How do women with a history of SEED-AN experience navigating their lives away from and beyond their illness.

A Narrative Inquiry study

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Abstract

The purpose of this study was to explore through narrative inquiry methodology the experiences of four participants as they navigated their lives away from severe and enduring anorexia nervosa (SEED-AN, Robinson, 2009). Whilst positions of what recovery can mean emerged its aim was to open up the ‘how’; how may a person journey away from a life dominated by anorexia nervosa? These first-person narratives stretched across early developmental disturbances to being caught between dread of the past, repetition in the future and their experiences in the present time. This study emerged from my own long experience of anorexia, my professional relationship within my private practice and as co-founder of Anorexic Aid, now B-eat, a UK national charity for eating disorders. This insider-researcher perspective provided what I believe to be a unique subjective and reflective dimension to this study. To analyse and frame the narratives in a way that enabled the reader to travel alongside the participants’ journey Bettelheim’s (1976) framework used to analyse fairy-tales was adapted and became a scaffold to begin the analysis. A cross-case analysis followed with Connelly & Clandinin’s (1990) three-stage narrative inquiry analytic tool adapted for this purpose. From scrutinising the transcripts in this way what began to emerge was a sense whereby relationships for all the participants were viewed as unsafe and unreliable and their sense of self shifted between invisible and invincible. There followed two distinct stages the first I refer to as ‘transition’ whereby from consistent, containing relationships new relational configurations displayed a shift from concrete ‘knowing’ to experiencing the idea of possibilities in the future. They also began to develop a capacity, to be reflective and reflexive. The second stage I have named ‘Integration’, where the narratives demonstrated a more grounded sense of ‘self and other’, of relinquishing the need to be special, of taking in the idea of being ‘ordinary’ and good enough. This study has provided a depth of understanding of SEED that appears to be little attended to in current research, the confusion of what are

‘normal and socially acceptable’ thoughts, feelings and actions and what may be eating disorder residues particularly around food, body shape and exercise. This study has further highlighted organisational challenges for the provision of therapy within the public sector which remains time-limited and focused on symptom alleviation; it conveys the importance of therapeutic consistency. A further outcome from this study that is relevant to all our clients who have experienced a long history of struggling with mental health has been to shine a torch on the importance of hope and encouragement in the therapeutic endeavour. It expands the importance of mentalisation and provides an additional concept of understanding ‘relapse’ as a positive experience, one not to be viewed negatively but rather a flag towards unprocessed material. To summarise this study has identified the primacy of emotional nourishment achieved with and through human relatedness.

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Chapter One

Introduction

"It is the ultimate irony for the anorectic that, unlike the starving millions of the world for whom the primacy of hunger is life-saving, she is resisting eating and attempting to starve in the presence of abundant food"

(Crisp, 1995, p79)

Unlike the name implies, anorexia nervosa is far from a 'nervous loss of appetite' (Crisp, 1995, p 3), rather, there is an active engagement and over-evaluation in maintaining the symptoms. This includes a massive embargo on food intake, an overwhelming terror of weight gain and preoccupation with body-shape. Psychological manifestations include a relentless drive by the person to feel in control of their life with moods ranging from high anxiety to a deadening of emotions.

Statistics relating to the number of sufferers in the UK vary with figures predominantly based on individuals seeking professional support at primary and secondary care level. NICE (2004) recorded approximately one in 250 females and one in 2000 males will experience anorexia in adolescence and young adulthood. Suggested lifetime prevalence in the UK population in 2012 ranged from 0.9% to 4.3% for females (Hudson et al., 2007) with a risk of death weighted higher amongst females (Arcelus et al., 2011). Death from suicide amongst this group in a meta-analysis of mortality rates (Arcelus et al, 2011) suggested one in five individuals with anorexia committed suicide. For those in their 30's and 40's suicide rates were three to four times greater than the general population (Crisp & Collaborators, 2006) with suicide more common in those who presented a continuing and severe eating disorder. Studies have indicated where early onset of anorexia occurred the mortality rate averaged

20% when in their twenties; for those individuals aged over 30 years it increased by 5-10% every decade thereafter (Touyz & Hay, 2015). Steinhausen's (2002) study reviewed 5,590 patients, he argued that while treatment focus had shifted in the second half of the 20th Century, aetiology of anorexia remained complex, not fully understood and prognosis remained relatively poor.

Rationale for this research

With more females than males experiencing anorexia this study focused on women and specifically how four women with a history of severe and enduring anorexia nervosa (SEED-AN) navigated their lives away from the chronicity of this illness. Robinson (2009) described two groups of anorexic patients, the acutely ill young patient, who experienced a short spell of anorexia and the chronically ill patient with a severe and enduring eating disorder that sat alongside physical, psychological and social complications; where understanding appeared to be most sparse yet they were the most vulnerable. Without being prescriptive, Robinson (2009) suggested approximately ten years be adopted as the minimum duration of continuous illness for SEED-AN, whilst acknowledging individual variations. Severity he argued related to where the illness "interferes substantially with quality of life" (Robinson, 2009, p8).

Whilst questions of 'why' a person may suffer with an eating disorder and 'what' treatment may support them have long been studied 'how' a person may experience relinquishing this illness, physically and emotionally, has been less attended to. Previous studies, as identified in this study's literature review have largely drawn on a medical model where two distinct positions exist, the patient is ill or recovered with physical measures and scales of beliefs about their body constituting a notion of recovery. This study provides a subjective and reflective dimension offered through and inspired by unfolding first-person narratives of women conveying how they conceptualised and experienced reclaiming their lives after more than ten years. It draws on Moussakas' (1990) heuristic frame of inquiry, whereby the researcher's "internal frame of reference … (is) present throughout the process and incorporated as an organised and systematic form for investigating human experience" (Moustakas, 1990, p 9). This study, including the chosen methodology, narrative inquiry, emerged from the significant affinity I have personally and professionally with the subject under inquiry. The premise of the researcher's personal narrative being positioned to the fore is a feature within narrative inquiry and chime with Etherington (2004) who argued how this reflected the researcher as an active agent with an inner story. Speedy (2008, p 41) conveyed the author's personal narrative represented the relationship between the researcher and their research as well as their commitment to their position of transparency. My exploration and choice of methodology for this study is discussed further in Chapter Three, methodology and method.

Locating myself in this research

This study began to form in my mind and take shape shortly after being accepted at the Metanoia Institute. I was in my fifties and had experienced a successful and largely enjoyable career in the corporate world. The idea of wanting to do something meaningful with my life had taken hold a few years earlier when I studied for a degree at the Open University. This was my second foré for I had been to university when I was eighteen but never finished my studies, weighing five stone I was sent home, feeling ashamed I never returned. Anorexia continued to haunt me for over thirty years over which time I was hospitalised on two occasions for over a year when my weight fell below four and a half stone. After many years of therapy I was accepted to study at the Institute and pursued a change in career; I considered myself one of the lucky ones, I had 'recovered', 'survived', phrases that I used back then without too much thought. Having experienced the very worst and the best of professional support my hope, in part, was to support others through this debilitating illness, one that I believe so few people really understood. I knew what it was to live in a bubble of despair and control, a life full of contradictions where good days were what a healthy person could not possibly fathom, not to eat and become 'high' because of it.

As I became more passionate about my new career in a more rounded way there emerged a nagging question “Am I recovered enough?” What I was searching for was a ‘yes’ or ‘no’ answer, certainty. Was it normal I wondered to check menus for ‘safe’ food before going out to dinner? I hated cooking and frequently eat the same ready-meal four nights in a row, my ready-made answer has been that’s what they’re there for, busy people like me. I ‘eat to live not live to eat’, another ready-made phrase.

Maybe my research study took shape when I began to question the original title of my study, ‘how do women who had experienced anorexia nervosa for an extended period of time recover?’ When my tutor suggested that ‘recover’ was a rather rigid, positivist position I strongly defended it, of course the word was recovered, this after all was where I sat. Aware of my discomfort led me to a more reflexive place, one of acknowledging how my protective black or white thinking had been activated. To doubt this word led me to doubt my position of wellness which in turn triggered my seeking certainty, that I was well-enough. Anything else was far too messy.

My mind moved further back in time, to years as an in-patient and out-patient, when psychiatrists and psychologists asked “Don’t you want to recover?” Arguably I was faced with the black and white thinking of the professionals I encountered (few appreciated the ambivalence that this question engendered). My fixation with the word recovery had, I reflected, been influenced by the institutional language I had experienced. Whilst I appreciate today how this word can be reductive it was once seductive, a destination of hope.

Today I appreciate how narrow my lens was focused when I began this research. For this study to be faithful to the narratives of my participants it needed to encompass the varied, storied landscapes of their life experiences as well as my own. From this intersubjective relational inquiry position, where the to-and-fro between my participants’ experiences and my own opened up I recognised how looking at what may be submerged beyond the dominant medical and theoretical discourses was imperative. Holding this in mind I asked a colleague of mine to interview me before I started interviewing my participants so that I could be clear about my own storied landscape, my own experiences rather than overlay them as I moved forward with this research.

Locating myself, professional knowledge

B-eat is a UK registered national charity for eating disorders, an organisation I co-founded over twenty years ago (then called Anorexic Aid and later EDA) and one of my proudest achievements. Until recently I sat on its Governing Board where discussions and activities included political lobbying, increasing eating disorder awareness amongst General Practitioners, schools and universities. As well as accessing emerging research, treatment protocols and engaging in psychosocial discussions this position offered me exceptional networking opportunities. Sitting alongside eminent eating disorder specialists they expressed an interest in this research title which motivated me further to pursue this line of inquiry. I am an active member of the Academy of Eating Disorders, as an International association my networking, knowledge and voice expanded with access to senior professionals across Europe, North America and Australia. I have been a visiting tutor at a London university, courses include Masters Level, Nutrition and Advanced Diplomas in eating disorders for international students. I have been a guest speaker at eating disorder units in the private sector and the NHS. More recently I have been a member of the British Psychological Society’s working party committee producing an eating disorders document to be published in 2019.

In my private practice approximately 85% of clients experience a range of eating disorders. Some individuals may also be receiving support from CAMHS, NHS Adult Services or private ED services, I encourage within these organisations an interdisciplinary approach and attend patient ‘care programme’ meetings alongside the psychiatrist and team. In my practice as an integrative, relational psychotherapist whilst it is inevitable that conversations regarding eating disorder symptoms will find their way into the therapy room my curiosity and interest throughout our work together is to consider with my clients what these thoughts and actions may be ‘saying’ and thinking about how these defensive strategies can be otherwise understood.

Chapter Two

A narrative literature review

Introduction: ‘Ploughing before sowing” (Kim, 2016, p90)

In the above quote Kim was conveying how literature searches were one of the pre-conditions for doing substantive, thorough research. It was, she argued, akin to the farmer who rigorously ploughed the soil to ensure a good harvest. Grant & Booth’s (2009) study, considered fourteen varieties of review types and associated methodologies and concluded there was no one systematic review typology, no ‘one size fits all’. A review’s strengths they argued depended on numerous factors including an appraisal of quality (of the literature), its congruence and robustness (validity and reliability) and relevance. Key they argued was that the chosen literature was evaluated according to contribution and the starting point for further evaluation not an endpoint in itself. Barker, Pistrang & Elliott (2002 p 39) provided a useful checklist in relation to the primary tasks of delivering a substantive literature review which included an appreciation of what gaps may exist in the field under interest, review whether there has been sufficient preliminary descriptive research to define the phenomena of interest, consider what this study can add to the existing literature and help formulate the research question and research design.

When conducting this review of published literature related to my field of inquiry my aim has been to actively explore and become familiar with the scholars, researchers, lines of inquiry and approaches. Selected sources used to investigate this study included key journals and in particular The International Journal of Eating Disorders, European Eating Disorders Review and Advances in Eating Disorders: Theory, Research and Practice. Additional searches were key search words in psychology databases and specifically SEED-AN, books relating to the field of inquiry and chosen methodology, conference papers and psychotherapy literature.

From here a conceptual framework was created to establish a context for the topic from a variety of perspectives leading to a justification for the study I had in mind. This framework also provided a flow of thought-streams shaped in three relatively distinct parts:

- Overview of the field of eating disorders and SEED, these appeared largely drawn from a medical model, within institutional settings, the focus predominantly measurement, protocols, defining treatment and recovery
- Looking beyond clinical interpretation towards mixed method and qualitative studies
- The therapeutic relationship, first hand experiences, integrative, relational psychoanalytic and psychodynamic approaches to the field of inquiry

It was important that this literature review should be in harmony with my narrative inquiry methodology and two key guiding sources in this endeavour were Clandinin (2000, 2013) and Kim (2016). The literature review below has stayed close to my epistemological and ontological commitment which includes demonstrating intellectual curiosity alongside a position of open inquiry, as Kim wrote “We don’t need to position ourselves as ‘the one who knows’ or the ‘expert in the field’. Rather we can write a literature review as a way of knowing’” (Kim, 2016, p 92).

Narrative inquirers enter research relationships in the midst of both the participants and researcher’s lives, Clandinin (2013) suggested literature reviews be interwoven throughout the research rather than separated, thus the narrators were positioned foremost throughout the study. I have adapted Clandinin’s (2013) model to meet academic requirements however

I have continued with literature references within the study where I felt it highlighted, strengthened or deepened my critical thinking of the participants' narratives.

Through a process of critical examination of what has gone before this literature review opens up a space that supports this research study as one that provides a unique contribution to existing studies. It creates "a place of possibilities from which we can engage in learning, to 'un-know' and 'not-know'" (Clandinin, 2013, p 77) and expand our knowledge by inquiring into lived experiences.

Classifying anorexia nervosa – a clinical model and diagnostic challenge

Research studies to-date have been predominantly quantitative in design with community norms of weight, eating related cognitions and behaviours as the basis of defining what constitutes anorexia and recovery from this illness. Nevertheless the relationship between the studies do not appear to have a common language of what treatment, 'outcome' or 'recovery' may look like. This review highlights some of the key studies, exploring the variance of clinical perspectives.

The Diagnostic and Statistical Manual (DSM 5, APA 2013) defined three core features required to make a formal diagnosis of anorexia. Summarised they are:

- Significantly low body weight, less than minimally normal
- Intense fear or persistent behaviours that interferes with weight gain, even at a significantly low weight.
- Where self-evaluation is overly influenced by body shape and weight; persistent lack of recognition of the seriousness of current low weight.

These are further sub-typed into restricting type and binge-eating/purging type, both to be present during the last three months. Within the DSM criteria behavioural and physical factors appear of prime importance.

Fairburn & Cooper (2011) argued that the behavioural nature of DSM 5's taxonomy was challenged by emerging co-morbidity studies. They indicated more complexity and diversity, adding affective dysregulation and addictive and personality disorders. A study by Meguerditchian et al (2009), of 141 anorexic patients displayed that the majority of weight restored patients still viewed themselves as not completely recovered. The same study quoted an International Health Behaviour Survey (2006) that encompassed 18,512 university students from twenty-two countries which reported the "fear of becoming fat is so widespread in the normal feminine population that it is questionable whether body image concerns and weight control behaviours are necessarily pathological" (Meguerditchian et al, 2009, p.402). It appears that symptom alleviation and weight restoration while crucial are not the sole indicators of recovery.

