

The Committee was satisfied with the PI's responses to these questions.

NHS site specific approval for the study was also required, applied for and granted (Appendix 1c).

3.3.1.1 Researcher–clinician role overlap

The NHS NRES Committee had asked whether the research participants could be recruited from another hospital or clinic in order to avoid a 'blurring of boundaries' between the PI's role of clinician and researcher. The PI's reply was recorded as saying, among other things, "the study is about meaning and therefore you thought it would be better to do it with people who are from your own team as you will get more effective interviews from them".

When designing the research and considering the role overlap of the PI as researcher and clinician, it was felt that the PI's presence as a clinician in the team would benefit more than hamper the research, because it was hypothesized that families' trust in the team would support participants' trust in the researcher, and thus enhance willingness to open up their thoughts and feelings in an interview that had the potential to be both probing, and personal. The thinking behind this hypothesis relates in part to the theoretical concept of 'epistemic trust', that is "trust in the authenticity and personal relevance of interpersonally transmitted knowledge. Epistemic trust enables social learning in an ever-changing social and cultural context and allows individuals to benefit from their (social) environment" (Fonagy & Campbell, 2017, p4). It was felt that the PI's access to knowledge about the families through multiple clinical sources in the team, including written assessment reports, clinical team meetings and case discussions, and clinical participation conducting the parents' support group, would also enhance participants' trust.

It is known that expertise is a characteristic in eating disorders therapists highly valued by patients (Wufong et al., 2019; Gulliksen et al., 2012) and this also seemed to speak in favour of the hypothesis that trust in the team, and its expertise, would support trust in the researcher and the research process.

The NRES Committee also asked a question about whether participants might feel coerced into participating. Presumably what the Committee meant was that if families coming for treatment in a state of crisis are asked to participate in research, they may believe implicitly that their treatment may be jeopardized if they refuse. This is a common dilemma in recruitment for mental health research, but less specific to the clinician-researcher role overlap.

Inferences that may go some way to illuminating these questions can be drawn from the process of recruitment, retention and drop-out as they unfolded.

3.3.2 Recruitment of research participants

Ten families who met inclusion criteria were recruited to the study over a period of approximately one and a half years, in sequential order, F1 representing the first recruited family, and F10 the last.

One pilot interview with parents and child in one family (Pilot F) was conducted four months before recruitment began, in order to test acceptability. The pilot family was reaching the end of treatment. The feedback from parents and child was positive about the acceptability of the interview; family members overtly welcomed the opportunity to have time and space to reflect on what had happened and the impact of treatment. In addition, one marked finding from this pilot was that the young person stated clearly that she felt that change in the family had been for the better. These views were expressed both under the interview domains of 'Impact' and 'Recovery':

Impact: "My family is a lot closer, because they've realized that spending a lot of time with each other and talking, you understand a lot better about each other. Things that I might have kept secret before I now tell them, so there are good things about it." (Pilot C)

Recovery: "Well I need my family to stay as they are now, close, not have my dad at the pub and my mum rushing around and my brothers not really asking much about how I feel." (Pilot C)

On the basis of this positive feedback and interesting finding about the young person's perspective on changed family relationships, it was decided to go ahead and recruit families for the study proper.

The investigator was mindful, however, that the pilot family was recruited at the end of treatment and therefore had left behind the worst of the family crisis occasioned by their child's eating disorder, and that it was as yet untested how families at the start of treatment would react to a request to participate in a research interview.

Recruitment was embedded into the clinical process of assessment, when families first were referred to the service. The clinician conducting the assessment, which could be any member of the team, made a verbal query at the end of assessment about the family's willingness to participate and if received favourably, offered families a patient information sheet (PIS), in two different versions for parents and children respectively (Appendices 2a and 2b).

Families would usually take the sheet away and consider at home, and return with a response the following week.

Although it was not expected that only families who continued into treatment after assessment participated in the research, this was in fact what happened, suggesting that the relationship of trust in the service, and willingness to participate, were related.

As regards the success of recruitment of all family members at T1, this varied between families. It appeared generally that mothers headed the process of consenting or declining. Where 10 families were recruited, this in practice meant 10 mothers. Eight of 10 fathers consented, and five of 10 children. Fathers and children were also more likely to drop out at T2.

Table 1 summarises the final status of recruitment at both time points.

Table 1. Interview status at end of project

Identifier	T1	T2	Full sets
F1 M	✓	✓	✓
F1 D	✓	✓	✓

F1 C	✓		
F2 M	✓	✓	✓
F2 D	✓		
F2 C			
F3 M	Damaged	✓	
F3 D	✓	✓	✓
F3 C	✓	✓	✓
F4 M	✓		
F4 D			
F4 C			
F5 M	✓	✓	✓
F5 D	✓	✓	✓
F5 C	✓	✓	✓
F6 M	✓	✓	✓
F6 D			
F6 C		✓	
F7 M	✓		
F7 D	✓		
F7 C			
F8 M	✓	✓	✓
F8 D	✓		
F8 C	✓	✓	✓
F9 M	✓		
F9 D	✓		
F9 C			
F10 M	✓		
F10 D	✓		
F10 C	✓		
TOTAL	23	13	11

Identifiers with a strike-through in column 1 indicate individual members of a family who did not consent to participate at either time point.

It can be seen that of a total possible 60 interviews over both time points, 36 (60%) were achieved; 23 of a possible 30 (77%) at T1, and 13 of a possible 30 (43%) at

T2. Mothers were most likely to stay the course. Eleven complete interview sets (T1 & T2) out of a possible 30 were achieved. Possible reasons for difficulties in the recruitment of children are discussed in the next section, and reasons for dropout, particularly in relation to Fathers, are considered in Chapter 6.

High rates of drop-out in both treatment and research in AN have been reported, for example, in a systematic review by Dejong, Broadbent and Schmidt (2012), who reviewed 19 studies across a range of treatments, concerning adults and adolescents. They found the drop-out rate from family therapy, which usually included adolescents, to be the lowest (4.8%), while Lock et al. (2010), on the other hand, reported a higher rate of refusal or dropout for FBT (21.4%) compared with AFT (6.7%). A recent study of the willingness of adults with a lifetime history of eating disorders to participate in health research found that such individuals at least reported themselves to be significantly more willing than other users of a U.S. community health project to participate in research (Nutley, Varma, Chen & Striley, 2019).

Where one or more family members in this study sample refused the interview, interviews still went ahead with consenting family members.

Each participant signed a consent form. These were written separately for parents (Appendix 3a) and children (Appendix 3b).

3.3.3 Problems in the recruitment of children

It can be seen from Table 1 that five out of ten children refused consent to the interviews. One child, C6, agreed to be interviewed at T2, after the end of treatment. At T2, two further children (C1 & C10) dropped out, reducing the number of total T2 interviews to four, and the total number of child interviews to nine. C1 refused and C10 and her family could not be contacted.

Why might the children have been more inclined to refuse the interviews at T1?

As mentioned in the previous chapter, we may speculate that children with eating disorders may feel very private and even secretive about their thoughts, feelings and motivations for the eating disorder.

They may be suffering from difficulties in putting feelings into words (known as *alexithymia*, previously considered associated with eating disorders but now more likely to be associated with autism spectrum disorder).

They may have lacked trust in the service and the interviewer. Where parents hoped that their children would get better through treatment in the service, children may have felt in opposition to treatment, owing to the well-known 'ego syntonic' nature of the disorder, regarding their symptoms as desirable and perhaps necessary.

Finally, one might speculate that for some children, refusing to participate in research that their parents consented to, was one small expression of opposition to their parents. The children and young people in the families recruited were at the younger end of the age spectrum and therefore more likely to be under parental pressure to adhere to their parents' decision to attend treatment. The refusers at T1 were mostly at the upper end of the age range of the sample: C2 (14), C4 (13), C6 (16), C7 (13), while C9 was 11. Further demographic data can be seen in Table 2, below.

A literature search using the terms 'children', 'eating disorders' and 'research' identified no results relating to issues with recruitment and dropout of research with children with eating disorders.

3.3.4 Sample

The research took place in a national specialist eating disorders outpatient clinical service. It was a centre that was known for its expertise in early onset AN and was therefore the treatment service of choice for pre-pubertal children with AN, though available to children up to age 16. It was also available for children and their families where locally available treatment had failed or not fully met their need. Thus it was a diverse treatment cohort in all respects, particularly in terms of treatment history.

The sampling therefore was naturalistic, that is, research participants were recruited sequentially from those presenting at the service from the time that the research project received ethical approval. Besides the exclusion criteria mentioned, no attempts were made to recruit a sample representing any particular spread of features.

A result of this sampling approach was that no families with boys with an eating disorder meeting the inclusion criteria presented during the period of recruitment. The fact that all child subjects were female is reflected in the title of the study.

This apparent bias to some extent, at least, reflects the differences in incidence and types of eating disorders in boys and girls, and in the respective rates of presentation at services. It remains the case that the single largest risk factor for developing an eating disorder is being female (Nicholls & Viner, 2009), and that the majority of sufferers are girls and young women. It has been estimated that 25 per cent of individuals with AN are males, and that for other types of eating disorders, men and boys may have nearly as high an incidence as women and girls (Mond, Mitchison & Hay, 2014). It is believed that boys and men do not come to eating disorders services in the same proportion to incidence as girls and women. In fact, reliable statistics for the incidence of eating disorders in boys, diagnosed and undiagnosed, are hard to come by. Academic reports generally suggest that 25 per cent of community sample with eating disorders are male, and only 10 per cent of clinic based samples (Sweeting et al., 2015).

ARFID (Avoidant Restrictive Food Intake Disorder) was potentially included in this study as it is a restrictive eating disorder and, furthermore, was accepted for treatment at the service where the research was carried out. However, no boys with either AN or ARFID presented during the recruitment phase.

A further result of the recruitment context was that the recruited cohort was diverse and had few homogenous characteristics, beyond the femaleness and the youth of the children compared with the average age of incidence for AN, believed to be at its highest for girls aged 15-19 (Micali, Hagberg, Petersen et al., 2013). As a national service with no defined referral pathway, patients and their families reached the service for a number of reasons and through a number of routes. Examples of reasons for referral might include: poor or inadequate local provision of services; complexity, either in terms of treatment resistance or co-morbidity; parental persistence in requesting referral to a national service perceived as having greater expertise; poor treatment alliance with the local service and the request for a second opinion, or a combination of these. For all the reasons above, the research cohort was heterogeneous and many types of family, child and illness and treatment journey were represented, precluding the drawing of any conclusions in the analysis based on cohort characteristics.

T1 interviews began on 13 November 2012 (D1) and continued until 22 July 2014 (D10); T2 interviews began on 26 April 2014 (M3 and C3) and continued until 10 July 2015 (D5). T2 interviews took place whenever families made themselves available a minimum of one year after T1; most T2 interviews took place between 12 and 18 months after T1 but in the cases of F1 and F2, interviews were two and a half years apart, owing to the length of subsequent treatments of the children. That is, treatment at the centre where the research took place was not the last treatment.

Table 2 below gives key demographic data about the child in each family, including information about treatment before and after the service where the research took place.

Table 2. Demographic table

	Child age	Family intact	Sibs	Home	Parent educ	M employ	F employ	Parent past ED	MH problems in family	Physical illness/ family bereavement	T1 First tx/ previous tx	T2 recover/ more tx
	1	2	3	4	5	6	7	8	9	10	11	12
F1	10	Yes	O	Far	Higher	No	Yes	D	Yes	No	Prev	More
F2	14	Yes/no*	No	Near	Higher	Yes	No		Yes	Yes	First	Recov
F3	11	Yes	O	Near	Higher	No	Yes		No	No	First	Recov
F4	13	Yes	Y	Near	Higher	No	Yes	M	Yes	Yes	First	More
F5	14	Yes	O	Near	Higher	No	Yes		No	Yes	First	Recov
F6	15	No	Y	Near	Higher	Yes	Yes	M	No	No	Prev	Recov
F7	13	Yes	Y	Near	Higher	Yes	Yes		No	Yes	First	More
F8	14	Yes	O/Y	Near	Higher	No	Yes		Yes	Yes	Prev	More
F9	11	Yes	Y	Far	Higher	No	Yes		No	Yes	Prev	Not known
F10	11	Yes	O/Y	Near	Higher	No	Yes		Yes	Yes	Prev	Not known

1. Age at Time 1 interview
2. *F2 separated between Time 1 and Time 2 interviews
3. O/Y refers to older and younger siblings
4. Near or far from treatment centre; ie. travel required. 'Near' within 50 miles.
5. Best estimate based on employment.
6. At time of T1 interview. M8 and M9 had given up work to care for designated child, others were not working before.
7. D2 had given up work to care for designated child.
8. As reported by parents themselves.
9. As reported either in assessment, clinical records or in interview. May refer to parents or wider family/generation.
10. As reported either in assessment, clinical records or interview. Refers to a family member with a current or recent illness or bereavement.
11. Presentation at the researcher's service a first presentation or subsequent. Earlier treatment for mental health problems other than eating disorder has been included where known.
12. Child recovered or continuing to receive further treatment elsewhere at time of second interview. No data are known for F9 and F10. but a telephone conversation

3.3.5 Interview process

Interviews were audio recorded. Interviews were stored securely with no identifying data on the voice files except date of interview and a moniker for each family, as follows:

F1 signified Family 1

M1 (1) mother in Family 1, Time 1

M1 (2) mother in Family 1, Time 2

D1 (1) father in Family 1, Time 1

C1 (1) child in Family 1, Time 1

and so on. These have been used consistently in all analysis and presentation of results in this study.

Parents were given the option not to mention their child's name while speaking on tape to doubly protect anonymity.

Interview protocols were shared with the participants and followed in the same way in each interview. In particular, although there was a set order of questions, it was also explained to participants that the interview's semi-structured style allowed for going back and forth between topics, in order to encourage a natural, conversational flow where the interviewer was free to follow up participants' topics as they appeared.

Each interview began with an opening statement in which the interviewer/PI distinguished the research from families' treatment and emphasized that the content of the interview would not affect their treatment. The full text of the statement can be seen in the interview protocol for parents (Appendix 4a) and for young people (Appendix 4b).

Sometimes in the course of the interviews, parents would mention events in treatment or stories heard and told in the parents' group. At these times it was pointed out that topics from the interviews would not be shared with the treatment team, and that if parents actually wanted to address their treatment team about an issue that had arisen in the interview, they would need to do this themselves and not through the interviewer.

3.3.6 Interview design

Finding the right words and phrasing for the research protocol to express ‘meaning-making’ was one of the most challenging tasks of the design stage of the study. In addition, the best way of phrasing questions and structuring the interview so as to stimulate participants’ reflection and original thinking, was intensively discussed and underwent several revisions after consultation with senior colleagues experienced in research, and supervisors.

The interview protocol needed to take into account both the exigencies of both IPA and RF as these were the intended, mixed methods of analysis.

‘Meaning-making’ was named as ‘understanding and making sense’. It was further broken down into four separate domains:

1. UNDERSTANDING - making sense of

Stem question: How do you understand/make sense of your/your child’s eating disorder as it is at the moment?

2. IMPACT - on self, social world, family and peer relationships – then and now

Stem question: How does your/your child’s ED impact on your life?

3. VALUE - does/did anything good come out of it?

Stem question: (Parents) Is there anything that [child] values about the eating disorder? And for yourself: is there anything good or valuable that has come out of it?

(Child) Are there things you think are good about your ED?

4. RECOVERY - what is/was needed to get better?

Stem question: Looking ahead... What do you think is needed now for you/your child to get better?

Prompts were included to allow conversation to flow. Prompts were also used to probe for RF, known as ‘demand questions’ (Fonagy, Target, Steele & Steele, 1998; Ensink, Target & Oandason, 2013). These are discussed in more detail in Chapter 8 in connection with the Results of RF analysis.

For the full interview schedules, see Appendices 4a and 4b.

The four domains were followed in chronological order in every interview and also contributed to the organizing and analysing of data as will be seen in Chapters 5-9 where Results are presented.

The Value question is of particular interest, as it was formulated on the basis that it is known that for young people, at least, AN may bring a number of valued feelings and behaviours (Koruth et al., 2012; Nordbø et al., 2006; Serpell et al., 1999). Therefore the question made the assumption that there could be value for the young person. It was hoped that showing this knowledge, or 'expertise', would allow young people to elaborate more easily. The question had a double meaning for parents, where they were both asked to think about their understanding of the putative value of AN for their child, thus probing for mentalizing, and on their own lives. Indeed there has been little research indicating value for parents, on the contrary, most research into parents' experience has yielded strongly negative results as was shown in the literature review in Chapter 2, Section 2.5.1.

Nevertheless, as will be seen in Chapter 5 reporting on the IPA Results for mothers, there were some unexpected findings in this area.

3.3.7 Time points

Participants were informed at the point of recruitment and consent that they would be contacted for a follow-up interview after the end of treatment. It was made clear that they could refuse consent to this second one although it would be valuable to the research.

T2 was set after families' discharge from the service because it was thought that the richness of the interviews would be enhanced if participants were reasonably settled and not in crisis at Time 2. In addition, it was hypothesized that lower levels of anxiety and affective arousal at T2 would allow for higher levels of mentalizing and hence higher RF scores, in accordance with the theory that mentalizing suffers when affective arousal is high. Hence there was flexibility around T2 depending on the individual circumstances of each treatment trajectory. It was felt that this flexibility was appropriate given that the study was not an evaluation of treatment outcome, and that richer interviews would ensue. This flexibility resulted in some Time 2 interviews taking place up to two and a half years after Time 1, while others took place one year after Time 1. As could be seen in Table 2, the children in this sample had a varied

treatment career after their time in the service of the researcher and this meant that a suitable time for T2 occurred later for those who went on to more treatment.

3.4 Method of data analysis

Interviews were transcribed and analysed twice, once by means of IPA and once for RF.

All interviews were transcribed and analysed line by line, using first the IPA method, followed by a second reading assessing RF, and annotated for each. Below follows a description of this process step by step.

1. Transcripts were formatted in a table with empty columns to the left and to the right.
2. The left-hand column was designated RF. Lines or sections of the interview deemed to demonstrate a type of RF were highlighted in red in the text, and the type of RF allocated written in the column, along with any observations.
3. The right-hand column was designated IPA. Lines or sections of the interview deemed to be relevant either to the pre-existing interview domains of Understanding, Impact, Value and Recovery, as well as other emerging sub-themes, were highlighted in blue. Notes were made in the margin. The start of a new interview theme was noted in capitals to help orient during subsequent readings. If a theme was returned to later in the interview, its heading (e.g. VALUE) was written anew in capitals.
4. All annotated interviews were saved in this format and an example for a mother, father and child can be found in Appendix 5a, 5b and 5c.
5. At the same time as interviews transcripts were annotated and coded in this way, a table collating each individual parent's IPA themes was being constructed. Each table was constructed according to the same template. Across the horizontal axis were the four pre-determined themes of the interview, Understanding, Impact, Value and Recovery. The first two had columns alongside allowing for the researcher's own comments. Along the vertical axis themes were listed as they appeared in the text, and allocated to the correct domain. Below the grid was a series of rows containing extracts from interviews illustrating certain themes. Fathers' tables covered both T1 and T2 interviews, mothers' only T1 and a different method was applied for T2. Four examples of the individual IPA thematic collation for mothers and fathers can be seen in Appendix

6a-d. (All individual tables are available upon request). Children's IPA themes were collated into one large table, Appendix 6e.

6. At the same time as the IPA tables were being filled in, a spreadsheet recording RF scores for all four domains individually, as well as total RF scores for whole interviews at T1 & T2 was also being filled in. The spreadsheet was converted into Table 13 (see chapter 8).
7. As the analysis of interviews progressed, comparisons within sub-groups and within families could be made. As a result, themes sometimes were added or re-allocated.
8. Further iteration and modification also took place as fathers interviews were analysed and tabulated, which took place after mothers' interviews, and this amplification shed a two-way light on themes in both.
9. This process of iteration continued as children's interviews were analysed and tabulated, and compared with their parents' interviews and with other children's.
10. Writing and analysis became bound up with each other. The iterative process continued until the end of writing, as re-readings of interviews were likely to yield new themes or modifications of existing themes.

This process followed the guidance for systematic thematic analysis in general in Smith (2009), including the allowance for the researcher's own variation and innovation.

3.4.1 IPA - Ordering results- IPA

For IPA analysis, this process led to identifying themes at three levels.

1. *Phenomenological themes at the individual level*, that is, themes relating to the interview subject's current experience of living with and caring for their child with an eating disorder, or for the child, of having an eating disorder. This level of thematic analysis also included observation and notation with regard to the emotional experience of interview participants, often implied through tone and language and sometimes also expressed directly.

2. *Phenomenological themes at the group level*, that is themes that were shared between at least two interview participants, called over-arching themes.
3. *Interpretative themes*, that is themes elicited through the researcher's interpretation of features of the interview itself.

Several factors could contribute to an interpretative theme. Besides noting both manifest and latent content (Joffe, 2011; Smith 2004), note would also be made of, for example, the use of extreme or unusual language and extreme or unusual ideas, or the amount of time and space in the interview devoted to a particular topic according to the subject's own choice, the recurrence of a theme in different contexts, expressed or implied emotion, and other features, demonstrated and discussed further in relation to the data itself in Results Chapters 4 and 5.

These features were interpreted as relating to underlying, unspoken or partially spoken thoughts and feelings that were perceived to permeate the interview subject's material. This interpretative level represents a more tentative but also bolder component of the analysis with IPA. The researcher became a more active, freely thinking and reflecting, participant in the analysis process. In the chapters that follow will be presented both the themes themselves, and the steps by which they were arrived at.

3.4.2 IPA - Collating and presenting results

Results were collated and presented in tables at the individual and in sub-group levels for IPA. Sub-groups were composed of mothers, fathers and children respectively.

The following tables for presenting IPA results were constructed:

Tables 5 and 8

These are examples of individual thematic tables for each parent interviewed, encompassing T1 one for mothers and T1 & T2 for fathers. One table each is shown within the Results chapters respectively and further examples of these tables are in Appendix 6a-d.

Tables 3, 6, 7 and 9

These four tables represent all mothers' and all fathers' qualitative themes at the sub-group level, mothers and fathers presented separately. The IPA analysis resulted in a separation of themes into 'Phenomenological' and 'Interpretative', broadly speaking representing more cognitive and more emotionally communicated themes respectively. These intriguing findings have been further explained and illustrated in the Results chapters for mothers and fathers respectively.

3.4.3 RF - Ordering and presenting of results

RF was presented at the group level in a variety of ways and combinations.

Key to the assessment of RF was the question of whether RF changed over the time that elapsed between T1 and T2. This was more difficult to assess where T2 interviews were sparser, as they were for both the sub-groups of fathers and children.

It was also interesting to compare children's and parents' RF within the same family.

RF was presented in **Tables 13-17 and Figure 1** as follows:

Table 13 RF for all participants at both time points. Parents RF was also shown for each interview sub-domain.

Table 14 RF for parents only.

Table 15, 16 and 17 set RF alongside the IPA qualitative results for mothers, fathers and children respectively.

Figure 1 showed RF change over the two time points in family groups.

Results are discussed in the chapters that follow.

Chapter 4 presents and discusses IPA Results for Mothers at T1

Chapter 5 presents and discusses IPA Results for Fathers at T1&T2

Chapter 6 presents and discusses IPA Results for Children at T1&T2

Chapter 7 presents and discussed RF Results for all participants

Chapter 8 presents and discusses IPA Results for Mothers at T2.

The analysis of mothers' interviews at T2 was separated sequentially because its findings present a type of coda to the other results and, in places, help the researcher and reader to make sense retrospectively of the themes presented earlier.

3.5 A review and evaluation of available research methods and rationale for choice of methods

At the start of the research, the hope was expressed in a preliminary chapter (written for the upgrade to doctoral study), that the research methods used would result in a “creative bringing together of the tradition in qualitative research of non-leading but facilitative questions that allow the subject to elaborate freely, with some psychoanalytically informed ‘probing deeper’.”

Statistical methods of data analysis were excluded even for the quantitative data, beyond numerical description by virtue of the small sample of families manageable for a single researcher-clinician to interview, together with the dropout rate.

Despite this, at the very early stages of development of the project, the hope had been to find out whether there might be any association worthy of further study, between the process of making meaning of the eating disorder, and improved outcomes.

Recent studies of the impact and outcome of FBT give some preliminary support that ‘meaning-making’ might be a subject relevant to treatment and worthy of further study (Forsberg et al., 2018; Lock, 2015; Richards et al., 2018; Wagner et al., 2016; Wufong et al., 2019).

Even had the number of research participants in this study not been too small to allow statistical testing of the association between meaning-making and recovery, key operational questions would have remained, such as:

- How should ‘meaning-making’ be defined?
- How should it be measured?
- How should recovery be assessed and measured?
- How should other factors affecting outcome be controlled for?

Other methods of approaching the question, probably more appropriate and richer than statistical analyses, were then explored.

The first port of call, when looking for a research method to uncover personal, possibly as yet unarticulated meanings, thoughts and feelings, might be thought to be research in psychoanalysis and psychoanalytic child psychotherapy. Psychoanalysis and empirical research have historically been considered incompatible research paradigms (Fonagy, 2003; Midgley, 2006).

The next sections review, first, possible research methods in the child psychodynamic framework. Second, three of the most accessible options for qualitative research methodology are reviewed. Third, research methods using RF are set out. Finally, the emerging field of psychoanalytically informed qualitative research is reviewed. The rationale for the methodological choices made is elaborated.

3.5.1. Consideration of psychoanalytic child psychotherapy research

At the present time, there is no qualitative research method routinely used by child psychotherapists. There have been some attempts to develop research methods that would both preserve the particularity and clinical detail of child psychotherapy and also meet criteria for systematic research, but as yet these are in their infancy, insofar as their use and application is concerned; the body of research in child psychotherapy is small, incoherent and composed mostly of quantitative studies, very few studies have been produced by clinically active child psychotherapists in the UK (Midgley & Kennedy, 2011; Midgley et al. 2017, Palmer et al., 2013).

In child psychotherapy doctoral training programmes in England, one method only has been adopted for students' theses, namely Grounded Theory. The pros and cons of this method to fill the yawning research gap in child psychotherapy have been debated (Rustin, 2003, 2016; Fonagy, 2003). Rustin argued that research 'takes place in the consulting room', while Fonagy asserted the urgent need to demonstrate outcomes of child psychotherapy; the two purposes being something akin to apples and pears.

In addition, there have been some attempts to bring together existing qualitative methodology with something like 'countertransference', or 'researcher reflexivity', that would allow the researcher to use their own emotional or affective experience, when reflected upon, to inform the interpretation or other use of their data (Hollway & Jefferson, 2000; Midgley, 2004a, 2004b, 2006, Strømme et al., 2010). This field certainly seems ripe for development (Holmes, 2013).

3.5.2 Consideration of grounded theory

“Grounded theory sets out to discover or construct theory from data” (Tie, Birks and Francis, 2019). The method was developed by Glaser and Strauss (1967) during a study on how terminally ill patients behaved in relation to their differential levels of knowledge about their health status, and through it, the ‘constant comparative method’ was born, considered the unique feature of grounded theory. The constant comparative method is an iterative process whereby the researcher produces theoretical ideas drawn from the data, while always returning to existing and further data for comparison and further production of theory. Data collection and analysis are advanced simultaneously. Grounded theory has undergone evolution since the original account by Glaser and Strauss (1967), through divergent work by Strauss and Corbin (1990) and more recently, the work by Charmaz (2006, 2009), which is described as ‘constructivist’.

Charmaz is a proponent of grounded theory in its modern form (Charmaz, 2009), whose main research has been on chronic illness and identity in addition to her theoretical contributions on grounded theory. She summarises the main tenets of grounded theory research process and analysis in these bullets:

- “simultaneous involvement in data collection and analysis phases of research
- developing analytic codes and categories from the data, not from preconceived hypotheses
- constructing middle-range theories to understand and explain behaviour and processes
- memo-writing – that is, analytic notes to explicate and fill out categories
- making comparisons between data and data, data and concept, concept and concept
- theoretical sampling – that is, sampling for theory construction to check and refine conceptual categories, not for representativeness of a given population
- delaying the literature review until after forming the analysis.” (Charmaz, 2009, p83)

Charmaz’s emphasis is more on the dynamic interaction between the researcher and the subject of research, including the data, and the interpretations that emerge. She writes,

“Perhaps their enthusiasm for developing an inductive methodology that anchored emergent theory in data led Glaser and Strauss (1967; Glaser, 1978) to imply in their

early works that categories inhere in the data and may even leap out. I disagree. Rather, categories reflect interactions between the observer and observed.” (Charmaz, 2009, p86).

Grounded theory has become the main research method for child psychotherapy doctoral candidates in the U.K., spearheaded by the Tavistock Clinic child psychotherapy clinical doctoral programme, where it is the only taught method. Anderson (2003, 2006), an early user of the grounded theory method of research and doctoral graduate of the programme, described child psychotherapy and grounded theory as ‘well-suited partners’, making an effort to shoehorn its principles, and the principles of qualitative research, into partnership with child psychoanalytic therapy sessions, without making changes to the latter. Her thesis, ‘The mythic significance of dangerous, risk-taking behaviour’ (Anderson, 2003) involved voluminous record keeping from both clinical sessions and real-world case data. The method of analysing data ‘from the inside’ appeared extremely interesting, as well as laborious. Nevertheless, the sources of data were only partially from the research participants themselves. Data was also drawn from: “child’s history, mother’s history, father’s history, family history, emotional environment of the child, presenting difficulties and their history” (Anderson, 2006, p340) and referral and assessment reports.

A critical reading suggests that ultimately the author succumbed to forcing a voluminous and unwieldy amount of data, including an unexpectedly large volume of data from third party sources, into overarching, pre-existing psychoanalytic categories, such as ‘the Oedipus complex’, without distinguishing whether these were descriptive or explanatory categories. The grounded theory analysis ultimately became indistinguishable from a traditional psychoanalytic case formulation, where a great number of factors are assembled and causality is assumed. Anderson’s summary of the process of grounded theory analysis begins:

“Family violence, family complexity (indicating the numbers of family members who were temporary members of the family unit) and the unsafeness of family members in the home were found to be common factors, as was the absence of fathers, and the unsatisfactory childhood experiences of parents which often included sibling violence. All of the children were found to be either victims or witnesses of violence and each family had at least one member who had been expelled or who was threatened with expulsion. All of the children used the manic defence and did not recognise generational boundaries. One factor that seemed to be a possible core

category was mothers who were hated by their mothers because of their gender.” (Anderson, 2006, p341)

The resulting interpretations seem far removed from the data and to be born out of combination of the author’s psychoanalytic theoretical knowledge and a reading into the material without tracing back to the actual data.

Charmaz’s fascinating and creative work notwithstanding, it was concluded on several grounds, that grounded theory did not fit the requirements of this study.

First, and practically, its iterative method, moving between data and analysis in a continuous pendulum, or spiral, did not fit with the planned method of recruitment, where recruitment would be completed first and analysis conducted second.

Second, Anderson’s (2003, 2006) study, despite its claim to be a ‘well-suited’ method for researching clinical data, did not offer a model for combining a psychoanalytic theoretical framework with qualitative data analysis.

Third, the grounded theory method seemed to go in the wrong direction, as the intention was not to generate new theoretical concepts or categories. Rather traditionally, this study began with a clinical observation that produced some research questions that required an answer. A more linear research method was required.

For this reason, the mass of data that grounded theory seemed to require seemed a wasted resource. The method seemed unwieldy and grounded in chaos yielding eventually to a unpredicted shape or structure – described by its proponents as a creative, even magical process. This seemed unmanageable and too complicated for the purposes of this study, which was essentially quite straightforward.

3.5.3 Consideration of thematic analysis (TA)

Thematic analysis presented itself at the opposite end of the complexity spectrum, straightforward in its intentions and free of epistemological-philosophical underpinnings or research procedures that would require substantial practice and study in their own right. Thematic analysis was described as “a poorly demarcated, rarely acknowledged, yet widely used qualitative analytic method within psychology” (Braun & Clark, 2006), and “a method for identifying and analysing patterns of meaning in a dataset ... It

illustrates which themes are important in the description of the phenomenon under study. The end result of a thematic analysis should highlight the most salient constellations of meanings present in the dataset. Such constellations include affective, cognitive and symbolic dimensions.” (Joffe, 2011).

Braun and Clarke went on to argue that thematic analysis could be ideally suited for those new or inexperienced in qualitative data analysis, who might be looking for a systematic yet flexible approach to organizing data, but that any thematic analysis needed to make its theoretical position and assumptions clear and transparent.

In fact, Braun and Clarke asserted that

“...grounded theory seems increasingly to be used in a way that is essentially grounded theory ‘lite’ - as a set of procedures for coding data very much akin to thematic analysis. Such analyses do not appear to fully subscribe to the theoretical commitments of a ‘full-fat’ grounded theory, which requires analysis to be directed towards theory development.” (Braun & Clarke, 2006, p81).

Joffe (2011) argued that thematic analysis allowed for the recognition and exposition of both ‘manifest’ and ‘latent’ themes, and that inductive and deductive reasoning could be used together in this method.

Joffe considers that thematic analysis is particularly well suited for “elucidating the specific nature of a given group’s conceptualisation of the phenomenon under study”, including symbolic meanings and her own research concerns large population samples and popular conceptualisations of a social phenomenon (such as her own research the spread of infectious diseases). At the time of searching for a suitable qualitative method for this research project, TA seemed appealing in its flexibility and simplicity and capacity, but most of the studies using it seemed to use larger samples, nor scope for ‘latent’ or ‘personal’ meanings at the same depth that was hoped for. As the researcher was new to research and to qualitative research, models of practice were needed and not obviously available within TA, precisely because of its ill-defined and fluid nature.

‘What is a theme?’ is a theme addressed by writers on thematic analysis, and they note possible definitions. The following is a condensation from Braun and Clarke (2006) and Joffe (2011).

Prevalence is a common-sense approach to identifying a theme, across the entire data set, or in a proportion of participants, or within certain sub-groups of participants.

Rich description offers a way of searching for and identifying a particular theme, often 'latent', particularly if the method of identification is deductive, that is, driven by a pre-existing theory or expectation.

Inductive thematic analysis describes searching for themes from the data and attempting to approach the data with as little preconceived theory as possible. This means that the themes identified might bear little relation to the original research question(s). It is generally acknowledged by all writers on qualitative research methods that researchers cannot free themselves of 'theory' completely as one cannot have an 'empty mind'. Therefore the usual advice is to be as 'transparent' as possible about pre-existing theories, expectations and intentions that the researcher brings both to the data gathering and to the analysis.

Deductive thematic analysis acknowledges the pre-existence of theory, whether in the research question(s) themselves or in the minds of the researcher(s), and explicitly comes to the thematic analysis of the data with these factors in mind. This may mean that data that is not relevant to the theoretically formulated research questions may be dismissed from the analysis.

In the case of this study, research questions were specific (see Section 3.2) and derived from both pre-existing theory and clinical observation and experience. This was transparent, as was the data analytic process that followed. At the same time, attempts were made to remain open to unexpected phenomena in the data, and as will be shown, this yielded unexpected results.

Like Charmaz, Braun and Clarke (2006) take issue with the idea of 'themes emerging' like autonomous entities from a mist clearing, and emphasise the active, shaping and interpretative influence of the researcher on both the research participants and the data. A method with a clear stance on the interpretative function of the researcher seemed required for this study.

3.5.4 Consideration of Interpretative Phenomenological Analysis (IPA)

IPA, a latecomer to the qualitative research methods stable (Smith, 1996), is likely one of the most popular methods of qualitative psychology research at the present time.

IPA offers an appealing combination of potentially quite uncomplicated methods of data gathering, usually interview or written sources such as diaries; a linear method of analysis, with allowance for flexible methods of analysis; permission for the researcher to apply transparent interpretation, and a foundation in the relatively comprehensible philosophy of idiographic epistemology. The wish to capture research participants' 'lived experience', as Husserl's (1931) epistemology is often distilled as, is an uncontroversial ambition to embrace.

IPA offers a clear distinction between epistemology and interpretation, thus supporting the ambition of transparency. Breadth and depth may be combined in analysis, which permits themes to be analysed both within and across groups and sub-groups, as well as the unique perspectives of individuals.

Interpretation leading to partially buried personal meanings is supported. "Husserl's work has helped IPA researchers to focus centrally on the process of reflection" (Smith, Flowers & Larkin, 2009, p16). The 'interpretative' in IPA added the opportunity to make good the aspect that many psychoanalytic clinicians claimed to miss in qualitative reports, that is, an actual encouragement of the researcher's own perspective and interpretation of the qualitative data collected, so as to go beyond merely reporting what interview participants said. (Midgley, 2006; Holmes 2013)

Descriptions of IPA often use the phrase 'making sense of' to describe several processes: the intended focus of a research interview, the process of the researcher analysing the material gathered in interview, and an observation of the research participants trying to make sense of things themselves. "A two-stage interpretation process, or a double-hermeneutics, is involved. The participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world." (Smith & Osborn, 2009, p55) IPA is also said to be particularly suitable when "complexity, process or novelty" characterize the topic of study.

IPA was an appealing methodological option for this study, with its combination of emphasis on personal meaning, thematic flexible mode of analysis, an invitation to researcher interpretation, and the advice to use IPA for purposive sampling on small

sample sizes because of its rich data. This suited the aim of the study and capacity of a single researcher well.

It was anticipated that the interpretative aspect of IPA might particularly be required for going beyond what may be called 'habituated material', that is, constructions of 'meaning' that might be variations on received orthodoxy in the field. This might be expected in treatment for eating disorders where families at the beginning, at least, receive a manualized treatment, a degree of 'one size fits all', with the agnostic stance regarding aetiology. An example of this could be the statement made repeatedly by a parent in the Parents' Group when discussing their child's anorexia: 'It's multi-factorial.'

As represented, IPA should sit well with interpreting beyond the spoken words alone (Midgley, 2004; Smith 2004). An interesting and inspiring combination of IPA with psychoanalytic material can be found in Midgley, Target & Smith (2006) 'The outcome of child psychoanalysis from the patient's point of view: A qualitative analysis of a long-term follow-up study.' They wrote of the 'disturbing' effect of having the patient's perspective on their own therapy in a field where traditionally (at the time of publication) the therapist's perspective had been prioritized. It is hoped that a similar sort of disturbing effect may be found in this study where the accounts of mothers, fathers and children in the same family are collected and set alongside each other, in both family groups and groups of mothers, fathers and children.

3.5.5 Consideration of RF

RF is the gold standard measure of mentalizing in adults (Fonagy et al., 1998), designed for the Adult Attachment Interview (AAI) (George et al., 1985); it has been adapted and extended for use on interviews with parents (Slade, 2005) and children (Ensink et al., 2013). It was chosen as the method for operationalizing 'the extent of meaning-making' as described in Section 3.2. RF is not a measure of the content of subjective experience but rather an assessment of the interviewee's focus and complexity of thinking in terms of mental states and motivation (psychological mindedness), as a way to understand personal history and relationships. It allows the rating of the qualitative data from a guided conversation such as a semi-structured interview. The interviews in this study were designed to probe for RF both in the main domain of 'Understanding and Making Sense' and in the probes for the subsequent domains of Impact, Value and Recovery.

As described, the original spark for the study was the observation of variation in parents capacity and inclination for imagining themselves in their children's shoes mentally and emotionally, known as mentalizing (Fonagy, Gergely, Target & Jurist, 2004).

Mentalizing has associated constructs, such as 'insightfulness' (Koren-Karie et al., 2002, Koren-Karie & Oppenheim, 2018). Fearon (2018) provides a commentary on the relationship between mentalizing and associated constructs. He points out that an important component in the theory of mentalizing, is that the capacity for mentalizing is a fluctuating capacity dependent on the subject's mental state.

"In our work on Mentalization-Based Treatment for Families (MBT-F, Keaveny et al., 2012), we take the view that a great deal of the low insightfulness that can characterize struggling families does not reflect a lack of basic capacity for insight. Instead, we think of this as resulting from the effects of chronic stress and chronic patterns of unsupportive and non-mentalizing family interactions. These chronic patterns of interaction make seeing or understanding each other in new ways very difficult. The challenge often seems to be to find some way of creating a sense of curiosity in the minds of family members and a sense of sufficient security in the moment to explore." (Fearon, 2018, p343).

The idea that the capacity for mentalizing fluctuates according to participants' own psychological states is certainly pertinent to a consideration of the mentalizing of parents with children diagnosed with anorexia. It is well documented that parents with children with anorexia suffer powerful ill effects on their own mental health, well-being and functioning. (Cottee-Lane et al., 2004; Treasure et al. 2001; Whitney et al. 2005) and colleagues amply testifies – see literature review). Therefore, although low RF might have been clinically observable, this could not be assumed to be a stable trait. The need to observe RF over time was the impetus for conducting interviews at two time points, at beginning and after end of treatment.

The process of identifying and scales for scoring RF in parents and children respectively are demonstrated in Chapter 8 where RF Results are presented.

3.5.6 Consideration of psychoanalytically informed qualitative interviewing

There exists a small body of qualitative research, still pioneering, that aims to bring together aspects of psychoanalytic theory and practice, with qualitative interviewing techniques. The kinds of methods used may be akin to 'free association' or unstructured interviewing, where the subject is allowed to 'tell their story' and follow their own thoughts only minimally prompted by the researcher (Holmes, 2013; Hollway & Jefferson, 2000; Kvale, 1999; Strømme, Gullestad, Stånicke, & Killingmo, 2010). The analysis of such material usually invokes the theory of countertransference or splitting and projection (Holmes, 2013), or defence mechanisms more broadly (Strømme et al, 2010). While Holmes's self-reflexive account of two research interviews with immigrants in Bogota, Colombia is highly engaging, the reader arguably learns more about Holmes's thoughts and feelings and the 'selected facts' that he picks out of two long interviews rather than anything that may have general applicability. That is, his findings *may* have general applicability, but Holmes's method precludes generalising, and is limited by its n of 2.

There have been earlier attempts to integrate a psychoanalytic 'approach', with various defining characteristics, with qualitative psychology research. Kvale (1999) claimed that "major parts of knowledge" in psychology textbooks stemmed from psychoanalytic interviews although unacknowledged.

Hollway & Jefferson (2000) developed what they named their 'free association narrative method' in relation to research on fear of crime and the seemingly conflicting and irrational data in that field deriving from less idiographic research methods (e.g. one of their starting point questions was, why are women more afraid of crime than men when they are less likely to be victims of crime?)

Although Hollway & Jefferson are always cited as pioneers of 'doing qualitative research differently' (Hollway and Jefferson, 2000), their method is rarely replicated because the method is laborious and resource intensive, highly subjective and dependent on the researcher's own self-mentalizing, resistant to validation, and despite all this effort, yields only a small volume of data.

Strømme et al (2010), in their attempt to conduct psychoanalytically informed research qualitative interviews with trainee therapists about their experience, spelled out that interpreting data drawing on countertransference, depended on the assumption that the "relational attitudes" of participants were "robust across relations", meaning that transference would be akin to a stable trait rather than a feature that fluctuates

depending on the person being related to.

However, the assumption that transference is 'robust' or stable across relationships has been called into question with research in the attachment field showing that attachment status can change over time (Pinquart et al., 2013), and hence transference and countertransference interpretations extrapolated from a research interview could not be generalized to other areas of a research subject's experience.

As yet the putative field bringing together systematic methods and strategies from qualitative research with psychoanalytic methods, concepts and theories, though intriguing, remains uncharted territory.

3.6 Mixed methods

Two methods of data analysis are applied in this research, one qualitative, namely IPA, and one quantitative, namely RF. Bringing together discrete research methods is known as 'mixed methods', 'multimethods', or mixed and multimethods research (MMMR), a field of knowledge in its own right. Beginning in earnest in the 1970s, as part of the movement to advance qualitative research methods and findings, mixed methods research was first concerned with establishing frameworks and typologies for synthesizing or integrating qualitative and quantitative methods and data (Tashakkori & Teddlie, 2010; Bryman, 2006; Cresswell & Cresswell, 2018). This brought a degree of rigidity to the field, which in the most recent decade has been challenged on several fronts. Most recent proponents of mixed methods research hold that MMMR need not necessarily involve a quantitative and qualitative component but can use two or more methods from the same umbrella category, based on the perception that no method is purely quantitative or qualitative because data are always subject to interpretation; further, that there need be no rules for which stage or stages of the research process should be subjected to multiple methods, and that results need not, in fact, be 'integrated' at all insofar as integration implies a neat complementarity that may not reflect the reality ((Bazeley, 2018; Hesse-Biber & Johnson, 2015; Morse, 2015; Sanscartier, 2020; Uprichard & Dawney, 2019).

Recent work in MMMR highlights and underlines the importance and value of methods that don't fit together neatly. This could be because they illuminate differing perspectives, or uncover conflict within the data, or because the methods and designs themselves change and evolve in tandem with the emerging data (Hesse-Biber &

Johnson, 2015). Even data gathered from the same source, for example, a cohort of interview subjects such as in this study, can conflict internally as a result of several methods of data collection and data analysis. The words 'mess' and 'diffraction' have become technical terms in MMMR, denoting non-linear, iterative, non-complementary, recursive research paths (Sanscartier, 2020; Uprichard & Dawney, 2019).

Most writers attempt to define MMMR in terms of providing multiple or deeper perspectives on the same phenomenon or object of study. For example:

"In a sense, more *insight* into a problem is to be gained by mixing or integration of the quantitative and qualitative data... Mixed methods research, therefore, is simply mining the databases more by integrating them." (Cresswell & Cresswell, 2018, p213).

"Put simply, the concept of triangulation means that an issue of research is considered – or in a constructivist formulation is constituted – from (at least) two points or perspectives." (Flick, 2018, p528).

'Triangulation', somewhat confusingly, was also conceived an approach to validation of qualitative research methods and findings, an activity more concerned with asserting the robustness and reliability of the research process and findings and therefore with somewhat different aims than mining data at depth. It was proposed that the greater the number of domains in which triangulation was applied, the more claim to validity could be made. Triangulation in investigators, theories, methods (within and between), data and perspectives may be referred to a 'comprehensive triangulation', and was held up as an ideal.

But the research reality may not meet such standards. A typical, recent 'mixed methods' study is represented by the report by An Pham et al. report (2019) on disordered eating in transgendered youth, which used two sources of data, one quantitative (the Eating Disorders Examination - Questionnaire, [EDE-Q], Fairburn, Cooper & O'Connor, 2014) and one qualitative (semi-structured interviews). Results from each data source were reported separately. The EDE results were reported in percentages and the interview results in terms of themes. No attempt to have the results illuminate each other was made, let alone 'integrate' them.

Writers in the field assert that this is a common shortcoming in mixed methods research. For example, in 2006, Bryman published a review of 232 mixed methods

studies, where he stated as his aim to “move beyond typologies of the ways in which quantitative and qualitative are integrated to an examination of the ways that they are combined in practice”, and he found that

“An examination of the rationales that are given for employing a mixed-methods research approach and the ways it is used in practice indicates that the two do not always correspond.” (Bryman, 2006, p97).

Typologies, rules and checklists proliferate in the field. They may be exclusive and narrow, such as Bryman’s (2006) assertion that a ‘mono-strand’ study (that is, containing one source of data, such as the present study, where the semi-structured interviews would be viewed a single source) cannot genuinely be regarded as mixed methods. By contrast, Morse (2015) describes mixed and multi methods research in a way that would define the present study as containing multiple sources of data and highly amenable to MMR:

“We must think of mixed-method design as one-and-a-half studies; the supplemental component uses strategies that add data, which cannot be accessed by the core component, but is not a complete project in itself. Thus mixed-method designs increase the scope, and possibly the dimensions, of the project. They provide an answer to an additional sub-question, often a question that is significant to the project as a whole but that cannot be answered by the core project alone... *Because these different data are an incompatible analytic fit, the supplementary component cannot be incorporated into the core component until the results are separately analysed* (my italics.) For example, there may be

1. different types of data, requiring a different mode of analysis, most commonly numerical data and textual data... But there may be observational data, photographs, documents, maps, or anything that requires different handling or mode of analysis.

2. different levels of analysis—for instance, group data and micro-analytic data.

3. different groups that cannot be combined but are discussed separately to meet the needs of a research question: male and female, individual data and family data, data from a different ethnic groups, or data from two time periods.” (p208)

This summary seems indeed to describe the present study, with its core qualitative data collection and analysis through semi-structured interviews and IPA, and its subsidiary question about mentalizing capacity and its quantitative measure applied to the same interviews. Further, this study is composed of a number of potential sub-groups, such

as mothers, fathers and children; couples of adults, couples of one parent and child, and families. There are potential sub-categories, such as the temporal ones of Time1 and Time 2, or sub-cohorts such as those who stayed the full course, and those who partially dropped out. Further, going into the data itself, there are categories of those who were angry and blaming, and those who weren't, 'high mentalizers' and 'low mentalizers'; those parents who thought of their children in developmental terms and those who thought of them in terms of fixed personality traits. The more the data are 'mined', the more potential groupings emerge.

There are a number of ways to look at, analyse the data and follow hunches in this study. "Research always begins with a hunch, and this hunch becomes (or is modified post literature review) to form the *aim*." (Morse, 2015). Bazeley (2018) reaffirms the importance of connecting methods to the research question(s):

"Researchers freed from thinking about data and methods in binary terms will be guided in selection of data sources and methods of collection and analysis primarily by their purpose and questions, by the kinds of data that are accessible, and practically (though not desirably), by their analytic skills (or access to same)... mixed methodologists will be particularly attuned to the potential for iterative exchanges between data sources and between methods, as they work through a project (p338).

Therefore, this section furnishes a good opportunity to reiterate the original research questions in this study, and why two different methods of inquiry and analysis were chosen, before proceeding to analysis of the data themselves and then further inquiry and tentative interpretation derived or deduced from those data.

The first question concerned how parents *understood* their child's eating disorder, and how the children themselves understood their own eating disorder. For this inquiry, termed an exploration of meaning making, a qualitative method of data collection and data analysis was judged highly apposite. IPA allowed both the freedom and structure for participants to choose their own words and thoughts within a framework set and analysed by the investigator.

For this question, the researcher attempted to a certain extent to shape participants' understanding of the meaning of the question about meaning making, while also allowing participants significant latitude to arrive at their own accounts. Some things were clearly excluded from the concept of meaning making, such a chronological

narratives of events, or descriptions of typical symptoms of eating disorder pathology. As will be demonstrated, some parents and even a few children addressed the question of meaning quite easily, while others struggled to understand the question itself. For this latter group, the researcher attempted to scaffold the question, by rephrasing it or guiding participants further. In these instances, a mentalizing stance would be proposed, for example, parents would be invited to put themselves in their child's shoes and try to think about what the eating disorder could mean to them either emotionally or in terms of the impact on their lives. Parents would also be invited to take a mentalizing stance towards themselves, and explore their own thoughts, experiences and emotions about their child's eating disorder.

In other words, the researcher's conception of meaning was informed by the theory and research in mentalizing and if participants required clarification of what was being asked, the mentalizing approach of imagining the meaning of the behaviour, would be shared in the interview discussion in this straightforward way.

The second, connected question concerned participants' capacity, primarily parents' capacity and ability to 'mentalize' their children at the time their children were unwell, when in treatment at the Eating Disorders Service. As will be recalled, this question was prompted by clinical observation of parents' narratives and conversation in the parents' support group, and the extent to which parents varied in their apparent curiosity about their children's minds, their thoughts and feelings.

There were several reasons why a 'measurement' of mentalizing capacity through RF was of potential interest in the study. Given the small sample size, there was no expectation that measuring RF would result in any kind of evidence of association between RF and any other factors, but even so, it was hoped that it would throw up interesting results that might merit further exploration.

Indeed, there were unanticipated findings in both types of analysis, and as the analysis progressed, the question presented itself about how these findings might be presented alongside or integrated with IPA. It should be said that the study in its current scope does not exhaust the possibilities in this regard.

IPA results are presented at length in Chapters 4, 5 and 6; RF results in Chapter 7, with the two brought together in various ways in Chapter 9. Even in this small sample of 35 interviews (15 mothers, 11 fathers, nine children), interesting patterns emerged

(not 'findings' or 'data', if these terms suggest results from larger samples).

Briefly summarized, it could be seen that the capacity for mentalizing appeared to be stable across time points for individual parents but not for children; that parents varied significantly in their capacity for mentalizing, and that there might be an association between the types of emotions experienced by parents of children with eating disorders, and their capacity for mentalizing. These are intriguing suggestions that, it will be argued, merit further exploration. Such exploration could particularly concern further uses of the RF measure alongside other measures of mental attributes.

3.7 Validity in qualitative research

Validity in qualitative research is a field of lively debate that includes questioning whether there is correspondence between the concepts of validity in quantitative and qualitative research, with 'trustworthiness' emerging as a key concept for validity on qualitative research (Yardley, 2008). As yet, there are no agreed standards or criteria for assessing validity in qualitative research (Rolfe, 2006). For this study with its relatively straightforward design, three common issues of validity were considered: participant/respondent bias, researcher bias, and reactivity.

'Participant bias' was taken to denote the possibility in qualitative research that people may not give full or honest answers, for reasons relating to intra-personal factors, such as wanting to maintain a degree of privacy or opacity, tiredness, distaste for the interview and so on.

'Researcher bias' was understood to refer to the potential influence of the researcher's previous knowledge and resultant assumptions on both the process of study design and data interpretation. Researcher bias is usually considered a potentially powerful factor in qualitative research. An example of potential researcher bias in this study might be, for example, the mentalization framework adopted by the researcher that might influence their conversation when talking to participants about 'meaning'.

'Reactivity' denoted the possibility of the researcher influencing participants, for example, through their reactions, including unconscious reactions, which might encourage or discourage certain types of responses or narratives by participants. Other mechanisms might also obtain, such as an unequal power relationship between researcher and participant. In this study, 'reactivity' might obtain in the dual position of

the researcher in the service as both researcher and clinician, and what this might mean to the participants.

There are a number of strategies that are offered in the literature to bring about a reduction of bias in qualitative research.

1. Prolonged involvement

One strategy often promoted to reduce both participant bias and reactivity is to have the researcher be involved with the participants for a prolonged period of time. It is argued that this process allows trust to build between the two parties, allowing participants to become more authentic in their responses. On the negative side, prolonged involvement can also be argued to increase the risk of researcher bias, if the researcher and participants together generate narratives that the researcher then reports uncritically. In other words, the very joint production of data could result in bias on the part of the researcher.

Prolonged involvement of the researcher with participants was a marked feature of this study through several channels. As described, the researcher had contact with the families interviewed in her capacity as therapist in the clinic and convenor of the Parents' Group. She met some families during some components of their assessment at the service; most parents in the Parents' Group setting for longer or shorter periods, and in one case was the co-therapist for a family's treatment and in another was the former therapist for one young person. This duality of roles may have brought other problems with bias, for example, participants may have wanted to please or be amenable to influence the quality of care. The prolonged contact certainly afforded the opportunity for building trust, both at the personal and institutional level. Further, the process of re-contacting families to re-recruit them for the second interview involved emails and telephone calls, and catch-up conversations. These were expected to build further trust in participants, so that they could believe that their own views, thoughts, feelings and experiences were genuinely valued by the researcher.

2. Triangulation

Triangulation – using several approaches for either gathering or interpreting data – is a core strategy for increasing validity in qualitative research. Triangulation may refer to the use of multiple data sources, methods, or theories, or a mixture of these. In this

study, data were derived from only once source, albeit at two time points. However, the dual interpretative methods of IPA and RF certainly yielded quite different types of results that cast light on participants' thinking and experiencing in quite different ways. The attempt to integrate these two methodological approaches further produced discrete results groupings within the participant cohort that were unexpected and intriguing, prompting ideas for further research.

3. Peer consultation

Peer consultation or peer feedback is another well-established way to enhance validity in qualitative research, based on the simple idea that substantial feedback from peers will help the researcher to achieve multiple perspectives and greater objectivity. In this study, peer consultation and feedback was sought and received from colleagues in the service from which participants were recruited, students who used parts of the data for further analysis for their own dissertations, conference attendees, colleagues experienced in research, and supervisors. A matter of regret is the absence of a formalized, regular peer research group where aspects of the research could have been presented and systematic feedback received over time. Even so, each discrete occasion for consultation brought fresh perspectives.

4. Member checking

Member checking is one of the most well-know but also one of the most challenging qualitative validity methods, that is, consulting with participants themselves about their interviews either informally or through a formal follow-up interview, with discussion about the researcher's understanding and interpretation (Birt et al., 2016) This method was not employed in this research. Logistical difficulty played a part in this decision, as the data gathering and analysis stretched over a period of years and, further, spanned a change of employment for the researcher. These challenges aside, an important reason for eschewing this validity strategy was the concern that some of the results from both the IPA and RF analyses might upset or offend participants, especially given the passage of time, where parents and children alike might have moved on from the strong emotions displayed at the time of the interviews, when many of the participants were in deep crisis.

3.8 Epistemological position

Fundamental to the interpretative approach in this study is the idea that people express themselves through multiple channels, both cognitive and affective, that is, through words and verbal communication, and through emotions as communicated by means of a variety of media such as tone, intonation, and body language. To understand these discrete means of communication, the researcher needs to employ a variety of methods of interpretation, and be alert to multiple channels of communication. Further, it is assumed that the words and emotions are not always internally consistent and may even seem to contradict each other, or their connection may be opaque to the interviewer or other observer.

Misunderstandings between people are often founded in one person's difficulty in reading verbal and non-verbal emotional expression simultaneously.

For example, mention was made of a father in the Parents' Group who described the causes of the eating disorder as 'multi-factorial'. This was presented as an example of parents absorbing the beliefs of the service and therapists. However, as the father was saying this, tears began to roll down his cheeks and he cried. With this additional component, what sort of communication could this father be understood to be making?

This was not a research interview but is presented only as an example of complex communication. Were his tears signs of relief that he was not guilty of causing his daughter's eating disorder? Were they tears of sadness independent of the question of what had caused his daughter's eating disorder? Were they tears of regret and guilt that contradicted his expressed beliefs, or something else entirely? It was hard to interpret, but without doubt this father's emotions did not seamlessly match his words. This situation, to a greater or lesser extent, is repeated often in our normal daily discourse.

In interviews, the aim was to gather knowledge and information about participants' thoughts, beliefs, ideas and other cognitions as expressed through their speech, and their non-verbally or partially expressed emotions. To access people's thoughts *and* emotions, which combine to represent their experience, questions may suffice, but often other means of interpretation were also required in order to give the best chance of rich understanding. To this end, the employment of two research methods, one purely qualitative (IPA) and the other 'a quantitative measure of qualitative data' (RF) was considered a rich and rounded approach to exploring 'meaning-making' in the participants' accounts.

3.8.1 Meaning-making in IPA and RF - overlaps and distinctions

Both the methods of analysis used for the data were intended to bring participants' meaning to the fore. IPA prioritized idiographic, personal accounts, emphases, anecdotes, metaphors, and emotions. In this sense, IPA promised to allow the development of a kind of intimacy between the researcher and the interview subject; in the moment of the interview, and subsequently, when poring over the accounts. Furthermore, many of the meanings expressed were not presented under the heading of 'meaning' or 'this is what the eating disorder means to me'. Rather, the categories in the interviews ceased to be distinct and instead blended together; the pre-identified domains of understanding, impact, value and recovery blurred their boundaries and resulted – usually – in a holistic account of 'what it is like' or 'what it was like' to live through the days and months of being the parent(s) of a child with an eating disorder, and, in a few of the children's narratives, what it was like to have an eating disorder.

RF, on the other hand, was applied to the interviews as a form of evaluation of meaning-making – of whether those interviewed created meaning in a format pre-decided by the researcher, mediated through the choice of measure. RF measures mentalizing, the capacity to imagine another person's mental state, and grasp their intended communication, including emotion, through their behaviour or verbal communication. In this sense, the RF measure was literally created for the measurement of meaning-making. However, the meaning emerging through the use of RF is not personal. Here, the focus is entirely on the capacity to imagine meaning on behalf of the other in an attachment-based relationship.

Different as these two approaches may seem, they did seem to have some sort of relationship, by the end of the analyses. What their relationship might be is discussed in Chapter 9.

Chapter 4. RESULTS: Mothers' IPA T1

4.1 Introduction

In this chapter the results of analysing mothers' T1 interviews using IPA are presented and discussed. IPA informed both the design of the semi-structured interview protocol itself, and guided the analysis of the results.

Mothers' interviews were the most numerous, 16 in all, 10 at T1 and 6 at T2. M3's interview at T1 was damaged and could not be transcribed. Therefore only her T2 interview could be included in IPA and RF analysis.

Mothers' interviews at T1 and T2 are presented separately for two reasons. First, the volume of data at both time points benefitted from separate presentation of results. Second, the themes found in the two time points were quite distinct. For many mothers, things had changed profoundly, particularly in terms of the question of Impact.

The method of analysis, the ordering, presenting and tabulating of results, was presented in Section 3.4 in the previous chapter.

We begin with a close examination of the Results of the first level of phenomenological analysis, that is, the range and type of individual responses to the four main questions in the interview:

1. Understanding and Making Sense

How do you understand/make sense of your child's eating disorder as it is at the moment?

2. Impact

How does your child's eating disorders impact on your life?

3. Value

Is there is anything that [child] values about the eating disorder? And for you yourself, is there anything good or valuable that has come out of it?

4. Recovery

Looking ahead... What do you think is needed now for your child to get better?

4.2 First level of analysis (superordinate themes)

Superordinate (group level) themes are here presented first, and subordinate (individual) themes in Section 4.3. This may seem counter-intuitive; should superordinate themes not spring from the detail of the individuals' interviews? In fact, the two processes of analysing individual and group data thematically, proceeded side by side, iteratively, through moving back and forth between individual textual reading, annotating, and checking these against proposing group themes, as the number of analysed interviews accumulated.

For the sake of clarity, superordinate themes would be presented first, the process of creation of these themes described and backed up with extracts and quotations.

The subordinate themes and the process of creation of thematic tables for each individual participant are then presented in Section 4.3.

Table 3 shows all six superordinate themes that were constructed, and the breakdown of which mothers subscribed to which themes within the domain Understanding and Making Sense. These will be discussed and supported with examples and extracts from interviews, in the sections that follows.

Table 3. All mothers' IPA themes - phenomenology - T1

UNDERSTANDING & MAKING SENSE: phenomenological themes T1											
What mothers thought and said											
		M1	M2	M4	M5	M6	M7	M8	M9	M10	Total 9
1	"I don't know and don't understand"	✓		✓	✓				✓		4
2	"An ED is a disorder of eating"	✓			✓	✓	✓				4
3	Genetics, biology, inc ASD*			✓				✓		✓	3
4	Child's own character traits – anxiety, low self-esteem, perfectionism, etc.	✓		✓				✓		✓	4
5	Impact of family events – illness, divorce, bereavement, parental discord - control		✓	✓	✗	✓			✓	✓	6
6	Impact of adolescent development and its social demands – school, peers, friends, media	✓	✓	✓		✓	✓	✓			6

*Autistic Spectrum Disorders (ASD)

4.2.1 Understanding and making sense

The first domain of the interview, and the primary research question of this study, was about parents' and children's *understanding or making sense* of the eating disorder.

The question yielded the longest section of many interviews and the most varied answer through the course of the interview, and hence has been illustrated with its own set of tabulated themes.

4.2.1.1 Understanding and making sense: first responses

Some participants initially struggled with the question and asked for clarification. Some gave a brief, perhaps spontaneous answer at the beginning and returned to it later or near the end of the interview, perhaps as they felt more relaxed and able to reflect. Some began with an account of how their child was eating, or an account of events leading up to diagnosis, until prompted or redirected by the interviewer.

Here follow brief extracts from mothers' initial responses. Except for M9, interviewer's prompts were not important and have been edited out. Interviewees' repetitions and hesitations are shown in modified form.

Table 4. Mothers' T1 Understanding and Making Sense: first responses

Identifier (mothers T1)	Understanding and Making Sense: first response
M1	Well, at the moment, I feel, I mean it's all about control. Basically, it's just taken over her whole head and she's controlling anything that goes into her mouth, you know. And there's just nothing, we feel, ah, I feel at the moment that can, there's not any part of her that wants to get better I can see. Its just complete, it's just this thing has taken over. So I don't know what...
M2	Well, I think for me making sense of it changed very, very rapidly. ...The day her dad and I knew she had anorexia was the day she said to us that she was trying to eat 300 to 600 calories a day. And when we asked what weight she was trying to reach, it became apparent that no weight was going to be low enough. So we knew, to us it meant she had anorexia. And initially, I have to be honest, I was terrified and horrified and I thought there was a very high

	chance that she would die.
M4	Do you mean how do I understand how she has an eating disorder, how it developed, yeah ok. Um, I've spent a lot of time thinking about that and trying to make sense of it...So how is it that we have this daughter who was seemingly so on track in life and was a girl who was always, people always picked her out as somebody who was incredibly kind, helpful, capable, yeah, a pleasure to be with. How is it that she's now at [hospital]?
M5	I understand that she finds food a very difficult thing at the moment, um, and by that I mean she'll avoid eating, but she'll avoid eating I think particularly during the day, and the evening it's not so bad. But I think that's something she's developed, so when we weren't aware of her problems with food, she was developing them, that's how I understand what was going on.
M6	It's difficult because I think she is in a period of change, and she <i>is</i> eating more. Um, she's rather surreptitiously eating bars of chocolate and so on. Which I make no comment on. But, you know, she's clearly put on a bit of weight. She looks healthier. Um, and even her mood is right now, she's in, you know, as of this week, she's in a good place. And actually the food has become better, but she has odd behaviours around it, so she's clearly not sorted on the food front.
M7	I think she, she, has a massive fear of gaining weight. That's the... I don't think she's scared of food. I think it's the consequences of eating so she's terrified of gaining weight. She has this body dysmorphia so she thinks she's fat even though she's paper thin, or she doesn't think she's fat she's aware that she isn't. But after a meal she thinks her belly has become huge so that's another thing. Um, but I think it, it's not just about gaining weight I think she's, um... she seems to feel the need to punish herself? Um, she doesn't think she should enjoy food. She seems to think it's wrong to enjoy food so generally she wants her food to be very, very plain.
M8	Ok, so in one way I look at it from different perspectives so that she has anorexia because there was a perfect storm, things all came together in different patterns, that's how it's been described and how I understand it, that she was genetically or biologically

	<p>predisposed to getting an eating disorder and different things came in at different points, so she had her period, she had Ramadan, where potentially her weight dropped below a certain, er, she had the month of fasting, she was in a group of friends who were all quite miserable and there was a lot of discussion about eating and a lot of quite judgmental behaviour, ... and I suppose family/home, I don't know I mean I've looked at that without trying to create that blame perspective on any of us</p>
M9	<p>I'm finding it very difficult to make sense of. Um... I just can't make sense of it. I'm struggling. I'm just confused by what you mean by make sense of it, is it about how I'm coping with it, is that it?</p> <p>I: No, that's more about the impact on your life. This is, how do you understand it?</p> <p>M9: What, how it happened?</p> <p>I: Yeah, how it happened. What it means... to C9.</p> <p>M9: Right. I don't, I don't really understand what the question is asking to be honest.</p>
M10	<p>I don't know. It's really tricky... Um... We were, when C10 was little we used to say that we were concerned for her future. We saw that something, that something wasn't right with the way that she thought. And that we always thought that there would be some sort of crash when she got older. When she stopped walking, we thought that was it.</p>

These first responses, mothers' 'first take' on the question, were taken account of and honoured in the first three whole-group level phenomenological, or superordinate themes, as seen in Table 3:

1. 'I don't know and I don't understand'
2. 'An eating disorder is a disorder of eating'
3. Genetics, biology (including ASD)

Certainly mothers elaborated and the first response might change or become richer through the course of the interview, but these first responses were nevertheless signposts of how mothers were 'thinking about understanding', in the context of the start of the interview.

These first three themes are by their nature non-mentalizing, that is, not founded in mental state thinking.

1. 'I don't understand' indicates giving up on mental state thinking (M1, M4, M5, M9).

This theme expressed, for some, the breakdown of understanding in the face of their child's eating disorder.

2. 'An eating disorder is a disorder of eating' is a perspective mainly describing eating behaviour. This might at times be nuanced by attributing mental states about eating itself (M1, M5, M6, M7). One might say that these mothers had entered into their child's world to the extent that they were able to share their child's perspective on their own eating behaviour – their child's meaning-making.

M7, for example, spoke as though she hoped that if only she could understand her daughter's behaviour around food, she might find key to a cure, a familiar hope in parents new to the eating disorder.

M1 went on to describe her daughter's behaviour around food in provocative terms.

"She's, she's like a princess, she's in control of it all, she can kick her legs and choose herself what she wants to do. 'I don't have to eat'."

M1 developed a narrative about control, where she perceived her daughter as controlling not only food intake but also them, her parents.

M5 had a concrete understanding of the eating disorder as a disorder of eating. As will be seen, this remained throughout both interviews and she did not develop alternative explanations with any conviction.

M6 spoke about her daughter's eating disorder both as a disorder of eating, and later in the interview as a mental health problem, a family problem and a developmental and social problem - and these alternative versions remained somewhat disconnected throughout. This may have had something to do with M6's own history of an eating disorder – she knew the landscape of eating disorders, but by her own account not the mental health issues that accompanied it.

3. 'Genetics, biology including ASD' was a thematic category for those mothers who attributed the eating disorder to pre-existing fixed traits, biologically based rather than environmental or psychological (M4, M8, M10). M8 and M10 went on to give accounts of long-standing social and behavioural problems and, in fact, both their daughters were diagnosed with ASD subsequently. Both M8 and C10 described their daughters as unbidable and unamenable to the influence of their own parenting, prone to extreme, intransigent behaviour. M4's take on 'genetics' was narrower in the sense that she was relating her daughter's eating disorder to her own as a young adult.

For these parents whose daughters not only had eating disorders but who also were found to meet or partly meet criteria for ASD, it seemed that the attempt to make sense of their daughters' behaviour became unmanageable. It seemed that they settled on an account where sense could not be made except in terms of a genetic or developmental disorder – something their child was born with. Importantly, as M10 put it, it meant for them as mothers that 'No amount of love or patience or consistent parenting has ever been able to change [her behaviour].'

This theme therefore captures a sense where meaning is separated from the child's behaviour, whether in the realm of the eating disorder or otherwise, and ascribed to fixed character traits deriving from genetic and biological inheritance.

As the interviews progressed, first responses sometimes – not always – mutated or deepened. We will examine the next three themes now.

4.2.1.2 Understanding and making sense: subsequent responses

The three subsequent themes of Understanding and Making Sense were constructed by means of the analysis of conversations as they broadened to encompass their child's personality, nature, characteristics and emotions; their child's social world and developmental context, usually school; and the family environment and family events. The detailed content of this theme varied, as one would expect.

A table as concise as Table 4 to capture these themes was not possible to construct; therefore what follows is a description of the components for each theme, from each individual mother's narrative, evidenced with examples.

The themes were:

4. Child's own character traits – anxiety, low self-esteem, perfectionism, etc.
5. Impact of family event – divorce, bereavement, parental discord and control of
6. Impact of adolescent development and its social demands – school, peers, friends, media

Theme 4 overlapped with Theme 3, but represented a less static, more developmental account. This was very important, because this theme allowed parents to include themselves as 'influencers' on their child's personality. Put another way, when parents spoke about their children as having emotional problems, they also saw themselves in relation to their children. This could be painful for parents to think and speak about, particularly in the early stage of the eating disorder.

Theme 5 was allocated when the interview included reference to the impact of family events or circumstances on the child's mental state and behaviour. This theme was the most common across all interviews, featuring in six out of nine interviews with mothers at Time 1.

Theme 6 was allocated when a narrative was built that included thinking about the child's experience in their social world, including the difficulties and challenges that they may have encountered and not known how to navigate. Theme 6 also included a developmental perspective, the idea that as children grow older and enter adolescence, they can no longer resort to old ways of managing and have to find new ones, be they in the realm of identity, social awareness, or more complex emotional communication.

M1 gave prominence to the impact on C1 of a friendship (Theme 6) where the friend was perceived as powerful, demanding and manipulative, wanting C1 all to herself and allowing her no other friendships, while also making C1 feel inferior. C1 was also seen as unable to stand up to this friend. M1 wove a complex narrative around this situation, involving lack of control, C's own timid character, and linking this to her own lack of confidence and hinted at how this may have impacted her parenting (Theme 4).

"At this coffee morning the other day, my friends were saying, "Oh, we do role play at home and I taught her how to cope with that." And I thought 'Oh God, I wish, I've failed as a mother. I

should have been doing that.' But I mean, I find it difficult in life to stand up to these sorts of people. Because I meet them all the time ... She needs to believe in herself because I didn't believe in myself. And I think, you know, she's got to start believing in herself." (M1, T1)

M2 thought that long-standing marital discord (Theme 5) had created a tense, false atmosphere in their home, and that C2 was, through AN, calling them out on it. She was hopeful that family treatment would lead to greater emotional honesty in their marriage and in the family, and that the eventual outcome of C2's AN would be improved relationships.

"I wasn't even authentic, I was pretending to be happy when I wasn't. We weren't communicating. Once a month, I was throwing all of my toys out of the pram and screaming at [D2]. That's a horrible environment to grow up in! And I'm sure she was sad about that." (M2, T1)

M4 produced a narrative that wove together Themes 4 and 5. First she described her daughter (C4) in somewhat fixed character terms as a child competent and sensible beyond her years, eager to take on adult responsibility (Theme 4). She described herself as shocked at the apparent change in her child's character, having not previously considered that C4 might suffer from anxiety. M4 placed this within a family dynamic narrative where she blamed herself for having relied too much on her daughter to keep the wheels of the family turning, because parents had had to take younger sister on frequent hospital visits for a recurring health condition. Curiously M4 did not much entertain the impact of the developmental challenges of adolescence.

"Competent, capable, responsible, with such a level head, so it's so shocking that she's so anxious, I mean that has been really shocking actually... she would cook a three course meal at the age of ten with her friends - so that's been one of the most shocking things - I didn't realise that she was actually quite anxious although it's difficult to know." (M4, T1)

M5 entertained the idea proposed by a previous therapist that the impact of the loss of her father, C5's maternal grandfather, was a factor (Theme 5), but then seemed to change her mind, leaving an ambiguous final statement about the role of family events:

"I was, totally wrapped up in my own grief, and, selfishly, I don't know, didn't ever consider that C5 being the youngest, would, um, be affected in such a way that she was... I think I just took my eye off the ball, and I didn't consider her, I suppose I didn't consider anyone else except for me, and I think in that time, the "healthy eating" started to take hold even more."

"I didn't link it, it was linked by the people that we saw, it wasn't necessarily my idea, but I went with it because I thought well I don't know what else it is, I really don't know." (M5, T1)

M6 in her account prioritized the impact of the acrimonious divorce with C6's father (Theme 5), an event that preceded the onset of depression in C6, followed by AN. M6 looked at the effect of divorce on C6's development and speculated that it had impacted her in a variety of ways. She thought that the divorce had made C6 'clingy' to her and 'disappointed' in her father. She wondered whether the divorce had made C6 'more selfish' in that, perceiving that her parents were preoccupied, she put her own needs first. She considered that, as a single mother, she might have put C6 under pressure to 'cope' because she needed her cooperation to make the household run. Overall, she concluded that the divorce likely made it harder for C6 to grow up, thus implicitly also situating C6's anorexia in the context of adolescent development and its tasks (Theme 6).

M7 similarly attributed the eating disorder to C7's growing difficulties with friends and friendship groups (Theme 6). This was in fact M7's only theme besides Theme 2. She noted an intense friendship with one girl where C7 was 'wrapped up' in the relationship and then left vulnerable and exposed when this friend 'pulled away' from her. M7's account was coloured by bewilderment at C7's withdrawal from peers and social life in early adolescence, commented on what a turnaround this was from how outgoing and independent she was in late childhood. Rather than see these changes as developmental, M7 saw them as a break with her daughter's 'normal' character.