Treatment guidelines in the UK for the National Health Service (NHS) were published by the National Institute for Clinical Excellence (NICE, 2004). Diagnosis of anorexia was described "in its typical form" to be "relatively straightforward" (NICE, 2004, p. 14). Difficulties were placed within the individual whereby "the person's own willingness or otherwise to disclose his or her motives, symptoms and behaviours" (NICE, 2004, p.14) and other such "maladaptive behaviours" were the main obstacles in symptom cessation. While these guidelines offer useful information in relation to stakeholder contributions and co-ordination of care there is minimal interpretation of psychological recovery beyond cognitive functioning in relation to weight and body shape. The guidelines' summary concluded that "there is no uniform or agreed approach to the psychological treatment or management of anorexia nervosa in adults" (NICE, 2004, 6.2.2, p. 81). The emerging picture appears to be far from straightforward, instead it conveys a complex illness, where outcome is poor and with little evidence to suggest a guide or route for improving treatment. When eating disorders are delineated to specific diagnostic entities for epidemiological purposes I argue that it throws a shadow over statistical prevalence, incidence and how recovering from eating disorders is interpreted.

Attempts to define recovery from anorexia

Recovery has generally been framed by the medical model, where treatment is symptom-centric, “defined by the absence of symptoms and a return to normal, pre-morbid functioning” (Dawson, Rhodes & Touyz, 2014). My concern with this definition and in particular in relation to SEED-AN is how does one establish what ‘normal, pre-morbid functioning’ looks like when a person has experienced this illness for over ten years? Couturier & Lock (2006) argued that what was missing and crucial to recovery research was a coherent definition; something that could guide the patient, their families and clinicians. Yet, they argued “…an outcome as important as recovery is undefined … (and) without a benchmark” (Couturier & Lock, 2006, p 555). Noordenbos (2011) argued that with no consensus in relation to prognostic indicators nor criteria of recovery, treatment goals were unclear. A definition of recovery from anorexia remains imprecise and variable (Jarman & Walsh, 1999) and studies appear to use ‘recovery’ and ‘outcome’ interchangeably, despite there being distinct differences. ‘Outcome’ (Oxford English Dictionary (OED, 1998) is defined as a way something turns out, a consequence; ‘recovery’ as “a return to normal”. The Morgan-Russell (1975) criterion, a tool measuring global outcome of recovery classified good, intermediate and poor outcomes based on sustained normalcy of weight and menses (the latter removed from DSM 5) The authors however acknowledged that ‘good outcome’ was weak as it “excluded from consideration the presence of psychological symptoms”.

Attempts to measure recovery

Even with an unclear definition of recovery, there is a significant amount of epidemiological data on recovery available:

- Strober et al (1997) argued that recovery was protracted; their studies ranged from a median of 57 months free of physical symptoms and 79 months for psychological symptoms.

- Noordenbos & Seubring (2006) compiled a list of 52 possible criteria for measuring recovery taken from published ED research. In the majority of studies length of time at normal weight was specified alongside ‘normal eating related cognitions’.
- Couturier & Lock (2006) observed that weight restoration preceded psychological recovery by at least a full year; follow-up five years later nevertheless showed a large proportion, whilst exhibiting normal body-mass index (BMI), considered themselves as still suffering with AN. Psychological recovery in both instances was evaluated as “normal eating related cognitions”.

Even with ‘comprehensive and standardised measures’ there appears to exist a reduction in confidence of criteria and prognostic-indicator reliability. Differences in recovery times can be influenced by different cut-off points in relation to follow-up and size of study. There is also the question of the often repeated phrase ‘normal eating related cognitions’ (Noordenbos & Seubring, 2006; Couturier & Lock, 2006) leaving one to wonder how ‘normal’ can be measured. As Crisp (1995) wrote, attempting to define ‘normal’ adolescents was difficult and it was not just their irregular eating habits but their psychosocial functioning in general that made this hard to define or describe.

Alongside the challenges of defining criteria for measuring recovery it is perhaps unsurprising that there appears large differences in reports of how many sufferers recover. Couturier & Lock’s (2006) study ranged from 57.1% to 94.4%, depending on the instrument of measurement used. Using the Kaplan-Meier survival analysis, where the diagnostic criteria for weight indicated 85% ideal body weight, (IBW), long term recovery was 94%; where IBW and eating disorder examination questionnaire (EDE- Q) scores were combined, recovery fell to 74% (Couturier & Lock, 2006). When combined with co-morbid symptoms including depression and anxiety the percentage reduced to 30%. Highlighting the disparities their conclusion suggested “leaders in the field come together to agree on a working definition of recovery” (Couturier & Lock, 2006, p.555). From a clinical perspective seeking universal goals of weight and psychological symptoms could be considered as “relatively straight-forward” (NICE, 2004) to adhere to however, as Strober & Johnson (2012, p 158) argued “It isn’t that consensus among us is completely lacking; it’s that it’s elusive”.

The Recovery Model and anorexia

The recovery model’s origins emerged in the 1930’s in the United States as a political response from service-users and advocates to what was considered as the medical model’s pessimism in relation to long term mental illness, in particular schizophrenia. Today, the UK recovery model is integrated within many mental health (MH) services and Government policies (Hudson et al, RCPsych, 2009; Shepherd et al., Sainsbury Centre for MH, 2009; NIMH, 2012). Its overarching philosophical position is one of recovery being a journey rather than a destination. It is a personal process emphasising hope, empowerment and optimism; where individuals are encouraged to take self-responsibility and active participation in their own care with advocates, family members and MH teams where appropriate. I consider the medical model and recovery model in relation to anorexia as complementary and in agreement with Dawson, Rhodes & Touyz’s (2014a) comprehensive argument of support being extended in a more holistic and less limiting way.

Moving beyond clinical interpretations

Research to-date has generally emphasised what emerged from “within” (NICE, 2004) the person, what was absent (weight gain, healthy attitude towards food), rather than what was present and achievable. There is a growing body of research offering experiential reflections of what may support the individual including Tozzi et al’s (2002) study of causes and factors that fostered recovery. Their subjective perspective of patients, including temperament and personality features although refreshing nevertheless measured recovery against DSM-111-R descriptors. The use of statistical analysis to explore the participant narratives left me wondering about how nuances can get lost in statistics and how these may have been opened up further from a qualitative perspective which the authors alluded to in the research summary.

Qualitative research has displayed a shift in emphasis beyond absence of symptoms, a concomitant of this has been to broaden the perceptions of both the illness and the multiple meanings of recovery. Studies from this perspective include Garrett's (1996) Durkheimian study and Jenkins & Ogden's (2011) phenomenological inquiry. Malson et al's (2010) discourse analysis of in-patient views about recovery offered a poignant study of the 'self' and culturally dominant notions of recovery. The participants however were highly enmeshed in the illness and the study acknowledged its lens was largely based on treatment with only limited content on recovery. It is possible that, like the study's title, 'Un/imaginable Future Selves' readers could be left despondent in relation to the possibilities of moving away from anorexia. Hardin (2003) focused on psychological traits using a discourse and social construction methodology to investigate social and cultural assumptions of recovery. Of particular interest was her opening up a discussion about Westernized influences of cultural norms around the body, self-surveillance, self-discipline and the potential struggles of individualism.

Erikson et al (2012) used a quantitative and qualitative methodology to study the "possible selves" of adult women with anorexia. This research investigated the thought-processes of sufferers' versus a control group and their findings suggested largely negative self-beliefs, particularly in relation to expectations of health and social situations. What I particularly appreciated was their focus on the person as an individual and whilst there have been many articles published on the self and eating disorders the clinical implications offered were insightful through their continued theme of subjectivity and implications of self beliefs in therapy.

Dawson et al (2014) explored the process of the recovery of eight women who had experienced SEED-AN and described the use of stringent recovery criteria drawn from the medical model and recovery model. The methodology was narrative inquiry. Their findings described four themes:

- Unable or unready to change
- Tipping points in motivation to change
- Actions taken
- Reflection and rehabilitation.

A diagram used to track these phases showed movement towards the next phase via arrows which only moved in one direction. I found this interesting given the prevalence of studies suggesting a back and forth movement (Richard et al, 2005). Dawson et al's (2014) study argued that certain eating disorder research lacked trustworthiness, including where participants self-defined themselves as recovered. Whilst I appreciate that a person ensconced in the illness may well have a polarised sense of what moving away from the illness may look like, it could be argued that our own professional community could find it hard to embrace and juxtapose alternative positions. This led me to wonder how narratives were chosen for their study and what "extraneous material" they discarded as being "unrelated to the research question" (Dawson et al., 2014). I believe that "life at the boundaries" (Clandinin & Connelly, 2000, p 29), which includes context, cultural, social, familial and institutional narratives render additional, meaningful narratives beyond the grand narrative. Their research shares this study's methodology and we are in agreement that additional understanding of SEED-AN is important. Dawson et al's (2014) position nevertheless conveys 'full recovery', with no 'residual symptoms'; I argue that moving away from anorexia after a decade or more can hold complex psychological, cultural and social nuances, which this research will explore.

Diary entry: I have struggled with the interpretations and the connotations that sit beneath the words recovery, recovered, recovering. From the outset they have provoked frustration as I bumped into the words at every turn of this literature search. Having experienced anorexia for many years, its persecutory voice omnipresent, the idea that residual thoughts, feelings and/or behaviours may be present at varying degrees in times of stress I believed was not unreasonable, or was this me seeking to justify my interpretation of what I preferred to call ‘moving away from the illness and starting to appreciate myself’? What has become important as I move forward with this research, is to quell my own sense of ‘knowing’, born out of my own experiences and be curious about and open to other perspectives. Whilst I would like to replace the word recovery from this study it is a term that holds meaning beyond the medical profession, it is a beacon of hope for the sufferer.

Psychotherapy literature and anorexia

Having explored a selection of quantitative and qualitative research literature in relation to anorexia nervosa and in particular severe and enduring anorexia nervosa I now turn to psychological literature with the intent of conveying how this study may add value to what has been written to-date. From the vast array of material written from a variety of psychological theoretical perspectives I have drawn on material and authors who particularly influenced my own thinking and way of being with my clients. As an integrative psychotherapist the developmental and relational psychoanalytic authors including Mitchell (1988), Aron (1996) and Bromberg (2011) provided useful books and papers. From search words of ‘anorexia nervosa’ ‘long-term’ and ‘SEED’ I added further search words including polarised and concrete thinking, relational, relational psychoanalytic and self-states. There was a wealth of literature connecting the developmental course of attachment disruption and anorexia which I have explored (O’Kearney, 1996; Delvecchio et al, 2014, Tasca & Balfour, 2014; Petrucelli, 2015). Whilst attempting to keep this as contemporary as possible three highly influential individuals in the arena of eating disorders cannot be omitted. In the United

States the psychiatrist Hilda Bruch looked beyond the emaciated bodies of her patients, her research and notably her book ‘The Golden Cage’ (1978) proposed anorexia was linked to long-term, disturbed mother-child interactions whereby the adolescent failed to develop a sense of autonomy. As a consequence they developed a highly compliant ‘false self’ (Winnicott, 1969**)** as a defensive strategy whereby the body became a strategy to achieve individuation. Arthur Crisp in the UK was another trailblazer who assiduously researched this illness and worked with patients for more than twenty years. Crisp perceived anorexia as a primitive resource, a defence mechanism whereby the anorexic felt unable to understand and address their confused internal world. His books and in particular a volume titled ‘Let Me Be’ (1995) sensitively explored existential, maturational crises of adolescence. What Bruch and Crisp offered were ideas beyond the clinical concepts of behaviour and weight loss. Farrell’s book ‘Lost for Words, the psychoanalysis of Anorexia and Bulimia’ (1995) emphasised the meanings behind the symptoms including the pre-verbal nature of the illness with its concrete and defensive organisation to shield the individual from vulnerability. From Winnicott’s (1969) object-relating and object usage and McDougall’s ‘Theatres of the Body’ (1989) in relation to early narcissistic deprivation Farrell conveyed how, from a state of internal deprivation the anorexic felt “superior and powerful because of their ability to deny their own needs and so assume they are fundamentally different from other individuals” (Farrell, 1995, p 49).

Attachment theory (Bowlby, 1979) is one of the most important developmental frameworks for understanding affect regulation and human relationships. As an inborn survival system that motivates the infant to seek proximity to its caregiver it has no cognitive or verbal representations. Repeated interactions over the course of infancy with others are encoded in the implicit memory system that act as templates for future relationships (Schore, 2012). When trauma is attachment related dysregulation can take the form of chronic hyper-arousal (preoccupied/anxious) or hypo-activation (dismissing/avoidant). Attachment functioning, namely affect regulation, interpersonal style, coherence of mind and reflective functioning are interrogated by Tasca et al (2011) with an in-depth study researching the links between insecure attachment styles and implications for treatment of eating disorders. One conclusion was that “those with attachment insecurities most likely benefit the least from current symptom-focused treatment approaches” they suggest instead a ‘dual focus whereby clinicians assess domains of attachment functioning and possible disorganised mental states related to loss or trauma’. I agree with the authors that by tailoring treatment in this way can offer improved emotional regulation and interpersonal relationships. Unfortunately current service provision within the NHS in relation to eating disorders is time-sensitive and patient support as such suffers making the suggestions offered by Tasca et al (2011) difficult to implement, an argument further developed in this study.

Contemporary writing that I have frequently turned to for a deeper appreciation of my clients and proved useful for this study have been those authors who interrogate the relational meanings of eating disorders (Aron, 2001; Skarderud, 2007; Schoen, 2015). One example is Bromberg’s (2001) essay, ‘Treating Patients with Symptoms – and Symptoms with Patience: Reflections on shame, dissociation and eating disorders’. Bromberg looked at the shifting array of self-states and the struggle to co-construct a transitional reality when human relatedness has been eroded. Bromberg provided eloquent arguments in terms of restoring an appetite for life in the individual, how this can be achieved and conveyed the interpersonal tensions that can be enacted with the therapist being drawn in. Bromberg’s engaging writing conveys a balanced relational sense of traumatic dysregulation through case histories and thoughts for therapist which included:

“The therapist must simultaneously recognise and respect as an achievement the means by which a patient has constructed her eating ‘disorder’ so as to preserve its dissociative structure and thereby give each part of self some of what it wants without unbearable conflict” (Bromberg, 2001)

In my experience this perspective can be overlooked by clinicians and Bromberg takes this one stage further by describing how the patient-therapist relationship can be pulled into a war as each finds the other an adversary. As a way forward Bromberg offers Winnicott's (1969) writing of object usage and argues:

"…the analyst has to lose in order to win. A transitional reality has to be constructed in which human relatedness begins to become possible" (Bromberg, 2001).