"It was her birthday and she hadn't organized anything with friends for her birthday and the previous year we had a really wild sleepover, a much more *normal*, kind of activity 'cause C7 used to be in a big group of friends and sort of in the centre, you know, in amongst them, but I had already become very concerned that she had become so close to this one girl. Um, because it was always going to happen that if they drifted apart she was going to be left with...not much." (M7, T1)

M8's daughter C8 was subsequently diagnosed with ASD. At T1 this diagnosis had not been made but M8 wondered about it, when thinking about her daughter's personality characteristics (Theme 4):

"There's anxiety and then there's anxiety you know, you need a certain amount of fight or flight mechanism, the sort of pumping that gets you a little bit more geared up to take a test or whatever, there's that, and then there's, 'I can't put my hand up in class because everyone is

going to mock me, I cannot, I am paralysed with fear because I have to go to school, I cannot potentially choose blue from red because will those decisions be catastrophic, it's that level of... it's just nobody ever picked up on that this isn't normal levels of anxiety. Trying to make her see, could you be anxious about A, B or C and then allowing her to manage it... because she just goes into a sort of ball and unable to cope with the world and this is another thing, that the crossover between Asperger's and autism spectrum disorders and anorexia was quite interesting - they're now looking at autism almost as if it's too much and with C8 I've always said she's so porous, everything comes in, she's got no filters and so everything comes in, it's overwhelming..." (M8, T1)

M9 spoke about one particular family dynamic (Theme 5), from two points of view. It seemed to be about the tension between being a working mother with two jobs and giving her daughter enough attention. This situation was exacerbated when M9's aunt died, as this aunt had provided M9 with a great deal of both practical and emotional support.

"She [C9] was worried about me. She knew that every time my aunt's name was mentioned that I would cry and she hated me crying and was like, 'is, is mum ok?' When she got ill, I said things like, to my family and you know, 'if aunty M had been here, she would've picked her up from school. She wouldn't have had to be up in the office for a few weeks' – the office at work, because we were so caught up in work for a few weeks and our childminder was sick. And it was, 'this wouldn't have happened.'" (M9, T1)

M10 saw C10's difficulties in terms of her character (Theme 4), and was also seeking a diagnosis of ASD at the time of the interview.

"C10 has real trouble being in the world and living in... She just finds life really, really tricky. She doesn't know what she wants but she knows that she ... opposes everything. And she always has done. Ever since she was tiny and... No amount of love or patience or consistent parenting has ever been able to change that. Um, she would tantrum every day about knickers. ... I'm actually scared of going shoe shopping with her. It terrifies me. The ordeal of taking her shopping for shoes is just tremendous and always has been. If you walk along the pavement and if someone's feet are dragging - she has a thing about dry pavements. She has a real sensory issue with dry pavements. She cannot bear the sound of dry pavement."

Besides her strong emphasis on C10's genetic make-up, made a link between her eating disorder, and family dynamics involving her older sister's AN (Theme 5). Before developing AN, C10 had suffered a period of 'not being able to walk' and was treated

with physiotherapy and psychological therapy. When she resumed walking her older sister got AN. When her older sister recovered from AN, C10 developed it:

“It’s almost like I shifted- I stopped looking at C10 and I started looking at [sister]. And the minute I started looking at [sister], C10 ramped it up. To get me looking at her again kind of thing. Now it’s a really simplistic way of looking at it and it’s probably largely inaccurate but there’s something in there somewhere....” (M10, T1)

4.2.1.3 Commentary on subordinate themes 1-6

The above summarises qualitative findings from nine mothers of children between the ages of 10 and 15, all but one (C6) fairly recently diagnosed with AN, two with previous histories of mental ill health (C8, C10). It would be impossible to generalize to the maternal population of children with AN at large, not least because this cohort tended towards the younger end of the age group, and because the treatment centre was a national specialist service, serving both this younger age group, and more generally patients for whom suitable local treatment was not available, or where it had been ineffective. With this caveat, it was interesting to note the following features.

Themes 1 and 2 can be interpreted in various ways. At its simplest, beginning an interview with an assertion that their child’s eating disorder behaviour was incomprehensible, could be a simple expression of how they saw it – that something alien and untoward had hit their daughter, themselves and the family. Similarly, beginning with an account of how their child currently ate, could be a way into the interview in the face of the interviewer’s somewhat baffling (for some) first question. It might feel safe to start with observable behaviour and then, encouraged by the interviewer’s questions, find one’s way to reflecting on the meaning behind the behaviour.

However, some mothers did not move far beyond Themes 1 and 2 in terms of the relative weight they gave these compared to themes 3-6. When this was the case, as in the narratives of M1, M5, M7, and M9, some further understanding or interpretation on the part of the investigator is surely required. Was there actual repudiation of meaning-making? Did the stance of ‘it makes no sense’, ‘I can’t understand it’, or a preoccupation with the detail of eating, speak of the mothers’ difficulties with thinking about their daughter in terms of their respective mental states, termed ‘low RF’ (Fonagy, Target, Steele and Steele, 1998)? Or could it mask strong negative

emotions, such as anger, outrage and frustration with their daughter? These questions are weighed up and discussed in Section 4.4 on Interpretative Themes.

Themes 3 and 4 overlapped in their combined focus on more or less fixed, long-standing and familiar child characteristics and personality. Together they were seen in seven of the nine mothers narratives (78%). It seemed that reaching for explanations rooted in the child's own, known, personality and functioning, could be a comforting way of making sense, and further have the added benefit of removing blame from mothers in regard to their own parenting.

Theme 5 concerned their child's environment at home and family events and relationships. The extent to which mothers sought and found understanding in the home environment varied from, at one extreme, M2's near certainty that their unhappy marriage and 'inauthentic' home atmosphere was the main cause of C2's eating disorder, to M5's active repudiation of factors relating to themselves as parents, at the other. It is understandable if mothers felt themselves navigating the shallow rocky waters of being blamed when they spoke about their child in their family. Furthermore, many knew that they should not be blamed, that no research supported pointing the finger for eating disorders at parents, and had been told so by therapists. But as M2 said,

"M2: The first thing I felt when C2 got anorexia was "Oh, you know, we've really mucked up as parents. That's why she's got anorexia." And the first five or six weeks, D2 and I talked about that and we knew that idea wasn't helping us, so we just pushed it to one side and just got on with it.

I: Did you know that officially that thought is considered unhelpful or ...?

M2: Yeah, no. We, I read about that in a book. And it's a really ... there's no point in going there. But the trouble is, you see, you can put it on one side, but it niggles away at you." (M2, T1)

Given both the great delicacy of the topic, and the orthodoxy with which many parents were conversant, it is a surprise how much time and space mothers gave to discussing their child's eating disorder in relation to their family and even their own parenting. It was the single most common theme in all accounts arising in six out of nine mothers' narratives at T1 (67%).

Theme 6 concerned mothers' perception of the impact of development, particularly as their child reached adolescence or its threshold. Six of nine mothers (67%)

incorporated this theme into their accounts. However, all but M7 gave it a relatively brief airing. M7 spoke at length about her daughter's social withdrawal where previously she had been popular and outgoing. M1 and M8 pinpointed unhelpful friends and body judgments among peers. M2 and M4 mentioned academic pressure and perfectionism. M6 mentioned schoolwork and friendship groups generally.

It was thought surprising both that a greater proportion of mothers did not address this theme, and that of those who did address it, all but one did so relatively superficially.

The treatment manual for AFT (Fitzpatrick et al. 2010) positions AN directly in the context of adolescent development. It proposes that AFT is

“designed to address key deficits in development associated with AN. Adolescents with AN are viewed as using food and weight to avoid negative affective states associated with adolescent developmental issues that they perceive as intolerable.” (Fitzpatrick et al., 2010, p31).

Yet a strong idea that adolescence would bring enormous changes in their children's emotional worlds, their social relationships, their place in the family and their identity, was lacking in these interviews. This observation warrants a study in its own right, asking the question about what conception parents have of adolescence, and what sources they draw on to conceptualize adolescence. Do they think about their own experience of adolescence as well as their observation of adolescence in their child's generation? How do they synthesize their own past, the present cultural features of adolescence, and their own child's character? How do they conceptualize the very process of development?

4.2.2 Impact

The second domain of the interview, Impact, brought a great volume of information and at times high levels of emotion, in mothers and fathers. By no means all of this information and description of lives turned upside down, of unimagined distress, fear and helplessness, produced meaning or meaning-making, understanding, or making sense.

For the purposes of this study on the kinds of meanings that families made of the eating disorder, how should the results of the conversations in the Impact domain be

treated? There would not be space for it all to be reported with the same attention to detail as the domain of Understanding.

As the interviews were read, analysed, annotated and reflected upon, an awareness began to form, that led to a hypothesis. The Impact part of the interview was often accompanied or marked by overtly expressed or barely repressed emotion on the part of the interviewee. The emotion might be couched in language that shocked, or descriptions that made a vivid impact on the interviewer. While the 'Understanding and Making Sense' domain in the interview could lead to some complex formulations as well as simple ones, they were more cognitive. The Impact domain of the interview was usually more emotionally engaging. The hypothesis was put forward that in the Impact section of the interviews especially, parents let the interviewer have a glimpse of their true feelings at the time, and what they were really experiencing.

It was decided therefore that although the Impact themes were recorded systematically in each participant's individual thematic table (see Appendices 6a-6d), an overall table in the same model as Table 3 would not be a worthwhile exercise in its own right. Rather, the emotionally laden Impact sections would be focused on and analysed, reported and collated first separately, using the transparent and interpretative method of IPA. Second, they would be set along the themes from the Understanding and Making Sense domain, to search for any patterns or associations. For example, might a parent who experienced a strong emotion of a particular kind also have a tendency to attribute meaning to the eating disorder in a particular way?

This process and the results that it yielded form the substance of what follows in this chapter in Sections 4.4 – 4.6. This process is repeated again in Chapter 5 for the analysis of interviews with fathers, with intriguing results.

In Chapter 8, where mothers' interviews at T2 are reported, analysed and discussed, the Impact domain plays a significant role in a somewhat different way. At T2, those six mothers who participated were able to see more clearly the full impact on themselves, their child and the family, of the eating disorder and its treatment. This part of their narratives is reported on separately, and in this context Impact denotes both the emotional impact and the actual, real-life impact of their child's eating disorder.

4.2.3 Value

As with the Impact domain, the interview domains of Value was also recorded in detail in each individual participant's thematic table, but not collated into a separate table.

Value and Impact sometimes overlapped. Where participants identified that something valuable had come out of their child having an eating disorder, this naturally meant that the same subject featured under the Impact heading. This will be highlighted particularly when we come to examine the interviews of mothers at T2.

The presence of Value was related to the time point of the interview. Generally, mothers identified little of value either for their child or themselves at T1, when their child was relatively newly diagnosed and they were entering treatment with an uncertain outcome, struggling to adapt to the dictates of FBT and their new family dynamic, caring for a child with a mental health disorder with high risks of harm. At T2, the narrative could have changed. Mothers were more likely then to reflect on the changes in the family and to identify some positives. These will be presented in Chapter 8 with mothers' Results at T2.

For example, in the interview of M2 at T1, the following themes were identified under *Impact*:

'My daughter teaches me about *myself*, my anxiety, and how to change',

And

'Positive impact on couple communication'

And

'More honest relationships'

These themes were first recorded chronologically in M2's individual thematic table, under the heading *Impact*. As these were all seen as valuable outcomes or side-effects of having a child with an eating disorder and family treatment, they reappeared, in the interview itself, and in the table, under the heading *Value*. This time, they are phrased as:

'Release from pre-existing family relationships'

And

'Wouldn't go back'

They all refer to the same phenomenon, described in M2's own words in her T2 interview nearly two and a half years later:

"What I came to understand, um, at a relatively early stage, within the first year, was that C2 was trying to get our attention. That she wanted my husband and I to, sort of man up and take responsibility for the terrible mess our family was in. And it was almost as though she was the *only* person in the family who was saying, 'We can't go on like this.' And, um, when I look back at the mess we were in I wonder how on earth D2 and I were just continuing, we were just repeating the same mistakes year in, year out and our marriage had become very dysfunctional, we were all very unhappy. ... I think, looking back, that C2 was really trying to say look guys you've really got to do something about it. Because of her, the way she, uh, got our attention it became very apparent that something had to change and that we all had to move on. And I now can look at the eating disorder and see it in a very positive light. C2 has managed somehow to overcome the challenges of that and she's also managed to negotiate all the challenges of growing up... she's come out the other end very mature. Um, and I wonder would she be quite as mature, and quite as together and quite as authentic if she hadn't been through this awful time. So I wouldn't wish it on anybody and I would to hate have to do it again, but having seen where C2's got to... it almost looks like a blessing in a strange sort of way." (M2, T2)

4.2.4 Recovery

The fourth domain, Recovery, came to assume secondary importance in this collection of T1 interviews with parents, with the exception of M8 who had a great deal to say on this subject. It was difficult for parents to address and yielded the least rich or original answers.

This makes sense when one considers the timing of the interviews. At T1, parents may have had ideas but were mostly expecting the clinicians and experts to prescribe what would aid their child's recovery. At T2, on the other hand, they could both identify helpful component of the treatment(s) that they had had, and subject them to critique and criticism. Perhaps strangely, at T1 there seemed to be limited range of

options or ideas in parents' minds about what would help their children recover. At T2, some parents extended their learning to their own parenting, but in those cases the themes had already appeared in the Impact and Value domains. Nevertheless the Recovery section of the interview was addressed consistently in the interests of maintaining the systematic framework of the research.

It should be noted that in the children's interviews, the relative importance and time devoted to the respective domains differed from their parents'. Recovery was a more stimulating topic for the children interviewed, as was Value. Impact was of less concern to them. Understanding was important. This will be evidenced and discussed in Chapter 6.

4.3. Second level of analysis (subordinate themes)

Interviews were annotated at first reading in the way shown in examples in Appendix 5a-5c. At the second reading, thematic tables were constructed, one for each participant, each one following the same template. The themes were collated under the main interview domains of Understanding, Impact, Value and Recovery.

In addition, quotes were copied from the interview and pasted into a section below the table for easy reference to back up themes with direct examples from the interview.

Table 5 is an example of an individual participant table. Further examples of individual tables are in Appendix 6a-d.

Table 5. Example of individual participant's thematic table M8(T1)

	Understanding	Impact	Value	Recovery
1	“Perfect storm” – everything & nothing	Mum’s professional demise – spend four hours feeding C8	Working on marriage. Questioning own conflict avoidance. Learning not to please everyone.	Clear guidelines and non-negotiables (Quote R1)
2	Always anxious child with history of OCD	Huge anxiety carried without support of husband – ‘he carried on in his own world’	Faith in God gets me through	Not surrendering to C8’s anxiety
3		C8 was already most difficult child – made me feel a ‘rubbish parent’	C8’s new state school better for her than private school	The ‘clear guidelines’ segue into frantic measures and behaviour
4		Violence to Mum		CAMHS to be better & more creative, open minded
5		Couple conflict and anger with husband		Help child to relax bodily and build identity

REFLECTIONS & QUOTES T1

Understanding Theme 1: biological/genetic predisposition

- period
- Ramadan fasting for a month with weight drop
- friendship group miserable, judgmental, eating talk
- home? Nothing [thick padded winter coat]

Understanding Theme 2: AN as an attempt to control the anxiety and OCD

Predisposed to anxiety “for whatever reason”- “she is pretty much anxious about everything... I used to laugh and be like, she’s in the middle of a family party doing her science work and I used to laugh thinking ha, isn’t she a, you know, studious child but actually, it was probably...” Story about extreme levels of anxiety, mum-as-therapist, as form of relationship with C8, and raison d’être

Impact Theme 3: “she’s always been the most difficult of the three children, and always made me question my parenting skills, if I look at [other children], I actually think hey I’m actually quite a good parent, wow, and C8 has always made me feel like a rubbish parent”

“well ok, if I haven’t conveyed, it’s like a small piece of hell”

Impact Theme 4:

“if anybody had told me this was what it was going to be like I would not have believed them, I mean sitting there next to a child trying to get her to eat for four hours I mean when I say, you know I don’t miss

my public life, you know I'm not crying for it or craving it but do I want to sit there and feed my child for four hours, no, you know we've had moments where her anxiety levels are so high that she's lashed out with violence and that's not pretty"

Impact Theme 5:

[Husband] just like carried on in his own world and sometimes I feel like C8 is trying to push it so that she wakes up, and if it is about love and attention it's not my love and attention she wants it's his, and this, I would constantly say look she's trying to tell us something, we need to work out what she's trying to tell us so we can move on. [Husband] doesn't have any sense of someone trying to communicate something between the lines and it really showed the sort of difference of how we approach the situation which has been incredibly difficult.

I then called one of his friends to come down who sort of who stepped in and basically told him he was being an idiot and he recognised that, so we've been working on our marriage really hard, whilst at the same time working on C8, so that's been difficult."

Recovery 1: "clear guidelines" – that lead C8 to extreme reactions

"so we actually have very clear guidelines, it's only since last week, so we're still trying to work it out but she has 45 minutes to eat a meal, and if she doesn't then she has 10 minutes to drink, and if she doesn't then she has 10 minutes time out, and then I get annoying because she goes into this kind of fetal position where she just hides from the world and so, in order to get her out of the fetal position in the toilet I've used cold flannels and things like that, and that's where she turns violent, and that's the point where it's not very pretty but at least if we know the process that's going to get us there so she can make a decision before she gets there - and I've become less, well, caring, not caring, it's not that I don't care just that I've become less sort of ..."

Recovery 1: clear guidelines that lead Mum to extreme reactions

"so basically it was quite late at night, she was getting very, very difficult and she wouldn't drink Ensure, and she didn't end up drinking her Ensure it has to be said, but I put the Ensure down, she locked herself in the toilet, she went into the fetal position, I said I'm going to get the flannel, she locked herself in the toilet, and so basically I was like, I'm not going to sit there all night, so I just laid out her bedding downstairs, I went up, I took and hid all of the knives, I took every knife just in case, I also took a piece of computer equipment, the remote control, the x-box, her electronic wireless thing so she couldn't get Wi-Fi on her computer, so she had nothing, I took her iPad, I took her kindle, I took everything, so the next night she came back out of the toilet I said 'night, I'm going to bed', you can stay in the toilet if you want to, so when she came out everything was gone so she couldn't sit there and watch..."

Recovery 4: CAMHS to be better & more creative

CAMHS services at port of call need to be better, it's not to say we had a terrible experience,

- But we spent many weeks looking at the blame and C8 being told you're doing this for attention and stuff like that. We lost time there.
- the advice from CAMHS to take her out of school – no, she needed to have life and life needs to be full on
- People need to be open to some of the alternative thinking that might be slightly off the board right now, I mean I go back to the milk intolerance thing - as I said 16 years ago no one would believe my son's problems, a whole spectrum of health problems were being caused by milk absolutely no one and it took me, I mean [son] became a very, very sick child and he was hospitalized for three weeks before someone would actually listen, erm and he became the expert in his field, I think that people are incredibly quick to dismiss things and I wish the services were quite so dismissive of things [traumatized reiteration?]

"it would be great if the whole services would offer things which are a bit more creative, for example body dysmorphia, i.e. a separation from the insula to the prefrontal cortex of the brain and different elements of the brain are not talking to each other, there are studies and there is science about how the brain to talk to each other so, yoga actually causes the brain to allow the body and the mind to reintegrate, so if you have body dysmorphia yoga is really helpful in creating a body mind reintegrated helpful to teach mindfulness, there are studies being looked at creation of avatars in terms of, an study that's in Carrie Arnold's book, which is a fantastic book...[speech slightly disintegrating, this edited version, see original transcript]... If I had to imagine my perfect service, right, it would be looking at the... criteria for mental health and that sort of includes time with nature and you go through of them, really looking at the whole well-being of the person, it's very, very narrow and it's not particularly holistic, erm so, I mean a complementary thing such as massage, acupuncture, sound a bit off the top but they allow people to relax, and they allow people to get a sense of themselves, and I think that know, I personally feel that if mental health services were to introduce these types of things we get...

[relief from anxiety and building identity in fact]

The table is laid out simply, with the four main domains of the interview along the horizontal axis, and numbers of themes along the vertical. The process of allocation under these headings continued until all themes seemed noted. During this process the interview would be read at least twice and often more. In M8's interview we can see that there were actually only two themes relating to Understanding and Making Sense, and many more to Impact. Recovery garnered a long piece of text because M8 spoke so volubly on the kinds of changes that CAMHS should make in their treatment of young people with mental health problems and eating disorders. The researcher was uncertain whether this contained several discrete themes or really perhaps just one, for example, 'CAMHS should listen to patients more'. However the researcher decided to err on the side of caution and not over-condense.

Quotes are taken from the transcript and reproduced below the grid, in relation to each item. Not every item is garnished with a quote.

Table 5 was drawn from M8's T1 interview, a particularly full interview: there were long descriptive stories of C8's difficult behaviour; accounts of tension and misunderstanding between her and her husband; historical reflections about C8's development and genetic inheritance; speculation about possible medical triggers and concomitant factors; proposals for improved, patient-centre services.

4.3.1 Mothers' emotions in the interviews

Besides the actual content, there were other qualities in some mothers' T1 interview that required researcher reflexivity.

For example, speech was torrential, sometimes driven, sometimes seeming to almost disintegrate into incoherence. The same mother could take up a knowing, expert stance as the mother of a child with what seemed to be long-standing mental health difficulties at one time, and at another time communicate the desperation of fruitlessly looking to help her daughter.

Similarly, M8's affect came across in different ways along with the variation in her delivery. Sometimes the way she spoke came across as peremptory and certain, brooking no opposition or even discussion, for example when speaking about the doctors not believing her when she tried to make them see that her son was not thriving because of a milk allergy. At other times M8 seemed vulnerable and uncertain, as when speaking about her disintegrating career, or saying that C8 was always the one of her children who made her feel "a rubbish parent".

M8 had a habit of using quite strong language, and speaking about her daughter in quite an extreme way, and the researcher puzzled about this too – what did it intend to communicate and was it deliberate or unintentional?

Finally, the researcher was aware of a feeling in herself of needing to 'tread on eggshells' with M8 – that there could not be the sense that the researcher might have a different view or knowledge. What did this mean?

Of course, there could be no definitive answers to these questions. Although aware of countertransference, this was not a clinical therapy session in which countertransference responses could be transparently articulated, elaborated and checked with a patient as to their own state of mind and the two compared and discussed openly.

The researcher was left with her own responses and related questions, and tentative formulations.

These sorts of experiences, and later reflections, both around the time of the interview itself, and at the time of reading, annotating and analysing the transcripts, and creating the individual thematic tables, occurred with variation in every interview. They brought forth the idea that the content and themes of an individual's interview could also be analysed in terms of emotional impact.

For example, M8's interview communicated powerfully the impact that her daughter had had on her, both as a younger 'difficult' child, and now as a teenager with an eating disorder. M8 in turn conveyed some of that impact to the researcher, through her choice of anecdotes, her style of delivery and her emotional tone.

It seemed that these variations in self-presentation were at least as much part of what was being communicated, as the content of the words and sentences themselves. To allow them to pass unremarked, unanalysed, would be to leave the interview partially unanalysed. But how should the researcher interpret?

These qualities were 'gathered up' and put into categories and themes. This time, the categories related to parents' affective states as expressed through the course of the interview.

Emotional and mental states change. What follows is presented not as a static statement about the parents in question, but as a snapshot in time of what these parents of children with eating disorders were thinking, feeling and going through - as the researcher understood it.

4.3.2 Mother's implicit representations of their relationship with their daughters

Besides the observations of emotions in mother's/parents' narratives, another feature was noted in mother's interviews. There was variation in the way mothers implicitly represented their relationships with their daughters. Some spoke as though an important relationship between themselves and their daughter was to be taken for granted. Others communicated more diffidence and distance. This was a quality that permeated the whole interview, not something explicitly spoken about, as mothers were not explicitly asked about their relationship with their daughters. Nevertheless, it was thought that this feature might bear a relation to the question of mentalizing and RF with which interviews would also be analysed, and hence this feature was also noted thematically.

4.4 Interpretative themes

Table 6 shows the themes, called 'interpretative themes', developed by the researcher out of observation and reflection on mothers' implicit relationship with their daughters (themes 7a, 7b and 7c), and their emotions as expressed in their narratives in various ways (8 and 9).

What follows now is a description of how the themes were elaborated; in Section 4.5 how individual mothers' were allocated to them, and in Section 4.6 a discursive summary, and in Section 4.7 a comparative discussion of the phenomenological and interpretative themes.

Table 6. All mothers' IPA themes – interpretative

UNDERSTANDING AND MAKING SENSE: Interpretative themes											
Researcher observation and interpretation of emotional impact											
	Theme	M1	M2	M4	M5	M6	M7	M8	M9	M10	TOTAL
7a	Impact/importance of mother-child relationship		x	x		x			x		4
7b	Imagining child's mental state	x	x			x					3
7c	Self referential thinking	x	x			x			x		4
8	Guilt		x	x		x			x		4
9	Rage (at child)	x					x	x	x	x	5

Themes 7a.-7c.

Where mothers spoke in terms that showed that they assumed that they as mothers had an important relationship with their child, three types were identified.

1. Theme 7a. 'Impact/importance of mother-child relationship – or its absence', denotes whether this theme appeared in the interviews.

It could be argued that this quality in mothers' narratives might be impacted by having a daughter with an eating disorder. It is common for parents to describe their daughters as 'alien' when in the grip of an eating disorder, and that they feel as though they have 'lost' her. What this theme can be said to denote is the extent to which parents felt that they could continue to have a relationship – an influential one – with their daughter through her eating disorder, and in this case in the early stages.

2. Theme 7b. 'Using self to imagine child's mental state', included expressions of mentalizing, though was not exclusive to this. It did not include an evaluation of whether or not mothers (and fathers) 'got it right'. Some parents tried to imagine their child's mental states by actively attempting to themselves in their child's shoes, while others more directly tried to extrapolate from their own feelings. Either way, it was an interesting aspect of the mother-child relationship, worthy of identification, exploration and discussion.

3. Theme 7c. 'Self-referential thinking' was broader than thinking in terms of the parent-child relationship and could include a mother's sense of herself as a central influence on her child and her family whether in her identity as worker, wife, parent, woman, or in her behavioural and emotional leadership, and in all those ways a powerful player and influence in her child's life and child's development.

Perhaps it is surprising that this theme needs to be highlighted. Some might think it could be taken for granted that mothers are, and see themselves as, powerful influences in their children's development. However, this theme arose because it stood out in contrast with the narratives of those mothers who excluded themselves from the account of their understanding of their child and her eating disorder.

Themes 8. & 9.

The final two themes, Guilt and Rage, were created to capture strong emotions in the interviews and it was found that these seemed to represent two ends of a spectrum of extreme emotion.

As described above, strong emotions were often elicited under the Impact domain in the interviews. There are many ways to express strong emotions. These will be noted, and the rationale for the particular selection of these two will be tracked and made transparent.

The method of this part of the analysis is founded in IPA, by furthering participants' own overtly expressed themes by adding the observations, explorations, reflections and interpretations of the researcher.

Every theme will be illustrated by reference to the interviews themselves. As can be seen from Table 6., mothers varied quite widely in how these themes appeared, or not, in their interviews.

4.5 Mothers' individual interviews related to the Interpretative themes

M1

M1 emphasized not understanding her daughter and feeling controlled by her at the time of T1. Her meaning-making of her daughter's illness related primarily to her daughter's social timidity and lack of confidence, which M1 herself identified with. She repeated that getting better had to come from C1 herself, C1 had to want to get better. She did not speak as though she thought she had any influence on her daughter to bring about this will; on the contrary, on hearing how other mothers did role play with their children to help them cope with difficult situations with friends, she exclaimed (perhaps ironically), "Oh God, I wish, I failed as a mother. I should have been doing that."

M1's incomprehension of her daughter's behaviour was expressed by calling her "a princess", and seeing it as an act:

"At the moment she's got this horrible character that she's playing."

On the subject of wanting to get better, she compared her own experience to C1's:

"It's got to be from her. It's *got* to be. You know, I've been in positions where, you know, life's been a bit drab and all, and I wanted to do something, and I wanted to be, I wanted to get out, I wanted to get a degree, I wanted to be self-employed, I wanted to be an entrepreneur. You've got to want to do it. You've got to want to get better. She just doesn't want to."

The developmental perspective was lacking though with M1 comparing her capacity for motivating herself and overcoming her own lack of confidence as an adult with the mental state of her ten-year-old. One might also speculate that M1's own lack of confidence extended to her role as C1's mother and particularly so in the context of C1's mental ill health.

If M1 lacked a model of how to help her daughter, it was perhaps not surprising that through some of her communications in her interview, she expressed anger.

"We're just getting dictated to, you know. This weekend, for example, you know, she's not done what she said, we made a goal about how she can go out this weekend, but she's not interested in it. ... She doesn't want to live a life at the moment. She's quite happy having whatever it is ...
I: So how does that make you feel?

M1: Out of control... I just don't know how to deal with the situation. We don't know how to turn it around, how to grow the little bit inside of her that might or might not exist to get her on track. You know, to try and persuade her. We just can't seem to do anything right at the moment. ... And however many people say that it's a hard process, we just feel like we're at the bottom here, scraping around. D1 and I were just saying, surely there's an experiment out there that is just waiting to happen, to find out why ... what can you break inside her head to break this cycle of self-destruction, cause that's at the bottom, that's what it is. And if you left her to her own devices, and took the tube out, she'd just starve to death. So how we, how can we ... what can we do to convince her, you know?"

Later, M1 summarized that she hoped that as parents they could find ways to increase C1's self-esteem and confidence and "then gradually, if there's anything inside of her which wants to get better, it will."

D1 was present in M1's interview at T1 at M1's request. This was the only interview where this occurred. He remained silent for the most part but at the end took up M1's mention of 'an experiment'. He added:

“Part of me thinks to myself, you know, better if we just stuffed her on a desert island and gave her a fridge full of food and said “Alright, C1, we’re coming back in a month. You’ll either be dead or alive. If you’re alive, that’s great ... and if you’re dead, that’ll be your choice. Come on.”

Together M1 and D1 laughed at their own idea for an experiment, perhaps with black humour.

Example of process of thematic allocation:

7a. M1’s expressed sense of helplessness as a parent, both in relation to the time before and during the eating disorder, led to no allocation to Theme 7a. (“It’s got to be from her. It’s *got* to be.”)

7b. & 7c. M1 attempted to understand C1 through relating her own lack of confidence to the same perceived in her daughter. This led to allocation to both these themes.

8. M1 did not express guilt in relation to C1 (except for the brief reference to other mothers talking about role play, but this was ironically said and therefore discounted for the sake of caution). It follows logically that if M1 does not view her relationship with C1 as potentially influential and important, she would not feel guilt about C1’s difficulties now

9. M1 expressed substantial anger towards C1 in her frustration with her current behaviour throughout the interview, her view that C1 was happy as she was and not trying to get better, that she was playing a role, that she was controlling them, and in her participation in D1’s desert island fantasy.

M2

M2 was clear that she saw her relationship with her daughter as a key relationship in the family, and her overtly expressed emotion was Guilt. The researcher was thus helped to interpret and there was less need to make inferences in the analysis of M2’s interview.

This clarity of expression by M2 may be compared with her RF scores (in the following chapter), which were the highest of the whole cohort.

M2's interview was rich with mental state thinking in regards to herself and her daughter. She also expressed her own emotions repeatedly and clearly, and made various attempts to actively imagine her daughter's mental state. She placed family relationships centre stage in her understanding of her daughter's eating disorder. However, this central idea was also at times a preoccupation, and may have become a possible hindrance to imagining alternative factors. Nevertheless, M2 managed to consider things also from the point of view of C2's own development, her relationships at school, and her ways of coping. Finally, M2 interpreted the eating disorder as a communication, a "calling out" on her parents to improve family relationships and functioning.

M2 spoke about her guilt at the impact on their daughter of their "rubbish parenting", in the context of their "dishonest" marriage. In addition, she implied feelings of guilt that she, and her husband, had left it to their daughter to shoulder a burdensome task that should have been theirs, namely addressing the problems.

Themes 7a-c and 8 were allocated to M2's interview, but not 9. M2 did not express anger or rage with C2, and this seemed to follow logically because of her assumption of responsibility for the situation they were in.

M4

M4's Time 1 interview was characterized by a degree of caution during its first half. She spoke at some length on the themes of not understanding what had happened, and being shocked at the apparent change in her daughter's character and the realization that her daughter, who in late primary school had seemed so calm, competent and confident, seemed to have changed character and become crippled by anxiety. She was cautious about understandings that encompassed the family. She seemed not to think in terms of developmental imperatives and did not explicitly entertain the idea that C4's pre-adolescent personality might be expected to change under the impact of adolescent developmental tasks. Therefore her interview was not allocated to themes 7b or 7c.

However, M4 certainly spoke in terms that assumed the importance of her relationship to her daughter, and her parenting. She mentioned her own eating disorder as a 'contributing factor' without saying more. She also expressed guilt openly. This allowed for allocation to themes 7a and 8.

She said:

“I think she has - I think she can't feel intrinsically good about herself. I think I go to... oh god, how did we not manage to make her feel good enough, you know, of course I go to what have we done, even though I know that's probably a pointless question but there is that bit in me that goes to that.”

“If I had my time again - and I'm not sure how I would have done this because my daughter was a child who volunteered it and seemed to be able to cope with it and that wasn't just at home but replicated it in all the environments she was in - I'd say I probably allowed her too much responsibility too young. Yeah, that's probably one thing ... so I think probably when I ask her about it she's says, um, what she didn't like was being left in the house alone for a little while or period of times, although she never told us that and she always had the opportunity to come with us and do things but she always wanted to stay in the house on her own ... But she tells me now she didn't like that.”

M4's interview in fact covered the largest number of phenomenological themes of *Understanding and Making Sense* of all interviewed mothers (see Table 3).

M5

M5's interview was not allocated to any of the interpretative themes. This was the result of an absence of discourse on the topics identified. Phenomenologically, M5 did not advance any understandings of the eating disorder with any conviction. Arguably, M5, uniquely among parents, completed the two interviews without constructing any narrative concerning meaning or understanding.

M5 did not speak about, or in terms of, an assumed important and influential relationship with her daughter (theme 7a), nor try to understand her daughter on her own terms (7b) or through thinking about her own feelings and experiences (7c). There were not expressions that could be construed as expressing either guilt or rage.

It was a curious experience for the researcher to come to this conclusion upon textual analysis of the interview transcripts. The interview itself was recalled as affable and collaborative, with M5 making an effort to respond helpfully and thoughtfully.

As would be expected, such a minimalist result in the domain of *Understanding and Making Sense* was also reflected in the scores on RF for M5, and will be discussed further in Chapter 7.

M6

M6, like M4, referenced her own eating disorder, but wove it richly into her account, noting where she felt that she and her daughter were alike or different. Like M2, M6 gave centre stage to the impact of the family environment, in this case the aftermath of an acrimonious divorce. She went further, tracing the impact of the divorce on her own parenting as a single mother, and the unspoken needs that she may have imposed on her daughter as a result.

C6 had been diagnosed with depression before the onset of the eating disorder, and further, had been treated elsewhere before coming to the service where this research was carried out, and so M6 would have had more time to reflect and synthesise the various components of her understanding of her daughter's eating disorder.

With such a comprehensive, rich and reflective narrative, M6's account was allocated to themes 7a-c.

There was hesitation about whether her account could be categorized as communicating guilt. M6's emotions came across less raw than in the interviews of mothers of more newly diagnosed children, but her association of her daughter's eating disorder with the divorce and her own parenting pointed to guilt, nevertheless, as the accurately descriptive emotion, hence allocation to Theme 8. She did not express anger or rage at her daughter.

There were passages in her interview where she appeared to get caught up in a narrative where the distinctions between herself and her daughter blurred, and she blended, so to speak, the two positions, her own as mother and imagining herself in her daughter's place. These are interesting to consider in more detail.

When talking about C6 her own eating disorder and how this threw light on C6's:

"I just have to be very cognisant of it, that I had an eating disorder at her age, but it was different. I had it, I got over it, I didn't have the depression and anxiety and so on that she's experienced. I didn't do self-harming. It was, I think it was, more, not sure what. But I was very conscious of not imposing on C6 my understanding of why I might have done it... My intuition was to know that she was pretending that she was eating at school when she wasn't. And I kind of thought, yeah, I think I remember doing that many moons ago. Um, you know, the lies

were very transparent to me. Luckily, C6 doesn't lie very well about anything, which is good. Um, I would say her reasons for not eating were tied up in a mixture of worries and anxiety, and a kind of being very preoccupied about friendships and how people perceived her, her self-esteem. It was a whole number of different things... You know stepping back you, I don't remember worrying about things when I got anorexia, but for C6 I could perceive this..."

M7

M7's understanding of her daughter's eating disorder was focused, as noted previously, on her daughter's withdrawal from and difficulties within her peer group. Her anger with her was palpable - perhaps all the more so for not seeing adequate 'reason' for her eating disorder. M7's anger was not expressed directly, but in an emotionally powerful section of her interview, during which she became tearful, she described the impact of her and her team of having to cut down her work to one day per week.

"For me there are no issues. My concerns are for the people who are dependent upon me. I have nine people working for me and it makes a *huge* difference to them if I'm only there one day a week. It's so specialized that they're doing projects that only I can supervise. This worries me. You know, I'm responsible for these people and their jobs and they're not going to get another job unless they get [these projects] finished. So it has a massive impact on *them*. A much bigger impact on their careers than mine actually. So I've been doing this at like two o'clock in the morning and things like, this has been the only time that I have to, to do it. And they won't get, they won't get another job if they don't get the results from what they're doing with me ..."

The emotional intensity about how her daughter's eating disorder was destroying other people's careers suggested the allocation to Theme 9. without any allocation to the themes 7a-c. Again, it seemed logical that where understanding was lacking or limited, anger and rage might arise more easily.

M8

M8's expansive T1 interview was shown tabulated thematically in Table 5., above in Section 4.3.

Given that M8 described her daughter as "intransigent" and "stubborn" and gave examples of her exhibiting oppositional behaviour since she was a small child, with a history of anxiety and obsessive compulsive disorder, it perhaps followed that she did

not speak in terms of the mother-daughter relationship being important. On the contrary, she spoke at length about the difficulty of influencing her daughter at all. Memorably, she said that C8 was the one of her children who made her feel a “rubbish parent”.

Similarly, she did not attempt to put herself in C8’s shoes, either from C8’s own perspective, or by referring to her own experiences and feelings. And it presumably followed therefore that she did not express any sense of guilt or responsibility for C8’s mental health problems or eating disorder. She spoke as if C8 was ‘a given’, and her task was to manage and endure, but not to expect to change her.

M8’s narrative therefore did not meet the criteria for any of the Themes 7a-c or 8. However, she spoke in a way that was often extreme, using language and descriptions that at times shocked the interviewer. On reflection, the shock was administered through the combination of descriptive terms such as “intransigent” with the matter-of-fact acceptance, as though – exaggerating only slightly – M8 had been delivered a kind of ‘monster’ child, a being quite independent of her as a mother:

“Well, she’s always been able to kick up a storm quite quickly and alter, so say we’re going to X, a wedding for example, and [other children] would always be like ok, and C8 would always be, ‘I hate weddings, I don’t want to go, I’m not wearing any nice clothes, I’m going in jeans, blah blah,’ she’s always been ... the most difficult of the three children, always, and always made me question my parenting skills, if I look at [other children], I actually think, hey I’m actually quite a good parent, wow, and C8 has always made me feel like a rubbish parent. ... Because, I’ve not been able to do anything about her anxiety, because she’s always kicked off in a way that the other two never did, she’s always incredibly difficult to discipline, always fought and pushed back in a way which was impossible to negotiate, you know, and leads you to become the parent you don’t want to be.”

M8 spoke openly about being angry with her husband for “not participating”, with CAMHS for their lack of imaginative treatment and listening, and spoke with implied anger about her loss of public status:

“If anybody had told me this was what it was going to be like I would not have believed them, I mean sitting there next to a child trying to get her to eat for four hours, I mean, I don’t miss my public life, you know, I’m not crying for it or craving it, but do I want to sit there and feed my child for four hours, no, you know we’ve had moments where her anxiety levels are so high that she’s lashed out in violence and that’s not pretty.”

She described the experience of having a child with an eating disorder as “a small piece of hell”.

For all these reasons, Theme 9. only was allocated to her interview after several careful readings.

M9

M9 used the striking term ‘kidnapped’ to refer to what she felt her daughter did to her. She was also consistent in describing the emotions that this ‘kidnapping’ engendered in her as anger, even hate. Her words spoke for themselves:

“It’s like she’s actually kidnapped me. I feel like that- I mean, you know, we were always very much attached at the hip and when I came back from wherever I would tell her everything from start to finish....But I came back from a trip and the following day I noticed the restrictive eating and by the Friday she was actually eating nothing. ... So I haven’t been allowed to go to work, I haven’t been able to go to work because I have to feed her twice during her school day. And I pick her up, even though I have a childminder also three days a week. She just wants me at home even though the childminder’s there. ‘I need you.’ The childminder rings and says she won’t eat her mid-afternoon snack, only with me.”

“The emotion towards her is... one of anger. And dislike. And sometimes the hate word. It’s very, very tough and I was such a hardworking person before. This sitting down at home doing nothing while the housework is building up is so frustrating. Because, now I’m home and I still have to have a housekeeper. It’s like, it’s a nightmare. The violence is kicking, usually kicking in the leg, she just gives really hard kicks. So the first thing that I try and do is that I try and remove her shoes, two months ago I would’ve been sitting on top of her for hours on end.... Two, three months ago she would have had five episodes of violence, which took up a lot of the day. Now, it’s screaming, violence and screaming.”

In spite of, or perhaps because of, M9’s unflinching expression of rage with her daughter, she positioned her relationship with her daughter as the central theme and hung her understanding of the onset of the eating disorder upon it. Her narrative contained the thought that she had probably been too absent owing to the demands of her work, and that somehow her daughter’s AN now represented some kind of retribution for all the times she had not been available. There was also the idea that in their close relationship, she, M9, was the primary player and C9 her ‘little pet’. For this,

too, it seemed that it was payback time with her daughter indubitably placing her own needs and wishes first.

As it was M9's own account that gave rise to this interpretation, her interview was allocated to themes 7a, 7c, 8 and 9.

M10

M10 understood her daughter's eating disorder primarily in terms of her pre-existing character and disposition, and did not advance and thinking about relationship dynamics and her own relationship with her daughter as having any place. Her narrative did not fit the interpretative categories 7a-c. However, there was anger present in the way she spoke in the interviews, hence her allocation to category 9.

M10, said, for example:

"Well, the impact of the illness is just huge. It's become all consuming - we're letting C10 take over everything. Which we're trying not to do. Last weekend was a 'sister weekend'. [Sister] has done brilliantly and achieved loads this year. She got a prize at speech day on Saturday morning, then she sang in a show on Saturday night and then Sunday afternoon she sang at a garden party. And so we made it a 'sister weekend'. But we said to C10 that you've got to go to other people because this is about [sister], this is not about you. [Sister] didn't want C10 there and frankly I don't blame her, she's embarrassing, you know, she's ticking and shouting and crying loudly all the time. So um... I stayed home with her, which was a shame."

M10 then developed this theme of self-sacrifice:

"I do put myself on the back burner. I've got three children and they will get what they need from me and if that means that I don't get what I need then I won't get what I need. So. I'm quite... clear about that in my own mind. So yeah, a summer holiday in [location] was one of the motivators for [sister] to get better [from AN]. She's had tears because C10 is sick: 'Well we won't be able to go now', but why? They will still be going. C10 wants to go into the in-patient unit so that I can go to [holiday location] as well. No, absolutely not. I'm not. It's kind of this self-sacrifice thing."

Although M10 did not explicitly describe herself as angry, the interpreter's view and experience of these sorts of statements was that anger was present, leading to allocation to Theme 9.

4.6 Summary of interpretative themes

Themes 7a-c concerned the extent to which mothers placed themselves in their own narrative of their child's eating disorder.

The themes were intended to capture mothers' conceptualization of their relationship with their daughter, their mentalizing of her, and their use of themselves as guidance (rightly or wrongly) in understanding their daughter.

The Theme 7 sub-categories overlapped, certainly, but it was felt that this lack of clear delineation was permissible to allow for subtle distinctions between relationship, mental state thinking about their child, and mental state thinking about themselves in relation to their child.

How mothers conceptualized their role and influence in relation to their child was mostly implied, and needed to be noted and apprehended by the researcher. This task was made easier as more interviews were analysed, and the marked divergences between one mother's account and another could be observed and compared.

Theme 7a, the importance and influence of the mother-child relationship, could be expressed in the way that some mothers naturally spoke about their pre-existing and current relationship with their child in very personal terms. It was as if their child was live in their mind during the interview. Their way of speaking about their child showed their bond, their closeness, and their mutual interaction and impact, as something could be taken for granted. M6 evidenced this stance, for example, as did M4 and M2. M9 was also allocated to this theme for the importance she gave their relationship, although their closeness was presented as much more problematic and ambivalent.

The quality was different from, say, M8 and M10, who spoke of their children more as difficult and demanding projects, requiring them as mothers to develop forbearance, self-sacrifice and patience.

Theme 7b, imagine their child's mental state, maps onto the concept of mentalizing and RF. It was allocated where specific examples of this were seen in the narratives. M1 fitted this category, despite not fitting Theme 7a, because she clearly strained to understand her child and turned to her own experience as a resource to help her in this endeavour.

Conversely, M4 did not fit this category because there were no explicit efforts on her part to put herself in her daughter's shoes, and indeed she expressed shock and bewilderment about her daughter's mental state, particularly her anxiety. But she did speak about her daughter in relational terms and referenced her own parenting both in understanding the eating disorder and in her plans for bringing about change and recovery.

Theme 7c, self referential thinking, was usually present in the same interviews as either 7a or 7b. This was a different way of expressing relationship and RF together – a 'reaching for' a narrative that encompassed both relationship and imagination, but might not be as skilled as actual mentalizing of their child or as confident of the relationship.

Themes 8 & 9 were extrapolated from the kinds of emotions expressed either directly, or communicated through the ideas, choice of words, and impact on the interviewer, often under the Impact domain in the interview. When mothers were asked about the impact of the eating disorder on themselves, their daily life, their careers, their own mental health, on their couple relationships, their relationships with their other children, their daily routines, and so on, the answers often led to descriptions of extreme disruption, distress and destruction of family life, alongside description of attempts to save family life. They were moving accounts, often all the more so for the emotions revealed, whether explicitly or inadvertently.

The emotions could be explicitly named, such as in the interviews of M2 (guilt) and M9 (rage). They could come through stories of the kinds of experiences that parents have gone through with their children through the course of their eating disorder, with extreme behaviour and violence, far outside our societal norms of parenting and family life, as in the interviews of M8 and M10. They could sometimes be expressed through contradiction between content and emotion, as seemed to be the case with M7. They could also be conveyed by means of the impact on the interviewer, such as the shock of desert island fantasy of D1 and M1, or M9's description of her daughter's habitual kicking of her shins and how she dealt with it, or M10's apparent resignation to self-negation. All of these communication channels for strong emotion were traced in the interviews.

These themes and emotions are important to capture. They do not appear much in the qualitative literature on the impact of eating disorders on carers and families, although this literature is now quite large. While it is now not only acceptable, but common, to study mothers talking about the impact on their mental health and the suffering of family members, it seems that it is less acceptable to name anger and rage. Why this should be so is unclear, but may have something to do with our societal prejudice against associating the caring role with anger and rage towards those we care for, particularly children, and particularly sick children. This may be the subject for other research.

Guilt is not an emotion or state of mind written about much in the qualitative literature either. Why should this be so? Perhaps it has something to do with the prevailing orthodoxy of treatment for children with eating disorders, FBT, which is predicated upon lack of theory about aetiology. Parents are told repeatedly by therapists and books that they should not look to their own parenting or family life for explanations for the eating disorder, and that blame has no place in treatment, and hence there would be no place for guilt either. This orthodoxy actually has gone so far that it threatens to pathologise parents who feel guilty. But in the words of M2, "it niggles away at you."

Guilt and rage, interestingly, seemed to be of an 'either or' character except in the case of M9, as can be seen in Table 6.

There also seemed to be an association between the presence or absence of Themes 7a-c and Guilt and Rage.

Mothers who thought of their relationship with their child as important in shaping their child's emotional world and development (Theme 7a), were more likely to express feelings of guilt: M2, M4, M6, M9.

Those who spoke in interview as if they did not think of the mother-child relationship as important and did not place themselves in a central, influencing place in their child's life, were more likely to express feelings of rage: M1, M7, M8, M10.

M9 expressed both – rage at her daughter’s outrageous demands; guilt at her own assumptions of love and loyalty and the advantages possibly taken in the past.

M5 was unique in having no themes relating to understanding, no self-referential thinking, and no expressions or displays of emotion either.

There is a logic to these associations. If a mother believes that she can influence and guide her child, through their bond and through her love, presumably it is more likely that she will question and review her own actions, skills and capabilities as a parent, if her child develops an eating disorder. Feelings of guilt would be logical in this context.

If a mother believes that her child’s character is mostly independent of her own maternal influence, genetically pre-ordained as it were, then she will indeed have limited expectations of the extent to which she can shape and guide her child’s personality and behaviour. In the words of M10, “No amount of love or patience or consistent parenting has ever been able to change [C10’s oppositionality].” Why such a situation should lead to anger and rage is perhaps less immediately obvious, but may be fuelled by a sense of helplessness, frustration and even failure, essentially at having been dealt such a genetic and biological hand.

4.7 Concluding discussion: phenomenology and interpretation

What does this mean for our understanding of mothers’ understanding and making sense of their daughters’ eating disorder?

The results of the phenomenological and interpretative analysis of the nine mothers’ interviews at Time 1 fall into two distinct groups.

Group 1: M1, M5, M7, M8 and M10.

These mothers tended to offer a limited range of possible understandings of and meanings to their child’s eating disorder. They were more likely to interpret their child’s eating disorder in terms of their child’s pre-existing character or ‘genetics and biology’ (Themes 3 & 4). This could include fixed characteristics like ‘stubborn’, ‘oppositional’, ‘timid’, ‘unconfident’, but they did not necessarily go on to create links between these characteristics so as to spell out what role these characteristics might have in the eating disorder. The impression given was more that their child was already difficult,

and the eating disorder represented another level of difficulty, something like a cross they had to bear as mothers and parents. This was so even in the case of M8 who identified 'anxiety' as her daughter's pre-eminent characteristic but did not advance a suggestion for how the eating disorder might be linked to anxiety. This group tended not to see their child's eating disorder in relational terms to do with family relationships or peer relationships (Theme 5). Nor did they tend to think of their child's eating disorder as having anything to do with their child's own developmental challenges (Theme 6).

Nevertheless, these mothers spoke powerfully and usually negatively about the enormous impact of their child's eating disorder on the family and their own well-being. Emotionally, as we have seen, these mothers expressed more rage with their children (except M5 who communicated no strong emotions). The reasons for this rage warrant further exploration.

Group 2: M2, M4, M6 and M9.

These mothers provided more rich and varied understandings of their child's eating disorder, trying out their thinking in the interview and seemingly more comfortable with uncertainty, speculation, and imaginative thinking. They were more comfortable with mental state thinking (linked to RF). They were more likely to advance a range of possible understandings, taking in their child's character and weaving into a more complex web, giving more space to family dynamics (Theme 5), peer group dynamics, and developmental pressures (Theme 6). These mothers placed their relationship with their daughter, and their parenting and influence in the family, centrally in their accounts, revealing through both the content of their interviews, and their taken-for-granted stance towards their daughters, that they saw their child's eating disorder as emerging in a context.

These mothers, as we have seen, were more likely to express emotions of guilt, regret at certain aspect of their parenting, and a resolve to try and change things in their relationship and family dynamics. They felt themselves to have influence and, perhaps therefore, more hope of being able to help their children. Although they also gave accounts of their child's eating disorder impacting powerfully and negatively, these mothers were also more likely to find positives in the crises that the eating disorder represented, to learn from it, and to use the opportunities provided, often in the domain of improving family communication and family functioning. As we will see in the next

chapter, these mothers scored higher on RF, that is, the ability to put themselves imaginatively in their children's shoes and imagine the emotions and intentions that lay behind their behaviour and behind the eating disorder.

Group 1 mothers' themes could be argued to fit more closely with the prevailing orthodoxy in eating disorders treatment. This approach disavows a causative model, takes a firmly agnostic stance on aetiology, and discourages speculative thinking by parents about their own possible role in the onset of their child's eating disorders. The active 'absolving' parents of blame, is considered the all-important first plank of FBT. Where explanations are sought, they may indeed be more likely in the region of pre-existing character, genetics, and a 'trigger event' outside the family, such as problems with friends or bullying.

What has not been considered in this model is that there is a 'throwing the baby out with the bathwater' effect. If parents feel, and believe cognitively too, that their parenting and their family functioning has no place in understanding their child's eating disorder, they are likely also to feel more helpless, more ineffectual, more frustrated, and more angry with their child.

Group 2 mothers' accounts can be seen as going against the prevailing orthodoxy. They included their own parenting and their own family, especially family relational difficulties, in their understanding of the meaning of their child's eating disorder. The finding made here that these mothers felt guilt, would be difficult to address, rather than assuage, in FBT until the final stages of treatment. Yet, as we have seen, these mothers also felt more effective in their child's treatment, because they saw themselves as having influence and being able to help.

These are surprising findings that turn on their head prevailing beliefs about the place of parental feelings of self-blame, responsibility and guilt being unhelpful in treatment.

Chapter 5. RESULTS: Fathers' IPA T1 & T2

5.1 Introduction

The IPA analysis of father's interviews followed the same foundation procedure as mothers'. Interview transcripts were annotated for IPA and RF and individual thematic tables created for each participant, during which times there was an iterative process between text and thematic analysis.

Superordinate themes are presented first as in Chapter 4 (Table 7). Subordinate themes are presented afterwards, including an example of a father's individual thematic table (Table 8) of the kind that was constructed for each individual participant (further examples of such tables are presented in Appendix 6). Table 9 shows comparisons between mothers' and fathers' interview themes.

Analysis of fathers' interview themes was begun, experimentally, with the pre-existing thematic categories extrapolated from mothers' interviews, to see if they fitted with fathers' content. Themes emerged as similar to mothers', with a few marked differences. These will be shown and discussed in parallel, section by section in this chapter.

Nine T1 mothers' interview results were analysed in the previous chapter (owing to M3's interview being unobtainable because of damage). Eight fathers' T1 interview results are analysed in this chapter. The fathers of C4 and C6 did not give interviews at all. D4 refused participation and did not give a reason. D6 was not approached as the couple was divorced and D6's involvement was limited.

Fathers' T2 interview results are integrated with T1 results in this chapter, unlike mothers' results. This decision was taken because there were only three T2 interviews (D1, D3, D5).

This chapter is by its nature comparative, fathers' interviews being compared both with each other as a sub-group, and with mothers' interviews across groups.

5.1.1 Comparisons between mothers and fathers

Mothers' and fathers' interviews were conducted individually, with one exception, when M1 requested to have D1 present in the room for her T1 interview.

Usually, a date for mothers' interviews took place first, and fathers' second (again with the exception of F1 at T1, where D1 was interviewed first, and F3 at T1, where D3 was interviewed first).

Analysis of the interviews was conducted so that all mothers' interviews were analysed first and all fathers' second, to facilitate both within group comparison and cross group comparison. Further, partners' interviews were then re-read in parallel for comparison of couples' narrative themes.

Conducting separate interviews with a couple meant that the interviewer was in a unique position to compare partners' accounts. On the other hand, this also had the potential to create bias. The possible skewing of interpretation resulting from this is discussed further in Chapter 9 Discussion.

In Section 5.5, a detailed example is given of how themes were analysed, allocated and comparisons made within the couple, demonstrating the way their respective themes shed light on each other's accounts.

Care has been taken not to make inferences about the couple's relationship beyond what is evident through their own accounts. A comparison of how parents manage a child's mental health disorder might make for an interesting study elsewhere, perhaps in the field of gender relations and gendered ways of representing the idea of family, parenting roles, care and emotion.

For the purposes of presenting results in this chapter, it was decided that besides the special fine-grained analysis of one couple in Section 5.5, it would be noted within the text, when partners' interviews diverged particularly far, for example, where partners barely mentioned the same themes, or where partners had markedly different interpretations of the same event.

5.1.2 Broad differences between fathers and mothers

First, and strikingly, several fathers (D1, D2, D3, D8, D10) used parts of the interview to talk about themselves and their own personal experiences, including personal

experiences dealing with mental health issues. In the case of D2, and to a lesser degree, D8, this was at a level of detail and length that could be said to derail the interview and even came across as inappropriate. That is, they were unable to stay on topic of their child's experience. A few mothers strongly referenced their own learning from their own personal experience and development (notably M1, M2, M6) but this was kept brief and relevant to their role as caring for their troubled child.

Second, fathers' positioned themselves differently from their partners in the family. They made clear in various ways, that will be discussed, their sense of being peripheral in the management of this family catastrophe. Emotions of bewilderment, helplessness and anger were to the fore. Pain and anger was also expressed strongly on behalf of their partners and other children; sometimes fathers seemed to empathise with their other children's and partners' suffering more strongly than with that of their sick child. Fathers more easily expressed feelings of frustration and blame of their sick child than did mothers.

5.1.3 New themes for fathers

Fathers' phenomenologically analysed themes can be seen in Table 7 in the same format as mothers' in Table 3.

During the course of analysis of fathers' interview transcripts, which took place after the analysis of mothers', a new theme was added.

This theme was named 'Seeking attention – a communication'. All eight fathers' accounts contained this theme, a uniquely unified thematic category. Evidence from each father's interview to support this new theme is presented in Section 5.2.1, and a discussion about why it was so prevalent in fathers' accounts and not in mothers' in Section 5.2.1.1.

Blame was more openly expressed by fathers. It was important to try to understand, and not shy away from this. Blame could be directed at their sick child, or in some cases, at the child's mother, their partner. In one way, fathers' accounts were refreshing in not adhering to 'political correctness' of the no-blame treatment orthodoxy in eating disorders. It seemed that that this orthodoxy was not in control of some fathers' emotions, often expressed artlessly. In another way, the anger that could be

expressed towards their child could be quite shocking. The impact on the interviewer was memorable, in both these ways – refreshing, and shocking.

Therefore, a new category was duly added to the 'Interpretative' thematic table, Table 8. This category was called 'Mother/Child blame', and it was indicated which of these was intended. In no instance did an account contain blame of *both* mother and child. It was almost as if, for some fathers, someone had to be blamed as a release of emotion, and that blame could be directed either their sick child or their partner in her role as mother.

The sense of being peripheral was expressed in a number of ways: fathers might say that they were bewildered and had never seen anything like this before (D8), that they were horrified at witnessing what seemed like madness being played out in the family (D9), that they felt like a 'spare part' (D5), or a more general sense of detachment (D2). They spoke about supporting their partners, observing that the burden on care fell on her, but being unable to do anything about this, protect her, or initiate change.

This sense of helplessness may have lain behind tendencies to blame, insofar as blame can be seen as a psychological defence against helplessness. It could also be overtly expressed self-pity ('why me?'), or a general sense that they had been unlucky in how their family life was going.

Various headings were tried out in order to capture this emotional theme notably running through several fathers' accounts, the evidence for which will be presented below. 'Helplessness' was a strong contender but failed to capture the emotionally intense and angry quality running beneath the descriptions that fell into this theme. Bewilderment, 'peripheral-ness', complaint, resentment, self-pity all were considered. In the end the word 'plaintiveness' was settled upon to try to capture all of the emotions above. 'Plaintiveness' was added as another, new, theme in the Interpretative section of Table 2b., and was found present in six of eight fathers' accounts, that is, three-quarters of interview respondents. It was only absent from D1 and D3, and in Chapter 9 Discussion, Section 9.7.4, it was interesting to consider why and when it was present and absent.

Finally, an adjustment was made to the Interpretative theme 'Rage', and was differentiated into Rage at Child/Professionals, because one father's account was

suffused, and at times taken over, by enormous anger at and criticism of treatment providers at both time points, including that of the researcher at Time 2.

5.2 Results of phenomenological thematic analysis

Results are presented first in tabular form and then discussed in detail through textual evidence from fathers' interviews followed by comparative discussion with mothers' results.

Table 7. shows all fathers' phenomenological themes presented in the same way as mothers' in Table 3.

Table 8. is an example of an individual father's thematic table, with comments and quotations, parallel to Table 5 in the last chapter. All individual thematic tables can be seen in Appendix 5.

Table 9. offers a simple visual aid to the discussion that follows below, in relation to the spread of themes between mothers' and fathers' sub-groups and some of their curiosities.

Table 7 All fathers' IPA themes – phenomenology - T1 & T2

UNDERSTANDING & MAKING SENSE: phenomenological themes													
What fathers thought and said													
		D1/ 1	D1(2) *	D2	D3/1	D3(2)*	D5/ 1	D5/2*	D7	D8	D9	D10	Total 8 (11)
1	"I don't know and don't understand"		✓				✓	✓		✓		✓	4
2	"An ED is a disorder of eating"			✓			✓	✓		✓	✓		4
3	Genetics, biology, inc ASD												0
4	Child's own character traits – anxiety, low self-esteem, perfectionism, etc.	✓	✓		✓	✓				✓		✓	4
New 4a	Needing attention – a communication	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	8
5	Impact of family events/ relationships – illness, divorce, bereavement, parental discord - control	✓	✓	✓	✓	✓							3
6	Impact of adolescent development and its social demands, school, peers, friends, media	✓	✓		✓		✓	✓	✓				4

*represents a T2 interview. Each participant's themes are counted only once for the purposes of the count in the totals. T2 interviews are represented in a lighter colour for easier identification.

Table 8 Example of individual participant's thematic table D3(T1 & T2)

T1	Understanding	Impact	Value	Recovery
1	"An eating disorder is a disorder of eating"	Couple strain	More involved as Dad	C3 to start thinking and linking
2	Anxiety control/pre-morbid OCD	Deteriorating relationship between C3 and mum		
3	Sibling rivalry			
T2	Understanding	Impact	Value	Recovery
1	Control – of family situation and needing help and attention	Positive experience for C3 to have overcome an ED	Like Impact 1	Seeing other girls miss out life and school
2	Attention - needy	Withdrawal of older sister and incipient ED		
3	Fixed character traits e.g. perfectionism	Brought family closer		
4	Feeling less loved than sister	Continued strain on couple		
5	Poor mother-daughter fit			
REFLECTIONS & QUOTES T1&T2				
Understanding 1 (T1) "I see that she seems to draw to her eating and er there are sort of different aspects so sibling rivalry, anxiety, approval, control, right so I'm not quite sure and it just seems to be that I don't know which one it is really."				
Understanding 2 (T1) Anxiety & pre-morbid OCD "excessive habits so she would repeat at bedtime goodnight, goodnight and make us say it a number of times and there was quite a lot of other repetition stuff going on. And just behaviour sessions where she would just go on for ages getting upset and saying are you happy with me: you know it all became very stressful for her right, screaming shouting fits for no real reason, she certainly calmed down, right, or well she found there was a reason but it was to do with not coping with either her homework or some small thing that became a big obstacle so not really enough help yeah, so for that kind of behaviour and similar workings so we went, because we got referred by the GP, to the [] Centre. And um: then they saw her-they saw the family really, for a while, a few sessions, and then they recommended she have um ... psychotherapy"				

“Many things were too much for her, not everything, but she was quite happy as a you know in some sense as a younger child, erm: but I think she did struggle to, well we saw homework, she struggled with very simple homework and just made a big thing out of small things and would take a long time doing them. I mean I think that she, yeah we saw it more as a always seeking reassurance, even when she knew something”

Understanding 3 (T1)

Sibling rivalry

“I guess she's always um ... been looked up to her sister is how my wife thinks about it. And not got her sister's attention the way she wanted her attention, the way she'd get an adults attention, right, so she sort of felt-and then I think um: ... and then I think in her primary school she didn't get into the same school as her sister, so she tried, her sister got in but she didn't get in, right, so-so there was a school rejection - these days you know it's hard it's hard at 7 they have a group selection, you know, they kind of interview the kids, right, so I think there were at least two instances in which she didn't get into the same school as her sister and-and I think she took those on board that she wasn't as good as her sister”

“She was very keen to go to the same secondary school as her sister, and she become-became over focused on that goal, and has really proved academically ... but, she does work in a way that she doesn't really enjoy it - her sister kind of enjoys it, so her sister can enjoy stuff and doesn't make a meal out of it, for C3 it's like constant struggle, right, so we feel she's ... compared for quite a long time and at some point that comparison became comparing eating”

“little bit on the chubby side compared to her sister and then I think she equated the .. not eating and getting slimmer with doing better at school right”

“And I think that's her self-image it's all about we like her sister more than her”

Understanding 5 (T2)

Poor mother-daughter fit

“And partly just, I think, I think it's just personality-wise I think she, she was more of a needy child and M3 is less, um, you know inclined to indulge that, right, than some parents might be and I think that sort of, um it works for [sister] but not for C3. It didn't work for C3, yeah.”

Impact 1(T1)

Couple strain

“Yeah there-there-there's a bit of that so I would - because you know M3 and I are quite different so you know she's um kind of perfectionist, everything has to be perfect right, um whereas I'm pretty laid back. I'm also a bit obsessive in terms of my work so I tend to-so something will happen at home and I'll go to work and forget all about it,and I'll just carry on right. So I think she felt that

my personality was to ignore things, go to work ...and um because she's not working she's at home, she's always there things won't change and feel stuck.”

Impact 2 (T1)

Deteriorating relationship between C3 and M3

M3 sort of believes that, or that's what she says anyway, that, she'll never have a good relationship with C3, C3 will always think she's not a wonderful a mother and that's how it's going to be, right

...and: it's like *stuck*, stuck on that, eh, well because I guess it feels as if life has to go on, right, C3 one to one is quite good. So we have quite similar things so one to one is quite good. But somehow the one to one doesn't translate into the family. It's not strong enough that when all four are together. I remember as a child you know, I got on with my father much more than my mother and my brother was opposite so it's fairly common to attach, for one child to prefer another parent and stuff. But for C3 it's somehow she feels with her mother she's not getting, something, which is too much, you know, to bear a bit. So I guess it's not compensating her enough, even though I spend far more time with her than I do with [sister].

“I think it makes people angry that she's just ungrateful really she doesn't really believe, she's not happy that things are not done the way she would want even though they always end up getting done right. So it does make people angry yes. I would say what gets me angry is when she upsets M3, that's what gets me angry right, yeah:, whereas she gets M3 angry directly”

Impact 3 & 4 (T2)

Brought family closer/continued strain on couple

“Yes, well, I certainly I've made a very conscious effort while in that process to be much more involved.

Um, with family and making time et cetera. So I think that has brought us closer. Um, sorry and I think, with M3 I guess, yeah, it didn't really help, I think this issue with M3 was a bit, um, is a bit, yeah I think, um, because we, we've focused so much on the children's needs, I think that's something we've always done maybe too much, right. Um, it's not helped, and then we, you know, never find time for each other and doing things, it happens but not regularly enough, I'd say. So, so, so, so I think part of so part of the trying to work as a family to try to help your child you maybe do less for yourself.”

Value 1(T1)

Being involved in children's lives more

I'll tell you the only positive thing and: it's probably just for me, maybe not for M3 and [sister] is that,

the positive for me is that I think it's made me more involved in their lives, in my children's. I would say you know M3 always accuses me as being obsessed about work, and not being there at home, right, in a mentally... I think it's true I think it's definitely got me much more, involved:, I guess in more intimate things, yeah than I guess I would otherwise have been otherwise. I think

men, and I think I'm much more ... I don't think about those things or don't want to be involved or keep barriers and stuff right, so I think both with M3 probably as well really because she always accuses me of not being intimate, yeah mentally and er: so I guess she probably wouldn't say that now, although I'm not sure whether she would or not. But-but I think we talk a lot more about these things, we're more involved"

"Yes so it's C3's need, conversation, talking about it, which in the past I would not think about, you know to me the way I would have responded to things would be some event happened deal with it but not think about it or discuss it or give my impression"

Reflections

Treads a fine line between accusing M3 of giving up on C3, of having high demands of himself, and also giving her criticisms due consideration and thinking about himself and trying to change. Change in his position in the family, or at least in his conception of his own position in the family, seems to have happened, and brought about something positive, by T2. Many topics are covered: how his own upbringing influenced how he was in the family and his role as worker and father and partner; his helplessness in the face of the poor relationship between M3 and C3 tending occasionally towards blame (C3 couldn't get what she needed from M3 because C3 is needy and M3 won't 'indulge' her); his support of the family as a whole but also very much playing second fiddle to M3, peripheral in decision-making and solution-finding and yet pivotal. Perhaps he also feels blamed.

Table 9. Spread of mothers' and fathers' phenomenological themes

	Theme 3 Genes & biology	Theme 4 Personality factors	Theme 4a Attention	Theme 5 Family factors	Theme 6 Social/ development
M1		✓			✓
M2				✓	✓
M4	✓	✓		✓	✓
M5				✓	
M6				✓	✓
M7					✓
M8	✓	✓			✓
M9				✓	
M10	✓	✓		✓	

D1		✓	✓	✓	✓
D2			✓	✓	
D3		✓	✓	✓	✓
D5			✓		✓
D7			✓		✓
D8		✓	✓		
D9			✓		
D10		✓	✓		
Total M+D	3(3+0)	8(4+4)	8(0+4)	9 (6+3)	10 (6+4)

5.2.1 Theme 4a. 'Seeking attention – a communication'

This was the only new theme added to the phenomenological section of fathers' individual tables. Extracts from fathers' interviews will show evidence for creating this new theme. The question why this theme should stand out across *all* fathers' interviews, and not mothers' interviews, will be discussed.

Attention-seeking could be expressed empathically, designated 'a cry for help' (D5), or pejoratively, such as trying to hog parental attention at the expense of other siblings (D10), sometimes both ways at different points in the same interview. Fathers said, for example:

D1 "A kind of healthy, constructive way of looking at it is that it is her last resort way of getting heard, and making us listen, *properly*, and take note, that things aren't right, in a way that nothing else before had worked."

D2 "I don't think it is control, health-wise it's anything but control. But it feels good, and actually what comes out of it is that they get attention, I think they bring the spotlight on the family..."

D3 "I think it's just personality-wise she was more of a needy child and M3 is less, um, you know, inclined to indulge that, right, than some parents might be, and I think that sort of, um, it works for [older sister] but not for C3. It didn't work for C3, yeah."

D5 "Was life as enjoyable as it had been before? Maybe for her, it wasn't for various things... But that's the trouble. We didn't notice. Maybe M5 didn't give her time and attention and C5 was used to that a lot more and it doesn't take much to ..."

D7 "I've come to see that in some ways it's a kind of a cry for help, in the most dramatic way possible, you know, the only other thing that would be as dramatic I guess would be you know an attempt on her own life... [C7] is finding it difficult to make the transition [through adolescence], and so part of it is 'I don't want to do this, or I'm not ready to do this. So, I'm gonna to do the worst thing I can think of to get you focused on me and help.' In a way because she cannot, or feels she can't...or together as a family we can't, or don't communicate effectively enough to...deal with it."

D8 “Our younger daughter thinks it’s attention seeking, she’s doing this to seek attention and she certainly is getting a lot of attention. We have given her a lot more time and attention, not necessarily all of it good, because some of it is prodding at her, nagging at her, you know, why aren’t you eating? I don’t think she wants that kind of attention and we don’t want to give her that kind of attention but we have to...”

D9 “Sometimes M9 would be working late, C9 would still be there with her and she’d be tagging along. Like she was with her but we didn’t do enough fun things I think. When we look at it now, you know, we - they [the children] were kind of deprived a bit I think. That we made them rhyme with us rather than ask them what they’d like to do.”

D10 “I don’t know why. It’s not like we haven’t given her any attention. You know she is one of three siblings so there is that. You know, you’re always going to be sort of battling with the other two I guess for the attention of the parents. But, um... yeah, it seems to be extreme attention-seeking behaviour. So, obviously when she couldn’t walk we had to give her an awful lot of attention and she was the centre of attention for a year.”

5.2.1.1 Commentary on Theme 4a ‘Seeking attention – a communication’

This was a new theme for fathers, present in *all* fathers’ accounts, and it is perhaps more curious that this theme was not identified in the IPA analysis of mothers’ accounts, than that it was identified in fathers’.

A few reasons for this curious discrepancy could perhaps be in operation.

‘Attention-seeking’ is a socially widespread and popular way of stigmatizing young people with AN. It is a pejorative term. (For example, an internet search using the term ‘attention-seeking’ brings up definitions relating to histrionic personality disorder). Mothers, who had generally informed themselves more through reading, researching and speaking to other mothers, and had more contact with professionals, would likely have been aware of this stigma and therefore can be assumed not to have wanted to describe their daughters’ motivations in terms that might echo this.

For the purposes of this analysis, the theme has been labelled ‘seeking attention – a communication’, in order to remove the stigma and to indicate intentional communication.

Even then, this theme did not stand out in mothers' accounts. It could be proposed, speculatively, that for mothers to speak in terms of their daughters seeking attention through restricting their eating, would be to acknowledge that their daughters lacked sufficient attention. Such an interpretation would imply mothers' own failure to notice their daughters' needs and might be a painful, guilt suffused idea.

However, fathers noticeably made use of the idea of seeking attention, or occasionally more subtly, seeking to communicate a need through restricting eating, without seeming to feel that this way of understanding reflected negatively on their own parenting. Occasionally, however, the idea was floated that their partner had not been paying sufficient attention to their daughter. Where this idea is present, it has been noted also in the new interpretative category of 'Mother blame'.

5.2.2 Themes 3. and 4.

Theme 3. Genetics, biology and ASD

This theme did not appear at all in fathers' interviews. This was the case even with those two fathers (D8 and D10) whose daughters were subsequently actually diagnosed with ASD, and where mothers anticipated this likelihood in their own interviews.

Theme 4. Child's own character traits – anxiety, low self-esteem, perfectionism, etc.

D8 and D10, along with D1 and D3, did give much consideration to their children's pre-morbid personality characteristics as factors in the eating disorder.

For example, D1 at T2 wove a subtle, rich and, in terms of his hopes for change, optimistic, account of the way his daughter's personality and AN came together:

"I can identify things in C1's life from a really early age that could be consistent with a trajectory to be anorexic. She was always very small, she wasn't particularly interested in food from early on. I can think of times from a very early age when she was, um... quietly sensitive to things going on around her that... I can see looking back now that she would internalize, she had a tendency to internalize things quite hard, in situations where other people would take the same basic experience and react very differently and let it bounce off them. Also, she does have some educational special needs, a bit, and I had a bit of that as well when I was a kid, and I

know it's not good for the morale, and when I was about 8 or 10 I reacted differently by being naughty at school, but because of the kind of person she is, you know, she took it out in a different way and she started just internalizing it and saying, oh I'm rubbish and stuff. I think she's getting all that and gradually being able to think, if this person doesn't like me, so what, hey, I don't exist so that this person can like me. Um, I think she's building that up. And she's got this fantastic, fantastic personality, and just getting comfortable in her own skin." (D1,T2).

Some fathers spoke negatively of their children's characters. D8 and D10 both described their daughters as selfish and difficult.

"Certain aspects of what she is manifesting now, she has always manifested ever since she was a child - she can be quite unfeeling or uncaring" (D8)

"With C10 we had the earlier sort of period where she had this funny, odd thing where she had a fever for a couple of days and then she couldn't walk. And there was no sort of medical reason, you know, they did all the tests and scans and couldn't find anything medically to explain it ... she kept not walking for another year. And maybe that was a sort of earlier incarnation of this kind of behaviour. And then she got better from that and, and a year later, she's doing something else. Which is another, um, sort of very selfish type disease, or illness. Um, and it's incredibly selfish" (D10)

D3 recalled:

"She would repeat at bedtime goodnight goodnight and make us say it a number of times and there was quite a lot of other repetition stuff going on. And just behaviour sessions where she would go on for ages getting upset and saying are you happy with me: you know it all became very stressful for her, right, screaming shouting fits for no real reason, or well she found a reason but it was to do with not coping with either her homework or some small thing that became a big obstacle" (D3, T1)

5.2.2.1 Commentary on Themes 3 & 4

No fathers cited Theme 3 in their accounts. In Chapter 4 it was proposed that mothers who attributed their child's eating disorder in part to genetic and biological factors, might derive some relief from feelings of helplessness and inefficacy as mothers. This was memorably articulated both by M8 and M10.

For example, where D10 described his daughter as selfish and attention-seeking, M10 put it this way:

“If she's not on the spectrum she has some kind of drive in her to... self loathe. That's always been there so... I don't know if that's the right phrase. I think it is. It's that she'd always take something nice and destroy it.” (M10, T1)

On the other hand, where a child's personality factors such as anxiety or low self-esteem were cited, this might point the finger at mothers in the way articulated by M4, “oh god, how did we not manage to make her feel good enough”...