Petrucelli's (2015) book 'Body States' is a collection of essays that offers the reader an interpersonal and relational perspective on the treatment of eating disorders'. It looks beyond the diagnostic framework towards useful resources for professionals and encompasses discussions that include neurobiology, developmental, political, cultural and social influences. From the polarised mind-states, concrete thinking and the enactments that can get played out as the anorexic may shift between compliance to defiance, powerlessness and powerful omnipotence it opens up and advances an understanding of anorexia nervosa and how this can be thought about in the clinical encounter.

Summary

This literature review has sought to demonstrate the ongoing polarities that have perpetuated between the positivist, scientific model of measurement and statistics and a growing body of research and case-studies offering a flexible, creative stance situated within psychologically informed, integrative approaches. My own view is that both offer practitioners insight which can inform our practice. What appears to be missing and will enrich our appreciation of SEED-AN as well as offering a more nuanced picture can be achieved by listening closely to the narratives of the people who have experienced the illness first hand. In addition, there is a story to be told that puts to one side current guidelines, where psychological recovery is clinically measured to 1 standard deviation of community norms (EDE-Q, Fairburn & Beglin, 1994). I argue this prioritising of eating, weight and shape concerns privileges universal standardisation over individual differences. This research seeks to respond to this tension by interpreting the multiplicity of possible meanings. Of prime interest is how a person seeks to find meaning in their life beyond their illness; of struggling with the interplay of feelings and thoughts, together with social context and relationships. From a professional and personal stance my experience has demonstrated that some of the most challenging times for clients are when they are weight-restored and continue struggling with their inner landscape of troubling emotions and thoughts. With anorexia's maladaptive defensive armour gone their relational world and fragile self-concept can feel terrifyingly out of control.

Research Aims:

A principle research aim of this study is to provide an additional layer of understanding to the small body of qualitative research that currently exists relating to the experiences of women who meet Robinson's (2009) criteria of SEED-AN and have positively moved forward with their lives. Whilst positions of 'what' recovery can mean will undoubtedly emerge, the aim is to open up the 'how'; how may a person journey away from a life dominated by anorexia nervosa? My research aims to explore this by being open to what unfolds through my participants' narratives. The narratives shared throughout this research convey their unique, unfolding stories as well as my own. It places the individual at the heart of the study, aiming to offer therapists a deeper understanding of this traumatic illness and more especially when it has been experienced for a significant period of time. As such it meets the therapeutic aim of listening to our clients' unfolding stories, appreciating where they position themselves within their surrounding constellation. By shedding light on some of the emerging challenges, thoughts and experiences it aims to support understanding and thus positively contribute to the future well-being of our clients. Alongside this it aims to provide the reader with greater understanding, hope and the potentiality for a better quality of life, whether the reader is a professional, sufferer or carer.

Research question:

How do women with a history of SEED-AN experience navigating their lives away from and beyond their illness? A Narrative Inquiry study.

Professional contribution to the field of eating disorders and specifically SEED-AN

"The illness (AN) has a stubbornness so persuasive it brings patients to do things different from what we plan for them" (Strober & Johnson, 2012, p.158)

Research has demonstrated how clinicians can be affected by "negative reactions to patients with eating disorders" (Tierney & Fox, 2009, Satir, 2013). Thompson-Brenner et al's (2012) study indicated that longevity of illness, high relapse rates and patient negativity evoked a sense of frustration, hopelessness and lack of competence as being experienced by specialists and non- ED specialists alike. Negative attitudes by therapists in turn appeared to affect the therapeutic alliance and therapeutic outcomes. By enabling professionals to achieve a more nuanced appreciation of the illness, including the potentially lengthy time-frames involved it aims to contribute positively to the management of therapist and client expectations of what moving forward can feel like. A further contribution is related to high 'burn-out' amongst therapists working with anorexia. Satir (2013) identified three specific areas that manifest themselves with this group and more especially where a therapist's experience of eating disorder was low. These were a tendency to over problem-solve, over-identification with the client and negative influences coming from knowing a client's long history with anorexia. As a result therapists were tempted to seek or rely on treatment manual guides rather than their integrative training and intuition. It is quite possible, particularly with less experienced therapists, how the transference and countertransference of two high-achieving perfectionists, both eager to please, with neither feeling 'good-enough' may impact on the therapeutic relationship. As a consequence the professional can start to mirror the rigidity of the eating disorder through the rigidity of a standardised approach. By holding in mind the multiple interpretations and individual meaning-making of our clients it may offer the professional both containment and confidence.

Reflection: Contributions for sufferers and carers

Reading about therapist ‘burn-out’ (Satir, 2013) I noticed a sense of unease which I needed to locate. What about ‘burn-out’ of parents as they watched their child’s skeletal frame move around the house? What about the ‘burn-out’ of the client battling with the illness, reflecting on years of failed treatment, seeing other sufferers struggle and possibly die? This study aims to demonstrate to these groups that change can be achieved. It demonstrates that professionals acknowledge a piece of the jigsaw requires attention; ‘how’ sufferers can positively navigate their lives beyond this illness?

Chapter Three

Methodology and method

Methodological considerations

A subjective and relational exploration

For a subjective and relational exploration of how women with an enduring history of anorexia experience moving away from this illness requires gathering personal accounts of individuals to sensitively examine their narratives. A quantitative methodology, conceptualising people and social groups as objects that can be experimentally manipulated, where predictions, universal laws and cause-effect factors are sought would be unsuitable for this research. Instead it seeks to convey how individuals talked about their experiences and holds a position of curiosity about their meaning-making of their individual journeys. As a psychotherapist and researcher I acknowledge the tentative, provisional nature of interpretations as potentially generating new insights. For this reason a qualitative approach was taken; that by inquiring into my participants' experiences in a relational way it will open up and provide new understandings to the reader.

A social constructionist landscape

This research is positioned within an epistemology that considers knowledge and understanding of the world as being socially, culturally, politically and relationally constructed (Emerson & Frosh, 2004, p5; Speedy, 2008, p 15). It pays close attention to how people make sense of their world and forge identities through an interactional and intersubjective context with the surrounding vistas of power, institutions and systemic influences. This is particularly relevant for this study which pays attention to the individuals whilst scrutinising the social, political and cultural backdrop. Visible is a landscape which appears to be saturated with Westernised practices including a proliferation of instructions of what to eat which is reinforced with political messages of what constitutes healthy eating. What has not been interrogated in depth are influences from social media, print, the fashion and retail industries however their influences are part of this study for within these “an individual’s experiences are constituted, shaped, expressed and enacted” (Clandinin, 2013, p 12).

The centrality of reflexivity

Emerging from a post-modernist tradition reflexivity is central to qualitative studies as it positions the human condition and human experiences at the heart of the research. Hertz (1997) conveyed reflexivity as providing a degree of the researcher’s internal dialogue, a sensitive scrutiny of “what I know and how I know it” (Hertz, 1997, p viii). Etherington (2004, p 31/32) described reflexivity as the capacity of the researcher to acknowledge how their own experiences, whilst fluid and changing informed the process and outcomes of their inquiry. Etherington conveyed reflexivity as more than a “decorative flourish” (2004, p31), that all personal exposure had to be essential to the argument, that it represented a place for transparent awareness and potential influences and nuances of being in the field “to become more aware of lesser known aspects of our selves” (Etherington, 2004, p 29). Allowing room to step back and evaluate my role and how my knowledge, thinking and emotions may have been shaped was essential for this study; by scrutinising my interpretations reflexively I have become more aware of the variety of selves that I bring to this study and more especially as an ‘insider-narrative inquirer’

Reflexivity and its role as an insider-researcher

“Do you have to be one to know one?” (Dwyer and Buckle, 2009)

As a member of the group I am studying I occupy the position of insider-researcher however this title led me to consider whether I was taking up a dichotomous position. Robson (1993) having argued the challenges and merits of being an insider-researcher concluded there to be “pretty substantial disadvantages” (Robson, 1993, p 382) and suggested mixed insider-outsider research teams. Trahar (2013, p5) offered a more nuanced position, a realm of 'the between', between 'this part of me and that part of me'; a place where there were intimate relational spaces and spaces where only the individual had travelled, experienced, lived. Dwyer & Buckle's (2009) paper 'The Space Between: On being an Insider-Outsider in Qualitative Research' offered an additional dimension of being an insider-researcher which resonated. Discussing how a shared language could privilege knowledge growth I was reminded of how many times the phrase "y'know" was spoken by my participants during the interviews. I sensed that beyond a common language we 'felt' the nuances that accompanied the narratives. Dwyer and Buckle (2009) suggested there was frequently a greater willingness by participants to share their experiences and a high level of trust and openness when an insider-researcher was involved. Their paper also debated how shared status could bring challenges which included role conflict and role confusion. From a coherent debate they addressed the question "Do you have to be one to know one?" What chimed for me as a researcher and an integrative psychotherapist was their notion of placing the personhood of the researcher as being at the heart of the study. From this place there opened up what Dwyer and Buckle (2009) referred to as 'the space between' being an insider and outsider researcher, a third position and I was reminded of how my participants and I may have shared experiencing similar symptoms of an eating disorder however there were other identities that were influencers in our lives. Kerstetter (2012) studied the relative nature of researcher identity within community-based research programmes and emphasised how multidimensional identities were at play including socioeconomic, gender, culture, politics and ethnicity. These she argued can influence to varying degrees how participants and researcher relate to the other and have an impact on the research process from how one collects and interprets data to communicating findings. Kerstetter concluded that researchers worked as both insiders and outsiders and referred to Dwyer and Buckle's (2009) notion of 'a space between' as an important component. Greene (2014) argued that a heightened awareness of 'positionality' was required, where one stands in relation to the other. I argue that where one stands in relation to the other is not static it will shift throughout the research process, nor is reflexivity a bridge between researcher and participants, the challenge for me is not to seek or reconcile similarities and differences but to notice where I may be particularly sympathetic or not to thoughts, feelings and shared experiences. As Etherington (2004, p 30) argued, reflexivity is more than self-awareness, it challenges us to be more conscious of what is being studied and consider how it may inform and influence the data. It is with this in mind that my research diary entries and reflexive thought-processes are integrated within the body of the study.

Credibility and authenticity

The terminology of validity and trustworthiness, emerging from a positivist stance arguably seeks ‘truth’, whereby findings are measured and results are seen to be transferable. From my epistemological position, participants will be articulating their unique stories, my role is to humbly and thoughtfully re-search their narratives honouring the subjectivity and temporality of their meaning-making. Narratives through story-telling are a human activity and I argue that remaining constantly vigilant can never be fully mastered hence my preference of ‘credibility’, “…a position that allows you to feel confident about observations, interpretations and conclusions” (Eisner, 1991, p. 110) and ‘authenticity’ (Lincoln and Guba, 1985), through heightened self-awareness, honesty, transparency and trust with my participants and of myself.

Having articulated my place as an ‘insider researcher’ it was imperative that I acknowledge how biases and assumptions may impact my inquiry. Kim (2016, p 162) reinforced the importance of not assuming a position of trust and rapport between researcher and participants, that the researcher was seeking an optimal rather than maximum level of rapport. When rapport was too high she argued there may be a bias which can obscure the purpose of the interview and the data which followed. A strategy before I embarked on interviewing participants was to unpack my own meaning making of the research question with a colleague. An awareness of where my personal story sits within this study was carried out to reduce the possibility of my meaning-making being “merged and reported as one story – which is actually the researcher’s interpretation” (Etherington, 2004, p.83).

Choice of Methodology: Narrative Inquiry

I was aware that my own history of anorexia, including pre-existing thoughts and concepts of moving away from this illness were highly likely to play a part in this inquiry. My open appreciation of this offered me choices, of ‘bracketing’ them off as with interpretative phenomenological inquiry (IPA), (Smith et al, 2009, p25) or allow them to emerge, be part of the study. Smith et al (2009) argued that the researcher’s involvement through their own preconceptions and prejudices constituted an obstacle to interpretation. Barker, Pistrang & Elliott (2002, p78) conveyed bracketing within IPA as, ‘as far as was humanly possible’ an attempt to set aside one’s assumptions and expectations. It was they argued a process of demonstrating validity of the data collection and analysis process, of not confusing the researcher’s own conceptions and interpretations with those of the participants. McLeod (2001) argued phenomenology whilst striving to describe the ‘essence’ of everyday experiences “tends not to include much in the way of strategies for contextualising findings” (McLeod, 2001, p 38). These additional factors were influencers for this study is saturated with and contextualised by social, cultural, political and institutional influences which led me back to narrative inquiry. I believe that my personal position in this study would inevitably be present; that within this research there sits my own ‘knowing’ and ‘not-knowing’ position. Today for example I see the perniciousness of this illness, how seductive and dangerous it can be whilst recognising that my world has no room for it anymore. ‘Back then’ I could only express to others how I felt by using my emaciated body to talk for me, it was a signal of my despair. Today I notice my feelings, reflect on them and verbally express my thoughts and emotions.

Placing myself within this study as a researcher with a history of an eating disorder arguably has ethical and procedural implications. One could argue that I am too close to the material. Johnston et al (2005) suggested therapist numbers with an eating disorder history was a matter of speculation, with no empirical data, nevertheless they suggested it appeared to be significant. I appreciate a reluctance to 'come out' however my choice to include myself in this research comes, in part, from knowing that my eating disorder history no longer defines me, that my understanding can positively inform this inquiry. I am conscious that from this insider perspective I pay close attention to and make visible the inevitable struggles for coherence and a-priori assumptions. It was from this place that Narrative Inquiry (NI) captured my interest, where there exists an appreciation that all researchers come to inquiry with varying degrees of personal tension, where researcher and participants work relationally and collaboratively. NI, Riessman (2008) argued inferred "we do not stand outside in a neutral, objective position…instead I'm implicated at every step along the way in constituting the narratives I then analyse" (Riessman, 2008, p28) Within narrative inquiry a stance of researcher reflexivity and self-awareness is held and from this position I open myself up to new insight that I will garner personally and professionally.

The background of narrative inquiry in the 20th Century emerged alongside "the decline of an exclusive positivist paradigm for social science research" (Clandinin & Rosiek, 2007, p 36). As a methodology it adopted a view of studying human experience, "it's a knowledge of the particular, the unique, the development rather than a kind of abstractive common concept" (Polkinghorne, 2007, p633). Its ontology views knowledge as relational, temporal and continuously presenting itself within a person's narratives (Clandinin, 2013, p 16). Polkinghorne (2007), reflecting on where narrative inquiry sat in relation to other qualitative research methodologies suggested that in qualitative research "there is a general push to provide taxonomies and conceptual systems" (Polkinghorne, 2007, p 633). Clandinin (2007) agreed arguing that an outcome from looking for commonalities across people was of losing the uniqueness of personal history and experience. Narrative inquirers explore narratives as a shifting landscape which includes the retrospective representations of human experience alongside the unfolding, lived immediacy of the narrator. It was this inquiry that Clandinin and Polkinghorne suggested led to the difference between analysis of narratives and narrative inquirers with the latter framing human experiences as storied amidst social and cultural references. Kim (2016, p189) wrote narrative data analysis worked in tandem with interpretation, that is, we analyse data to develop an understanding of the meanings of our participants and their lived experiences. Narrative inquirers concurrently try to interpret meanings through analysing plotlines, and social and cultural references within a transitional period and always open to further interpretation.