At the same time, if one believes that one's child's personality traits are shaped by the family environment, this gives more agency to a parent, more expectation of adaptability and change in one's child, and consequently, more hope. Half the fathers chose the latter option, perhaps feeling less afraid of being blamed, and more hopeful of their influence?

5.2.3 Theme 5. Impact of family events/relationships

While Theme 5 was the most widespread among mothers (67 per cent, or six out of nine), it was the least common among fathers (37.5 per cent, or three out of eight).

This was partly owing to an accident of distribution, in that those mothers whose partners/ex-partners did not participate, that is, M4 and M6, presented this theme in their narratives.

D1, D2 and D3 brought up this theme in their interviews.

D1 was more articulate than M1 about the impact of family events, and specifically their own parenting. His view was that their parenting had not suited C1's particular needs and vulnerabilities and that they needed to change their way of looking after and supporting her. M1 shared this view to some extent, hence both M1 and D1's narratives were allocated to this theme, but D1's formulation led the way for M1's. In F1, it was, uniquely, D1 who placed family functioning centre stage.

In F2, the divergence in parents' interviews regarding the family factors was almost complete. Both parents' narratives were allocated to Theme 5 (Family events/relationships), but for quite different reasons.

M2 thought that their long-standing marital unhappiness and dysfunction as a couple had had a big impact on their daughter and that her eating disorder was a communication about this making her unhappy and needing to be changed. D2, on the other hand, thought that M2's illness – something M2 didn't even mention – had made their daughter fearful and anxious, afraid even that her mother would die. His account focused on the impact of M2's illness, and his reaction to it, his interview at times including a reliving of his wife's hospital admission and surgery, that seemed to speak of ongoing trauma. He explicitly related his experience of his wife's illness to his experience of the loss of his father at the age of 12. While affecting, this singular account also derailed the interview insofar as the focus did not reach their daughter.

Unlike M2, D2 did not mention the couple relationship being in trouble in relation to their daughter's eating disorder, though he did attribute 'Value' insofar as it had brought them to couple counselling, which he considered a positive thing. At Time 2, M2 let me know that the couple had separated. At this point, D2 was not contactable despite efforts being made, and therefore no longer available for interview.

D3 had a similar understanding of the role of family relationships in their daughter's eating disorder as his wife, that is, that their younger daughter felt competitive with and inferior to her older sister, and that this had impacted negatively on her self-esteem and confidence.

Discrepancies arose between the interviews of M5, M9 and M10 and their partners D5, D9 and D10, where mothers highlighted this theme in their interviews, and their partners did not.

For example, D9 hardly mentioned M9's bereavement of her aunt that had made such an impact on her well-being and work stress, and which featured large in her own account of the onset of C9's eating disorder. D9 highlighted that his wife worked in a way where she expected their daughter to fit in and put her needs as a working mother first. Therefore his way of framing this aspect was considered more appropriate for allocation to the category of 'Mother blame' in the Interpretative section.

Where M10 spoke about the impact on C10 of her older sister's AN precipitating a degree of sibling competition, D10 framed it as typical of C10's selfish character, which again lent itself for allocation to the category of 'Child blame'.

D5 only referred once in passing to the possible impact of M5's bereavement, but as M5 herself was extremely ambivalent about whether this topic was valid, this was not able to be explored in greater depth with D5.

5.2.3.1 Commentary on Theme 5 'Family events/relationships'

In two fathers' accounts, this theme encompassed blame directed towards their partners (D2 and D3). In these instances they were allocated to both Theme 5 and Theme 8 'Mother/child blame'. One additional father (D9) blamed his partner without situating this within family events particularly (in contrast to M9's own account of the impact of her aunt's death on her mental well-being and coping).

It is noteworthy that the situation was not reversed – where mothers considered parenting failures or weaknesses to be part of the picture when the eating disorder took hold of their child, they did not blame their partners. The exception was the narrative of M6, who had been through an acrimonious divorce. Even then, it was not articulated enough to merit a thematic category and most of M6's narrative relating to Theme 5 concerned her own perceived parenting weaknesses, in the light of being a single mother and relying on her daughter for support in various practical ways.

Theme 5 was a broad theme, and within it contained a number of stories, situations, and reflections, including:

- accounts of self-critical evaluation of parenting (D1 and M1, M2, D3, M6)
- self-critical evaluation of marital relationship, or divorce, and its impact on daughter (M2, M6)
- bereavements causing the self-preoccupation of loss and grief (M5, M9)
- illness in one member of the family causing preoccupation and anxiety (D2, M4, D10 and M10)
- sibling rivalry or strained sibling relationships was often cited, seemingly more by fathers (D1, D3, D5, D8, M10 and D10)

Does this disparity reflect our culture, in which fathers are still often perceived, and may themselves feel, as mere deputies for their partners – mothers being the custodians of family functioning and attending to children’s needs? And further, does it reflect an aspect of our culture where, when children and teenagers do have diagnosed mental health disorders, their management is ‘genderised’, with mothers becoming home-based experts and co-therapists, while fathers become deskilled and marginalized? Anecdotally, and clinically, this is an observable phenomenon. In research literature, it is a barely noted phenomenon, where, despite a literature existing on parental burden in paediatric illness and, more recently, paediatric and adolescent mental health, there is little writing differentiating the burden on mothers and fathers and, further, documenting the impact on the family as a whole.

Could these disparities also reflect lack of a shared understanding, in these particular couples, and perhaps more broadly in our culture, about what aspects of family functioning are important for children’s well-being?

5.2.4 Theme 6. Impact of adolescent development and its social demands, school, peers, friends, media.

D1, D3, D5, and D7 talked about this theme in their understanding of their daughters’ eating disorder. Discrepancies arose between D5 and M5, where M5 did not include this theme, and D8 who didn’t mention it whereas M8 included it regularly.

What unified the four fathers who gave time to this theme was their focus on difficulties in relationships with friends and peers. D1 and M1 spoke about the same issue with their daughter being involved with a ‘domineering’ friend and also, to some extent, a ‘domineering’ older brother (D1 used this word repeatedly).

D3 saw his daughter’s difficulties at school as part of the bigger canvas of her lack of confidence in relation to her sister.

D5 had quite a different account from his wife and made much bigger capital of his daughter’s social problems, returning to them several times during the course of both interviews. He thought his daughter had always been shy and called her ‘second tier’ in social terms:

“So if there’s a bunch of girls having fun or whatever, they’d stand around and watch that until they became comfortable. And her cousin was absolutely identical. When we’d see the two together, they couldn’t stop messing around and being loud. As soon as you put them with others, nothing... You’d think, ‘Goodness me, are you two ever going to say anything?’ When you see them now, you can see how [cousin] has developed and grown up, whereas if you put C5... C5 will see herself against [cousin] and without a doubt she’ll see herself ten times less of a person. I know that M5 feels that way. But actually, if she was second tier with [cousin], C5 has dropped down to third and fourth tier and she’s probably on her own. And that’s why she doesn’t have, I think she has friends in school to sort of talk amongst class chat or maybe the odd playground chat, but outside of school ... I don’t know, I find that pretty unhealthy.” (D5, T1)

D7 shared his wife’s perspective on their daughter’s social and peer problems though he added the observation seen in Theme 4a that if they as parents could not help her with these problems, perhaps the AN was a call for help.

5.2.4.1 Commentary on Theme 6

Fathers were attentive to their daughter’s problems at school and with peers and attributed importance to them. This also stretched to taking account of sibling rivalry more strongly than mothers seemed to do. Sometimes they cited their own adolescent social experiences in support of their understanding. It seemed that here fathers might have been well able to put themselves in their daughters’ shoes in their awareness of how debilitating and corroding of self-esteem it can be if one does not develop good friendships and a standing within the peer social hierarchy. This can be an aspect of children and adolescents’ lives that mothers overlook.

5.3 Results of interpretative thematic analysis

5.3.1 Introduction

The same interpretative themes as for mothers were used initially, and, as highlighted in the introduction to this chapter, through the course of the analysis, two striking two new interpretative themes emerged in fathers' accounts. These related particularly to the emotions expressed in relation to the Impact domain – the impact of their child's eating disorder on their families and themselves. The two new themes were: 'Mother/child blame', and 'Plaintiveness'. Table 10 shows the interpretative themes with their new additions.

Theme 7c. 'Self referential thinking' was implicitly expanded to include some self-referential accounts with fathers thinking about their own emotional development either as teenagers or as adults, partners and fathers. Sometimes these accounts were offered as springboards for fathers trying to draw on their experience of life to date to try to understand their daughters. At other times, fathers seemed to get lost in their own accounts. The interviewer's reflections were that in these instances, it was as though these fathers were lost in a new and unfamiliar landscape, when trying to speak about mental health, both their own and that of their daughters. Extracts to support this reflection will also be given.

Theme 9. 'Rage' was refined to differentiate between rage at their child or rage at professionals, since one account in particular (D1) gave lengthy attention at both T1 and T2 to the failures of treatments and services.

As a reminder of the explanation in Chapter 4, themes 7a-c were intended to represent aspects of the possible pathway to RF, or 'mentalizing', of a child by their parents. Themes 8 and 9 capture two ends of the spectrum of maternal emotions as interpreted by the researcher.

Table 10. All fathers' IPA themes – Interpretative T1 & T2

UNDERSTANDING AND MAKING SENSE: Interpretative themes													
Researcher observation and interpretation of emotional impact													
	Theme	D1	D1(2)	D2	D3	D3(2)	D5	D5(2)	D7	D8	D9	D10	Total/8
7a	Impact/importance of parent-child relationship – or its absence	✓	✓	✓	✓	✓	✓	✓					4
7b	Using self to imagine child's mental state	✓	✓	✓			✓		✓	✓			4
7c	Self referential thinking	✓	✓	✓	✓		✓		✓	✓			6
7d	Mother/child blame*			//	//	//				//	//	//	5
8	Guilt	✓			✓						✓		2
9	Rage at child /at professionals*	/✓	//		✓/				✓/	✓/	✓/	✓/	6
10	Plaintiveness			✓				✓	✓	✓	✓	✓	6

* Themes 7d and 9 contain options indicated by the symbol '/' (forward slash). The tick is on whichever side of the symbol that fits the fathers' narrative.

5.3.2 Theme 7d. Mother/child blame

The new category 'Mother blame' was invoked when fathers' accounts included suggestions that their partners had in some way neglected their daughters or in some way fostered an atmosphere at home in which the eating disorder could grow. 'Child blame' was invoked when they revealed their frustration with their child, and the idea that she could have chosen to behave differently, or implied that there was some intentionality to the suffering being imposed on the family. Five out of eight fathers' narratives included this theme: 'mother blame' by D2, D3 and D9; 'child blame' by D8 and D10.

5.3.3 Theme 9. Rage at child/professionals

Six fathers' accounts fitted with this theme, three-quarters of the sample. Five (D3, D7, D8, D9 and D10) directed their anger at their child, or at the impact their child's illness

and behaviour was having on the family and themselves, and one at professionals only (D1).

Plainly this category overlaps with Theme 7d. 'Child blame', and to some extent Theme 4. 'Child's own character'. However Theme 9 was created specifically to capture the emotion of rage, even when not moored to cognitively based assertions of blame.

5.3.4 Theme 10. Plaintiveness

This theme was identified and named in order to capture a rich emotional mix of helplessness, bewilderment, self-pity, and perhaps a sense of loss of old certainties, including a profound challenge to the fathers' sense of their role in the family. Sometimes this theme emerged when fathers seemed to go off topic, not answering the question, speaking intellectually or theoretically, or asserting their values. At other times, a raw emotion, a plaintive cry, seemed to characterize their narratives. A selection of quotes from interviews will illustrate this theme.

It may be relevant that those fathers who could be considered the most 'engaged' in the research interview process, i.e. those who completed both interviews, D1, D3 and D5, did not meet criteria for this category, although D5 hit some notes in that direction in his second interview, when he spoke about his older daughter developing an eating disorder in the interim, bringing what seemed to be a sense of defeat.

It would seem reasonable to hypothesize that the more agency fathers felt in their families including their daughter's treatment and recovery, the less they were prone to the mixed emotions of helplessness, self-pity, bewilderment and complaint, that make up the theme of 'Plaintiveness'.

5.4 Fathers' interviews: Summaries, extracts and evidence

D1

D1 gave two rich and layered interviews, 19 months apart, that managed to encompass a focus on Understanding, on the importance of their relationship with their child and their own parenting, without allocating blame to either his partner or daughter. His understanding contained the idea that he and his wife had not been observant about the ways in which their ten-year-old daughter was struggling, and for this he blamed himself, or took responsibility. As can be seen in Table 10, his interviews met

criteria for the 'mentalizing' qualities of Themes 7a-c, and Theme 8 'Guilt', and avoided both blame and rage directed at either his wife or his daughter.

However, powerful jets of blame were directed towards professionals by D1. This might have been a 'defence mechanism', a safe directing outwards of emotions that, if kept inside the family, could have damaged it. It could also have been an accurate portrayal of inadequate services and poor treatment. Nevertheless, in both interviews D1 took up considerable space to criticize professionals.

D1 summarized his understanding of his daughter's eating disorder, and its implication for him and his wife as parents, as follows:

"But, well, one way of looking at it is, that it's the best way that a child has got of expressing something that is really important to express. And one way of looking at it is that there are better ways of expressing things, and OK we try and help C1 with that, and we try and make sure that she does express the things that need expressing and that she doesn't have to do it through food. But if food is all you've got, then it's better to express it through food than not express it at all. So one thing that happened is, C1 got noticed in a way, you know, she's had a lot of attention from her parents, we've thought long and hard about what are C1's best interests, and we received a message that things weren't working for C1. I think now we know that there were things in C1's life that were really painful for her, and no one had noticed that they were really painful for her, so you know." (D1, T2)

But he described professional failings at both time points as being extreme. In the first treatment centre D1 described parents as being 'demonized'. After successful treatment in the third centre, he looked back on the second centre (where the researcher worked) and described a culture of parent blame there too:

"Not just with C1 but with other kids as well, there was a frustration with kids going backward, and I think that got taken out, everybody finds going backwards frustrating, and the temptation to take it out on the child, and the parents, subtly, directly and implicitly, was very strong, actually. ... What we did see were some other families being given a pretty hard time which was like being implicitly blamed that things weren't moving forward. And what I can say is that it's sort of a human tendency that we all have, to go and find someone to blame when things aren't working out, but if you look at the way the power dynamics are stacked up, with a child and parents and a hospital unit, its incredibly one-sided, and it's a very cheap trick, to take it out on the parents, a very cheap trick." (D1, T2)

D2

D2 was not able to be kept on the topic of how he understood his daughter and the evolution of her eating disorder. He was compelled, as it seemed, to use the time with the interviewer to speak about what might fairly be described as his own trauma. This consisted of relating his father's death when he was a child to a health condition of his wife and a re-living of her surgery, in the year or so preceding the onset of his daughter's eating disorder. When prompted by the interviewer for links between his lengthy account of his wife's condition and treatment, and his daughter's eating disorder, he could not make them, but concluded that he thought that his daughter had feared that her mother was going to die. In this unusual sense he met the criteria for themes 7a-c, but also for 7d and 10, as half of his interview was essentially a plaint, complaint, blaming his wife for his and his daughter's distress.

This interview is used as an example of how themes were analysed and allocated in Section 5.5.

D2 and M2's interviews were poles apart; as we saw in Chapter 4., M2 was very focused on the impact on their daughter of their unhappy marriage and saw the eating disorder as an opportunity to fix it. D2 barely mentioned this aspect; M2 herself didn't mention her health condition and surgery at all at T1. At T2 she participated in the interview but D2 was no longer contactable as the couple had separated. M2 framed this as a positive outcome.

D3

D3 participated in both interviews and gave a rich account both regarding ways of understanding his daughter's eating disorder, as well as describing the painful impact on all members of the family. He foregrounded the importance of parent-child relationships (Theme 7a), for example, in the way he attributed value to the eating disorder in its impact of forcing him become more involved in family life (Theme 8).

D3 allocated some blame to his wife (Theme 7d); he thought that she did not meet their daughter's needs and he and seemed both angry and sad about what he described as the poor relationship between M3 and C3. At the same time he spoke of how he had had to change, in his expectations of himself as a father, husband and worker, comparing this with his own upbringing (Theme 7c). At Time 2, he was at pains to emphasise the value that had come of the experience, in that he felt closer to his

children and more involved. Perhaps this derived value prevented him from expressing the sorts of feelings that were associated with Theme 10.

D3 expressed some anger with his daughter at T1

"I think it makes people angry that she's just ungrateful really, she doesn't really believe, she's not happy that things are not done the way she would want even though they always end up getting done right. So it does make people angry yes. I would say what gets me angry is when she upsets M3, that's what gets me angry right, yeah, whereas she gets M3 angry directly." (D3, T1)

D3 was unique in the fathers' sample in expressing Guilt (Theme 8) *combined* with Rage at his daughter (Theme 9) and blame of his partner (Theme 7d), and hence presented a more complex, subtle and uncertain account, working hard to present fairness and balance as well as his real feelings. In psychoanalytic terms, his position might be described as 'ambivalent'.

D1 and D3 were the only fathers who expressed guilt through the way they spoke and took responsibility for things that had happened in their families and in their child-rearing.

D5

D5 participated in both interviews, struggling to find ways of understanding his daughter's eating disorder, while prioritizing the importance of the family as a resource in his account (Theme 7a). He had some unusual and quirky ways of expressing himself; for example, at T1 he used the metaphor of a train to help orient himself.

"And why she's picked on food versus maybe an adult, now, I might guess who, you could see why people might go for the bottle, when events trip their mind and they get locked onto a new track that they can't get off themselves. And I think that's where C5 is. She's on a track that we don't recognize nor does she. And that's a track that's got its own, you know, it's got its own path. I suppose in a way you're trying to make us drive the train, and you're giving us that professional bit to say 'Come this way, try this way.'" (D5, T1)

D5 met criteria for Themes 7a-c at T1 as a result of his urgent thinking about how they as a family might help their daughter, without exhibiting any of the emotions in Themes 7d-10. It may be remembered that his wife, M5 uniquely had no allocations to the interpretative part of the analysis at all.

But by T2 D5 appeared sadder and had lost this drive (Theme 10). While C5 was mostly recovered from her eating disorder, family relationships were not, and in addition their older daughter had a newly developed eating disorder:

"It's difficult to find a positive out of such a negative other than you've gone 360 plus twelve months and everything's where it should be. So you can look back and go 'where the hell did that come from', or 'what a terrible two years.' I think C5 is closer to M5 as a result than she is to me. ... I don't know, I don't feel as close to her as I sort of, this might be a bad admission- she seems closer to M5 than she does to me.... And M5, I think she had the toughest role last time, being tough with C5, maybe she was tough with me, she's tough now with [older sister], she's now tough with me, C5 and [third sibling]... She sort of takes it out on the rest of us. Whereas with C5 I was the only one there to take it out on. Whereas now she'll take it out on whoever's around."

D5 finished by calling himself 'a spare part in the family.'

D7

D7 participated in T1 only, although responded to telephone call at T2, when he communicated extreme anger at the failure of professionals to save his daughter from what had by then become a long journey, with multiple diagnoses, through mental health services with multiple diagnoses. He communicated anger at his daughter (Theme 9), but not blame; distress and frustration at its impact on his work (Theme 10), as did his wife. D7 situated the eating disorder in the context of adolescent development and referred to his own adolescent experience to help him think about adolescence generally (Theme 7c), as well as his daughter's state of mind (Theme 7b) though signalled his difficulty at understanding what his daughter was actually going through.

"You know, I look back on it as probably the worst time in my life, this, the age that C7 is now. And...I can imagine that, if she cannot easily talk about where she's at, what the problem is, for whatever reason within the family in a straightforward way, then another way to do it is to blow everything up. Um, and then something out of that will help and one way to do it, is, is, what she's done. I mean, it's a very high price to pay, for everybody, including her, you know, I mean it could...I think for my daughter, she is not completely withdrawing although she is sort of doing her damndest, from life. In my disengaged moments I feel quite hopeful, rather than you know grinding through the day-to-day misery of dealing with it. Got no real grounds for that, I don't think um, except that we seem somehow to be coping. It could all go wrong, I mean my wife is carrying much more of the burden than myself. Um, and I surely fear that at some point, she

will go bang. And then C7 will have to go into a ward or something and I have no idea how we would pick up the pieces after that. Yeah it's as bad an experience I can imagine really." (D7, T1)

D8

D8 gave an interview only at T1, signalled his willingness to be interviewed at T2 but in the event could not make time away from work, and indeed the impact on his work of his daughter's illness was of significant concern to him. D8, as we have seen, spoke mainly in terms of his daughter's pre-existing character contributing to the eating disorder, advanced relatively limited understanding of it, and expressed blame and anger with her (Themes 7d, 9). He was more preoccupied with the devastating impact on the family and seemed lost in this new territory, hence also the emotions of 'plaintiveness' (Theme 10) were to the fore in his account.

Comparison between D8 and M8's interviews highlighted very different preoccupations, with M8 entirely focused on C8, and D8 resentful of the impact on the family, the loss of his wife and his family life as he had known it.

"We always used to eat around a dinner table until six months ago; we didn't have a television and so we always had breakfast, even during school days, lunch obviously not except at weekends, and after school meals, snacks and dinner around the table. And we would take pride, we spent a lot of money buying our dinner table, it's a big oak dinner table, very comfortable chairs because, not the television but the dinner table is the focus round our house, or it has been, but things all went a bit wrong a year ago obviously. So even to this day now C8 doesn't eat at the dinner table, it's very awkward obviously, the four of us sitting there, and she's, well at least she's in the same room now, before she used to be in a different room." (D8, T1)

"What I do resent is the impact on the relationships it has, the dynamics within the family, there's more hostility and friction, particularly between C8 and [younger sister], and [older brother] doesn't come home, sort of until seven o'clock, eight o'clock, stays at school, he says he likes to do work, but I don't think so because he's actually a very home loving boy, always has been, he loves being at home, or used to love being at home..." (D8, T1)

His reflections about the impact on his own well-being led to allocation of Theme 7c.

"I've become much more indecisive than I used to be and I think M8 will tell you that as well, unsure, uncertain, erm, and I suppose more introspective as well; a friend of mine, a doctor

friend of mine came and had a chat with us just before Christmas and he felt I was, not clinically depressed, but you're just more sad and he's known me for 25 years." (D8, T1)

D9

D9's account and thematic allocations will be considered below in greater detail in Section 5.5, as an example of the process of thematic allocation. This account also pays attention to a comparative analysis of D9 and M9's interviews. Together they illuminated a rich and very complex array of emotions, contradictory and raw.

D9 expressed anger towards his daughter (Theme 9) and blame towards his wife (Theme 7d), and limited understanding, but he also combined it with some self-reflection on not having been present enough within the family as a result of the pressure of work, and expressed feelings of guilt too, like M9.

His expression of disappointment at what the family had become had the quality of plaintiveness (Theme 10).

"This sense of entrapment that M9 felt: she felt that I should be sharing more with the burden. And then, I still had to work. Like, it's hard to balance it, like we still have to bring in- we still have financial obligations that we have to live up to... Because I came home at lunchtime and like I came home to a house of dysfunction and I was thinking 'Jesus, we are really-' [older daughter] really said a lot of stuff about the family, you know, she was really feeling- she said that 'I'd love this family to start all over again. She was, she was right...[crying]" (D9, T1)

D9's rage appeared allied to his difficulty in believing that his child was genuinely ill:

"Well I suppose when I'm admitting it's a mental illness I have to admit that look it's not all about control - and like that's what we forget sometimes, sometimes we think: 'this kid is doing us a puppet show.' And you know, really you keep have to keep stepping back and saying 'look, it's not her fault, it's not her fault.' Treat her calmly, try and be sympathetic. What I'm saying to you is it's hard to be that the whole time. Like, see at times I think this is a form of schizophrenia because she has a blow out and she'll be going hell for leather and next thing, 'can we go watch a movie now?' It's kind of (clicks), it's instant. And that has been the way for a long time." (D9, T1)

D9 and D10 were the only fathers that said nothing in their interviews to lead to allocations under the more 'mentalizing' themes of 7a-c.

D10

D10 and M10 also participated only in T1 interviews. Their accounts were similar in terms of the focus on their child's pre-existing personality traits, in M10's account, prefiguring the autism spectrum disorder diagnosis. However, where M10 spoke about self-sacrifice and being resigned to her role, D10 struck a different note by expressing frustration, anger and blame towards C10 (Themes 7d and 9) .

"She's always been very, quite difficult at times. Some of her behaviour, tantrums and oppositional behaviour, so not doing what we want her to do. And she seems to be displaying that to the absolute extreme now. I mean, we're just asking her to put a spoon in a cup and she will not do it. You know, even after two or three hours of just telling her to do it... Yeah I don't know how much of it is just herself, or the voices - are they just an extension of her own thoughts or?" (D10)

D10 described some of his daughter's behaviour as 'sheer bloody mindedness' in relation to her determination to have an illness, something that, in his view, made her feel or believe that she special and unique:

"And that's the thing- she'd have been happy to stay on those crutches probably for the rest of her life. And it seems to be the same thing now with the eating disorder. She'd be happy- she'd be absolutely happy to have that tube in her nose."

D10 also felt cheated out of family life (Theme 10):

"Yeah, we used to have good days out. That was part of what [older daughter] promised to herself when she was trying to recover from anorexia. You know, it was, at least when we recover we'll have nice family days out and er... That's now not happening because C10 is the way that she is so you know. Yeah.... I mean you go through the thoughts of, sort of, why me? Yeah. It's just, you know, one thing after.. ...Um, for myself er... Just get on with it. You know, and I just started, I was going to be in a band." (D10, T1)

5.5 Interpreting and allocating themes: a step-by step demonstration

Allocation to interpretative thematic categories was a synthetic process, combining both close textual analysis, and an interpreting behind words.

Many fathers' narratives contained words and phrases that might be considered surprisingly explicit and uncloaked by language that might have been learned through

contact with mental health professionals. Their emotions were raw and their views unschooled. As noted, the impact on the researcher could be both shocking and refreshing.

This section aims to unpick aspects of the 'reading behind the words', and the self-reflection of the interpreter about her reactions, what was part of the thematic allocation process in relation to the interpretative themes.

What follows are two step-by-step examples of the process of transcript analysis, including categorizing the content, being alert to emotion variously expressed, and searching for corroborative content across the whole interview. One example from a fathers' account (D2) and one from a couple's (M9 and D9) have been selected. Owing to their lengthy quotations from interview transcripts, and the detailed description of the process, these two examples have been placed in Appendix 9a and 9b respectively.

5.5.1 Summary

The two accounts above are intended as illustrations of the step-by-step process of analysing interviews interpretatively, with attention to the emotions expressed, and the frequently iterative process whereby interview subjects may revisit, and reveal, a theme several times, from several angles, such as the presence of guilt in D9's account and, less explicitly, M9's. In D2's account, the presence of an unspecified accusation is interpreted, and its specificity speculated on, as a result of a narrative that substantially followed its own predetermined path and could not be diverted to the interviewer's agenda.

Every interview in the sample was subjected to an analytic and interpretative process of this kind.

It is in the nature of the enterprise, with one primary interviewer, researcher, analyser and writer, that features may have been missed, or material not sufficiently noted, and these factors add to the limitations of the method here proposed.

On the other hand, its fluidity, boldness and use of a psychoanalytic framework where unnamed features may be noted and highlighted, also is a strength, as long as the source of the eventual thematic allocations can be traced.

Chapter 6. RESULTS: The children

6.1. Introduction

There are challenges in carrying out qualitative interviews about meaning with children suffering acutely from an eating disorder.

An unwillingness, or inability, to communicate is the first such challenge. Young people with eating disorders often seem to give up communication for a time altogether.

Difficulty thinking is the second challenge, an eating disorder being for some, a moratorium on thinking, for various reasons.

In this study, a further possible challenge, but also a possible favourable factor, was recruitment of the whole family.

Nevertheless, despite these challenges, six out of ten children agreed to participate, three at both time points. Some gave interviews that contained surprising topics and a surprising range of ideas and expressions of emotions. With a less complete set of interviews, it has been less possible to extract themes, that is, ideas that would be held by more than one or two participants, but themes have been tracked where possible and also due consideration given to each individual interview. The result has been some interesting and fresh findings.

6.1.1 Numbers and drop-out

Ten families who met inclusion criteria were recruited to the study over a period of approximately one and a half years, in sequential order, F1 representing the first recruited family, and F10 the last.

Of twenty possible interviews with children at both time points, nine were actually achieved. All children were interviewed on their own without their parents present. The spread is shown in Table 11.

Table 11. Recruitment of children

Identifier	Age at T1	T1	T2	Time elapsed between T1&T2
C1	10	✓	X	
C2	14	X	X	
C3	11	✓	✓	13 months
C4	13	X	X	
C5	14	✓	✓	24 months
C6	15	X	✓	
C7	13	X	X	
C8	14	✓	✓	16 months
C9	11	X	X	
C10	11	✓	X	

Note that C6 refused an interview at T1 but agreed at T2.

All the first interviews were conducted in the service premises where the interviewer worked, but none of the families were still attending the service at Time 2, all had been discharged, some had gone on to have treatment in other services.

Therefore T2 interviews where consented to were carried out as follows:

C3 was visited at home; her parents were also interviewed separately at home.

C5 and her parents came in specially to the service and were interviewed separately.

C6 at T2 also by special visit to the service.

C8 by Skype.

6.1.2 Introducing the child research participants

The children who were interviewed were a diverse group, not only in terms of their age and development, but also in their own treatment histories and their family mental health histories, their respective attitudes towards their eating disorder, and their level of interest in trying to make sense of it. Judging by their affect in the interviews, which will be described further, C3, C6 and C8 were eager to communicate their experience

and open to thinking about the meaning of the eating disorder. C1, C5 and C10 were more closed in their interviews.

Table 2. in Chapter 3 displayed key demographic data and brief treatment and outcome data. These data was gathered from clinical records made at assessment and during treatment. Follow-up data after patients were discharged were not routinely collected by the service. However, the researcher was able to gather follow-up data through phone calls made to families when re-recruiting them to T2 interviews, and through the T2 interviews themselves, where parents and children consented.

Below is presented a thumbnail sketch of each child to give a fuller picture of each child's treatment history and condition at time of interview.

C1

was 10 years old and still in primary school at the time of treatment in the service and the T1 interview. She was first admitted as an in-patient to a general hospital in her locality, then transferred to the researcher's service. Her parents let it be known in their T2 interviews that after this service, C1 went on to another in-patient service where she was said by her parents to have done well. At the time of T2 interviews with her parents, C1 was back living at home. She refused the T2 interview although her parents agreed to give their own T2 interviews. The interviewer had no clinical involvement with C1.

C3

was 11 at the time of T1 interview, in Year 7, first year of secondary school. She was 12 at T2 a year later. She was treated as an out-patient and recovered in the researcher's service. The researcher had no clinical involvement with C3.

C5

was 14 at the time of T1 interview and 16 at T2. She was treated as an out-patient and recovered in the researcher's service. The researcher, together with a colleague, was also the family therapist for F5.

C6

refused the T1 interview but agreed to the T2 one, at which point she nearly 17 and was doing A-levels. She had been an in-patient elsewhere before attending out-patient treatment at the researcher's service. The researcher had been her individual psychotherapist, although therapy had ended a year before the interview. Thus she had been discharged for a year at the time of the T2 interview. She was recovered.

C8

was 14 at the time of the T1 interview. She did not recover in the researcher's service and went on to an in-patient facility and another out-patient service afterwards. It may be noted that M8 informed the researcher at T2 that C8 had received a diagnosis of ASD in the interim. The researcher had no clinical involvement with C8.

C10

was 11 at the time of the T1 interview. She had previously been treated in another service for an unspecified disorder manifesting as not walking, and she had recovered from this before getting an eating disorder. She largely recovered in the researcher's service, being transferred back to her local service for aftercare and relapse prevention. During her time in treatment in the service, she also received a diagnosis of ASD. The interviewer had no clinical involvement with C10.

6.1.3 Children with their parents

In the accounts that follow of the children's themes, children's thoughts, feelings, communications and preoccupations will be thematically and affectively analysed and interpreted on their own merits, and also set alongside their parents'.

In the cases of F2, F4, F7 and F9, there is no child's voice in the family mosaic, leaving the researcher forever curious. What light might these children have shed on their parents' attempts to understand, and, in some cases, frank torment, if they had agreed to speak out?

Where there are interviews, C1's was so limited (see Appendix 5d) as to tell us little, as will be seen. C5 was a little more forthcoming, as was C10. C6 attempted to explain as fully as she could how she understood her illness and her recovery, in her only interview at T2. However, the two richest interviews were the double time point interviews of C3 and C8, allowing the interviewer and reader to note unexpected preoccupations, personal themes and even startling changes over time. These will be demonstrated and discussed in more detail below.

For these two interviews in particular, and to a lesser extent for C5, a process is undertaken whereby they are set alongside their parents' interviews. This is not done in a theme- by-theme way, but in a way where parents' main themes, beliefs, concerns and emotions are recalled, and then organically compared with their children's, and the results summarized.

6.2 Methods

6.2.1 Child recruitment, ethics and consent

The recruitment method, and process of gaining ethical approval for research with children, was described in Chapter 3. Children can sometimes be asked for 'assent' to research where they can understand some but not all points of the research, but in the context of this study, consent was certainly required in order to engage a child in a semi-structured interview focused on her understanding of her own mental health disorder and the meanings she attributes to it. In addition, consent was obtained from the parents of all the participating children in their role as their children's 'gatekeeper' (The Research Ethics Guidebook, ESRC/Institute of Education).

Children were initially approached with their parents present, or parents were approached first. Patient Information Sheets (PIS) were given to parents and children separately, sometimes to parents only, or if to children directly, in front of their parents. Sometimes mothers promised to speak to their partners and children and took PIS's for all to distribute at home. Families were then given time to read and consider their participation. Usually they would tell the researcher their decision at their next visit to the clinic.

It is not possible to know what factors influenced those children who agreed to participate and those who refused.

However, of those who agreed, informed gleaned through the subsequent unfolding of the interview, might suggest the following factors:

C1 was so passive and voiceless at the time of interview T1 that she simply did what was suggested, perhaps unable even to make a decision one way or the other. She may have consented to attending the interview, but she was in practice too unwell to give active consent. At T2 she refused the request made by the researcher via her parents, this time making a clear assertion of will.

C3 was a lively, eager, thoughtful participant at both time points, keen to make her voice heard both times. In her case, consent was active.

C5's motives for participation were harder to gauge. She may have been influenced by her parents, both of whom participated in both interviews. There was a sense that the family was participating out of a sense of duty, of doing what they felt to be the right thing.

C6 was clear about her own wish not to participate at T1. At T2 she was engaged and articulate and eager to communicate; she may however also have been influenced by a request made by her former individual therapist and a sense of 'owing' something.

C8 was, like C3, a lively, opinionated, articulate participant. The change and development of her thinking between her first and second interviews were striking and, in the context of this small sample, unique.

6.2.2 IPA analysis

Thematic analysis using IPA was conducted with children's interviews in the same way as parents', to begin with.

Interviews were transcribed, formatted into three columns, with text in the middle column, Reflective Function noted in the left-hand column and text highlighted in red where RF was noted, and phenomenological themes noted in the right-hand column with relevant text highlighted in blue.

Next, a thematic table was constructed but this differed from parental interviews. As many interviews were briefer than parents', themes stood out more clearly. One might say that when children didn't have an answer to a question, they said 'I don't know', whereas when parents didn't have an answer to a question they might nevertheless talk until something was woven together from strands, making the job of thematic analysis more complex and laborious.

Children's interviews were clearer, then, in that answers followed questions (or not). The transcript followed the interview protocol more closely in terms of the sequencing the four main domain questions. The interviews were generally shorter by approximately one-third, sometimes more. At one extreme, for example, C5's first interview, the shortest, was just under 4,000 words, compared with her father's first interview of over 13,000 words.

For this reason, it was considered manageable and expedient not to construct an individual thematic table for each child, but to collate them into one table covering all child participants, all interviews, and all domains. These are presented in Table 12.

At this first reading, potential interpretative themes – themes that, as in the parents' interviews, required the researcher's interpretation of emotion, feeling, and unspoken meanings, were noted in this table in the 'Comments column'.

In addition, extracts and quotes from the interviews were collated to illustrate a selection of the themes shown in Table 12. It was a long collection and hence is presented separately in Appendix 6e, with the title 'Children's Interviews T1 and T2 – extracts and quotes.' Some of these quotes are featured in this chapter to support a deeper description of themes and discussion.

6.2.3 Reflective Function

A separate table recording items demonstrating RF, and scores, was constructed. This is presented and discussed in Chapter 7 alongside parental RF.

6.3 Results

6.3.1 Introduction

Children's themes varied widely. Naturally many spoke at length about the eating disorder, in a way that was 'from within' the eating disorder, as if from within their own internal system of government, where the rules, and the consequences of breaking the rules, were taken for granted. It was decided, intuitively at first analysis, and then purposefully at subsequent iterations, not to create themes out of these 'internal to the eating disorder' topics, or indeed subject them to RF analysis. It was decided that for the purpose of discovering and creating phenomenological and interpretative analysis, the researcher would remain within her own 'system of government' outside the eating disorder, despite her clinical familiarity with it.

6.3.2 First statements

Some child interview subjects found it very difficult to get to grips with the question of how they understood and made sense of their eating disorder; others couldn't wait to dive in. At one extreme was C1, at the other perhaps C8:

C1 (T1)

I: "How do you make sense of getting an eating disorder or having an eating disorder - how can you understand it or think about it?"

C1: Hmm... What does that mean like ...

I: Well ... does it make sense to you to have an eating disorder

C1: ...(4 seconds) Um ...(5 seconds)

I: How do you understand it happening to you?

C1: Dunno."

C8 (T1)

C8: "Um, well, at first I thought it was quite stupid to think that a thought, that it was described as something quite physical and I didn't understand how a thought could be that physical, but I suppose now because I've been kind of doing it, it's, er, I don't know I only really recently started to understand what it's like, but it's more like a, powerful thought, like a glitch that has, that has you know un-rational thinking, but the subject believes it very strongly.

I: The subject, being you?

C8: Yeah, the person and erm, and that it's just a, like a strong thought that cannot be swayed, and it's a very hard thing to try to take control over and to instead of it being so negative, become positive."

The researcher wondered if the very act of taking part in a conversation about the meaning of having AN might be felt as a betrayal of the AN itself – a familiar observation in psychotherapy with eating disorders. Could this have accounted in some part for the extreme reticence of C1 and the muted interview of C5? On the other hand, no such holding back was present in the touching interview of C3, or the powerful anger communicated by C8 and C10, as will be seen.

6.3.3 Phenomenological themes

Table 12, summarizing the child participants' themes, is dense, diverse, and at first sight a little challenging to analyse thematically across the whole group of children.

The table has all nine children's interviews on the vertical axis, and the four domains of the interview, plus a column for the interviewer's brief comments, along the horizontal axis.

C3, C5 and C8's interviews at both time points are given; the others refer to one time point.

The children said some surprising and powerful things. Not surprisingly, each child had some passages where their thinking was expressed 'from within' the eating disorder – vocalized internal monologues about what rules applied when, as in the case of C3, or arguments for why the eating disorder was a functional response to not liking herself and others not liking her either, as for C8.

The surprises were mostly in the arena of relationships.

All children (besides C1) spoke about their parents, their families, and their thoughts and feelings in the context of their families.

One unifying theme seemed to be that most children spoke ambivalently about their parents, in terms combining love, attachment, and anger. The ambivalence could be within the same interview, or where there were two interviews, between the two.

This in itself it perhaps not surprising, as synthesizing love and hate, attachment and independence strivings including rejecting parental opinion and guidance, are a natural part of growing up.

However, these children all had an eating disorder, that is, a mental health disorder. We may speculate that the emotion that accompanied their statements about their families and their parents, both mothers and fathers, might have been the very difficulty for these children – the difficulty in tolerating mixed positive, need-based, and negative feelings in themselves, and adapting to the demands of late childhood, early adolescent development for change in the parent-child relationship.

6.3.4 Children's thematic analysis

Table 12. IPA themes - All children - T1&T2

	Understanding	Impact	Value	Recovery	Comments
C1 (1)	1. Don't want to get fat 2. Didn't mean to go so far 3. 'I thought everyone thought like that' (Inhabiting the ED)	1. Have to keep moving 2. Have to share a room on unit	Refers to 'secret' thoughts	Parents would like me to meet young people	<i>Deep within ED – little to say, mostly 'don't know'</i>
C3(1)	1. Always had rules 2. Stressed; worried 3. Want mum's approval – poor relationship 4. Compare myself with sister	1. Don't like my rules 2. Relationship with mum worse 3. Family stress worse	None, explicitly	1. Learn to relax my rules 2. Have friends 3. Laugh with sister 4. Hugs with mum	<i>Synthetic, complex, high RF re. Mum, felt as hostile, rejecting, confusing</i>
C3(2)	1. Change of mind – "I realized..." 2. Vicious spiral down	1. Unhappy then /happy now 2. Made family unhappy 3. Fun with sister	1. Experience 2. Help others 3. Not do it again	1. Running & sports & fun 3. Friends 4. Hospital deterrent 5. Treatment 6. Courage	<i>No mention of relationship with Mum now. RF much lower – emphasis on being better</i>
C5(1)	1. Healthy eating 2. Went too far – lost control 3. Did something bad; disappointed people 4. Control when grandpa died and everyone upset	1. Tired 2. Can't do things 3. Awkward with friends 4. Parents worry	1. Can watch out not to get too [fat] 2. Control	None	<i>Either deep within ED or not curious. Is it own ref to grandpa's death?</i>
C5(2)	1. Control (see Value at T1) 2. Went too far	1. Still worry 2. Have anxiety re exams and friends 3. Worse	1. Have something to offer friends 2. Stand up for myself	1. Distractions and other preoccupation s	<i>Muted. New grasp of anxiety and need to cope</i>

		relationship with Dad	3.Value family and friends		<i>with it.</i>
C6(2)	1.Depression – focus for feelings and for aimlessness 2.Self-deprivation because loved food 3.Influence of ED unit 4.Depression linked to parents' divorce	1.Still anxious & conscious re food/eating 2.Social meals difficult 3.New friends – new me - feels weird 4.Close to mum 5.Dad empty relationship 6.Better with brother	1.More self awareness 2. Running 3.More sympathetic to others 4.More prepared for relapse of depression 5.Appreciate friends 6.Appreciate being happy	1.Running 2.New passions politics and philosophy 3.New friends 4.Therapy 5. Talk to people	<i>Optimistic about progress and presenting determination to be well. Perhaps without full foundation; still confused sometimes</i>
C8(1)	1.Irrational thoughts –OCD 2.Not eating part of me 3.Felt ugly at school 4.Didn't like who I was	1.Feel better & more confident about myself 2.Loss of relationships with family and friends	1.Same as Impact	Don't want to get better.	<i>Anger with friends and family – dealt with by assertion that ED trumps them all</i>
C8(2)	1.Low self-esteem – not deserving of food, friends	1.Feel more confident 2.Still want to change appearance (at uni) 3. As Value	1.Improved family relationships esp with Dad 2.Improved family openness 3.New trusting friendships	1.Mix of tough love and reassurance on unit 2.Challenging anxiety with GCSEs and a job/volunteering	<i>180 degree turnaround with happiness that friends and family matter again</i>
C10(1)	1.Genetic – heavy MH load in family listed 2.Admired “super skinny” on TV – and sister with AN 3.Control and coping	1. No school 2. No friends 3. Nothing fun or nice except sleeping in parents' room 4. Parents not nice	1.Can be angry, shout and scream (don't want medication to change me)	1.IP unit with more young people in it (parents' idea)	<i>Very angry – confused whether it's her own MH problems/ own feelings</i>

6.3.5 Summary of children's phenomenological themes

The kinds of ideas advanced by the participants under the heading Understanding and Making Sense, ranged from the simple, yet bewildered, 'I didn't mean it to go this far' (C1 and C5), to the weighty and existential, 'I didn't like who I was' (C8), the childlike and plaintive 'I want Mum's approval' (C3), the mature and knowledgeable 'needed a focus for my feelings' (C6), to the curious combination of 'genetic loading' and 'Superskinny on TV' (C10).

However, where there is unity is under the headings of Impact and Value. These interview domains, though not framed as probing for meaning, nevertheless yielded rich data when the children and young people spoke about their relationships with their Mum, their Dad, their siblings, and their sense of their own place in the family – encompassing the time before the onset of the eating disorder, during it, and during recovery. This was true of the interviews of C3 and C8 especially, and also appeared in C5 and C6

In tied second place in terms of thematic unity, came relations with peers or friends, and issues around not liking oneself. These two themes are further elaborated below.

6.3.6 Relationships with parents and their families

Let us look in detail at what the interviewed children said, noted in the table above briefly as 'relationships with family' or a specific family member, whether recorded as worsening or improving.

C1

C1, aged 10, uniquely, said very little, except that she missed her parents when she was on the in-patient unit. An excerpt from her interview to illustrate her interview content is in Appendix 5e.

C3

C3, aged 11, spoke at repeatedly and at length about her relationship with her mother, both from her own perspective, and trying to put herself in her mother's shoes. She was undoubtedly preoccupied and struggling to understand what was happening between her and her mother, shifting perspectives and emotions continually through her T1 interview. Her account segued through, in this order: describing her timing and other rules for eating, which appeared to be the primary feature of her eating disorder

(not a fear of being fat); comparisons with her sister and feeling her sister was preferred; assertion that she had always been considered more like her father and was calmer with him, to a description of long-standing problems with her mother.

She thought that her mother was “fed up” with her. This was corroborated through D3’s T1 interview where he also spoke about long-standing difficulties in C3 and M3’s relationship. Unfortunately, M3’s own interview from T1 was not available to integrate her perspective. At T2, she no longer spoke very much about her relationship with C3 but was focused on her older daughter, and how neglected she had been, and the overall damaging impact on the family and the couple relationship. Certainly M3 demonstrated no special understanding or the eating disorder, or mental state thinking in relation to her daughter, C3.

C3 acknowledged having displayed difficult behaviour ever since she was little, such as screaming, and insisting on following rules long before the eating disorder. This also featured in D3’s interview. She acknowledged that her rules made everyone in the family more stressed. She didn’t like her own rules and wanted to relax them. A particularly striking, because so confused, part of C3’s T1 interview was where she compared herself to her mother in terms of their “bad temper”:

“C3: I’m quite happy but sometimes I guess, yeah, I didn’t behave very well. Like I remember throwing a remote control at something...not very good but I think I just have a bad temper, which I think I need to learn to control. Because like my mum has a bad temper but she controls it more than me. But I don’t-I haven’t learnt how to control it

I: And does she have ways of controlling it that you can learn from do you think?

C3: No because, um, well, everyone says she has a bad temper like when she’s not there, but she doesn’t really admit it ... She doesn’t, I don’t think she says, she doesn’t, I don’t know if she thinks it but she doesn’t say that she has a bad temper.

I: So you just sort of sense it but she doesn’t show it?

C3: Well everyone says it; my sister says it when she’s not there, my dad says it when she’s not there, everyone says it when she’s not there. But sort of no-one says it when she’s there and when she says it she, when you say it to her she gets angry so...” (C3, T1)

C3 seemed in utter confusion about who was to blame for her and her mother’s clashes and where to get help. At the end of the interview, when asked about what she needed to recover, she said perhaps her parents could support her with breaking her ‘rules’ around eating.

C3: Just some support, some support from them, just patience, and 'you'll do well', maybe like 'it's fine', just some reassurance. Like my Dad's good at reassurance but my Mum's an only child and she doesn't really know what it's like, she doesn't really ... her parents didn't really do anything with her.

I: Really?

C3: No they didn't take her anywhere she said, they weren't, well my grandpa like he worked in a shop, they weren't that, like ...she was in her room and like quiet and stuff so, I guess she doesn't know, she doesn't give people hugs, and she doesn't really know what it's like because I don't think people hugged her that much. My Dad's pretty different ... so I guess he knows what it's like to have a hug, so he, he can do it because he knows that people need one, but maybe my Mum grew up without one so she doesn't think people really need one..." (C3, T1)

It was this section, near the end of C3's T1 interview, that ended with C3 saying she thought her Mum was "fed up" with her.

A year and a month later, at her T2 interview, C3's account was almost unrecognizable. Gone was the preoccupation with her mother. In the foreground was an upbeat narrative about having new friends at school, enjoying activities, particularly sport and especially running – perhaps with a caveat to the keen ear, when she said that sport was not so much for fun as to be good at something. She spoke with pleasure about spending time with her older sister again. She ascribed her recovery to a substantial change of mind on her part, "realizing" (she used that word frequently) that she was wasting her time:

"I don't know maybe it was just cause like, um I was like, like my sister didn't like me cause I was always like making fusses and like I didn't like, like school, I didn't have any friends like maybe that's sort of stuff. But like *now*, like um, me and my sister get on quite well and, it's quite fun and like everyone's like in a much better mood and like I have quite a lot of friends, and I see them a lot and like, um school is a lot of fun and like...um I can do all my exams and get good marks without like stressing and stuff..." (C3, T2)

The researcher was left wondering if, or how, the relationship with M3 was healed. No one in the family spoke of the troubled relationship between C3 and her mother any longer, at least not in the T2 interviews. It was mentioned that C3 had gone to live with her grandparents for a period of time. Now the troubled waters seemed to have closed over.

C5

C5 gave quite restricted accounts at both interview time points and indeed both times put friends more in the foreground than parents or siblings. This certainly contrasted with her parents' accounts. M5 thought that C5's older sisters leaving home and going to university was a relevant though undefined contextual factor around the onset of the eating disorder. D5 repeatedly referred to C5 as 'tier 2' socially, unlike her siblings whom he perceived as more confident and 'tier 1'. Perhaps C5 felt his implicit criticism, because at T2 she provided a brief, unflattering and unmitigated account of her father's behaviour during her eating disorder, saying that he shouted at her, didn't understand, and kept on at her. Her distancing of herself from him was certainly felt by him, as he spoke in his own T2 interview about having lost closeness with her, and indeed, he seemed to be quite lost, having lost his wife and second daughter to another round of eating disorders.

So the interviewer was left with a sense of disconnectedness in F5 between all three parties. Parents spoke as if they were a very close family, but cracks appeared, with M5 in her first interview, and D5 in his second, acknowledging continuous arguments and then avoidance between the couple, and another blow in the form of another eating disorder. C5's focus on friends and school in her T2 interview, and minimal description of home life, belied the idea of a homeloving child deriving her 'structure, discipline and comfort' (in D5's phrase in his first interview) from the home environment.

C6

C6 was nearly 17 when she gave a T2 interview, a year after discharge, where she placed emphasis on having grown closer to her mother and her brother, while daring to acknowledge that her relationship with her father (the parents being divorced) was 'empty'. At nearly 17, C6's focus was more on looking to the future, studies, and making new friends, but she spoke with particular warmth about having forged a new relationship with her younger brother and being more available for him. About her parents, she also said:

"Yeah, well, I mean, I suppose what is different is when you're 12 or 13 your parents are still very, very central in your life, whereas now, like they're not, like I love my Mum so much and I love my Dad, I mean he's a pain but I love them, but they're not central to my life, they're not the most important people in the world and I know that they're flawed and I suppose that what they do doesn't impact me in the same way. Also just time, um, they're much less, I suppose that's a

good thing, they're much less aggressive towards each other and they can actually tolerate each other and be civil as a result of being dragged to so many group therapies and being forced to sit in the same room." (C6, T2)

In this way, C6 gave a brief but vivid glimpse of the multiple ways in which she had been affected by her parents' relationship and divorce – and how she had, inadvertently, responded. At the time of the interview, these storms were receding. She said she preferred to live with her Mum now, and would turn to her to talk when she felt depressed. But she insisted that there was a distance, that she was moving away.

C8

C8, aged 15, on the other hand, and like C3, was very preoccupied with family relationships. Memorably, she concluded her T1 interview with the assertion that if the price to be paid for hanging on to her eating disorder was the loss of trust between her and her parents, then so be it:

"I just prefer it that way because like I don't tell my parents I love them, I don't tell anyone I love them and so my Dad was saying to me, and I won't say anything back because it's easier to shut yourself off so then when you're horrible to them it doesn't hurt as much." (C8, T1)

At her T2 interview 16 months later, C8 was celebrating the unification of the family, resurrection of closeness with her mother and brother, and speaking warmly of her father's new participation in the family.

In this, C8's T2 interview contrasted strongly with her mother's T2 interview, given a few days apart. M8 spoke at length about the traumatic events since the T1 interview, involving an in-patient admission and a frightening array of risky and self-harming behaviour in her daughter. M8's interview was so fraught that it was interpreted as, among other things, betraying ongoing trauma. Thus where C8 spoke as if both she and her family were healing and recovering, her mother's account contradicted this perception and contained the themes of being tested, relying on her faith to get her through, and adapting to the carer role, while living with behaviour in her daughter that she described as 'normalising the abnormal'.

C10

C10, aged 11, had some uncompromising things to say about her parents, when asked about the impact of her eating disorder on family life and relationships.

“But they're usually not very nice....Mum and Dad. They can be really nice but sometimes they can be not nice. Um... I make them angry. But, I feel like it isn't my fault. That they're just taking it out on me- they're taking something else that isn't to do with me out on me... An example is if my mum asks me what I think - what my thoughts are - I won't usually tell her. But sometimes I might tell her without her asking but then she'd get cross, so then it makes me not want to answer when she asks it more.” (C10, T1)

Something of the same internal tussle and confusion as C3 was experiencing is palpable here, with C10 trying, then failing, to hold on to some positive image of her parents and especially her mother, feeling blamed, feeling angry and in turn blaming.

It is hardly surprising that family themes are writ large in the interviews of these young people, but nevertheless noteworthy, in the context of a mental health disorder where the orthodoxy dictates that family are the healthy resource, the allies in treatment.

That said, it is also important to note that the children interviewed did not directly link their eating disorder with their family relationships even where there were difficulties, ambivalence, anger, hostility and rejection. They spoke about their eating disorder and they spoke about their families with strong emotion. But they did not posit any association, let alone causal connection, between the two. Emotions in family relationships, and the meaning of their eating disorder, were themes that ran in parallel for these children.

Nevertheless, many of them seemed to be in a state of needing help with managing their feelings about their families.

6.3.7 Liking oneself and having friends

Many of the young people interviewed spoke about:

- not liking themselves (C3, C6, C8)
- being unsure if they were nice or not (C3, C8, C10)
- feeling ugly (C8, C10)
- comparing themselves unfavourably with sisters or peers (C3, C6, C8, C10)

- and having no friends (C3, C8, C10).

This pervasive sense of possessing a part of themselves that was felt to be bad, angry, ugly and unlovable, is no surprise in the context of an eating disorder. However, in some of the children's accounts, the link is clear between feeling bad inside and having a conflictual relationship with parents and family:

C3: Before I had any problems with eating I was seeing a person in the centre about like anger and stuff... It wasn't as bad but it was kind of bad because I did kind of make some scenes and I remember standing outside doors and shouting and stuff like that but otherwise I've always been quite a happy child apart from that... I'm very different as school that's the thing. When I'm in public I'm very different because um like when I'm at school and stuff people like on my report they always say that I'm a very calm well behaved mature child and stuff..." (C3, T1)

Having friends is to children an all-important sign of being likeable, and the importance of friends, and their contribution to newfound happiness, was emphasized in all T2 interviews by those interviewed (C3, C5, C6 and C8). C6 gave quite a complex account of negotiating difficulties with friendship groups, shedding old "toxic" friends and having a "lovely group" of new friends. C8 related her eating disorder directly to her difficulties with friends, including being bullied, at her T1 interview. At T2, she was even more explicit about the link between her struggles with friendships and her self-esteem, but this time her wish, her goal and her hope was to improve both.

"C8: I do think the school I used to be at, it was an all-girls school and people were very judgmental on the way you looked and a lot of people used to say to me that my legs weren't that thin and my hair wasn't that nice, and people just used to say, you know it was a normal thing to kind of

I: criticise each other?

C8: Yeah, and cut down on what you eat

I: Oh, that was normal too?

C8: Yeah and to go to the bathroom and puke it all out, it was quite regular

I: and did you do that too?

C8: yeah, it's kind of where I started ... I started when I was 11 and um, it was the winter and my dad wanted me to wear a coat and it was a very big, sleeping bag kind of coat and it made me look a lot bigger than I was, and people used to make fun of the coat, so I used to throw my lunch away and then when I stopped wearing the coat people would still make fun of me... I recently got some messages from them saying how much they hated me and that they don't

want to be my friends anymore and that I was horrible and that it was all my fault that I left and that they didn't know me anymore and it was kind of out of the blue... yeah last week, I wanted to meet up with them because there was me thinking that it was ok to, you know, carry on being friends with them and meet up, it's the holidays so, I sent a group message to four of my friends and then one of them replied so and so, I don't like you, you're horrible, you're this and that, you're not worth my time, and then another girl sent a message and then a third girl sent a message...

I: How was that, how did you feel?

C8: Yeah, well I kind of stopped eating, yeah, it would just sort of be like, you're horrible I don't like you and then I'd just sort of miss lunch, I'd be upset, sit in the library and that's it, and then now it's like you're horrible I don't like you, right now I'm not going to eat, so now I make the decision not to eat... I suppose because when they say, you're not thin, well, I'm not eating so I am going to be thinner eventually, so it makes me feel better...

I: It sounds like you want to be a different person altogether, is that true?

C8: Yeah, I mean people don't like me as I am I might as well change." (C8, T1)

At T2, C8 had moved to a new school and she said,

"You just have to keep doing it to make yourself believe, you have to keep on going and you have to keep proving yourself wrong and like sometimes I feel like I'm not good enough for my friends and like they don't really like me, but then I've made friends and I've proved that they actually do like me and they do care about me, so it's about finding proof that actually you do deserve it and that nothing bad is going to happen if you have friends, or if you have, or if you eat or something." (C8, T2)

6.4 Summary of Children's Results

The surprise – or perhaps, no surprise – was that family relationships took such a primary place in children's accounts, taking up much space and also generating much emotion. Sometimes the emotion was expressed in a back-to-front way as with C8 professing that her eating disorder was more important than the losses; sometimes it was expressed directly and plaintively, such as C3 saying she would like her mother to hug her more and then moving on to an elaborate inter-generational high RF account of why her mother might not understand the value of hugs. In fact, we may recall from Chapter 2 that Tozzi et al. (2003) in their retrospective study of 69 adult sufferers of AN, family factors were prominent in patients' own accounts of the causes of their eating disorder.

Additionally, important themes around acceptability in the peer group, instability of friendships, and a sense of self-liking and self-esteem, were highlighted in the children's interviews.

These themes were less surprising and also familiar from the literature surveyed in Chapter 2 (for example, Koruth et al., 2012; Nordbø et al., 2006; Serpell et al., 1999; Tan et al., 2003).

6.4.1 'Interpreting' the themes

It was thought at first that the same two-step IPA based process would be applied to children's interviews as to parents', that is, a first level analysis concerned with the content of participants' experiences as they expressed them (phenomenology), and a second level analysis using more researcher reflexivity to interpret participants' statements in terms of their emotional content. When it came to the parents' interviews, parents' emotions were particularly strongly on display when the Impact part of the interview was underway.

However, it became apparent that this second, interpretative layer of the IPA analysis was somewhat superfluous when it came to the children's narratives. Their emotions were communicated so clearly through their accounts, as in C8's T1 account of the bullying by girls in her school, above. There surely can be no mistaking her feelings of outrage, her hurt, her rejection, feeling outcast and disliked, her sorrow, and her wish for revenge. They all seem to come through her telling quite naturally.

The account of this socially inflicted humiliation was painful and outraging to hear and to read again in the transcript – a 'countertransference' response to a transparent intentional communication.

It seemed that 'body ostracism' was the norm in this school, and was used by these early teenage girls to, most likely, manage their own wavering and uncertain self-esteem, by projecting these painful feelings onto each other through criticizing each other. C8 located the start of her eating disorder within this psychosocial norm.

We also know from the parallel interviews of M8, C8's mother, that there was a long family history of feeling frustrated with C8 and her intransigent behaviour. This was

also true of the interviews with parents of C3 and C10, where it was felt that mothering/parenting of their daughters had gone awry, and that they were left with angry and 'oppositional' girls. In these instances one might speculate that when fragile self-esteem was wrought in the context of a conflictual mother-daughter relationship and then encountered a peer culture of body ostracism, the young person in question would be doubly vulnerable. This vulnerability would likely come both from fragile self-esteem and from not knowing whom to turn to for guidance if family relationships, or particularly relationships with mothers, were unpredictable.

This hypothesis may sound suspiciously like the psychoanalytic literature critiqued in Chapter 2 for its blanket blaming of mothers when daughters develop eating disorders. Here, though, the hypothesis springs from sources closer to the ground, a few tripartite interviews with families where every perspective could be heard. It is a hypothesis advanced speculatively, without blame, and most of all, without a control group, hence keeping firmly in the speculative arena.

6.4.2 Comparing daughters' and parents' interviews

Given that there was no pre-existing hypothesis about what would be shown through a comparison of parents' and children's interviews, it is difficult to decide whether it should be viewed as surprising, or unsurprising, that parents' and children's interviews in some respects dovetailed.

C3, C8 and C10 were angry, C3 and C10 explicitly with their mother/parents, and their mothers and fathers were angry with them. In the case of all three, the anger pre-dated the eating disorder and dated to early childhood. We may recall that D3 reported that M3 felt that her relationship with her daughter was damaged and unlikely to every improve as a result of C3's difficult and 'demanding' or needy behaviour. M8 recounted that C8 made her feel a "rubbish parent" and had always presented with difficult and highly anxious behaviour. C10's mother asserted that her daughter was always "oppositional" and "no amount of loving or consistent parenting" could change her.

Hence one might frame these triangulated narratives as being about a long-standing, mutually inflicted injury of self-esteem in these children and their mothers, which their fathers observed and described, but appeared to feel perhaps less keenly, in their accounts 'from the sideline' of these mother-daughter relationships.

In psychoanalytic theory, drawing on child development theories of Stern (1985), Trevarthen (2001) and others, it is considered essential for the development of self-esteem that the infant and young child feels herself to be uniquely lovable in the eyes of her mother:

“In normal development the child acquires a sense of himself as attractive and loveable through the earliest, preverbal, interactions with others, most notably with the ‘object of desire’ (Britton, 1998), typically the mother. I am choosing the term ‘object of desire’ as opposed to primary object or significant other to underline the sensual, bodily components of this earliest relationship and how critical it is to the establishment of a ‘desirable’ body-self as the foundation for the expectation that the self will be loved... Where there are difficulties in the early relationship with the object of desire these may become manifest – typically in adolescence – in the form of disturbances of body image in which the body, or part(s) of the body, are perceived to be ugly and so has to be concealed and/or altered. (Lemma, 2009, pp753-4.)

In a recent article on the development of narcissism, as distinct from self-esteem in children, Thomaes and Brummelman (2018) write, “Psychoanalytic theorists (Kernberg, 1975; Kohut, 1971) have held that children develop narcissism as compensations for deprivation in their bonds with parents and, specifically, when their parents are cold or indifferent toward them. According to psychoanalytic theory, narcissistic children seek to obtain what they have been insufficiently able to obtain from their parents: approval.”

The authors cite recent research into the socialization of narcissism in children by parents that has found that contrary to psychoanalytic theory, narcissism in children does not develop as a compensatory mechanism for absence of parental warmth and approval, but self-esteem is enhanced by the presence of parental warmth. We can suggest then that the variability, at least, of parental warmth towards C3, C8 and C10 may have contributed to their fragile and uncertain self-esteem.

Through the dual perspective, or even triple perspective, we also get the mother’s side of the story. We saw in Chapter 4 particularly regarding the results of mothers’ interviews, that M8 and M10, and perhaps also M3 through D3’s account, are injured in their self-esteem as mothers. Therefore it might seem that a troubled attachment occurred in the relationship between C3 and M3, C8 and M8, and C10 and M10, and

what is interesting is to see how mutual it is, something less highlighted in psychoanalytic theory with its traditional perspective on the mother as the 'internal' object and the imagined infant as the subject, and rare recourse to a double, let alone triple, perspective, when drawing on clinical data.

6.4.3 Limitations

6.4.3.1 Sample size and sample coherence

The first limitation of this analysis of the children's research interviews probing for the meanings that they attributed to their own eating disorder, is the incompleteness of the sample.

In itself, nine interviews with children with restrictive eating disorders would suffice for a qualitative study using IPA as the method of data gathering and analysis.

However, this sample was intended to be larger to allow for, first, more systematic comparison with parents' interviews, and second, comparison between time points for a larger number of children.

In the event, C3, C5 and C8 have all given interviews at both time points, as had at least one of their parents.

This sample, small as it is, has nevertheless allowed for an interesting observation of themes, and a discussion of how themes appear within families. In particular, we were able to see, in these three families, how family emotional dynamics may play out in ways that would not be discernible to an outsider without the three individual, discrete perspectives afforded by separate interviews with mother, father and child.

6.4.3.2 Age and developmental stage, and stage of illness

Another limitation was the wide variation in child participants' ages and developmental stages. With ages ranging from 10 years (C1) to nearly 17 (C6), the differences in terms of cognitive maturity between C1 and C6 were most likely greater than between C6 and her own mother (M6).

However, stage of illness, not to mention more nebulous factors such as personality, also played a great part in differentiating the children.

For example, while C1 and C3 at T1, aged 10 and 11 respectively, were both very entrenched in their eating disorder, C1 was almost mute while C3 was voluble and working hard in her mind to try to understand and respond to the interviewer's questions.

It would seem, with only a bit of exaggeration, that children's developmental stage is endlessly variable, with age and stage of illness being only two factors, by no means decisive. A larger sample would have allowed greater understanding of the factors that divide children – including, most likely, their emotional state at the time of the interview.

As it was, the recruitment outcome meant that our small sample allowed these factors to be glimpsed, but not tested further.

Chapter 7. Reflective Function: Parents and Children

7.1 Introduction

Reflective Function is not just a measure of mentalizing in the context of an attachment relationship, its specific definition, but denotes “the essential human capacity to understand behaviour in light of underlying mental states and emotions” (Slade, 2005, p269), and is “central to developing deeper experiences with others and ultimately, to experiencing life as more meaningful” (Ensink, 2004, p85). This construct, developed by Fonagy and colleagues over the past 30 years (for example, Fonagy & Target, 2005) has had a profound impact on research in the field of relationships between parents and children in particular, and its reach and ability to fire curiosity in researchers, only keeps growing.

In Chapters 1 & 2, it was explained that the clinical spark and partial rationale for this research was located in the researcher’s experience of facilitating, over many years, a therapeutic group for parents of the children being treated for their eating disorder. The group was a therapeutic group, albeit without a manualized model. The explicit and expressed purpose of the group was to give parents the opportunity to share experiences and offer each other support, to express their feelings about what was happening to their child and their families, and to think more deeply about their child’s experience, with a view to mobilizing themselves to the task of empathizing with their child, the better to manage the eating disorder. This last purpose would have been designated ‘mentalizing’ (Nicholls & Magagna, 1997).

From time to time the group was subjected to qualitative audits within the service although results have not been published. The audits consistently showed that the group was highly valued by parents, in particular the opportunity to speak to other parents going through the same challenges.

The observation was made clinically, that not only did parents vary in their capacity to ‘mentalize’ their children, but also in their inclination to do so. As mentioned, this was initially conceptualized as some parents demonstrating low *expectations* of how well they might understand their child, or be acquainted with their child’s mind.

At the early stage of research design, it was hoped that a way would be found to capture something about the variation in the observed parent-child relationship, particularly from the point of view of parents' thinking about and understanding, and expectation of thinking about and understanding, their children's mental states and how these influenced their children's behaviour. The context was their children, gripped by an eating disorder, displaying behaviour that was apparently irrational and presumably difficult for parents to understand, to say the least.

This hoped for outcome was operationalized as 'Reflective Function' (RF), the quantitative measure of mentalizing within an attachment context, (Target, Fonagy, Steele & Steele 1998) and was introduced as a secondary measure of analysis of the research interviews, besides IPA.

7.1.1 Rationale

It was anticipated that a quantitative measure of qualitative data would add a more solid dimension to the results. Several questions arose.

1. Would a validated measure that relied on scoring sections of transcribed text systematically, with a clear focus, and according to a scale, reveal features of interviews that could be missed in the more subjective and intuitive analysis of IPA?
2. If comparative data were produced, would interview subjects, particularly parents, who scored low on RF, also find it difficult to give meaning to their child's eating disorder in other ways? In other words, would there be a correlation between low RF and limited meaning-making qualitatively analysed?
3. Third, with RF measured at two time points, the first presumably at the stage of high anxiety and the second, if all went well with treatment, at a stage of lower anxiety and more normal family functioning restored, would the RF change?

In particular, it was hypothesized that parents might demonstrate a rise in RF between the first and second interviews, under the impact of treatment and an improvement in their child's condition, accompanied by a lowering of anxiety.

Would the researcher's clinical observation of apparently 'low RF' in many members of the parents' support group turn out to be a stable characteristic in the parents

concerned, or could it be argued that it was more likely the result of high anxiety in the context of a family crisis?

The theory of mentalizing posits that high anxiety and other affective arousal works against 'controlled mentalizing' and predisposes the individual to 'automatic mentalizing', that is, non-reflective assumptions about self and others (Luyten & Fonagy, 2015). Mentalizing – the capacity to understand the behaviour of self others in terms of underlying intentional mental states - is understood as an umbrella concept encompassing both a focus on self and other, affect and cognition; a developmental achievement fostered in the context of early and subsequent attachment relationships, that is, however, vulnerable to stress and arousal, and dependent on the use of particular attachment strategies in the face of such stress and arousal. (Luyten & Fonagy, 2015) Mentalizing is therefore seen a capacity that combines 'state' and 'trait'. Although empirical studies of mentalizing and RF are multiplying, to date there is not conclusive evidence of the theory that high affective arousal undermines mentalizing capacity.

Questions 1-3 were considered worthy of examination and a good rationale for including the RF measure in the design and analysis of the study, for at least two reasons.

First, if low RF and poor mentalizing by parents of children with eating disorders were, in part at least, a function of high anxiety, this finding could have implications for the focus of treatment, for example, adaptations to FBT to direct more specific clinical time to parent support, parent education and indeed parental mentalizing.

Second, it could be hypothesized that parents mentalizing their children better would be a developmental benefit in itself for children, as well as beneficial to eating disorders treatment. If children with eating disorders felt better understood, would they recover more quickly, for example? The theory of mentalizing and RF holds that feeling understood is an essential component of a child's relationship with its parent, necessary for both attachment security and the development of the capacity for RF in the next generation.

7.1.2 Designing the interview

At the time that the study was being designed, RF had mainly been measured on interviews, although more recently there have been attempts also to analyse clinical material. In consultation with the primary supervisor of this thesis, Professor Target, who was also an author of the Adult Reflective Functioning Scale (ARFS) for use with the AAI (Fonagy et al., 1998), questions were phrased so as to probe for mentalizing ('demand questions'), that is, to invite parents actively to put themselves in their children's shoes in an attempt to understand and make sense of their child's eating disorder.

With the child interviews, this was not amenable to an exact mirror design, as children were not going to be asked to put themselves in their parents' shoes in the same way.

7.1.3 RF probes in the parent interviews

The first domain of the interviews, Understanding and Making Sense, was easily amenable to probing for reflective function.

Understanding and Making Sense

The first stem question, 'How do you understand or make sense of your child's eating disorder as it is at the moment', met well the requirements of a question probing for RF, being open-ended and asking parents to think about their children in a loosely directed way.

Prompts were designed to help parents along the same lines, all phrased as 'how' questions:

- What are your thoughts about how the problems began? And about how they went on from there?
- How was it before the ED/EP started?
Within the family? In your child's peer group?
- Can you tell me about your thoughts about *why* or *how come* your child has developed this problem?
- Reiteration: Are there any other factors that you think may help to understand or make sense of your child's eating disorder?

Impact

The second stem question, 'How does your child's eating disorder impact on your life?' could at first seem to invite parents to describe rather than mentalize, but the prompts were designed to redress this balance, particularly the ones asking parents to think about their relationship with their child, the impact on their other children, and to mentalize themselves by thinking about their own experience and own feelings, for example:

- How does it impact on your state of mind/how you feel? Your emotions? Your thinking?
- On your health, physical and mental?
- On family functioning?
- How does it impact on your relationship with your child?
- How does it impact on your relationships with others: husband/wife/partner, other children, extended family, friends?
- And how does it impact directly on other members of the family?
- How does it impact on your work and career?

Value

The Value question again required parents to think 'outside the box' in terms of putting themselves in their children's shoes, and also look at the impact on the family from another angle: 'Do you think there is anything that your child values about the eating disorder? And for yourself: is there anything good or valuable that has come out of it?' As we have seen, sometimes at T2 interviews, parents asserted that something good had come out of the family going through this experience, often in the realm of family communication. Prompts included:

- Are there ways in which it is important to your child?
- Are there ways in which it may be useful for your child?
- And the reverse – are there times when your child views her eating disorder as valueless/useless?

Recovery

The recovery question turned out, in practice, to be the question that brought the least rich data both qualitatively and in terms of RF. It was a difficult question and the timing of it was never quite right: too early for families at the beginning of treatment, too late for parents at the end of treatment. The question read, 'Looking ahead, what do you think is needed now for your child to get better?' An alternative, more probing version

was, ‘How do you think you and your family would need to be thinking about things for your child to get better?’

In section 7.2.3 (parents) and 7.3.2 (children) some examples from interview transcripts are given of how the probes worked to elicit RF, or showed absence of RF.

7.1.4 RF probes in the child interviews

For the analysis of RF in the child interviews, the Child Reflective Functioning Scale (CRFS, Ensink, Target & Oandasan, 2013) was used. This measure was originally designed for use with the Child Attachment Interview (CAI, Shmueli-Goetz, Target, Fonagy & Datta, 2008), parallel with the way in which the ARFS was created for use with the AAI. As with the ARFS, the CRFS can be applied to data obtained using other interviews (Ensink, Normandin, Target, Fonagy, Sabourin, et al., 2014; Ensink, Bégin, Normandin & Fonagy, 2016; Ensink, Bégin, Normandin, Godbout & Fonagy, 2017). Ensink (2004) writes:

“...reflective functioning, like attachment, is revealed in the context of speaking about oneself and one’s close relationships (Fonagy and Target, 2003), and it is expected that it will be most evident in the context of being asked to describe specific incidents which reveal something about the self, interpersonal interactions and affective reactions. These descriptions require a process of retrieval of specific events and narratives, and these episodic or autobiographical memories are expected to provide a good indicator of the child’s “working knowledge” of mental states and of both intrapersonal and interpersonal thinking. These memories are expected to reflect an ability quite different from that demonstrated when the child describes relationships in general terms; in the latter case, intellectual ability is expected to play a greater role.” (Ensink, 2004, p212)

As described in Chapter 3, and above, the semi-structured interview was constructed with the intention that particularly the first domain, Understanding and Making Sense, would probe for reflective function and mental state thinking, and that the opportunity would be increased in other domains also and where necessary by the interviewer’s prompts.

It was therefore judged that the parent and child interviews in this study allowed measurement of RF as they contained sufficient ‘demand questions’.

In the child interviews, RF was assessed more on children's capacity to think about themselves, and their own feelings and motivations, in the domain of Understanding and Making sense particularly. The Impact domain also gave them particular opportunity also to think about the mental states that might lie beneath the actions of their parents, siblings and friends. The Value and Recovery questions were expected to related primarily to themselves.

Children's reflective functioning is in part developmentally determined; that is, the RF of a late adolescent is likely to be considerably different from that of an 11 year old. However, with one exception (C6), the children in this sample fitted the age band for which the CRFS was developed, i.e. ages 8 to 14.

In addition, the children being interviewed were at varying stages of succumbing to or recovering from an eating disorder and therefore, it was surmised, their mentalizing capacity would be affected. There is as yet no research comparing the same child's RF before and after treatment for a mental illness, although Ensink's original study (2004) compared children referred to CAMHS with a population of presumed normative school children, while her recent studies compared mother-child dyads where children had suffered child sexual abuse, with normative mother-child dyads, as well as comparing mother and child within-dyad scores (Ensink et al., 2014, 2016, 2017).

7.2 Analysis: scoring RF for parents

Parents' interviews were scored for RF statement by statement. Each instance demonstrating RF was noted and an annotation made on the transcript, as shown in Examples 1&2 in Section 7.2.3 and also in Appendix 5a-c. In the transcripts, the type of RF was noted in the margin, while the relevant section of text was highlighted in red.

RF was scored separately for each of the four main interview domains. The number of different types of RF were then added up for each section, and then for the whole interview. This total was then divided by four and the final number constituted the overall RF score.

7.2.1 Using the PDI model and divergences on this interview

The RF analysis and scoring was based on the model of using RF on the Parent Development Interview (PDI, Slade 2005a; Slade, Aber, Bresgi, Berger & Kaplan,

2004; Slade, Bernbach, Grienenberger, Levy, & Locker, 2004). The researcher attended a three-day training on this procedure at the Anna Freud Centre in February 2015, and also achieved the post-training rater reliability test satisfactorily. This reliability test involved scoring ten parent interviews and having them marked by the trainer, Michelle Slead.

The scoring system for RF on the PDI is based on the original ARFS for the AAI (Fonagy et al., 1998) and adapted for use with parents talking about their children, rather than adults talking about their own childhoods and own attachment figures as in the AAI. The same four main domains of RF are used for scoring in the PDI as for the AAI, with some adaptation of the sub-scales. The PDI rating scale has also been applied to the interviews with parents in this study. The four domains are:

- A. Awareness of the nature of mental states
- B. The explicit effort to tease out mental states underlying behaviour
- C. Recognising developmental aspects of mental states
- D. Mental states in relation to the interviewer

The majority of instances of parents demonstrating RF in this study fell into domains B and C, with occasional forays into domain A., and rarely into domain D. The domains are further sub-divided as shown below, and each of these sub-categories also has further descriptive definitions (Slade, Bernback et al, 2004).

For expedient presentation, the ARFS categories are shown below.

A. Awareness of the nature of mental states.

- A1. The opaqueness of mental states
- A2. Mental states as susceptible to disguise
- A3. Recognition of the limitations of insight
- A4. Mental states tied to expressions of appropriate normative judgments
- A5. Awareness of the defensive nature of certain mental states

B. The explicit effort to tease out mental states underlying behaviour

- B1. Accurate attributions of mental states to self or other
- B2. Envisioning the possibility that feelings concerning a situation may be unrelated to unobservable aspects of it
- B3. Recognition of diverse perspectives

- B4. Taking into account one's own mental state in interpreting other's behaviour
- B5. Evaluating mental states from the point of view of their impact
- B6. A freshness of recall and thinking about mental states

C. Recognising developmental aspects of mental states

- C1. Taking an intergenerational perspective, making links across generations
- C2. Taking a developmental perspective
- C3. Revising thoughts and feelings about childhood in light of understanding gained since
- C4. Envisioning changes in mental states between past/present, and present/future
- C5. Envisaging transactional processes between parent and child
- C6. Understanding factors which developmentally determine affect regulation
- C7. Awareness of family dynamics (*in CRFS: and peer group dynamics*)

D. Mental states in relation to the interviewer

- D1. Acknowledging the separateness of minds
- D2. Not assuming knowledge
- D3. Emotional attunement

Rating was conducted according to the model of the PDI as follows:

Rating scale

- 9 High RF – many types
- 7 Marked RF – at least two types
- 5 Definite or ordinary RF – at least one type
- 4 Rudimentary RF – inexplicit, may require scaffolding by interviewer
- 2-3 Low RF – inexplicit, vague
- 1 Absent but not repudiated RF
- 1-0 Anti-reflective, hostile or disavowed RF

7.2.2 Feasibility and reliability of using the RF on the PDI model

Initially a sub-section of interviews was analysed and scored for RF by the researcher. The sub-section was composed of those mothers' who provided interviews at T1 and T2, six mothers and 12 interviews in all. The results of this exercise were presented in a workshop at a Society for Psychotherapy Research conference in Philadelphia in June 2015.

Two whole interviews and a selected extracts from others were analysed by Professor Target as a test of the researcher's inter-rater reliability. Ratings were discussed and agreed. The researchers' awareness of factors pertaining to the rating and scoring was heightened as a result of these discussions.

Among other factors, it was noted, reiterated and discussed that RF is a variable capacity that can 'come and go', be perceived as present and absent, through the course of a single interview. A parent may be able to 'mentalize' their child in relation to some features of their life and behaviour, and not others. For example, parents who are able to think in terms of their child's mental state in relation to their own, and their mutual influence, would likely score highly. Such items would fall into categories such as, for example:

B4. 'Taking into account one's own mental state in interpreting other's behaviour'. Further defined as, "Parent recognizes that her interpretation of event might be distorted by her own feelings or thoughts."

And

C5. 'Envisaging transactional processes between parent and child'. Further defined as, "Recognition that child affects parent's mental state and parent affects child's mental state. Must be at least three consecutive transactions – mutual influence back and forth between them."

The RF on PDI model was well adaptable for use with the parental interview in this study. The thrust of the interview was an explicit request for parents to imagine their children's behaviour in terms of their current and pre-existing mental states. The urgency of this task was self-evident in the context of their child having and being treated for an eating disorder and therefore there was generally a sense of acquiescence and little sign of hostility to the interviewer. Questions also probed explicitly for awareness of the developmental perspective, essential in the PDI.

7.2.3 Examples from the interviews: parents

Below follow brief extracts from the beginning of two mothers' interviews, demonstrating high RF and low RF respectively. The type of RF is shown in square brackets after the statements. Longer version of these two extracts can be seen in Appendix 7a.

Example 1. M2 (T2) High RF

Beginning of interview

[looking back two and a half years to when C2's eating disorder began]

M2: We were living in a very strange dynamic, I'll describe that briefly...

I: Also maybe tell me how you think maybe C2 felt that dynamic, how she experienced it?

M2: You know it started about a year earlier when she lost some weight, um, because she'd been to the States and hadn't had a diet that she liked with her relatives. And when she came back from the States all the girls at school told her that she looked stunning. Um, and she just moved into GCSE year and she'd always been in the middle of the class. But she knew that if she did nothing but study she was able to be at the top in some of some of the subjects. And I think suddenly, she thought, well, my parents might make an awful mess of life, but I'm going to be both successful *and* popular *and* beautiful. And I'm sure she didn't work it all out but suddenly she had a distraction that was all encompassing, that allowed her not *feel* what was going on at home and something else she could focus on. [A1, A3, A5, B1]. Um, but it certainly got, got, got our attention [B5].

This statement contained demonstrations of many types of RF from domains A and B. She is able to stay on task with mentalizing her daughter, remain tentative, and acknowledging many different perspectives. These features were further developed through the course of the interview, including the demonstration of a developmental perspective (category C).

Example 2. M5 (T2) Low RF

Beginning of interview

M5: Um, she's completely better. You probably wouldn't recognise her if you saw her. And her, her manner I think.

I: Wow.

M5: Um, I, it'd be interesting to see her, if you do get to interview her how she would be now. But she, she to us she's very, very different. [D1]

I: Do you want to say in what ways?

M5: Well socially, she's always out. She has a *huge* circle of friends now. And when she wasn't well, the friends, they didn't disappear, she chose for them to disappear. They were always there but she didn't join in with any of the usual teenagery things and now she most certainly is. In terms of other changes she doesn't feel quite, she doesn't want to be close to me all the time. Which when she wasn't well, she was...

M5: And that was stifling, in so many ways, for me. **[B1]** But now she's just, you know, she'll stay with me, not stay with me, but she doesn't kind of, um...listen to every word that I say, she's quite happy to plug her ear phones in [laughs] and drown me out. Um, I still take her to school every day, which I did anyway but that's more as a process of helping *me* to get started for the day ...rather than see her off and then probably squander an hour or so. Um, and also I pick her up, because that means she's back and she can start studying pretty quickly so...last year when she finished here, um, she would have been doing her GCSE's, so exams. Now she's doing her AS's, more exams and then on to A2's. So, for me it just makes sense to get her home and she can relax and then have more time to study rather than mess around on buses. It's silly, I'm able to. **[absence of RF regarding the described attachment behaviour, on both their parts, in terms of mental states]**

There was acknowledgement of differing perspectives between participant and interviewer, and a brief reference to own mental state, but strikingly, all mental state thinking is stripped from an account of attachment-based behaviour, and it is recounted in purely practical terms, particularly strangely in the context of the previous 'clingy' behaviour of C5 mentioned.

7.2.3 Commentary

Two comparable T2 interviews were chosen to illustrate high and low RF respectively (see also Appendix 7a). Both interviews were with mothers of girls who had recovered. It was hoped that by choosing T2 interviews of mothers of recovered girls, the possible effect of high anxiety on RF and mentalizing would be controlled for. In addition, mothers, not fathers, were chosen, as mothers were the primary carers and therefore, as a result of providing consistent daily care and being in close contact with their daughters, it was postulated that they would have the best opportunity to develop and demonstrate RF in regard to their children.

It can be seen that M2 thought and reflected consistently in terms of mental states underlying behaviour - that of her daughter, herself, her ex-husband, and also the

mental states underlying her own interactions with her daughter, and family dynamics in general.

This interview was given an overall score of 8. At T1, M2's interview was scored 9, demonstrating consistent high RF across both time points, and suggesting that her capacity for thinking in terms of mental states was a capacity that had developed, and continued to be present, independently of the impact of her daughter's eating disorder and the wider family crisis of which she spoke.

M5, on the other hand, described observable behaviour, mostly without attributing it to mental states, but rather allowed behaviour to 'speak for itself' although without elaborating. As can be seen in the full extract in Appendix 7, when prompted, she used physiological terms to account for behavioural changes, viz., increase in body weight equals increase in 'weight in the brain' which was assumed to restore mental health. M5 brought to attention attachment issues, again described purely in practical and behavioural terms. There was a moment of reflection on her own emotions at the end of the extract, quickly brushed away. Interviewer prompts and even scaffolding did not bring on mental state thinking, sometimes the opposite.

This interview was scored 4 for RF overall, the previous one at T1 was scored 3, both low RF, demonstrating again consistency in RF across time points irrespective of likely levels of anxiety.

These two interviews are extremely different. It was as if for M5, uninterpreted, observable behaviour, was the safest form of communication, and talk about possible mental states represented something like wild, possibly dangerous, speculation. For M2, on the other hand, nearly all behaviour and all events needed to be understood in terms of mental states, emotions and intentions. For M2, 'unmentalized' events seem to feel dangerous, and security of communication was found by making sense of things through mental state thinking.

Unfortunately, M2's daughter C2 was one of the children who refused participation, so we don't have her interview for comparison. M5's daughter C5 completed both interviews at T1 and T2, and scored low RF like her mother.

7.3 Scoring RF: Children

7.3.1 Using the CRFS on this interview, and divergences

Because RF for children could not be assessed as systematically and as frequently through the course of the interviews, owing to the nature and context of the interview, children's interviews were given an overall interview score, but an attempt to score each separate interview domain was not made.

The CRFS (Ensink, 2004; Ensink et al., 2013) is based on the Adult Reflective Functioning Scale (ARFS) for the Adult Attachment Interview (Fonagy et al., 1998) and the Parent Development Interview (Slade et al., 2004, Slade 2005). The CRFS was adapted and developed for use with children aged 8-14 and initially intended for use with the Child Attachment Interview (Shmueli-Goetz et al., 2008), but also intended as a basis for extension to other interviews with children, as in recent studies (Ensink et al., 2014, 2016, 2017).

The CAI consists of a series of specific questions asking children to think about and describe their relationships with parents and friends (for example, 'three words that describe what it is like to be with Mum/Dad'), and also asks for specific examples and situations called 'relationship episodes' (RE's), including occasions when Mum and Dad were upset with the child, and when Mum and Dad argued (Target, Fonagy & Shmueli-Goetz, 2003). The present interview obviously did not follow the CAI protocol but substituted with 'demand questions' in the interview domains and in the follow-up prompts.

The rating categories in the CRFS, while similar to the ARFS, contain a few adaptations, emphasizing the interactional nature of mental states. Specifically the additions are:

Category A: Recognising the interactional aspects of mental states

Category B: Understanding that an interpersonal behavioural interaction may be used to regulate negative affect

Category C: [Awareness of family dynamics] or peer group dynamics

Rating was consistently applied. Higher RF was rated where children spontaneously or in response to prompts described specific relationship episodes in mental state terms, and lower RF where mental states were vaguely or generally attributed, or absent.

Attention to features demonstrating RF was particularly directed to:

1. Occasions where children were able to think about their own mental states in relation to their own behaviour, whether in regard to their eating disorder or not. Given the very nature of the interview questions, children were particularly focused on their eating disorder. Therefore any demonstration of the capacity to reflect on their own mental states in relation to situations and contexts besides the eating disorder was particularly prioritized and noted.
2. Occasions where children were able to think plausibly about the mental states of their parents, siblings or peers underlying their behaviour.
3. Occasions where children were able to take a perspective involving family dynamics.
4. Occasions where children were able to demonstrate awareness that mental states are opaque or that feelings expressed or displayed may not relate to the immediate situation or context.

Scoring was then undertaken according to Ensink's (2004) Outline of the Revised CRFS as follows:

- 1 Repudiated RF: "Active evasion of mentalizing... freezing and becoming completely silent... bizarre and inappropriate explanations"
- 0 Absent or repudiated RF: "No evidence of active evasion, but child unable to respond"
- 1-2 Absent but not repudiated RF: explanations are given in physical or behavioural terms and there is no evidence of thinking in terms of mental states"
- 3-4 Low RF: "...references to mental states but with limited elaboration...alternatively an elaboration only approximates a clear RF type and the rater must 'fill in the gaps'..."
- 5 Definite RF: "...fairly simple and unsophisticated, but must be described clearly and briefly reflected upon. Explicit reference is made to how mental states are related to contexts, relationships, behaviour..."
- 7 Marked RF: "...more elaborated, sophisticated... may reflect an original view of a mental state which is not bizarre, or include an account of complex multilayered mental states..."
- 9-10 Full and exceptional RF: "The response clearly rates a 7, but is more sophisticated..."

(Ensink, 2004, pp427-438)

Ensink also explains the process whereby it was decided that the 'I don't know' response, should be rated as an absence of mentalizing. This was applicable in one whole child interview in this study and in briefer sections of other interviews. One might have argued that it was a likely response in the interviews of children with eating disorders, which are known for going hand in hand with reduced communication. However, this turned out not to be the case across the board by any means, as was shown in Chapter 6. Some children were fulsome and voluble in their replies on specific topics, belying the idea that an eating disorder would represent a moratorium on feeling, thinking and speaking for all sufferers.

7.3.2 Examples from the interviews: children

In order to be consistent with the choice of examples of RF from the parental interviews, a T2 children's interview was chosen, so as to control for the possible effect of both high anxiety and the most florid moment of ill health owing to AN. There were only four T2 interviews in the children's sample, none of them scoring above 5: C3 - 3, C5 - 3, C6 - 5, C8 - 5.

Shorter sections from C5 and C8 were chosen. C5 was chosen for the extra value of setting her own thinking about her recovery alongside her mother's (see Section 7.6). C8 was chosen for the opportunity to view moments of higher RF in a child's interview. C6 also demonstrated moments of high RF but owing to her age at the time of the interview, nearly 17, fell outside the age bracket deemed suitable for use of the CRFS.

Example 1. C8 T2 Definite/Marked RF

Beginning of interview

I: So, if you want to start, I mean it's not an easy question but do you want to start with how you understand your eating disorder? How do you make sense of it, then and now?

C8: Well, I think it's like a part of you that turns things that are normal into something negative and like you shouldn't do, so like eating, going out and stuff like that, and it restricts you by stopping you from eating. And so I think that it's, for me it's like a little voice that says don't eat this or have less calories or make sure your weight is lower, but I think it's like a part of you that has just, I don't know, just gone wrong somewhere and confused what is normal and changed it.

I: And I'm really interested in all of that, that's quite an original way to put it, you're saying things, things that are normal turning them negative?

C8: Yeah, so eating is normal, but they turn it into something that you shouldn't do and that you should avoid because you're not good enough for it.

I: Okay, so can you tell me more about the not good enough for it?

C8: For me, it took away things that I would usually do and like school and eating and, well, friends and family because it told me that I wasn't, I wasn't worth having those things, I wasn't good enough or worth having. I shouldn't have those things because yeah, I, I haven't done anything to deserve them.

I: Do you have any thoughts then on why you would feel like that, but other people wouldn't, I mean most people don't feel like they don't deserve to eat...

C8: I think that I have really low esteem, low self-esteem and it just started as like oh let's lose weight because I just want to change the way I look and then it turned into something more and the feeling of hunger became addictive and throwing away food was just routine and so it started off as a like a little way to lose weight

I: Which do you think came first, the low self-esteem and the not feeling deserving or the wanting to lose weight or are they connected? In which case maybe could you explain more?

C8: I think the low self-esteem came first, like from when I was quite young but in the same way they're connected as in, I didn't really think I was worth anything, so I wanted to stop anything that made me happy or made me live.

[Marked RF – 7]

Example 2. C5 T2 Low RF

Beginning of interview

I: So how do you understand your eating disorder basically. What was it about? It could either be looking back, or it could be about now if you still have an eating disorder. So maybe you want to say something about how you see your eating disorder now and then we can think about how do you understand it -

C5: Just didn't want to eat. Is that what is meant- it was anorexia -

I: Yeah, but maybe a bit more about why, you know, and are you talking about now or then?

C5: Then.

I: Yeah.

C5: Um, just didn't want to eat because it's the only thing I had control of.

I: What were the things you didn't have control over then? What did it feel like? That you didn't have control of?

C5: I think I just felt it was the only thing I could have control over, control over what I was eating. And then it was after my grandpa died. So it was the way of kind of coping with it.

I: Hm... Can you say a bit more about how it helped you cope or how you hoped it would help you cope?

C5: Um...

I: How does it work? I mean, I know that you know... I know that you know that I'm an eating disorder professional. But that doesn't mean that I know how it looks inside your mind about it. So just really spell it out for me, how did you think not eating and gaining a sense of control would help you cope?

C5: I don't know, I think it was just one thing and then it got too far after a while. And then I couldn't stop.

I: Yeah. Can you tell me a bit more about that process then? About... so you started off thinking you would have control?

C5: Yeah. Just thinking, just lose weight and not eat as much and then it just got to, well I didn't really eat at all.

I: Yeah.

C5: And then I'd only eat dinner. And then- and then people started noticing.

[Low RF 2-3]

7.3.3 Commentary

In Appendix 7b, the longer extract, it could be seen that C8 demonstrated variable RF; 'marked' (7) when she described her own complex, multi-layered thought processes around her eating disorder at the beginning of the interview; 'definite' (5) when describing family relationships in more general terms; and again 'definite' (5) when, at the end of the interview, she seemed to relax into a narrative that was more uncertain, more ambivalent, and perhaps more genuine, revealing the hold that the eating disorder still had on her and the confusion of thinking that it brought.

In Section 7.5 it is shown that, interestingly, C8's T1 interview was scored -1 because it was quite bizarre and attributed positive value to negative emotion and behaviour in the context of the eating disorder – much as she herself described here at T2. The T2 interview overall scored 5. Therefore in the case of C8 there was a big leap up between her two interviews. In her case, it would seem that the eating disorder had a marked impact on her capacity for mentalizing self and others.

This was not the case with C5, who demonstrated low RF throughout – some awareness of her own mental states, in relation to feeling bad about eating, not liking her father shouting at her, worrying about her friends. She showed no capacity in

these excerpts for putting herself in other people's shoes to understand their motivations for their behaviour despite there being some opportunities for this when speaking about her parents or her friends. She demonstrated overall low curiosity about others' mental states. This interview was given an overall score of 3, 'low RF'. C5's T1 interview was rated 1, as a result of the same level of low RF but, presumably under the impact of the illness, with even less elaboration on her own mental states. Her scores are therefore more consistent over the two time points.

A point of interest is that C5 said at T2 that she could still frequently feel bad after eating. This was not something known to her mother judging by her mother's description of her as entirely recovered from the eating disorder, and therefore presumably a state of emotion that C5 kept concealed within the family.

Another point of interest when comparing C5's interview with those of her parents, was her comment about her father getting angry with her, and this having made her want to avoid him. M5 did not mention this dynamic in her interview. However, D5 was aware of their loss of closeness and commented on it sadly. In his account, though, he showed no awareness that a factor may have been his anger with his daughter at the earlier stages of the eating disorder. He attributed this change in part, at least, to the developmental imperatives of C5 growing up.

A noticeable and intriguing difference between C5 and M5's interviews concerned the extent to which the eating disorder continued to exist in memory. M5 made repeated statements to the effect that it was as if the eating disorder had never existed, basing her statement on her observations of C5's much normalized adolescent social behaviour. C5, on the other hand, spoke about still feeling bad after eating, continuing to be aware of calories, grappling with anxiety both around exams and about friendships, and generally being aware of lingering effects.

An equally intriguing point arose when contrasting C8's T2 interview with that of her mother, M8 (D8 did not give a T2 interview). While C8 generally communicated positivity and a sense that she was recovering, although allowing some doubt and uncertainty to be seen towards the end of her interview, her mother at the same time gave an interview suffused with traumatic experience and high levels of negative affect. In terms of RF, M8's interview at T2 scored a 2, much lower than her daughter, showing little capacity for imaginatively understanding her daughter's motivations.

How these two interviews can be understood together, and others like them, will be discussed in Section 7.6.

7.4 RF Results: parents

In Section 7.1.1, where the rationale for measuring RF was laid out, three questions were posed:

1. Would a focus on measuring RF unveil features of interviews that had been missed in IPA analysis?
2. Would there be a correlation between high RF and high levels of meaning-making qualitatively analysed, particularly in parents' interviews, and vice versa?
3. Would parental RF in particular change, specifically rise, between T1 and T2 interviews in tandem with the impact of their child's recovery, if all went well, accompanied by a lowering of anxiety? This question was based on one of the theoretical planks of mentalizing, that is that 'controlled' mentalizing (Luyten & Fonagy, 2015) and concomitant RF are likely to be impeded at times of high affective arousal, including high anxiety.

We will now attempt to answer these questions.

7.4.1 Tabulated results

Tables 13-17 and Figure 1 have been produced showing the RF data in different combinations and will be presented sequentially.

Table 13. RF all shows all RF scores for all participants. For parents, sub-scores for each interview domain are shown, as are changes between T1 and T2 on both sub-scores and overall scores. This table is so large that it has been presented in landscape orientation format in Appendix 8.

Table 13. RF all participants

Table 14. RF Parents only shows a sub-section of Table 13, for parents' RF only. The table includes sub-scores for the various interview domains as well as overall scores. It shows change between T1 and T2 for the overall score but not for the sub-scores.

It should be noted that parents' scores are more detailed and numerous than children's, as each interview domain in parents' interviews was scored individually as well as each interview being given an overall scored.

Table 14. RF Parents only

	U1	U2	I1	I2	V1	V2	R1	R2	O/a1	O/a2	+/-
M1	7	3	7	3	3	3	3	3	5	3	-2
D1	8	5	5	7	5	8	5	6	6	6.5	+0.5
M2	9	9	9	9	9	7	8	7	9	8	-1
D2	-1		5		4		3		3		
M3		3		4		2		1		2.5	
D3	5	5	7	7	5	5	3	3	5	5	-
M4	3		4		2		2		3		
M5	3	4	4	5	3	4	0	4	2.5	4	+1.5
D5	5	3	3	5	3	3	5	3	4	3.5	-0.5
M6	6	4	5	4	6	8	7	7	6	6	-
M7	2		2		3		2		2		
D7	7		5		5		5		5.5		
M8	4	2	3	2	1	3	2	1	2.5	2	-0.5
D8	2		7		5		4		4.5		
M9	7		7		5		7		6.5		
D9	3		4		3		4		3.5		
M10	2		3		1		2		2		
D10	5		5		3		3		4		

Legend

U: Understanding and Making Sense; U1 Understanding at T1, and so on

I: Impact

V: Value

R: Recovery

O/a: Overall

+/-: change from T1 to T2

Scores in blue denote the availability of interviews with both time points, where change between them can be seen.

RF scale:

9 – exceptional RF

7 – high RF

5 – definite RF

3 – low RF

1 – absent RF

-1 – bizarre or inappropriate RF

7.4.2 Summary of Results in Tables 13 & 14.

Table 14 shows that for the eight parents who had interviews at both time points and for whom comparisons between the two can be made, there was little change in RF across the time points.

It would seem, then, that for this sample of parents who provided both interviews, there was little sign of the impact of treatment, or their child's recovery, or indeed any other factor inherent in the passage of time, in their RF scores.

In answer to Question 3. then, 'With RF measured at two time points, the first presumably at the stage of high anxiety and the second, if all went well with treatment, at a stage of lower anxiety and more normal family functioning restored, would RF change?', the answer based on these interviews seems to be that it did not change.

In fact, the levels of RF across both time points looked remarkably stable.

M1 showed the biggest change, with a drop of 2 points in her overall score between T1 and T2, from 5 (definite RF) to 3 (low RF). Although representing the biggest change in the sample, this was still a small change and could be attributable to the subjectivity of the scoring as well as to an actual change. What change there was, was in the opposite direction of that hypothesized.

However, looking more closely at M1's sub-scores, the change between M1's T1 and T2 sub-scores was greater, dropping from 7 (high RF) at T1 to 3 (low RF) at T2 in both the domains of Understanding and Making Sense, and Impact.

It was in fact the impression of the interviewer and rater that this drop represented a real change in M1's mentalizing. It seemed that the reduced anxiety in the family at T2 had actually *reduced* M1's impetus for mentalizing her daughter. The qualitative basis for this assertion can be seen in Chapter 4 where mothers' IPA results at T2 are presented.

The largest increase between T1 and T2 was in M5's interviews, an increase of +1.5 (strictly speaking, +1.75). The change is largely accounted for by an increase from 0 to 4 in the Recovery section of the interviews. Again, the qualitative basis for this increase is presented in Chapter 4.

Besides M1 and M5, as regards the other parents, the high scoring parents, D1, M2 and M6, all had consistent scores across both time points: 6/6.5, 9/8, and 6/6 respectively.

The average scoring parent, D3, scored 5 at both time points.

The low scoring parents D5 and M8 were also consistent over time with 4/3.5 and 2.5/2 respectively.

Therefore the overwhelming picture for those eight parents who gave interviews at both time points, five mothers and three fathers, is that their RF scores remained consistent over time.

Questions 1 & 2 concerned the relationship between RF and parents' capacity to make meaning, analysed qualitatively with IPA.

Would RF analysis reveal any aspects of interviews that had been missed in the IPA analysis? And would those parents who scored highly on RF also be skilled at thinking of ways of understanding and making sense of their child's eating disorder?

There could be several different ways of presenting the phenomenological and interpretative findings alongside the RF numerical scores. A simple way is presented

below, where a row of overall RF scores for T1 or T2 as appropriate are added to parents' IPA tables.

Table 15. RF with IPA – Mothers

Table 16. RF with IPA – Fathers

These tables show the overall RF score added to IPA tables for mothers and fathers respectively, in a row along the bottom, to explore possible relationships between the two types of results.

Table 15. RF with IPA – Mothers

UNDERSTANDING & MAKING SENSE: phenomenological themes											
What mothers thought and said*											
		M1	M2	M4	M5	M6	M7	M8	M9	M10	Total
1	"I don't know and don't understand"	✓		✓	✓				✓		4
2	"An ED is a disorder of eating"	✓			✓	✓	✓				4
3	Genetics, biology, in ASD			✓				✓		✓	3
4	Child's own character traits – anxiety, low self-esteem, perfectionism, etc.	✓		✓				✓		✓	4
5	Impact of family events – illness, divorce, bereavement, parental discord - control		✓	✓	✓	✓			✓	✓	6
6	Impact of adolescent development and its social demands – school, peers, friends, media	✓	✓	✓		✓	✓				5
UNDERSTANDING AND MAKING SENSE: Interpretative themes											
Researcher observation and interpretation of possible emotion											
		M1	M2	M4	M5	M6	M7	M8	M9	M10	TOTAL
7a	Impact/importance of mother-child relationship		✓	✓		✓			✓		4
7b	Imagining child's mental state	✓	✓			✓					3
7c	Self referential thinking	✓	✓			✓			✓		4

8	Guilt		✓	✓		✓			✓		4
9	Rage (at child)	✓					✓	✓	✓	✓	5
	RF T1	7	9	3	2.5	6	2	2.5	6.5	2	
	RF T2	3	8		4	6		2			

7.4.3 Summary of Table 15: RF with IPA - Mothers

First we can note that there is no correlation between the *number* of themes of Understanding and Making Sense ticked for mothers, and RF. This is evidenced in M2's column. M2 had the highest RF score and yet only two ticks for phenomenological themes. When we look at the detail of the phenomenological themes, it makes more sense, as the first two themes represent almost a disavowal of meaning and the second two themes represent meaning in terms of pre-morbid personality traits and genetics of the child. The fifth and sixth themes represent more nuanced, dense and complex psychosocial ways of understanding, located in the social systems of the child.

M4, on the other hand, ticked all but one of the phenomenological themes but still scored low on RF.

We might argue tentatively that we fare better when trying to relate RF scores to the interpretative themes. The high RF scoring mothers M2, M6 and M9 ticked four out of five interpretative themes focusing on their emotions about their child and their own relationship with their child. The very low scoring mothers – M5, M7, M8 and M10 – only ticked one interpretative theme each, or none in the case of M5. For M7, M8 and M10, this theme was 'Rage at Child'. Nevertheless, M1, who scored highly at T1, also ticked this theme, while low scoring M5 did not. No association is clear.

Still, it would be possible to argue, plausibly, that for mothers who struggle to understand their children, to think in terms of mental states underlying their children's behaviour, the experience of bewilderment, confusion and frustration that followed their child's descent into a mental health disorder might easily translate into a feeling of rage.

It is popularly said that rage is a secondary emotion, concealing more vulnerable emotions of self-doubt or failure, and it would be easy to imagine – to mentalize – that those mothers who scored low on RF and high on rage felt deeply injured in their self-esteem as mothers. If they mothered as best they could, and their children got mentally unwell, what greater indictment of their mothering could be imagined?

Table 16. IPA with RF – Fathers

UNDERSTANDING & MAKING SENSE: phenomenological themes													
What fathers thought and said													
		D1/ 1	D1(2)*	D2	D3/ 1	D3(2)*	D5/ 1	D5/ 2*	D7	D8	D9	D10	Total 8 (11)
1	“I don’t know and don’t understand”		✓				✓	✓		✓		✓	4
2	“An ED is a disorder of eating”			✓			✓	✓		✓	✓		4
3	Genetics, biology, inc ASD												0
4	Child’s own character traits – anxiety, low self-esteem, perfectionism, etc.	✓	✓		✓	✓				✓		✓	4
New 4a	Needing attention – a communication	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	8
5	Impact of family events/ relationships – illness, divorce, bereavement, parental discord - control	✓	✓	✓	✓	✓							3
6	Impact of adolescent development and its social	✓	✓		✓		✓	✓	✓				4

	demands, school, peers, friends, media												
UNDERSTANDING AND MAKING SENSE: Interpretative themes													
Researcher observation and interpretation of emotional impact													
	Theme	D1	D1(2)	D2	D3	D3(2)	D5	D5(2)	D7	D8	D9	D10	Total
7a	Impact/importance of parent-child relationship – or its absence	✓	✓	✓	✓	✓	✓	✓					4
7b	Using self to imagine child's mental state	✓	✓	✓			✓		✓	✓			5
7c	Self referential thinking	✓	✓	✓			✓		✓	✓			5
7d	Mother/child blame			//	//	//				//	//	//	5
8	Guilt	✓			✓								2
9	Rage at child /at professionals	//	//		//				✓	✓	//	✓	6
10	Plaintiveness			✓				✓	✓	✓	✓	✓	6
	RF	6	6.5	3	5	5	4	3.5	5.5	4.5	3.5	4	

7.4.4 Summary of Table 16: RF with IPA – Fathers

We may recall that IPA analysis for fathers revealed some special features – the phenomenological theme ‘Seeking attention – a communication’, was one which all fathers ticked and yet had not appeared in mothers’ interviews at all. Whether the father then felt sympathetic to or irritated by this clamour for attention then varied.

Similarly, the interpretative theme ‘Plaintiveness’, named thus to capture a particular mixture of bewildered outrage at what was happening to them and their family, coupled with a sense of not being responsible or in charge, was special to fathers’ accounts.

It is possibly worth noting that D1, the highest scoring father, did not tick the theme plaintiveness. Nor did D3, the next highest scoring father, but his RF peer, D7, did.

It may also be worth noting that D1 and D3 were the only fathers to tick phenomenological theme 5, 'Impact of family events/ relationships – illness, divorce, bereavement, parental discord – control', perhaps the most complex theme requiring parents to situate their child's eating disorder within the family context, requiring levels of self-awareness and openness to considering their own role.

Overall, we draw the conclusion that to relate RF to IPA meaningfully, requires discussion on a case by case basis. This may be even more so when we try to relate parents' RF to their children's in Section 7.

7.4.5 Mentalizing and parental reflective function: a different sort of meaning

At the start of this research project, it was hypothesized that analysing and scoring RF in addition to the IPA method of analysis, would throw some special light on the parent-child relationship. RF is a time consuming process of analysis, and considerable investment of time, training and research was made in it.

The results were limited, but also interesting.

The limitations were partly imposed by the small sample.

It was found that there was no change in parental RF over time, a significant finding that seems to turn on its head the theory that mentalizing is impeded by high affective arousal, although as we saw in Chapter 3, Target (2008) argued against this theory, suggesting that when there is no impetus to understand the emotions and behaviour of a loved one, mentalizing and RF may indeed sink. It would make sense to argue that that may have happened with this sample of mothers in particular – mothers with high RF maintained their capacity and mothers who may have strained to mentalize their children in the eye of the storm, may have been able to ‘relax’ and reduce their efforts once their children were recovered and family functioning somewhat restored.

Qualitative analysis using IPA, and assessment of RF, measure different things. It has transpired that through the IPA analysis, with its dual focus on content and emotion, cognitive and affective elements, allowed a bringing together of these aspects to create themes relating to meaning, many of them rich and complex, and very personal. We were able to see how parents, and children, made meaning in a number of ways through description of the emotional impact, revealing their feelings and experiences, in addition to advancing their more cognitively based ideas about the meaning of the eating disorder.

RF, on the other hand, refers to a capacity or level of self-awareness and self-reflection. With deep knowledge of the contents of the interviews, it is possible, in this small sample, to propose that those parents who demonstrated a capacity for mentalizing and high RF, also developed the richest qualitative accounts. This was true of parents, at least.

In particular, the systematic attempt to relate emotion to content yielded some unexpected and challenging results as documented and elaborated in the Results for Mothers and Fathers in Chapters 4 and 5 respectively. .

7.5 RF Results: children

Table 17. RF Children shows RF for all nine children’s interviews, three of which were T2 interviews. Each child’s RF results are discussed individually, briefly, and in relation to their parents’ RF scores.

Table 17. RF with IPA – Children

	Understanding T1	RF T1	Understanding T2	RF T2
C1	1. Don't want to get fat 2. Didn't mean to go so far 3. 'I thought everyone thought like that' (inhabiting the ED)	-1 Evasion of questions	n/a	n/a
C3	1. Always had rules 2. Stressed; worried 3. Want mum's approval – poor relationship 4. Compare self with sister	7 Self aware MS affect behaviour Intergenerational & developmental thinking High RF re. M3	1. Change of mind – “realized” 2. Vicious spiral down	3
C5	1. Healthy eating 2. Went too far – lost control 3. Did something bad and disappointed people 4. Control when grandpa died and everyone upset	1 Little self reflection or MS thinking	1. Control – unelaborated 2. Went too far	3 New awareness of own anxiety states
C6	n/a	n/a	1. Depression. ED a magnet for feelings, incl for aimlessness 2. Self-deprivation (because loved food) 3. Influence of ED unit 4. Depression linked to parents' divorce	5 Aware of own MS and their shifts Little MS thinking re. others

C8	1.Irrational thoughts – OCD 2.Not eating is part of me 3.Felt ugly at school 4.Didn't like who I was	-1 Don't want to feel regret about so prefer to sever family relationships. Pleasing the bullies by getting thinner (revenge motive)	1.Low self-esteem – not deserving of food, friends	5 Synthetic account of ED. Sister being angry with her. Family communication improved
C10	1.Genetic – heavy MH load in family listed 2.Admired “super skinny” on TV 3.Control and coping	3 Struggling to make sense of family relationships and place of mental health in the family	n/a	n/a

Children’s interviews received an overall score for the whole interview, based on the number and variation in type of statements demonstrating RF through the course of the whole interview. Examples of how this was done were given in Section 7.3.2 and Appendix 7b.

Children’s thematic items under the domain of Understanding and Making Sense have been reproduced in very concise form in this table, and set alongside the RF score, first, in order to make it easier for the reader to situate the score in the context of each child’s interview.

Second, we may compare the extent to which children were able to make meaning of their own eating disorder, with their RF score. Details of the items making up their RF score are briefly recorded in the same box as the score.

A brief, speculative, reflection on each child’s score, and where available change of score between T1 and T2, is offered. Comparison with parental RF is presented and discussed below in Section 7.6. Quoted definitions of ratings are from Ensink (2004, p214).

C1

C1's interview, punctuated as it was by 'don't know' answers, long silences and by some expressed unwillingness to answer, qualified for a negative RF score of -1, because of her active evasion of answering questions and falling completely silent, or resorting repeatedly to 'don't know' answers. This was ascribed on the face of it to C1's all encompassing eating disorder. There was no T2 interview for comparison. It is also not possible to know if she had any cognitive deficits that might account for some of the paucity of her responses. However, it was known from her father's interview that she had had some difficulties at school.

We may note that D1, C1's father, had one of the highest RF scores of the parental sample. Her mother, M1, scored high at T1 and low at T2. C1 seemed to fall into the category of participants for whom it could not be said that difficulties in mentalizing particularly 'ran in the family'. It is difficult to draw further conclusions, and we are left curious about C1's recovery and developmental journey through adolescence.

C3

C3 scored an RF score of 7 at T1, 'marked RF' and the highest score of all child interviewees, defined as "elaborated and sophisticated... may include an account of complex multilayered mental states". Clearly her young age (11) in no way hampered her mentalizing ability or expressive language, though generally there is not the expectation of a good correlation between chronological age and RF in this age group (Ensink, 2004). C3's high score appeared brought about primarily by her apparent, urgent need to try to understand her mother's mental state and its impact on how her mother treated her. At T2, when C3 was much recovered, C3's RF score had sunk to a less remarkable 3 denoting low RF, "references to mental states but with limited elaboration". This could be the consequence of her lowered anxiety, possibly restored relationship with her mother, and overall happier emotional state.

C5

C5 scored 1 at T1, absent but not repudiated RF: "explanations are given in physical or behavioural terms and there is no evidence of thinking in terms of mental states." By T2, when she was recovered from AN, her RF score had risen to 3, 'low RF'. Overall, her responses were muted which seemed to be in keeping with her rather flat affect. It was not possible to pinpoint the reasons for this persistent, generalized mutedness. It was as if C5's world were painted in beiges and greys where C3's and C8's were painted in the full range of colours. C5's father seemed to be indicating this feature also when he described her as always having been quiet. However, we have noted that her

mother also displayed low RF and uniquely her narrative fitted none of the interpretative themes concerning emotions.

C6

C6, who only gave an interview at T2 when she had recovered from AN, scored 5: 'definite RF': "the response may be fairly simple and unsophisticated but must be clearly described and briefly reflected upon." We saw that C6 made several attempts to reflect but also was able to say that she quite quickly reached a state of not understanding or still feeling unsure. She was the oldest in the sample and therefore, at 16, outside the age range on which the CRFS was developed.

C8

C8 scored -1 overall in her T1 interview; this score was allocated primarily for the 'bizarre' or 'inappropriate' thinking proffered in relation to the impact of her school peers' bullying as a justification for her eating disorder or her assertion that she valued her eating disorder more than her relationships with family, and that it was good to lose trust so that it hurt less when she was 'horrible' to her parents. Some of her more ordinary responses, while on the face of them could have scored 3, lacked genuineness and much of her interview was given to generalities. At T2, however, she scored 5, indicating 'definite RF'. She gave a fresh account of her view of her father, her sister and family functioning in terms of some mental states even if briefly reflected upon.

C10

C10 scored 3 at T1, with no T2 interview for comparison, 'low RF'. This was perhaps not surprising given the unusual and ambiguous value placed on mental health problems in her family, where poor mental health was understood both as a genetically determined load and fate, and something that gave special status, but was not open to being questioned.

C10's evident anger about her situation and at her parents may have reduced her capacity for RF and indeed, the extent to which intense emotion may have interfered – or enhanced - RF in all the children's interviews, is a matter for discussion in the next section.

7.5.1 Summary of children's RF results

The small sample certainly limits the conclusions that can be drawn. Nevertheless, almost the whole range of RF scores was seen in these interviews, from -1 to 7. This suggests that an eating disorder alone need not be an obstacle to reflective function in children.

Nevertheless, C3's T1 interview with a score of 7, 'marked RF', was an outlier, with the other interviews scoring 5 or below.

In section 7.3.2 excerpts from T2 interviews for C5 and C8 were given, illustrating very different levels of reflective functioning, as well as quite different stances in relation to their own mental functioning and motivation.

Where interviews for both time points were available (C3, C5 and C8), we see movement both in the direction of a lowering of RF between T1 and T2 (C3), and a raising of RF (C5 and C8).

This seems to suggest the possibility of two, seemingly contradictory, ways of understanding the presence or absence of RF. On the one hand, one could propose that a difficult or troubled attachment relationship, such as the one between C3 and M3 at T1, drove an increase in mentalizing on the part of C3, in order to try and understand her mother better so as to know what to do to restore attachment security.

On the other hand, it could be argued that once mental health is restored and attachment security improved or resumed, the child will have the peace of mind to reflect and think more deeply about the link between their own feelings and behaviour, and that of important others such as parents, and also friends, insofar as their developmentally acquired capacity for mentalizing might permit, as perhaps for C8 whose score rose from -1 at T1 to 5 at T2.

Both possibilities seem evidenced in the RF scores for the children interviewed for this study.

Another notable feature was that the oldest and seemingly most recovered subject in the sample, C6 at T2, did not achieve higher than a score of 5, despite her apparent fluency and articulateness. When looked at carefully, her responses were still quite brief and unsophisticated in terms of RF, highlighting that linguistic skill, or intellectual ability, can actually mask undeveloped RF.

C5's interview, unlike C1's and C10's, was apparently characterized neither by evasion nor anger, yet she scored consistently low. In this regard, she and her parents were alike. We turn now to see if a comparison between parents' and their children's RF scores, where they were both available, may spark any additional observations about the meaning of RF in conjunction with our knowledge of the rich themes and emotions of our subjects' narratives.

7.6 RF Results: comparing parents and children

Figure 1 shows scores and direction of change in scores, even though they were small, for those families where parents and children had interviews in parallel.

It also allows at a glance simple comparisons between parents' and their children's overall level of RF in their interviews.

Figure 1. RF parents and children - change in overall scores from T1 to T2

7.6.1 Commentary on Figure 1

We know already from parents' RF results that the changes were small and that overall, RF remained stable. In the three children with interviews at both time points, the picture was more mixed.

C3's RF sank from 7 to 3.

C5's RF rose from 1 to 3.

C8's RF rose from -1 to 5.

Interpretation of these results needs to be sought within the detail and particular circumstances of each child's narrative. These have been analysed in Chapter 6 with IPA. We may recall, briefly, that C3 was preoccupied with the rejecting relationship with her mother at T1 but hardly mentioned it at T2. C5 had resumed adolescent life at T2 but on the whole remained low in terms of RF. C8 was in the grips of her eating disorder at T1, memorably telling the interviewer in essence that she would rather lose her family than her eating disorder, and, solipsistically, that it was actually positive to lose her family relationships so that it hurt less to lose them. This way of thinking had undergone a 180-degree turnaround by T2.

We may also conclude that RF is by no means a stable trait in childhood but rather can undergo rapid change and subject to the vagaries of emotional and cognitive development, family fortunes, the ups and downs of primary attachment relationships, and mental ill health.

We can also see how parents' and children's RF compares.

In F1 we see D1 as a lone figure with high RF amid a wife and daughter with low RF.

In F3 each member has different scores – M3 low, D3 consistently average, and C3 fluctuating from high at T1 (when affectively aroused) to low at T2 (when better).

In F5 we see consistency across all family members, a generally low RF family.

In F8, C8 emerges as a high RF child in the context of low RF parents.

Where RF differs markedly among family members, it is interesting to wonder about the child-parent fit, and indeed the couple fit.

Chapter 8. Mother's themes at T2

8.1 Introduction

Mothers' themes at T2 were gathered into this separate chapter for three reasons.

First, six mothers completed the interviews at T2 (see Table 1), a substantial enough number in IPA research to warrant a comparison of changes in their narrative themes over time, allowing the possibility of some more substantial findings relating to change in how these mothers understood and made sense of their children's eating disorder. RF scoring was also carried out on these T2 interviews and the results of this process, with observations of little change between T1 and T2, were presented in the previous chapter.

Second, a substantial volume of data was collected through these six interviews, but although the interview protocol was the same as at T1, the primary focus on the meanings attributed to their children's eating disorder had inevitably faded. Five of the six mothers were 'out the other side' to varying degrees at their T2 interview, and one mother (M8) was still in the middle of it, though on a more even keel at the time of the interview. It became apparent in the first phase of annotating the interviews, that the emphasis had shifted from making meaning of their child's eating disorder, to making meaning of the experience of living through it.

Third, because of this shift, a decision had to be taken about how to select data for presentation in this study. It would have been possible to select only those statements and passages that related directly to mothers' understanding of the eating disorder. However, this would have resulted in a skewed, and impoverished, representation of their actual narratives. The six mothers presented here had often given a great deal of thought to the experience they had had, they had made meaning of the experience itself, and they had learned many things that they were keen to impart. They also wanted to communicate through this research with other families going through the same shock and upheaval.

Doing justice to these aspects of the T2 mothers' interviews would make a powerful separate study but it did not provide a substantial contribution to answering the original research question.

Consequently it was decided to present the results reordered, according to the weighting of the data itself. This meant that more attention has been given to the interview domains of Impact, Value and Recovery. In order to manage the volume, themes are usually supported with data from a couple of participants but not all.

Emotion ran high in many of these interviews. The results of may provide a fitting coda to this study, encompassing as they did the entire range of experiences and emotions that they, their daughters and their families endured through the time of their child's eating disorder, and how it changed them. Even if the specific focus on meaning may have shifted temporally from the meaning of the eating disorder to the meaning of the experience, the results are interesting in their own right, showing how mothers and make sense of their own and their daughters' lives in a specific context.

M3 is included in this group of T2 mothers, even though change over time was not able to be tracked for either her qualitative themes or RF scores, owing to her T1 interview being unavailable. Nevertheless, her presence here adds to the T2 results for the whole group.

These findings will be integrated with previous findings where possible and discussed in Chapter 9.

8.2 Summary of treatment and recovery

Table 2 showed, among other things, whether children in the interview sample had gone on to more treatment after being treated in the service where the researcher worked. In terms of physical recovery, all daughters in this group were at a healthy weight, they were eating normally with varying degrees of supervision by their parents, and were living at home. They were receiving either non-intensive follow-up treatment, or had been fully discharged. Except for C8, all the children had returned and reintegrated into school.

The children's mental health status was more variable, as will be evident in their mothers' accounts. Some were understood by their mothers to have genuinely

recovered and moved on from the eating disorder; others were being closely managed by their parents, and in practice mainly by their mothers. In addition, mothers gave accounts of close observation of their children's eating behaviour and mood.

These interviews had a dual focus of both how mothers understood their children now, and on how they understood what had happened to themselves and their families.

8.3 Method and presentation

Interviews were annotated in exactly the same way as T1 interviews, with RF annotations on the left of the transcripts and IPA annotations on the right.

However, the format of the thematic presentation was changed, as it became apparent that for these mothers, an emphasis on a retrospective reflection on the meaning of the eating disorder sat uneasily with what was of greatest interest to them at this time – reflecting on the impact of the experience on themselves, their child, their families, and their whole life, as well as their learning from it.

The emphasis of the tabulation of themes had to shift in the direction of Impact and its ramifications.

Allied to Impact was the domain of Value; this was addressed with marked emotion by some of the participant mothers.

The Recovery domain was now fleshed out as mothers had treatment experiences to evaluate and reflect on, with their child usually having had at least two treatment episodes and often more, including in the cases of M1 and M8, further treatment after the researcher's service.

The Emotions section also had some additional items as a result of analysis of T2 interviews.

A change in the mode of analysis and presentation was made. Instead of creating individual thematic tables, themes were noted through the course of the reading and allocations made. This resulted in one long table with four different headings.

'Impact & Value' were combined under heading I.

'Understanding' and 'Recovery' were presented separately under headings II & III. 'Emotions' were presented under heading IV.

The results can be seen in Table 18.

Table 18. Mothers T2 All themes

		M1	M2	M3	M5	M6	M8	T ✓/x
I. Impact & Value		Change: ✓ positive x negative						
1	Relationship with daughter		✓	✓		✓	x	3/1
2	Relationship with partner		x	x	x	na	x	0/4
3	Relationship with other children		na	x	x	✓	x	1/3
4	Change in family dynamics		x	x	x	✓	x	1/4
5	Change in parenting style	✓	✓	✓			x	3/1
6	Change within myself		✓	✓	✓	✓	✓	5/0
7	Change in child's behaviour/mood	✓x	✓	✓	✓	✓	✓x	6/2
8	Good/bad things have come of it	x	✓	x	x	x	x	1/5
9	Impact on work and career		✓			x	x	1/2
II. Understanding & Making Sense		M1	M2	M3	M5	M6	M8	Total
1	Depression and/or anxiety		✓	✓		✓	✓	4
2	Low self-esteem and self-worth	✓		✓				2
3	Family factors		✓	✓			x	2
4	Peer group	✓	✓	✓	✓	✓	✓	6
5	Child's genetic inheritance or character	✓	✓	✓			✓	4
III. Recovery		M1	M2	M3	M5	M6	M8	
1	Child's treatment experience: positive	✓				✓	✓	3
2	Child's treatment experience: negative	✓	✓	✓	✓		✓	5
3	Recovery noted through behaviour (eating or other)	✓	✓	✓	✓	✓	✓	6
4	Recovery noted through mental state, e.g. anxiety & mood	✓	✓	✓	✓	✓	✓	6

5	“Boundaries”	✓	✓			✓	✓	4
6	Medication	✓	✓				✓	3
IV. Emotions		M1	M2	M3	M5	M6	M8	Total
1	Importance of mother-child relationship		✓			✓		2
2	Loss, grief, sorrow		✓				✓	2
3	Guilt, regret		✓					1
4	Anger		✓	✓	✓		✓	4
5	Trauma	✓	✓	✓	✓	✓	✓	6
6	Need for time and care for self		✓	✓	✓	✓		4
7	Hope and optimism for future		✓		✓	✓		3
8	Trepidation and fear for future		✓		✓	✓		3
TOTAL no. of themes overall		13	25	19	15	18	21	

Legend:

Impact & Value:

✓ = positive change in this area

x = negative change in this area

Understanding, Recovery, and Emotions: a tick represents presence or absence; a cross signified that the subject was discussed and actively repudiated.

Empty boxes signify that the subject wasn't discussed either explicitly or implicitly.

8 3.1 Impact & Value

This time, Impact & its allied category Value, were promoted to primary results. This section specifically tracked change over time, and recorded whether change was considered positive or negative. Where a box was left blank, it meant that the topic was not discussed nor did it emerge implicitly through what was said.

Themes 1-5 related to change in relationships.

Themes 6 & 7 related to self-reflective observations on mothers' own internal change, and similarly, what they perceived about internal changes in their daughters.

Theme 8 was an overall evaluation of Value

Theme 9 specifically concerned changes in mothers' work and careers.

8.3.2 Understanding & Making sense

This domain reproduced the themes from T1 and added new ones according to mothers' own retrospective accounts. Notably the first new theme was 'Depression & Anxiety' as several mothers retrospectively identified depression and anxiety as factors that they thought contributed to the onset of their child's eating disorder. This had not emerged as a theme at T1. The relative sparseness of allocations indicates that mothers were no longer talking so much about the original meanings attributed to the eating disorder.

8.3.3 Recovery

The Recovery domain was reshaped by mothers now looking backward, not forward (except in the case of M8). Themes were added concerning their child's experience in treatment, their own ways of interpreting whether their child was recovering or not, and specific factors in recovery earmarked for special mention ('boundaries' and 'medication').

8.3.4 Emotions

The final domain, Emotions, had some crucial additions to the old themes of T1, including 'Trauma', and 'Need for time and care for self', as well as feelings about the future.

8.4. Results

Table 19 is long and somewhat unwieldy, but it does justice to the range of mothers' thematic accounts, prioritizing subordinate themes and giving them due space. The 'Total' column at the end of each theme row allows a counting up of the number of mothers who mentioned a particular theme, and also the spread of positive and negative changes.

The 'Total' column at the bottom of each mothers' individual column simply adds up the number of topics covered in her T2 interview, out of a maximum of 28.

A couple of the themes are striking in their ubiquity among the sample, as a quick glance shows.

Certain themes were addressed by nearly all mothers. These concerned changed relationships within the family, and personal, internal changes (Section I, Questions 1-8), treatment experiences and observations (Section III, Questions 9-12), and in Section IV, specifically the emotion of Trauma (Question 5).

We can see that topics under section II, Understanding, no longer captured the attention and interest of the participants as much as at T1. It is possible that this factor played its part in the unchanging RF scores seen in the previous chapter.

8.4.1 Impact and Value Results

The most unitary whole group results in this domain were:

1. Positive changes in their child's mood and behaviour (Theme 7): all six mothers (100%) subscribed to this theme. Two mothers also saw negative changes, i.e. mixed changes.
2. Positive changes within myself (Theme 6): five out of six mothers (83%)
3. Good/bad things have come of it (Theme 8): five mothers (83%) said bad things had come out of it; only one mother (M2) came down on the side of good things.
4. Relationship with partner (Theme 2): four out of five mothers with partners/hubands at T1 (80%) said that their relationships had changed for the worse.

Besides these, the balance fell on the positive side for 'Relationship with daughter' (Theme 1) and 'Parenting style' (Theme 5), and on the negative side for 'Relationship with other children' (Theme 3), 'Family dynamics' (Theme 4), and 'Work and career' (Theme 9).

Some stark and even shocking statements were heard in this domain. Sometimes the narratives painted a landscape of devastation as in the aftermath of a tornado. M3, for example, dwelled on the damage to the family, to her relationship with her husband, and with her older daughter who, on the one hand had been 'completely neglected' during C3's eating disorder, and yet M3 was now in a conflictual relationship with her:

“[Older daughter] does annoy me after a while, ‘cos just like with C3 I used to soak it up until I got completely saturated and then I would lose my temper, or get angry, or withdraw, and it’s the same with [older daughter]. I just put up, put up, put up with all her, you know, sarcasm, and eye-rolling, and rudeness and whatever and there comes a point where I think, “I don’t really want to help you anymore, I really want to like, you know, smack you or something.” (M3, T2)

M8 spoke about ‘normalising the abnormal’, but she was also one of the mothers who elaborated on the positive changes within herself (Theme 6), saying that she had confronted her own avoidance of conflict, her perfectionism, and had learned to value small things:

“I think gratitude is what I’ve learned most, and that sounds crazy because you know it’s such, but to be able to be thankful for the small things, the very small things, so it was her birthday, her 16th birthday and we had a very good day.” (M8, T2)

M3 and M5 spoke about doing more things for themselves, sport related and also seeing and making new friends, although the flipside of this seemed to be spending less time with their husbands and going separate ways. We may recall the D3 and D5 both gave rather sad accounts of this development in their relationships from their own perspective (D5 calling himself a ‘spare part’ in the family, for example).

Uniquely, as we saw in Chapter 7, M2 called the eating disorder ‘a blessing in a strange sort of way’ because it forced the parents to confront their own marital unhappiness and ‘terrible mess our family was in’. Her own take on positive changes within herself included leaving her job and taking responsibility for her own mental health and well-being, and ‘being authentic’.

8.4.2 Understanding & Making Sense

This domain was more sparsely populated at T2. Ticks to the table were allocated where mothers mentioned these themes spontaneously, but the interviewer did not specifically either remind mothers of their views at T1, nor ask for updates.

Small changes included M1 this time explicitly locating her daughter’s eating disorder in the context of her genetic loading:

“I think in the past she was really unhappy and I think that ... she’s a child that’s always going to probably be susceptible to ... mental illness maybe,... her self-esteem and things like that and be affected by what people say, and I think it’s her general genetic make-up, I mean I swear to god but I think it is, it is something about *her*. You know, I think she’s very intelligent and I think there’s just, you know, maybe her eating disorder is just another form of how a mental illness would have come out anyway, hers has come out as an eating disorder, some people come out as, I don’t know, paranoid schizo... I don’t know, whatever. I do think it was her wiring that came, you know, just completely broke down, um, and she just got onto that slippery slope.”
(M1, T2)

The marked addition to the themes in this domain was Theme 1, Depression & Anxiety. M2, M3, M6 and M8 all mentioned this spontaneously as being at the root of their daughters’ eating disorder, perhaps with hindsight that was not available at T1, except for M6 where it was known that C6 started her mental health treatment with the diagnosis of depression, while C3 had begun with treatment for unspecified behavioural problems which were now labelled ‘depression’ by M3. M8 rehearsed facts about C8’s long-standing extreme anxiety, and M2 had a new take on her daughter’s eating disorder as being spawned by depression among other factors, thereby leavening her intense focus on the family dysfunction at T1.

All mothers gave attention to the influence of the peer group – M5 and M8 for the first time. Now, though, mothers seem to attribute power to the peer group with more certainty and brought it up both as a factor in their child’s former unhappiness, and as an important factor supporting their child’s newfound mental health. All mothers (except M8) spoke with pride and relief about their daughters having friends, a new friend group, and being happy at school.

8.4.3 Recovery

The domain of Recovery came into its own at T2, not so much in direct response to the question in the protocol, ‘What do you think is needed now for your child to get better?’ given that five of the six were better, but more as an opportunity taken to review treatment and to share with the interviewer some complaints and dissatisfactions, as well as praise and gratitude for professionals in general.

Five out of six mothers (83%) recounted negative treatment experiences, referring both to their own opinion and their child’s experience. These experiences related sometimes to the service of the researcher, and to other services. Two of those

mothers also balanced their criticisms with noting positive experiences (M1 & M8). M6 was the only mother who only noted positive experiences.

All mothers were keen observers of their children's eating behaviour and some gave lengthy accounts of how their children were eating now, but this was not to the exclusion of noting their mood and emotions. These were also carefully observed.

'Boundaries' (Theme 5) was noted by two-thirds of mothers as an aid to recovery. Some mothers spoke strongly about it:

"I think she just needs really firm boundaries. She needs to be reminded that if she, you know mucks about with her eating then she doesn't get what she would like, you know, she won't be going on the trampoline, and she won't be going on her residential, if you don't eat then you're ill, you know." (M1, T2)

Or M8 in relation to the benefits of her daughter's in-patient treatment in a highly structured programme:

"She was fed up of cleaning up her own sick... I mean it's a very harsh regime but it's very clear, there are the absolute boundaries... if you tapped your foot once you were given a warning, if you tapped your foot twice you were given a replacement chocolate biscuit, um there's no crumb allowed on your plate, you have to clear it to every crumb to the point you know you lick the chocolate wrappers... It was very clear, and her consultant was one tough woman and as C8 said, I met my match with her. C8 couldn't have done it if anybody had been gentle with her, there was no way, she needed that kind of clear unambiguous tough love." (M8, T2)

8.4.4 Emotions

Theme 1, 'Importance of mother-child relationship' represented the former themes 7a-c at T1. Only M2 and M6 subscribed to this; they were the mothers with high RF who we saw in Chapter 4 believed that they had an important role to play in influencing their children, even if this also brought guilt at the thought that they might have played a role in bringing on the eating disorder.

Themes 5, 6, 7 & 8 were new for T2: 'Trauma', 'Need time and care for self', and regarding the future, 'Hope and optimism' and 'Fear and trepidation'.

'Trauma' was identified both through what mothers said, and how they said it. For example, M8's T2 interview was so relentless in its description of horrendous experiences both of their child's self-harm and her subsequent treatment, and so unsparing of detail, that the interviewer concluded that the method of delivery betrayed ongoing trauma.

For example:

"We got to the first of July, 30th of June actually, she um, she really wasn't eating, allowing the tube in at all, and she wasn't drinking water and we got to the point where couldn't take it at home, she already um, we had a laceration, I think that was around the same time where she'd taken a lightbulb and she lacerated her wrists um, she'd only been left for a couple of minutes, she was asleep and I'd gone to the toilet and I came back and she had lacerated her wrists with the lightbulb and that was on the, I think the 30th of June and she wasn't taking any water and by that point, I don't know the dates are slightly mixed up, but by that point I couldn't take it..." (M8, T2)

Or in relation to the impact on the couple relationship and family relationships:

"Because it put so much stress on the family, it kind of makes people a bit sick of each other and they stay, I think they stay together because they have to, to solve that problem. And they don't...they don't hate each other in the sense that they want to separate and go off, I don't know maybe some of them do, but it certainly changes something. So you kind of feel like, you, almost you see each other in the context in solving horrible problems rather than in the context of doing something fun or enjoying each other's company." (M3, T2)

It was also noteworthy that those three mothers who mentioned their thoughts about what the future might hold, spoke in ambivalent terms, that is, balancing hope and optimism with fear and trepidation, in likely realistic terms. In particular, they wondered how their child would come with the challenges and setbacks inherent in growing up, and also how they themselves would cope if they ever had to deal with this again. For M3 and M5 this fear was becoming a frightful reality as both their older daughters showed signs of developing eating disorders in the wake of their younger daughters' recovery.

Anger continued to be present in many accounts, but now more rarely directed at their daughters, and more towards husbands, other children (M3 and to some extent M5 was angry with her older daughter for getting an eating disorder), and towards professionals who had not helped.

8.5 Commentary

On the whole these findings are consistent with, and belong to, the literature surveyed in Chapter 2 concerning parents' experiences of caring for a child or adult child with AN (Bezance & Holliday, 2014; Cottee-Lane et al., 2004; Honey & Halse, 2006; Svensson et al., 2013; Treasure et al., 2001; Whitney et al., 2005; Zabala et al., 2009) where high levels of emotional distress, mental ill health, deteriorating relationships and social isolation were found through a variety of quantitative and qualitative research methods.

This small study brings those findings to life, but also adds some unexpected complexity and even findings that may look internally contradictory. There is, for example, the parallel presence of the strongly negative Theme 8, where five out of six mothers subscribed to 'Bad things have come out of it', compared with Theme 6, where five out of six mothers spoke about 'Positive changes within myself'.

Similarly, three out of six mothers identified positive changes in their own parenting style, although this did not particularly correlate with some parents' emphasis on 'boundaries' as a tool of recovery.

Five out of six described their relationship with their husband as having deteriorated. One couple separated between T1 and T2. What would be the final outcome for these couples and families? Was a child's eating disorder too great a strain for some.

And finally, what further light do these findings shed on the 'taboo' mentioned in the previous results chapters, that is, the extent to which parents feel either guilty towards, or angry with, their children, how do these tempestuous currents of emotion between parents and children eventually affect all concerned? These sorts of studies in the 'carer burden' field, and they are numerous, warrant a sustained long-term follow up effort. They would surely tell us much that could be put to use earlier in the treatment journey of these families.

Finally, many mothers had strongly critical accounts of services and treatments. These accounts are not systematically heard, much less acted upon. This is a situation that needs redress. 'Service user involvement' is still little more than an aspiration in many

services and the interviews collected in this study, and similar ones, could do much to contribute to such redress.

An excerpt from M8's T2 interview illustrating what these mothers endured will bring this chapter to a close. M8 wept and said,

"I think it's the pain of seeing your child in so much pain and you can't do anything about it really, you can just try to love them."

She quoted a verse from the Quran, 'God will not burden a soul with more than it can bear,' then asked the interviewer if she was familiar with the biblical story of the footsteps in the sand:

"So, it's extra footsteps in the sand, one set is God's and one is the person's, and the person looks back at their life and says to God, 'But you know every time I'm at the worst time in my life, there's only one set of footsteps in the sand, how come at the worst times in my life you leave me?' And God says, 'My dearest child, I will never leave you, when you see only one set of footsteps in the sand it's then that I carried you'. And so I think that it's about believing in those horrific times that you're holding onto a rope that will not break to a divine creator that will not drop you and so that's how I get through most days." (M8, T2)

Chapter 9. Discussion

9.1. Introduction

The aim of this thesis was to discover the kinds of meanings that families attributed to their child's eating disorder. Ten families were recruited sequentially to the study from a national specialist eating disorders service and qualitative interviews conducted individually with each member of the family at two time points.

This final chapter will provide a review of the rationale for the study in the context of the existing literature, the methodological challenges of operationalizing and analysing 'meaning', and the rationale for the choice of methods. It will then provide an overview of the main findings from the results chapters. Implications of the findings will be discussed for future research and for clinical practice.

9.2 Aims of the research

The primary aim of this research was to discover the kinds of meanings that mothers, fathers, and the children themselves, attributed to the child's eating disorder, or if they attributed meaning at all.

A second aim was to find out if meaning-making was important. It could be important in relation to the child's recovery, or it could be important as an activity in its own right.

A third aim was to discover whether the types of meanings constructed changed over the time that the child and their family were in treatment.

The inspiration for the study came from the clinical setting and work, and specifically from the weekly parents' therapeutic group facilitated by the researcher. Observation of the variation in and variety of parents' narratives in this group sparked the curiosity about meaning. There was variation not only in the types of meanings advanced, but also, the extent to which parents seemed to *expect* to make meaning. There was variation in the extent to which parents were inclined to try to understand what their children were thinking and feeling, and what lay behind the behaviour associated with the eating disorder.

More broadly, inspiration also came from the researcher's belief, founded in professional and personal experience, that meaning-making is a therapeutic, healing activity.

The research took place during what might fairly be called the heyday of FBT (Family Based Treatment), following the publication of the RCT by Lock et al. (2010) comparing FBT with AFT. The FBT model (Lock & Le Grange, 2012) recruits parents as a resource in their child's treatment and promotes an agnostic stance regarding the causes of eating disorders. It does so both because such a stance is scientifically accurate, and as a therapeutic tool to support parental confidence and to mitigate against parents blaming themselves.

However, the emphasis on no-blame has in practice led to a clinical situation where clinicians can be afraid to explore individual motivations and family relationships, for fear of being non-adherent to the model. The exploration of meaning can be felt to be dangerous and to lead to blaming – whether blaming parents or the children themselves. The search for meaning in children's eating disorders has faded as the FBT model has advanced. This was also the clinical situation in which this research was conceived.

In psychoanalysis, the search for personal meaning is the priority, but further, there is a theoretical assumption that discovering personal meanings will also have a positive and mitigating impact on mental distress. It is assumed that the need to understand and make sense of one's experience is an innately human endeavour, the pursuit of which brings emotional relief and a greater sense of coherence of self. The wish to test out this assumption was a thread running through the research. This was one of the rationales for conducting twin interviews at the beginning and after the end of treatment. It also inspired the phrasing of the research question, 'Does meaning matter?'

9.3 Limitations

9.3.1 Sample completeness

This study comprises a small sample, though substantial in qualitative terms. It was incomplete within its own terms. While the data collected is voluminous and rich with opportunities for thematic analysis and reflection, the aim of comparing narratives within families was somewhat hampered by incomplete family data sets. What could still be fruitfully compared were many couples' accounts, and also mothers with fathers as discrete sub-groups. There was also a substantial enough group of mothers providing interviews at both time points for a further reflection on change. The relative

paucity of children's accounts, allowing for greater triangulation of results, stands out as the greatest limitation and a matter for regret and, it is hoped, redress in future research.

9.3.2 Methodological limitations

The study would undoubtedly have benefitted from member checking, or participant validation. As in much qualitative research, the data collector was also the data analyst and interpreter. The potential is for the researcher's perspective to dominate the selection of themes, the interpretations and reflections, is considerable (Birt, Scott, Cavers, Campbell, Walter, 2016). Would the interpretations in the emotional domain have been made quite so boldly if member checking had been written into the research protocol and methodology? Would the RF analysis even have been undertaken? On the other hand, if member checking had been carried out, would the researcher's freedom to reflect on what was communicated have been inhibited?

In addition, the study would have benefitted from systematic input from colleagues involved in research. IPA methodology and RF analysis would have been more robust if more opportunity had been had for reliability testing by discussing the results with other researchers familiar with the methods used.

The researcher was a full-time clinician and self-funded researcher and regrettable could not take up most of the opportunities for academic enrichment that exist at UCL.

9.4 Summary of chapters in this thesis

The thesis is laid out as follows.

Chapter 1 introduces and considers the place of meaning in the current treatment landscape for children and young people's eating disorders, the value of meaning-making more broadly, and the tension that may be observed to exist between meaning-making as a clinical endeavour, eating disorders as a psychosomatically oriented mental health diagnosis, and the family based treatment (FBT) model.

Chapter 2 reviewed relevant literature in a number of fields – historiographical, psychoanalytic, attachment theory and research, treatment literature, and qualitative research.

Chapter 3 presented the research design and methodology and considered methodological alternatives for the operationalizing of ‘meaning’ as a researchable construct.

Chapters 4, 5, 6, presented the findings of the analysis using the method of IPA, in sub-groups of mothers, fathers, and children. Where possible, these results were compared.

Chapter 7 presented all participants’ results achieved through analysis with RF.

Chapter 8 presented the findings of mothers only at T2, and a rationale was given for this separation of results.

These chapters, their arguments and findings, will now be reviewed and discussed.

9.5 Discussion of literature review

AN was set in historical context and psychoanalytic approaches to its treatment through the course of the 20th century summarized, with particular emphasis on the literature around mother-daughter relationships and how these have been held central to the aetiology of eating disorders in psychoanalysis and allied fields. This review showed clearly that specifically mother-blaming (not ‘parent’ blaming, as fathers were not blamed in the literature) has been prevalent in the field and set the context for the subsequent flourishing of non-blaming narratives and treatments in more recent times, during the first two decades of this century.

This review of this psychoanalytic literature was undertaken because of the focus on personal meaning in psychoanalysis, and the great variety of meanings attributed to eating disorders within psychoanalysis, and because until the end of the twentieth century, psychodynamic treatments were still common in the treatment of eating disorders.

A review of literature concerning attachment theory, research and findings was undertaken next, first, in order to explicate the rationale for the choice of a second analytic method from this field, namely RF. A comparison between psychoanalytic and attachment theory based conceptions of the mother-child relationship and its vicissitudes was put forward.

Treatment approaches to eating disorders for children and young people were reviewed next, introducing the current strong prevalence of family based models of treatment and recovery, and the evidence for this model was reviewed. Also noted was recent literature calling for its development and augmentation, to address continuing unmet need and relatively substantial rates of treatment failure or only partial treatment success. Literature arguing for the adolescent developmental perspective as an additional focus for treatment, was also reviewed.

Finally, findings from qualitative literature in the field of subjective experience of eating disorders from multiple perspectives was reviewed, encompassing studies of the views and experience of parents, siblings and sufferers themselves, this literature representing the closest field allied to the present study.

One angle from which to survey this landscape of discrete fields of scholarship, like a patchwork cohering around the psychiatric diagnosis of 'eating disorders' or even more specifically, AN, is to note their respective placing of personal meaning. Psychoanalysis places personal meaning to the very fore of its endeavour. This can also be the case in certain types of qualitative research, and it has been noted that this should make them ideal partners (Anderson, 2006; Hollway & Jefferson, 2000; Midgley, 2004, 2006a), but so far these efforts at match-making must be judged unsuccessful, as they have borne no offspring in the form of new and serviceable research methods. Attachment theory based research, though founded in psychoanalysis, has made its mission the subjecting of personal experience to robust empirical testing to allow for generalization and evaluation - to find ways of assessing and comparing what people say about their relationships (George, Kaplan et al., 1985; Shmueli-Goetz, Target et al., 2008) and increasingly what they do in relationships (Shai & Meins, 2018), to systematic analysis and production of evidence for the theory. Attachment research supports and organizes individual narratives and it was one of the reasons why it was chosen as a secondary measure in this study.

Next, treatment and outcomes literature in young people's eating disorders and specifically AN, was surveyed. Curiously or not, this body of literature seems quite isolated from the other fields of reviewed. Further, it appears to have little relationship to the field of psychotherapy research as a whole, a vast field which was not reviewed here, but where the findings from the last 20 years point to an ever more complex range of efficacy factors, where manualization of a specific set of techniques is but one small component (Fonagy, 2015; Fonagy, Cottrell, Phillips, Bevington, Glaser & Allison, 2015; Kazdin, 2009; Shedler 2010, 2015). Yet treatment outcome studies continue to be predicated on the assumption that the model is what matters, and who delivers and how it is adapted, to individual patients' circumstances, is less important, and so also in FBT. This will surely change as the findings from the psychotherapy outcomes research field look set to bring an about turn in mental health treatments over the next twenty years – even in the field of eating disorders.

9.6 Discussion of methods and design

Finding a way to operationalize 'meaning' so that it could be identified, thematically analysed and organized, and somehow evaluated, was a methodological challenge. Considerable thought was given to the question of how to design a study that would turn the nebulous concept of meaning into a robust and researchable construct.

The study was conceived as qualitative because this seemed the most appropriate method for the focus of interest, that is, how the very personal narratives of all the members of the family might reveal their perspective on the meaning of the eating disorder.

In addition, the researcher's clinical skill and experience, and expertise in eating disorders, predisposed towards this choice of method. Careful listening combined with sympathetically formulated, probing questioning, was relied upon as the best means of obtaining rich data. The researcher's professional training in psychoanalytic child psychotherapy was viewed as a strength in the interviewing process as it was expected that it would support the focus on idiographic meaning, that is, the different ways in which people account for themselves and make sense of things for themselves. This focus overlaps with the philosophy underpinning the qualitative method of Interpretative Phenomenological Analysis (IPA), and this method was therefore chosen as the primary method of research design and analysis.

A larger study would have allowed for the use of some quantitative methods of analysis to balance the strong qualitative focus, but a larger sample was beyond the capacity of a single clinician-researcher. This sample contained 37 interviews, already a large sample for an interview based, qualitative, single-researcher study.

Nevertheless a secondary, quantitative method was adopted, namely Reflective Functioning, the measure of 'mentalizing' in the context of attachment relationships (Fonagy et al., 1998). This measure, characterized as a quantitative measure of qualitative data, seemed a highly appropriate measure given that interview participants were talking about their family members, that is, their primary attachment relationships, and especially parents talking about their children.

RF also had the advantage that it provided a framework for evaluation. Therefore there was now the possibility of a comparative analysis, where the qualitative analysis of meanings could be set alongside parental and child RF, and the putative relationship between the two examined and explored.

9.6.1 Recruitment challenges

The sample was large but ultimately weighted in favour of mothers, who are without doubt the overall primary informants in the literature, and in this study, concerning child and family mental health. Mothers drove recruitment within their families, and mothers were also more likely to acquiesce to the interview at the second time point. Children were more reluctant to be interviewed, and fathers more reluctant to be interviewed once their children had recovered, and this phenomenon was discussed in Chapter 3.

The data collected is voluminous and rich with opportunities for thematic analysis and reflection, the aim of comparing narratives within families was somewhat hampered by incomplete family data sets. What could still be fruitfully compared were many couples' accounts, and also mothers with fathers as discrete sub-groups. There was also a substantial enough group of mothers providing interviews at both time points for a further reflection on change.

Even so, the impact of this incomplete sample is a limitation of this study and will be discussed further in Section 9.8.

9.7 Discussion of results

Thematic results have been reported in detail and with much supporting evidence from the interviews, in Chapters 4-8. In this section, findings will be reviewed. Then there will be reflection on the unexpected directions in which the IPA methodology led the researcher. The interpretative aspect of the method allowed participants' emotional communications and emotion-laden statements to be given proper consideration and be dwelled upon, and integrated with the analysis, not separated.