This relational methodology takes narratives as the data and from a place of curiosity analyses how people may think through and describe events, it studies the experiential element in their re-telling. It questions whose perspectives they may have drawn on, how tensions may have been conveyed; it reflects on how sentences were constructed; were stories consecutive or consequential and what may be absent. All the time the inquirer is curious about the possible purpose or reasons for why those individuals or stories may have been included (or not) in the narrators' story. Above all NI, similar to psychotherapy, studies how human beings "create a narrative so that our lives and the lives of others will make sense…and through narratives we define who we are, who we were and who we may become in the future" (Crossley, 2000, p 67). This study analyses the narratives of four women as they told their life-stories, from the experiences of anorexia it encompasses how they transcended their life's circumstances over time. I acknowledge these narratives as being situated in the midst of their lives, that is, told from a particular place and setting, at a particular time when sitting with another for a particular reason in the recounting.

Narrative inquiry: a philosophical stance

Creswell (2013) described research design as beginning with philosophical assumptions and from this position the researcher employs interpretive and theoretical frameworks to further shape them. As a qualitative researcher I do not seek to perpetuate 'truths' rather via my ontology and epistemology, which are the very fabric of qualitative research I seek to open up, inquire, be curious about what is being studied. Narrative inquirers consider continuity as an ontological matter, highlighting the temporality of knowledge generation, “that experiences lead to further experiences….and that is all we have to ground our understanding” (Clandinin, 2013, p16). From knowledge open to revision, embedded in and through a social constructionist lens all phenomena are open to reflective, experiential and interpretive scrutiny, including social, cultural and political environments; where ‘reality’ is subjective the narrative inquirer has no privileged position, no “G-d’s eye view” (McLeod, 2001, p 29, 2005).

(*Note to reader, in the Jewish religion there is a tradition not to write G-d in full, hence the middle letter is taken out, the reasoning being that if the paper on which it is written is discarded the author is not being disrespectful*).

As I contemplate ‘No G-d’s eye view’ my thoughts move to what this phrase means to me and recognise how my Judaism has shaped my thinking. From historical oppression Jewish families throughout the world continue to cry out ‘lest we forget’; from Jewish festivals such as the Passover (escaping persecution by the Egyptians) to Holocaust Remembrance Day talking about the past has been necessary through every generation. We learn as children how our ancient Jewish traditions and philosophical thinking were handed down orally by learned Rabbis, encouraging a position of relational inquiry; to recognise the multiplicity of interpreting G-d’s laws, to understand these better through talking together. From these intergenerational connections I believe my clinical work and this research are similarly influenced through taking a position of ‘curious explorer’, always seeking a deeper ‘mitzraim’ (Hebrew: construction) of meaning rather than an omnipotent, omniscient position. Relationality for me encompasses my relationship with my clients and participants, it includes events and feelings between people and the relational influences handed down through each of our storied lives and our cultural and social histories. The philosopher Thomas Nagel (1986, p 57) wrote “Mine is only one of the many points of view from which the world is seen”. I value the sentiment this imbues, that we locate and relate to the world from our own subjective experiences, “…we begin in the midst and end in the midst of experience” (Bruner, 1990)

Research design

Constructing a methodological framework

From narrative inquiry’s ‘shifting methodological landscape’ (Mishler, 2007) there exists a flexibility of approach to analysing narrative data. Having studied various analytic forms of narrative analysis including Josselson & Lieblich (1995), Speedy (2008), Bold (2012), Trahar (2013) my preferred model was Clandinin & Connelly (2000) and Clandinin (2013), which in part mirrors Ricoeur’s (1991) “three-fold present”, whereby the past and potential future co-exist with the present. Mishler commented that research inquirers address the kinds of problems they are interested in “and find that one or another form of narrative methodology is useful for doing it” (Mishler, 2007, p 635). It is also possible that my interest in Clandinin reflected how I work as an integrative psychotherapist, whereby “awareness of the past and perceptions arising from former experiences inform the present and in some cases governs present ways of being, acting and thinking” (Jacobs, 2006, p1).

Clandinin’s (2013) model does not set out to define narratives or knit together themes, it illuminates experiences as positioned within a three dimensional space of time. The first, temporality, sits along one dimension, the personal and social setting a second dimension and place the third. Analysing narratives from this framework brings into focus the experiential history within a flow of time, where the past in the re-telling may be shaped by the narrator within what Clandinin (2013) refers to as ‘bumping stories’, that is where the stories include other influences which may have shaped the person’s experiences. This can be seen in-action throughout this research from my ‘reflections’ boxes which provide my personal ‘bumping stories’ reflecting Clandinin’s model.

My personal research journal was an important container throughout the research process to unpack my inner thoughts. It was a place to convey how the conversations impacted me including where there was a sense of reciprocity and where I may have been personally drawn in to the material.

Clandinin argued there is no master narrative for all stories come from that moment in time. Rather than offering a ‘research question’ Clandinin promoted ‘research puzzle’ (Clandinin, 2013, p 42) that a single phenomenon inevitably becomes a kaleidoscope of puzzles; that one question closes down the possibility of investigating others. One outcome of this led me to change my title on three occasions as emphases shifted and expanded as I progressed. Clandinin’s model uses the term ‘narrator’ and ‘participant’ interchangeably and similarly narrative inquirer and researcher. I have followed suit in most cases and note this to the reader for ease of understanding. Clandinin’s perspective of literature reviews and its positioning within narrative inquiry has been discussed in chapter two of this study.

Putting skin on the bones

Staying close to the narratives I selected key material and moments to interrogate. These included my participants’ thought-processes of ‘back then’ and today (temporality), explicit and implicit beliefs, actions, behaviours, values and social and family systems. This offered an additional layer, a sense of what their narratives may have elicited in me as I sat with them, as well as later as I processed the material more deeply. Whilst acknowledging the ambiguous representations of the conversations, texts and interactions I set out to examine what may be inferred from the narratives using the following themes:

Narrative construction; tone; sentence structure which included hesitations, interruptions, fluency, emphases; contradictory and transformative narrative structures.

The data exploration trail that followed required incorporating the twists, turns and amends as new insights presented themselves. One such amend was in relation to participant criteria.

Participants:

Selection criteria and rationale

- Women were chosen as statistically there currently exists 80%-20% ratio of females to male sufferers of anorexia nervosa.
- Their symptoms had met DSM-IV-TR (APA, 2000), eating disorders, anorexia nervosa criteria
- In keeping with Robinson's (2009) criteria of SEED-AN participants had experienced severe symptoms for approximately over ten years.
- *****Participants self-defined themselves as having moved away from the illness and had not received professional support in relation to their illness for over five years.

*****The amend followed a discussion with all participants about whether they felt comfortable incorporating the words 'recovered' and/or 'recovering', a word used initially in the research title. Having 'moved away from the illness' was considered less rigid, less representational of the 'concreteness' of the illness and acknowledged residues of the illness may be present but did not interfere with their day-to-day lives. As such this was adopted and the title amended.

Recruitment

Recruitment of participants via B-Eat was excluded as a possible tension of power and imbalance could exist through my past association with this organisation. From my network of professionals in this field I made contact by email with two psychiatrists I am acquainted with and hold in high esteem. Both have been responsible for the design and management of in-patient eating disorder units in London. The first psychiatrist had, over ten years ago, been my psychiatrist, subsequently he encouraged my change of career and over the years we had met professionally and shared a stage at eating disorder speaking engagements and events. The second psychiatrist sat with me on B-eat's Governing Council; we had also met at various professional events.

Ethical considerations

Ethics within narrative research, Josselson (2007, p538) argued, begins with forging an ethical attitude. Beyond ethical practices, considerations and codes for safeguarding the confidentiality of participants, their families and other individuals referred to in a study narrative inquiry requires an ethical attitude which asks "how best to honour and protect those who participate…while still maintaining standards for responsible scholarship" (2007, p538). Josselson cogently argued there was both an explicit and implicit contract. The former attended to the relationship between researcher and participants including the purpose of the study, formal consent, withdrawal at any time etc. The implicit contract constituted "what constitutes respect and compassion in the minds of this researcher/participant pair…" (Josselson, 2007, p539). It involved the concerned, emotionally responsive responses "as well as her/his ability to contain affect-laden material" (Josselson, 2007, p539). With this balance in mind I considered ethics and how to protect the integrity of those involved in this study.

My reason for approaching the two psychiatrists beyond their extensive network which could provide potential participants was their exemplary reputations over many years as empathic professionals. This study is grounded in a relational enterprise which led me to reflect on the growth that I had travelled, one that enabled me to be in a position to contact them when seeking participants who would have been discharged from the medical system. Both of these people were likely to have kept open a relationship with some of the people they had cared for long after their discharge. This community knowledge and contacts mirrored Trahar's (2013) book 'developing methodological inquiry for local contexts'. Trahar described a collection of local, community led research studies and argued that all stories are composed in a familiar context, what was important was collaboration, trust and transparency. I was conscious of my responsibility of being ethically vigilant and confident that both individuals would hold and respect professional boundaries.

Having emailed both psychiatrists I met them at their respective workplace and described my research. Both responded positively and in respect of ethical considerations both agreed that any contact requests should come from myself via the hospital rather than signed by the psychiatrists. This was to reduce or minimise any feelings of obligation by ex-patients or power relations that may be attached to the institution. I followed up our meeting with a formal letter explaining the aims of the research (Appendix 1), requesting this be disseminated through their internal channels.

The first psychiatrist received four responses. Three had been patients and I was familiar with two of them as our paths had briefly crossed when in-patients although we had not met for over five years. All three knew each other. The fourth person was a member of staff who I had not previously met. The second psychiatrist responded with one potential participant who was a member of her research team. After a telephone conversation with the person recommended by the second psychiatrist she agreed to participate, signed the consent form and we met at her workplace for the first interview. I received an email from her four days later withdrawing from the research explaining her life was currently dominated by eating disorders, personally and professionally. The taped interview was erased and I checked she had support if she felt this was needed.

I did wonder if she felt some coercion to please the psychiatrist who brought this research to her attention, which left me wondering whether this may be the case for the other participants. I made a note to further explore this with each participant.

A telephone conversation with the four participants followed to discuss the research in more detail and address any concerns they may have at that time. A warm and relaxed discussion ensued aided by our common association of people, places and our shared experiences of anorexia. The question of any potential power dynamics was re-visited following the participant from my other contact retracting from the study. I wanted to ensure as far as possible that these women did not feel coerced into agreeing to participate in this research. I spoke openly about this with each woman acknowledging that there was a high degree of respect and trust for the professional who had made the introductions; all remained happy to proceed. I reiterated their right to withdraw at any time. Each person agreed for interviews to take place at their home where they felt at ease and a time was arranged when we would not be disturbed. Each person signed a consent sheet (see appendix 2) prior to the interview commencing.

Ethics, power dynamics and potential research limitations were interrogated when, on inviting my four participants to read the completed study they declined. Each conveyed in a variety of ways how having participated in this study their part was done. From sharing their experiences and having rolled back time in the process they recognised they were in the midst of another life stage; they had looked back and now preferred to carry on moving forward. The other factor voiced and likely emerged from my insider status was one of trust, that I would craft their narratives with sensitivity, integrity and honesty.

Their responses led me to be curious about why they may have declined reading their part in the study and by extension how quickly I accepted an arguably powerful position, to write, interpret and publish without censor. It occurred to me that as an insider-researcher our relationships were forged at a rapid pace, few introductions were necessary for we had mutual experiences and shared relationships. When they said ‘y’know’ I did not stop to inquire further, our subjectivity and ‘knowing’ was omnipresent. With deeper reflection I wondered if this relationship had contributed to the participants handing control over to me which is interesting when one considers this study). From this place control could be linked to avoidance, for my participants a reticence to read their narratives in black and white and as an insider-researcher was there less objectivity on my part as I attempted to shield them from any possible discomfort? A potential limitation to this study following my participants' preference not to read the final piece could arguably be that it may have offered an additional layer of depth beyond my own reflections and interpretations. It would have provided a layer for my participants to expand on certain areas and counter what they may have viewed as assumptions, blind-spots or bias on my part and perhaps scrutinise where my voice may have over-shadowed their own. From this deeper level of reflection I was aware of how I had long considered this study to be a 'collaborative endeavour', it was participatory however it could be argued that a limitation was in that collaboration did not continue all the way to the close of this study. I use the word 'close' because from a narrative inquiry perspective as conveyed by Clandinin (2000) inquiries are on-going. As a qualitative researcher from a narrative inquiry methodology the researcher's subjectivity and "our own biases shape the research process" (Bourke, 2014, p1). Holding in mind Clandinin's (2000) centrality of temporality I made a judgement to respect my participants' wishes to leave in 'time present' in the knowledge that research is ongoing, a snap-shot in that moment of time.

Taking a position of being reflective and reflexive opened "an invaluable platform for exploring power relations and expertise" (Finlay & Gough, 2003, p206). Through closely liaising with my supervisor, utilising my diary entries, critical reflections and reflexive insertions throughout I was attuned to what Finlay and Gough (2003, p23) referred to as 'functional reflexivity'. From this place attention is focused on ensuring the distribution of power and status within the research process. A further scrutiny was to ensure my data analysis was rigorous and transparent allowing the reader to scrutinise any possible influences of power, authority and authorship on the production of research data.

Ethical considerations were in strict adherence to the ethical guidelines as provided by the British Psychology Society (BPS, 2009) and HCPC (2012) rules of ethics and conduct. I was also mindful of Josselson's chapter in the Handbook of Narrative Inquiry (2007) concerning the ethical attitude in narrative research.

An ethical consideration in relation to this study was an awareness that having experienced anorexia it could be argued that this study was coming from a self-serving place, to quieten my own anxieties as a therapist working predominantly with this population. I have deliberated on this since formulating my research interest in SEED over six years ago. The answer is not black or white, “yes” or “no”; that would be too…anorexic, a tendency towards polarised thinking. Mindful of my own self-care and the interplay of being an insider-researcher I have used my research journal throughout the entire process and sought, where necessary, assistance and advice from my personal therapist and research supervisor.

Whilst anonymity is extended to participants as this research is disseminated I am aware that it will provide my peers with personal information about myself that I may not have otherwise disclosed. I have always been open about my eating disorder history however I have also been judicious with regards to whom I disclosed this to and the depth of details. I recognise this research will enter a wider domain and my belief is that this study will provide narratives of hope and possibilities, an important stance to be shared.

Bar-On (1996 p. 9) wrote “we hold the meaning of people’s lives in our hands”. Participants are individuals and co-researchers, located in specific situations at particular points over time. I am mindful of my responsibility as I listen to and respond to their personal, often intimate stories. Although informed consent forms were signed by the participants in advance and information provided about the nature of the study within NI there will be a re-framing of narratives, of connecting one story to another whilst adding my own meaning-making or theoretical perspective. Chase (1996) reflected on whether NI consent forms could be tailored to this process and concluded that “we need to remind ourselves as well as prospective participants that narrative research is a contingent and unfolding process, the results of which we cannot anticipate or guarantee” (Chase, 1996, p45) An ethical consideration will be the care of participants, to seek their permission throughout the process and prior to publication to address any concerns. I will also check that each participant has a support system in place should difficult feelings be evoked.

Narrative inquiry comes from a small body of narrators which means that they and others included in their stories could be more readily identifiable potentially leaving them feeling exposed. Pseudonyms have been used as one means of protecting their confidentiality I have also removed other possible identifying features including place names.

This study may challenge dominant narratives in relation to SEED-AN and the meanings of ‘recovery’ and I was aware that this may provoke critical responses from some professionals with a more medical-model perspective. Apter (1996) suggested some blindness seemed to strike psychologists as they position themselves as experts, explorers, or detectives thus, in the spirit of openness, transparency and integrity I hope readers will consider these narratives in the same light as this study, one that seeks to convey lives lived and experienced on a continuum.

Interview structure

Sample size within qualitative research is smaller than quantitative research, the emphasis being to elucidate rather than generalise experiences. My decision of four participants to be interviewed twice was to enable the participants time for unhurried reflections and time to visit and re-visit, to search and re-search their storied lives (Clandinin & Connelly, 2000). Kim (2016, p164) conveyed the importance of the interviewer being flexible enough so that the interviewee feels in control of the content but that did not mean being a passive listener, active listening required probing, clarifying and allowed for unexpected data to emerge remembering “that what appears irrelevant to the research topic can also be beneficial”. Riessman (2008, p 26) suggested extended rather than ‘one-shot’ interviews can be preferable, arguing they generated more detailed accounts, displayed more emotional attentiveness and encouraged a greater degree of reciprocity. Each interview in this study was a conversation of approximately ninety minutes and in keeping with narrative inquiry they were unstructured and open-ended in design. The interviews and interaction between myself and the four women were shaped by the experiences we shared and this may well have influenced how they told their stories. However, whilst we shared a similar history of illness symptoms, of hospital and professional experiences these were not mirror images. The first interview with each person began with our reflecting on the research question and I asked that they tell me their story, to begin wherever they wanted and thereafter each person told their unique narrative of how time, place and relationships shaped their lives.

Recording and storage of interviews

Interviews were recorded on a digital recorder and stored on my home-computer within a dedicated folder which was password protected. All tapes were backed up on a password-protected portable data storage device.

My choice to personally transcribe the interviews was to immerse myself further in their narratives. I assiduously replayed them, moving back and forth, seeking to achieve accuracy of ‘what’ was said and provide the reader with a flavour of ‘how’ the narratives were spoken, to bring alive the written words. To achieve this I noted pauses, hesitations and notable displays of emotions which I have expanded upon further in chapter four.

Chapter Four

Interpretation of the analyses

Adaptation of a three-stage analytic tool

Connelly and Clandinin's (1990) 'three-stage analytical tool' became a useful concept model for me to explore each of the participants' narratives analytically (see figure 1). What it conveyed was the excavation rather than any dismantling of the narratives which I was keen to achieve. Below is a description of how I utilised this three-stage model in a fashion that provided the pathway to move from the storied lives of each participant, hone where similarities and diversions may have occurred and from this place I move to the data analysis arrived at from using this tool.

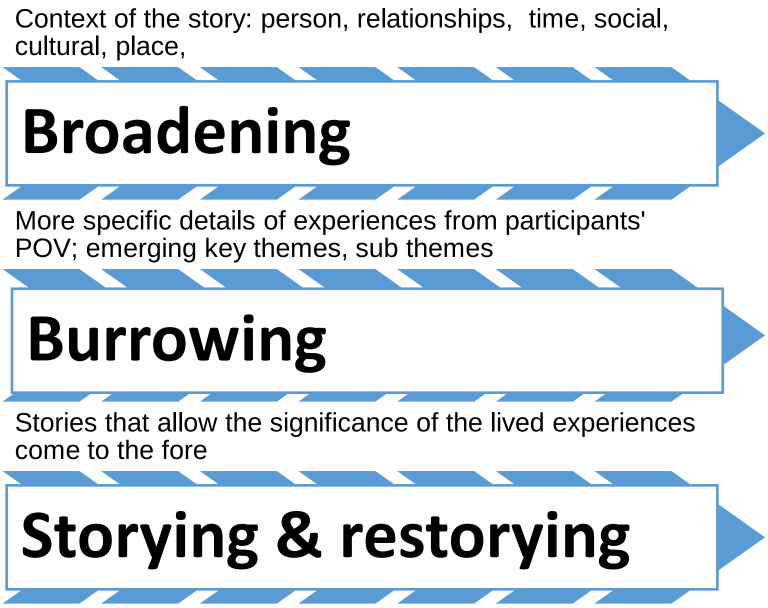


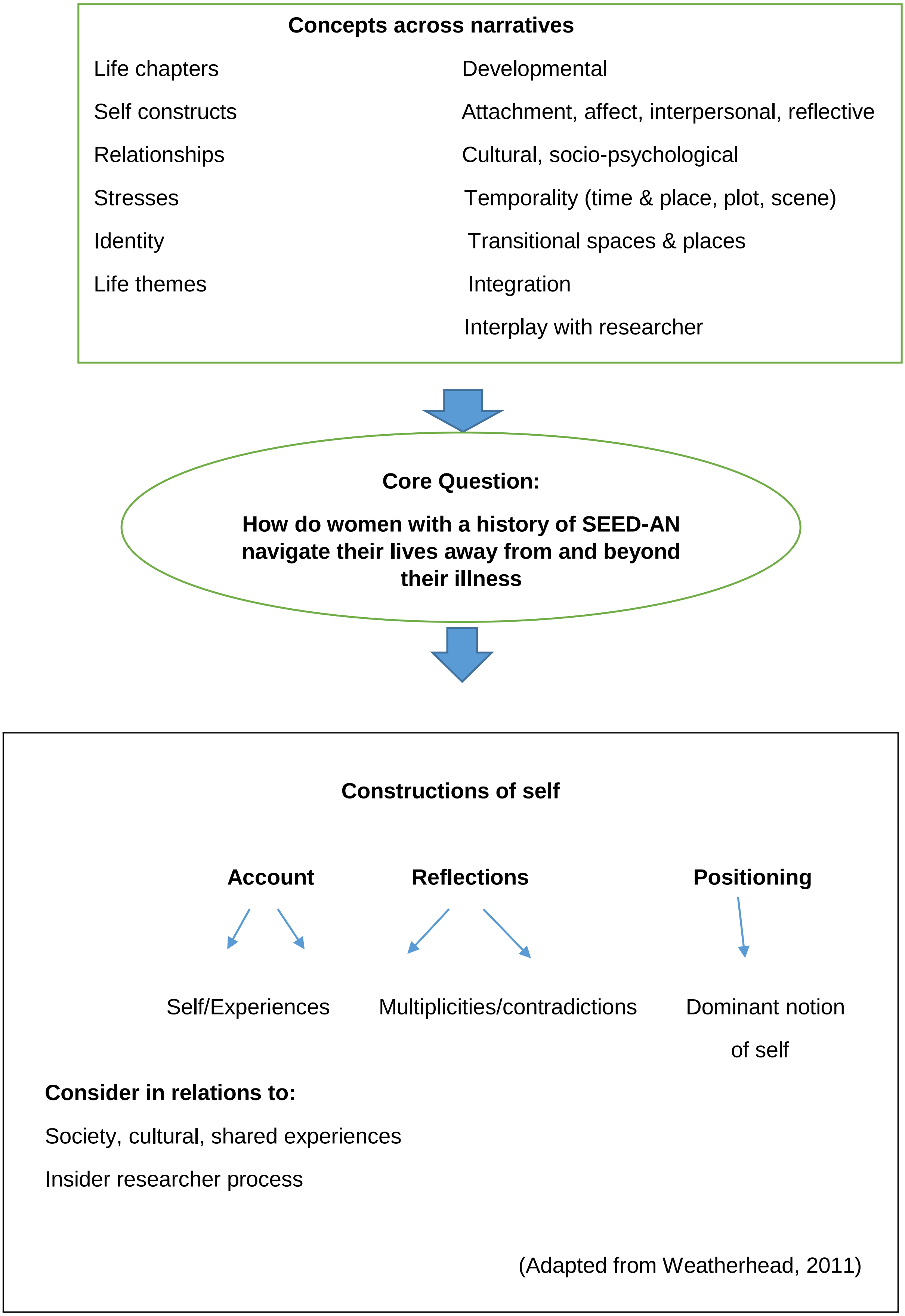
Figure 1

Adapted from Connelly & Clandinin (1990)

Stage 1: Broadening

After transcribing the tapes I closely examined these line-by-line making notes in the margins. These included recurring themes, notable relationships, places and repetition of phrases that felt significant (appendix 3). Looking across the notes I created ‘bubble diagrams’ (example in appendix 4) for each person with each bubble denoting common threads or themes; these diagrams acted as early generalised representational storyboards. This choice of design sought to provide a sense of floating movement, of expanding and evaporating themes. To achieve a rounded sense of each person for myself and the reader I condensed the two interviews with each participant and penned a profile of approximately 3500 words (see Participant Narratives). To achieve a balance of presenting the person whilst holding in mind the research question and, in keeping with Clandinin & Connelly’s (2000) narrative inquiry to convey the person alongside the societal, temporal and institutional setting I used as a guide Weatherhead’s (2011) diagrammatic representation of features to explore within participant’s narratives (see Figure 2)

Figure 2 **Features to explore within a participant's narratives**



Stage 2: Burrowing

Having written a profile for each participant I returned to the tapes and transcripts to ‘burrow’ further, my aim being to appreciate further the multiplicity of meanings and experiences within the narratives relevant to this inquiry without fracturing them. Rooted in subjectivity my participants’ stories were foremost experiential and care not to re-shape them in a way that would lose fluidity was important. To provide structure and direction I used excel to code and categorise key themes and emergent themes (Appendix 5). I was particularly interested in textual detail and to achieve a multi-layered interpretation I paid particular attention to the following:

Narrative construction: including hesitations, interruptions, emphases on words or phrases

Context: Including where the person located themselves in the process of narrative construction. Exploration of institutions including school, university, hospital, work-place; context of family, social norms and sanctions.

Temporality: Including where it shifted grammatically within a story

Threads and key motifs: Narrative discrepancies, metaphors, symbolism, imagery

Joint construction of meanings: Who was I to the narrators; did our joint construction of meanings influence their stories?

Stage 3: Storying and re-storying

Storying and re-storying for the purpose of this study was a component designed to bring together the participants’ experiences and shine a light on how they made sense of events, actions, relationships and behaviours in their lives as they moved further away from their illness. It seeks to illuminate narratively how these women constructed their stories by offering a deeply relational narrative inquiry, where the storytellers and the story-listener are in a dynamic relationship (Clandinin & Connelly, 2000). As threads and tensions were further analysed it acknowledges the multiple forms of interpretation and the subjective meanings attached. To accomplish this I returned to the excel sheets to code recurring themes across the four women which provided a visual 'bubble' representation of what emerged (see figure 3). Whilst the key and sub-themes for the purpose of this exercise are placed in boxes its design was to pull out what felt important and not privilege any one of these. I do not consider any of the themes to be operating in isolation, rather they are intertwined and overlapping.

Data analysis

Shaping an original scaffold from Bettelheim's fairy-tales

Appreciating that a rigorous, structured process was required for meaningful observations to emerge from my data it took a while for me to shift from seeking the 'perfect' model, one that preferably came with concise instructions, to a place where structure and creativity could co-exist and flourish. Helpful in this endeavour was McLeod's notion of bricolage (McLeod, 2001, p 119), whereby the researcher negotiated their own personal route through the methodological terrain rather than imposing a pre-determined method or structure to their research. To encourage this emerging process McLeod (2001, p 121) conveyed the idea of 'posturing', whereby the qualitative researcher worked towards finding their own strategic position. In a similar fashion was Phillips' (1994) notion of 'flirtation' which in this context I interpreted as flirting with the data in a less rigid fashion, one that provided room for an expansion of new ideas and new thoughts to emerge.

Searching how to convey my participants' aliveness for the reader led me to reflect on story-telling of a different kind, of Bruno Bettelheim's (1976) fairy-tales and the imaginative form (stages) of human development, from inner conflict towards "where the hero returns to reality, one devoid of magic and more able to deal with life" (Bettelheim, 1976, p 63) . Appreciating how I was in danger of possibly moving to an unmalleable structure which I was trying to avoid, I nevertheless believed it could offer me a scaffold, one that I could shape and make my own.

Bettelheim (1976) argued that as human beings our greatest need and most difficult achievement was to find meaning in our lives. From a psychoanalytic perspective he explored fairy-tales as conveying a quest, whereby the child, unsure his immediate environment could protect him turned to “superior powers” (1976, p52), to watch over him. Bettelheim expressed the importance and need of interpersonal relations and security which “when experienced for sufficient length of time, permits the child to develop that feeling of confidence in life which he needs in order to trust himself” (p50). Fairy-tales, he suggested depicted this through defined stages that the hero or heroine moved along to fulfil their quest.

Initially I was tempted to use Bettelheim’s depiction of ogres and heroines and tried this for a while however I soon recognised an inherent danger of a single archetype detracting from the multiple and diverse experiences of my participants. Narratives are also less defined in relation to where one stage begins and ends, meaning that where a person transitioned to the next stage was not straightforward.

A fairy-tale’s structure he wrote “*are the coordinates which place the story not in time or place of external reality, but in a state of mind”* (Bettelheim, 1976, p62). Below is the adaptation of Bettelheim’s fairy-tales, a quest with six stages that I adapted for presenting my participants:

1. Once upon a time
2. Because of this…
3. And then
4. Moving forward
5. From SEED to ‘normal’

6. Reflections: Past present and future

Bettelheim's 'stages' provided a useful scaffold nevertheless to be transparent about what material I was attempting to follow from the interviews and to signpost these to the reader in a way that honoured Clandinin's (2013, p34) attention to narratives within a three dimensional narrative inquiry space (temporality, sociality, place) I incorporated a further structure. This was an adaptation of Clandinin's (2013) 'interim research texts' "to make visible the events that shape our understanding as well as our emotional, moral and spiritual responses to these events" (Clandinin, 2013, p 18). This provided further exploration of how my participants' narratives may have been constituted, shaped, expressed and enacted. As inquiry texts these are intended to build on and further the position of a multiplicity of possible meanings. Finding creative ways to re-search the narratives of my participants also met with Clandinin's (2013, p46) sentiment of how NI researchers "stay awake to the multiple ways to tell and live experiences…and may also point us to the diverse ways we might re-present the retold stories"

Participant narratives in six stages

Julie

Julie showed signs of suffering with an eating disorder (ED) from the age of seven; her first admission to an ED hospital unit was at the age of seventeen. It has been over seven years since Julie was last in hospital. She works full-time, is in a long-term relationship and has an active social life. At our second interview Julie announced with great excitement that she was pregnant.

Stage one: In the beginning

Knowing and not knowing

Julie's earliest memory of 'getting rid of' food was at the age of seven when she began throwing away her sandwiches on the way to school.