It is in the nature of qualitative research, particularly of the very personal kind produced in these research interviews, that interpretation is generated from a close reading of the data, and stays close to its source. It makes structural sense to first present the data, then summarize it, reflect upon it, comment and discuss. So also in this study; each Results chapter had discursive and reflective sections within them, following the presentation of the themes and other findings relating to of the three sub-groups of participants, as well as the chapter presenting RF for all the participants. These sections attended to the detail right down to individual statements

Therefore what follows here is a discussion about the larger landscape rather than its discrete features. What follows is intended to upon the earlier discursive sections.

9.7.1 Interpreting meaning through emotions

The first question in the interview protocol, asking parents to think about how they understood the eating disorder, could lead to reflective thinking, but often in a cognitive mode. The second question, asking about the impact on themselves and their family, was formulated in order to allow parents a potential different avenue for coming at the question of meaning. The results of this were unexpected, and a source of surprise and pleasure to the author through the course of the analytic process.

The question about impact brought out emotions and it became apparent that these could not be ignored, but were part of participants' narratives and responses.

It was decided that these variously expressed emotions would be subjected to an interpretative analysis –they would be acknowledged, recorded, grouped thematically, and sense made of them for the purposes of study results and findings. In other

words, the expressed emotions would not be by-passed or seen as mere by-products of an at times emotive interview but would be part of analysis.

Further, if possible, they would also become part of the analysis of meaning.

This element of the data analysis makes use of the interview data in a novel and creative way in the thesis, combining textual, emotional and, perhaps, psychoanalytic elements. The interviewer-researcher combined her experience as a clinician working with people's strong feelings with sensitivity to the many ways that people have of showing them. Further, the interpretative analysis remained close to the data and proposed no loose moorings or wild analyses, but brings together the following factors:

- Close textual analysis, including paying attention to language that shocks or otherwise has a strong impact
- Awareness of the impact of an interview subject's affect on the researcher and reflection on this
- Confidence derived from clinical experience in reflecting upon the way that people communicate emotions without always expressing them directly in emotion-words
- Respect for interviewees' boundaries during the interview by not proposing to people what they were feeling but responding sensitively when strong emotions seemed to be expressed. This meant that follow-up questions such as 'does that make you angry?' were rarely used, still less statements such as 'you seem to be angry'. Therefore the interpretations of subjects' emotions, though grounded in content, remain unconfirmed directly by subjects themselves, except on those occasions, of course, when the named their own feelings.

In this way, this part of the research method combines psychoanalytically derived reading of data with systematic, tested, qualitative research methods.

It was felt as a bold direction to take, and the pay-off is seen as follows:

Instead of yielding a merely cognitive account of what people think about eating disorders, and their own child's eating disorder specifically, a rich account of what people both think and what they feel was developed. It showed, overall, that however much people may be told that there is no fault and no blame when an eating disorder

takes a child in its grip, this statement rarely does much to reassure, mollify, comfort or guide parents. It may even have the opposite effect. Parents' feelings were sorrowful, guilty, angry, raging, blaming, pitying of themselves and their family, bewildered, helpless, fearful, extremely anxious, and lost. If they were to feel that such feelings had no place and should be censored, their suffering would be compounded, not alleviated, even if the intention were the latter.

These observed, documented, and thematically organised emotional states were, therefore, an unexpected gift and substantial building block in the analysis of the construction of meaning on the part of the interview subjects.

9.7.2 Mothers: discussion of results

We are now able to take further the observation made at the end of Chapter 4, that mothers fell into two groups: those who made limited meaning, who tended to interpret their child's eating disorder in terms of genetic inheritance and fixed personality characteristics, and whose narratives were coloured by anger and blame towards their children. We proposed that the very absence of comprehension of the eating disorder fuelled the anger, because their incomprehension had the effect of undermining their efficacy and power to do good, as mothers. They felt that they could not help their children very well, or at all.

Subsequently we saw in Chapter 7 where RF was analysed, that this group of mothers not surprisingly also generally displayed low RF. In other words, their difficulties with attributing meaning qualitatively also scored lower on the quantitative RF scale.

This group was contrasted with a second group of mothers, who produced a richer array of possible meanings, who were comfortable with imaginative and mental state thinking, who scored higher on the RF scale, and whose dominant emotions were interpreted not as anger and guilt, but as self-blame and self-questioning, based on an assumption of their influence and importance in their children's lives.

Finally, in Chapter 8, for those mothers who completed the T2 interviews, we could catch a glimpse of how things unfolded as they described the impact on themselves, their children and their families.

In this way, a thread began to be woven connecting mothers', fathers' and children's interviews at the relational and emotional level. The question became, not, 'are they saying the same sorts of things about the eating disorder and seeing it in a similar light to each other?' but rather, 'is there an intentional communication emanating from this eating disorder into the family, and if there is, in what ways is it being interpreted and understood?' The language of communication between family members was given in emotions just as much as in words. In this way, the IPA claim to allow the researcher to find 'the meaning behind the words' was fulfilled.

The actual themes elicited, named and recorded allowed connections to be built also between how participants *thought* about the eating disorder, how they *felt* about it, and how they *acted* upon it. These threads could only be fully identified at the end of the whole analytic process.

As an example, and as a reminder, here is a thumbnail sketch of the 'headline' data gathered from F1, that is, M1 and F1, at both time points.

Phenomenological themes: M1 explicitly stated that she didn't understand her daughter's eating disorder, but attributed it to her character ('timid') and to her difficulties with one particular friend at school, also due to her timidity.

Interpretative themes: M1 made attempts to put herself in her daughters' shoes self-referentially through her own struggles with self-confidence but could not think of herself as efficacious. She betrayed rage with her daughter through assertions that she sought to control them (her parents) and was putting on a 'princess act'.

RF: M1 scored 'definite' RF (score 5) at T1, but this dropped to 'low' RF (score 3) at T2. It was speculated that her mentalizing was higher at T1 (7 in the categories of Understanding and Impact) stimulated by the urgent need to make sense of her daughter's behaviour, and also possibly by her husband's presence, himself a more consistent 'mentalizer' with a much more relational understanding of the eating disorder.

T2 themes: M1 described on-going strict management of her daughter's eating. She spoke forcefully about the need for immovable 'boundaries' and struggled to understand why her daughter would still 'muck about' with her eating, attributing it now to 'habit, manipulation and teenage hormones'.

Bringing all these aspects together –phenomenological analysis of cognitive themes, the interpretative analysis of emotional themes, the RF ratings underpinned by

validated studies, and the final elaboration of impact both past and present at T2, gives us a very rich pool of data to draw on for thinking about – what? What should we think about this summary of data about M1?

The data gathered around M1, and other ‘low RF’ or ‘non meaning making’ mothers in her group, could lead to some kind of new type of mother blaming, old wine in new bottles. This version would have it that unimaginative mothers, unable to entertain mental state thinking, and out of touch with their daughters’ emotional developmental needs are, at least, a risk factor for developing eating disorders.

Even if the objectionable and insulting language seen in the review of psychoanalytic literature about mothers, daughters and eating disorders from the 1930s to the 1980s is gone, ‘low RF’ and its concomitants could easily become a euphemism for maternal failings anew.

9.7.3 Mother blame by another name?

The tension between the concepts of ‘blame’ and ‘meaning’, and the ‘double think’ touched on in Chapter 1, lies before us now in the actual data. It concerns the way in which the ‘no parent blame’ doctrine could lead to negation of meaning of various kinds: the assumption that there is meaning behind disturbed behaviour, for example, or that parent-child relationships are meaningful and important in a child’s development.

The question seems to be, how is it possible to develop meaningful narratives without blame? If a mother believes herself to be part of her child’s developmental ‘story’, as proposed by our shared social belief, and underpinned by increasing volumes of research in the arena of attachment and child development, then she cannot write herself out of the story when her child develops mental health problems, and the inevitable consequence is that she will question her own parenting, suffer self-doubt, guilt and loss of confidence. Paradoxically, a mother who sees herself as more peripheral to her child’s development and may see mothering as less mentalizing activity, may suffer less self-blame.

There is certainly a tension here between a sense of parental self efficacy and self-blame, on the one hand, and parental inefficacy and absence of self-blame on the other.

For clinicians in the field of eating disorders, a fine line needs to be trodden between enhancing parents' capacity for understanding their child, including thinking in mental state and developmental terms, and helping parents' through self-blame to a more nuanced position of self-evaluation, perhaps resulting in a more reflective and self-aware approach to parenting adolescents.

This proposal is elaborated in Section 9.7 Implications of Results.

9.7.4 Fathers: discussion of results

This discussion tries to understand why fathers' results showed some important differences from mothers', as presented in Chapter 5. As a reminder, fathers expressed emotions of anger, blame, helplessness, bewilderment and frustration more strongly and overtly than mothers. They usually (with the clear exception of D1) positioned themselves as peripheral in the management of this family crisis. Some spoke bizarrely about their own experiences and went off the topic of their children's mental health. The overall impression might fairly be described as one of fathers being disoriented, destabilized and lost in an unfamiliar landscape.

The three main new thematic categories allocated to fathers, but not mothers, were:

1. 'Seeking attention – a communication'
2. 'Mother blame or child blame'
3. 'Plaintiveness' – a word chosen to capture a mix of helplessness, outrage and a sense of injustice about what was befalling them, 'why me?' in the exact words of one father.

'Attention-seeking' is a socially widespread and popular way of stigmatizing young people with AN, a pejorative term. (An internet search using the term 'attention-seeking' brings up definitions relating to histrionic personality disorder). Mothers, who had generally informed themselves more and had more contact with professionals, would likely have been aware of this stigma and therefore may be assumed not to want to describe their daughters' motivations in terms that might echo this.

For the purposes of the thematic analysis, the theme was labelled 'seeking attention – a communication', in order to remove the stigma and to indicate intentional

communication. Fathers spoke about 'seeking attention' both as a justified need, and as a selfish behaviour. It could be seen in both ways.

Even then, this theme did not stand out in mothers' accounts. It could be proposed, speculatively, that for mothers to speak in terms of their daughters seeking attention through restricting their eating, would be to acknowledge that their daughters lacked sufficient attention. Such an interpretation would imply mothers' own failure to notice their daughters' needs and might be a painful, guilt suffused idea.

'Seeking attention' and 'mother/child blame' were allied themes in fathers' accounts. The sense of being peripheral to the family allowed fathers not to shoulder responsibility or blame. Fathers made use of the idea of seeking attention, or more subtly, seeking to communicate a need through restricting eating, without considering that this reflected negatively on their own parenting. Some floated the idea that their partner had not been paying sufficient attention to their daughter. Where this idea is present, it was noted also in the new interpretative category of 'Mother blame'.

It would be easy to invoke stereotypes or make fun of fathers who blamed their children's mothers for their child's eating disorder, ignoring their own parenting role. But how might we understand the gendered discrepancies in these interviews?

Speculatively, these findings presumably related to the broader cultural phenomenon of the changing role of fathers from providers and enforcers of discipline, to equal parents. Popular parenting advice exhorts fathers to be caring, nurturing, involved, playful, citing research findings that 'involved' fathers enhance their children's social, emotional and educational development. Even in this framework, 'involved' implies that participation but not leadership, more like being assistant mothers. In this sample, six of the ten families maintained traditional divisions of labour, where the fathers were the breadwinners and mothers were full-time mothers. This proportion was out of step with national UK figures where 75% of mothers are now in the workforce. In these traditional families, fathers might well feel even more like secondary parents - less influential, and also less responsible.

At T2, of three fathers who gave interviews, two spoke about a deterioration of couple relations, feelings of exclusion and drifting apart. Their wives were working to recover from the family trauma but the couple was not finding its way back to each other. The emotions of exclusion were, if anything, exacerbated.

A systemically inspired explanation might propose that the 'seeking attention' theme might even signal that fathers felt in competition with their sick children for their partner's attention. Children with eating disorders typically regress to attachment-seeking behaviour from an earlier age and indeed many mothers spoke of being shadowed and not let out of their children's sight. Fathers are indeed pushed out by the exigencies of the eating disorder, both as a result of its separation anxiety symptomatology, and the intense labour of feeding that nearly always fell to mothers. This account makes sense of the anger and blame that they directed towards their children, when they called them 'selfish'. Finally, fathers may also have wished to protect their partners against their children's excessive demands and found themselves helpless and unable to do so.

9.7.5 Children's results

In Chapter 6, the limitations of the sample size and its coherence was highlighted, and thematic analysis needs to be treated with caution. What could be seen was that those mothers who were angry with their children also had children who were angry with their mothers in return. This was an intriguing dual perspective, indeed in some cases triple perspective where a whole family set of interviews existed (F3, F5, F8). Fathers were not exempt from their children's anger, but mothers were targeted more explicitly and pained stories were told about conflictual events and occasions.

In Chapter 6, Lemma (2009) was quoted, proposing the term 'object of desire' to describe the kind of mother-infant experience that psychoanalytic thinking believes to be essential for the child to grow up feeling lovable, with a profound sense of self-worth. Many of the mothers, at some point in the interviews, gave out a cry of pain when wondering why their children appeared not to have developed an internal feeling of being worthy, feeling good, having 'self-esteem' and, albeit fleetingly, associated themselves with this absence or lack – specifically mothers M1, M4, M5, M8, who were also the mothers with the sense of having less efficacy and influence over their daughters' development. To feel, to believe, or to see that one has brought up a child who does not value themselves, is surely an almost unbearable indictment of one's own parenting. (Anecdotally, in the Parents' Group, a discussion was held where some parents concluded they would rather see their daughters' have anorexia than depression, because the former could be treated, but how could one make someone who felt bad about themselves, feel good?)

This discourse, though, has also been subjected to scrutiny and criticism by writers such as Parker (1995) and Rose (2018) who speak of the social tyranny of the mothering ideal, self-less, ever-loving, un-ambivalent, and burdened with the task of imparting 'self-esteem' to the next generation. The image of the 'apple of his mother's eye' may be a fiction, a social construct concealing the reality of ambivalence, of love and hate co-existing.

It was also noted in Chapter 6 that it came as something of a surprise to the researcher to discover that narratives of family relationship took up such a central role in the children's interviews. It is possible, indeed in some cases likely, that this situation spoke of a preoccupation, an unresolved relationship characteristic of an anxious insecure attachment. This would not be a surprising finding, given that insecure attachment is more prevalent in the mental health disorders than the general population.

Returning now to the question of meaning: was meaning unveiled in the accounts of the six children who were interviewed? Two (C1 and C5) could not communicate meaning very well or without significant scaffolding by the interviewer; one (C6) provided a kind of synthetic summary of ideas without great depth, and two (C3 and C8) gave accounts that contained howls of pain, it would surely be fair to say. In distilled form, C3 was in agony about the derailing of her longed-for relationship with her mother. C8 was in pain about her own utter wrongness, not fitting in, not being 'normal'.

Perhaps these two articulate and generous young speakers had not experienced the things, whatever they may be, that make us feel lovable, wanted and safe from an early age. It is surely necessary that we find a way to speak about this possibility, without blame and with compassion for all parties involved, about relationships between mothers (parents) and daughters where some essential ingredients are missing, when working not only with eating disorders but mental health in young people in general.

The findings from the children's interviews above all point to the value of interviewing children with eating disorders and the need for more highly powered qualitative studies of children and young people with eating disorders. Very few studies of children with eating disorders ask them about anything else than their disorder, replicating a

common complaint of children in treatment. Asking these children about their relationships and hearing their answers was a worthwhile endeavour that brought a clear reply to the research question: in the case of (some) children with AN, the meaning is all-important. And further, these children wanted their parents to hear, understand, and help.

9.7.6 Reflective Function and mentalizing

Assessing RF alongside qualitative themes brought some intriguing findings, as well as absence of findings.

First, we saw that there was no very striking relationship between RF scores and the qualitative themes.

Second, we were able to speculate tentatively that mothers and fathers who felt very angry towards their children, and in the case of fathers, who blamed their children for their behaviour, or blamed their partners, had lower RF.

Regarding the children's RF, the important observation was made that RF was variable depending on affective arousal and events, and indeed it could be higher under emotional duress (C3) or lower (C5) or even remain much the same (C5). This suggests that certainly in childhood, RF is by no means a stable trait but a highly variable ability.

In parents, on the other hand, RF seemed to be more stable, some people were given to mentalizing and others were not – just as in the normal population. This did not change markedly even when their children were in the grip of an eating disorder. This juxtaposition between children and adults is an interesting one that will surely gather weight as the research using the CRFS (Ensink et al., 2013) grows.

Thus the RF results bucked the hypothesis that RF in both children and their parents would be lower when the children were ill, and higher when the children were better, the family calmer, and had benefitted from FBT.

Naturally the sample was too small to allow much more to be said about the actual findings with any certainty.

However, the combination of RF with IPA was, it could be argued, a happy one. RF scoring, bald and numerical as it was, provided a kind of magnet for ordering the phenomenological themes and the interpreted emotions. This allowed some important reflections around the theme of blame, rage, guilt, and parental efficacy, and these would benefit from a significantly greater research effort, as they are so central to the success or failure of family therapy for eating disorders.

9.7.7 Whole family results

Below follows an extension of the 'thumbnail sketch' of M1 in 9.7.2. Similar sketches for every family group interviewed are offered in Appendix 10a-i. These sketches improve our understanding and, it is hoped, signpost the internal connections between family members, between T1 and T2, between phenomenology, interpretation and RF. All families are sketched, even ones who only participated at T1. Obviously richest results were obtained for families who stayed through Time 2.

The discrete sources of data were mothers', fathers' and children's interviews. From these, different types of data were derived: phenomenological themes, interpretations of those themes with a specific focus on emotions expressed, and evaluations of mentalizing using RF scoring.

Connections can be sought and comparisons made

- i. internally within one individual's interview between phenomenological (P) and interpretative (I) themes respectively
- ii. internally within one individual's interview between P and I themes, and RF
- iii. internally within one individual's interview between P and I themes at T1 and T2, where the participant gave interviews at both time points
- iv. between parents on all domains, where sufficient data exist
- v. between mothers, fathers and children on all domains, where sufficient data exist

Each sketch has these headings with relevant extracts from interviews and tables:

Phenomenological themes

Interpretative themes

T2 themes (where available)

RF

Family 1: M1 and D1 (T1&T2)*

Phenomenological themes:

M1 explicitly stated that she didn't understand her 10-year-old daughter's eating disorder, but attributed it to her character ('timid') and to her difficulties with one particular friend at school, also due to her timidity.

D1 wove a more complex narrative in which essentially he saw his daughter as having particular emotional and social needs which they, as parents, had not noticed or taken proper account of until the wakeup-call in the form of the eating disorder, which he interpreted unequivocally as a communication and a call for help to them, her parents.

Interpretative themes:

M1 made attempts to put herself in her daughters' shoes by referring to her own struggles with self-confidence as an adult, but could not think of herself as efficacious. She betrayed rage with her daughter through assertions such as that she sought to control them (her parents) and was putting on a 'princess act'.

D1 was frustrated with C1's resistance to treatment and her slow recovery, but never criticized her, instead taking the blame for not understanding her. He appeared to bifurcate his emotions so that overt anger was channelled towards the professionals, with many aspects of treatment and individuals criticized, while empathy and care was directed towards his daughter. Unlike many fathers in the study, D1 never criticized his wife. D1

	1&2 Don't under stand	3 Genes & biology	4 Persona lity factors	4a Attenti on	5 Family factors	6 Social and adolescent developme nt	7a Importance of parent- child relationship	7b Imagini ng child's MS (RF)	7c Self ref thinking	7d Mother/ Child blame	8 Guilt	9 Rag e chil d/pr of	10 Plai ntiv ene ss
M1	✓		✓			✓		✓	✓			✓	
D1			✓	✓	✓	✓	✓	✓	✓		✓	✓	

T2 themes:

M1 emphasized the strict boundaries by which she was managing her daughter's eating and by this time point expressed little attempt to understand her behaviour. D1 again demarcated his narrative by attributing their daughter's improvement to changing themselves as parents. He also attributed value to their experience by saying they had got to know their daughter much better as a result of the experience they had been through.

RF: M1 scored 'definite' RF (score 5) at T1 but this dropped to 'low' RF (score 3) at T2. It was speculated that her mentalizing was higher at T1 because stimulated by the urgent need to make sense of her daughter's behaviour, and also possibly by her husband's presence, himself a more consistent 'mentalizer' with a more relational understanding of the eating disorder. D1 belonged to the group of high mentalizing parents and had the highest RF score of fathers. He was consistent over time in trying to actively mentalize his daughter's experience. His consistent composite score in fact reflected fluctuations in the sub-scores, with the core for the 'Understanding' domain sinking between T1 and T2, and the score for 'Impact' and 'Value' markedly rising.

	U1	U2	I1	I2	V1	V2	R1	R2	Total1	Total2	+/-
M1	7	3	7	3	3	3	3	3	5	3	-2
D1	8	5	5	7	5	8	5	6	6	6.5	+0.5

Totals and change over time are shaded in pink

*[C1's T1 interview has not been factored into this family account, as it did not yield any substantial data.]

All other family 'thumbnail sketches' are shown in Appendix 10a-i.

9.8 Implications of results

First, as suggested above, the results have implications for clinical settings and for clinicians treating the families of children with eating disorders.

Second, the results also have implications for future directions for research in eating disorders.

9.8.1 Implications of results for clinical practice

There is a danger that in inexperienced hands, manualized FBT becomes reduced to little more than a weekly weighing, a review of what has been eaten in the past week, and a prescription for what should be eaten in the coming week, concluded with some encouraging words to parents to keep going, and perhaps, if there has been weight loss, a veiled warning to the child. Clearly, this simplistic approach would never have been its authors' intention.

However, many clinicians treating families with eating disorders are not therapists by training or nature, and are particularly unskilled in addressing complex and disturbing parent-child relationships and huge swells of rage, anger, blame, guilt, and despair and self-loathing, such as we have seen expressed through these interviews.

The FBT model is composed of stages, and in theory the final stage is intended to address, if not exactly the above, nevertheless family communication and also adolescent development issues and how they impact on family relationships (themes also addressed by Minuchin and Selvini Palazzoli in their day). However, in practice, many families and children end treatment before the last stage is reached, or it is somehow implicit in physiological recovery, and improved mood and social functioning, that family relationships and emotions would have been implicitly addressed. When a child is better, why talk about the painful past, particularly as it sometimes may seem as though the eating disorder was the cause of the disturbance. Indeed, we recall that one mother (M4) refused a T2 interview precisely because she didn't want to rake over painful old ground.

We cannot know, without further research and especially, long-term follow-up, if troubled parent-child relationships, and associated issues of low self-worth in children, implicitly resolve themselves through the course of treatment and recovery even when they are not directly worked with in therapy. Would M1 and C1, M3 and C3, M8 and C8, find each other sufficiently to heal past ruptures and would the children's developmental trajectory be able to resume?

Despite the specialization of research in eating disorders, we still have only broad psychosocial treatments (the talking cure) to hand for psychological, developmental and relational treatment. It would be beneficial to invest more research in making

these more effective, and perhaps more differentiated depending on individual family needs, in line with the argument above that overwhelming negative emotions and troubled relationships require skilled and confident therapists..

9.8.2 Implications of results for future research

Just as eating disorders therapy research has become somewhat isolated from the mainstream psychotherapy outcomes research, so also eating disorders research, at least until recently. Some research in eating disorders concerns highly rarefied topics of study from the fields of genetics and neurobiology, or pinpointing a particular personality trait. At these times it can get forgotten that an eating disorder in late childhood or adolescence represents a 'developmental breakdown' (Laufer, 1988), a moment in the child's life when their emotional and social resources no longer are adequate to the social and emotional demands of their environment. The environment of a child or adolescent is one of continuous expectation of development towards adulthood.

Hearing children's voices in this study was refreshing because these children were implying that they had something to say, meanings to impart.

What they said was that there were things that needed fixing in their family relationships and in their own development. Eating was not really what needed fixing. Of course, the questions may have shaped the answer, but most of the children were not lost for words. An eating disorder is a communication.

If this is true, then it would seem that situating eating disorders in the context of adolescent and developmental challenges, would be beneficial. There are medical and political reasons why eating disorders has been treated differently from other child mental health problems, that is, the associated medical risk and sometimes emergency, the prevalence and cost of in-patient treatments, and the communication difficulties of the young person with the eating disorder.

If more children's voices could be heard in the way those of the children in this study were, treating eating disorders might become simultaneously less specialized and more effective.

In sum, situating eating disorders research within the existing fields of a) adolescent developmental research b) adolescent parenting research c) attachment research and d) psychotherapy outcome research would likely benefit the field, the families, and the outcomes.

9.8.3 Implications for parents

If the things that matter to children and young people with eating disorders (or mattered until they got the eating disorder) are not so very different from the things that matter to other children and young people growing up, with or without mental health problems, how can parents be helped to help their child cope with the challenges of managing new, strong, previously unknown emotions, particularly if parents themselves struggle with coping with emotions too?

More broadly, how can we talk to and amongst parents about adolescence as a time when parents are still very much needed? It did not escape the parents in this study, and all parents of children with eating disorders, that their children regress and become 'clingy' to their mothers, 'my shadow', in the words of M5. This is a feature that flies against the orthodoxy that adolescents are striving for 'independence'. Mothers of children with eating disorders are forced to revert to feeding their children with the same vigilance as they fed their newborns.

Arguably the results in this study were curious in how little, really, parents situated the eating disorder within the framework of a crisis of adolescent development. Parents generally advanced little or no concept of their expectations of their child's journey through adolescence. Comments ranged from brief references to it having been a horrible time in their own lives (D7) to surprise that their child had changed from the sensible 10-year-old they used to be (M4).

This lacuna might represent something about how we view adolescence as a society, or it might say something specifically about this group of parents, or something about how parents in general struggle and may falter in parenting adolescents.

Parents often seem to forget their own adolescence. This was observed clinically in the Parents' Group, for example, despite invitations to parents to recall and share their own experiences. What might be the reasons for such forgetting? Could it be that for many, adolescence itself was experienced as a kind of traumatic caesura in their lives,

unfathomable at the time and undigested subsequently? Adolescence is suffused with anxiety about social hierarchy, personal identity, sexual development, educational success, and loss of parental protection. Many adults possess memories of humiliation and failure in adolescence that they would like to forget. In these cases, they would likely be poorly equipped to help their children face the same types of experiences. If we can help the parents of adolescents with eating disorders and other mental health problems reflect upon, and understand, their own adolescence better, we may help to create family environments in which this generation can be better understood too, and perhaps avoid eating disorders altogether.

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Appendices

Appendix 1

Appendix 1a



Health Research Authority NRES Committee East of England - Cambridge Central

Victoria House
Capital Park
Fulbourn
Cambridge
CB21 5XB

Telephone: 01223 597685
Facsimile: 01223 597645

20 August 2012

Ms Cathy Troupp
Child and Adolescent Psychotherapist
Great Ormond Street Hospital NHS Trust
Department of Child and Adolescent Mental Health
Great Ormond Street Hospital for Children
Great Ormond Street, London
WC1N3JH

Dear Ms Troupp

Study Title: Does meaning matter in the recovery from anorexia nervosa? A qualitative study of the experience and meaning of illness for children and young people diagnosed with anorexia nervosa and other restrictive eating disorders, and their parents.

REC reference: 12/EE/0348

Protocol number: as above

The Research Ethics Committee reviewed the above application at the meeting held on 10 August 2012. Thank you for attending to discuss the study.

Documents reviewed

The documents reviewed at the meeting were:

Document	Version	Date
Covering Letter	Cathy Troupp	
Investigator CV	Ms Cathy Troupp	
Other: Academic Supervisor CV	Professor Mary Target	20 July 2012
Other: Academic Supervisor CV	Dr Dasha Nicholls	20 July 2012
Other: interview schedule - parents	3	31 May 2012
Other: interview schedule - young persons	3	31 May 2012
Other: Email correspondence		31 May 2012
Participant Consent Form: Parents	1	27 April 2012
Participant Consent Form: Young persons	1	27 April 2012
Participant Information Sheet: Parents	3	31 May 2012
Participant Information Sheet: Young persons	3	31 May 2012

Appendix 1b

19 December 2012

Ms Cathy Troupp
Child and Adolescent Psychotherapist
Great Ormond Street Hospital NHS Trust
Department of Child and Adolescent Mental Health
Great Ormond Street Hospital for Children
Great Ormond Street, London
WC1N3JH

Dear Ms Troupp

Study title: Does meaning matter in the recovery from anorexia nervosa? A qualitative study of the experience and meaning of illness for children and young people diagnosed with anorexia nervosa and other restrictive eating disorders, and their parents.

REC reference: 12/EE/0348
Protocol number: as above
IRAS project ID: 94620

Thank you for your email of 11th December 2012. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 11 December 2012

Documents received

The documents received were as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Participant Consent Form: Young person	3	11 December 2012
Participant Consent Form: Parent	3	11 December 2012
Participant Information Sheet: Parents	6	11 December 2012

Appendix 1c



Great Ormond Street 
Hospital for Children
NHS Trust

Joint Research and Development Office
Division of Research and Innovation

Direct Line: 020 7905 2249
Email: Thomas.lewis@gosh.nhs.uk

28/03/2013

Cathy Troupp
Psychotherapist
C.A.M.H.S./DPM
Great Ormond Street Hospital NHS Trust

Dear Cathy Troupp

PROJECT TITLE	Does meaning matter in the recovery from anorexia nervosa?
Protocol version	2
Protocol date	11 th July 2012
REC Reference	12/EE/0348
R&D Reference	11B509
Sponsor	Great Ormond Street for Children NHS Foundation Trust
Chief Investigator (CI)	Cathy Troupp

Notification of Great Ormond Street Hospital NHS Permission.

The research approval process for the above named study has been completed successfully. I am pleased to issue approval on behalf of Great Ormond Street Hospital for Children NHS Trust (GOSH) for the above study to proceed.

All research carried out within this Trust must be in accordance with the principles set out in the Research Governance Framework for Health and Social Care (April 2005, 2nd edition, Department of Health (DoH)).

This approval is issued on the basis of the project documentation submitted to date. The approval may be invalidated in the event that the terms and conditions of any research contract or agreement change significantly and while the new contract/agreement is negotiated.

The conditions for host site approval are as follows:

- The Principle Investigator (PI) must ensure compliance with protocol and advise the Joint R&D Office of any change(s) to the protocol. Failure of notification may affect host approval status.
- Under the terms of the Research Governance Framework (RGF), the PI is obliged to report any Serious Adverse Events (SAEs) to the Sponsor and the Joint R&D Office in line with the study protocol and Sponsor requirements. Adverse Incidents (AIs) must also be reported in accordance with the Trust Adverse Incident Reporting Policy & Procedures.

Joint Research and Development Office
Division of Research and Innovation
UCL Institute of Child Health, 30 Guilford Street, London WC1N 1EH
Tel: 020 7905 2179 Fax: 020 7905 2201
www.gosh.nhs.uk

Page 1 of 2

Non-CTIMP approval V2.0

The child first and always

11B509

Appendix 2

Appendix 2a

**Department of Child & Adolescent Mental Health (CAMH)
Feeding and Eating Disorders Service (FEDS)
TEL: 020 7829 8679 EXT: 5853
FAX: 020 7813 8411**

Great Ormond Street
London WC1N 3JH

T: +44 (0)20 7405 9200
www.gosh.nhs.uk

INFORMATION SHEET FOR PARENTS

Research study: Does the meaning matter in the recovery from anorexia nervosa and other restrictive eating disorders?

We would like to invite you to take part in our research study.

Before you decide, we would like you to understand why the research is being done, and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish.

Part 1 tells you the purpose of this study and what will happen to you if you take part.

Part 2 gives you more detailed information about the conduct of the study. Ask us if there is anything that is not clear.

PART 1: THE PURPOSE OF THE STUDY

We would like to find out, through interviews, how young people, and their parents, understand and make sense of the eating disorder. We would also like to know whether it is important for recovery to make sense of it. We hope to learn how young people's and parents' understanding of the problem is expressed, and how this may change over time.

Why have I been invited to take part?

You have been invited to take part because you are the parent of a young person assessed by the Eating Disorders Team at Great Ormond Street Hospital. Your child may be diagnosed with anorexia nervosa, or with another restrictive eating disorder.

Do I have to take part?

It is up to you to decide to join the study. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not affect the standard of assessment and treatment of your child by our service in any way.

What will happen if I take part?

Parents and children are interviewed individually with each interview lasting up to one hour. Interviews will be conducted around the time of your child's assessment in our service, and repeated after one year, and two years. Each participant will have three interviews in total.

The interviews take the form of a fairly free-flowing conversation, with four overall themes:

- i. your understanding of your child's eating problem
- ii. your experience of how the eating problem impacts on your life
- iii. your thoughts about the changes that it brings about
- iv. your views about the way to recovery

Other topics will most likely arise through the course of the interviews. Each participant's account will contribute to the themes that will be reported when the study is written up. As we are interested in the detail of what parents and young people say, all interviews are audio recorded. Following the interview, a written transcript is prepared for the purpose of analysis.

What are the potential benefits of taking part?

We cannot promise that this study will help you or your child, but the findings from this research may help us to plan therapeutic interventions that are better tailored to the individual needs of young people and their families.

Are there potential disadvantages to taking part?

There are no real disadvantages to taking part in the study, as the study will not change your child's treatment. You may find some of the interview topics upsetting. The interviews are conducted by expert clinicians, who will be able to deal with this sensitively and appropriately.

Will my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you and your child will be handled in confidence. The details are in Part 2.

What will happen to the results of the research?

The results of the research study will be published as a report in a relevant academic journals concerned with eating disorders and psychological research. Participants will not be identifiable in this report.

What if there is a problem?

Any complaint about the way you have been treated during the study will be addressed. The detailed information about this is given in Part 2 of this sheet.

This completes part 1. If you are interested in what you have read so far, please read the additional information in Part 2 before making any decision.

PART 2: THE CONDUCT OF THE STUDY: FURTHER INFORMATION

Why is this study being done?

There are few studies that directly ask about the way that young people themselves, and their parents, make sense of the eating disorder. Very few studies have addressed young people with early onset eating disorders and few repeat interviews at several time points to track changes. There have been no studies at all where young people and their parents have been interviewed in parallel. We hope that we will learn more about your and your child's experience, and way of thinking about the eating disorder, through this study.

As yet, we have fairly little idea about what kind of therapy in eating disorders works best for whom. Currently, eating disorders in children and young people are treated by a combination of psychological therapies such as family therapy or multi-family therapy, individual therapy, and group therapy. We would like to understand more about what kind of therapy might suit a particular young person and family.

At each interview, we will ask for your child's current weight-for-height and general health. If you are not in treatment at Great Ormond Street, we will ask briefly about the therapy package that your child is receiving locally.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given a favourable opinion by Cambridge Research Ethics Committee. The study has also been reviewed and approved by the Clinical Research Adoptions Committee in the Research and Development Directorate at Great Ormond Street Hospital.

How can I see the results?

You can ask to see a preliminary report of the themes that have emerged from the interviews. The study is intended for publication as one or more articles for specialist journals in eating disorders and psychological research.

The interviews may be edited and collected into a book for lay readers such as parents, young people, and others connected to young people with eating disorders. If this happens, we will contact you again for your consent for extracts from your interviews to appear.

How will my personal details and interviews be kept confidential?

Your and your child's personal details and your interviews are stored entirely separately. Personal details are kept confidential in the patient file, accessed only by the clinical care team, in the usual way. The research interviews are stored separately by the principal investigator in a locked cabinet, in an office that is also locked when she is away. Interviews will initially be audiotaped and then transcribed. There will be no identifying personal details spoken on the audio recording and none written on the interview transcript. The transcripts will be identified by a code only. The audio recordings will be wiped at the end of the study.

There are likely to be quotes from the interviews in the publications that follow from the study. Any potentially identifying details will be removed or altered, so that confidentiality is preserved for you and for your child. However, you may recognize your own child in some of the quotes, just as your child may recognize you.

What if I want to withdraw from the study before completing all the interviews?

You can withdraw from the study at any time. You don't have to give a reason, though we will listen carefully to any reason that you do give. If you withdraw, your child's care at Great Ormond Street will not be affected in any way.

About the principal investigator

Cathy Troupp, Principal Investigator, is a Child and Adolescent Psychotherapist with 12 years' experience working psychotherapeutically with young people with eating disorders, and their families. She has been part of the core team in the Eating Disorders Service since September 2009. This research will be part of a PhD degree that she is undertaking at University College London (UCL). Cathy will conduct most of the interviews but some will be conducted by colleagues from the Eating Disorders Team. All interviewers are experienced clinicians.

The research is supervised by Professor Mary Target, UCL and Anna Freud Centre, and Dr Dasha Nicholls, GOSH and Institute of Child Health.

Contact details

Email: Cathy.Troupp@gosh.nhs.uk

Tel: 020 74059200 ext 5853, or 020 78298679

What if there is a problem?

If you have a complaint about this study you can speak to the principal researcher, another member of the team, or the head of the Eating Disorders Service, Dr Dasha Nicholls. Dr Nicholls' contact details are:

Email: Dasha.Nicholls@gosh.nhs.uk

Telephone: 020 74059200 ext 5858, or 020 78298679

If your complaint is not resolved satisfactorily, you can contact the Patient Liaison and Advice Service (PALS) at Great Ormond Street Hospital:

Grainne Morby grainne.morby@gosh.nhs.uk

Head of PALS and Patient and Public Involvement

Great Ormond Street Hospital for Children

London WC1N 3JH

020 7829 7862 (direct line) pals@gosh.nhs.uk

Appendix 2b

Department of Child & Adolescent Mental Health (CAMH)

Feeding and Eating Disorders Service (FEDS)

TEL: 020 7829 8679 EXT: 5853

FAX: 020 7813 8411

Great Ormond Street
London WC1N 3JH

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INFO
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SHEET FOR YOUNG PEOPLE

Research study: Does the meaning matter when you are recovering from an eating disorder?

We would like to invite you to take part in our research study.

Before you decide if you want to take part, it's important to understand why the research is being done and what it will involve for you. Please consider this leaflet carefully, and talk to your parents, friends, or member of the clinical team, if you want to. Don't hesitate to ask us if anything is unclear or you would like more information.

Part 1 of this leaflet explains the point of this study and what will happen if you take part.

Part 2 gives you more detailed information about the running of the study.

PART 1: THE PURPOSE OF THE STUDY

Why are we doing this research?

We would like to find out, through interviews, how young people think about and make sense of their eating disorder. And we are interested in how young people's understanding changes over time. We are asking similar questions of young people's parents.

Why have I been invited to take part in the study?

You have been invited to take part in this study because you are a young person who has been assessed in the Eating Disorders Service at Great Ormond Street Hospital and found to have an eating disorder or eating problem.

Do I have to take part?

No. It is up to you. We will ask you for your consent and then ask you to sign a form. We will give you a copy of this information sheet and your signed form to keep, as well as a copy to your parents. You are free to stop taking part at any time during the research without giving a reason. If you decide to stop, this will not affect the care you receive from Great Ormond Street Hospital in any way.

What will happen if I take part?

The study involves interviewing you once now, once in a year's time, and once in two year's time, meaning three interviews in total. Your parents will be interviewed too.

Each interview lasts up to an hour. It is more like a conversation than questions and answers. These are the main topics:

- How you think about and make sense of your eating disorder.
- How the eating disorder affects your life.
- What changes it brings about.
- What you think you need to get better.

Other topics may come up as well. We are interested in hearing your personal account and we are not trying to influence your views in any way. As we are interested in the detail of what you say, all interviews are tape recorded. After the interview, the interview is typed up and we look at it carefully.

What are the possible benefits of taking part?

We cannot promise that the study will help you, but the results may help us to plan therapies that are better suited to the individual needs of young people and their families.

Is there anything to be worried about if I take part?

Not really, as this study will not change your treatment. You may, possibly, find some of the interview topics upsetting. If that happens, the interviewers should be able to help you, as they are experts in working with eating disorders. You can stop the interview any time you want to.

How will you keep my personal information private and confidential?

All information about you will be handled in confidence. This is explained in Part 2.

What if there is a problem?

If you are worried about anything that happens in the study, you should speak to one of the researchers or the clinical team, who will do their best to help. If you are still unhappy and wish to complain formally, you can do this through the NHS complaints procedure. Details are available from the Patient Advice and Liaison Service (PALS) at Great Ormond Street Hospital. If you need to contact them, their number is 020 7829 7862.

This is the end of Part 1. If you are interested in what you have read so far, please now read Part 2 before making a decision.

PART 2: FURTHER INFORMATION THAT YOU NEED TO KNOW IF YOU DECIDE TO TAKE PART

Why is this study being done?

There is not enough research about how young people themselves make sense of their eating disorder, and what their own experience is like.

When we listen carefully to young people, we can learn more about each individual's experience, and this can help us plan how we offer treatment in the future. Not all young people with eating disorders are the same. We want to learn more about *different* kinds of experience—including your personal, individual experience. We also want to learn how your thoughts, feelings and views change over time.

Similarly, there are few studies that interview young people and their parents. We will be able to look at whether young people's and their parents' interviews are similar or different in certain areas.

Can my parents hear or read my interviews?

No, you and your parents will be interviewed separately. You parents will not be able to listen to your interview and they will not be able to read it either. They will not be told anything about what you have said. Your parents' interviews will also be private to them.

Will anyone else know that I'm doing this?

We will keep your information in confidence, and it is very unlikely that anyone other than your parents will need to know.

The only exception would be if you let us know that you were being hurt or harmed in some way. Then we would need to let your parents and possibly other adults know, so that you can be protected.

What will happen to my interviews?

The tape recording of the interview will be written up into a 'transcript'. The researchers will read it carefully and find themes in it. After this, the researchers will write reports about the themes that have come out of the interviews. The reports will be published in journals about eating disorders and psychological research.

How will my personal details and interviews be kept confidential?

Your name is not spoken on the tape and it is not written on the transcript, just a code. Only the researchers will know that it is your interview. The transcripts are stored in a different place from your hospital file. They are stored in a locked cabinet in the researcher's office, which is also locked when she is away. In the research reports, there might be quotes from your interviews, without your name or any personal information. This way, nobody who doesn't already know you could recognize you. However, your parents might recognize you because they may know the kinds of things you are likely to say. In the same way, you might recognize your parents' statements. The tapes are wiped at the end of the study.

What if I change my mind and don't want to take part?

You can change your mind and pull out of the study at any time. You don't have to give a reason. If you do want to pull out, everything about your treatment will stay the same.

No one will be cross with you.

Who has said this study is okay to do?

Before any research goes ahead it has to be checked by a Research Ethics Committee. It makes sure that the research is fair. This project has been checked and approved by the Cambridge Research Ethics Committee. It has also been checked and approved by a Great Ormond Street Hospital research committee.

Contact details

Cathy Troupp, who is leading the study, is a Child and Adolescent Psychotherapist in the Eating Disorders Team at GOSH. She is very experienced in working with young people with eating disorders and their families. This study is part of a research degree that she is doing at University College London (UCL).

Email: Cathy.Troupp@gosh.nhs.uk

Tel: 020 74059200 extension 5853 (direct line)

or 020 78298679 (CAMHS Reception)

Appendix 3

Appendix 3a

CONSENT FORM FOR **PARENTS** IN RESEARCH STUDY:

Does the meaning matter in the recovery from anorexia nervosa?

A study about the experience and meaning of illness for children and young people diagnosed with anorexia nervosa and other restrictive eating disorders, and their parents.

1. I confirm that I have read and understand the information sheet dated 29/11/12 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my or my child's medical care or legal rights being affected.

3. I agree to take part in the above study.

4. I give permission for the research team/chief investigator to invite my child to participate in the study.

5. I understand that my child's consent for participation in the study is sought separately from mine. I understand that I cannot make my child participate but I can participate even if she/he does not.

6. I give permission for my child to participate in the study even if I choose not to, or if I choose to withdraw at a later date, subject to her/his own consent.

7. I give permission for the chief investigator/research team to have access to the information contained in my child's assessment in the Eating Disorders Service at Great Ormond Street Hospital.

8. I give permission for the chief investigator to ask me, or my child, for some basic health information at each interview (including weight for height or BMI).

9. I understand that my identifiable personal data will be stored separately from interview recordings and transcripts. My interviews will not be identifiable by name or other personal details.

10. I give permission for interviews to be audiotaped.

Parent's name:

Signature:

Date:

Name and signature of Chief Investigator:

Date:

**One signed copy of this sheet is for you to keep. We will keep the other one.
If your child also consents to participate in this study, we will give you a copy of
his/her consent form as well.**

Appendix 3b

CONSENT FORM FOR **YOUNG PERSON** IN RESEARCH STUDY:

v3 11.12.13

Does the meaning matter in the recovery from anorexia nervosa?

A study about the experience and meaning of illness for children and young people diagnosed with anorexia nervosa and other restrictive eating disorders, and their parents.

1. I confirm that I have read and understand the information sheet dated 29/11/12 for this study. I have had the opportunity to think about the information, ask questions and I have had my questions answered satisfactorily.
2. I understand that I can stop taking part in the study at any time without giving any reason. I understand that no one will be cross with me if I decide to do this, and that staff at GOSH will look after my care in the same way as they have done before.
3. I agree to take part in the study.
4. I understand that my parents are also invited to participate in this study, and that my interviews and theirs will be carried out separately.
5. I give permission for the researchers to read the information in my assessment in the Eating Disorders Service at Great Ormond Street Hospital.
6. I give permission for the chief investigator to ask me, or my parents, for some basic health information at each interview (for example my weight for height).
7. I understand that my personal information will be stored in a separate place from the recordings and written records of my interviews. That is, my name or other personal information will not be on these records, so no one would be able to identify me from the interview records.
8. I give permission for my interviews to be audio recorded.

Young person's name:

Signature:

Date:

Name and signature of Chief Investigator:

Date:

One signed copy of this sheet is for you to keep. We will keep one, and give one to your parent(s).

Appendix 4

Appendix 4a

'Does Meaning Matter' study Interview schedule Parent v4

29.11.12

SEMI-STRUCTURED INTERVIEW – PARENTS

Does meaning matter in the recovery from anorexia nervosa?

Guidelines for interviewing.

1. The aim is to obtain as rich and reflective interviews as possible.
2. Prioritize the subject's own narrative and experience, while bearing in mind the aim of getting as full a set of responses as possible.
3. Questions can be posed in any order – whatever flows most naturally. There is likely to be jumping back and forth between domains.

(For example, one might anticipate that after Question 1 in the first domain, which is concerned with 'understanding' ('How do you understand/make sense of your child's eating problems as they are at the moment?'), it might be natural to move on to a description of how the eating problems impact on the subject's life, which belong to the second domain concerned with 'impact'. The 'value' domain may arise at any time (for example, 'she seems completely satisfied with things as they are and doesn't want anything to change').

4. Each domain starts with an openly phrased 'stem question'. The subsequent questions are intended as prompts to be used when interview subjects need support to elaborate their answers.
5. Stem questions are phrased as 'demand' questions, that is, they explicitly elicit the subjects' reflections. (This is in line with the guidance in Fonagy, Target, Steele H. & Steele M. (1998) Reflective Functioning Manual version 5).

Introduction:

"This interview is a research interview, and it is separate from your child's assessment/treatment here, though of course some of what you talk about is likely to overlap. As you may remember it said on the information leaflet, this research is intended to help us understand better how parents *understand* and *make sense* of their child's eating problems, and also how the young people themselves makes sense of what they are going through. There are no right or wrong answers in this interview. It is about reflection and understanding. We hope that the research will further *our* understanding of the thinking and experiences of families where a child has an eating disorder."

DOMAIN 1: UNDERSTANDING

Stem question: How do you understand/make sense of your child's eating problems/eating disorder as they are/as it is at the moment?

Prompts:

What are your thoughts about how the problems began?

And about how they went on from there?

How was it before the ED/EP started?

 Within the family?

 In your child's peer group?

 At your child's school?

Can you tell me about your thoughts about *why* or *how come* [child] has developed this problem?

Reiteration [e.g. at the end]: Are there any other factors that you think may help to understand or make sense of your child's eating disorder?

DOMAIN 2: IMPACT

Stem question: How does your child's EP/ED impact on your life?

Prompts:

Both day to day, and more broadly, including thinking about the future?

How does it impact on your state of mind/**how you feel**? Your emotions? Your thinking?

On your health, physical and mental?

On family functioning?

How does it impact on your relationships with [child]?

How does it impact on your relationships with others:

 husband/wife/partner

 other children

 extended family

 friends

And how does it impact directly on other members of the family?

How does it impact on your work and career?

Reiteration/elaboration: How does your child's eating disorder change your life – both in reality and in terms of your hopes and expectations for the future?

DOMAIN 3: VALUE & IMPORTANCE

Stem question: Do you think there is anything that [child] values about the eating disorder? And for yourself/yourselves: is there anything good or valuable that has come out of it?

Prompts:

Are there ways in which it is important to her/him?

Are there ways in which it may be useful for your child?

[if yes] And the reverse – are there times when your child views her/his eating disorder as valueless/useless?

Or even further, times when your child sees it as damaging to her/his life and future?

Has anything good come out of it?

DOMAIN 4: RECOVERY

Stem question: Looking ahead... What do you think is needed now for your child to get better?

Prompts:

Are there any things getting in the way of getting better?

Can you imagine what it would need to be like for [your child] to get better? What might need to feel different?

Factual questions:

1. Can you describe to me what help s/he and your family have had so far?
2. And what did you/do you think of it?
3. Are there other sorts of help that you might like, for your child and for your family?
4. Can you tell me your child's current weight for height?
5. And how her/his health is generally? Any current physiological concerns?

Appendix 4b

SEMI-STRUCTURED INTERVIEW – YOUNG PEOPLE

Does meaning matter in the recovery from anorexia nervosa?

Guidelines for interviewing.

6. The aim is to obtain as rich and reflective interviews *as possible*.
7. Prioritize the subject's own narrative and experience, while bearing in mind the aim of getting as full a set of responses as possible.
8. The interviewer needs to take care not to offer her own reflections or interpretations, but to support through close listening and some prompting, the subject's own.
9. Questions can be posed in any order – whatever flows most naturally. There is likely to be jumping back and forth between domains.

(For example, one might anticipate that after Question 1 in the first domain, which is concerned with 'understanding' ('How do you understand or make sense of your eating problems as they are at the moment?'), it might be natural to move on to how the eating problems impact on the subject's life, which belongs to the second domain concerned with 'impact'.)

10. Each domain starts with an openly phrased 'stem question'. The subsequent questions are intended as prompts to be used when interview subjects need support to elaborate their answers.
11. Stem questions are phrased as 'demand' questions, that is, they explicitly elicit the subjects' reflections. (This is in line with the guidance in Fonagy, Target, Steele H. & Steele M. (1998) Reflective Functioning Manual version 5).

Introduction:

"This interview is a research interview, and it is separate from your assessment/treatment here, though of course some of what you talk about is likely to overlap. As you may remember it said on the information sheet that you read, this research is to help us understand better how young people who come here *feel* about their eating problem, and how they *make sense* of it. There are no right or wrong answers in this interview. The thoughts that you give won't be used, for example, to persuade you to change. This interview is really just to help us understand better how young people like you think and feel."

DOMAIN 1: UNDERSTANDING

Stem question: How do you understand or make sense of your eating problems/eating disorder as they are/as it is at the moment?

Prompts:

What are your thoughts about how the problems began?

And about how they went on from there?

How was it before the ED/EP started?

At home in your family?

With your friends?

At school?

Reiteration/elaboration: [e.g. at end]: Is there anything else you think helps to understand your eating problems?

DOMAIN 2: IMPACT

Stem question: How do your eating problems/eating disorder impact on you – on your life?

Prompts:

Does it change things for you day to day?

How you think about the future?

How you are developing – that is, growing up?

Does it change how you are with your family? (*relationships* with mother, father, siblings, wider family)

Does it change things *for* your family? (family functioning)

Does it change things with friends?

At school?

Reiteration/elaboration: How do these problems affect your life, both now and in the future, do you think?

DOMAIN 3: VALUE & IMPORTANCE

Stem question: Are there things you think are good about your EP/ED?

Prompts:

Are there good things that have come out of it?

Are there ways in which it is important to you?

Are there ways in which it helps you?

Are there things that might be more difficult if you didn't have your eating disorder?

[If yes to either or both questions above]

Are there things that would be easier if you *didn't* have your eating disorder?

Can you explain to me the things that are good and bad about your eating disorder – show or tell... [eg use a pros and cons list with headings drawn from the conversation, draw pictures, etc.]

DOMAIN 4: RECOVERY

Stem question: Looking forward now... What do you think is needed now for you to get better?

Prompts:

Are there things that are getting in the way of getting better?

Can you describe to me what help you and your family have had so far?

And what did you/do you think of it?

Are there other sorts of help that you might like, for yourself, or for your family?

Can you think of anything else that could help?

Factual questions:

1. Can you tell me your current weight for height?
2. And how your health is generally?

Appendix 5

Appendix 5a

<p>RF coding Red for RF Green for absent RF</p>	<p>M2 (T1) 04.12.12 and 11.12.12 (in two parts owing to time shortage)</p>	<p>IPA coding in blue</p>
<p>Overall: exceptional RF (9)</p>	<p>(04.12.12)</p> <p>I: Okay, it is recording. So, there are these four domains: one is how you understand C2's eating disorder and make sense of it, one is about the impact on your family, and another is about change. um, and particularly, although this question was maybe phrased more for young people, the value and importance of the eating disorder. But, um, for adults, for parents it becomes more of a change, cause sometimes something good can come out of it. But the question is more about change all together. And then about what do you think C2 needs for change.</p> <p>So, should we just talk freely about those and then, what usually happens is, one ends up skipping between categories and that's completely fine. So the first question really is: How do you make sense of C2's eating disorder?</p> <p>M2: Well, I think for me, um, making sense of it changed very very very rapidly.</p> <p>I: I'd love to hear about those different ... ideas</p> <p>M2: So, actually, first there was all the contention that she might have anorexia, but the day her dad and I knew she had anorexia was the day she said to us that she was trying to eat 300 to 600 calories a day. And when we asked what weight she was trying</p>	<p>1.UNDERSTANDING and MAKING SENSE</p> <p>Shock of realization, diagnosis</p>

B5	<p>because she couldn't understand. um, and so until we got back to England, I didn't know any more about it. I then went on the Internet and, um, started to learn about it from the Internet, but again, even being medical, I didn't know which sites to go to, so I didn't, um, ... in the end, I began to, I think I was in a panic so I was just reading stuff in a panic. And we'd been to our GP who said yes, she had anorexia and she was to eat 1000 calories a day and, and we managed to do that somehow. I don't know what, I don't know how we got there because we didn't know what we were doing. We were just with her all day, ahm, and I suppose our days merged into one long meal. That's how we did it then, that first week. And, I was on holiday and D2 was at home cause he is out of work at the moment, so that, that was how we did that. But, I remember then finding the NICE guidance and that was a little bit helpful. And I was aware we needed help. Eh, but then when we were referred to the CAMHS service, I think probably because we were so stressed, we didn't hear everything they said, and all we heard was that she was to eat 2000 calories a day and we were to, it seemed like, the message I got, which I think was incorrect, but my understanding at that point was, we were too soft as parents, we needed to be really tough, we needed to treat her like a two-year old and she just had to do it, and to fill her up with whatever we could, which included ice cream and chocolates and things, and we did those things. And at that point, I, I felt very alienated from C2 because we'd always been close and gotten on but suddenly this person I didn't know... I have a brother who has bipolar and when he is hypermanic, he can be very difficult to be with. You can't speak to him, he's aggressive, he's angry, and C2's behaviour was very</p>	
B5		
B5, C1		<p>Child is alien and different now – treat her like a two-year-old</p> <p>Loss of child</p> <p>Association to brother with bipolar disorder, MH</p>

	<p>the same. So ...</p> <p>I: Were you aware of that similarity at the time?</p> <p>M2: Immediately.</p>	<p>problems in family</p>
<p>B1</p>	<p>I: Right.</p> <p>M2: And, um, I remember thinking “ Oh this is a very serious psychiatric disorder”. um, but I had no tools to deal with it and I wasn’t able to separate C2 my daughter from this behavior. To me it was just one big thing and I didn’t know how to interact with her. I found it very difficult. um, but by, within a week, so we’re now at about week 3 I suppose, ... the CAHMS team had recommended a book and it was Janet Treasure’s book from the Maudsley about how, I think it’s “How to help...”, I can’t remember the title, but it’s basically their approach, the new Maudsley method. And we bought the book, which came from Amazon within 24 hours, and I remember devouring it, and, within 24 hours ... <i>that’s</i> helped.</p> <p>The thing that really helped me was this concept that there is a person you love and then there is this eating disorder on their back, so that you start, you re-engage with the person you love and know, but there is this other aspect that you're trying to interact with, and that was a break-through for me, because we’d been to a session, family session that day and C2 had careened at me that all I saw was the Anorexia, which was true. I just looked at her and thought “Oh my God, I don’t know what to do. Who is this and what do, how do I help her?” And she’d run off down the street and, um, the only way we were able to get her back was D2 run after her and persuaded her to come back home with us. um, and</p>	<p>Loss of known self-as-mother (no tools)</p>
<p>B5, C7</p> <p>Seeing impact of own MS on own management of the situation – systemic view</p>	<p>the same. So ...</p> <p>I: Were you aware of that similarity at the time?</p> <p>M2: Immediately.</p> <p>I: Right.</p> <p>M2: And, um, I remember thinking “ Oh this is a very serious psychiatric disorder”. um, but I had no tools to deal with it and I wasn’t able to separate C2 my daughter from this behavior. To me it was just one big thing and I didn’t know how to interact with her. I found it very difficult. um, but by, within a week, so we’re now at about week 3 I suppose, ... the CAHMS team had recommended a book and it was Janet Treasure’s book from the Maudsley about how, I think it’s “How to help...”, I can’t remember the title, but it’s basically their approach, the new Maudsley method. And we bought the book, which came from Amazon within 24 hours, and I remember devouring it, and, within 24 hours ... <i>that’s</i> helped.</p> <p>The thing that really helped me was this concept that there is a person you love and then there is this eating disorder on their back, so that you start, you re-engage with the person you love and know, but there is this other aspect that you're trying to interact with, and that was a break-through for me, because we’d been to a session, family session that day and C2 had careened at me that all I saw was the Anorexia, which was true. I just looked at her and thought “Oh my God, I don’t know what to do. Who is this and what do, how do I help her?” And she’d run off down the street and, um, the only way we were able to get her back was D2 run after her and persuaded her to come back home with us. um, and</p>	<p>problems in family</p> <p>Loss of known self-as-mother (no tools)</p>

<p>C2</p>	<p>she screamed at me “All you can see is Anorexia. You’re not listening to me. You don’t hear me. I’m not here anymore. I’m invisible to you.” And that is what had happened in that 3-week period, which was very, it was very good she was able to say that. And I suppose it was good I read the book and I was able to hear it? um, and so after that, it was much easier to see “that’s Anorexia, and Anorexia [is the great white trickster?]” um, although I didn’t have that word in those days. Manipulative, challenging. And D2 and I who’d had a <i>lot</i> of problems in our relationship, we were able to come together at that point and understand what Anorexia was, and the critical thing was that the anorexia mustn’t be able to put a piece of paper between me and D2, which would have been so easy for it to do. And we had to learn a new way of behaving at that point that we hadn’t been able to do for a few years, which was we had to be together. We had to understand what we were trying to do. We had to make sure we agreed and that we and the CAMHS team were together.</p> <p>I: So, um, would it be right or wrong or somewhere in between, to draw from what you’re saying is that at that point you were seeing anorexia as some kind of wild animal that had jumped on C2’s back?</p> <p>M2: [laughs] Yeah. Exactly. um, exactly. And I don’t know if that’s the way it is, but it worked for us.</p> <p>I: And is that in a way still how you see it now or ... we’re about 3 months in?</p> <p>M2: Oh yeah. We’re now... that was the middle of August and we might even, we’re coming at, we’re about 16 or 17 weeks in. And things have changed.</p>	<p>Impact on couple – pulling together</p> <p>(Impact)</p> <p>UNDERSTANDING</p>
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<p>C4</p>	<p>um, and, I see it differently now. So, and now, if anything it's more challenging. I have to really observe [?] every day because C2 is much more taking charge of her wellbeing. But, for example, Tuesday was the first time she said "I want to stabilize my weight" and she, she really meant it. She meant "I don't want to go any lower than where I am." But she was honest. She wasn't sure she could do it. But, you know, she, she verbalized it "I want to stabilize." You know, I thought that might be a concept that would come and go. And it did a bit, but she said it again this morning. So, so we're at a point which is so completely different and yet we have to, the anorexia is still there. Um, but not as evident. So most of the time we're seeing C2 as the C2 we knew, although she is a much more, already a more mature C2 who is communicating better.</p> <p>I: That is interesting. So if we think about changes, and positive changes in particular, cause that sounds positive, she's more mature. And certainly more mature than the C2 who used to, before she got anorexia.</p> <p>M2: Yeah, well, I think though, because, well I, yes, definitely. Because we only knew C2 had anorexia in August, but I know there was something seriously, well I don't know about seriously wrong, but there was something very different about C2 since January. She was, her personality had changed, she was withdrawn, she might even have been described as depressed. And I remember thinking "My God, this teenage business nowadays is horrendous" because she really <i>had</i> changed. But I think the person before that, so I think back to the C2 was, I think back to the C2 a year ago maybe, and...</p>	<p>Encompasses change</p>
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<p>B1</p>	<p>I: 'Pre-'being withdrawn?</p> <p>M2: Yeah.</p> <p>I: What – the C2 now is someone you recognize from pre-January 2012?</p> <p>M2: Yeah.</p> <p>I: Can you say a bit more about that?</p> <p>M2: Yah.</p> <p>I: How she was before and how she changed in January.</p> <p>M2: First, I remember her really vividly from the summer 2011 where she was a happy child, she was out, she was gregarious, she was interacting with people, she loved life. She loved what she was doing. And she didn't care whether she was winning or not. You know, she loved to win. She was competitive. She loved, she likes polo jumping and she loved to win, but if she didn't win, it didn't matter. She loved what she was doing. And she seemed very balanced and seemed quite mature, I think, for her age. In retrospect. But that all changed...</p> <p>I: And that was at 14?</p> <p>M2: She would have been, er, where are ... eh, yeah, that's right, that's right, 14. That's right. Eh, just, eh, yah, exactly. And then, I hadn't noticed things changing a lot before Christmas, but I noticed a big change in January. The way C2 was being</p>	<p>Change in C2's mood/ Personality/ Development?</p>
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<p>C2, C5, C6?</p>	<p>now, she's not as happy go lucky as she was, she's not as content to not, you know, she's definitely got more perfectionist though, she wants, she either wants to be very good or not do something at all. So that's a change. But she's more mature in that she's starting to challenge me and D2, but in a very mature, constructive way? You know, we had all that shouting and screaming and aggression in September. Now, she, she, on Friday, she took me on in a very mature way and taught me something about myself I didn't know that was really hard for me to hear. And I was hard, difficult to work with cause I didn't want to hear it, and she got there and I thought "That's quite extraordinary!"</p>	
<p>B6</p>	<p>I: Totally, are you willing to share it with me ... if it's not difficult ...</p> <p>M2: Yeah, I am! Shall I say what happened?</p> <p>I: Yeah.</p>	
<p>C7, B5, B1, B6</p>	<p>M2: And stop me if I'm going on too long. What happened was, going to school has been quite a challenge and she's been very tired. And it's been because, it's been difficult to get her to bed on time and that's always been a challenge. And last week, our family goal with [therapist] was to develop a routine for the family and we'd agreed that, um, we were going to turn the TV off at 9 o'clock, stop doing all screens, you know, iPods, i- all the things. We got to turn off at 9 o'clock and we were going to relax, maybe do some yoga, which we have been doing – that was C2's idea – and then go to bed.</p> <p>I: Okay.</p>	

<p>A3</p> <p>B1, B5</p>	<p>M2: [deep inhale] And on Thursday night, for various reasons, she wasn't in bed in spite of all of this plan until about 20 past eleven. And we get up at 6:30. And we couldn't, I could not get her up. Well, I could but it was really difficult.</p> <p>I: On Friday morning?</p> <p>M2: On Friday morning. And it was a stressful day for me cause I, I was supposed to be at work but D2 was away, so I had to get her to school before I went to work, and this was all quite a challenge in the morning. And we'd had a few mornings, we'd had quite a lot of mornings where getting C2 up was difficult. And she was at a point where she wasn't saying that she wouldn't go to school but it was like "I'm so tired there is no point in me going to school." And by the time we got out of the house and into the car, I was at the end of my tether. I suppose, when I talk about it I wonder why, but it was all at the end of a really long hard tiring week and what I did was, instead of thinking "Okay, this is a stressful time." Breakfast is a stressful time because she's been eating her breakfast in the car. You know, these are big stress times. If I wanted to talk about it and plan how we were going to avoid this, some other time would have been a good time. But being me, and I suppose it's the way I behave at work, I was like "Okay, problem! This didn't work for me." You know, and I go into, um, solution mode, which is identify the problem, identify the solutions, line them all up, tell everyone what we're doing, get them sorted in two minutes and move on. And you see, that's how I deal with my anxiety. But this blew C2's brains because she is already really anxious. She's going to school,</p>	
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<p>B5, C5, C6, B6</p> <p>B5</p> <p>B3, B1</p>	<p>which is difficult. She's having her breakfast, which is difficult. She's very tired. And now her mother is there saying "Dam de di dam de di dam" You know. And it was so stressful that she got to school and she did the first two sessions and then thought " I can't do the rest of the morning". She didn't come home. She went to the library and studied. But when I picked her up, she said, "Mom, I'm really angry about what happened. We need to talk." And I said "Okay." And I must be honest, I had, I knew I'd made a big mistake. And I had sent her a text saying "Sorry if I stressed you out." So maybe that was an opener.</p> <p>[17:00]</p> <p>I: Yeah.</p> <p>M2: But she, we, ahm, must have been in the car in the end for 45 minutes, and she suggested we drove around so that we weren't, you know, facing off in the car. And she was really clear. And every time she said something to me that I couldn't get, I'd say "I don't get that." And I found myself getting quite irritated with her. And she was calm and said "Mom, calm down, you need to hear this." And by the time we'd driven around for 45 minutes, I got it. And she really had to work hard to stay calm cause I wasn't calm.</p> <p>I: And are you, are you saying that this ability to sort of manage you in a way was a new kind of maturity?</p> <p>M2: Yeah! I've never seen it before.</p> <p>I: What was it that she taught you?</p> <p>M2: She taught me that, I suppose we worked it out</p>	<p>Self-awareness in mother growing</p>
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<p>RF3</p> <p>RF5 B1, B5 C7</p> <p>Value Question addressed by mother</p>	<p>together cause she was just saying “This didn’t work for me. Don’t do it again.”</p> <p>I: Ah, okay.</p> <p>M2: And I was trying to understand what I had done and why and in the end, ah, I said “Yeah, you know, the way I deal with anxiety is by trying to fix everything immediately.” But I hadn’t realized that before, in my whole life. um, and so now, if I start doing this, and I’m sure she’d just go “Ah!” And so this is quite, this is good. And in the meantime, I didn’t realize this before, she’s taken her father on and told him something that really drives her mad. And that came up in our family session. And we as a family don’t communicate well and D2 and I are working through that at the moment with some help, but I’ve been so impressed with C2’s problem solving [laughs] and is already doing that for herself. So the anorexia...</p> <p>I: Do you see that having anything to do with...</p> <p>M2: Yeah. That wouldn’t have happened without the anorexia. We would have carried on being ... I don’t need to label it but we were quite dysfunctional as a family. There’s been a lot about our situation at home that’s been very stressful and made a lot worse by D2 being out of work for four years and being at home but not really doing anything at home.</p> <p>I: So about D2 being out of work?</p> <p>M2: Yeah. And about being ... And the way I’ve coped with it is, the way D2’s coped with it is by pretending it is not happening. And the way I’ve</p>	<p>IMPACT</p> <p>My daughter with AN teaches me about myself and my own anxiety and how to change</p> <p>Also VALUE</p>
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<p>A2, A4, B2, B3, B4, C7</p>	<p>coped with it is by trying to force recognition, but at the same time just pretending he can't help it. And that's how we functioned, which ... we just can't go on. And and because C2's developed anorexia, D2 and I <i>had</i> to find a way to communicate. We just had to. There were just, unless, you know, if we, it was really clear if, we had to work together and it was almost easy because there was a bigger reason than ourselves to do it. There was something we both really believed in, which was C2 And for some reason, trying to sort our marriage out wasn't enough incentive. Maybe it's because we were too embroiled in the problem. And so, for a month to 6 weeks, D2 and I <i>really</i> communicated. But about the time we came here, it started falling apart again. But we've been able to use the skills we learned in the first six weeks to now talk to each other to resolve some of things that have been going on in our marriage for a very long time. So there's, you know, a lot of positive in this for us. But ...</p>	<p>IMPACT</p>
<p><i>Overall Understanding Question RF9 [to here]</i></p>	<p>I: And it is quite impressive and early days, isn't it, to recognize that something positive is developing.</p>	<p>Positive impact on couple communication</p>
<p>C7</p>	<p>M2: Yeah.</p>	<p>Impact and Value – already noting positives</p>
<p>A1 (maybe...)</p>	<p>I: C2 sounds More able to adjust to the situation. And also, developing a different relationship to you and others?</p> <p>M2: Yeah. She's growing up. In a very healthy way I think. Well, the beginning of something healthy. Being able to talk to us and talk about differences and say what works for her. And we did say to her this morning, we'd encourage her to practice at home and then start practicing out in the real world,</p>	

<p>A1, A2, B2</p>	<p>because I think she's gotten ...</p>	
<p>C5</p>	<p>I: Practice...?</p> <p>M2: Interacting with people. Because I think the ways she's coped up till now is by just fitting in with whatever everyone else wants. Because she's been a very biddable, easy, good child, you know.</p>	
<p>C2</p>	<p>I: Have you any thoughts then about how this changed from a 14-year-old who you described as sort of who you were observing in the summer 2011 where you thought she was very balanced, happy, competitive, but not excessively so, and then something changed, didn't it, about that.</p> <p>M2: Yeah. I think that's the way it looked on the surface, now that I think about it, because C2 would say that she can't remember a time when she was happy. Yeah... And I don't think, I don't know to what extent the anorexia and feeling depressed about that coloured that ... but I thought we got to believe what she said, so maybe actually, even though it looked like everything was great, I think we had a very sad, worried child that was living at a home where she was very worried about her parents....</p>	<p>Anxious, sad</p>
<p>C7</p>	<p>I: That's what you think her main worry was?</p> <p>M2: Yeah, I do. And well, I think the other thing is if I'm her, you know, the model of an adult woman, I wasn't in the last few years giving her something really she would aspire to because I haven't been thriving or happy. I've really been struggling and, um, it must be quite frightening for a young girl to think "Oh my goodness, if I want a career and a family, it</p>	<p>Importance of herself as model of woman to daughter</p>

<p>B1</p>	<p>looks like that. No thank you.” You know, so I think this being... [23:10]</p> <p>I: Are you relating that to anorexia as well?</p> <p>M2: Yeah, I just wonder</p> <p>I: Not thinking there's much to aspire to?</p> <p>M2: Yeah, or maybe I wondered if the anorexia was a way of dropping out.</p> <p>I: Yeah.</p>	<p>UNDERSTANDING Theme 2 we had a very sad, worried child that was living at a home where she was very worried about her parents....</p>
<p>A2, C6, C7</p>	<p>M2: Because I don't think her dad would say this yet, but I think he will come to see what happened in the last four years is being a sort of dropping out. And that's the other model about adult behaviour. You know, the one who does it all but really isn't coping, and the one who is doing nothing but is pretending it's all right. It's not really, it hasn't been a healthy environment.</p> <p>I: So, um, C2's having anorexia has sort of, I don't know, pulled this apart...</p> <p>M2: Yeah, it really has. Put a bomb in the middle of it all. And I would say, now I am sitting here speaking very calmly, it's been emotionally horrendous. I can't remember having emotions that have moved and changed and all the feelings of hopelessness and all the rut, it's been horrendous. But I wouldn't go back to where we were before.</p> <p>I: Wow.</p>	<p>UNDERSTANDING Theme 3 Self-blame or guilt about self as role model</p> <p>Impact - positive</p>

<p>C5</p>	<p>M2: I feel we're all on the way to somewhere much better. And I can say that now because I feel very confident C2 will be all right. You know, I can see her taking more initiative and learning and I know it's going to take a long time, even though she's a child who does things in extremes, you know, she ... everything. She's so determined. But I feel she will be alright now.</p> <p>I: What do you know about her own sense-making of her eating disorder?</p> <p>M2: She said she gets very angry if we talk about reasons outside of her. You know, we, she wouldn't accept that, um, we'd done anything that has caused this.</p> <p>I: So you actually need to keep that interpretation to yourself?</p> <p>M2: Well, hmmm, I don't really. I feel ...</p> <p>I: So you're happy to ... You are happy to have your own opinion?</p> <p>M2: Yeah.</p> <p>I: Okay.</p> <p>M2: Yah. Ah, I suppose maybe that's something I've learned lately, that it might be very nice ... that it's important...</p> <p>I: C2 is not to silence you?</p> <p>M2: No, no. It is very important I'm authentic and that</p>	<p>Positive impact –</p>
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B1	I'm, you know, not just trying to keep the peace. That, you know, I'm clear what, you know, how it is for me too. So I did say to C2, um, when this, um, communication thing came up, I did say on Friday, you know, did she think that, um, you know, not being able to communicate how she felt, and having to keep everything bottled up, did she think that had been healthy in the past. And she said it hadn't been healthy. But I didn't go so far as to say "Do you think it could have anything to do with your anorexia?" So,	improved family comms
B1	she's very, she's very clear, she keeps saying to me, you know "Stop thinking it has anything to do with you. This is me." And she said that she's never been happy. Well, up until a week ago, she said she's always hated her body, she's never been happy with any of it. So it was in the last week, she now said "The only bit of my body I don't like is, I can't remember what bit it is, um it's her legs! It's the top of her legs. She just doesn't like the top of her legs.	
B1, B3	So, you know, I think even for C2 she's, she's changing what she thinks, you know. I think three weeks, a month ago, she said "I've got anorexia because I hate my body." Now she's saying "I don't like this bit. What can I do that's healthy to come to terms with that or, or to move on." You know. So I think she's going to keep changing her mind about what caused the anorexia. She goes through this probably.	
C7	<p>I: I would be very ... you know the, you did take in that I'll talk to you again in a year's time. And in two years' time.</p> <p>M2: Yeah, yeah! Of course.</p> <p>I: And it'll be very interesting to see how, whether</p>	

<p>B5, C7</p>	<p><i>you</i> change your understanding of it or thought about it in a year's time. But it sounds as if, as you say, that the changes have been very fast and furious already.</p> <p>M2: Very fast. Very furious. Um, and I think we're all moving at different paces, which makes it challenging at home so the big, the greatest difficulty I found in the last month, you know, in the first six weeks, it seems so important to keep it calm and compassionate and everything at home. We managed that nearly all the time. Then in the last month, I just became so angry with everybody and everything [in a whisper], and you know, particularly with me and with D2 and what, ugh, everything! And so that was much more difficult. um, I think D2 is about to go through a phase of being a bit angry about everything. So we're all moving at different paces, times, and one of the things we agreed in our family session this morning was our goal now – we worked on routine last week – our goal now is communication. And we came up with the word 'respect'. I think I perhaps brought that in because I think that's going to be key to us as a family, getting through this in a way where everybody can be themselves. Because, the way we've coped in the past was by withdrawing. So...</p> <p>I: How do you understand your anger? I mean, it may be blindingly clear, but maybe you can spell it out?</p> <p>M2: I think what happened ... the day we came here, the first day we came here about a month ago, um, I think up till then, you know, D2 and I put all of our problems behind us. We were just focusing on being together, caring for K, trying to get through, and do what we could. On the day we came to the first</p>	
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<p>B5, B1</p> <p><i>Overall for Impact Question RF7</i></p>	<p>session, ahm, – I don't know if other people describe the moments where suddenly you see everything differently – we were all sitting there and I was describing how, whatever it was I was worried about. And D2, it was, his message was, I am an accountant, my family is boring, I'm alright, Jack. And I just thought "Urgh!" You know, to me, I was just living one life, he was in some parallel universe which had nothing to do with what I was experiencing, and if he wasn't going to shake himself out of that, how are we going to relay what's going on in our home for C2? And I was so angry with him. So that was the start. And I think it's this thing that you suddenly see life as it is and all of a sudden, I was angry about all the times something... I just allowed we live life as D2 saw it, because I didn't think he could see it any other way. And I thought my role was to just make it okay at home. um ...</p> <p>I: On this thought for a minute. So what, what do you think...</p> <p>M2: It's awfully complicated, isn't it?</p> <p>I: Hmmm...</p> <p>M2: It was like my eyes were opened...</p> <p>I: Yes, some kind of pulling of a veil...</p> <p>M2: Yes!</p> <p>I: What he ... so you're saying he, your, what made you so angry was suddenly the experience that you weren't together.</p>	<p>IMPACT: anger with husband</p>
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<p>B1</p>	<p>M2: We weren't together. I thought we were together...</p> <p>I: You thought you were</p> <p>M2: and we put everything ... you're right, that's what it is. I, I, I hadn't quite figured out exactly what it was. We were doing this together. And what I think what sort of happened was, C2 to D2 was better because she physically was better. Maybe that isn't it. But I think he was less concerned and we <i>weren't</i> together. And, and then, um, so I just got very very angry I think I was angry with myself, I was angry with him, I was angry with the life we've lead. I was angry that C2 was ill, it didn't have to be like this. I was just angry about everything. I seem to have moved to a different phase now, but I think D2 is just beginning to notice where his life's been. Because the way he's coped is by pretending it's not, you know. They have that ... Janet Treasure's book, with the ostrich. D2 is the ostrich, I am the rhino. [laughs]</p> <p>I: [laughs] Okay.</p> <p>M2: And I've been trying to be something in the middle. And D2, he knows he's the ostrich but had come out of it and maybe, as C2 got better, we were reverting again. Yeah, I was becoming the rhino and he was becoming the ostrich. Anyway, I don't know. We have a lot of stuff to work out. I don't know how it will end, but as long as we're all authentic, honest, do our best to communicate, and are healthy in the way we interact, I know C2 will be alright and I know we'll be alright.</p> <p>I: What do you think allows you to feel confident that</p>	
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<p>C2</p>	<p>C2 will be alright?</p> <p>M2: Because I've noticed that, as ... as times goes on, each week she amazes me at how she changes. Very fast. She's been very fast of course. And I know, cause she tells me, it will go backwards, and it does, but every week there's one or two things that are so amazing – I like to write them down, I have a little book I write them down –</p> <p>I: That's fantastic.</p> <p>M2: And then I can look back at the book, and I think if I read stuff from September, I think I'll just cry. It's so awful. And I felt so sorry for the lady in the family session last week. The family session I've realized how lucky we are. Eh, I've stopped ... maybe that's when I stopped being angry, um, when we went to this ... not the family session, the parent session ...</p> <p>I: Ah, yeah yeah. The group</p> <p>M2: The group. We realized how lucky we are. There was a mum there who is clearly at a stage with a child that's so much iller within the hospital, an she's at the very beginning. And, um, that ... we're so lucky, you know, I can't imagine it being worse than it was. But I know that for that woman it's worse than it was for us. And I don't know who's supporting her. Anyway, I realized that's not for me to get involved in, but you know I realized we are so lucky, it could have been so much worse.</p> <p>I: Mm. Anything that's kind of taking that ... anger away</p>	
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	<p>M2: It's taken a lot of the anger away, yeah.</p> <p>I: That's interesting. That seems to point to the value</p>	
B1	<p>M2: Yeah. I didn't want to go because I had this, I think I can be quite rigid, and I had this idea that what C2 needed was to talk to someone one on one. And this was just to me what was going to fix her [laughs]</p> <p>I: Yeah. Which was when we met.</p>	Recovery: one on one therapy for C2
C2	<p>M2: Yes! When I heard she didn't want to meet too, I just thought "Ah, it's hopeless! Nothing's going to work!" You know, bla bla bla. And so I couldn't get my head around going to this session and I thought "I can't go!" And I was still furious when I got there, more furious than I'd been the previous month, and then I began to think "Oh Gosh! All these parents have been through the same. It's been just as bad. It's been much worse for so many of them. It's been going on for so long. Even though it's going on so long, I don't seem to have this feeling anymore "We've just got to fix this." You know, it seems to me this ... there's a lot of stuff for D2 and me to change.</p>	Value Recovery
C1	<p>C2 is growing up. This could take a long time. But it doesn't seem to matter anymore as long as we're all moving forward.</p> <p>I: Yeah, that's what comes across very clearly. You seem to see this as some kind of emphasis to changing growth and development.</p>	
B1	<p>M2: Yeah. Well, the day I first came here, it was "Oh my God, somebody please help us cause we're in a terrible mess." And, and then on top of that came a</p>	

<p>C1, C7</p>	<p>whole <i>lot</i> of anger. Um, so it's, it's all changing still very quickly and it is frightening at times because if I, if I start focusing on things I worry about ... like income and jobs and what we're doing and where we're going, that's all very frightening stuff, but this all seems to be something we're just all going through, we have to go through, it will all get better in the end. Ahm, and that's a good place to get to.</p> <p>I: Is it something about feeling that you're family, so that you, D2 and C2 have come alive again?</p> <p>M2: Yeah, yeah. We're all getting to a place where each person is themselves. Um, I know that where is, D2 and I might find that we can't be together long-term, but I know that if we get to that point, at least it will be a more healthy process even if we're apart. Because my parents split in a very dysfunctional way and 25 year on the family is still suffering. You know, at Christmas time I had one of those discussions with my mother on Sunday night and I said "You know what, mum? I have a lot going on, I can't do this at the moment. Goodbye." Click. You know, this is ridiculous, 25 years on. So I don't... you know ... what, wherever D2 and I get to, I hope we'll be together, but if we're not, that would be alright. Because where we were before was, I was at breaking point with our marriage and it was just a question of when I was going to say "That's it!" and just walk out the door. Which would have been the dysfunctional way to do it. Whereas I think all of this has stimulated us... we just have to work through stuff that D2 and I could not work through before.</p>	<p>Impact & Value domains reiterations</p> <p>Impact on marriage, forcing communication and opening taboo subjects, questioning future</p>
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<p>B5</p>	<p>(M2 (T1:2) 11.12.12)</p> <p>M2: One of the things we, we, I didn't talk about last week was the impact of anorexia on our family and on C2</p> <p>I: Yeah. So really it's the impact on yourself and C2, but also wider family and work. That stuff is often neglected.</p> <p>M2: Yeah. So, I think what was, it was quite shocking when we realized how ill C2 was. Um, in her mind. You know, physically, she had lost a lot of weight, but it was more the way her mind was working. And, so, in one way, we were lucky that we were on holiday because we had a few days to sort of draw a breath and try to decide what we were going to do before I had go back to work. um ...</p> <p>I: But you were quite, um, if I remember rightly, you were quite remote.</p> <p>M2: Yeah, we were in I.</p> <p>I: And unable to get medical help.</p>	
<p>C7, B5</p>	<p>M2: That's right. So that was difficult because I had already been to the GP twice, so I knew that when I phoned ... And we were, we were on holiday in I., but we were in the middle of nowhere. Eh, so we were on an island on a lake. And we were the only house that you could see. And even when you went on a boat on the lake, you couldn't see other houses. So we were in the most remote place we'd been recently. Ahm, and we were very aware suddenly hat C2 had anorexia and that she needed to eat. What</p>	

<p>B1, B5</p>	<p>was good about our situation was that, because we were on our own, D2 and I had to come together as her parents and, and come up with some sort of plan. And we did, and that was very good for us cause he and I had been going through a very difficult time with our marriage, particularly since about March of that year. About, yeah... so six or seven months. And...</p> <p>I: Are you saying, this is in the last few days you say of the holiday. How long was that holiday?</p> <p>M2: The holiday, it was two weeks in all and we were, it was Thursday and we'd gone on holiday on Saturday and we were...</p> <p>I: This was the Thursday of the next week?</p> <p>M2: Yeah, so this was the following Thursday, so about six days into the holiday.</p> <p>I: Ah, okay. And are you saying that ... um ... not to be nosy, but are you saying that you having a bit of time together wasn't making you and D2 communicate better, but C2's anorexia ...</p> <p>M2: did</p> <p>I: ... was the catalyst?</p> <p>M2: Yes. D2 and I got into a very difficult place with our marriage where we know we want to be together, but we couldn't make it work. We had tried, we'd looked for help I think four times, and we couldn't get through to each other. We couldn't communicate on any level that was meaningful. We could get on with</p>	<p>Impact of couple on</p>
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<p>B1</p>	<p>most practical things, but even on this holiday we were like two people alone together. That's how our lives had become. Two people like islands living together. Very difficult. Um and very difficult for C2</p> <p>I: Was it painful, wouldn't it have been obvious to C2 that you two are in personal pain, or are you quite normal to pretend that ...</p> <p>M2: Oh, she has known that, um, there was ...</p> <p>I: Or would you switch in front of her and be...</p> <p>M2: We did. We tried to put her on a, um ... I tried, I was the one who was down about it cause D2 felt a bit if I was just being in a good mood all the time and not get cross with him we had no problems. That the problem was me. And I was very distressed about it for a long time. I was becoming more and more distressed.</p> <p>I: So you were actually quite churned up</p> <p>M2: Yes.</p> <p>I: ...in those first two holiday days about your whole marriage and D2 rather than C2?</p> <p>M2: No, I wasn't. Because we got distracted by my dad who has bipolar affect disorder and he was very depressed. And my brother, who for the first time in many years was actually hypermanic, but not so severe that he needed admitting. But he was very borderline. So we're in the middle of nowhere, trying to decide whether my brother needed to be admitted and how we were going to ...</p>	<p>C2</p>
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bonded because we both love nature and sports and physical things and skiing. And so suddenly I thought there was hope cause I loved all the time behaving in a way we used to behave. And that was good. And so perhaps we'd been coming together a little bit anyway. In fact we had. Because I remember all of us swimming across the lake and D2 and I were on the outside and C2 was in the middle and she's a fantastic swimmer – much better than either of us – and this had been spotted and they wanted her to swim seriously

I: In a club?