I can't remember why, I've got no connection. I obviously know what was going on in my life, like home wasn't very good, I wasn't very happy with myself at school, but, I'd never made a conscious connection.

Being bullied at school Julie thought could have been because she was shy. What she was more certain about was that throwing away her sandwiches was *never* about seeing herself as fat and wanting to lose weight:

(The underlined words highlight her emphatic tone)

It was never about losing weight I never looked in the mirror and thought I want to lose weight. I just know that, I just, just, oh I'll throw my sandwiches away at school and I'd stop eating and I'd, but it never, it never was, sort of consciously about, never ever.

It was aged thirteen, enduring 'horrible family holidays' that Julie started 'throwing up':

I just can't remember what made me do it. I just went to the toilet and did it. I must of known about bulimia I guess, somewhere, I can't remember, I must have known, I suppose you do at thirteen, maybe, I don't know. But it just happened, and then I felt, and I felt a relief from it…if I was stressed it felt like it was a release.

When her cousin caught her throwing up and told her parents what she was doing Julie 'sort of got' how they didn't know what to do. She told her parents she was fine which was readily accepted and not long after this Julie began restricting and purging.

Taking control and feeling special

It was a year after that 'horrible holiday', feeling very alone Julie remembered desperately wanting to be liked by everyone, to 'fit in'. She listened attentively to what the girls around her were talking about, which appeared to be about their appearance, what skimpy clothes they longed to wear and what diets they were on. 'Ordinary' teenagers she concluded were really conscious about their bodies and weight, just like her mother who was forever on a diet. *This* she reflected was when she made the connection between food, weight and body-shape; this was something she could be *really* good at, be ‘special’:

I suppose I did start to think oh I, I don’t know, I can, I’ve got the will-power or the, you know, the control not to eat and all those girls that are bullying around me are eating, you know, I can do that and they can’t.

There was a similar thought in relation to her family:

Like fuck you, you can’t make me eat or you can’t stop me throwing up and, and if you’re going to behave like that, this is what I’m going to do.

Julie learned later from therapy that those thoughts and actions were her way of coping, or in her words ‘a bit of a fuck you’, back then though she felt powerful, in control.

Stage two: Because of this

Hospital: ‘please look after me’ alongside ‘what have you done to me’

Julie’s weight plummeted and for the next three years what little social world once existed diminished. Aged seventeen Julie was referred to an ED unit by her GP; physically and mentally exhausted, her ‘fuck you’ to the world was replaced by ‘just leave me to die’. This slowly shifted as she encountered attentive and caring staff and formed a close attachment to her psychiatrist, Dr Green, and Jane, her ‘named nurse’ (a dedicated staff member allocated to each patient). In this environment Julie felt sheltered from the ‘scary’ outside world, the hospital became a safe place:

And quite soon after going into hospital I really got, I suppose, that, I got that it was about control, I got that, that thing that I was doing to my parents.

Yet this knowing made no difference, what now mattered was staying in hospital:

I spent all that time in hospital thinking, I dunno, I was waiting for that thing to click and then go 'I can do this now', I feel alright about it. I'll start eating and I'm ready for the world', like I'm going to wait for that to happen.

Julie's safe place soon became intertwined with dependency:

And I literally remember thinking I don't know how to wake up in the morning and breathe without being in hospital, I don't get how people do that. How do people know what to do or think when they're outside of hospital?

Arising from this a new fear developed, that having been in hospital for so long she had become institutionalised and as a consequence the gap between her life and those of her peers would widen to such a point she would never catch up. From this conflicting place the hospital was also unsafe:

So I hid and it just went on and on and on.

Recovery as black and white

From her 'I'm institutionalised' narrative there arose further conflict, leaving the unit meant you were recovered:

And for me recovery was very much at that time, was very black and white, you're either recovered and you're out of hospital or you're ill and you're in hospital, there was no in-between.

Stage three: And then

Feeling powerless

After nineteen months Dr Green decided it was time for Julie to be discharged from the in-patient unit and offered her a transition programme. If she maintained her weight for a specified period of time she could return to their on-site rehab house. This small residential facility provided more freedom than the locked ward and practical support to prepare patients for life ‘in the world’.

Viewing this retrospectively Julie saw this as a key turning point:

I never would have reached the point where I’d say, yeh I’m ready to be discharged now…I suppose they started to force that separation…but that forces me I suppose, to find other things in my life that fills that gap.

However on hearing their decision she had been horrified:

I was like fuck I’ve been here for nineteen months I can’t, I can’t, you can’t do that to me, like, like you’re giving me a death sentence.

The new programme however became less scary as it contained a degree of continuity. The rehab house was headed by Jane, the named nurse she had forged a strong attachment with and Dr Green continued looking after her overall care.

Julie nevertheless maintained her weight across that time using eating disorder behaviours:

It was like the only way I could justify maintaining my weight out of hospital was doing it through eating disorder behaviours…I’ve not done, I’ve not just done this in a way that you’d want me to, I’m still not well. And it was the only way I could do it without feeling really guilty and feeling like I’d taken responsibility to look after myself.

(Translation: taking responsibility to look after yourself meant eating, to eat meant being ‘well’, recovered, so by not eating you are demonstrating to others and yourself, you’re still not well)

Containing relationships

What Julie experienced from the ED unit was caring relationships however the rehab house became like a home to her. It was where staff would call her to account when she transgressed from the house rules whilst maintaining their caring attention towards her. In hospital she was told she couldn't stay if she didn't keep to the programme however *'I knew they wouldn't let me go'*. The rehab house maintained clear boundaries and she took in a different message:

It was very definitely 'you don't maintain or you're out, no more. And it worked for me in that sense, it worked.

The other major difference was the mind-set of her fellow patients. On the unit her belief was that crying and not eating was the only way she could maintain support. In the house, whilst she knew that a large part of her was there because she was too scared of being 'out there', what she experienced was of being amongst others '*who wanted to do it'*; there was no room for those old behaviours.

A taste of what could be

In the rehab house a more practical 'hands-on' approach was taken, the hospital unit for example handed out prepared meals on trays, here you shopped and cooked your food and went out for meals. Julie though found ways to cheat the system:

If there's stuff you want to get away with, you find your ways around it don't you. You think you're really clever (laughs) but you're not, you're not clever about it in any fucking way…I really was just trying to maintain my weight so they'd keep me at the rehab house.

Yet something was changing for Julie, deep down she wanted to get better, whatever that was:

or, em, I wanted to be better whilst holding on to the illness

And from this, 'w*hat could be*' emerged:

I guess it was, it must have been a bit about me wanting it, but not wanting to accept that this is also coming from me, you know, so I suppose I placed a lot of that responsibility on thinking, well, it's the pressure of the group…It started to give me, I suppose a taste of what it could be.

Looking back Julie recognised “*I was kidding myself”* by trying to control her eating whilst attempting to move on.

Stage four: Moving forward

Seeking an identity away from the illness

Although Julie’s eating behaviours had only marginally shifted after six months it was time to leave the house and she felt ready. She found a part-time job at a mental health charity as a ‘service user’ advocate and became passionate about the work. It also engendered a degree of conflict, seeing herself being ‘*rolled out’* at events as ‘the token service user’:

I was going fuck that’s my job, that’s the label I need. I can’t move away from that because I don’t know anything else …so that was really difficult to think about becoming, you know, more well.

Julie moved into a house-share and wanting *a fresh start* decided not to tell her house-mates about her ED history:

I suppose I did start to become, em, motivated to stay well, em, and I wanted to be able to go out with my friends and enjoy stuff and especially now I’d got the work I needed to keep it up.

Julie’s bingeing and restricting food continued although it was harder to do this in the house-share and a year later her weight dropped significantly. When her line-manager suggested she sought professional help Julie wrote to her psychiatrist, Dr Green:

I sort of thought I need to write this because like, I need to take like ownership of this, actually, I’m saying I want, I want help and I, this isn’t me saying ‘rescue me I don’t want to take responsibility’, this is me saying actually I do now.

There were additional factors going on in Julie’s life at this time:

I don't know if it was all about my experiences or if, I still hadn't, you know… that first part of rehab I binged and I restricted through all of it. I'd never actually gone through a period of time without, using those behaviours, ever. And this was, em, I was twenty-two then, I went into hospital when I was seventeen…it was still all I knew.

Julie reflected on therapy as being largely focused on the past which was not matching '*where my head was'*:

I've talked a shit load in therapy and I've talked and talked and talked and talked about it. And it almost, I'd worked through a lot of that and it becomes more about the present and the future and what's ahead and that feels more of the issue than what brought you to that in the first place.

Julie's sister at the same time was diagnosed with an eating disorder and referred to Julie's psychiatrist. Although he referred her to another professional it was devastating for her:

And that was just a huge head fuck, I just couldn't handle it. I absolutely couldn't handle her being, em, in the place that felt safe to me and where I deal with my shit. …it wasn't the reason I relapsed but it was definitely a factor. I just couldn't deal with it.

Then her father was diagnosed with a terminal illness:

And that really changed things. Then, for the first time, ever, I began to think fuck, I actually want my dad to see me well now and it was a real, it really shifted.

From feeling guilty came huge sadness and regret, of the years lost to the illness, it was still palpable as she spoke. It was from this place that Julie returned to the rehab house and from asking herself:

Who the hell are you without the illness?

It was replaced with:

I actually had a life and I didn't want to lose all of that…I can either carry on being unwell and staying in this bubble or, I try to catch up a bit and have an identity with friends and without the illness.

Taking time-out enabled her to look at her relational world:

I sort of wanted a life with friends…but deep down I didn't really…I just didn't feel alright about myself.

Working closely with Jane she re-established her eating routines:

And I knew I need to get into a routine, it's going to be hard and those first few weeks, it's bloody hard, because you're undoing what you've developed and you go through all the feelings and the guilt.

Moving forward was a 'gradual process' and this was not the last time Julie returned to rehab. For quite some time it was her way of coping:

It was still very much like using food when things were really stressful…It was like the fear of letting go of that identity…It was like I still really had to know that the eating disorder was still there; that bit of me was still there and I wasn't letting go completely.

Stage five: From SEED to 'normal'

"What the fuck is normal?"

Back 'in the world' Julie struggled with *feeling a bit behind compared to people my age*, she also recognised numerous 'milestones'. Like making 'healthy' friendships, her career and 'dealing with normal stuff', like her first intimate relationship and sex, both of which felt massive.

She kept (and remains) in contact with two friends from the rehab house which provided supportive conversations that she could not have with her 'non-ED friends. She also maintained contact with Jane and Dr Green which she valued enormously. Combined, for Julie this meant:

There's less room for your eating disorder…it's that shift like...allowing yourself to, and the more you do it and I do think it's true that the more you eat and do normal stuff the easier it becomes…there is an element but there's allowing yourself, there's something about giving yourself permission for it to be easier.

A major contribution towards Julie's progression away from anorexia was meeting Mike, her partner:

I think part of me becoming well, a huge part of it is what I would reflect on after we first met, is taking responsibility, for myself, and owning my recovery…it's about I need to own this myself because I want to be well.

Difficulties though arose, such as his questioning from time to time what she eats, which she has found difficult and frustrating:

Because I want to say, 'you have no idea', he's known me for, five years, we've been together, and 'you've known me at my most well'…I want to say to him 'you've got no idea what I've been through to get to this point, without you'. That sounds awful, but like, 'I've fucking done this, I've not needed you to get me to this bit'.

Julie acknowledged a 'difficult balance' was in relation to feeling in control, albeit a healthier control. Mike for example will eat when he's hungry, or they will go out with no defined plans of when and where to eat:

I feel guilty for saying I need dinner, like I need to look after myself and then I end up like…I don't want an excuse, because that feeds really unhealthy thoughts. I don't want to go down that road.

Julie has struggled with what it means to be 'normal'; what's acceptable thinking around body-shape and food. An example was when Mike's mother remarked to her son about Julie ‘is this the end of an eating disorder?’ Julie was mystified. It was, he told her because ‘*people have butter on their jacket potatoes’*:

I was like fuck, I go out for curries with them, I’m sitting eating whatever they serve me, I eat desserts in front, …and I was like <u>*really*</u>*, the one thing you pick up on, that I don’t pile butter on my jacket potato, you’re fucking kidding me, I mean what the fuck is normal?*

This question more recently emerged in her pregnancy with Mike being ‘*kind of extra cautious’:*

He’ll just suddenly come up at night and say eat these walnuts (giggles), I don’t really want them but I feel like I have to sometimes. It’s just his way of wanting to look after me…but that’s been tricky because sometimes it’s like I am looking after myself…but sometimes I’ve felt like I’ve needed to force myself, just to prove to him that I am well enough and looking after myself.

<u>Stage six: Reflections: past present and future</u>

These are a few threads that Julie reflected on in relation to moving away from SEED.

Control

I’m more well than I thought I could ever be; I never imagined I’d get to this point, ever, where I’ll, where I won’t think about everything that goes in my mouth…does it still control me? To a point yeh, but not, I suppose not to the point where I think I will ever get ill again….still, I think, going through that again, I just couldn’t…but equally it still feels scary, it still feels it’s in reach, in a way…and he (Mike) wants me to be able to say that I will never, ever, ever go back there again, but you just can’t.

I suppose it’s about ‘life is a bit messy’, that’s what it’s about and what I found hard, and it still is a bit; it’s that control thing.

Eating

Julie does, at times, struggle, whether around eating meals at a certain time or looking at a menu before going out to eat:

Do I pick what I really want on the menu? Probably not, no, yeh, but I go out for dinner and pick something that's alright, y'know, like do I pick a tiny starter salad? No, I'll just pick an average meal and it's absolutely fine and I enjoy it…I don't shy away from that.

Relational world

A big thing is having an identity away from the illness

For a long time Julie 'put off moving forward' because she feared the 'outside world'. Filling the huge space where her anorexia existed was where her work and her friendships really mattered:

And I suppose, when you start doing that stuff it forces you to join the real world.

With healthy friendships came a realisation that paradoxically from feeling superior in her thinness over time it also made her feel inferior:

And it feels like people will see me through completely different eyes and I didn't want to be that person.

One special and transformative relationship has been with her named-nurse, Jane. Perhaps unsurprisingly she was the first person Julie told that she was pregnant. Jane provided continual, steady hope and belief in her and Julie reflected on how their relationship shifted over time:

In the beginning…I was telling myself I was doing it for Jane and then probably realising actually I don't think it is dependent on that now but I probably had to tell myself that for quite a while. I think finding that someone is so crucial and maybe that's also what's different from people that don't manage to move on.

Taking responsibility

Julie’s abiding question for over twenty years has been ‘why me?’

It was almost like I wanted a justification, a reason, I wanted a reason to still be ill and not move forward…this is what has happened and this is why I am who I am…I think it definitely reaches a point where it’s just not helpful anymore.

This she recognised was where rehab was helpful as they emphasised taking self-responsibility, of owning your feelings and the idea that she had choices:

(Believing you have no choice) reinforces your reasons to stay unwell it was like I don’t have a choice, I have an eating disorder, these are the thoughts in my head that I have no control over. This is what it does to me, this is what it makes me feel. And actually, starting to admit that there’s an element of choice is quite a hard thing to do, it’s a big thing to do because then it means you have a choice in whether you eat or don’t eat or do or don’t binge. And yeh, there’s definitely times where it feels like it’s not and it can take you over.

Sitting with uncertainty

I’ve finally learned that it’s not about being ill or recovered, there is a place in-between and it’s not just existence, it’s a life, em, and I feel like I’ve got a life and I think that’s the difference. I’ve still got those thoughts and feelings but I learn not to act on them, which stops me relapsing I guess.

As for her black and white world, it’s ‘*not giving in to that really black and white thinking*’*…I think for me, unless I started to accept that there will be grey in between, I was never going to be where I am.*

Julie sees her journey of *recovery and discovery* as on-going:

There isn’t an end-point, you know, and who knows in about ten years’ time, who knows.

Carla

Carla is in her late thirties, married with two children and works part-time. For over eighteen years Carla suffered with anorexia alongside a period of binge-drinking. She was an in-patient for ten months, a day-patient and received residential rehabilitation (rehab) support. She has not received professional support for over nine years.

Stage one: In the beginning

Jolly Carla, maybe!

Carla had mixed memories of her childhood. One was of being happy, her parents never argued, but then they rarely expressed their emotions:

I, from what I can remember, pre-illness, was very laid back about, if someone had said to me, in my teens, I wasn't happy as a teenager, I know that, I remember I was overweight, em, but, but putting myself in someone else's shoes, I was a very happy-go-lucky person, I was very jolly, which is what they used to call me, jolly-Carla.

Whilst 'jolly Carla' was part of her personality, another part was her '*possibly unhealthy relationship with food':*

I would over-eat, a lot, and I would binge, was never sick, but I'd over-eat…but I, probably, the more low I got in feeling that, that I wasn't attractive, and I wasn't in the 'in-crowd', the more I ate. I wasn't quite so het-up about things…I don't remember being controlling and stressed and anxious. Maybe I was and maybe I was just dealing with it by over-eating, but I wasn't aware of it at the time…once the illness took hold, that, the stress and anxiety and the neurotic thoughts came with it.

Later she reflected:

When I think to when the illness started, I think the illness was in me before, way before, probably in fact early teens… But the more I look back at my teenage years, I wasn't happy, I wasn't happy at all.

And later in our meeting:

I can’t really remember who I was before the illness

‘Being what my parents want me to do’

Carla felt as if she lived in the shadow of her brother:

I know she (mother) doesn’t love us any different but at the time I think, as a child and as a hormonal teenager that hit hard.

Carla’s mother was and remains a big influence in her life:

I remember going shopping and she would use the hard method of ‘well, you’re not going to fit into that are you…and I suppose it was just, ‘if I tell you outright, then maybe you’ll lose weight’, but it never worked, it never worked.

Growing up Carla always did what she felt was expected of her:

I didn’t really challenge…I was never a Goth or, I never really rebelled, I think because…because of the ‘well, you don’t want to do that’ and then you think, actually, did I ever really know what I wanted to do or did I just follow what I thought my parents expected of me?

Stage two: Because of this

University life – I ‘just’ started losing weight

Going to university was when the illness ‘started to show itself’; where Carla ‘completely lost control’. Her growing dislike of her body size was exacerbated when she became attracted to a boy who was attracted to her friend from home who visited her:

And obviously he didn’t take any notice of me…you know, I was never given a name I was just Emma’s friend…and that was really how it all started, because, well, he was obviously then giving me attention and had obviously made it clear that he liked her and, I suppose, I just got it into my head, well…I just started losing weight.

She wonders now if, without this incident ‘*would it have happened anyway*?’

I don’t know, I mean yes, I think this friend that I’d lived in the shadow of, for some five, six years and thought, you know, if only I was her, y’know, and then my life would be perfect, my life would be amazing…

Carla began cutting out complete food groups until she was having one slimmer soup a day. What little socialising she had done was also cut-out, it was she recalled just a horrific time. Returning home for the holidays Carla looked extremely ill and her mother’s attitude shifted from *shock* to ‘*the emotional thing’* (tears) to ‘*she just gave up on me’*, Carla recalled feeling she was no longer part of the family as her mother excluded her from meal times and conversations, yet:

It never really touched me enough to think, I need help, but I was aware that I was being excluded…but then I think I just took it out on myself even more… I didn’t, I didn’t see I had a problem, they had the problem. I was the one that, you know, was in control

Binge-drinking

Carla began binge-drinking in her third year:

I then became that relaxed person. And it was like wow, I, y’know, I can be anorexic me but have a relaxed mind.

It was also to convince her friends she was fine:

Look how can there be anything wrong with me…you’re all drinking wine and I’m drinking wine so look, you know, I haven’t got a problem…apart from the fact that I hadn’t eaten anything.

The following day though she retreated back into her struggling world:

Doing my own thing… being very much a loner…but I was 21, 22, it was easy for no one to share my day, walking round everywhere, watching people, and em, but so consumed with my own thoughts that you're never alone.

Strict self-discipline resumed:

There was that need to get that control back and obviously hit the gym and be even harder on myself…but it did give me that release that I so dearly longed for, to just be at one with myself, and confidence perhaps.

This loss of confidence was expanded upon later:

I don't think I ever lost that thought process of me being the fat one in the room and why would anyone want to come and speak to me?

Looking back Carla felt ashamed of her behaviour alongside a retrospective appreciation of this 'outlet', where for a few hours 'all those thoughts would just go out of my head'.

I suppose it was my kind of way of trying to fit in with people and still saying 'look I need your friendship, I need you to stay with me'. So I was trying not to shut everybody out, but I was shutting everybody out because obviously there was so much of my world I didn't want them in…I mean everyone has regrets don't they and I just think it was me sort of grabbing at something as another coping mechanism to be honest.

Stage three: And then

A moment of clarity

After graduating Carla returned home and started work however less than a year later, still living on cuppa soups and dry bread, weighing under five stone (Carla is 5'7") Carla collapsed at work.

When her boss told her to take time out to get better Carla saw this as a transformational moment:

That was when it hit me…I wasn't socialising, I didn't have anything in my life other than, other than this job…and I thought, if I've not got a job I've got nothing and it was a moment of clarity.

Nevertheless this clarity held a degree of ambivalence:

It was a really odd feeling because, because I didn't want to get well; I wanted to get well but I didn't want to get well. I was so tired of, of being tired of it…because, I don't know why it happened.

Carla's GP acted swiftly and she was admitted into a hospital's ED unit. For a brief moment Carla was relieved, acknowledging:

I can't do this, I can't, I don't know, I don't know where to start

Hospital life and feeling cared for

The hospital regime required her spending the first two weeks in her bedroom overseen by her 'amazing', caring Primary nurse. She hated it but struggled on, that was until she started eating in the patient dining-room only to find they were not so compliant. Laughing, she recalled thinking:

What the hell have I been doing and then I just reverted back…that was really hard, to fight with it in there.

In hospital Carla experienced something new, being held in mind by her work colleagues and in particular, Daniel, a young man she had become friends with. What was not new was her mother's expectations of Carla.

When people put words in your mouth

Carla's parents dealt with her admission in a similar way to what she had experienced growing up. Her father, born near to where the hospital was situated spoke largely about how the area had changed, her mother meanwhile 'had that hold on me':

Come on, you've got to succeed…and, 'I'm telling everyone how well you're doing and 'you don't want to be in here all your life' or you want children'…and, it was very hard to say, do you know what though, this is really, I, I just don't want to do it.

With therapy Carla began to recognise how so much of her life had been about doing what others expected of her, which provoked feelings of guilt and frustration. On the one hand:

M*aybe I just don't want to do what you want me to do.*

Yet she felt unable to hold this position:

I began to not do it for me anymore. I was doing it for everybody else that had expectations of me. And it was like, you know, when people put words into your mouth… and it was like, no, I've got to keep going because they're expecting me to keep going.

Carla recognised how back then and today:

I would never have been that person who said 'actually mum no, this is what I want. Again it's that loss of who I am and who, can I think for myself and that, I think, I lost a long time ago to the point where I think, so mum tells me this is what I need to think, so this is how I think.

Carla viewed her time on the in-patient unit as useful, offering her the opportunity to 'talk things through' and after ten months she was discharged at a 'healthy weight'. Transferred to the hospital's out-patient 'day' programme included having some meals at the hospital each week; she relished the days when heavy traffic meant she missed snack times.

Returning home was 'hell', still struggling with food her mother 'replaced the unit' in terms of managing and monitoring her food, and she slowly returned to work.

Carla's anorexic thinking had barely shifted:

I was a healthy body weight but there was still a lot of turmoil in my head

Stage four: Moving forward

Feeling powerless then powerful

Something shifted the following year, still under the hospital Carla started dating Daniel:

He gave me the confidence to eat…I was in a position to relax and look around and see everybody else…and I suppose the power had gone from me

This lost power was ‘of being able to resist’ (eating), instead she saw herself ‘living a life’ and decided:

I remember going to Pizza Hut on the second or third date and just wanting to be accepted by him and if that meant eating that thick crust of pizza, you know, I’m just going to go with it, I’m just going to be that normal woman.

This was tempered with another recollection, of how she also struggled:

I look back now and I can say I probably didn’t let myself enjoy it, it was a process that I had to go through. It was a long while after that I can genuinely say I actually enjoyed food.

After a year Carla and Daniel got engaged and bought a place together; a year after this she relapsed. Work she thought was one factor, needing to be the best, the top sales person each month. There was also a sense of freedom, of not being under the surveillance of her mother which brought a feeling of power:

It was the, I can still do this (restrict) and I can still be healthy…I hadn’t gone back to being ill, how could I be ill, I’m still working, I’m still commuting into London…and then I would just get into a habit (of missing lunch) and then I’d skip breakfast. And once you’ve done it once, you then carry on... it was still needing that control.

Carla’s weight dropped and at an out-patient appointment Carla broke down:

I’ve got back into a rut… and I can’t break it.

Carla agreed to the hospital’s residential rehab programme which allowed her to get her eating routine back on course. This was the last time she had contact with the hospital as regional funding regulations changed meaning she had to be discharged. When her local MH services made contact she left after one appointment; it was *‘just awful’:*

So my appointment was at 12 o’clock and all she kept saying was ‘so would you like to eat your lunch during the session…it was like all she kept going on about…and I remember sitting in the waiting room and they called out ‘Carla, eating disorder appointment’ or ‘anorexia appointment’… and I remember thinking, this isn’t the right unit for my mind.

Carla recognised she would have to manage on her own, alongside her mother reminding her ‘you can’t get ill now’. Carla described this time as a period filled with loss:

I think probably like everything else I just buried it… There was certainly great loss. That one place that had played such a big part of my life, was gone. .And it really was like, well, it was feeling as though part of my life had sort of drifted off and it wouldn’t be within reach again.

She did though keep in touch with a friend from the rehab house which helped her:

I don’t know, maybe it was the illness wanting to keep hold of…or whether it was kind of almost wanting to realise, to remember that I’d been ill and that I wasn’t just OK, you know, that I’d been through that. I think when I was an out-patient I could still sort of, it was still part of me…I’m probably not explaining myself very well but kind of, in a weird element, a pride that, rarely have I ever achieved anything in my life, but I achieved in-patient status with my anorexia. How perverse is that.

Stage five: From SEED to ‘normal’

What is healthy eating?

Carla and Daniel married and, she reflected, he provided significant support in her life. Whilst he acknowledged he had little understanding or time for the illness he remained patient and caring; he also belittled the illness not her. Becoming a mother and building a social life around her provided a sense of comfort but also came with difficulties as her anorexic symptoms receded.

Eating out was one example:

It’s a thought-process, right, if I’m eating out at lunch, do I graze in the morning or should I wait and, and that’s still with me. But then, is that, I mean you watch all these diet programmes and the other things on and you think, but, well, well it’s not abnormal, you know, what is a healthy diet? Like, well, what is a healthy relationship with food?

Watching people eat at work with their ‘quirky’ choices remains confusing for Carla although this thinking is tempered with:

How much does it take over your day? I think for me, the thoughts are there and, it can be with me but it doesn’t take over my day, I’ve got other things going on… I can go out and enjoy a meal out. Do I enjoy it as much as they do? No, no, but from where I was twenty years ago it’s a healthier, I don’t turn invites down, I eat at different times, but, the thought process is there.

Relationships

Experiencing healthy relationships was another important factor that enabled Carla to move further away from her illness, particularly those friends who remembered her pre-illness and ‘stuck by her’:

Had I not had such good friends and family…whether I would have had that ‘I need to fight for this, I need to fight to live’, because I think that is part of the illness isn’t it.

Nevertheless the extent she went to, to hold on to even these old friends troubled her:

It's that loss of power...the fear, I think when the illness became me then I didn't need anybody else and now the illness has almost gone, I need other people. And I think there's a genuine fear of not having other people, and I'm fearful of that. I'm fearful of losing friends, em, I don't feel comfortable enough in myself to feel like I deserve friends. So I'm a walk-

over, because then I feel like I deserve the friends...I can justify being me today...and it's exhausting.

Carla's struggle to say 'no', her need to be involved in everything from organising the church crèche to school committees was reflected on further:

Maybe it's a diversion, maybe the more I do the less I have to think, perhaps.

Stage six: Reflections: past present and future

Still pleasing others

Carla viewed her journey away from anorexia as a series of stages which began when she started work. What she was mindful of was how much pleasing others, notably her mother, still consumed her:

I can't seem to say no...it just doesn't seem to come out of my mouth.

Recovered and recovering

Carla was aware that residues of the illness, unseen by others were nevertheless present:

The percentage I see, of it, in my life, is miniscule to what it was, but it's still there and I see the word 'recovered' as it's gone, and it hasn't gone. Em, it's just that I have more in my life now...there's still elements of a control factor that I put into my day, and that's down to the illness. So, em, and they're really minute things, it doesn't mean that I need to be admitted again.

Sense of self

For Carla anorexia 'formed' her into who she is today:

When I step outside myself I see that I've replaced the stress that was controlling food, in that, now that control has been released, to some extent it's channelled elsewhere. So it's channelled into social arrangements…but it's just how I live my life…I have forgotten how to relax, I genuinely have…but then there's a lot of people out there who don't sit still.

Reflecting further she wondered whether, going from one stress to another had another meaning:

Is it because I'm not really feeling, am I not really allowing myself to feel...I just don't know how I do that...but then being under my BMI range I wasn't at peace...so I know the answer is not what I did twelve years ago.

Self and mother

Her mother continues to be very present in her life:

There's the guilt of what I've put them through...and I think thank G-d I was able to give them grandchildren at least.

I love her to bits but there's always this, the way she says things...and even now as the primary carer for my children she'll ring me and say "well you want to make sure (daughter) is on that book stage don't you by the time…" and I see that she sets the standards.

And a final reflection, for now

I can't, I can't change that for better or worse...do I think I'm well? Yes. Am I recovered, no, I'm not recovered. Will I ever be? No, I don't think I will ever be. But it doesn't mean I can't live a happy, healthy life...I certainly think I have more empathy and understanding for people's feelings.