M2: Yeah. She didn't want to. She said it was too much like hard work. Which is fine. um, but she's a very good swimmer. Interestingly, she was lagging behind and we both noticed that and didn't understand it. But I remember feeling that D2 and I were on the outside, pulling C2 along with us. And that we were all together as a family. And I felt very strong – I hadn't been feeling physically strong – I thought I noticed how fit I was, how fit D2 was. And then you know just C2 wasn't fit. But there was this sense of togetherness and strength, so that must have kicked in ... that was the day before C2 told us what was going on. And she told her dad, which is interesting because she and I had been very close emotionally. I think she knew I would be very upset and frightened. But she told her dad that she was trying to eat 300 calories a day. And she, when he asked her what she was trying to achieve, she said weight loss. And when he said "What weight?" she said no weight was low enough. So, and he told me and we both told C2 we knew what was happening. So, that was very frightening.

I: And had you not noticed anything visually?

M2: Ahm, in retrospect. Then my eyes were opened and then when I looked at her I realized she was very very thin. But I think, I think I stopped ... looking and seeing cause ...

I: And you weren't aware of the 300 calories?

M2: Mm, oh, no! And that's what's so ridiculous! And I realized then she was very, she was so expert with food, she knew how to make it look like a lot of food. And she knew how to make it look like she was eating. Whereas what she was doing was piling up large amounts of very low calorie food, eating it extremely slowly, and then moving it around the plate, or chucking it in the bin, or, or ... and once we started watching what she was doing, it was very ... she was eating 300 calories a day.

I: Wow

M2: But nobody had really noticed. Except my dad, who had started saying things like "is that all you're eating, C2?" You know, and because there was so much else going on, we hadn't noticed. And then, then we knew. So...

I: And was that some ... we're coming full circle cause you said what was so shocking, talking about impact, was to discover not her changed body only but her changed mind.

M2: And then the other thing I realized was that actually I, I couldn't sleep that night – I'm sure all

<p>B1, B5,</p>	<p>parents are like that – and I started remembering things. And I remembered that she'd been very sad. And ... you know, she reminded me of my dad and my brother when they're depressed. She, looking back, I knew she'd been very sad or maybe even a bit depressed since January, that she'd ...</p> <p>I: Had you an idea what she was sad or depressed about?</p> <p>M2: Well...</p> <p>I: Or not necessarily about something, but how come?</p>	
<p>C7</p> <p>C2, C6, C7</p>	<p>M2: I wondered... well, I am sure living in a, in a ... I know from growing up with my parents when your parents are not able to be ... I wasn't even authentic, I was pretending to be happy when I wasn't. We weren't communicating. Once a month, I was throwing all of my toys out of the pram and screaming at D2 That's a horrible environment to grow up in! And I'm sure she was sad about that. But, yeah. But looking back, I realized that from January – and it was now August – her personality had changed. She was suddenly, she had suddenly become this very ambitious, very perfectionist, very nothing-was-good-enough person who changed our cupboards at home and wanted to get all A's. And... it was before Christmas, she had been a different, more relaxed, happy person. Um, so it's as though – and I realized I, I had somehow not seen this, but I must have seen it because that night I remembered it all – and it was hard looking back to know "Was that her just becoming a teenager?" I had thought she'd just become a bit moody because she was a</p>	<p>Sadness, family and adolescent development all in</p>

<p>B3</p>	<p>teenager. But really in retrospect she'd been sad and depressed. um ...</p> <p>I: Did she ever say anything? I was wondering ... this is really just wondering, you offering your understanding about what she was sad and depressed about in terms of the impact of your and D2's poor relationship ...</p> <p>M2: on her</p> <p>I: And I wondered whether she had said anything that sort of gave substance to that or whether it was led by your own experience and sense of ... guilt</p> <p>M2: ... guilt. Yes, definitely. Because when I speak with C2, you're right, you're right, cause C2 is ... said she'd ...</p> <p>I: I'm not saying you're wrong!</p> <p>M2: No no.</p> <p>I: But because she may not be able to say what she wants. But is there anything C2 says that was wrong right now?</p> <p>M2: Yeah, no.</p> <p>I: Sorry, not say what she wants. She may not be able to ...</p> <p>M2: Yeah</p> <p>I: ... know everyth ... you know, um. I'm not questioning your own judgment because everything</p>	<p>one</p>
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B5	<p>you say</p> <p>M2: ... is valid</p> <p>I: ... is valid on its own term.</p> <p>M2: But what does she think? But yeah, it's a good point. Cause she hates if we talk about triggers cause <i>she</i> says there are no other triggers, she said, ah, and, than what was inside her.</p> <p>I: Right</p> <p>M2: That she never liked her body. She said that she's been trying to diet from the time she was ... maybe eleven? No no no no, she's six-, fifteen now, thirteen fourteen maybe more around there. But that the difference was she hadn't been able to do it.</p> <p>I: Though I remember from the assessment we learned she's never had lunch at school. So that would have been eleven...</p> <p>M2: You're right! It would have been eleven! You're right. And she'd been trying to diet and she was then very proud of herself cause then she cracked it. So as far as she's concerned what had happened until January was she's been failing. But then in January she cracked it and she learned to diet and be what she called "in control".</p> <p>I: But coincidentally ...</p> <p>M2: She was sad</p> <p>I: ... you're noticing her becoming sad.</p>	
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<p>C4</p>	<p>M2: Yeah. And I think she was becoming very...</p> <p>I: Cause she's claiming that she's feeling great now, and you're seeing a change within herself</p> <p>M2: And we also, she was sad also then because she had had problems with friends. And in January, she started talking about her two close friends and how they let her down. And, ahm, they were excluding her. And now she acknowledges that she had become isolated from them through the anorexia.</p> <p>I: Mmm</p> <p>M2: Yeah. She would say it was the anorexia that drove ...</p> <p>I: I wonder what particular</p> <p>M2: Yeah. True.</p> <p>I: Have you ever thought about that?</p>	<p>Sad, depressed</p>
<p>C7, C5</p>	<p>M2: Well, she did go through some difficult times with her friends, before all of this. But she did, there was definitely a withdrawing from everybody and everything in January. um, so, eh... the impact on C2 was that she became <i>very</i> isolated. Oh, I also noticed that even though she'd become more ambitious, she was less able to concentrate and was less motivated to stay in a healthy routine with work and study. Because she'd developed a very balanced, mature routine in her new school when she was eleven. That's what they taught them to do</p>	<p>Family environment</p>

<p>B1</p> <p>B1, B5, C7</p> <p><i>Overall for Impact Question RF9 ('doesn't get much better than this')</i></p>	<p>that first year and she lost this in January. And ... it was strange because there was this sort of dichotomy: she suddenly wanted to do medicine and get straight As, but she was no longer in a healthy working routine. And she would ...</p> <p>I: What was the diff ... what ... [?]</p> <p>M2: The difference..., well, the other one was quite a relaxed routine where she would come in, she'd have a break, and at some point she'd, she'd then study a bit, she'd have her dinner, she'd study a bit more, she'd put it away, she'd watch some TV, and she'd go to bed. Now, it was like "I <i>must</i> work! I <i>must</i> work! I <i>must</i> work! Oh, I'm not working, so I'll start tomorrow." And it was, it was all, you know, um, stressing in [phonetic?], but not effective. Ah, um, and this was all ...</p> <p>I: And then, so if we're thinking about impact, what impact did that have on you and D2 and the family functioning? Her suddenly not being able to manage work. Did it change your parenting? Or were you suddenly surprised to discover you had ...</p> <p>M2: um, yeah. I, I remember, we had a different perspective on this. D2 is very ambitious for her and tendered to lecture her about what she was trying to achieve and this wouldn't help get to ... um, and this is possibly where his parents ... we've learned a lot, moved on I think We're now much more together. My approach was completely different, which was to talk to her about why she wanted to do medicine. Cause I thought she'd overreached herself and this stress was ... why it was all falling apart. That she was overwhelmed by what the bar, where she'd put the</p>	<p>Divergent parenting, according to each parents' personal perspective</p> <p>C2's AN has become</p>
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<p>Segues into Getting Better Question</p> <p>B5, C7, C5</p> <p>A4, C1</p>	<p>bar for herself. Because...</p> <p>I: Was that hard to speak about given that you're a doctor?</p> <p>M2: No, because ... um, I had no prob..., for some reason I had no trouble speaking about this because she's never shown any interest in medicine before. And also, eh, she, she didn't seem, I have no, I suppose, I have no difficulty saying my medical career for me actually hasn't been satisfying. So maybe it was easy for me to...</p> <p>I: Is that the case?</p> <p>M2: Yeah, unfortunately [sigh]. Um, I probably should have stopped five years ago. That would have been good. But it wasn't practical. It, eh, it, I've got very burnt out and, um... it's hard to know for me what went wrong first. But no, it hasn't been satisfying for the last five years, quite frustrating and difficult to keep going. um, so I feel it's important for a person to do the thing their hearts is in, and I don't think C2's heart was in medicine. So it was easy for me to say "Follow your heart, because when you get to your middle years, your heart's what will take you through and, you know, your heart needs to be in it." Ahm, but no, she's, she was <i>fixed</i> on this concept of medicine. So, um, that probably caused more stress between D2 and me, because I felt he was stressing her out whereas he felt I wasn't being pushy enough. um, so in terms of the family, I think we could have just fallen apart, but we didn't for some reason. um, and then the first five, six weeks we managed to really come together for C2 I think we're at a difficult point now cause D2 and I ...</p>	<p>a) attributed to stress and b) this stress interpreted through lens of Mum's own career</p>
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<p>B4, B5, C5</p>	<p>I: That was August to the end of October?</p> <p>M2: That was August to the end of October.</p> <p>I: So roughly when we met you.</p> <p>M2: Yeah, that's right. And I think we know that if we're going to be calm and compassionate and all the good things for C2, that we need to look after ourselves. We know, but D2 and I are equally aware that we got a lot of stuff to sort out if we're going to be ... hmmm ... we've been, we've had a very dysfunctional relationship for a long time. And I think what's really challenging for us is to shake ourselves up and look at where we are and try and sort some of that out while maintaining a calm environment for C2 And it's really pushing us to our limits. And we have, we have ...</p> <p>I: Can you say a little bit more about that?</p> <p>M2: Well, you see, if you're trying to be the adult and the parent and calm and ... sort of ... you have to have a sense of confidence and where you are and how you've dealt with life. And I think D2 and I...</p> <p>I: Peace of mind?</p>	
<p>B1 but shift to 'you' – [painful topic]</p>	<p>M2: Peace of mind</p> <p>I: Or not quite?</p> <p>M2: Oh yeah yeah. You have to...</p> <p>I: I mean is that what you're describing? You're</p>	

saying something about the state you need to be in to be a good parent. Or rather, not necessarily a good parent, but to *feel* good as a parent.

M2: Well, maybe, maybe I am not putting it right. Anorexia is really challenging. And ... I find that if I am calm and centred [laughs], if I'm calm and centred, then when the anorexia comes out and starts poking at me and you know pushing me, I, if I'm calm and all the rest, I deal with it really well. And ...

I: So you have to be able to really focus in a way.

M2: Yeah.

I: And it's about not having your mind on too many things.

M2: I'm not having a whole lot of emotions swirling around, so that when the anorexia gets in there to bother you and point out how hopeless and inadequate and all the other things you are, uhm [giggle], um, you, you just put those to one side and you just stay firm and you just, you know, like the thing we're dealing with at the moment about getting up in the morning, you know, and you have to be very calm, we're getting up, that's just the way it is, and it's not about anything else. It's just about getting up and it's what you do and you have to do it. um, whereas if, if D2 and I have had a good old shakedown with ... we're going to see a marriage guidance counselor at the moment, we did that yesterday ... so you do that on a Monday. And then it's hard to get back to centre and to, you know, hmm, move with all these pressures rather than

<p>B5</p>	<p>break. And I think what possibly was going on before was I was trying to do that and D2 was dealing with it a different way. Whereas now he and I understand, we've got it, we've got all our dirty laundry on the table and he understands why it's difficult for me and I understand why it's difficult for him and we share some of that with C2. So when we have a bad morning like we did this morning, then ... I mean our parenting this morning was rubbish, it's a miracle we got here. But C2 turned up grumpy, we were grumpy, but we were able to move on in the session and all get to a better place. So I suppose, I suppose we're just working it out as we go along. I'm feeling a bit..., feeling..., knowing we'll get there but we've had a much more difficult week this week than last week, so I 'm not sure how we're going to do the next week, but I know we'll get there. So it's been quite an undermining experience.</p> <p>I: Last week you said, um, you had an ... [?]</p> <p>M2: I did!</p> <p>I: It was about the having a stressful morning and then C2 saying, ahm, "Can I just tell you what you're like?"</p> <p>M2: [laughs] Yes, I know!</p> <p>I: um, but you listened. And you felt that had been a really sort of mature conversation for both of you, but now this week feels as though ...</p> <p>M2: I think what it is, is it's lots of little steps. So we got to a really good point last week and that's very good. I think then this week, life kicked in and I've</p>	
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<p>B6</p>	<p>had an exhausting week on call, we've have a difficult session with the marriage guidance counselor yesterday and I'm just wiped ...</p> <p>I: Was that just starting? Was that a first visit?</p> <p>M2: No no no. We've been doing this now for about three weeks together. And I think probably I'm just more negative today because I'm exhausted. But pers... this happens, this is the cycle, you know. You go through days where you feel you can't get through another day. And then you have a good week. And then you put yourself together and you get on to the next phase. I still know C2 is, C2 is doing so well now. I mean, the way she was able to verbalize this morning how she's eating and what's not good about that and what needs to improve is fantastic.</p> <p>I: Why was it fantastic?</p>	<p>Hopeless and inadequate</p>
<p>B5</p>	<p>M2: Because she was able to say she could see that the way she's eating is not normal. um, that she needs some advice on how to move her diet from a point where she knows how to gain weight, she knows how to lose weight, she's told us that she doesn't know how to eat normally and she wants help to do that. So that was really good. I thought that was fantastic. She also explained how there are certain foods she'll eat <i>only</i> to gain weight, and she doesn't know how to integrate those into a normal diet. And there's other food that's <i>just</i> to lose weight. And the way she's stabilized her weight in the last few weeks is by undereating most of the time and overeating enough to get her weight to where, you know ... so she needs more advice on that. So we've known that's what's happening, but it was really good</p>	<p>Family rollercoaster of coping and falling apart</p>

<p>B5</p>	<p><i>she</i> was able to say it. So that's really reassuring and I should be in a really positive place, but I think maybe what I'm trying to say is this is exhausting. It's an exhausting process, um, but it is what it is. It is what it is. Ah, but the parents ... it is hard for parents because you have to ... you have to ... sort of ... mmmm ... what do you have to do? ... you have to ... know yourself ... keep learning about yourself... and keep going forward even though what you really need is a good holiday [laugh]. So that's what's hard.</p> <p>I: You sort of need to be on top of your game the whole time.</p> <p>M2: You do, you do. That's what I'm trying to say.</p> <p>I: That's what's exhausting.</p>	
<p>B1, B5, A4</p>	<p>M2: That's what I'm trying to say. And I think last week, I'd had more sleep and this week I haven't. And I think maybe the important thing to say is looking after yourself is so critical. And, um, perhaps ... I haven't had enough of that in the last week I definitely haven't. So the way I look after myself is I like a nice day in the spa. And sometimes I need a nice weekend in the spa, and that puts me back together again. And I can do another month. And I haven't had that for a while. So yeah, it's a very exhausting ... process. um, and I think caring for yourself is so important because then, then you can keep going. And also, when I am exhausted, I'm much more likely to get furious with C2.</p>	
<p>B1, B3, B5</p>	<p>I: Funny enough, I was just going to ask you about that.</p>	

<p>B6</p>	<p>M2: Yeah.</p> <p>I: Yes, so can you say a little bit more about that?</p> <p>M2: Yeah, so this morning, I got furious ...</p> <p>I: And just to link it to – okay, so I won't interrupt you ...</p> <p>M2: That's alright</p> <p>I: But is it fair to say... uhm, there's something you said earlier ... I lost my thread, yes. Sorry to interrupt.</p> <p>M2: So I'm much more likely to get furious, so what I'm, what's unfortunate about getting furious is the timing. I mean there are times when a parent can get cross and it's very appropriate. But unfortunately I got furious this morning – this happened twice now – and it was not the right time to get furious, because okay, she didn't get up and couldn't get up this morning, but this morning is more about anxiety about coming here than about "I'm just not getting up. I'm being lazy." We get normal teenage behavior as well, which is the "I can't be bothered so I'm staying here." Whereas this morning, I know it's about anxiety. So this morning is not the morning for me to get furious that she won't get up, because then we get into a vicious circle. And if I was less tired and had taken better care of myself recently, I would probably have stepped back and managed it better. But then, that's life, you know? We're, we're, we're all human beings and ... you know ...</p> <p>I: And is it bad to get furious because you feel bad or</p>	<p>Mum getting furious regularly (is this part of 'family rollercoaster'?)</p>
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<p>C5,</p>	<p>because C2 reacts badly or because D2 reacts badly or...?</p> <p>M2: Oh, I think the reason it wasn't good today is because it rebounds on me then, to be honest. Because C2 shook it off and by the time we got to the end of the session, she was having a good session with the dietician, which was great. But I was sitting there for the first half thinking "Oh, blow!" You know? Ah, I've blown it all out of the water this morning and we've all wasted our time coming here because we're all so cross that we're not benefitting from the session. um, so I get cross with myself. um, but...</p> <p>I: It leaves a hangover</p> <p>M2: [laughs] Yeah.</p> <p>I: And I now remember what I wanted to link it to. You said something about, you said it's a power thing, but ... just doing the ten minutes here ... something about being poked at and prodded and poked by anorexia.</p> <p>M2: Yeah, yeah.</p> <p>I: ... which shows you you're inadequate and crap, and hopeless. Is that what anorexia ...?</p>	<p>Guilt</p>
<p>C5</p>	<p>M2: Yes, oh yeah, that's such a good point. Cause the first thing I felt when C2 got anorexia was "Oh, you know, we've really mucked up as parents. That's why she's got anorexia." And even though, um, um, ... the first five or six week, I just ... D2 and I talked about that and we knew that idea wasn't helping us,</p>	<p>UNDERSTANDING AN is caused by our rubbish parenting</p>

so we just pushed it on one side and just got on with it.

I: Did you know that officially that thought is considered unhelpful or did you ...?

M2: Yeah, no. We, I read about that in a book. And it's a really ... there's no point in going there. But the trouble is, you see, you can put it on one side, but it niggles away at you and, um, ...

I: Like we talked about in the parent group?

M2: Yes, exactly! Exactly. And D2 and I had been able to use that in a constructive way to go and get some help, which I know is going to, is already better for us as a couple and as a family. D2 and I have come closer in the last week than we ... in a deeper way than we'd been for a long time. So that's *really* good. But of course, when everything goes wrong, you constantly – at least I do, you know, it's my personality – you constantly think “Oh, you know, I haven't got it together. I'm a rubbish parent, I ... you know.” And teenagers ...

I: And is there something about anorexia saying you're rubbish or do you think ...

M2: Ah!

I: Are you clear that is the anorexia communication or your interpretation? [30:40]

M2: Well, that's a good point. But what I noticed was: when the anorexia was really florid, out there at home, where that's all we were getting from C2, like

<p>C6, C7, B6</p>	<p>a very skilled teenager, she was able to push my buttons, cause her goal was to get me to lose my temper, cause then I lost authority. And I managed to overcome that. I used to see this little angry man running around in my head and then I'd flick him out of my head and I would just stay calm and, and say: "Now, this is what we're doing." Which is not a style, not a style of parenting I had used a lot before. I mean when C2 was very small, she became very very stubborn about once a month, and then we had to be very firm, sit her on the naughty step and all the rest. But in recent years she'd been a very goody two shoes child, particularly in the last year, and if anything too good, too biddable, too ... you know, compliant. So, getting tough with her was, was not easy. But once or twice in the early days, I lost my temper and I realized that just doesn't help anybody. So not allowing the anorexic C2 to push my buttons – and I can't even remember how she was doing it, but she was really good at it – how to just get over that so that I could be calm and centred. I think what's been difficult lately is D2 and I are pushing each other's buttons in a big way. Meaning to and trying to and trying to get to a better place and trying to do it with the counselor in a safe environment. But it is demoralizing and maybe we've bitten off more than we can chew, trying to do it all at the same time, but ...um, what's been interesting is that as D2 and I are being more honest with each other and with C2 about our relationship, she's felt confident enough to talk to us in a mature way about things <i>she's</i> not happy about at home. And that's been very good. So, you know, that's all good. I think we're doing the right thing, but it's very hard. Yeah.</p> <p>I: And no peace of mind? There's no kind of ...</p>	<p>Impact/Value</p> <p>More honest relationships</p>
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<p>C7 Overall for Getting Better Question RF8 (strongly situated in context of parenting)</p>	<p>M2: Well</p> <p>I: ... basically rest?</p> <p>M2: um, D2 copes really well by just switching out and pretending it's not happening. And he goes back to bottling it all up and that's very good for him, as long as he can come out of it when I need him to, which is not easy. um, and the way I cope is by being solitary and I meditate and I play the piano and I go ... and, and that works for me. And I'm trying to get back to a good place at least once a day. That's what keeps me going.</p> <p>I: And I'm curious about – we have to finish it like four minutes, but I have two questions. One is: I'm curious about how C2 perceived the fact that the attention isn't only on her. Because I do know from my experience that people with anorexia do, um, well, actually want to feel that ... that the problem is getting full attention. And I just wondered, in a funny way is making clear from the beginning of treatment “Do you know what? We're also getting some attention.”</p> <p>M2: Ah!</p> <p>I: And I just wondered if she's responding well to that?</p> <p>M2: I think she is, because – excuse me using this language, but – we could see the spoiled brat syndrome creeping in quite regularly. Ahm, and I know at the beginning, I certainly did some things that were probably not wise. You know, trying to ...</p>	<p>Spoiled brat syndrome</p> <p>Pandering</p>
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B5, C7

trying to make her feel better rather than somehow allowing ... you know, trying to bring something good into her life, trying to give her something to feel happy about, trying... I remember taking her out and buying her a Pandora bracelet with a little dragonfly on it, which is the symbol for recovering fr ... apparently, she told me it's the symbol for breaking free from anorexia.

I: Really? I didn't know about that.

M2: Yeah, apparently. And I remember buying her this bracelet, the first ... she said to me, I, you know, I, this ... it was the first time we'd spoken about her wanting to get better. And I mean we rushed out to the shop and we bought the Pandora bracelet and the dragonfly and I ... you know, and maybe there was nothing wrong with that, but it was just too much of that. And there was a point where I found myself cooking everything and anything, you know, it was just my whole [?] was anything to make C2 feel better. And it wasn't helping. And we were getting spoiled brat syndrome kicking in really quickly. And I thought "My goodness, before we know where we are, C2 will be ruling the world."

I: Yeah, I find that interesting. It's an interesting observation. And what do you think will help to, well it's not promote change because she's already changing and everything is changing, but to support positive change? That's the last question.

M2: Yeah. Mhm. Well, I suppose there is the practical stuff and then there's the more difficult stuff. So one of the practical things we're doing is we're, we rush around a lot and eat a lot of meals out, and

	<p>things. And we're eating at home six days a week and we're eating at the table at least every second night, and we're cooking a much ... we've become foodies. I mean food to me has always just been a bloody nuisance. Whereas – certainly in recent years anyway – it's just something we have to do. Whereas we're all taking, D2 and I are taking more interest in food and are trying to make sure we have a variety of evening meals which are, that are pleasant to eat and that eating is pleasant, and that we don't talk about anything stressing at the dinner table. And that's probably the most important practical thing we've got to do right now. Apart from C2 having a strict framework about 'she must get up, she must go to school.' It's not negotiable, she just does it. Um, but in terms of everything else, I think for D2 and me and C2, we're all trying to be honest and we're trying to be authentic and we're trying to find ways of bringing prickly subjects, you know, to the table – not when we're eating, but to the table at least once a week. So we air the stuff that's not nice, and we find ways within the family of, of, of living in a, you know, more authentic, more honest, but also more respectful way at home. I think that's going to be very helpful as well.</p> <p>I: Well, let's finish there, but thank you very much.</p> <p>M2:</p>	<p>Key theme – family will get better, more honest, more open</p>
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Appendix 5b

RF in red	Data	IPA in blue
	<p><u>D10 (1) [22.07.14]</u></p> <p>I: So basically I've just got four questions, now these are research questions so this doesn't in any way go back to your treatment team here, your family therapists-</p> <p>D10: Er [names]</p> <p>I: Yeah, so I won't be putting anything to them unless, unless you want me to or unless there's some clinical concern when I have to follow ethics procedures anyway- but erm, you know you're being looked after by them. So just take it as this confidential space. But sometimes it happens that something comes up and I say well haven't you told your treatment team that and you say: 'no', and I encourage you to. So to-</p> <p>D10: Well-</p> <p>I: Make clear that it is a separate interview, separate process. And that I just have four basic questions, but when we talk around them more and elaborate them. And the first one is how do you understand your daughter's eating disorder as it is at the moment? That's a big open question.</p> <p>D10: That's a big question (laughs)</p> <p>I: Yep, well it's intended to be because the whole purpose is-</p> <p>D10: Yeah absolutely</p> <p>I: What kind of sense do you make of it-</p>	

	<p>D10: Er yeah-</p> <p>I: And then the second question one is how does your child's eating disorder impact your life?</p> <p>D10: Uh-hm</p> <p>I: And there are lots of sub-sections one can look at</p> <p>D10: Yup</p> <p>I: I prompt you if, you know, I need to-</p> <p>D10 Yep</p>	
	<p>I: And then there's do you think that there's anything that your daughter values about the eating disorder? And if anything good has come out of it for yourself? And then, and that's a biased sort of weighted question because we know that good things- people, we know that good things do come out of it, or, that the child values it. So that's why it's asked in that way. And then the fourth question is what do you think's needed now for your child to get better?</p> <p>D10: hm</p> <p>I: But usually they just come around-</p> <p>D10: Yeah, yeah</p> <p>I: We'll start with the big one and then usually they just sort of- I'll keep us on track</p> <p>D10: Then they just sort of blend into each other and things like that-</p>	

	<p>I: Yeah... So how do you understand your daughter's eating disorder as it is at the moment? How do you make sense of it?</p> <p>D10: Erm...</p> <p>I: What sense does it make?</p> <p>D10: It's- it doesn't make a lot- a lot of sense. I mean the whole behaviour that it is, you know, refusing to eat or not wanting to eat... Erm, you know, you'd think survival instinct would kick in at some point or hunger even... But erm I asked A this when A went through it, because obviously, this isn't about A this is about O but A went through it, not as severe a case I don't think as- as O but-</p> <p>I: Well it's fine for you to bring it in, because she's part of it-</p> <p>D10: Yeah er-</p> <p>I: and your understanding therefore-</p> <p>D10: Yeah and I asked, I asked her about it and I said: 'you know, don't- don't you get incredibly hungry? And I know from my own experience that I would just</p>	<p>UNDERSTANDING "it doesn't make a lot of sense"</p>
<p>Explicitly saying I can't mentalize but</p>	<p>absolutely be starving and I would just eat.' And she said: 'you- you know, you just get used to it.' You- she starved herself for a bit and I guess her stomach got smaller and she got used to that and then, and then I'm guessing that the overriding power, or to have this voice inside their head, that says, you know, 'just don't eat any food'. And, it's- it's hard. It's very hard to understand that as someone, you know, I love my food um, I'm a very healthy eater I think. Um...</p>	

<p>it's a form of trying – or is it? Or is it dismissing meaning?</p>	<p>I: So if you have to imagine being hungry and saying to yourself: 'well i'm not going to eat...'</p> <p>D10: Yeah</p> <p>I: That makes no sense.</p>	
<p>Brain malfunction</p>	<p>D10: It- it doesn't... It just- it doesn't... I mean I, so the way I see it is yes there's something in her brain that, either it's a biochemical imbalance or just the way that she's wired up and is thinking at the moment, that is just completely telling her you must not eat. If you do eat, you know, I don't know what will happen but something will happen that's bad. Erm... Yeah so, there's just... Something wrong in her brain and in her head. In her thought processes. Um, that's taking her- taking her down-</p>	<p>UNDERSTANDING 2 Something wrong in her brain and thought processes</p>
<p>I probe for Mz</p>	<p>I: Ok so, so shall we look a bit closer at that so that's sort of step one; there's something wrong in her thought processes. So what, what's wrong in her thought processes? In your answer?</p> <p>D10: Erm...</p> <p>I: From what you know-</p>	<p>I invite elaboration</p>
<p>Descriptive detail – not MS</p>	<p>D10: It's a complete rejection of, well, first of all she's restrictive of food. And then, she was just on the insures, and then somebody came in, a dietitian, when she was in Harlow Hospital erm, admitted into Dolphin Ward. Erm... She was drinking insure and then the dietitian and said: 'well look we haven't got insure, we've got these other supplements'. So then she said: 'oh right, so now they're like food. There's all these different types of food, different types of supplement- which are like different types of food.' And so then she started rejecting, just drinking all the</p>	<p>Descriptive detail</p>

	Ensures. And drinking the supplements. So then it was a struggle with	
<p>Does this mean something to D10?</p> <p>No MS thinking, repeating what he's been told</p>	<p>that, and then after that it's been- ended up a few days later having to stick the nd tube in... Erm, and then she's- she's been on that. And we're, you know, we're giving the food, you know, we're giving the supplement ok and the weight's going- So that's the thing, I mean, the weight has sort of come back on. Erm, and it's kind of- it has improved some aspects of her thinking so, something that's sort of severe depression i think has lifted a little bit. Erm, and she does allow herself to laugh. She still, sort of, gets a little anxious if people see her laughing. Erm, but still now the objection erm, to eating anything, any food- even supplement going into her mouth now.... Is- is er, that's- that's just still there and that's not recovering at all. Even though, yeah weight seems to be going back now, and absolutely fine-</p> <p>I: So to pin you down, that's not at all becoming a refusal to eat and thought processes- can I get you back to that?</p> <p>D10: Uh-hm</p> <p>I: What is it about- what do you think it is about, her thought processes that-</p> <p>D10: Um...</p> <p>I: Stops her from eating?</p> <p>D10: Yeah, it... There must be a thought in there or bad- I mean, she was always, early on, talking about the bad thoughts and that's, you know, voices screaming at her. I don't know whether it's from out- whether she could hear them as outside voices or I thi- I think she actually said that they were within her head. Within her own mind. Erm,</p>	<p>Mentions depression</p> <p>?UNDERSTANDING 3 Repeats what C10 has told them</p>

	<p>and these voices' sort of screaming at her. Telling her that if she eats anything, that's a- that's a bad thing. And it's- it's never, well it didn't seem to be too much about the actual body image with O. You know usually I think with girls it's um, with anorexics, it's about wanting a, you know, to be incredibly slim er, painfully slim. Erm, but with O and it's only been recently actually, within the last couple of weeks where she's, maybe a bit longer than that, where she's actually starting to get a bit worried about her belly looking a bit fatter because of the, the weight's coming back on. Erm, and I guess she's seeing it that- when she sort of bends over, but everybody's belly does sort of, you know,</p>	
	<p>bulge out a little bit but maybe she's noticing that more. Erm, but it's never been that strong I don't think about the body image. It's just been some sort of, thoughts about food is bad, food is bad for you. Erm, if you eat it something bad will happen. And I don't know what the something bad will happen- actually is. Or whether it's-</p> <p>I: So sometimes-</p> <p>D10: Whether it's, if the bad thing that will happen is just that the voices will scream at you even more that you shouldn't have done that.</p> <p>I: So when you said thought processes you're including the voices, sort of, in the internal voices.</p> <p>D10: Er yes. Yeah.</p> <p>I: And you don't mean voice in the sense of psychotic experience, this is separate from- you mean part of her.</p> <p>D10: (Exhales loudly)... I don't know. I don't know if early on it was... It was er, psychotic. Or even is psychotic...</p>	<p>Has listened to his daughter but added no thoughts of his own</p> <p>UNDERSTANDING</p>

	<p>Erm... I mean some of it could be a magnification of itself. She's always been very, quite difficult at times. Some of her behaviour, tantrums and- and trying to- oppositional behaviour, so not doing what we've- what we want her to do. And she seems to be displaying that to the absolute extreme now. I mean, we're just asking her to put a spoon in a cup and she will not do it. You know, even after two or three hours of just telling her to do it. Erm... (Sighs). So um I've just... Yeah I don't know how much, how much of it is just herself, or the voices- are they just an extension of her own thoughts or? I don't know, what's the definition of psychotic?</p> <p>I: It doesn't really matter but I was wondering if you thought it was, sort of, some kind of mental illness or some part of her personality I suppose would be a different way to put it</p> <p>D10: Er, I- I... I mean yeah, I think, I think... I completely think it's a mental illness.</p> <p>I: You do</p> <p>D10: Yeah, yeah. And I've-</p>	<p>4</p> <p>Seeing it in terms of extension of C10's pre-existing oppositional and difficult character/behaviour</p>
	<p>I: So that's what you mean by wrong thought processes really, is the mental illness?</p> <p>D10: Yeah, yeah.</p> <p>I: And, um... Er wait I had a question in my head related to that... Building on, you know, because what we're doing is working around 'how do you understand it?' And you've said quite a lot of things. So if you- and now you've started talking about oppositional behaviour, so, and that that was there before she got an eating disorder-</p>	

<p>“Incredibly selfish” – suggestive of emotional honesty but not thinking, opposite blame character</p>	<p>D10: Hmm</p> <p>I: So do you see, do you see this as part of oppositional behaviour?</p> <p>D10: I mean yeah, whether it's just part a... A complete magnification of- of behaviour that's always been there with O... Um... I mean I can't imagine it; it's like that for all of the cases. I mean there's probably cases where it's complete bolts of the blue but with O we had the earlier sort of period where she had this funny, odd thing where she had a fever for a couple of days and then she couldn't walk. And there was no sort of medical reason, you know, they did all of the sort of tests and scans and couldn't find anything medically to explain it erm... And at the time there's this called mycoplasma infection that was picked up in one of the tests and it was a possible, you know, maybe it might be a mycoplasma infection in the brain that set it off. Erm, but still why she stopped, or kept not walking for another year erm... And maybe that was, was a sort of earlier incarnation I suppose of- of this kind of behaviour. And then she got better from that and, and a year- just over a year later, she's doing something else. Which is another, erm, sort of very selfish type disease, or illness. Erm, and it's incredibly selfish.... Er...</p> <p>I: So let's bravely go down the route of selfish because, I suppose, oppositional and selfish might not be the same thing. Oppositional is about not wanting to do what your parents want isn't it-</p> <p>D10: Uh-hm</p> <p>I: to some extent and now you're saying selfish. So if we see these as linked, what do you think about that</p>	<p>UNDERSTANDING 5</p> <p>Trying now to synthesise knowledge of child's pre-existing character with illness, illness triggering behaviour</p> <p>IMPACT 1</p> <p>Selfish, incredibly selfish</p>
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	<p>I: So now that's moved to how does it impact your life. You're looking a bit sort of, as you sit there, thinking life is a bit incredulous</p> <p>D10: Erm... Yeah it's sort of obviously yeah it's very disrupting erm... I mean the major, well the, I mean there's the, there's this Tuesday so I'm having to take obviously a day off work every week. But that's fine, work -work is ok with that. They're um... Kind of flexible-</p>	<p>IMPACT Time off work</p>
	<p>I: What is your work?</p> <p>D10: I'm er, I'm a scientist, research scientist. So I work for a company, erm, we make machines that sequence DNA so er... I do that. And we're doing very well and it's a very big company now, it started as a small but we've grown very big so... So they can, they can, you know, handle- take the slack. Erm, and handle me being away for a day a week that's absolutely no problem. Er, so I've cleared it with them. Er, um but that's still- that's still disruptive as to, you know, if you're not- yeah clearly my work output isn't going to be as high as it was. Erm...</p> <p>I: And do you worry that they'll get fed up and you'll be surpassed? You know, that you won't build the career-</p> <p>D10: Yeah, they probably- yeah, yeah in the end yeah. Erm, you know, if it keeps going on for six months or twelve months, that kind of time, then yeah. It's- I'm going to have to think about whether I can still come to this every Tuesday. But then there's the the the the life at home, you know, if we're not sitting there whilst she's being fed because, you know, if you're not in the room she's going to press the buttons and not feed. Er, if we're not that we're doing the snack time, erm, which we did start out we were</p>	<p>IMPACT Worry about career impact</p> <p>IMPACT Home life- time spent feeding C10 and neglecting other daughters, loss of</p>

	<p>just doing fifteen minutes each time. But then that wasn't really getting us anywhere so this last week we've just been sort of doing it until she's done something. Erm, and that can go on for two or three hours so obviously that's taking up a lot of time during the day. Er and then you're just thinking, when you're sat there doing all of that stuff and you've got the other two daughters who, you know, you're not able to do stuff with. So it's- it's disruptive on the relationship with them. Er, as well and we've had also M10 well she's back in our bedroom now but she was sleeping on our floor with O to stop her- because were kind of almost on suicide watch in our house. Erm, so that's pretty disruptive as well so. M10 was falling asleep on the floor in that room so if she woke up in the night she'd wake M10 up we also had obstacles outside the room so if she got through the door she'd trip over those or make a noise anyway. And then downstairs um jamming the kitchen door each night so that she can't get into the kitchen door and she has to go through the lounge which is a very loud door so I'd wake up. So, and we're moving knives out the way, and chemicals and- or bleaches and whatever had been hidden away.</p>	<p>wife to 'suicide watch'</p>
	<p>Erm... It's er... Yeah it- it pretty much takes over. I'm still getting out to do a job four days a week. Erm...</p> <p>I: And do you feel relieved and... Sort of -</p> <p>D10: (Laughs) It feels to get out yeah. The job is er a bit of a break from the home life really, yeah.</p> <p>I: Well it sounds as if the home life is all focused around O and it's grim. Is that, is that true?</p> <p>D10: Yeah, yeah. Yeah.</p> <p>I: So how does it affect your relationship with M10 if you're</p>	

	<p>willing to talk about that, not everybody is, but I ask-</p> <p>D10: It's- it's actually... I shouldn't really... It actually may have strengthened it a little bit to be honest. Because we're both having to sort of rally round and deal with this. Erm... Yeah probably feel- well we're both going through the absolute, you know, this is going through hell and back. Erm, and it's something that we're sharing. Erm, she's unfortunately having to do, you know, you know, 80-90% of it because she's there back with O during the day. Erm...</p> <p>I: And O hasn't been at school for a while has she. Remind me-</p> <p>D10: No yeah she's completely out of school-</p> <p>I: Yeah. Really so it's just her and M10 at home all day long-</p> <p>D10: Yep. Yep. Erm, which is... Yeah that's hard. It's getting slightly easier because she's starting to do- she's allowing herself to do a few more things. Like she does twenty minutes of something nice, er, or something like Minecraft or [Louvans?] or whatever. Erm, she's- she's doing that and she will also actually also pick up leaflets or pamphlets and she'll read and even the paper the other day. She will start to do stuff that doesn't count towards her twenty minutes but she will do it. And YouTube she watches videos on those. Erm, so she's at least doing some more stuff now so it's not just sat in a room with O doing nothing all day.</p> <p>I: So how does it affect family life? The other girls are older and younger is that right?</p>	<p>IMPACT /VALUE</p> <p>Relationship with wife improved</p>
	<p>D10: Er yeah she's the middle one. A's older and S's</p>	

<p>B1 for [older sister]</p>	<p>younger. We've got two and a bit years between each of them. Erm...</p> <p>I: So what? 9, 11 and 13?</p> <p>D10: Er 14, 11 and er yeah just turned 9. Yeah. Erm... Yeah...</p> <p>I: And their relationships with each other and your relationships with them? You know-</p> <p>D10: Yeah I mean S's been great. She's sort of tried to help out a few times with the taking of the snacks. She'll sit across the table from her and- but she hasn't been doing that, and I think the last few weeks when she really started screaming at us or a few weeks ago when she really started screaming and things the S sort of cleared off out of there as well. Because it um, can hurt your ears after a while. And well it's just not nice to see that. Erm... And she'll come and give you a little hug. When you tell her to.</p> <p>I: S?</p> <p>D10: Yeah. Er A is probably a bit more distant, doesn't want so much to do with it- anything to do with it. Because, I mean, she's been through it herself so... Erm... Maybe she doesn't want to be reminded. Unfortunately, it's sort of a constant reminder because, you know, she's sort of there with her tube in being fed at snack time or... Yeah it's got to be hard for... A recovered anorexic to be reminded.</p> <p>I: Well what would do you observe? I mean, do you- do you know it's got to be-</p> <p>D10: A. just sort of goes up off into her room and listens to her music. Or, she'll sit in the other- we've got kind of erm,</p>	
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	<p>two reception rooms basically. A back sitting room- a back reception room and a front reception room and O sort of spends most of her time in the front one and the other two are in the back watching telly so O won't watch telly at all so... So she won't let herself be in that room. So she's stays in the- in the front room.</p> <p>I: So are you losing the contact with S. and A. or do you seek them out? How do you divide up the attention?</p>	
	<p>D10: We try and I mean, we still take S to gymnastics and... Everything she does; Brownies, and so- so still be a taxi service to her. Erm... But yeah there's certainly long periods where she's just- we know, you know, she's watching little videos about Minecraft on her iPod and erm... Unfortunately she's doing that a lot. Er...</p> <p>I: Who?</p> <p>D10: S. At the moment. So she's- sort of, just doing that a lot. Which could be time spent doing other things. Erm... Yea, I mean A's probably getting to the age anyway - 14- when she probably wants to do things on her own anyway. And she'll go and, erm, we know it's summer holidays as well so it's a case of... She's having to find stuff to do to- but she'll just go out with her friends downtown and that kind of thing-</p> <p>I: Uh-hm</p> <p>D10: So... Erm... But, then again, family days out and stuff. They've stopped.</p> <p>I: Did you have family days out?</p> <p>D10: Yeah, we'd go out to the local- there's Hatfield Forest near us, that's quite nice. We'd go out up there or we'd go</p>	<p>IMPACT up to here – elaboration on neglect of other two daughters</p>

	<p>down to London-</p> <p>I: Did they always work well? Or were they all difficult?</p> <p>D10: Er...</p> <p>I: I'm just thinking that you've said that O had difficult behaviour before.</p> <p>D10: Yeah. Yeah. I mean it'd be difficult getting her out the door and things. There might've been a fight getting her out of the door, but then when we were out it was- it was... Yeah, we had good days out. Yeah but it could be a fight around getting out of the door. Getting her changed and getting the right pair of shoes on or something. Erm, but then we'd have -we'd have a nice day out after that. You know, we'd go down to Southbank or whatever and walk along there. Yeah, we used to have- we used to have good days out. That was part of the what A promised to herself when she was trying to recover from anorexia. You know, it was, you know, at least when we recover we'll have nice family</p>	
<p>Implicit empathising with [older sister] – could be identification, projection too Reaching for RF?</p>	<p>days out and er... (Laughs) That's- that's now not happening because O is the way that she is so you know. Yeah.</p> <p>I: How does it affect your family social life then? You know, er... Extended family like parents and friends and-</p> <p>D10: Erm...</p> <p>I: Does it interfere? Have you become more isolated or not?</p> <p>D10: Er...</p> <p>I: As a family.</p>	

	<p>D10: We've had like my parents have actually been down a couple of times to help out so-</p> <p>I: Where do they come from?</p> <p>D10: Erm... They leave near G at the moment so it's just a hundred miles north or something. Erm, and er, and they've been down a couple of times and stayed during the week. So to sort of cover taking S to school and things like that so... So, yeah so they've been down and I mean they probably wouldn't have normally stayed that long. Erm, so that's actually probably- well brought us a little bit closer. Er to them. Well i mean we'd have probably been up there to visit them... Er during this time. Erm, rather than them coming down to us twice. But we don't, you know, we- we- that's sort of the frequency that we'd see them anyway a sort of once every couple of months, probably once every three months anyway. Erm, and to be honest it's not been going on all that long with O, you know, it's been since about Easter time maybe. So, er what else? So yeah so the family holiday that's coming up, I mean, that now looks like it's just going to be me A and S going over to Marbella and we're sharing a villa with erm my sister and her family. So there's three kids there, and my brother in law. Erm, so that's obviously really-</p> <p>I: And why is it going to be broken up this year?</p> <p>D10: Er because-</p> <p>I: I mean I understand that she has anorexia but why have you decided that she can't come?</p>	
	<p>D10: Yeah we just don't think- we just think the risk, I mean, obviously that story that came out in the family</p>	

<p>I probe for MS</p>	<p>meeting, I mean that's amazing. I just- I just can't see that happening with O. She's so dead set in not eating at all and not wanting to recover. Er, and just the risks involved in taking somebody with an nd tube over there. Erm... I don't- I don't know, I think it's- it's too risky... I don't think- I don't think we can handle it. I don't think that we can do it. So M10's going to stay at home with her.</p> <p>I: How do you feel about that?</p> <p>D10: Er it's- it's- yeah it took me a while to come to terms with that actually. Because I thought, you know, M10's having to stay with her during the days when I go to work as well but during, you know, the school days she's been staying with her and now she doesn't get to go on holiday either. She'll-, you know, her holiday is now going to be spent looking after O. Erm, I mean she's probably going to end up going and staying with my mum and dad during that time. Erm... But the whole thing is taking her abroad with an nd tube. Can you do that? I don't even know...</p> <p>I: But it's not her weight that's-</p> <p>D10: I know yeah</p> <p>I:- That's high risk at all is it? Really-</p> <p>D10: No, no.</p> <p>I: I think the key is that you said that you don't think you can handle it. That's what you're thinking about.</p> <p>D10: (Long sigh)</p> <p>I: But just to be a bit devil's advocate why would it have to be M10's stay home? Why not mix it up and you stay at</p>	
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<p>thinking re. M10</p> <p>B1</p>	<p>home and she go on holiday?</p> <p>D10: No, it could be me staying home. Yeah. It could be, I don't think she'll agree to that. I think she wants to- she probably feels that she should be the one that stays at home.</p> <p>I: Do you know why she feels like that?</p> <p>D10: Erm... She probably thinks that- well she might not trust me to look after O for that long on my own.</p> <p>I: Well would you?</p> <p>D10: Er... Erm, I think I could. I think I could- I don't actually, I don't know (laughs). Erm, I don't know if I would trust me to look after O for ten days.</p> <p>I: And do you think that your roles are very different then? I'm just wondering if you feel something like, and this is- you haven't said this so I may be going a bit far, but something like: you're a bit peripheral to this whole process going on at home.</p>	<p>I am pushing –</p>
<p>B1 self</p>	<p>D10: Uh-hm</p> <p>I: And i'm not saying that you are, I'm saying is that how you feel?</p> <p>D10: Er, I don't think I can- I'm not particularly good at emotional support and emotional... Erm... Yeah, I'm not- I'm just not- I mean, yeah she gives much better, I think, sort of emotional support, erm, to O. I'm very much a kind of, sort of, nuts and bolts of just doing things like, you know, I'm put there to sit there with her for an hour or two and just sort of try and get her to eat. To get her to put that spoon in the cup. Erm, but... Yeah, you know, M10 is just</p>	

<p>B1 of self</p>	<p>much better at- at the whole kind of trying to understand exactly what she's thinking and coming up with, you know, why aren't you eating? Is it because of this? Is it because of this? And, I- I'm just not as good at that. <u>I'm, unfortunately I'm, well we've said I'm just this emotional sort of flat line where I don't really get extremes of emotion.</u> And I think M10 does, and I'm also um absolutely no good, <u>I don't think anyway, at understanding how other people feel at particular times.</u> Erm... Yeah I'm just not very good at that kind of thing. Erm, so I'd probably be ok for ten days, you know, putting the feeds in, erm, and certainly I mean when you're there that's one thing. A couple of weekends, you know, I've been left alone on the Saturday I think it was with her. And it completely slipped my mind to sort of start to feed her at the right time. So she was an hour late in- in one feed putting in. Erm, but it's- that's just because you're not into the routine of it. Whereas if I was left on my own for ten days with her, erm you know, pretty soon you'd get into the routine and I could do it. So I could do the getting the feed in, getting the snack times, or trying to attempt the snack times with her. Erm, I could do that for ten days but I don't think during those ten days she wouldn't sort of progress any- you know, sort of on the road to, kind of, getting her head right or getting her thoughts right because I wouldn't be able to put in that kind of, input. I mean all I can do with her I can make her laugh, and I can- I mean that's great and I love doing that. She's got a great sense of humour. Erm, I've got a very similar sense of humour. We'll crack up about things. So I'm good at that but, there's this whole other thing that I'm not very good at.</p>	<p>IMPACT Out of my depth in the role of therapeutic parent</p>
	<p>I: So, we're moving on to the question about do you think that there's anything that O values about the eating disorder? And you yourself, is there anything good that's come out of it? You have said a few things but I won't prompt you too much- what do you think?</p>	

<p>C7 attempt here</p>	<p>D10: And why does she need to feel more special?</p> <p>I: Well, the question was: is there anything that she values about it? And you've come through she gets ridiculous amounts of attention, and control, and then you were thinking whether she needed that.</p> <p>D10: Yeah... Why does she need that? Did we not give her enough when she was growing up? Is it because she's got two other sibling? Is it a big competition? Erm...</p> <p>I: Well what makes sense to you if- if...</p> <p>D10: Well the thing- yeah, the... The sibling rivalry makes sense to me but, it is so-</p> <p>I: Is that because you've experienced it yourself? Or because it's commonplace or-</p> <p>D10: Well-</p> <p>I: You've seen it in your-</p>	
<p>MS thinking of a sort but one would need to develop the idea about</p>	<p>D10: Er... Nah, I haven't seen it my own- because I had two older sisters who were eight and five years older than me. Erm, and we were- yeah we used to- certainly with the-not with the older sister, but with the younger sister I used to fight. A lot. So, that kind of- but never a physical kind of fighting. Erm... Er, yeah but that settled down when I was about twelve years old of course. Er so sibling rivalry? Could be a... Or she's just got this- this innate... Thinking in her head... That just wants the attention. Even though her sisters aren't getting much attention and she is, she just wants more and more and more and won't stop. Until she's got everything... Yeah.</p>	<p>UNDERSTANDING again – it's her character and brain and it's selfish</p>

<p>why someone would want to take everything</p>	<p>I: So that would be the value for her- getting everything?</p> <p>D10: Yeah</p> <p>I:And what about for you and M10 were there- if anything good's come our of it.</p> <p>D10: Erm, as I said earlier there's this sort of slight, you know, (laughs) we're both going through hell and there's that sort of strengthening-</p> <p>I: So can you say a bit more about that. I- I need to-</p> <p>D10: It's... Yeah it's just that you both have to- both have to get together and, you know, come up with plans about who's going to, you know, who's going where on each day and- and who's, you know. And the fact that we're having to get into a car together and plan our route or get on route and navigate our way into central London and back out again. Erm, you know, we're doing all of that together. Er and we're actually spending yeah- more time together even if you count the snack times which are horrible but we're doing them together erm... So we're probably spending even more time together-</p> <p>I: Do you you used to-</p> <p>D10: Hm?</p> <p>I: But- but with O there the whole time?</p> <p>D10: Yeah O is there the whole time. So yeah, we're probably spending less time together on our own. Especially now- now she's sleeping in the same bedroom as us, she's in the corner of the bedroom on a- on a</p>	<p>VALUE</p> <p>More couple time – sort of</p>
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	<p>mattress. Erm, but at least we are now in the same bed, whereas she was- M10 was sleeping on her bedroom floor.</p> <p>I: Right</p>	
	<p>D10: For a- that was a couple of months I think it was that she was there but now we're back all in the same bedroom but we've still got O there. Erm... Yeah no there's just, you know, this feeling that you're going through hell together er and you're having to do all these things and plan all these things and- and trying to work out how we're going forward. Or how we're going to get forward. And er talking about all the things that are happening in the sessions so when M10 comes in with O on a Thursday then she'll come back and say, you know, what's been going then then. So, it's probably actually more communication going on between us two, and more time spent together albeit with O in between us. Er than was going on before. Time. More time spent together. Doing something that's pretty extreme. You know, I don't think- I wouldn't wish it on anybody. Absolutely wouldn't wish it on anybody else at all. Erm, but there's something to-</p> <p>I: you have been doing it a bit long haven't you because she had her previous disordering-</p> <p>D10: She had the previous- yeah. Yeah.</p> <p>I: Was it similar then that you did things together?</p> <p>D10: Erm, it was probably not as much. Er she wasn't as bad- even though she wasn't walking. But she's quite happy to sort of pull herself round. The thing that- the thing is- it didn't have as big an effect I don't think at home. Erm, and for O as well she was still eating. We hadn't even considered not eating. Erm, but she was (coughs) pulling</p>	

	<p>herself around on her arms, she was perfectly happy with that. Then she got crutches. Er, then she got a wheelchair, and she's- well no, she got a wheelchair first and then she got crutches. And she was absolutely fine just pegging herself around on these crutches; swinging her legs through and she got really fast with it. So. And we still went out for days out with the family then. Because she was so fast on her crutches. She was an absolute- she was absolutely fine. And that's the thing- she'd have been happy to stay on those crutches probably for the rest of her life. And it seems to be the same thing now with the eating disorder. She'd be happy- she'd be absolutely happy to have that tube in her nose.</p>	<p>UNDERSTANDING her character</p>
	<p>I: So going back to that-let's just go back to- because that was- it's directly related to the question 'how do you understand the eating disorder'. If you think she'd be happy to be on crutches for the rest of her life, or happy to have the tube and have an eating disorder for the rest of her life, how do you understand that?</p> <p>D10: Erm</p> <p>I: Why would she be happy to be- erm, what's the word? Sort of debilitated almost-</p> <p>D10: Yeah... I don't know because it's just- it's like throwing your- throwing your life away. There's- it'll be... You know, she'd have such opportunities if she got better. Erm, and there's so much she could do and she's just choosing not to do that at all. And, it's very hard- I can't- you know I can't understand why you've got all these opportunities why you would throw them away? Other than, yeah you're trying to get something out of us... But that something's not going to be great, you know, it's going</p>	

<p>C7/B1 Trying to synthesize attention seeking from parents and identity seeking as motivation for stuckness</p>	<p>to be a life of being fed through a tube or- not having the tube. You know, that's not going to happen because there's no medical reason, not going to put a tube into your stomach... Anyway, it's... It really doesn't make- it doesn't make much sense to me other than it's extreme attention seeking behaviour, erm... But we've given her plenty of- I mean why she's- I don't know why she's doing it... Other than she's got an innate- that is what, who she is... And the thing is if that's who she is, that's what she wants to do... How do you um, how do you reverse that? Erm... Yeah.</p> <p>I: So that leads us directly to the last question which is what do you think's needed now for her to get better?</p>	
	<p>D10: Er...I... Erm... I do not know but we're happy to try anything. I mean, I'm quite- I don't know about with medication, any sort of medication? Couldn't sort of help clear her thoughts? Or stop the thought processes that are telling her not to, definitely not to eat. Or, you just wait for, you know, something like [other child]</p> <p>experienced or something like the others experienced before. Where you've got their- they just start eating again. Does that just happen? And we'll just have to wait for that time. Erm... And- and- we can- we can just up to that time we just have to- we just have to support her as best we can. Erm... And we, you know, we have these goals each week and- and the behavioural goals they're going fine and she's letting herself do stuff and she's laughing more. That's fine. Just the eating thing at the moment and- maybe it's that she has to get up to 100% wherever this value is. But, erm, and we certainly seem to be out of the</p>	

<p>Is this any sort of thinking? MS It could be bluntly so</p>	<p>danger area where she is, you know, critically underweight. And- and- she's heading in the right direction definitely with the tube. And whether at some point suddenly her mind clears? But I just feel with O that it's... She'd just keep on thinking this way... Also it's sheer bloody mindedness which is something my dad would come up with! But er, it just seems like it's just: 'I'm going to choose to think this way.' And then maybe that needs to be reversed by some medication but I don't- I don't know and then you just think that she needs to be on medication for the rest of her life.</p> <p>I: So if you are- you are diagnosing 'sheer bloody mindedness', how does one treat 'sheer bloody mindedness' in people who have it but in who it doesn't manifest in as an eating disorder? How do you treat 'sheer bloody mindedness' in other people?</p> <p>D10: Erm...</p> <p>I: I'm just scaffolding the question- the question of how- what do you think is needed for her to get better.</p>	
<p>Trying to Mz</p>	<p>D10: I don't know- I don't know if just talking with her or talking at her is going to do- do anything. Erm, because you can sit there for two to three hours telling her to do something and she just won't do it. Erm... Er... But then maybe- if we just wait she'll come round. Maybe if we put enough consequences in front of her so that you know, she doesn't do this that and the other. Er, that's the thing with O, the consequences at the moment she's gone so- you know, she's not in school. Erm, that she won't do it for any rewards. You know, we've offered to raise money for charity, she won't do it. That absolutely went the wrong way. She didn't want- she didn't want to raise anything for anybody. Erm, there's just nothing you can say that has any- I mean the only thing that we had earlier on which</p>	

<p>My interpretation based on interview with M10: C10 is showing her individuality by absolutely opposing mum's self-sacrificial character. D10 is able to name it behaviourally but not link it to family culture (raise things for charity for her to get better?)</p>	<p>was that she's not going to see her friend who she saw from the physiotherapy because she didn't put the spoon in the cup earlier. That's one thing. Erm, but that still didn't make her put the spoon in the cup. Erm, it's just something that's happened. And erm maybe, you know, not going on holiday is a consequence of not wanting to eat but she's completely realised that she's not going to be in a fit state to go on holiday for- for months so. For weeks. Erm, yeah and because she restricted she wasn't playing the games or watching telly or doing anything nice. There's no consequence, you know, couldn't say 'right you're not going to be doing this if you don't eat'. So (sighs). Yeah. Yeah at the moment I just don't know. I don't know. Other than just waiting and hoping something changes. With her.</p> <p>I: Hm</p> <p>D10: At the moment that's all.</p> <p>I: So that's where we end up waiting and hoping.</p> <p>D10: Yeah.</p> <p>I: Is there anything else you think your treatment team could be doing? Or any firm could be doing? That you haven't had.</p> <p>D10: (long pause). Well I mean we haven't even- even... I mean started on some medication, but then this little result sort of came through and we had to stop. But I don't- I don't even know now. Because I mean the one we've been prescribed at the moment is n anti-depressant. Um, I think it maybe had anti-anxiety associations with it as well but, it it's- I don't know because the behaviour isn't- is not as depressed. Erm, you know, holding her sort of upright, laughing more. I- So that's kind of got better. We're just left</p>	
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	<p>with this one thing. Just the outing bit. Erm... And, you know, I don't, you know- there isn't a drug to just check that off. So it was great, you know, definitely take it. Erm, so I don't- yeah. I don't know if medication is- is right now.</p>	
	<p>I: Well you might want to try it. See if there's anything that you might want to try.</p> <p>D10: Might want to try it yeah, yeah. See what happens. Erm, yeah. But I mean at the moment she doesn't want to do that as well. So it'd sort of be a case of forcing it, or, I don't know. It would be a horrible thing to do it secretly sort of, putting it in her feed. But, if it comes to down to that then maybe. Erm, yeah.</p> <p>I: So is there anything else you would like to talk about that hasn't somehow come out when- through my questions?</p> <p>D10: Erm... Er...</p> <p>I: Wait I haven't heard much about how you feel in yourself. And you say well 'I'm a flat line' and maybe you are, maybe you aren't, but is there something you want to say about how you feel?</p> <p>D10: Er, no not really. I mean you go through the thoughts of, sort of, why me?</p> <p>I: Uh-hm</p> <p>D10: Er... Yeah. It's just, you know, one thing after- the yeah past few years we'd heard her not walking. Got through that. About a few months later we had A going through anorexia and then a couple of months after that and then we've got O back going through anorexia. And I just hope that we can put some sort of barrier up between</p>	<p>IMPACT? Why me? (a theme here of Dads feeling a bit unlucky or sorry for themselves! Cf D9) like 'what did I do to deserve this?'</p>

all that happening and S. Because S is- erm, sort of, our little rock. She's great. I just hope that it doesn't hit her as well, in some way. Erm, for myself er... Just get on with it. Erm... You know, and I just- er... I mean, I- I started- I was in a- started going, being in a band (laughs).

I: Oh

D10: About- it was about January. It was about when-

I: Did you used to be in one-

D10: Yeah I used to be, about twenty years ago when I was er just leaving school. Er, we were in bands. Er and I've still been playing my guitar all that time. And I keep playing my guitar and that-that helps. Erm, and ... Er...

I: I mean are you actually doing gigs and things now?

D10; Er- almost-

I: With your band.

D10: Not quite. I mean- we're- we've been practising every couple of weeks but we rehearse every couple of weeks.

I: And are you saying that that cheers you up?

D10: Er that's a good- yes. It's a good release. (Laughs). Erm, right. It's er, yeah it's good. If I didn't have that er... Yeah. If I didn't have that, God. Er, that's about as much as I'm going to say.

I: So you don't do sport for release? That's your only-

D10: Nah, no I don't.

	<p>I: Yep</p> <p>D10: Never really done sport, it's ba-</p> <p>I: So the band is your-</p> <p>D10: Yeah playing my guitar-</p> <p>I: Release</p> <p>D10: Er, have a really good time doing that. Erm... But yeah it's hard...Yeah...</p> <p>I: Hm</p> <p>D10: (Long pause and then laughs).</p> <p>I: I'm not sure if that's, sort of, half laughing half crying really.</p> <p>D10: Yeah it's something- ha! I do, when I crack up laughing I really crack up laughing and I quite often cry. Er but then yeah I think it's a little bit half crying.</p> <p>I: Both...Ok it's hard.</p> <p>D10: Yeah</p> <p>I: Right.</p> <p>D10: Right, ok.</p> <p>I: Thank you</p> <p>D10: That's alright.</p>	<p>Laughs and cries strangely at same time</p>
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Appendix 5c

RF in cherry	19.03.13	IPA in blue
	<p>I: Ok I think it's recording now, so I don't say any names in here because after this I move the recording to my laptop and then I wipe it off. Um, so shall I tell you the four main questions that there are going to be, do you want to come a bit closer so turn your chair towards me, that's it. So this isn't anything about your therapy=</p> <p>C: =Mhm=</p> <p>I: =It's not about what happens in family therapy or well it can be but I'm a research-in this interview I'm a researcher so I'm not like being like your therapist giving you advice, or telling you what to do, this interview is really about what you think</p> <p>C: Ok</p> <p>I: So the first question I'll tell you all the four questions and we might cover them in a mix or we might cover them one after the other. The first one is how do you make sense of your eating problems, as they are at the moment. So that's about how do you understand your eating problems. Then the next question is how do your eating problems impact on you and your life so what effects do they have. Then there's a question which is are there things you think are good about your eating problems or good things that have come out of them. And then the last question is looking forward now what do you think is needed for you to get better now. So those are the four questions we'll just talk about those things freely and things will come up</p> <p>C: Ok</p> <p>I: So the first one, do you want to have a little go at, how do you understand or make sense of your eating problems as they are at the moment</p>	

	<p>C: ...(3 seconds) Um</p> <p>I: You can say whatever comes to your head and we'll take it from there</p> <p>C: Um ...(5 seconds)</p> <p>I: I know it's a hard ques[tion] so I'm not surprised your thinking a bit more, have a think</p> <p>[00:02:04.01]</p> <p>C: [Yeah] ...(4 seconds) Um you mean like are there - what they are sort of</p> <p>I: No, more how you understand them ... the meaning of them</p> <p>C: ...(4 seconds) Er, they're um, um ...(15 seconds)</p> <p>I: What's hard about the question</p> <p>C: I don't know I don't think=</p> <p>I: =Have you ever thought about that before</p> <p>C: No</p> <p>I: No, never thought about, how do they make sense</p> <p>C: Well I guess it's just like, what-since I'm going to have this I guess it's just sort of like, I don't know maybe a, I'm used to it and then maybe my mind wants to believe it or, even if it's not true I</p> <p>I: Oh, believe, ok, so see we've started so believe what [what] does your mind want you to believe</p>	<p>My mind wants to believe things</p>
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<p>B1 If you don't have rules to follow you feel lost</p>	<p>C: [Like] Like rules so like [timing]</p> <p>I: [Rules] ok</p> <p>C: So if maybe my mind want-like it wants to like make believe-it wants some like guidance like it wants something to follow</p> <p>I: Ok</p> <p>C: Something strict, to follow</p> <p>I: Well I won't keep doing this but that's exactly what I mean by understand so that sort of like a purpose of it, yeah, so you think your mind needs rules to follow</p> <p>C: Yeah, just like because otherwise you feel a bit like lost in a way</p> <p>I: Yeah?</p> <p>C: Like um, yeah</p> <p>I: And can you say what situations you feel lost and need rules</p> <p>[00:03:59.05]</p> <p>C: ...(3 seconds) I don't know I guess it's just something to worry about because it makes things easier because I-my mum says I'm not sure-I don't know ...(3 seconds)</p> <p>I: Is it your mum who says the thing about rules helping when you feel lost or [did you add that yourself do you think]</p> <p>C: [No I thought that] but she thought <something else but I didn't say that but um. Yeah also my like um if you're um it make it's like ... It's easier to like be worried than to like <u>do</u> something about it=</p>	<p>Mind needs rules to follow for timing Strict rules</p> <p>Worry Difficult to change</p>
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<p>B3</p>	<p>C: [No] No</p> <p>I: You never thought what would happen [if] I didn't</p> <p>C: [No]</p> <p>I: Ok fine</p> <p>C: I guess I just I just did it</p> <p>I: If</p> <p>C: It was kind of <u>annoying</u> for my parents, but it didn't really <u>bother</u> anyone that much</p> <p>[00:06:04.27]</p> <p>I: Well it's not as-as you say it's annoying and maybe it makes bedtime an hour later or something? But it's not as serious as [an] eating problem. Did you have rules about eating when you were younger?</p> <p>C: [Yeah] No</p> <p>I: No. Can you remember the first time you put a rule about eating?</p> <p>C: My exams</p> <p>I: The year 6 ones?</p> <p>C: Yeah well after-just after when I was really stressed out</p> <p>I: And-and can you just talk me through the moment when being really stressed out resulted in a rule being set about eating, can you remember that moment?</p>	<p>UNDERSTANDI NG Synthesises early rules, Timing ED</p>
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	<p>C: No</p> <p>I: So you don't know exactly how it happened</p> <p>C: They sort of just came, I don't know</p> <p>I: It just came?</p> <p>C: I guess yeah</p> <p>I: In what was the first rule</p> <p>C: I think it was probably um ...(5 seconds) the breakfast one</p> <p>I: I don't know-[by the way] treat me as someone who doesn't really know anything about you apart from when I met you that one time in the assessment because you meet with-I'm just saying this in brackets, you meet with C for family work and B for individual, but I don't know loads about you from them, and by the way this interview I won't-this will be completely separate so C and B won't hear a word about this interview this is for research so it can be written about later but it won't be part of your treatment, so what you say to me-if you want B and C to know you will have to say that to them separately, and if you don't want them that's fine. So I was-and I was only saying that because you said the breakfast one, and I was thinking no I don't know about the breakfast one, did you tell it to me when we met at you assessment? Or is this something you've talked to B or C about? Because you sounded as if you expected me to know about the breakfast [one] but I don't</p> <p>C: [That's (...)] [Oh] Um it was ((exhale)), well, it sort of changed=</p> <p>[00:08:00.04]</p> <p>I: =Yeah=</p>	<p>Worry Y6 exams</p>
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<p>B1</p>	<p>C: Well first it was just like, um, it was like not, I don't really know what the first one was I think that was the first one I'm not really sure</p> <p>I: Is it m-is the first one maybe that you remember anyway</p> <p>C: Yeah I guess=</p> <p>I: =And what was the, what was the rule, what was the breakfast rule ... Or can you not remember now? ((laughter in voice))</p> <p>C: I can't remember it was a certain time</p> <p>I: It was about time</p> <p>C: Yeah it's all about times</p> <p>I: It's all about time</p> <p>C: All of the rules-my rules are about times</p> <p>I: Ok, times and eating. Or are they rules for other things and time, how long things can take, now</p> <p>C: No</p> <p>I: Just about how eating</p> <p>C: Just time yeah</p> <p>I: What time you need to have your meal by</p> <p>C: Yeah I guess but they've become a lot more flexible but I'm not sure how: because, the-like the one a few, a few weeks ago like my lunch rule was one, and then we had lunch like at quarter past one, and then, um, for some reason afterwards, um I was more relaxed I was fine because I'm always better when I'm relaxed, and then for some reason I didn't feel like-</p>	<p>Confused because things are changing Mums opinion matters but is confusing – should she trust it or not</p>
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<p>B5</p> <p>B1 ++</p> <p>Aware of own confusion</p> <p>Searching for links between behaviour and MS</p> <p>Aware of mum's views and ambivalent relationship to them</p>	<p>I felt like I guess maybe my mind wanted my rules to be right so I wasn't hungry at all by seven, so: but my mum said because I don't know I was busy or m-I don't know</p> <p>I: So lets run that one through, your rule has been to have lunch by one, to have [finished lunch] by one?[Or] start at one, ok</p> <p>C: [At one] [No] Or just-or it can be before one, just not after</p> <p>I: Right, and is there a rule about how long lunch can take? No? And was this when you were relaxed, does that mean it was a weekend when you had it?</p> <p>C: When I relax I can usually bend them</p> <p>I: Ok</p> <p>C: Like break them a bit, but then when I'm really stressed out they usually get more-more like rigid and I usually get more worried</p> <p>[00:09:59.27]</p> <p>I: But you're saying, so you had lunch a little bit later than normal, but you didn't-did you worry about it afterwards?</p> <p>C: ... Not really</p> <p>I: But when it came to dinner time you didn't feel hungry. And did that annoy you or upset you?</p> <p>C: Not really I just felt <u>confused</u>) cos I ((exhales)), my mum said it was just because of um being busy because, because I wasn't, ↑she said because I wasn't thinking about anything=</p> <p>I: =Ok=</p>	
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	<p>I: =Because they're not helping</p> <p>C: I think I need to kind of try harder to like make them, to, no, make them um um not be rules anymore</p> <p>I: Sorry this is flashing, annoying me, can you ignore it?= C: =Yeah I'm not= I: =Yeah good. So, ok, lets move on to the next one then, that's been a very good conversation about how you understand it, is there anything else that makes sense? C: Not really I: So shall we think about how they impact on you and your life? So that means how do they affect you, and that could be how it changes your life from day to day C: The rules? I: Well your eating problem, yeah, and if your eating problem is rules then yes the rules C: Um I: And then how it affects your family C: Well it just makes everyone more stressed out I guess I: Ok, do you want to say quite a bit more about that then, s-how how it makes everyone more stressed C: Well we have to do everything at certain times so we can't do some things like, I don't know like sometimes you have other things that you need to do because you can't always do the same thing every single day,</p>	<p>IMPACT</p>
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	<p>and stuff like that without rushing</p> <p>I: Ok so everyone's life becomes more flexible. Um and then how does that affect people's feelings do you think?</p> <p>C: Well I guess the rules kind of like just make my life easier mainly because then I don't have to <u>worry</u> so much</p> <p>I: Ok. So you're not sure it really affects other people</p> <p>C: =That much=</p> <p>I: =That much</p> <p>C: I think it more affects me cos if I have so many rules then I'll be really unflexible and I'll ... it'll be worse for me I guess, cos=</p> <p>I: =And if you have to have dinner by a certain time your mum still has to cook it right</p> <p>C: Yeah, but I don't anymore so</p> <p>I: How did it used to be when your eating problems were worse and um the rules were tougher and more inflexible, what was it like then? ... Sounds like things have changed recently, can you think back to what it was like when you first came to GOSH?</p> <p>C: ... When I first came here everything-it was fine because I-I was eating properly since 20-20-20-25th December</p> <p>[00:16:00.25]</p> <p>I: Ok that's when you started eating properly</p> <p>C: But I still had rules but I'd just done things around-I'd just <u>coped</u> with the rules in a way, <u>obeyed</u> the rules=</p>	<p>Contradicting self saying was better when I obeyed my rules and coped</p>
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<p>B1</p>	<p>I: =Yes=</p> <p>C: =If you know what I mean=</p> <p>I: =But it did need other people to obey them with you didn't it?</p> <p>((Phone rings))</p> <p>C: Why?</p> <p>I: Because you had to have dinner, eh</p> <p>C: No because I'd broken my dinner rule, so, but</p> <p>I: Let me just answer the phone, sorry. ((Speaks on the phone)) So um hang on lets go back, there's two things to think about, one is how it used to be when your rules were kind of rock hard</p> <p>C: Mhm</p> <p>I: And then the other is how it's now, so now you describe it's quite flexible for example dinner can be at any time=</p> <p>C: But there are still a few rules that are [not] flexible</p> <p>I: [Ok] Tell me about those</p> <p>C: Like, the um, the lunch rule. Well I get a bit, I can have it a bit past but I get a bit like stressed out</p> <p>I: And what-when you say stressed out can you just [(. . .)]</p> <p>C: [Well I used to get] really stressed out and like get really like every-so like worries and is it ok and stuff but now I'm sort of just calm and stressed out inside</p>	<p>Hiding feelings now</p>
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were still hard and dinner had to be at 7 and other people had to fit around that, can you [describe] one situation?

C: [I had] I had to get really stress-I got really like stressed out and I said dinner was too: late I can't, w-what happens if there's a too late and people just get bored of it and just fed up

I: And you would just be very very upset, but did that mean that other people in the family [got] upset too?

C: [Yeah] ... And there's also another rule which is um it's a bit annoying because it makes me rush because like at school we have break, so um like I have a cereal bar or something like that whatever at break and um then my rule is even though, so I have to I make myself-well I have to get up really early, for breakfast, and then I have to-cos then I, yeah and then I have to um eat my snack at a certain time even though I don't want it at this time because like I'm not hungry at this time, but it has to be at 10, but like that's not a very good time like

I: So then breakfast has to be really early

C: Yeah but, it's fine anyway because I go to school and I have to get up early to get to school so you (. . .)=

I: Is it allowed to change on weekends the timing? That's=

C: =That's the bad thing. My sister gets up at half past 9 and I get up at like 7

I: On weekends [as well]

C: [Yeah]

I: So that rule hasn't been able to change yet

C: But my dad's quite nice cos he-he usually gets up with me and then

<p>B1</p>	<p>just goes back to sleep afterwards</p> <p>I: Oh? Have you thought then that sometimes some nice things come out of it? That's the other- third question I had which is has anything ... ((flips over page))</p> <p>[00:20:06.05]</p> <p>C: It's not nice=</p> <p>I: =Has anything good come out of eating-do you think there are anything good things that have come out of your eating problems=</p> <p>C: =No</p> <p>I: And eh I was thinking just getting up with you and your dad on weekend mornings could be good</p> <p>C: Well that's not about the eating that's just because he's being nice to accommodate my rules to make me feel better in a way</p> <p>I: But it makes the rule feel less ba-harsh harsh doesn't it because your dad gets up with you</p> <p>C: Yeah ... But I guess the reason I do that is because um but I mean I don't really know what kind of rules they are because just say every day I started eating breakfast at 8, then 8 would become my rule. Cos like my rule just changes according to what I do-what works</p> <p>I: Oh ok so it just sounds like you need a rule=</p> <p>C: =To-something that works basically, fits, that I'm happy with</p> <p>I: Yeah</p> <p>C: Because-but I think the breakfast one is a bit more firm because I am</p>	<p>Very smart observation that dad's niceness may not be really helping her change</p> <p>Rules accrue after doing something a first time</p>
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	<p>after my breakfast I have to have this like a drink thing which has got protein in it which for some reason I think that's quite filling too because it's just basically milk it's milk protein just milk basically but=</p> <p>I: =Mhm</p> <p>C: Yeah</p> <p>I: And how does that=</p> <p>C: =It's disgusting</p> <p>I: And you have to have that after breakfast?</p> <p>C: Yeah so it ruins my breakfast but still. So I think it fills me up more than I would be able to eat my cereal bar in a way. I-I think I have a pro-a really big problem about ti-If I got rid of my timings and my um my sort of my um but what happens if I'm really fully later what happens if this then I would- my mum says well that I'd be perfectly fine apart from that because like I-I eat desserts and stuff after dinner to help, but because I'm not stressed about time after that so I guess in a way like, I think it's just times basically</p> <p>[00:22:01.19]</p> <p>I: Although um I was wondering actually if you also have a problem with eating, like if you don't like eating very much</p> <p>C: No</p> <p>I: You don't have a problem with it</p> <p>C: No cos I eat desserts and stuff, I think-my mum and my dad don't think it's really that they think it's more like being obsessed with my sister too, like it's trying to compare with her in a way</p> <p>I: Mhm</p>	<p>Rules Timings Food</p> <p>UNDERSTANDI NG Obsessed with my sister – compare myself with her – my parents say</p>
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<p>B1</p>	<p>C: Cos I think she's better than me in a way</p> <p>I: Um is that your own feeling or is that [their idea that you think she's better]. You do think she's better than you?</p> <p>C: [Yeah I kind of yeah] Well, yeah in a way, [yeah]</p> <p>I: [Do you], do you really?</p> <p>C: Cos=</p> <p>I: =So can we talk a bit about that on the interview because that's maybe also part of something I don't know why but=</p> <p>C: =Well=</p> <p>I: =It might become clear</p> <p>C: Maybe it's cos, it's cos like well we're going in Easter for example we're going on holiday but um my mum and my sister are going to um Las Vegas and um me and my dad are going to Barcelona, and my mum didn't want to go with me for some reason she said I would be too-she didn't-I would be too-um-cos I she thinks um when I'm angry I take it out on her</p> <p>I: And you do you agree?</p> <p>C: ↓Yeah, <I think> yeah</p> <p>I: You do</p> <p>C: But like even if I've eaten properly and I'm fine, even though I'm in a good mood she says I still take out everything on her, like kind of always done that, so she gets, I don't know, so like like ever since I was little we haven't got on that well</p>	<p>Catch 22 Poor relationship with mum leads to estrangement and rejection and vicious circle</p>
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<p>Good mood leads to more friends and laughs with sister</p>	<p>and stuff like that but otherwise I've always been quite a happy child apart from that</p> <p>I: Hmm ...</p> <p>C: I'm very different at school that's the thing. When I'm in public I'm very different because um like when I'm at school and stuff people like on my report they always say that I'm a very calm well behaved mature child and stuff=</p> <p>I: =So you never shout and get angry at school</p> <p>C: No</p> <p>I: No</p> <p>C: Mm everyone thinks that I just bottle it up, like at school, and then [take it out]</p> <p>I: [Then it comes out] at home</p> <p>C: Yeah</p> <p>I: And so=</p> <p>C: =I've always been quite shy at school</p> <p>I: Yeah, um:, and I remember at the assessment meeting you said that I don't think my friends like me or the ones that you moved from primary to secondary school that true-would you say that? I mean I think you said something like that. You had some friends from primary school and you thought that they didn't like you. You don't remember that? Well maybe were-maybe you don't think that</p> <p>C: Well I don't hm. No the girls who moved with me from my old school they're quite nice, one of them doesn't like me but the other one's quite</p>	<p>RECOVERY Friends Good mood Laughs with sister</p>
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	<p>nice</p> <p>I: Mhm, ok ... so=</p> <p>C: =But I've made friends now anyway because when I had like a bad eating problems I was in a bad mood but now I'm fine so I have quite a few friends now and I come home with them as well so</p> <p>I: So that's something that's changed since-in the quite recently</p> <p>C: Yeah because I'm in quite a good mood so like my parents have noticed too that I'm in a much better mood and I've been talking to my sister and we've been laughing and stuff so I'm yeah</p> <p>[00:26:09.06]</p> <p>I: So actually we're having this interview at a time when things aren't so bad anymore, it sounds like things are getting better. So tell me a little bit about your relationship with your sister and a little bit about your relationship with your friends and school and your mum</p> <p>C: Well I'm a bit=</p> <p>I: =And your dad=</p> <p>C: =Well, um, well with my dad I'm always really relaxed like I'm always calm and he says I'm really different with him and:=</p> <p>I: From how you are with=</p> <p>C: =Yeah=</p> <p>I: =Your mum?</p> <p>C: Yeah. And um like well also when we go on holiday we'll see because in Barcelona um well people, um like um people think that my rules might</p>	<p>RECOVERY Things to look forward to e.g. continental breakfast with croissants and cereal in a hotel (but only with Dad)</p>
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	<p>get more flexible because I mean when I'm relaxed I can usually break them because I don't usually care so much=</p> <p>I: =Mhm=</p> <p>C: =Cos other people are doing them so I think it's fine cos in Barcelona you have to-people eat lunch from 2o'clock onwards and that's when the places open and they have dinner at 9 ((laughter in voice)) and that's when it opens so I can't, and the times are different anyways so and like we're going to a nice hotel like continental breakfast which is like my favourite thing in the world ((warmth in her voice)) but um ever since I was really small and then so</p> <p>I: Does that mean croissants and things like that</p> <p>C: It's like yeah like cereals and croissants and things</p> <p>I: Yeah</p> <p>C: Nice omelettes and things like that. And um so people will see like what's gonna happen there so in a week or two on the 10th of April [we're going]</p> <p>I: [Right ok] are you looking forward to it?</p> <p>C: Yeah</p> <p>I: How do you feel about the challenge of mealtimes being quite different in Spain?</p> <p>C: Well I think I should be quite-and they also eat very different things in Spain so</p> <p>I: Yes and how are you about that?</p> <p>C: Well I think um it'll be good to maybe-something will change, I'm</p>	<p>Wants to get better?</p>
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	<p>looking forward to see what will happen, try my best and see if maybe it'll improve things more</p> <p>[00:28:04.22]</p> <p>I: So really you are really talking as if you do not like your rules and you do want them to change and you like-you're welcoming this trip with your dad that will challenge that=</p> <p>C: =Yeah</p> <p>I: Um but you're sad that you're mum's not coming</p> <p>C: Yeah well she didn't want to take me=</p> <p>I: =And Z</p> <p>C: Yeah but I guess it's better in a way because it's more-it's less stressful for me. Because when I'm with my sister I always compare I don't get why but I eat desserts that she doesn't eat and other stuff but then at dinner at the meal I always just say I have more than her because I-my mum gives me mine and she gets her own and I always say see look I have more and mine is more because my mum says sometimes but sometimes I still keep saying it, just like prove some-I'm better than her which is a bit-isn't really link to what like the amount you eat is not what you're better or worse at it's just what you</p> <p>I: But you just kind of have to say it</p> <p>C: Yeah</p> <p>I: Is it a bit like a rule [you have a] saying rule</p> <p>C: [It's like a habit]</p> <p>I: A habit</p>	<p>Sense starts to break down around theme of comparing herself with sister</p> <p>A habit to say the same thing</p> <p>Mixing up habit with specificity of meal</p>
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<p>B1</p>	<p>C: Yeah</p> <p>I: A talking habit and a=</p> <p>C: =Yeah</p> <p>I: And how does that affect Z [do you think]</p> <p>C: [Well that's] not good because it makes her not it makes her not like me as much. But sometimes she because I haven't done it all the time, it happens only with meals that like that. Doesn't happen like if we have fish and chips cos can't really like it's like stuck together so, but it happens with like stir fries and rice and things that you just get</p> <p>I: Why doesn't it happen with fish and chips can't you count the number of chips and say I have more chips than you=</p> <p>C: =I don't really understand my rules=</p> <p>I: =I'm not saying you should count [the number of chips] I mean ((laughter in voice)) so you're saying your rules don't quite make sense to you</p> <p>C: [Yeah I know] ((laughter in voice)) No, no I don't do it with desserts cos like after I had like for example last night I had um a magnum=</p> <p>I: =Yeah=</p> <p>C: =Like a white chocolate magnum and my sister had an apple and for some reason I don't say anything</p> <p>[00:30:00.04]</p> <p>I: Ok, so things are becoming much more flexible really</p> <p>C: Yeah I don't really understand those</p>	<p>RECOVERY</p> <p>Being flexible feels very confusing and 'I don't understand my own rules'</p>
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	<p>I: And do you feel alright when you're flexible and don't say things like you've got more than me</p> <p>C: Yeah, sometimes, sometimes I really feel like I have to say something. Cos I've kind of made my sister's position more hard so now she thinks that I, I don't know what she thinks but she thinks something along the lines of I think she doesn't eat anything, which I don't think, so when she comes home she usually leaves some of her wrappers on the table, that she's, I don't know maybe it's to prove something and that's kind of annoying but I've just-my mum says I have to tolerate that because like I've made her life harder</p> <p>I: How do you feel when your mum says you've made Z's life harder</p> <p>C: Well it's obviously it's <u>sad</u> but it's true. I don't want it to be true but it's true so, it's not</p> <p>I: Do you feel worried? About it?</p> <p>C: Not worried but like I wish I could like fix it, quickly but I don't think that these things are very quick</p> <p>I: No</p> <p>C: They don't really fix overnight</p> <p>I: No. So your relationship with your dad hasn't been particularly affected by your eating disorder, in fact do you think in some ways it's got better because of your eating disorder?</p> <p>C: No</p> <p>I: No. And your relationship with your mum was difficult before and it is difficult now [has that changed?]</p>	<p>IMPACT</p> <p>Very worsened relationship with Mum</p>
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<p>Family dynamics: categories A, C</p>	<p>C: [She's got] worse</p> <p>I: It's gotten worse</p> <p>C: Cos she's got more stressed out and more I'm sick of this and more yeah</p> <p>I: So do you and she have arguments</p> <p>C: Yeah but now they're not about eating now they're just about behaviour and stuff</p> <p>I: Rules or other behaviour</p> <p>C: No just other behaviour, like a few days ago it was about my um homework I asked her something and then I was bothering her and then she got angry and stuff like that</p> <p>[00:32:02.18]</p> <p>I: Mhm, so that's sort of quite apart from the eating disorder that's a problem was before and is now</p> <p>C: Yeah I think if I get her, um even if I look healthy and don't have any problem with eating I'm still gonna have these problems because I've had them ever since I was really small. I remember when I was even when I was little I would scre-I used to scream outside the door. But I've always been quite a nice child even people have always like said that I'm really cute and stuff like that but um</p> <p>I: This one thing</p> <p>C: I'm quite happy but sometimes I guess, yeah, I didn't behave very well. Like I remember throwing a remote control at something ((laughter in voice)) (. . . . too quiet) not very good but I think I just have a bad temper=</p>	<p>Problems with my temper will remain</p> <p>I'm like my mum</p> <p>But she controls her temper better than I do mine</p> <p>Impact: sad</p> <p>Resentful</p>
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<p>Category B</p> <p>B1</p>	<p>I: =Mhm=</p> <p>C: Which I think I need to learn to control</p> <p>I: Mhm</p> <p>C: Because like my mum has a bad temper but she controls it more than me</p> <p>I: Ok</p> <p>C: But I don't-I haven't learnt how to control it</p> <p>I: And does she have ways of controlling it that you can learn from do you think?</p> <p>C: No because um well everyone says she has a bad temper like when she's not there but she doesn't really admit it ... She doesn't, I don't think she says, she doesn't, I don't know if she thinks it but she doesn't say that she has a bad temper</p> <p>I: So you just sort of sense it but she doesn't show it</p> <p>C: Well everyone says it my sister says it when she's not there my dad says it when she's not there everyone says it when she's not there. But sort of no-one says it when she's not there and when she says it she-when you say it to her she gets angry so</p> <p>I: So you're wondering what's going on in your mum's head</p> <p>C: Yeah I don't know if she thinks she's a bad temper or if she I don't know</p> <p>I: So I have a bit of a complicated question I don't know do you think that your difficult relationship with your mum which was difficult before you got an eating disorder has anything to do with getting an eating problem</p>	<p>Highlighting a family problem</p> <p>UNDERSTANDING SUMMARY</p> <p>Wanting mum's approval Stress Comparisons with sister</p>
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C: Kind of because I seem to always want approval from her, like isn't this good isn't this good see I'm eating this it's good isn't it. Like I-I've always wanted approval from her

[00:34:08.08]

I: And was it always about eating? Or only when you got an eating disorder

C: No it was just about everything in general, so I guess when the eating thing came, I don't really know but I think the eating thing came for lots of reasons

I: So one would be wanting approval

C: Yeah one would be stress

I: Yes

C: Then one would be obsession with my sister and comparing. And then I don't really know

I: So the obsession with your sister and comparing, can you say a bit about that and how it linked to have-getting an eating disorder

C: Well I've always wanted, [I've always kind of com]

I: [You wanted to be skinny?]

C: No

I: No

C: She's not even skinny she's just normal

I: Ok so it wasn't about being skinnier than her which was what I would

have maybe assumed, so that's not right

C: No

I: So what was it, how was not eating ... or=

C: =It's not not eating it's just proving that I have more than her basically

I: Because before you started eating, you were eating too little weren't you because you lost a lot of weight=

C: =Yeah=

I: =Otherwise you wouldn't have an eating disorder=

C: =Y[eah]

I: [Yeah] or you wouldn't have come to Great Ormond Street so when you were losing weight=

C: =Yeah=

I: =How did-how was that about were you comparing yourself with your sister, so that's before Christmas last year, in the autumn

C: ... I have no idea

I: Have you just forgotten do you think

C: I just I don't know=

I: =Or it doesn't or you can't think if you ever did have anything to do

C: I don't really know because I know I was just really stressed out and I had no friends I don't know I just felt that everything was too much and then I don't know

<p>Work in progress</p> <p>B1</p>	<p>I: Was that at the beginning of year 7 or year 8?</p> <p>C: 7</p> <p>I: 7 you still in year 7? Yeah. So the first term of year 7 was really hard, but you're not sure that eating-being s-not eating wasn't, was about [being better] than your sister.</p> <p>[00:36:00.15]</p> <p>C: [It made it worse]</p> <p>I: You weren't trying to be better than your sister by not eating?</p> <p>C: I don't know, it doesn't make any sense</p> <p>I: I doesn't when one tries to put it into words does it, but did it have a feelings that made sense did you somehow feel that by not eating you'd be better somehow</p> <p>C: I don't I don't know ...(7 seconds) I don't I really don't know</p> <p>I: What happens if you think back to that time ... (4 seconds) now you want to s-you want your mum to notice that you're eating more than her</p> <p>C: Yeah I don't ... I really don't know</p> <p>I: Ok, we can leave it like that but it just doesn't make sense but something about wanting to be better than your sister. Do you ever feel better than your sister? You don't?</p> <p>C: No</p> <p>I: You just keep trying?</p>	
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<p>Developmental pictures</p>	<p>C: I don't know it's just she, we:ll I don't know, but-she-because I also feel like people say like things more about her she's like really clever but everyone tells me that I'm really clever cos I get really good results but then for some reason I feel like she's really <u>perfect</u> but I don't actually know that for a fact ... But she's, I don't know I don't what she's like at work ... And I know she says things but she's a very confident person but I don't know if she-my dad says that she's over confident and a bit um what's it called arrogant but um I'm under confident so ((laughter in voice)) I wouldn't</p> <p>I: And right now nothing you're doing makes you feel more confident [in relation to] her?</p> <p>C: [Well I'm happy]</p> <p>I: Oh sorry go on you're happy?</p> <p>C: I'm happy that I'm improving getting better but I don't know I'm always not satisfied</p> <p>I: Mhm</p> <p>C: But I've started feeling more satisfied now like with my work and stuff and saying I'm happy with it so that</p> <p>[00:38:06.20]</p> <p>I: And more flexible</p> <p>C: Yeah</p> <p>I: But still things aren't quite right with Z and with your mum</p> <p>C: Not quite right yeah</p> <p>I: No</p>	<p>RECOVERY</p> <p>Need to try to break my rules</p>
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C: I'm not completely like better

I: ... No and that takes us to the last question which is ... ((flips over pages)) what do you think is needed now for you to get better?

C: Well I think I just need to try and break my rules like that's why that multi-family meal thing that's probably I don't know why it's like but I don't know if that could break my rules because I don't have a problem with actual food like if I eat a chocolate bar I'm perfectly fine with it if it's within rule time

I: So today, will be the first multi-family meal won't it

C: Yeah

I: And you think it might help you break your rules. Anything that will help you break your rules [might help]

C: [Yeah yeah] yeah I don't know what's going to happen there though I don't really know anything

I: So what happens if your parents try to support you to break your rules? Um at home if your parents encourage you to get up later on a weekend and have breakfast at 9

C: But then I say no because um I have cos it it doesn't really work because cos I have to have a bigger breakfast and I have to have a protein shake and I have to have a cereal bar all before lunch, if I get up at 9 I can't really fit that in

I: So they can't really help you with that

C: Not really. The lunch one they can though

I: How can they help you with that?

<p>Family inter generational perspective C1</p>	<p>C: Well I think it's more me, that I have to try because um I just have to because I have to realise cos like you can't like loads of people eat things at different times like my dad my dad was really busy like a few days ago and he ate lunch at 3.30. ... It's not ideal but ...12 to 2 should be fine, like people should, in a way you can have a rule that you should just have it from 12 to 2 because that's flexible it's 2 hours it's not exact bang on one time</p> <p>[00:40:19.15]</p> <p>I: Um, do you get hungry though if lunch is late?</p> <p>C: No because I have a snack and then I have yeah</p> <p>I: So you never feel very hungry</p> <p>C: Not now, but before yes</p> <p>I: Yeah, ok</p> <p>C: Well anyway I'm hungry on some days and not, like I'm more hungry on some days than other days, I don't know=</p> <p>I: =Mhm=</p> <p>C: =I think it's just normal</p> <p>I: Yeah, so you think it's up to you for things to get better and maybe something [like multi-family meal] but it doesn't sound like you feel your parents [have much]</p> <p>C: [Just some support] [Maybe just] some support from them</p> <p>I: From them? And what support (. . .)=</p>	<p>Support from parents in terms of patience – not direct help to break rules</p> <p>Mum can't help that much because of her own childhood, only lonely child, can't give reassurance because can't give hugs; Dad is different</p> <p>Sad account</p>
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	<p>C: =Just patience</p> <p>I: Ok</p> <p>C: And you'll do well, maybe like it's fine, just some reassurance. Like my dad's good at reassurance but my mum's an only child and she doesn't really know what it's like, she doesn't really ... her parents didn't really do anything with her</p> <p>I: Really?</p> <p>C: No they didn't take her anywhere she said, they weren't, well my grandpa like he worked in like an ice cream shop, they weren't that, like, she didn't really-she wasn't that she was in her room and like quiet and stuff so, I guess she doesn't know, she doesn't give people hugs and she doesn't really know what it's like because I don't think people hugged her that much</p> <p>I: Mhm ((sympathetic))</p> <p>C: So .. Otherwise my dad's pretty different he's a-one of three and he had a massive house, with like animals, and in Pakistan so he's a bit different so I guess he knows what it's like to and have a hug, so he-he can do it because he knows that people need one but maybe my mum grew up without one so she doesn't think people really need one</p> <p>[00:42:06.10]</p> <p>I: This is quite sad isn't it?</p> <p>C: Yeah</p> <p>I: So do you-are you saying she doesn't really hug you</p> <p>C: Not really, only if I ask her</p>	<p>RECOVERY Hugs from Mum</p>
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	<p>I: And in answer to my question what do you need now to get better, would you even go so far as to say well I kind of need a few hugs from my mum?</p> <p>C: Yeah I guess</p> <p>I: Mhm. And your dad, does he hug you?</p> <p>C: Yeah</p> <p>I: And do you ever hug your mum?</p> <p>C: Sometimes</p> <p>I: Do you start a hug?</p> <p>C: Yeah sometimes</p> <p>I: How does that go? Does it work?</p> <p>C: Yeah sometimes</p> <p>I: Does it feel ok?</p> <p>C: Sometimes</p> <p>I: Does she hug you back?</p> <p>C: Yeah some-yeah</p> <p>I: Sometimes</p> <p>C: Yeah</p> <p>I: And not other times</p>	<p>VALUE</p> <p>NONE</p> <p>Confusion re own opinion and that of mum</p>
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C: Yeah

I: Do you know why it sometimes works and sometimes not?

C: Cos sometimes she just says she's fed up with me ...(5 seconds)

I: And your way of understanding her difficulty with hugs is that she didn't have them herself when she was [little]

C: [Yeah]

I: ...(6 seconds) Good, alright ...(5 seconds) Is there anything that's been good that's come out of having an eating disorder would you say?

C: No

I: No ... I was just thinking about what you're thinking about now because you're thinking about things so deeply, um, but maybe you don't need an eating disorder to think about things deeply. Did you used to always think deeply before do you think or do you think its changed the way you think? You were a thinker?

C: I'm a thinker, I think I'm a t-I'm not really a thinker I'm more of a talker

I: Yeah?

C: My mum always says I talk more than I think

I: Ok, well you seem to be thinking now anyway

C: Yeah

I: You know about your mum's history and how that's affected her. Well what do you think about the future? Do you ever think ahead? For yourself? Like what will happen and what=

[00:44:09.18]

C: =Sometimes

I: Do you-does your picture of the future include having no eating disorder?

C: Yeah

I: And what else do you think about?

C: Just getting on with what most people do, just different bits, school

I: Nothing specific?

C: Not really

I: Mhm

C: I don't really want to know-I don't know what I want to be when I grow up really

I: Yeah, well you've got time

C: Yeah

I: I just wondered some people have an idea

C: I just have some subjects I don't like, and some subjects I'm good at

I: Yeah. So we-it's time for us to wrap up, is there anything-if you sort of just scan our interview in your mind is there something you think actually we missed out and we didn't talk about? No? Did you know that the ((phone rings)) idea is that I would um interview you again in a year's time and then in another year to see how [your] thinking has changed and how your eating disorder has [changed] and the same with your mum and dad

	as well. So I'll turn this off C: [Ok] [Ok]	
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Appendix 5d

RF in red	C3 (T1) Part 1 05.12.12	IPA i blue
	<p>I: Ok, shall I start with my first question. Look then, this will go off in a minute. Um, first I want to say that these interviews are completely separate from your therapies here. [This isn't]</p> <p>C1: [What does that mean?]</p> <p>I: Well you know you have family work, [individual work,] group work</p> <p>C1: [Oh ... yeah] ... Mhm</p> <p>I: This interview won't go to those people, won't affect how you're treated. A separate research interview about your thoughts opinions and feelings. And for the first question <and there are four main questions, one is how you make sense of your eating disorder. The second one is ... how it affects your life. The third one is what changes have come out of your eating disorder even good ones. And the fourth one is ... how can you move on from here do you think what do you need. [00:01:00.04] So shall we start? (. . .) because I can always skip between them. The first one is ... how do you make sense of getting an eating disorder or having an eating disorder how can you understand it or think about it?</p> <p>C1: Hmm: ... W:hat does that mean like ...</p> <p>I: Well, ... does it make sense to you to have an eating disorder</p> <p>C1: ...(4 seconds) Umm: ...(5 seconds)</p> <p>I: How do you understand it happening to you</p> <p>C1: Dunno ...</p>	

	<p>I: And you can't really think about that (. . .) Shall we think about the next question then which is how does it affect your life</p> <p>C1: ... Hmm? ...(5 seconds)</p> <p>I: Hmm=</p> <p>C1: =Umm=</p> <p>I: I'm sure you'll have some ideas about that=</p> <p>C1: =Umm</p> <p>I: Because that's a bit the same as what changes does it bring</p> <p>C1: ... What does that mean</p> <p>I: Like what changes have come as a result of your eating disorder ...(8 seconds)</p> <p>So you would have to I think ok what's different <u>now</u> from how it was before I had an eating disorder ...(10 seconds) Do you feel different</p> <p>C1: ... (. . . .) ...(5 seconds)</p> <p>I: Do you think differently or do you care about different things? Or do you do different things?</p> <p>[00:02:54.03]</p> <p>C1: ... Bit dif↓((different))</p> <p>I: Bit different ... What's different</p> <p>C1: Like ... I . don't . know. < Like when I live at home before like > I could spend like whole days playing lego . but . now I that I don't like sitting down I think that I wouldn't want to sit down all day.</p>	<p>No UNDE RSTAN DING</p>
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	<p>I: ... Do you mind if I repeat it because I think your voice is so quiet that the recorder might not have picked it up=</p> <p>C1: =Yeah=</p> <p>I: =So I'll say it back to you=</p> <p>C1: =Yeah=</p> <p>I: =And you just nod if it's correct but if it's not just just correct me. So what you said is one difference is ... before you might have been able to spend whole days playing lego but now you wouldn't do that because that would be sitting down and you wouldn't want to do that ... Ok, so would you be able to say why or how comes sitting down now feels something you can't do</p> <p>[00:04:03.09]</p> <p>C1: (. . .)(no?)=</p> <p>I: = So thats a st-that makes-we can narrow it down > How do you make sense of not wanting to sit down. I can see that you're struggling down and actually if you would rather stand up you <u>may</u> because this is an interview and not a therapy session. So if you want to sit up or stand up sometimes just do whatever you need to do, I'm not going to tell you not to because that's not what I'm here for I'm here to ask you your opinions and thoughts=</p> <p>C1: =Hmm=</p> <p>I: =So sitting down is hard=</p> <p>C1: [=Yeah] ((quiet))</p> <p>I: [How] do you make sense of that that sitting down is hard?</p>	<p>IMPAC T Don't play Lego anymo e becaus e don want t sit down</p>
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	<p>C1: Well=</p> <p>I: =Can you explain=</p> <p>C1: =Why is it hard?</p> <p>I: Yeah why is it hard</p> <p>C1: Because it is like ...(5 seconds) (. . . .) relaxing and stuff (. . .) like (. . . .)</p> <p>I: Its relaxing and stuff not exercise ... Ok, can you-so am i right in thinking you are-you feel like you mustn't relax?</p> <p>Ok, you nodded, I'm going to say that to the tape recorder [because] its difficult it can't see that you're nodding.</p> <p>C1: [Oh yeah]</p> <p>I: Ok why do you feel like you mustn't relax? Can you explain that?</p> <p>C1: Hmm:</p> <p>I: Is that a hard one? ... And maybe this interview is a good place to think about that, why why mustn't you relax. ... How does that make sense yeah?</p> <p>C1: ... Hmm ...(6 seconds)</p> <p>I: Umm ... I'm afraid unlike-you know therapists can help you with thoughts and suggestions but one of the things when ones doing an interview is that one mustn't really suggest things to the person</p> <p>C1: (. . . .) say yes and go along with it ((unclear))</p> <p>I: Sorry? What so you could just say yeah and go along with it and not really believe it? Is that what you meant? Yes exactly, ... exactly it really does need to be from you. But if you can't really explain either you can say I need to think about that, or say I can't.</p>	<p>Relaxir g i suspec</p>
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C1: Hmm. Dunno. Erm I think I kind of know but I don't really like

I: You kind of know

C1: Yeah=

I: =Ok, you kind of know why you mustn't relax. Would you be able to say it to the tape recorder, knowing that it's not going to go anywhere other than into research

C1: ... Umm ...(7 seconds) Um

[00:06:47.08]

I: Does it feel like a secret?

C1: Umm: ... yeah sort of (. . .)

I: Sort of. So hmm ... is it like you're not allowed to say?

C1: No=

I: =[No]

C1: [I'm] (. . .) scared

I: You're scared? Ok? I-I think I need to understand that better. What are you scared of?

C1: Umm scared of what people may think of me

I: Ok, so including what I might think?

C1: Yeah

	<p>I: ... Is there any way I can help you believe that I-it doesn't really matter what I think and also ... I wouldn't probably, I wouldn't probably be ... surprised because I have worked with children with eating [disorders] for many years</p> <p>C1: [Oh] Hmm</p> <p>I: But you're scared of what I would think ... But probably less scared of what I would think than of what you're parents would think. ... Or do you think your parents know why you think you can't relax? Do you think they do know? Nodding. [Exhale]. Ok. Is there anything else? Lets go back</p> <p>C1: Ok</p> <p>I: I think unless you sort of can put into words why you mustn't relax we should probably move on</p> <p>C1: Mm</p> <p>I: ... Is there anything else you'd like to explain about that?</p> <p>C1: No</p> <p>I: Can I try two suggestions, but I'll have to trust you to say no if its wrong=</p> <p>C1: =Mm=</p> <p>I: =So that it's not just nodding and going along with it</p> <p>C1: Yeah=</p> <p>I: =So the first suggestion is ... it makes you feel <u>lazy</u> and lazy is <u>bad</u></p> <p>C1: Yeah [or um]</p> <p>I: [Is that] correct?</p>	<p>Emotion: Scared of what people might think she says why she mustn't relax</p>
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YPI: N'umm I don't know[↑] what the other=

I: =And the other thing is ... you could get fat if you don't move

C1: Yeah

I: Is that the one more?

C1: Yeah

I: Ok ... So that's quite a common feeling and so I'm not surprised. What did you think I might think?

C1: I don't know_↓, I just didn't know what you would say.

I: Mhmm

C1: (. . . .)

[00:09:18.06]

I: And so what about other ways in which things have changed, so that's one thing that you can't relax anymore, you [can't play

C1: [(. . . .)] I just don't want to ...

I: Ok you don't want ... (9 seconds) Any other ways that things have changed since you got an eating disorder?

C1: Um um

I: What's different from how it was before

C1: ... I'm kind of not allowed to stand up if its-if I'm doing something that-where its normal to sit down because like if you're watching the telly I-me and my friends would usually stand up and watch it, but yeah, I'm not allowed to do it

	<p>now because I don't (. . . .) to do that because (. . . .)</p> <p>I: So wait, did you say it's really annoying</p> <p>C1: Yeah because people like don't let you do that ...</p> <p>I: I'm just going to repeat [beca]use I'm worried the tape probably won't have heard so what you just said was=</p> <p>C1: [Mhmm] =Mhmm</p> <p>I: Erm, you're not allowed to do things standing up if they're things that would normally be done sitting down like watching television</p> <p>C1: Yeah but sometimes we would normally do those things in our house and they not</p> <p>I: So the first time you said me and my friends would normally stand up</p> <p>C1: Yeah</p> <p>I: But then you said in our house</p> <p>C1: No I'm trying to explain=</p> <p>I: =So do you mean your family would also stand up to watch TV</p> <p>C1: I dunno, no, but me and like my friends like</p> <p>I: You and your friends would stand up to watch TV</p> <p>C1: Yeah, I dunno [exhale/laugh?]</p> <p>[00:11:30.10]</p> <p>I: Why would they?</p>	<p>UNDE RSTAN DING OF OWN BEHAV IOUR NOT SITTIN G ANI NOT RELAX ING: Fear c getting fat</p>
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	<p>C1: Because, I don't know (. . . .) ...</p> <p>I: What would do you while standing up while watching TV</p> <p>C1: Nothing, we'd ... erm I dunno</p> <p>I: Is that before you going an eating disorder you would still stand up to watch TV.</p> <p>C1: Yeah:, it was kind of like I hadn't stopped eating but I was still thinking things I erm ...</p> <p>I: It would be really helpful if you could try to put into words what you're thinking now that's the same as you were thinking then</p> <p>C1: It was like erm like I sort of I still didn't want to sit down instead erm ...</p> <p>I: So its about not relaxing because it might make you fat</p> <p>C1: Yeah</p> <p>I: So that's how you're thinking now</p> <p>C1: Hmm</p> <p>I: And that's how you were thinking then</p> <p>C1: Yeah ...(4 seconds)</p> <p>I: What's that you've got around your wrist?</p> <p>C1: A bracelet</p> <p>I: 2001?</p>	<p>TREAT MENT IMPAC T Can't stand up t watch TV</p>
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C1: What?

I: Whys it got 10th November 2001 on [it]

C1: [Oh] because that's my birthday

I: Is that when you were born?

C1: Yeah

I: And where did you get that from?

C1: Umm (. . .)

I: But how do you have a wristband dated 2001?

C1: What?

I: Oh did they make it for you just now

C1: Umm (. . .)

I: Oh: it's your like identity thing

C1: Yeah

I: Does everybody have one of those [] upstairs

C1: [Yeah]

I: Ok ... why do you have one of those

C1: Because we have to get them, I don't know (. . . .) they have to give me one

I: Um, isn't that another change that you're living on an inpatient unit for children

C1: Yeah

I: How do you feel about that

C1: Ermm: umm:, (. . .) it's not as nice as being at home

I: It's not as nice as being at home

C1: [High pitch murmured agreement] ...(7 seconds)

[00:13:59.06]

I: Erm is there anything that's good about it

C1: Umm ...(3 seconds) Dunno ...(5 seconds)

I: Anything?

C1: Dunno [exhale] Umm ... (. . . .) Umm my mum and dad would probably think of lots of reasons why they thought it would be good but (. . . .)

I: Have to say it a bit louder. You think your mum and dad would probably think of lots of reasons why they would think it was good but you don't think it's good ... (4 seconds)

Umm, what do you think they would think was good about it

C1: [Exhale] I don't know, they probably like for me to meet people and be getting better, and (. . .) but yeah, and ...

I: And you say people make you better, do you think that makes any sense to you?

C1: I don't know, a bit ... (6 seconds)

I: Umm, before you got an eating disorder [] do you think that you would have

found these kinds of questions about how you think about things, even if it wasn't about an eating disorder [], would you still have found it difficult to answer?

C1: [Mhmm] [Mhmm] Yeah

I: You would have (. . . .) Have you always found it difficult to sort of know what your opinions are

C1: Mhmm I know what they are, it's kind of just difficult to say them

I: Difficult to say them, ok ... Would you say that-that you feel shy about them

C1: A little bit

I: A little bit. So lets go back, ca-so to go back now, because I know the question was difficult in the beginning but lets come [] back to it

C1: [Yeah]

[00:16:00.21]

I: Did it make sense to you to get an eating disorder

C1: I don't know what that means

I: It means how do you understand getting an eating disorder

C1: I don't know I thought everyone thought like that

I: You thought every-see that's an interesting one so you thought everyone felt like that

C1: Yeah

I: And the like that would be everyone felt like they shouldn't relax and stay still

because they might get fat

C1: Mhmm yeah

I: And they should eat less because they might get it

C1: Yeah but I didn't because I haven't got round to it yet

I: Ok, so first of all it was about keeping moving

C1: Mhmm

I: And then it was about not eating ... and do you still feel that now?

C1: Umm, what do you mean feel that?

I: Do you still feel you must keep moving and not eat?

C1: Yeah ...(7 seconds)

I: So how do you get to sleep at night or do you find it very difficult to go back someone has to relax you

C1: Yeah I did find it difficult but they made me share a room with someone so it made me (. . .) to lie down, in a way which is horrible for me

I: The other person?

C1: Yeah

I: How many nights have you shared a room

C1: One

I: One, was that last night?

	<p>C1: Yeah</p> <p>I: How did you find that</p> <p>C1: Didn't like it</p> <p>I: You didn't like it ... Can you tell me what it made you feel like</p> <p>C1: Umm=</p> <p>I: =Being made to lie down</p> <p>C1: ... Umm, umm, umm, I don't know. It was just kind of ...(5 seconds) don't know</p> <p>I: So not good</p> <p>C1: Mhmm</p> <p>I: No. Umm can you find a more specific way to describe it</p> <p>C1: ...(7 seconds) Dunno</p> <p>[00:18:25.22]</p> <p>I: ... Angry? Did it [make you] angry</p> <p>C1: [No] not angry just kind of a bit annoyed that they made me</p> <p>I: You were a bit annoyed that they made you share a room</p> <p>C1: Yeah</p> <p>I: Are you going to have to be sharing a room tonight</p> <p>C1: Yeah because there's only seven rooms but at the moment we've got eight</p>	<p>Everyo ne thinks</p>
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	<p>people</p> <p>I: Ok=</p> <p>C1: =(. . .)</p> <p>I: So you're the only one that has to share, well you and the [other person]</p> <p>C1: [Well yeah] And now someone whose coming I think next week so two other people have to share ...(5 seconds)</p> <p>I: Umm what do you think you would like to happen next how do you think things can move forward</p> <p>C1: Umm what do you mean</p> <p>I: Well, of course they call it get better</p> <p>C1: Yeah</p> <p>I: Err, so I suppose, can you see: what could: ... help you get better?= C1: =Umm= I: =How could things change C1: I think they're trying to make it so I can't go out over the weekend, unless I do-unless I have certain things= I: =To eat or drink C1: Yeah I: Umm ... will that make you get better? C1: I don't know, I'm not doing it at the moment but, its like, sometimes, it</p>	<p>in a ED way?</p> <p>IMPAC</p>
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	<p>doesn't feel like it, sometimes in the weeks I'll have more than what I need to have, and then sometimes I won't have anything ...</p> <p>I: Mhmm</p> <p>C1: Well not all of what I need to have, but all of what I need to have-to go out</p> <p>I: And is going out especially important to you because you get to move</p> <p>C1: Kind of yeah</p> <p>I: Is there any other reason except for the exercise</p> <p>C1: (. . . .)</p> <p>I: It's fun?</p> <p>C1: Yeah</p> <p>I: Can you say what you enjoy about going out?</p> <p>C1: Umm, umm, this weekend I'm going out to (. . .)</p> <p>I: Oh yeah? With your friend?</p> <p>C1: Yeah, because she's going-she's coming up to London (. . . .) she says she can do it (. . . .)</p> <p>I: And which friend is this someone from your home</p> <p>[00:20:59.28]</p> <p>C1: She's from school</p> <p>I: From school? ... Do you want her to come? So you don't mind her seeing you [] with a tube</p>	<p>T</p> <p>Has t</p> <p>lie</p> <p>down a</p> <p>night</p>
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C1: [No] She's already seen

I: Ok. And umm what's her name?

C1: Lizzy

I: Lizzy. Ok and umm what do you think it will be like having Lizzy visit and then seeing you and then going out-or will you meet her one to one

C1: I don't know. Hmm yeah I don't know

I: You-did it make you feel nervous?

C1: Hmm: don't know really ...

I: So you're up for that

C1: Yeah

I: And that's the kind of thing that would make it worth eating?

C1: Yeah ...

I: So you're saying that that's the kind of thing that helps if you have something to look forward to and somewhere to go out

C1: Yeah

I: And it's better to do it with a friend than just with your parents? Or

C1: Well yeah but I usually go with my parents

I: You usually go with your parents

C1: Yeah

	<p>I: How are you getting on with your parents at the moment then</p> <p>C1: Umm ok ...</p> <p>I: Do you know anything about what they think about you [] having an eating disorder. Can you tell [] me</p> <p>C1: [Yeah] [Mh] Umm I think they're annoyed with me because they can't really understand it that much so they can-they're like oh: why don't you just eat it's so easy ...(4 seconds)</p> <p>I: Is that what they say</p> <p>C1: Yeah ...(6 seconds)</p> <p>[00:22:49.26]</p> <p>I: Hmm. Shall we-now that you know slightly what the interview is about</p> <p>C1: Mhmm</p> <p>I: Because we've had half an hour and I feel like that's probably enough for you today because you're looking kind of quite edgy now, umm can we have another half an hour, twenty minutes maybe next week?</p> <p>C1: Yeah</p> <p>I: Is that ok. And we can come back to these questions and see if you've had any new ideas. [] So the questions are ... how do you understand getting an eating disorder, and I know that's a really hard question it is about sort of having an idea about what it is about how it came about. And you said something, you said that you thought it was how everybody felt that they needed to keep moving and to not be fat. So maybe the next time I might ask you something about how do you understand people who don't have an eating disorder. Can you imagine what it's like for them. And then the next question was how does it affect your</p>	<p>Describes</p> <p>richocheting between GUI and giving in an regathering AN</p>
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life, we've talked a bit about that but particularly by not being allowed to stand up and move around. And then umm ... we talked about what changes it's brought about and if any of them have been good changes and maybe the last one was what's needed to move on so you gave an example of having to look forward to. Before we finish the last thing I'll just come back to is [] do you think anything good has come out of it? Any good changes

C1: [Mhmm] [Mhmm] Umm

I: Do you feel it's good that you keep moving and don't eat

[00:24:49.04]

C1: Umm

I: You're shaking your head

C1: Well I think I would have been better off if I hadn't because then no one would have stopped me from moving around and if I (. . . .) maybe no one would have stopped me

I: Hmm, you would have rather, that it had just not got out of hand? [If that's the] way to put it

C1: [Yeah] and I never intended to do it-to stop eating

I: Ok, well that's a really good place to stop that is a really helpful interview and maybe it'll-if you have any further thoughts can I come and find you again next week?

C1: Yeah

I: I'll ask your key worker to sort out a good time. Thank you very much indeed

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	<p>Part 2 11.12.12</p>	
	<p>I: Ok, here we go. So do you remember what we were talking about last time. I had four main questions, one was how does your eating disorder make sense to you? And I was going to ask you how it's changed your life which we didn't really get to talk too much about. Shall we talk about that now? How its changed or changng your life and for the better and the worst so do you want to say something about that? Like: . what about-do you want to think about how it was over Christmas?</p> <p>C1: Mhm ok:</p> <p>I: It was ok ... Because obviously I guess it was a different Christmas from last year?</p> <p>C1: Yeah</p> <p>I: And how did you think it was compared with last year</p> <p>C1: It was ok (. . . .) last year</p> <p>I: It wasn't as good as last year. What happened last year and then tell me what happened this year</p>	<p>But how i intervie w before Christn as?</p>

C1: Umm last year umm well we went to a house

I: You went to a house?

C1: No, we went to our house

I: Oh you were at home. Yeah

C1: And umm (. . . .) and this year↑ it was here↓.

I: Mhmm did you mind being here?

C1: Well, I wanted to be at home

I: Yeah, so would you say that in that way having an eating disorder made life worse. Yes, you're nodding. I have to tell the tape recorder that you're nodding because it um-so that's something that's worse that you're here. I mean are there some ways in which you like being here?

[00:02:15.15]

C1: N[o]

I: [N]o. You're nod-you're shaking your head. You don't like being on Milderd Creak at all. No. So that's definitely a way that in which it's made life worse. A- What are other ways has it made it worse or better

C1: I don't know

I: Do you want to have a little think how it's changed things because the question is how is having an eating disorder affected your life . And then it could be how has it affected your friendships and your relationships with your family. ... I could just sit back and let you have a little think about that how it's affected your relationships with your mum and your dad and your (. . .) ...(11 seconds) You don't have to look so worried

C1: Hmm

I: You can say what you think

C1: Probably I'm missing them

I: Hmm. Do you feel that you actually miss them

C1: What?

I: Do you actually miss them?

C1: (. . . .)

I: Not all the time?

C1: Well not when I'm doing something ...(5 seconds)

I: Um and when you do see them does it feel different [] from how it was before you had an eating disorder

C1: [Hm] No

I: It feels the same. So then everything feels normal

C1: ...(4 seconds) Hm ...(10 seconds)

[00:04:00.23]

I: And when you umm. Do you go to family therapy sessions?

C1: Umm. I don't know what you mean

I: Family sessions, where you talk. ... Do they change things how they are between you and your mum and your dad? No. ... So is there anything that you

thinks got better since you got an eating disorder some people think that it has

C1: [Not really]

I: [No] ... Just a few things are worse. And that would be not being able to be home and not seeing your family as much. And what about friends and school

C1: Don't know, what do you mean

I: Like having an eating disorder how has tha changed things for you to do with school and friends

C1: Umm ↓I think because I've got an eating dis-↑Because, I think [quick exhale ((eugh sound))] it's kind got me less friends because I havent been there

I: You think your friends have got other friends now because you havent been there, that sounds umm a little bit sad ...(6 seconds) Does it make you feel sad? You're shrugging. Does it make you feel worried?

C1: I don't know

I: Does it make you wonder what it could be like when you go back to school

C1: Dont (. . .)=

I: =Do you ever think about going back to school

C1: Hmm not much

[00:05:56.13]

I: Not much. Umm and is that-has anything happened to make you think that the friends have got other friends now-your friends have got other friends

C1: No my mum told me

I: Your mum told you? Did she, what did she say

C1: Hmm, she was just talking about it

I: Did she mention anyone specific. ... Do-do you want to say what she said?

C1: (. . . .)

I: But you can't say if it worried you or not, you don't know really know if you felt worried or anxious

C1: (. . . .)

I: You don't know ...(7 seconds) So that's one section of questions over how it affects you and your life and then the next set of questions, I'm trying to think from memory, is umm, well it's actually whether there's anything good about having an eating disorder for you ... Anything that feels valuable, good about having an eating disorder, does it help certain things, does it make you feel better, some people say it makes them feel better in some way

C1: Umm (. . . .)

I: Sometimes? Can you give an example

C1: Umm, well kind of before I wouldn't have talked [] like when I wasn't eating much because it made me feel better

I: [Mhmm] Before you went into hospital and you weren't eating much it made you feel better. Can you describe the better feeling what was it like

[00:08:01.17]

C1: Umm, it just made me feel (. . . .) ...(6 seconds)

I: What kind of thoughts did you have about your body=

C1: =H'umm: ...

I: Anything like, I'm thin

C1: Yeah ...

I: Well that's alright ... to say that isn't it

C1: Mhmm ...(6 seconds)

I: And then the last question is what do you think you need now, what do you think you need to move on, to get better from your eating disorder?

C1: I don't know

I: Would I be right in thinking that you don't think much about the future

C1: Mhmm

I: So you don't really think about the time when you would leave [the unit]

C1: No

I: No? Or a time when you would go to school. What year are you in?

C1: What in school?

I: Mhmm

C1: Year 6

I: So you would be going to secondary school next year. Do you ever think about that?

C1: Umm no ...(4 seconds)

I: Umm ... so yeah ... yes, so yes. The question is what do you think helps you now

C1: What do you mean

I: Like, what do you think would help you to-to stop having an eating disorder

C1: I don't know ...

[00:09:56.24]

I: Like, do you think talking helps?

C1: [inhale] mhm (. . .)

I: Does: being on the [the unit] help?

C1: ... Umm I don't know

I: Do you-do you know how-do you know how [the unit] is supposed to help. What do you think about [the unit]

C1: I don't know (exasperated tone)

I: ... Err, or could your parents help in some way

C1: I don't [know] (exhasperated/frustrated/upset? tone)

I: [You don't] know what would help you. I'm going to now look at my (. . . .) questions in more detail, see if there's anything that could help. Ok ... [sound of pages turning] By the way would you like an information sheet, or did you get one at the beginning and even if you did would you like another one? You don't. Did you know that the idea would be that I would interview you in a years time, so next December January 2014, and then the year after as well when you will be 13. Did you just turn 11? Yeah. [sound of pages turning (6 seconds)] Hang on. [sound of pages turning (25 seconds)]. [00:12:01.06] So shall we quickly go

through them again and then finish (. . .). So to go back to the first question about how you understand that you've got an eating disorder, now what I remember from what you said last time is you didn't expect it to go as far as it did, have you thought any more about that [] anything more you want to say about that

C1: [Mhm] ...(3 seconds)

I: Um and you also said, I remember that you said I can't imagine-I thought everyone felt like that, about not-about not liking sitting still, about needing to do exercise and be on the move. Umm maybe the question I didn't ask you properly at the time was how did it-how do you see it all beginning, how does it all begin

C1: I dont (. . . .) What do you mean

I: Can you remember how your eating problem began?

C1: No=

I: =When-how old you were, what thoughts you had at the time were when it started

C1: What were they like before?

I: When you first started cutting down your food? Or doing more exercise? Not liking the way you looked?

C1: I don't know I think I always just felt like that

I: Really always? As long as you can remember. And like that means? When you say I always felt like that. What do you mean by that

C1: I don't know

I: Not liking yourself?

C1: ... I don't know

I: Umm so before we leave that question is there anything else you think might help me to understand how come you have an eating disorder

C1: Don't know

[00:14:05.14]

I: Is it about not liking yourself?

C1: Umm. Err.

I: So it's not quite that. Is it about thinking you're too fat? Yeah, you're nodding. Ok and the next one was how it-how it impacts on you and your life and how its changed things. So for you you're saying that being here it makes you not see your family enough you miss your parents. Umm does it change how you think about the future? About what you imagine yourself doing in the future

C1: Not really

I: Can you tell me a little bit about what you imagine doing in the future

C1: Umm ... (. . . .) and designing shop windows

I: Designing-what was the first thing? And designing shop windows? And the first one?

C1: And umm I want to live in Scotland

I: Ok, so obviously my next question is going to be why? How come you want to live in Scotland

C1: Because it's much colder

I: Yeah, do you like snow? And is there any snow sport you particularly like or do

you just like snow balls and=

C1: =Yeah I like sledging and stuff

I: Sledging. So you'd like to live in a snowy country. Have you ever thought of living somewhere even more northern than Scotland?

C1: Err I'm not really (. . .) that much

I: Mhmm good point. So Scotland and designing shop windows for a living. And how did you have that idea

C1: Err=

I: =When did that first come to you

C1: I like like setting up the teddies and stuff, I want to work in toy shops doing the shop window

[00:16:02.25]

I: Oh yeah, umm ... And have you brought your teddies here

C1: Some of them

I: And do you set them up in sort of shop window style

C1: Not here but I do at home

I: Yeah, do you have lots of accessories for them

C1: Some of them have got clothes and scarves

I: But do you like the accessorising or do you like imagining games more

C1: (. . . .)

I: Imaginary games, so do you imagine them talking to each other and stuff ...
Umm do you worry that when you grow up you would have to give up teddies?

C1: Umm=

I: =Do you think you can keep playing with them even though you're growing old

C1: U'hmm don't know

I: Does anyone ever speak to you about teddies

C1: Not really

I: Like your friends, do they like joining in?

C1: Yeah loads of my friends have a teddy too

I: And so would it happen that if someone came to your house to play you would want to play together? Setting up scenes and imaginary=

C1: =Yeah

I: Do you miss that here or is there anybody on [the unit] who can-you can play with

C1: Not really

I: Not really. Are they too old or too serious

C1: [Exhale/laugh] I don't know ...(4 seconds)

I: Umm so that's the future. Have you thought at all about where you would study?

C1: [Umm:]

I: [Or go to school], no. And then I asked is there anything that you think is good about having an eating disorder

[00:17:55.28]

C1: ... Not really

I: You couldn't think of anything but at the beginning you felt better, you said. Is there anything now that's good

C1: No

I: No. And then the fourth question was looking forwards what do you think is needed now for you to get better and that was a hard one, and (. . .) you couldn't say ... can't think of anything that comes to mind

C1: No

I: So you may not be thinking about the future but I'm wondering what it'll be like when hopefully I meet you in a year and where do you think you'll be in a years time

C1: Home

I: Home, what else

C1: Umm

I: Do you think you'll be at secondary school?

C1: Yeah

I: Do you think you'll still have an eating disorder?

C1: ... I don't know

	<p>I: Can you imagine ever having that-you-(. . .) taken away, you can ...(6 seconds) So I'll just ask you one more time is there anything you would like-given that this is just a once a year interview (. . .) and the purpose is to help therapists and doctors to understand what it's like for very young people having an eating disorder, is there anything you would like to just say before we finish because that will go into (. . .) . No? Ok, well look ((end of recording))</p>	
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Appendix 6

Appendix 6a

M1 (T1)	Understanding	Comments	Impact	Comments	Value	Recovery
1.	“All about control – because she’s had no control”	See quote	Controlling us/feel controlled because -	Can’t get through. Got nothing to help us, “scraping around”, helpless	Primadonna princess on the pea (in mum’s eyes)	Role play- standing up to people,
2.	“It’s not her, it’s an illness”	Relates to “playing a horrible character”	Driving parents to extreme states of mind (desert island)		Safe place (safe from stress e.g. awful 3some)	Find things she’s good at (it helped me)
3.	Lack of motivation and will					

Understanding Theme 1: “she has got a big brother who is a bit domineering and has quite a forceful personality I would say. And, um, [D1] and I, we are ... you know, weren’t great both ...at school she’s got this controlling friend who is ... dictating to her what she should play, when she should see her, who she should play with a school. So, it’s just, she had no control whatsoever, and the thing that she was good was sports.”

Understanding Theme 2: “At the moment she’s got this horrible character that she’s playing” – also relates to **Value 1**

Understanding Theme 3: “It’s got to be from her. It’s *got* to be. You know, I’ve been in positions where, you know, life’s been a bit drab and all, and I wanted to do something, and I wanted to be, I wanted to get out, I wanted to get a degree, I wanted to be self-employed, I wanted to be an entrepreneur. You got to want to do it. You got to want to get better. She just doesn’t want to.”

Understanding 1,2 &3 together: “I thought about ‘well, if you look back and see this controlling friend and B being domineering and [D2] and myself bickering and not being as [?] we should have been and being ... you know, increasing her self-esteem, and being positive all the time. So if we try, and do it, you

know, help her to overcome those sorts of problems in life, I don't know, get her to do things at school, help her to be more confident, and ... then gradually, if there's anything inside of her which wants to get better, will.

Recovery Theme 1: “And that was another thing that came out this coffee morning the other day, my friends were saying “Oh, we do role play at home and I taught her how to cope with that.” And I thought ‘Oh God, I wish, I failed as a mother. I should have been doing that.’ But I mean, I find it difficult in life to stand up to these sorts of people. Because I meet them all the time ... She needs to believe in herself because I didn't believe in myself. And I think, you know, she's got to start believing in herself.”

REFLECTION: A self referential theme is that C1 is timid like mother was/is timid and she has to get self-belief like mother did (ignoring developmental difference)

Dad in Mum's interview – semi-concealed emerging Understanding Theme 1: “bloody-mindedness”

Oh, we don't have a model for understanding this. There is a girl who works for me who's 25 and she pulled me aside the other day and said “Look, I spent a week at the hospital ten years ago with a tube sticking out of my nose because I wasn't eating.” And, so we had a good chat about that. And I said: “Okay, come on then – what snapped you out of it?” And she said, “Okay, I went into the hospital. The hospital was really dull. There was no going out or any of that stuff. I started thinking about life in the hospital and life with my mates and my parents came in and they absolutely read me the riot act and said “What the hell are you doing chucking your life away?” And her dad said “Look, I'm going to go off to spend a whole lot more time with our other child because, ehm, she's not wasting her life.” And, so this girl said: ‘I had a think about it

Yeah. This girl said “I had a think about it and I decided that I had enough of it and I was going to get well.” That was very interesting.”

Dad in Mum's interview – self-referential thinking theme about C1 being headstrong and other people not changing one's mind, like himself

D1: So we've spent a lot of time at meal time, saying “C1, you really must eat, C1, it's really important to eat now” And she's going “Nuh” cause she hasn't made her mind up at all. A lot of my instinct says, actually it's not productive. We're just batting away, you know. If I made up my mind not to do something and somebody comes along and sits on my shoulders saying “You really must it, you really must do it! “ You know, it does not increase the likelihood of my doing it. If I'm really trying to do something, and I'm struggling to do it and somebody says “Come on, you can do it!” that helps me. But if I don't want to do it, and someone's on at me saying “Oh, you must really give it a try,” it's completely unproductive. And I feel, I've spent a lot of time with C1 in situations where *I don't in my heart of hearts feel I'm helping anybody.*

And I might be making it worse.

Dad in Mum's interview – Understanding Theme 2 'She's satisfied'

"She's showing us that she doesn't have to eat. And she's right. So I feel like, you know, part of me thinks to myself, you know, better if we just stuffed her on a desert island and gave her a fridge full of food and said "Alright, C1, we're coming back in a month. You'll either be dead or alive. If you're alive, that's great..."

... and if you're dead, that'll be your choice. Come on."

Appendix 6b

M9	Understanding	Comment	Impact	Comment	Value	Recovery
1	I'm finding it very difficult to make sense of. Um...I just can't make sense of it. I'm... struggling. Um....	(5a) "I don't know and I don't understand"	Being kidnapped/feeling disempowered	Palpable resentment – link with separation anxiety (quote)	Closer to older daughter	It has to come from herself – C9 has to get on team C9
2	Stop your busy life and look at me	Attention, undivided	Used up all leave - now loss of income		More family occasions	I have to change my personality and relax into being kidnapped
3	Great-aunt's death 2 years ago – trigger friend's granny's death – Mum bereft and distraught before and after – Mum now has a dying colleague, busier at work	(3) Impact of family life events	Loss of relationship with daughter (as mummy's little pet)			
4	"Separation anxiety thing?"	Development of 'undivided attention'	Violence, hard kicks, "blow outs"	Why do parents allow?		

SUPPORTING QUOTES, REFLECTIONS

Understanding Themes 1&2: can't understand the question/attention - separation

M9: I'm just confused by what you mean by make sense of it, is it about how I'm coping with it, is that it?

I: [reiterates]

M9: What, how it happened?

I: Yeah, how it happened. What it means... to C9. What its purpose might be. To C9.

M: Right. I don't, I don't really understand what the question is asking to be honest.

I: Ok. Well it's... Hm... Yeah, I think it's a sort-of *why* question. Er...

M9: Like why did it happen to C9

I: Yeah, looking at C9, as her mother – what do you think that this is about? Maybe, just sort of as rough as that... From what you know about her.

I mean... It's... ... I don't know what it's about, maybe it's C9's... It's probably C9's attempt to say stop your busy lives and look at me...

I: Well, well that's definitely a making sense type of thing. Yes?

M9: She doesn't want me going back to work.

[later] Re. coming back from a work(school) trip:

"I had thought erm, every time I go away from her she ends up either going to the doctor, erm... Something happening, you know, and we used to joke oh goodness what's going to happen this time..."

Understanding Theme 3: undivided attention [to be sure mum/mum's love is safe? My interpretation]

"It's a child who always rode in and got on with life, er now wants my undivided attention and that means when she's doing her homework that I'm not allowed to glance at something else. That I must be, give her 100%"

Understanding Theme 3: [3] impact of family event, great-aunt M bereavement:

"She was worried about me. She knew that every time my gran- aunt, my, my aunt's name was mentioned that I would cry and she hated me crying and 'is, is mum ok?' When she got ill, I said things like, to my family and you know, 'if aunty M had been here, she would've picked her up from school there first. She wouldn't have had to be up in the office for a few weeks' – the office at work- because we were so caught up in work for a few weeks with our childminder sick. And it was, 'this wouldn't have happened'. 'Aunty M would have made sure that she had a proper lunch every day.' So there's a lot of connection a round aunty M. And when, my, her little friend's granny died it was literally a week, days to a week, before this date named when she said I'm not eating anymore... So I think that that had a hu-, had a huge, I think it, I think it – she's so... She was at the graveyard of her friend's granny. Erm, I think it unearthed an emotion for her and brought back memories even though that family put on a much braver face than my family would put on at the burial of my relation. I think it unearthed things for her.

Impact Theme 1/Understanding Theme 2&4: like being kidnapped:*

"it's like she's actually kidnapped me. I feel like that- I mean, you know, we were always very much attached at the hip and when I came back from wherever I would tell her everything from start to finish: I was thinking about you the whole time, and I met somebody who was asking for you and, we just had this little routine, you know, that had gone on for the ten years but I came back from the trip and she literally - the following day I had noticed the restrictive eating and by the Friday she was actually eating nothing. One wonders is there a separation anxiety thing?"

* description of 'kidnapped': "Yeah well I haven't been allowed to go to school, I haven't been able to go to school because I have to feed her twice during her school day, and so every day I drop her at her school for 10 to 9 and I go up to her school at 25 to 11 for her midmorning break, and she

comes and sits in the car and has her little break. And, I go to her lunch at her school at half past 12 – she refuses to eat in the car so she’s driven out one mile, and she has her lunch and then usually a little bit of a “bus stop” and she comes back- A little argument. Not every day, 50% of time and she goes back to school and I pick her up, even though I have a childminder also three days a week, I pick her up and once a week we go to play therapist at half 2. She just wants me at home even though the childminder’s there. “I need you..” The childminder rings and says she won’t eat her mid-afternoon snack, only with me. So, it’s been really difficult.”

IMPACT Themes 3&4: “I... The emotion towards her is... One of anger. And dislike. And sometime the hate word. Erm... It’s very, very tough and I was such a hardworking person before. This sitting down at home doing nothing while the housework is building up is so frustrating. Because, now I’m home and I still have to have a housekeeper. It’s like, it’s a nightmare. The violence is kicking, um usually kicking in the leg, she just gives really hard kicks. So the first thing that I try and do is that I try and remove her shoes, erm, two months ago I would’ve been sitting on top of her for hours on end-... Two, three months ago she would have had five episodes of violence which took up a lot of the day. Now, it’s screaming, violence and screaming. Now she has a situation where she feels, I have to, ‘if I don’t have my blowout she calls it, then I’m getting back to normal then I’m good so I must have my blow out.’

RECOVERY Theme 2: “I am impeding right now, I’ve become cranky and cross and impatient at the moment. I need to relax into it, relax into this process. And slow my life down further.”

Appendix 6c

D9	Understanding	Comment	Impact	Comment	Value	Recovery
1	Attention- be the focus	<i>Uncertain at first; elaborated at end</i>	Shame	<i>Social shame</i>	M9 got closer to older daughter	Me being around more
2	Feeling bad about herself - bullying	<i>Uncertain; brief</i>	Shock, sadness, fear and guilt	<i>Own emotions</i>	Improved couple relationship	Staying calm – it works
3	Control	<i>Abandons this later and elaborates</i>	Strain on couple relationship	<i>Not pulling weight</i>	Chance to get family right	More challenge
4	Own parenting	<i>Guilt about an incident and treatment</i>	Social isolation – not going out			Sanctions and 'security'
5	"A bit plump" – eating and body focus		Family dysfunction	<i>Older daughter suffering</i>		
6	Boutique environment	Self-blame/ mother blame?	Violence	<i>Holding knife to stomach; kicking, blow-outs</i>		

7 REFLECTIONS & SUPPORTING QUOTES

UNDERSTANDING

1. Attention/neglect/guilt

[beginning]

"we were both working quite long hours and maybe we felt that we probably weren't giving her enough attention. Even though she was- even though she was with M9 a lot. She was kind of always with M9, which was on M9's terms."

[beginning] "When we look at it now, you know, we- we'd look at photos of C9 and [older sister]- they were kind of deprived a bit I think. That we kind of, we made them rhyme with us rather than ask them what they'd like to

do.”

[end] “But's she's very much regressed into erm, a smaller child. Even when she wants to be- she wants to be the baby like. If it was ever brought up about M9, sometime's M9 would joke and say 'I'd love to have a baby like' and she'd go mad at the time -because she wants to be the focus... she wants to be the baby.”

[end] “So maybe- maybe this knife thing is to get the attention. To say 'look I'm really serious here, you need to listen to me.”

3. Control

“Well I suppose when I'm admitting it's a mental illness I have to admit that look it's not all about control - and like that's what we forget sometimes, sometimes we think: 'this kid is doing us a puppet show.' And you know, really you keep have to keep stepping back and saying 'look, it's not her fault, it's not her fault.' Treat her calmly, try and be sympathetic. What I'm saying to you is it's hard to be that the whole time. Like, see at times I think this is a form of schizophrenia because like M9 had said earlier she had a blow out and she'd be going hell for leather and next thing, 'can we go watch a movie now?' It's kind of (clicks), it's instant. And that has been the way for a long time.”

4. Parenting Guilt: “somebody was missing from M9's business, she had to spend more time down there. C9 was kind of left alone a lot more in the office maybe. I know even one day I collected her from school and M9 was away, and she talked to me about how she had erm, kind of talked to the teacher and told the teacher about other kids that had been slagging off the teacher. I just lost my head with her to be honest. You know I just got really cross with her. And I was blaming her - like she was finished school for the day and I was going on and on until it was time to get something to eat. When she wouldn't come with me I felt so bad about it. That she just wanted me to drop her to M9's shop and she went upstairs, and went out on her own. At the time I felt guilty... And I brought it up with the doctor, like I felt really guilty about it like. But I- I- I kind of, in hindsight I think I overdid it. I know I did. Er, I mean, I knew straight away then that I did and I tried to apologise to her and... To be honest... Was it a contributing factor? It could've been. Maybe it was-’

6. Body preoccupation And I mean, even we were thinking the fact is she was- spent a lot time in the shop, which is a boutique, and you have these women coming in and saying 'my bum looks fat'. You know, she's listening to this. Not probably the best environment to put a kid that could be susceptible to this illness which we didn't know at the time-

IMPACT

1. personality change, irritable, rejecting, angry, unloving, clingy

"She was the sweetest, easiest..."

"There's one side of her brain she doesn't want to in this situation, but there's another side of her brain that wants to be the way that she is. And wants to be worse than she is. You know, which is very hard to understand... Erm... She wants us there the whole time now... On one level she has pushed M9 away and that- she won't give her a hug, and she won't tell her that she loves her. But still she wants her there the whole time. Which is frustrating for M9 and I'm constantly trying to say to her 'look if you want mum then you want mum, but if you want mum to stay you have to tell her that you love her and that you want her.' I don't- I don't know if I'm right or wrong by doing that...I mean she's constantly calling M9 a bitch. And telling her that she hates her. You know, and I like I know that you're probably thinking we have no discipline from what went down in the meeting earlier but to be honest we do. We obviously tell her that this isn't acceptable and I say to her that it's not acceptable but she gets violent I catch and I hold her down. You know, the kick has happened at that stage. And like, if we do put her in a room she like, she bangs doors, she breaks- she breaks stuff. I mean like we'd have no house left if we –"

3. strain on couple relationship – not pulling my weight

"This sense of entrapment that M9 would've felt. She felt that I should be sharing more with the burden. And then, I still had to work. Like, it's hard to balance it, like we still have to bring in- we still have financial obligations that we have to live up to."

5. Family dysfunction

"Because I came home at lunchtime and like I came home to a house of dysfunction and I was thinking 'Jesus, we are really-' [older daughter] really said a lot of stuff about the family, everyone knows that we're going to school to feed C9, we never do stuff. You know, she was really feeling- she

said that 'I'd love this family to start all over again. She was, she was right... " (crying)

VALUE

1. M9 relationship with [older daughter]

I mean one of the ways is that M9 hasn't been getting love from C9 so she has sought love from [older daughter]. And I think- I know that she's made a bigger effort. Not that she didn't make an effort- she's not, this isn't a critique. I know that she has reached out more to [older daughter].

2. Improved couple relationship after conversation with M9

"M9 sat me down one Sunday evening and she had a heart to heart. And I listened to her. And she articulated it very well, you know, where we were, where she was, what she needed from me. And you know what, she was dead right. I couldn't you know she- she said it all. No holding back. You know, and after that it made me realise that I wasn't really pulling my weight and, you know, since then our relationship has- you know, it is back to where it was. Really to be honest, I mean, you know- like much better place. And I think even C9 has improved a bit as a result of it."

3. Family 'gone wrong'

"I know we've gone wrong you know... But maybe it's been a good thing, made us realise that we've gone wrong,.That we feel we've gone wrong. Even though in a lot of ways we've... Some ways we've done some stuff right but-"

RECOVERY

1. Being around more

2. Staying calm

"Being able to stay calm. Not raise your voice, you know, take the hits if you have to without hitting back. Just try to restrain her and speak in a calm tone. Definitely works."

3. Home sanctions and 'security'

"You know, what I thought at home I said to M9 'I would love to have one of these small square rooms with just mattresses on the floors and we can just lock her in there for an hour-

Where- she will- where she can't harm herself. Like straight jacket. Yeah, time out room. But, genuinely like she needs- I think she needs some space to cool off. With her it's all physical. This blow out is a physical thing."

Appendix 6d

D8	Understanding T1	Comment	Impact	Comment	Value	Recovery
1	An ED is a disorder of eating – makes no sense as no family tradition of not enjoying food	<i>Goes off piste</i>	Emotionally destabilizing – uncertain, sad	<i>Speaks a lot about himself changing</i>	Improved couple communication – becoming aware how silence harms the kids	Love and compassion
2	Pre-existing personality – anxiety and not coping	<i>Was always selfish and uncaring</i>	Work time lost		Learning about relationship dynamics	Evolving as a father
3	Lack of self-confidence	<i>Barely elaborated</i>	Damaging family relationships – esp other children	<i>Older son withdrawing; younger daughter suffering</i>		
4	Attention seeking – acting	<i>Not much elaborated</i>	Couple strain	<i>Even considered divorcing</i>		

REFLECTIONS AND SUPPORTING QUOTES

UNDERSTANDING

1. An ED is a disorder of eating – makes no sense as no family tradition of not enjoying food

“we always used to eat around a dinner table until six months ago we didn’t have a television and so we always had breakfast, even during school days, lunch obviously not except at weekends, and after school meals, snacks and dinner around the table and we would take pride, we spent a lot of money buying our dinner table, it’s a big oak dinner table, very comfortable chairs because, not the television but the dinner table is the focus round our house, or it has been, but things all went a bit wrong a year ago obviously, so even to this day now S doesn’t eat at the dinner table, it’s very awkward obviously, the four of us sitting there, and she’s, well at least she’s in the same room now, before she used to be in a different room”

2. Pre-existing personality and anxiety

“certain aspects of what she is manifesting now, she has always manifested ever since she was a child - she can be quite unfeeling or uncaring”

“she’s more prone to certain things, or reacting to certain things more than other people would, I want to say normal people would but I’m not sure about that then yes, she’s more susceptible to, erm even a little bit of criticism and she’ll sort of, you can tell she’s very nervous, she’ll start shaking and is very anxious, anxiety is a big issue with her,

erm always has been and she reminds us now what some of the things would happen at school apparently, you know, this was only when they were about ten or eleven they were told this is the most important exam you're ever going to take in your whole life"

4. Attention-seeking and acting

oh S you're just doing this to seek attention, erm she is, she always has been, a bit of a, I always say she's a natural actor, she can put on a persona she can put on any emotion actually she can cry she can be happy, her timing, her sense of timing is perfect, she can repeat a song listening to it once

IMPACT (1)

1. Emotional impact

"I've become much more indecisive than I used to be and I think M8 will tell you that as well, unsure, uncertain, erm, and I suppose more introspective as well; a friend of mine, a doctor friend of mine came and had a chat with us just before Christmas and he felt I was, not clinically depressed, but you're just more sad and he's known me for 25 years"

2.& 3. Work time lost and family relationships damaged

"I'm fortunate in the sense I'm self-employed so I can manipulate things and have a degree of flexibility erm, and I know not all the parents are in that position but it's over a year now, we started in January last year, and erm twice a week sometimes, once a week, always all this time, but time ok that's fine I don't resent that but what I do resent is the impact on the relationships it has, the dynamics within the family, there's more hostility and friction, particularly between C8 and our twelve year old, erm and [son] doesn't come home sort of until later in the day, sort of seven o'clock, eight o'clock, stays at school, he says he likes to do work, and maybe now because he's an older teenager a later teen that that's the way it is but I don't think so because he's actually a very home loving boy, always has been, he loves being at home, or used to love being at home"

4. Couple strain

"so we've spoken more about separating in the last year than ever before but then we realise its absolute folly because we actually do seriously love each other a lot and I actually can't imagine my life with anyone else and I think the same with her and sort of draw back"

VALUE (1)

1. Learning about relationship dynamics

"Yeah, I think I'm dissecting relationships more, so for example you might drive a car and just drive it for your life and have no idea how it works which is fine, because you're not a mechanic, you're just driving your car to home and work but, if you investigate what happens here, how does this make that work then you're just better informed and I think that's what we're doing, we're just lifting up the bonnet, investigating how it works, well I am, I would say M8 as well but she's always been like that more than me in a way, investigating dynamics of a relationship more"

2. Communicating better for kids' sake

“definitely, because our kids notice, mum and dad you’re not talking, what’s up with mummy or what’s up with daddy, so we’re determined and I don’t think it’s happened in the last six weeks or however long ago when we decided erm that we’ve sort of not spoken to each other, because that’s my way of dealing, I don’t get angry, well I contain my anger but I don’t sort of throw anything, I don’t shout, I don’t swear, I don’t abuse, I don’t get violent or anything like that, I just go silent, it was the same with my mum when I was a kid, I just go silent er, and I’ve carried that on into my marriage”

RECOVERY (1)

1. Adapt as a father

“move it away from being a sort of father figure to a friend as well, I’m never going to stop being her father you know obviously, you know when she’s 15 or whatever, but realise the changing dynamics, she’s much mature at 14 then [son] was when he was 14 and I don’t think I’m recognising that that I can’t treat her like [son] when he was 14, I think she’s got somethings ahead of an 18 year old or even older, erm so I need to adapt to that”

INTERPRETATION and overlap with RF

D8 spends much of the interview thinking about his own development and becoming self-aware. Relatively little mentalizing of C8. Anger about impact on self, marriage, other children, and bewilderment and anger about the change of family expectations and roles.

Appendix 6e

All Children's Interviews T1 and T2 Extracts and quotes
UNDERSTANDING
C1: 'I thought everyone thought like that'
C1: Have to keep moving I'm scared of what people would think of me otherwise [if I relax/ lie in bed at night/sit down to watch TV]
C3(1): Rules So if maybe my mind wants to like make believe - it wants some like guidance, like it wants something to follow. Something strict, to follow. Because otherwise you feel a bit like lost in a way.
C3(1): Relationship with Mum Even if I look healthy and don't have any problem with eating I'm still gonna have these problems, because I've had them ever since I was really small. I remember when I was little I used to scream outside the door. But I've always been quite a nice child, even people have always said that I'm really cute and stuff like that but um, I'm quite happy but sometimes I guess, yeah, I didn't behave very well. I think I just have a bad temper... Which I think I need to learn to control... Because like my mum has a bad temper but she controls it more than me. But I haven't learnt how to control it... Well everyone says she has a bad temper like when she's not there but she doesn't really admit it .. Everyone says it, my sister says it when she's not there, my dad says it when she's not there everyone says it when she's not there. But sort of no-one says it when she's there and when you say it to her she gets angry so... I: So I have a bit of a complicated question I don't know do you think that your difficult relationship with your mum which was difficult before you got an eating disorder has anything to do with getting an eating problem? C3: Kind of because I seem to always want approval from her, like 'isn't this good, isn't this good see I'm eating this it's good isn't it'.
C6(2): Focus for feelings Yeah it was definitely a kind of a form of self- punishment, also, just because I felt so aimless and had such a sense of purposelessness almost, it was almost like a focus, like a way to focus all my feelings into one place and that was just kind of the structure and rigidity of restricting.
C8(1): Irrational thoughts It's more like a powerful thought, like a glitch that has, that has you know un-rational thinking but the subject believes it very strongly - yeah, it's just like a strong thought that cannot

be swayed, and it's a very hard thing to try to take control over and instead of it being so negative, become positive.

C8(1): Not liking self Don't like who I am I mean people don't like me as I am I might as well change... I don't really have any friends and my cousin doesn't talk to me anymore... I've always been quite insecure about my personality and just like when people just make friends with people, they feel sorry to me or they're too nice to say no... [with Mum] we fight, we've got into a couple of you know, not speaking for long periods of time and I'd smash things and I've been very violent, but I think we've both just lost trust towards each other... I don't really go out of the house with them anymore, and I don't talk about my feelings anymore. I just prefer it that way because like I don't tell my parents I love them, I don't tell anyone I love them and so my dad was saying to me, and I won't say anything back because it's easier to shut yourself off so then when you're horrible to them it doesn't hurt as much.

C8(2): Low self-esteem and self-deprivation I think the low self-esteem came first, like from when I was quite young but in the same way they're connected as in, I didn't really think I was worth anything, so I wanted to stop anything that made me happy or made me live.

C10: Admired "super skinny" on TV Like supersize vs superskinny... they have a part about eating disorders. I used to never believe- like I used to think I would never be strong enough to like, whenever it was on the TV like I'd never be able to erm, not eat that much.

C10: Sister's eating disorder My sister had an eating disorder too. I didn't know until she was nearly recovered. But I think that was partly what caused it because she said that she'd noticed me looking at my food and then looking at hers. And, because I thought if I'm eating more than her and she's 14, so and she's got an adult's body- but then I found out that she had an eating disorder.

C10 'Genetic' There's lots of mental health problems in our family... my grandad's uncle had schizophrenia, my grandad has bipolar disorder, erm, my mum had OCD but she doesn't anymore. Erm, my mum's mum which is the other side to the granddad has... She binge ate on Thursdays. And she has a kind of OCD cleaning kind of, and I think she might have anxiety. And my sister had an eating disorder... It's sort of, like there. Because we had genotyping done. All of the genes like come down and so... They all build up. So I might have like all of them. From all of the people. And I have anxiety. And depression.

IMPACT

C3(1): Missing out on holiday with Mum Well we're going on holiday but, um, my mum and my sister are going to New York and me and my dad are going to Paris, and my mum didn't want to go with me for some reason; she said I would be too, she didn't, I would be too, um, cos, I, she thinks when I'm angry I take it out on her. But like even if I've eaten properly and I'm fine, even though I'm in a good

mood she says I still take out everything on her, like kind of always done that, so she gets, I don't know, so like ever since I was little we haven't got on that well. Then I felt sad that she didn't want to take me on holiday."

C3(2): I don't really have arguments with [my Mum] anymore. I think it was just because I was like stressing her out and I was like a lot of like work and I wouldn't listen so that's probably why she got angry. And then I moved to my grandparents' because I was kind of...I don't know. But then when I was at my grandparents' I think they just like *tolerate* everything which isn't really a good thing I don't think. A change of scene is quite like useful sometimes but, um, yeah I think I was just like the only reason everyone was really in a bad mood and stuff. Maybe everyone was also like *scared* cause I was like really ill and maybe cause I was making everyone really upset. And my sister didn't come out of her room cause obviously she'd just hear me crying and shouting so it wasn't very fun for her. So now she's much happier and we get on quite well she's always, she's never really in her room anymore so she's downstairs and stuff so it's much nicer.

C5(1): Can't do anything Mm I just think about it all the time. What I have to eat next, what's in it, what's it gonna do to me. I just constantly think about it so I don't really do anything else. School, I just, I'm trying to concentrate I can't concentrate for a long time and then I start thinking about what I have to eat next. I find it difficult to go out because I feel ... I feel awkward and uncomfortable around my friends, not that they feel that but just because I just constantly feel that I have to eat things, and they have to maybe worry about me or what I'm doing and I don't want them to.

C5(2): Got on worse with Dad My dad didn't really know much about it. He used to get angry at me for it?

He used to just like shout and say 'why aren't you eating?' He didn't understand it. And then he'd apologise, but then he'd do it again. I didn't really like being around him for a while. Because he used to just constantly have a go at me for it.

C8(1): Loss of trust with parents We [mum and C8] fight, we've got into a couple of you know, not speaking for long periods of time and I'd smash things and I've been very violent, but I think we've both just lost trust towards each other. I just prefer it that way because like I don't tell my parents I love them, I don't tell anyone I love them and so my dad was saying to me, and I won't say anything back because it's easier to shut yourself off so then when you're horrible to them it doesn't hurt as much. If I regret that that means admitting that I'm wrong and I'm not prepared to do that.

C8(2): Improved relationships with family: Yeah, they're really good now, we get on really really well. I was really scared of my dad and I was really reluctant to talk to him or ask him anything, and then my mum, our relationship always used to be based around illness and like, 'oh mum I have a tummy ache', 'mum I don't want to eat', 'mum I don't want to be here', 'mum I self-harmed', just like always around illness. And my brother we just kind of avoided each other and he'd say things that upset me and I'd say things that upset him, we just didn't get on, but we're much better now, me and my brother we've grown up a bit and we kind of get each other and joke around with each other and we have fun and stuff. And

me and my mum, we joke around and it's not all about illness, and me and my dad, my dad has become a lot softer, he's kind of calmer and nicer, and so, we get on better.

VALUE

C5(2): Appreciate friends and family I think I can appreciate some things about it. Because my family and my friends were always there for me so... It's made me value that more.

C5(2): More assertive Someone's- don't know if it's me but kind of, if someone's annoyed me then I will say it. I just used to kind of sit back and let it happen. I do sometimes still do it, quite- not a pushover but kind of - I won't really stand up for myself very much but sometimes I do. And I never used to at all.

C8(2): Improved family relationships and openness: I don't think that we would have been that close because I think it brought us together, because sometimes people say being ill hasn't brought any good to your life, I find that quite hard to believe because it helped me and it helped my family I think. Before I got ill my mum and dad used to fight but silently, like they'd just go for days or weeks without talking to each other and then I got ill and we started having family therapy and they were like oh you can't do that that's wrong and then they started, and then, all the tiny little problems that we had as a family, that most families have, were just magnified and they were raised and we had to sort them out and I think my dad, funnily enough kind of grew up, he kind of became more like a dad.

C10: Can be angry Sometimes I have loud ticks – [part of explanation for why she doesn't go to school] I could get cross- I like hit and punch and kick and shout. And I scream and I cry a lot too. And it's like, school and the teachers and the children kind of made everything worse. Because the teachers were- they'd really be really stupid and patronising.... I can't see the point in having friends.

RECOVERY

C3(1): Break my rules Well I think I just need to try and break my rules like that's why that multi-family meal thing that's probably I don't know why it's like but I don't know if that could break my rules because I don't have a problem with actual food like if I eat a chocolate bar I'm perfectly fine with it if it's within rule time.

C3(1): Hugs from Mum Just some reassurance. Like my dad's good at reassurance but my mum's an only child and she doesn't really know what it's like, she doesn't really ... her parents didn't really do anything with her. They didn't take her anywhere she said, she was in her room and like quiet and I guess she doesn't know, she doesn't give people hugs and she doesn't really know what it's like because I don't think people hugged her that much. Otherwise my dad's pretty different, he's one of three and he he knows what it's like to have a hug, so he-he can do it because he knows that people need one but maybe my mum grew up without one so she doesn't think people really need one.

C3(2): Courage Um, I needed courage, I needed to keep going, like determination, like I needed to keep believing that it was going to be better if I just kept listening and stuff. And how much better it would be and that why do I need to be here like wasting my life when I could be doing a lot of other things.

C6(2): Running Yeah I mean, to be honest, I've always kind of exercised but not for the right reasons obviously, and it's not been an enjoyable thing, and I suppose when I started running it wasn't particularly, but now it's just become something where because it's outside it doesn't feel like it's just exercise - I actually think of it as my time off, my time to just think through things.

C6(2): Therapy – talk to people I do feel as if I now know my own thought processes well enough to think that if in the future if I have to go through anything similar again which is not impossible, like I know that people who have depression don't generally have it once, I will be much better set up for it. I don't have those thoughts anymore, I'm much more rational, I know that I was miserable, and I know that my life is 10 times better not actively having an eating disorder. I mean anxiety I struggle with the most actually - I do feel as if I have more resources and ideas on what to do if I feel really low but when I feel anxious I am still slightly paralysed and don't know what to do, because the two are very different but both stop you from doing anything... I think I'm much better at articulating how I feel, and I do I talk to people, like I said I have a couple of friends who I really trust and can talk to about things, I try to talk to my Mum sometimes.

C8(2): Challenging anxiety So it's about finding proof that actually, that you do deserve it and that nothing bad is going to happen if you have friends or if you eat or something.

C8(2): Tough love: I feel like I met a lot of people who would kind of beat around the bush and console me like 'oh I'm so sorry that you're sick that must be really difficult', but they [at the unit] were like pull yourself together that's not on, you have to stop yourself being sick and they kind of just gave me the kick up the backside that I needed and just told me to get my life together.

INTERPRETATION, RF, Reflections

C1 (age 10) has huge difficulty answering any questions that are 'about' the eating disorder because she is inhabiting it almost totally, it seems. She says at one point: 'I thought everyone thought like this.' Eliciting her thoughts and opinions appears near impossible. A typical sequence in which she says nothing in answer to the question of Impact (see Appendix C1) Affectively, she seems almost completely shut down.

C3 (age 11/12) works very hard in her T1 interview to mentalize her mother, with whom her relationship is breaking down. This is corroborated by D3's T1 interview (M3's T1 interview being lost!) She

alternately blames herself and her mother. She speaks from 'within' her rule-oriented thoughts but also makes clear that eating is not the problem so much as keeping things safe through her rules. When trying to unpick the rationale for her rules, she comes unstuck – sometimes she can be flexible, other times not. This begs the question whether her flexibility or rigidity is related to how loved or rejected she feels by her mother, at any given time. She hints at this at the end when speaking of needing hugs from her and again, mentalizing hard as to why her mother doesn't give her enough hugs. Her affect

In T2 things are much better with regards both to school, friends and the family atmosphere. Mentalizing of Mum has almost ceased, though there is some mentalizing of her sister. She is at pains to say how everything is all right now and attempts to distance herself from the rule-bound girl she was when she had her eating disorder. It is almost as if going back there in her thoughts could bring back the bad old times.

C5 (age 14/16) is quite shut down in T1 and mainly communicates that she didn't mean things to go this far but now that they have, her eating disorder has taken over everything, and she's not fighting it. This is corroborated by her father's T2 interview in particular, where he describes how C5 was comforted by the eating disorder, just sitting at home doing nothing and going nowhere. C5 herself also describes this in her own T2 interview. It is almost as if she is describing a needed developmental hiatus – a point of rest, pause, not able to continue. This also brings to mind her father's repeated statements in both interviews about C5 being a 'tier 2' sort of girl socially, unlike her sisters.

In T2 C5 is more communicative, but still not very interested in exploring either the eating disorder or her own mind. She is able to describe anxiety around other things – exams, friendships – and awareness that she needs help to cope. It stands out that she says her relationship with her father was negatively affected during the eating disorder – that he shouted at her – this would not have been apparent from interviews from any of the three in the family at the time.

C6 (age 16) only gave a T2 interview. It is apparent that she wants to give the impression of being very much better – from the eating disorder and also from the depression that preceded it. Yet when asked how she understands it, she remains quite limited, references to her parents' divorce and to aimlessness and needing something to focus her feelings are noted, but not elaborated. It is possible that she wished to please, or reassure, the interviewer, who was also her therapist, that she is well now. Talk of how she continues her own therapy also indicate her wish to be independent, standing on her own two feet, no longer a patient. She acknowledges, however, that food and eating are still sources of great anxiety and her social eating far from normal.

C8 (age 14/16) comes across as very angry in her T1 interview, culminating in her striking comment that

family relationships can be jettisoned in favour of the eating disorder – she wants it, it is her, and if the price to be paid is loss of family relationships then so be it and better that way as then the loss doesn't even hurt. Her anger about her social difficulties, impoverished friendships and sense of not being pretty or likeable, are clear to see and feel.

At T2 everything seems to have turned 180 degrees – she has friends, family relationships are good (except with younger sister who still avoids her, this is not much elaborated on), and the whole family has benefited, according to her account. In particular, it is striking that she says she used to be afraid of her Dad, but he is nicer and gentler now, more like a 'real Dad'. Something of this process can be discerned in D8's own T1 interview, the turmoil he feels in his family role. He did not give a T2 interview ultimately despite being willing. M8's T2 interview, though, stands in striking contrast to C8's. M8 is traumatised by all the events of the past two years involving self-harm and hospitalization in an in-patient unit. C8 dispenses of these events in a paragraph where she mocks and distances herself from the way she used to relate to her Mum – "our relationship always used to be based around illness and like, 'oh mum I have a tummy ache', 'mum I don't want to eat', 'mum I don't want to be here', 'mum I self-harmed', just like always around illness". It seems that C8 has found it much easier to move forward than her mother, whose T2 interview could be likened to a howl of pain.

C10 (age 11) also makes the impression of being angry in her T1 and only interview. There are a number of ideas that appear 'received', recognizable from her mother's interview in particular, that is that the eating disorder is genetically determined. C10's own concrete understanding of this is interesting, if dispiriting. It is almost refreshing, in this context, that she also speaks about being 'inspired' to have an eating disorder by the TV programme 'Superskinny' and, possibly, by her own sister. It is almost as if having an eating disorder is indeed an aspirational goal, her sister managed to have it, and C10 has a load of family models of mental ill health to live up to – as she says, she also has depression, and anxiety, like her grandmother and perhaps her mother (who did not mention her own OCD in her interview). It is almost as though C10 sees the diagnosis of a mental health disorder as a carte blanche to be as angry as she describes – shouting, crying, screaming, ticking, and kicking. With such a load on her shoulders, it is perhaps no surprise that she feels angry - about who she is expected to be, perhaps, or perhaps about the distortion of her own unhappy experience at school, and her rightful anger about it, into a mental health disorder.

Appendix 7

Appendix 7a

Addendum to Chapter 7. RF Results - Parents

Examples from parents' interviews demonstrating scoring of RF.

Example 1. M2 (T2) High RF

Beginning of interview

[looking back two and a half years to when C2's eating disorder began]

M2: We were living in a very strange dynamic, I'll describe that briefly...

I: Also maybe tell me how you think maybe C2 felt that dynamic, how she experienced it?

M2: You know it started about a year earlier when she lost some weight, um, because she'd been to the States and hadn't had a diet that she liked with her relatives. And when she came back from the States all the girls at school told her that she looked stunning. Um, and she just moved into GCSE year and she'd always been in the middle of the class. But she knew that if she did nothing but study she was able to be at the top in some of some of the subjects. And I think suddenly, she thought, well, my parents might make an awful mess of life, but I'm going to be both successful *and* popular *and* beautiful. And I'm sure she didn't work it all out but suddenly she had a distraction that was all encompassing, that allowed her not *feel* what was going on at home and something else she could focus on. [A1, A3, A5, B1]. Um, but it certainly got, got, got our attention [B5].

Middle of interview

I: Just tell me if this is right, you said, that C2 said, she couldn't stay at her school, and you went to see her and you said, I will take you home, but in that case you can't go back to school, you'll have to work in Tesco - and that sort of made her sit up.

M2: Yes...

I: So you were quite tough basically.

M2: I was. I think my biggest fear was that she was going to come home and sit at home on the sofa doing whatever teenagers do on computers. Pretending that this was normal. But you know, I thought we were going to repeat history from her dad. Because he still hasn't got a job. ... And I just thought, "Oh my god we've got this dynamic coming again," [C7] and I was determined that okay she might not be able for school but she has to be able for life. Um you know. Uh, I was really tough on her but every time I put my foot down, I very, I was very frightened [B1] that, you know it was going to fall apart. It always felt as I put my foot down that she wouldn't be able to rise to it, but I felt I had no other choice and *every time* she's risen to the challenge and she's responded constructively. [C5]...

End of interview

I: Do you know if C2 thinks too that it's to do with feeling the family was ... not working?

M2: I asked her lately what she thought set it all off.

I: Ah, what did she say?

She talked about bad experiences at school, when she went back to school when she was skinny. She talked about also going shopping, and two girls coming out of XXYY, an underwear company, and head hunting her to work in their shop because of the way she looked. But she said that the thing that frightened her, that she thinks set it off, was my illness. Um, um... the thing that frightened her she said was when I became ill. **[B1, B6]**

I suppose what she was relating it to was, she sees the whole eating disorder as an expression of anxiety and fear. **[B5]** And she, when she talks about it she identifies the things she was afraid of. She... She's also afraid...that she was losing her dad. And she does now, she still cries. She says she remembers when we were a family. She had a very sort of happy go lucky relationship with D2 where he sort of doubled up as an older brother and they used to wrestle on the floor and run around and play together and stuff . And that's all gone. But she needs a part of that it's just that she's grown up. **[C2]**But, you know, she was on the tube two weeks ago and saw a family, a mother, father, and a child and it reminded her of us and she said she just sat there with tears streaming down her face **[specific example]** ...and thought that was us, you know. Um, that's all gone. You know, so but likely she wouldn't go back, um. **[C4]**

In sum, M2's interview contains demonstrations of RF from domains A, B and C, and many different kinds. She is able to stay on task with mentalizing her daughter, while remaining tentative and acknowledging many different perspectives. She is also able to move through the course of the interview from one type of explanatory idea (family unhappiness) to another (fear about M2's illness), demonstrating B6, "freshness of recall, spontaneous thinking, changing perspective".

Example 2. M5 (T2) Low RF

Beginning of interview

M5: Um, she's completely better. You probably wouldn't recognise her if you saw her. And her, her manner I think.

I: Wow.

M5: Um, I, it'd be interesting to see her, if you do get to interview her how she would be now. But she, she to us she's very, very different. **[D1]**

I: Do you want to say in what ways?

M5: Well socially, she's always out. She has a *huge* circle of friends now. And when she wasn't well, the friends, they didn't disappear, she chose for them to disappear. They were always

there but she didn't join in with any of the usual teenagery things and now she most certainly is. In terms of other changes she doesn't feel quite, she doesn't want to be close to me all the time. Which when she wasn't well, she was.

I: Yeah.

M5: And that was stifling, in so many ways, for me. **[B1]** But now she's just, you know, she'll stay with me, not stay with me, but she doesn't kind of, um...listen to every word that I say, she's quite happy to plug her ear phones in [laughs] and drown me out. Um, I still take her to school every day, which I did anyway but that's more as a process of helping *me* to get started for the day ...rather than see her off and then probably squander an hour or so. Um, and also I pick her up, because that means she's back and she can start studying pretty quickly so...last year when she finished here, um, she would have been doing her GCSE's, so exams. Now she's doing her AS's, more exams and then on to A2's. So, for me it just makes sense to get her home and she can relax and then have more time to study rather than mess around on buses. It's silly, I'm able to. **[RF 1: absence of thinking about attachment behaviour for self or daughter in terms of mental states]**

Middle of interview

M5: You can tell even from Easter eggs, I don't know why I bothered getting Easter eggs for C5 last year because they weren't touched. Whereas this year, they definitely were touched. Not all at once. But, you know, they weren't left there for me to throw out because they'd gone white or something...

I: And is this all stuff that you have put into words to her or are you just, observing but not saying anything about how well things are going?

M5: Um, I think now observing, not even *really* taking notice. As I said, not unless I thought she's looking, she's looking different. To start with, when we finished here, I just didn't want to talk about it anymore. I thought let's just have a break. And then I think a couple of times I did broach it with her, you know, what did you think was going on? And she couldn't *really*... answer it or maybe she didn't want to, I don't know. **[A3]**

But it really feels now...like it never happened. [After leaving treatment] we were very quickly into exams. And then when exams finished, it was, "Mum, Mum, can I stay the night at so-and-so's?" So off she... So she was out *all* summer. She went to a festival, she loved it. So it was, it almost very quickly just disappeared, as if it hadn't happened. In her mind, she, from one day to the next, having finished exams, she found...freedom.

I: Do you have any thoughts about...what, what that could be about, that things changed so rapidly as soon as you left here?

M5: I can only assume that, having put on, you know, she was a healthy weight, that her head was healthy. Because it all, it had just all changed. And we'd always said, and we'd always been told, you know if you put the weight on, the weight goes on in your head as well. And then you can start to, you know, be more equipped to fight, whatever, you know anxieties you have.

And it happened almost without us noticing. It was almost at the end of the summer when I was thinking, "Oh now that's enough going out, you know, you're about to start A-levels."

End of interview

M5: As I said, it was almost like one day she was ill, next day, it back to normal. I suppose the one thing, I have said to her, I said, "Isn't it funny how you don't want to be with me much anymore?" [Laughs] And she laughs and it's in a kind of jokey way and I sometimes think, "Gosh am I, am I missing that now?" **[B3 possibly]** But...

I: Are you?

M5: No because I know that, naturally as a 17 year old, I wouldn't expect her to be hanging around me in the same way that the other two...didn't.

Appendix 7b

Addendum to Chapter 7. RF Results - Children

Examples from children's interviews demonstrating scoring of RF.

Example 1. C8 T2 Definite RF

Beginning of interview

I: So, if you want to start, I mean it's not an easy question but do you want to start with how you understand your eating disorder? How do you make sense of it, then and now?

C8: Well, I think it's like a part of you that turns things that are normal into something negative and like you shouldn't do, so like eating, going out and stuff like that, and it restricts you by stopping you from eating. And so I think that it's, for me it's like a little voice that says don't eat this or have less calories or make sure your weight is lower, but I think it's like a part of you that has just, I don't know, just gone wrong somewhere and confused what is normal and changed it.

I: And I'm really interested in all of that, that's quite an original way to put it, you're saying things, things that are normal turning them negative?

C8: Yeah, so eating is normal, but they turn it into something that you shouldn't do and that you should avoid because you're not good enough for it.

I: Okay, so can you tell me more about the not good enough for it?

C8: For me, it took away things that I would usually do and like school and eating and, well, friends and family because it told me that I wasn't, I wasn't worth having those things, I wasn't good enough or worth having. I shouldn't have those things because yeah, I, I haven't done anything to deserve them.

I: Do you have any thoughts then on why you would feel like that, but other people wouldn't, I mean most people don't feel like they don't deserve to eat

C8: I think that I have really low esteem, low self-esteem and it just started as like oh let's lose weight because I just want to change the way I look and then it turned into something more and the feeling of hunger became addictive and throwing away food was just routine and so it started off as a like a little way to lose weight

I: Which do you think came first, the low self-esteem and the not feeling deserving or the wanting to lose weight or are they connected? In which case maybe could you explain more?

C8: I think the low self-esteem came first, like from when I was quite young but in the same way they're connected as in, I didn't really think I was worth anything, so I wanted to stop anything that made me happy or made me live.

[marked RF – 7]

Middle of interview

C8: Yeah, I mean she [sister] stays away from me, we stay away from each other most of the time, she stays in her room and I stay downstairs and we don't really talk that often, erm, so it's kind of like silent arguing.

I: But things are ok with your Mum, your Dad and your brother

C8: Yeah, they're really good now, we get on really, really well.

I: And is that different from how it was before?

C8: Yeah, we used to be like, I was really scared of my Dad and I was really reluctant to talk to kind of talk to him or ask him anything. And then my Mum always used to, our relationship always used to be based around illness and like, 'oh Mum I have a tummy ache, Mum I don't want to eat, Mum, you know I don't want to be here, Mum I self-harmed,' just like always around illness. And my brother, we just kind of avoided each other and he'd say things that upset me and I'd say things that upset him, just didn't get on, but we're much better now, me and my brother, we've grown up a bit and we kind of kind of get each other and joke around with each other and we have fun and stuff. And me and my mum, we again, joke around and it's not all about illness, and me and my Dad, my Dad has become a lot softer, he's kind of calmer and nicer, and so, we get on better.

[Definite RF – 5]

End of interview

I: Oh, so are you still hoping that somehow you could change how you look?

C8: Yeah

I: And when you think about changing how you look what do you think about? Do you still think about losing weight?

C8: Yeah and just having thinner legs and a flatter tummy and a thinner face.

I: Do you think about doing things about that?

C8: Yeah, I mean I try to exercise to like tone up and look better, but that's about it, I can't, my Mum is so on top of it, I can't really not eat because she'll notice.

I: Is it something you think about that when you're an adult you'll lose some weight again if you want to, do you think like that?

C8: Yeah, I feel like, oh when I'm at university I can finally lose weight because no one is going to be watching.

I: And then, when you have that thought, do you scare yourself with that thought? Do you think uh oh what if I end up anorexic again?

C8: Yeah, because like I'll throw it all away and no eating disorder unit is going to hire me if I'm losing weight, so I don't want to throw away my future and throw away what I possibly could be doing, and before, anorexia was the most important thing in my life but the thing is now I've found more important things so like family, my friends, my school work, my job, well a job I want to have, that's more important to me than anorexia so...

I: So, anorexia has to compete in a way?

C8: Yeah

I: But it's still got a presence?

C8: Yeah

I: And are there days when you don't fight it? When you think I'm going to let it win?

C8: Yeah, I suppose there are some days where I might only have half a cup of tea and throw the rest away or yeah, throw away my food when my mum's not looking or something, but that's very rare.

I: And when you do that, what do you do after? Do you stop and think about why you did that or?

C8: I just feel like oh, maybe it will help me lose weight a little bit, or maybe it will make me happier, or it will, I find that if I have a plate of food if I leave a little bit I'll feel less guilty because it's like I haven't finished a whole meal?

[Definite RF – 5]

Example 2. C5 T2 Low RF

Beginning of interview

I: So how do you understand your eating disorder basically. What was it about? But er, it could either be looking back, or it could be about now if you still have an eating disorder. So maybe you want to say something about how you see your eating disorder now and then we can think about how do you understand it -

C5: Just didn't want to eat. Is that what is meant- it was anorexia -

I: Yeah, but maybe a bit more about why, you know, and are you talking about now or then?

C5: Then.

I: Yeah.

C5: Erm, just didn't want to eat because it's the only thing I had control of.

I: What were the things you didn't have control over then? What did it feel like? That you didn't have control of?

C5: I think I just felt it was the only thing I could have control over, control over what I was eating. And then it was after my grandpa died. So it was the way of kind of coping with it.

I: Hm... Can you say a bit more about how it helped you cope or how you hoped it would help you cope?

C5: Erm...

I: How does it work? I mean, I know that you know... I know that you know that I'm an eating disorder professional. But that doesn't mean that I know how it looks inside your mind about it. So just really spell it out for me, how did you think not eating and gaining a sense of control would help you cope?

C5: I don't know, I think it was just one thing and then it got too far after a while. And then I couldn't stop.

I: Yeah. Can you tell me a bit more about that process then? About... so you started off thinking you would have control?

C5: Yeah. Just thinking, just lose weight and not eat as much and then it just got to, well I didn't really eat at all.

I: Yeah.

C5: And then I'd only eat dinner. And then- and then people started noticing.

[Low RF – 2/3]

...

I: Yeah. And now, do you have any remnants of an eating disorder now?

C5: Is there any left of it?

I: Yeah. What do you notice about yourself?

C5: I feel very bad after I eat quite a lot of the time. **[B1]** Erm... I'm still kind of wary about what I eat... Or sometimes I'll just eat something and then something will come into my head, but then it goes quite quickly-

I: What kind of thing?

C5: Just, like I shouldn't have eaten it. Erm... I still remember, the calories of things.

I: Yeah.

C5: So I still kind of, memorise them.

[Low RF – 3]

Middle of interview

I: And what about the impact on your parents? Do you know now how they felt and how they were? Have you talked about it with them since or?

C5: No. No. Um... I didn't- my Dad didn't really know much about it. He used to get angry at me for it.

I: Angry. How did he show his anger?

C5: He used to just like shout and say 'why aren't you eating?' He didn't understand it. And then he'd apologise, but then he'd do it again.

I: And how did that affect you?

C5: Um...

I: In relation to him. Did it harm your relationship?

C5: I didn't really want to be - didn't like being around him for a while. Because he used to just constantly have a go at me for it.

I just didn't talk to him. Erm...

I: Have you and your dad ever had a heart to heart about that time?

C5: Not really no.

I: No? Well have things changed now? Or are you still a bit distant?

C5: No, we're fine now. I think it was just everything that was going on, just happened.

I: And your mum?

C5: Erm, well she was with me everyday. So she saw it all. She gave up a lot to be with me.

I: What did she give up?

C5: Just doing what she was doing during the day. Anything that she was doing, she used to come and have lunch with me at school.

I: Yeah.

C5: And then come up here. Which would take up the whole day.

[Low RF – 3]

End of interview

C5: I think I can appreciate some things about it.

I: Can you give me an example?

C5: Because my family and my friends were always there for me so... It's made me value that more.

I: Yeah

C5: Erm... I... I can notice things, it's made me become a lot more vigilant of my friends. So if I see something with them - or even anyone, and I notice that it's things that I used to do-

I: In terms of the eating disorder?

C5: Yeah. I'll say something. But in a way that I would have wanted it to be said to me, because I know how it will upset them.

I: Ah. I would like an example of that, can you say how things are said to you and how you actually say things to people?

C5: Erm... Well they would- people would say 'why isn't she eating? Oh she's just being stupid. She's doing it on purpose.' Stuff like that. But if I said-

I: Who might say something like that?

C5: That was one of- not really one of my friends, someone that knew, they knew of me. Erm, but I just asked them if they're ok. And then I'd just say 'I've noticed that you've', I'd say 'I could be wrong, but it's just my take on it.' And then, there's one who just said she was just stressed and hadn't really been eating that much. I just said 'just make sure you don't go too far with it.'

[Low or approximating RF – 3]

Appendix 8

Table 13. RF all	M1	D1	C1	M2	D2	M3	D3	C3	M4	M5	D5	C5	M6	C6	M7	D7	M8	D8	C8	M9	D9	M10	D10	C10
UnderstandingT1	7	8		9	-1		5		3	3	5		6		2	7	4	2		7	3	2	5	
UnderstandingT2	3	5		9		3	5			4	3		5				2							
Change +/-	-4	-3		0			0			1	-2		-1				-2							
Impact T1	7	5		9	5		7		4	4	3		5		2	5	3	7		7	4	3	5	
Impact T2	3	7		9		4	7			5	5		4				2							
Change +/-	-4	1		0			0			1	2		-1				-1							
Value T1	3	5		9	5		5		2	3	3		6		3	5	1	5		5	3	1	3	
Value T2	3	8		7		2	5			4	3		8				3							
Change +/-	0	3		-2			0			1	0		2				2							
Recovery T1	3	5		8	4		3		2	0	5		7		2	5	2	4		7	4	2	3	
Recovery T2	3	6		7		1	3			4	3		7				1							
Change +/-	0	1		-1			0			4	-2		0				-1							
TOTAL T1	5	6	-1	9	3		5	7	3	2.5	4	1	6		2	5.5	2.5	4.5	-1	7	4	2	4	3

Appendix 9

Appendix 9a

Step-by-step demonstration of the process of thematic allocation.

Example 1. D2

This step-by-step account is particularly intended to illustrate the process by which D2's interview was allocated to the interpretative category 'Mother blame' (Theme 7d), even though he never explicitly blamed his partner, his daughter's mother, for his daughter's eating disorder.

D2's interview was unusual and somewhat bizarre, as already noted, in that he struggled to respond to questions and dominated the interview with a blow by blow account of his wife's surgery. This account lasted for the first third of the interview. From there, D2 began an account of his own father dying when he was 12.

D2 began by implying, and when prompted, saying, that his daughter, C2, might have thought that her mother was dying, though there was still no explicit link to the eating disorder.

Interviewer prompts for links are highlighted in bold.

"D2: me being out of work for a long time and M2 having a hard job

I: how does that link to C2

D2: re my situation, being out of work for a long time, and in relation to M2, what it does to her, four or five years ago she had [chronic health condition]

I: oh, I didn't know that, I mean, I didn't know she had it

D2: M2 was on medication for 2 or 3 years on a low dose but eventually the episodes were coming back more even though she had doubled the dose, still to a moderate dose but doubled it, to 6 months before she went into hospital for surgery. So C2 has seen her mum go into hospital... 18 months ago

I: and I think you're implying that C2 would have felt very anxious about that, but can you spell it out, what do you think C2 took from that, how she felt about it. What do you know about that?

D2: What I do know is that M2's mum was over visiting at one stage and M2 was talking about 'the condition' and basically said, there are risks, they're not massive but there are risks involved, with the surgery, with the condition and the treatment ...either way it can be fatal but it's...the surgery is relatively new, I think the guy who did the

surgery is one of the best in the country, but he's only been doing that procedure for 15 years so he has been learning along the way how to improve outcomes...

I: He's the pioneer

D2: He's one of the UK pioneers, yeah (pause)

I: so what do you think C2 thought, or felt

D2: I think probably that she might lose her Mum"

Ten pages followed of detailed medical and chronological information. The interview passage which brought to a close D2's account of his wife's illness and segued into the account of his own father dying, began with a statement that after surgery, his wife took three months to return to work instead of the expected two weeks. He went on to explain this in physiological terms:

"D2: Probably because the guy who did it said that it's basically where, in terms of people being fitted with pacemakers they get fitted with them because their own pacemakers in their heart aren't working well, and there is a pacemaker which is ... a bunch of nerves that end in a clump, ahm, and so long as they do then you get a good clean signal 72 times a minute. If you've got [condition] the nerves, some of the nerves are going through either into another part of that chamber or I think even into other chambers, so that arc is getting the signals but it's conflicting, which is why it's inefficient and he said there was a lot of tissue there, so I think in terms of the heart recovering from what had been done to it, I guess there's more scar tissue, more to recover from, and I guess as well if there was that much more there then in your typical case she stood to gain more, but the flipside was, she was starting from a lower base point. She was tired-er.

I: So to get back to C2 – I wonder, I notice you're being careful not to say exactly what you think C2 took from that but maybe it's because you feel you don't really know exactly?

D2: yeah

I: But how would you

D2: and I guess thinking about it, rightly or wrongly, I haven't gone there. I really haven't quizzed C2 about it that much, and I think, er, yeah, and what I was going to say was, was probably erm that was ingrained in me, because my dad died when I was twelve and a half. Suddenly he was diagnosed with lung cancer, so he was ill for six months

I: wow

D2: and what I do know is that over that period erm I basically, not got my head down because I already had my head down, but kept my head down at school, got stuck into school work, carried on in all the sports teams I was involved in, and basically said let's not let this family anxiety around my father get in the way of me keeping going cos you can either keep going or you can stop and worry about it, so keep going. And erm as a by the by, probably about 8 years ago, M2 as a birthday present got me an hour's massage at the gym, and I'd had a few sports massages in the past when I needed them, but when I went over I thought well I don't need one, I can have one but I don't feel like I need one right now, asked what various things that that the massage therapist did and she said well I do x y and z and I do reiki. And I thought, well I don't know exactly what it is, as M2 has always said, I've acknowledged I'm not very religious at all but spiritual and quite open-minded, so I tried it and at the end of it she said something about 11 years... and that, she said, I sense there's a lot of emotion in your stomach which I think in terms of reiki and, was it, yoga shakras and all the rest of it, that's where emotion is, said, I've detected a lot of emotion in your stomach, erm, and said something about 11 years, and I said well I can think back through my career to some pretty stressful moments, but 11 years ago wasn't anywhere near any of them. And she said no, so this is when I'm now 42, 43, and she said no, not 11 years ago, *when you were 11*, and I thought well, that's a bit too close for comfort, can't really ignore that, my dad was diagnosed essentially when I was 12, he died when I was 12 and a half, which is...give or take one year, I think she's sort of literally put her finger on something so that's I think what I did with my emotion then - bottled it up. And so I think [pause]I was probably behaving in exactly the same way as a parent, as I was as a child."

As can be seen, the interviewer prompted repeatedly for links between these accounts and D2's understanding of his daughter's eating disorder, not least in an attempt to keep the interview on track, and also in an effort to understand what was motivating D2's choice of narrative.

" I: Yes but I'm puzzled by why that leads to an eating disorder – you have sort of implied there's a connection with M2 becoming very ill with a possibly life threatening condition and the eating disorder. I'm just saying, is there, do you have a formulation in your mind how they link?

D2: Not a very good one."

So in terms of looking at family patterns, I think my mum positively encouraged me to clear off on a gap year so when C2 disappeared at the age of seven off with a friend of mine for a week in Devon I thought great, good for her, whereas M2 was in a panic.

I: Mhm. So differences in terms of expectations of independence and autonomy.

D2: Yes, and I think her mother is very clingy around M2, erm

I: M2's mother?

D2: yeah, particularly around her, as the one girl out of the four of them

I: yeah

D2: So I think that's where we differ, but that's fine as well"

Putting together the pieces of this interview and trying to uncover the meaning of D2's preoccupation with his wife's condition and his own loss of his father as a child and the way he dealt with this, suggested that he may have been eliding his own childhood shock with his adult experience. In the first case, the illness and death of his father came as a shock, he was ignorant and not told of the seriousness of his father's illness. In the second, he went into enormous detail of his wife's illness, learning everything he could about it, as if to replace ignorance of childhood with knowledge. At the same time, his wife was upbraided for allowing their daughter to overhear a phone call about the risks of surgery, yet he acknowledged also that his wife had talked to their daughter about her illness.

An added aspect of the analysis concerned the fact that I had interviews with both parents. M2 in fact never mentioned her condition at all. As we have seen in the previous section of this chapter, she foregrounded her and her husband's poor and 'dishonest' relationship. D2 mentioned that they were having marital counselling and considered this a positive step for them, but placed the weight of his discourse on his wife's illness.

There is the implication, therefore, when putting together the various strands of the interview, that D2 was implicitly blaming M2 for either her illness, or the way she managed her illness, for playing a major part in their daughter's eating disorder. Yet when asked repeatedly how he viewed the link between what he was telling, and the question of how he understood the eating disorder, he could not really say, but used the phrase 'what I do know...' to lead the narrative in the direction he preferred. This lead the researcher to consider the possibility that he was answering a different question: not one about his understanding of the meaning of his daughter's eating

disorder, but his own question, concerning, perhaps, his understanding of his own trauma.

Appendix 9b

Demonstration of step-by-step comparison of themes in a couple's T1 interviews.

Example 2. M9 and D9

M9 and D9's accounts were in many ways consistent with each other, while each also adding a new perspective to the other's narrative. This example of thematic allocation makes transparent the process of how the privileged knowledge of the interviewer/researcher influenced the process.

Both M9 and D9 had only two themes each allocated in relation to their understanding of the meaning of her daughter's eating disorder, but they were different. M9 had Theme 1, 'I don't know and don't understand', and 5, 'Impact of family events'. D9 had Theme 2, 'an eating disorder is a disorder of eating', and 4a, 'Seeking attention – a communication'.

M9 began her interview declaring that the eating disorder made no sense and she didn't understand it, hence Theme 1. However, the substance of the interview that followed focused strongly on her own relationship with her daughter – hence allocation to the interpretative Theme 7a, 'Importance of mother-child relationship'. She also gave a coherent account of the way in which her aunt's death had impacted her, and therefore in turn her ability to care for C9, and a further thought about how a friend's grandmother's death awoke an emotion in C9 herself:

"She [C9] was worried about me. She knew that every time my aunt's name was mentioned that I would cry and she hated me crying and 'is, is mum ok?' When she got ill, I said things like, to my family and you know, 'if aunty M had been here, she would've picked her up from school there first. She wouldn't have had to be up in the office for a few weeks' – the office at work – because we were so caught up in work for a few weeks with our childminder sick. And it was, 'this wouldn't have happened'. 'Aunty M would have made sure that she had a proper lunch every day.' So there's a lot of connection around aunty M. And when, my, her little friend's granny died it was literally a week, days to a week, before this date when she said I'm not eating anymore... So I think that that had a huge ... She was at the graveyard of her friend's granny. Erm, I think it unearthed an emotion for her and brought back memories even though that family put on a much braver face than my family would put on at the burial of my relation. I think it unearthed things for her." (M9, T1)

This account did not appear in any form in D9's interview, but he thought that C9 was drawing their attention to some unmet need, hence Theme 4a:

"We were both working quite long hours and maybe we felt that we weren't giving C9 enough attention. Even though she was- even though she was with M9 a lot. She was kind of always with M9, which was on M9's terms. When we look at it now, you know, we look at photos of C9 and [older sister]- they were kind of deprived a bit I think. That we kind of, we made them rhyme with us rather than ask them what they'd like to do." (D9, T1)

Mainly, D9's interview, like his wife's, was suffused with reflection on C9 and M9's relationship. Below are some quotations from his interview on this theme:

"She wants us there the whole time now... On one level she has pushed M9 away and that - she won't give her a hug, and she won't tell her that she loves her. But still she wants her there the whole time. Which is frustrating for M9 and I'm constantly trying to say to her 'look if you want mum then you want mum, but if you want mum to stay you have to tell her that you love her and that you want her.' I don't- I don't know if I'm right or wrong by doing that...I mean she's constantly calling M9 a bitch. And telling her that she hates her." (D9, T1)

D9 also made an intriguing comment about M9 looking to her daughters for love:

"I mean one of the ways [the eating disorder has impacted] is that M9 hasn't been getting love from C9 so she has sought love from [older sister]. And I think - I know - that she's made a bigger effort. Not that she didn't make an effort- this isn't a critique. I know that she has reached out more to [older sister]." (D9, T1)

D9's comments about the centrality of the mother-child relationship, and the relationship being on M9's terms, led to allocation to themes 7a and the new theme for fathers, 7d. 'Mother/child blame.'

M9's interview also gave a fiery account of emotions where guilt and rage were blended, and her narrative was allocated to both these themes, as well as Theme 7c ('Self referential thinking') for the extent to which her own experience was central in her account, and of course Theme 7a, 'Importance of mother-child relationship'.

Her explosive statement about being 'kidnapped' needed careful thematic analysis:

“It’s like she’s actually kidnapped me. I feel like that- I mean, you know, we were always very much attached at the hip and when I came back from wherever I would tell her everything from start to finish: I was thinking about you the whole time, and I met somebody who was asking for you and, we just had this little routine, you know, that had gone on for the ten years but I came back from the trip and she literally - the following day I had noticed the restrictive eating and by the Friday she was actually eating nothing. One wonders is there a separation anxiety thing?” (M9, T1)

This quotation seems to contain two contradictory elements, or perhaps two sides of a coin. The theme seems to be about possession being part of the mother-child relationship, and M9 seems to be describing a kind of harmony that existed between her and her daughter for ‘ten years’ where her daughter fitted in with M9’s practical and work requirements – where, as D9 said, things were on M9’s ‘terms’. Then, something triggered a reversal where C9 no longer acquiesces to their ‘little routine’ and developed an eating disorder, the result of which was that now, family life had to be run on C9’s terms. In particular, she required her mother’s constant presence. Now M9 was possessed, or ‘kidnapped’, by her daughter.

The nature of the relationship was further illuminated by D9’s comment that M9 ‘seeks love’ from her daughters – an unintended admission, perhaps, of a situation that may well be common between mothers and daughters (ref Parker) but is nevertheless socially frowned on. Our cultural discourse requires that mothers give love, but do not demand love (refs Parker, Rose). Mothers who ask or expect their daughters to make them feel loved and good about themselves are, pejoratively, called narcissistic in psychoanalytic literature (ref). In attachment theory, attachment has traditionally been conceived as travelling in the direction of overt dependency, with a child being attached to its mother in the sense of seeking protection, comfort, and security particularly in situations of perceived threat (internal and external).

[Interviewer requested a description of ‘kidnapped’]

“Yeah well I haven’t been allowed to go to work, I haven’t been able to go to work because I have to feed her twice during her school day, and so every day I drop her at her school for ten to nine, and I go up to her school at 25 to 11 for her mid-morning break, and she comes and sits in the car and has her little break. And, I go to her lunch at her school at half past 12 – she refuses to eat in the car so she’s driven out one mile, and she has her lunch and then usually a little argument. Not every day, 50% of time and she goes back to school and I pick her up, even though I have a child minder also three days a week, I pick her up. She just wants me at home

even though the childminder is there. 'I need you..' The childminder rings and says she won't eat her mid-afternoon snack, only with me. So, it's been really difficult." (M9, T1)

In the context of treatment for eating disorders, the regime described by M9 is common to many families managing their child's eating disorder, but this does not alleviate M9's sense of 'entrapment' (to use her husband's word).

Mothers of children with eating disorders often find that no other adult will do as an attachment figure, or feeder, often not even fathers, let alone child minders. Eating disorders therapists expect this devotion to the task of re-feeding, and the 'separation anxiety' is taken as typical of an eating disorder. Many mothers comment on the restriction of their lives, although this was the first time the interviewer had heard it described as 'kidnapped'. Nevertheless, M9's account raises the question: do eating disorders treatments contain an inherent bias against working mothers, an expectation that mothers – but not fathers – will put everything aside in their own lives in order to feed their children? What would happen to eating disorders protocols if we decided that mothers' needs mattered and had to be balanced with those of their child?

As was already reported in Chapter 4, had M9's evocation of being kidnapped not been sufficient, she was also explicit about her current feelings towards her daughter, and the violence that regularly broke out from her daughter and her response to it, and therefore transparently a candidate for allocation to the Theme 9, 'Rage at child'.

"I... the emotion towards her is... one of anger. And dislike. And sometime the hate word. Erm... It's very, very tough and I was such a hardworking person before. This sitting down at home doing nothing while the housework is building up is so frustrating. Now I'm home and I still have to have a housekeeper. It's like, it's a nightmare." (M9, T1)

Finally, what evidence was there for allocation to Theme 8, 'Guilt', for both M9 and D9? M9's feelings of guilt were implied. They came through the account of how she worried C9 both by her state of mind, her crying, and her words, after the death of her aunt. But more than that, through some of the descriptions of C9's demands, violence and unreasonable behaviour, there ran an absence of defensiveness or even self-protectiveness. M9's stance in relation to the metaphor of being 'kidnapped' was not one of fighting her captor, but, while protesting how hard it was, nevertheless, a stance of acquiescence, submission. It was as though she felt this might be her come-

uppance for the ten years when C9 was, in her words, “Mummy’s little pet”. In fact, she concluded explicitly that she had to acquiesce:

“I am impeding [recovery] right now, I’ve become cranky and cross and impatient at the moment. I need to relax into it, relax into this process. And slow my life down further.”

D9 had his own account of guilt. Reluctantly at first, he included himself in the idea of C9 having been neglected owing to both partners’ work demands, where he used the phrase ‘made them rhyme with us’. But he also carried specific guilt about an incident that happened between him and C9:

“See, around the time that we copped what was wrong, just before that there had been a -. Erm, somebody was missing from M9’s business, she had to spend more time down there. C9 was kind of left alone a lot more in the office maybe. I know even one day around this time I collected her from school, and M9 was away, and she talked to me about how she had told the teacher about other kids that had been slagging off the teacher. So she got into the car and she was telling me this - how this other girl made her go up and tell the teacher- she said that the other girl made her do the talking. This was C9’s side of it but, I just lost my head with her to be honest. You know I just got really cross with her. She was finished school for the day and I was going on and on until it was time to get something to eat. When she wouldn’t come with me I felt so bad about it. That she just wanted me to drop her at M9’s business and she went upstairs, and was on her own. At the time I felt guilty.

It was around the time [of the start of the eating disorder]. I brought it up with the doctor, like I felt really guilty about it. I really got cross with C9, and I really gave out at her about telling on people. And I kind of kept at her about it.” (D9, T1)

A final piece of the puzzle of D9’s guilt concerned a conversation between himself and M9:

“M9 sat me down one Sunday evening and she had a heart to heart. And I listened to her. And she articulated it very well, you know, where we were, where she was, what she needed from me. And you know what, she was dead right. No holding back. You know, and after that it made me realise that I wasn’t really pulling my weight and, you know, since then our relationship is back to where it was. Really to be honest, I mean, a much better place. And I think even C9 has improved a bit as a result of it.” (D9, T1)

In the end, D9’s forthright account revealed guilt about neglecting the children, guilt about getting angry with C9, and guilt about not pulling his weight at home. Whether

all of these factors related to the eating disorder or not was not spelled out, but they strongly coloured his narrative, and were thematically ordered accordingly.

Appendix 10

Appendix 10a

Family 2: M2 (T1&T2) and D1 (T1)*

Phenomenological themes:

M2 gave a strongly argued, rich account of her daughter's eating disorder being a response to the dual factors of adolescent developmental challenges and their own family life being 'inauthentic' owing to their poor marital relationship. She gave considerable and detailed attention to the ways in which their family environment could have made their daughter unhappy, including her own modelling as a working mother. She considered how their daughter might have tried to use the eating disorder to separate herself from the dominance of her parents' arguments and 'fake' relationship. D2 gave an interview that was characterized as 'bizarre' because of his difficulty in addressing the topic, that is, his daughter's eating disorder. He devoted most space to an account of his wife's illness, which he related to his own childhood experience of his father's death, and eventually after prompting, seemed to suggest that his daughter's eating disorder was a response to her mother's illness.

	1&2 Don't under stand	3 Genes & biolog y	4 Personalit y factors	4a Attn	5 Family factors	6 Social and adol dev	7a Importance parent-child relationship	7b Imagini ng child's MS (RF)	7c Self ref thinking	7d Mother/ Child blame	8 Guilt	9 Rage child/ prof	10 Plai ntiv ene ss
M 2					✓	✓	✓	✓	✓		✓		
D 2	✓			✓	✓		✓	✓	✓	✓			✓

Interpretative themes:

M2 expressed a mixture of guilt at not having addressed the family troubles a long time ago. At the same time, she took a hopeful stance that the 'bomb' of the eating disorder would allow the family to take stock, change its functioning, and result in better communication and relationships.

D2's rambling account with excessive medical detail implied blame of the way his wife handled her illness in the context of their family life, while hardly factoring himself into the family narrative (further discussion of this is given in Appendix 9a where D2's interview is used to illustrate the process of this particular theme being deduced).

T2 themes:

By T2, D2 was no longer contactable as the couple had split up.

M2's account was focused on the outcome of the family journey being positive for their daughter although she herself was still reeling and unsettled in many ways. She was adamant that she would not have changed what happened – saying that their daughter's eating disorder forced them as a couple to face their differences.

RF:

	U1	U2	I1	I2	V1	V2	R1	R2	Total1	Total2	+/-
M2	9	9	9	9	9	7	8	7	9	8	-1
D2	-1		5		4		3		3		

*[C2 refused interviews at both T1 and T2].

Appendix 10b

Family 3: M3 (T1), D3 & C3 (T1&T2)

Phenomenological themes:

M3's first interview was damaged and was unable to be used, a significant loss to what would otherwise have been a whole-family set of interviews at both time points. It was a further loss because the interviews of D3 and C3 contained prominently the theme of C3's and M3's unsatisfactory relationship and the suggestion that it was implicated in the eating disorder.

D3 gave a multi-perspective, rich account of his understanding of the meaning of his daughter's eating disorder at both time points, describing both his view that C3 could not get 'what she needed' from M3 and reporting on his wife's despair that their relationship could ever be repaired. He gave space to descriptions of their daughter's long-standing anxiety and associated difficult behaviour riddled with need for reassurance. He also factored in her rivalry and sense of inferiority vis-à-vis her older sister, which further fanned the flames of her insecurity.

C3 herself covered themes similar to her father's, speaking about her feelings of straining to be like her sister and her conviction that her mother wasn't satisfied with her as she was. Touchingly, she made a big effort to mentalize her mother's lack of physical affection towards her, weaving together what she knew of her mother's own childhood with her own experience and concluding that her mother may not know 'what hugs are for'.

	Understanding
C3(T1)	1.Lots of rules 2.Stressed and worried 3.Want mum's approval – poor relationship 4.Compare myself with big sister
C3(T2)	1.Change of mind – "I realized..." 2.Vicious spiral down

	1&2 Don't understand	3 Genes & biology	4 Personality factors	4a Attention	5 Family factors	6 Social and adolescent development	7a Importance of parent-child relationship	7b Imagining child's MS (RF)	7c Self reflecting	7d Mother/Child blame	8 Guilt	9 Rage child/pr of	10 Plaintiveness
M3													
D3			✓	✓	✓	✓	✓		✓	✓	✓	✓	

Interpretative themes:

These data suffer from the absence of M3's first interview. D3 showed a true mix of emotions directing both anger and empathy towards his daughter – anger for her behaviour, empathy for what he perceived as her unmet needs and anxiety. He expressed guilt about the extent to which he may have been absent from the family and was self-critical about his tendency to be a 'workaholic'.

T2 themes:

M3's interview at T2 was notable for its lack of focus on the daughter who had the eating disorder. She was dismissed with the assertion that she no longer worried them M3 made few attempts to understand what might have motivated her daughter's behaviour, hence a low RF score. She spoke mostly about the damaging effect of what they had been through on their older daughter, now herself showing signs of an emerging eating disorder, as well as the damage to her own mental health, the couple relationship, and on the fabric of the whole family. Her emotions were evidently raw, with anger, blame and distress expressed.

D3's account at T2 was more balanced with concern shown for the whole family along with some fading hope that things could improve. He spoke about the damage to the couple relationship in particular while also highlighting his own greater involvement and the ways in which he was closer to his daughters.

C3's own T2 interview was notable in that her relationship with her mother appeared to have been air brushed out of her narrative. Her mood was cheerful and confident, which she attributed to improved relationships with her sister and having gained friends at school, but the account was more superficial than at T1, resulting in a drop of 4 points in her RF score, from 'high' to 'low'.

RF:

	U1	U2	I1	I2	V1	V2	R1	R2	Total1	Total2	+/-
M3		3		4		2		1		2.5	
D3	5	5	7	7	5	5	3	3	5	5	-
C3									7	3	-4

Appendix 10c

Family 4: M4 (T1)

Phenomenological themes:

Family 4 came to consist of only M4's single interview at T1. Hers was an interview that ranged over many possible topics without going into great depth, expressing shock and bewilderment at the apparent revolution in her daughter's previously capable and mature personality, and guilt at perhaps having laid too much responsibility on her.

	1&2 Don't understand	3 Genes & biology	4 Personality factors	4a Attention	5 Family factors	6 Social and adolescent development	7a Importance of parent-child relationship	7b Imagining child's MS (RF)	7c Self reflecting	7d Mother/Child blame	8 Guilt	9 Rage child/pr of	10 Plaintiveness
M4	✓	✓	✓		✓	✓	✓				✓		

Interpretative themes:

M4 cited her own eating disorder as a young woman as a 'genetic' factor, without elaborating on how she saw the links, and generally did not include herself or her relationship with her daughter in her understanding of the eating disorder.

RF:

M4 scored low for RF because of her apparent difficulty in linking her daughter's eating disorder with the themes proposed – it was more as though she were conducting a review of possible contributors rather than expressing her beliefs. As she refused the T2 interview after consideration, it was not possible to discern whether her score would have changed over time and with her daughter's treatment.

	U1	U2	I1	I2	V1	V2	R1	R2	Total1	Total2	+/-
M4	3		4		2		2		3		

Appendix 10d

Family 5: M5, D5, C5 (T1&T2)

Phenomenological themes:

M5 explicitly said she had no theories about her daughter's eating disorder and although she cited professionals' suggestion that it had something to do with the death of maternal grandmother, she later withdrew this idea saying she could not herself see any connection. She mostly spoke in terms of the eating disorder being about food and eating.

D5, on the other hand, had an idea that the eating disorder was at least in part a consequence of C5's social timidity, which in turn he linked to growing up with two older sisters and struggling to find a place for herself.

C5 herself had very little to say about her eating disorder at T1, appearing quite lost within the eating disorder thought hazarding generally the idea that it gave her 'control', while acknowledging that it wasn't really working.

	1&2 Don't understand	3 Genes & biology	4 Personality factors	4a Attention	5 Family factors	6 Social and adolescent development	7a Importance of parent-child relationship	7b Imagining child's MS (RF)	7c Self reflecting	7d Mother/Child blame	8 Guilt	9 Rage child/pr of	10 Plaintiveness
M5	✓												
D5	✓			✓		✓	✓	✓	✓				

C5(1)	1.Healthy eating 2.Went too far, lost control 3.Did something bad and disappointed people 4.Control when grandpa died and everyone upset
C5(2)	1.Control (but doesn't sound convinced) 2.Went too far

Interpretative themes:

M5 was something of an outlier in terms of the group of mothers, in that although she scored low on RF and advanced few ideas about understanding the meaning of her daughter's eating disorder either personally for her daughter or within the family

context, she harboured no overt feelings of rage or blame. Other mothers in the sample with limited idea and understanding, and low RF, tended to demonstrate strong emotions by contrast.

D5 similarly was emotionally quite muted, but he did factor in the importance of parenting into his account.

T2 themes:

M5 at T2 spoke about the impact on herself, and also let the interviewer know that the family was yet again being placed under great strain by their older daughter developing an eating disorder. She betrayed anger and resignation, but again, few ideas about why this might be happening. She showed gratitude for her younger daughter's recovery.

D5 at his second interview expressed sadness for himself at the decline of family relationships and his own feeling of being 'left out'. He thought the eating disorders had brought mother and daughters closer while his own relationship with all family members had become more distant, and he seemed quite lost, calling himself a 'spare part'.

C5 at T2 has some more definite ideas about the eating disorder, referring to a development within her of self-assertiveness. She also spoke about anxiety being something she always suffered and how the eating disorder may have been intended to help her, but had not, and she was now having to learn to tackle anxiety in other, more constructive ways. She spoke of gratitude to her mother for her care, and anger with her father for not understanding.

RF:

Everyone in this family scored low on RF and one might speculate that the practice of thinking in terms of mental states was not familiar ground for any of its members.

	U1	U2	I1	I2	V1	V2	R1	R2	Total1	Total2	+/-
M5	3	4	4	5	3	4	0	4	2.5	4	+1.5
D5	5	3	3	5	3	3	5	3	4	3.5	-0.5
C5									1	3	+2

Appendix 10e

Family 6: M6 (T1&T2), C6 (T2)

Phenomenological themes:

M6 was in the group of mothers comfortable with mental state thinking, scoring highly on RF, and full of ideas about the meanings of her daughter's eating disorder. These ranged across the impact of their divorce on C6's development and on her relationship with both parents, her self-esteem and her moods. M6 also factored in the impact of her own experience of having an eating disorder as a young woman. C6 herself gave only the one interview at T2 and therefore it was not possible to compare her answers over time. At T2 she spoke about a number of factors wrapped up in her eating disorder, prime among them being her linking of feelings of aimlessness and depression with her parents' divorce. She retrospectively saw her eating disorder as a mechanism for coping with such feelings, a kind of magnet for depressive thoughts and feelings.

C6(2)	1. Depression – focus for feelings and aimlessness 2. Self-deprivation 3. Influence of ED unit 4. Depression re. parents' divorce
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	1&2 Don't understand	3 Genes & biology	4 Personality factors	4a Attention	5 Family factors	6 Social and adolescent development	7a Importance of parent-child relationship	7b Imagining child's MS (RF)	7c Self reflecting	7d Mother/Child blame	8 Guilt	9 Rage of child	10 Plaintiveness
M6	✓				✓	✓	✓	✓	✓		✓		

Interpretative themes:

M6 spoke in the frame of a mother who took for granted that her relationship with her daughter was central both in the emergence of the eating disorder and in recovery. Her interviews were internally consistent in the sense that her rich seam of ideas about the meaning of her daughter's eating disorder was reflected in the full range of emotions she evidence about it, including guilt, but not rage. Her RF scores also were at the higher end of the scale and consistent over time. M6's interview could be held to confirm the hypothesis that parents who had strong ideas about meaning, who saw themselves as important in their child's development, and who had high RF scores, also suffered less from the negative emotions of rage and blame.

T2 themes:

M6's interview at T2 covered a great number of topics, as at T1, and a fresh look at previous themes as well as new ideas, plus an evaluation, mostly positive, of their treatment journey. Possibly this tendency of M6 towards diversity and broad reach rather than depth accounted for why her RF scores were not even higher than they were.

RF:

M6 had a high RF score on both T1 and T2 interviews, although the values on individual domains changed over time, with the score on the Understanding domain falling and the score on the Value domain rising. This movement was also observed in other mothers' RF scores. The logic behind this was laid bare in the thematic analysis of mothers' T2 interviews, where it was seen that at T2, mothers were more concerned with applying their understanding to assessing the impact and value of the eating disorder on their child, and on family relationships, and less motivated at this later stage to think about what lay behind the eating disorder itself. C6 scored RF of 5, suggesting that while she certainly had thoughts about the meaning of her eating disorder, she was in transition and still uncertain, hence didn't elaborate markedly on any one topic about self or other.

	U1	U2	I1	I2	V1	V2	R1	R2	Total1	Total2	+/-
M6	6	4	5	4	6	8	7	7	6	6	-
C6										5	

Appendix 10f

Family 7: M7 & D7 (T1)

Phenomenological themes:

M7 and D7 both struggled to attribute meaning to their daughter's eating disorder. M7 stopped at the idea that she was seeking attention from her friends and had lost her social circle, but could not reflect further on why this might have happened. D7 went further and also interpreted his daughter's eating disorder as a 'cry for help'.

	1&2 Don't understand	3 Genes & biology	4 Personality factors	4a Attention	5 Family factors	6 Social and adolescent development	7a Importance of parent-child relationship	7b Imagining child's MS (RF)	7c Self reflecting	7d Mother/Child blame	8 Guilt	9 Rage child/pr of	10 Plaintiveness
M7	✓					✓						✓	
D7				✓		✓		✓	✓			✓/	✓

Interpretative themes:

Both parents were very angry with their daughter, and this was palpably associated with their incomprehension. M7 seemed to feel attacked, and spoke with great distress about the impact on her professional life and letting her colleagues down. D7 reached into his own past for some understanding. Neither parent factored in the family environment or aspects of their parenting in their daughter's eating disorder, logically enough, as they did not conceive of it in developmental terms.

RF:

M7 was in the group of mothers that scored low for RF, combining little understanding or meaning-making with high negative emotion. D7 scored higher, given his attempts to put himself in his daughter's shoes as somebody needing help, and associating these thoughts with his own need for help in adolescence.

	U1	U2	I1	I2	V1	V2	R1	R2	Total1	Total2	+/-
M7	2		2		3		2		2		
D7	7		5		5		5		5.5		

Appendix 10g

Family 8: M8, C8 (T1&T2), D8 (T1)

Phenomenological themes:

M8 could be considered actively traumatized at both time points during the interviews, as her daughter was on a long and tumultuous journey through an eating disorder with co-morbid conditions such as ASD and OCD and many instances of self-harm, and recovery was elusive during the research period. M8's interviews consisted of many stories and descriptions of extreme emotions and distress of her daughter, herself and the whole family, including the way in which her life had become reduced to being her daughter's feeder. At this time, M8's understanding of the meaning of her daughter's eating disorder was in one way restricted to a simple attribution to her daughter's pre-existing character and personality, including the diagnosis of ASD.

D8 was much less involved in managing his daughter's eating disorder and at T1 (he did not return for T2) expressed bewilderment as well as anger towards his daughter for breaking family rules and parental expectations with her behaviour. Like M8, he attributed the eating disorder to C8's personality and in his account specifically to certain character flaws. He also questioned his own role in the family and had begun efforts to change and be more involved, resulting in self-reflection and feelings of guilt. Parents' accounts differed widely at this time.

C8 at T1 was deep inside her eating disorder but included a bitter and pained account of her peer relationships as part of her meaning-making.

Interpretative themes:

M8 belonged to the group of mothers who saw their child's eating disorder as indicative of their child's fixed personality, mostly divorced from family context, although issues with school and peers were cited as contributory. Where M8's account may have lacked meaning-making content, however, strong emotions filled the gap, with a narrative about suffering and personal growth through the testing provided by her daughter's eating disorder. M8 spoke of her own emotional experience, but it did not include guilt or reference to her own influence as parent. On the contrary, she believed she had very little influence over her daughter's development and saw herself more in the role of guardian than mother.

	1&2 Don't under stand	3 Genes & biolog y	4 Personalit y factors	4a Attention	5 Famil y factor s	6 Social and adolescent developme nt	7a Importance of parent- child relationship	7b Imagini ng child's MS (RF)	7c Self ref thinking	7d Mother/ Child blame	8 Guil t	9 Rag e chil d/pr of	10 Plai ntiv ene ss
M 8		✓	✓			✓						✓/✓	
D 8	✓		✓	✓				✓	✓	/✓	✓	✓/	✓

C8(1)	1.Irrational thoughts –OCD 2.Not eating is part of me 3.Felt ugly at school 4.Didn't like who I was
C8(2)	1.Low self-esteem – not deserving of food, friends

T2:

At T2, M8's religious faith brought her to other meanings, such as her daughter's eating disorder representing a test of her faith, her parenting, and her capacity for love.

RF:

M8's account remained primarily descriptive. Her demonstration of great emotional range, strength and passion, did not sit easily with a way of thinking herself into 'other people's shoes', mentally speaking, resulting in consistently low RF scores. We have seen that this association between strong emotions, including negative ones, and low RF scores, was apparent in other parents' results also.

D8 scored 4.5 at T1, his low score for the 'Understanding' domain (2) offset by a higher score for the 'Impact' domain (7), where he made concerted efforts to imagine the mental states of his other daughter and son, his wife and himself – but not C8 herself.

C8's RF scores at T1 and T2 were notable for their discrepancy, a difference of 6 points. This makes sense when considering that C8 was very ill with her eating disorder at T1, but after 18 months of treatment, in a better mental state at T2. At the

time of the T2 interview, she had returned from in-patient treatment to live at home and felt that family relationships were reviving. She made some marked attempts to be actively imaginative about her siblings' and parents' feelings. She also spoke about her own low self-esteem as meaningful in the context of her eating disorder.

	U1	U2	I1	I2	V1	V2	R1	R2	Total1	Total2	+/-
M8	4	2	3	2	1	3	2	1	2.5	2	-0.5
D8	2		7		5		4		4.5		
C8									-1	5	+6

Appendix 10h

Family 9: M9 & D9 (T1)

Phenomenological themes:

M9 saw her 10-year-old daughter's eating disorder as a way of capturing her (memorably using the word 'kidnapped') and strongly interpreted the eating disorder in the context of their family life. D9 expressed bewilderment but saw his daughter as issuing a need for attention.

	1&2 Don't under stand	3 Genes & biolog y	4 Personalit y factors	4a Attention	5 Famil y factor s	6 Social and adolescent developme nt	7a Importance of parent- child relationship	7b Imagini ng child's MS (RF)	7c Self ref thinking	7d Mother/ Child blame	8 Guil t	9 Rag e chil d/pr of	10 Pla ntiv ene ss
M 9	✓				✓		✓	✓			✓	✓	
D 9	✓			✓						✓		✓	✓

Interpretative themes:

M9 felt a powerful mix of guilt about her self-perceived neglect of her daughter's needs recently, and fury that her daughter should now rule her life with her demands. D9 expressed bewilderment at what had befallen his family and struggled to see his place in events, tending more towards blaming his wife and the mother-daughter relationship.

RF:

Because of the complex and contextualized way in which M9 understood her daughter's eating disorder as bringing together elements in family relationships and family functioning, she scored high on RF, even while at times her raw emotions contradicted her more subtle thinking. D9 by contrast could not really imagine the mental states of his family members or himself, and as noted tended towards blame.

	U1	U2	I1	I2	V1	V2	R1	R2	Total1	Total2	+/-
M9	7		7		5		7		6.5		
D9	3		4		3		4		3.5		

Appendix 10i

Family 10: M10, D10 & C10 (T1)

Phenomenological themes:

M10 understood C10’s eating disorder firmly as a dimension of her long-standing ‘difficult’ character, outside her own domain of influence as her mother. She believed that her daughter had ASD (later diagnosed) and that this drove her behaviour. Further, she believed that there was a strong genetic predisposition towards mental disorders within the wider family. M10 did also factor in sibling jealousy. D10 had little to say about his daughter’s character but saw her motivation for her eating disorder as seeking attention within the family, albeit he interpreted this negatively saying she had already had more than her fair share of attention. C10 herself expressed mistrust and anger with her parents, although she did not explicitly link this with her eating disorder. C10 also spoke bitterly about her school friends.

	1&2 Don't understand	3 Genes & biology	4 Personality factors	4a Attn	5 Family factors	6 Social adol dev	7a Importance parent-child relationship	7b Imagining child's MS (RF)	7c Self ref thinking	7d Mother/ Child blame	8 Guilt	9 Rage child/ prof	10 Plativeness
M10		✓	✓		✓							✓/	
D10	✓		✓	✓						✓		✓	✓

Interpretative themes:

Both parents saw their child’s eating disorder as outside of parental influence, were very angry with their daughter, and for them as for others in the sample, anger with and blame of their daughter seemed to be positively associated with lack of understanding or more in-depth meaning-making.

RF:

All in the family had low RF scores at T1, as might be expected given the narrative in the family about mental ill health being something that was genetic. The blame of their daughter's character logically contradicted this position nevertheless, and D10 scored slightly higher in that he was able to imagine her intentional mental states to some extent even though interpreted them to have negative intent. C7 was able to observe and describe mental phenomena and relational interactions to some extent, though she too interpreted what she observed negatively.

	U1	U2	I1	I2	V1	V2	R1	R2	Total1	Total2	+/-
M10	2		3		1		2		2		
D10	5		5		3		3		4		
C7									3		