Carla appreciated how, as other things came into her life it left less room for her anorexic thoughts:

I know that my coping mechanisms however need to be looked at and I worry far more than I should. I think that's just me, I don't know whether that's the illness, I don't know, but I am more at peace, I just need to work at being more at peace.

Bella

Bella is in her mid-fifties, married with two children. Her anorexic symptoms began in her early teens and continued at varying degrees of severity for approximately twenty years. Across this time she received individual counselling and psychoanalytic group therapy (ED specific). Bella has experienced a healthy quality of life for over ten years and today is a qualified counsellor.

Stage one: In the beginning

Secrets and shame

Bella considered her early years were shaped, in part, by her 'wartime parents':

There was a real demarcation between being an adult and being a child and they didn't know how to do adolescence at all*, because they hadn't really had much of an adolescence themselves…they weren't comfortable with us growing up really.*

Bella's family, she has two older brothers and a younger sister, had lots of secrets, her father for example had an artificial leg which Bella only learned about in her teens, before that she accepted her dad just had a limp:

It was all covered up, and it was a lot of shame that he felt and, so, so we grew up in this household where there were lots of secrets and lots of things that weren't talked about.

Emotions and feelings were definitely not talked about and Bella linked this to her parents having been scientists who demanded scientific, rational thinking:

I was a feeling person but that was always, er, denigrated in my family…it was always 'what nonsense'… 'What are you talking about, that's not very scientific'. So I was left feeling very confused because…I didn't know what my feelings were about and I didn't really know how to put my feelings in words because that just wasn't a language we spoke.

Reflecting on this for a moment she added:

…but otherwise it was a happy childhood…I think it was common in those days, in the '60's.

A vivid childhood memory was when her mother, aged forty fell pregnant. Bella was ten years old and recalled being ‘absolutely horrified’. Her brother explained that at her mother’s age complications were possible so ‘*don’t say a word about it’*. Another secret. Bella felt guilty about her bad thoughts and prayed every night the baby would be alright. When her sister was born with orthopaedic problems Bella felt lost, isolated and angry:

Because I was the only girl, I was the special one…and I was supposed to be helpful and I was supposed to be pleased. And I wasn’t, at all. I was really horrified actually.

This coincided with Bella’s body starting to mature which she found ‘mortifying’, just as she did when she had her first period. For Bella being a woman meant being like her mum, a woman who gave up her promising career to appease her husband, a woman who was always tired. Bella remembered longing to be near her mother as a child:

But when I was with her she just didn’t have much to give.

Another uncomfortable memory related to her father:

The way he looked at us sometimes felt awkward, very uncomfortable and I think one of my, one of my reasons I felt so uncomfortable having a woman’s body was partly the way my father looked at me and, it was all unspoken, there was one very inappropriate thing he did, em, which was obviously awful and had a huge effect on me, it makes me quite upset actually.

This led Bella to reflect on the spectrum of abuse and whilst she placed herself at the ‘opposite end of ‘full-blown’ sexual abuse’ she recognised the ‘thing’ that happened had a huge impact on her.

Stage two: Because of this

Relationships, one at a time

Bella was quite an anxious girl who could only tolerate one friend at a time:

I was always one to have one best friend and then something would go wrong, em, they wouldn't be perfect anymore, and then I'd have to get rid of them and find another best friend. I always wanted perfection in people, I couldn't bear imperfections.

A new focus

At fourteen Bella felt fat and ungainly particularly as her developing breasts provoked 'jokey' remarks from her family:

And I remember…standing on the scales and seeing my weight and thinking, Oh my G-d, I've reached seven stone that feels like a very grown up weight…there was something about wanting to reverse the whole, em, developing process and of course my periods stopped, which was <u>*hugely*</u> *welcome and then I just became hell bent on staying, staying like that.*

What Bella described as 'cutting bits out' was restricting whole food groups and from fourteen to aged eighteen Bella's weight plateaued at around five and a half stone.

Becoming a little bit more special

Her high school years she recalled were miserable and lonely as she became more withdrawn however there was another feeling which her thinness elicited:

There was some kind of specialness, that sort of singles you out and so I think there was a fear, that if I lost that, I would become a bit of an ordinary blob…of just being very invisible and very mundane and uninteresting.

Whilst others struggled with fad diets Bella felt in control; more disciplined:

And a little bit more special than other people I suppose. So yeh, I think there was an awareness, that underneath that, that I might not be very special, I might be very ordinary and that would be pretty awful and that would make me a bit like my mum.

Across the following four years Bella's parents said nothing about Bella's malnourished body other than tell her to eat more. It was when they saw a programme on anorexia that they sent her to the GP. Diagnosed as having an eating disorder what Bella remembered most was the GP's comment:

'Oh she's not as bad as I thought she would be' …which of course, it fuelled my desire to keep it going.

Counselling was recommended, Bella went for one session and never returned. It was many years before Bella sought professional help again.

Stage three: And then

University and a new phase

Bella chose a university in Scotland, 'as far from home as possible' and arrived feeling very naïve:

I'd been to very few parties, hadn't drunk very much alcohol…but I decided to pretend that I was very cool…I just sort of plunged in and I was picking things up from other people.

Almost immediately she met a boy*:*

…and became heavily obsessed with him and quite cut-off again. Em, I was really looking for a one-to-one you know, he was very cool…and it wasn't really a sexual relationship, well it was a sexual relationship but we didn't have sex, I couldn't go there…

This relationship lasted three years during which time her weight went up marginally to around six stone kick-starting her periods for the first time in five years. This brought relief and concern:

I was worried about being too relaxed

Bella believed that her successful school exam results were achieved because of her obsessional behaviours:

So I would sort of alternate between being incredibly rigid, get rigid about food and then I would get a bit more relaxed, so I was kind of going into a new phase.

This new phase included a keenness to experience new things but it did not last long as in her final year the relationship ended and once again Bella's weight dropped:

And I just hid myself away.

With university over her father told her she couldn't come home now she was an adult so she found cheap lodgings in London, a retail job and her weight dropped further.

Living a less rigid life

It was then that she met with old university friends who suggested Bella join them in Istanbul to teach English as a second language. It was, Bella reflected, an 'angry move':

Obviously my parents didn't really want me to go, but they couldn't say that and I was really angry I think with them, for not looking after me better. It was almost like two fingers up to you. This is what I'll do, I'll bugger off.

Bella's description of herself at that time was:

…an anorexic that could eat, but I never ate enough.

Nevertheless the year that followed exposed Bella to more new experiences:

I was able to take stuff in, I wasn't living a rigid cut-off life and I just think that experiencing all those things was helping me to grow.

Within a year Bella met her future husband Tom, and, she whispered, she had sex for the first time.

Marriage and a setback

Moving back to the UK with her fiancé Bella got married and they moved into cheap, rented accommodation akin to her student days. Almost immediately after this Bella plunged into deep depression, what felt like a good idea suddenly brought with it 'grown-up stuff':

I was still very, very child-like in my thinking; I didn't really want any responsibilities.

When Tom contracted TB and returned home to be cared for by his family Bella was resentful:

I didn't want to look after him at all, I wasn't at all nurturing. I think I felt resentful that he wasn't nurturing me.

And yet, from this bleak place Bella's life and her entrenched illness slowly shifted.

<u>Stage four: Moving forward</u>

Counselling

Bella found an interesting and rewarding career and Tom, fully recovered started his own business. As a couple though they struggled and Bella sought counselling:

I went to Relate, by myself, I don't think Tom really wanted to go. I don't think it was really his culture.

Bella had mixed opinions about the fifteen months she spent in counselling but overall her counsellor was not someone she would want to work with today:

It was my first experience of counselling and he was a bit forthright. He was a bit inappropriate as well actually, in some ways. I think he was a bit intrusive and, I think there were times when it was a bit more about him. He told me he'd had an eating disorder and he kept wanting to, he was a bit probing about sex and I…I felt very intruded upon by him.

What it did provide was a sense of 'where the eating disorder may have come from':

I started to understand my own psychology a bit with him and I started to understand various (relational) dynamics.

Becoming a mum

During her time in counselling Bella fell pregnant, initially it was a shock however she was determined to 'do it very differently from her mum'; her mother had frequently told Bella as a child how dreadful pregnancy was:

And I thought I’m bloody well not going to be like her; it’s going to be good for me...I think all the time I was motivated to be as different from my mum as possible.

Five days after the birth of her son with her husband preoccupied with his business Bella, having left counselling once again felt alone:

And I remember thinking right, I don’t have to eat any more. I can stop now…I was all on my own and I didn’t have a huge number of friends and it was just…I just felt devastated… I just felt completely and utterly isolated.

Bella remembered bonding well with her son however she had also felt ‘hollow’:

It was almost as if my life had been hollowed out into him and there was nothing inside…in some ways I had something worth feeding but, it seemed a bit pointless, eating somehow.

Group therapy: learning to be with other people

Bella went to her GP in tears, her bingeing, restricting and exercising were out of control, she was offered either anti-depressants or therapy, Bella opted for the latter. After an assessment it was recommended she join a local ED therapy group which met weekly and was facilitated by two psychoanalytic psychotherapists. The group comprised of, on average, five women and Bella attended the group for over six years:

It was really interesting because although our eating disorders were rather different we all shared a lot of psychology in common.

Bella began to notice how they all related with one another and the therapists in a similar way:

I always think of eating disorders as relationship disorders really…I mean the group itself was interesting because rather than use it as a group it was like we all wanted a slice of pie…we didn’t relate that much to each other. So it was like you were waiting to have your little bit of time with the therapists.

Taking self-responsibility

Over time and with the input of skilled therapists Bella slowly appreciated how she related to others and how this could impact on her sense of self:

Up until then I think everybody else, it had been everybody else was getting at me and then I started to realise that actually, I had power over the way I related, but it was a very gradual process.

Bella's 'concrete' view of the world when she first began therapy, with very little idea of what she was feeling gradually shifted. Therapy became a safe place, where she felt listened to and heard:

So they were really trying to get us to start thinking about our minds and thinking about the way we related to the world, and making links between the way we related to food and the way we related to people…and that was a revelation to me.

Having a mind of my own

Growing up…there was really no-one to talk to, to help me make sense of my inner world and I think that was the problem because…it was always invalidated in some way. So the group sort of enabled me to, to fill in a lot of missing bits of information I suppose.

From having taken in phrases like 'you've no right to be angry' or 'you're not supposed to feel like that', Bella linked the work of the group to Bion's 'container contained':

You need someone to make sense of what's going on not only in your body but in your mind as well, without language, someone who is going to reflect back and respond appropriately.

Stage five: From SEED to 'normal'

Is this mindful eating or post-anorexic eating?

Bella left therapy after the birth of her second child and considered her eating and weight had 'normalised', a word she attempted to define:

I'm constantly questioning, trying to figure out whether I'm OK…I suppose if you ask me now, I'm still quite careful. I don't want to go beyond a certain weight, but it isn't a problem anymore.

Bella neither obsesses about food nor worries about eating out, which was in stark contrast to some of her friends:

A lot of my girlfriends…talk endlessly about food and calories and bodies.

Recovered, recovering or self-discovery?

Bella's belief that people can make a 'full recovery' from anorexia shifted as she spoke. Perhaps it meant anorexic cognitions were hardly ever there, that food was no longer an important focus or:

…that it's in its rightful place almost…when you're hungry.

But then:

It's much more complicated than that really. I mean the whole issue of body image keeps coming up and that's something I suppose I still struggle with quite a lot, but then I realise so do 90% of the population and I don't really know…

I think I'm very much more aware though, what I'm putting in my mouth than other people are…that little calculation going on in my head where I think, 'well, no, you don't really want that do you, em, you've had your lunch'…but (sighs) I, I don't feel that I deprive myself, and I don't restrict any kind of food groups…but I suppose, if I'm really honest, I'm still quite careful but, I don't know if that's mindful eating or whether that's post-anorexic eating.

Stage six: Reflections: Past, present and future

Being softer with myself

As Bella reflected on her journey away from anorexia she returned to a thought she had earlier:

I have been thinking about what it means to me and whether it's really recovery from an eating disorder, or whether it's more to do with self-development…I think for me the self-development has grown out of the work I did on recovery…it hasn't stopped, it's still ongoing. I'm still learning new things about myself

This included relating more softly towards herself and others, so 'perhaps it started there', but then:

…it's difficult, I suppose it's difficult to tease out, what's you with an eating disorder and, and what's you, if that's something you've had for a long time.

Bella considered her ED as developing partly out of not having a strong enough sense of self which was happening long before she found a solution:

…anorexia was the solution I suppose, em, and then having got to that solution and worked through it somehow, or got through it and out to some sort of other side, em, that was the path that I followed.

Relationships

Bella viewed her relational self as having been very fragmented so part of the work had been around integration:

It was about creating some kind of structure and connected tissue where everything starts to hang together, that was a big part of it for me really and of course that process is still ongoing, there are still bits that are polarised.

Bella recognised that when she was stressed her black and white thinking returned but she was then able to see the greys 'and see the pros and cons of different points of views at the same time'.

What has quietened a great deal is her angry, critical inner voice which she recognised had been very much like her mother's voice:

There was a lot of needing to punish myself and attack myself for not being the way I felt I ought to be…and so because I wasn't fitting the mould in lots of different ways, I think that led me to, to attack myself at every opportunity.

Bella acknowledged that she could still find herself doing this but then she will catch herself and wonder what was actually going on:

I think that somewhere along the line I moved away from doing that and actually, just having a strong therapy relationship where, em, with a much more compassionate voice from the therapist really…something very soft…like 'that sounds very punishing'…and I think that that's an ability I've slowly been able to do for myself…I don't know when that started…it was just such a gradual process.

Bella's final reflections included her thoughts about whether she could envisage a time where she may relapse. Even when she was 'pretty well recovered' she recalled having the occasional thought of 'if the going gets tough I've always got this', but that was a long time ago:

No, I don't think I'll ever go back there actually. I think that there are other ways of coping now.

Diana

Diana is in her late thirties, married with three children and works part-time. Her anorexic symptoms began in her mid-teens alongside obsessive exercising. She was admitted to a hospital's ED unit aged eighteen then transferred to their in-patient rehab house followed by out-patient support. After a year her weight dropped and she was re-admitted for a similar length of time to the same hospital's in-patient, rehab and out-patient services. Diana has not received any professional support for over eight years.

Stage one: In the beginning

Massively sensitive and ‘G-d problems’

Diana’s childhood was initially described as happy, her mother was a good role model, her father was loving and she was very close to her brother, three years her senior.

She was also a ‘massively sensitive child’:

I had (small laugh) like, what I now know was OCD when I was younger but I used to call them G-d problems, because I used to think it was G-d telling me to do things. It wasn’t like voices, it was OCD. It was like classic things, like if you don’t turn that light off that many times before bed, or make sure that door was ajar a certain amount, em, everyone will die kind of thing.

As Diana continued talking she described a less than happy childhood:

They (parents) used to argue a lot but they were never, y’know, they were a fairly happy couple.

Diana became obsessed with the idea that her parents would divorce and what she found particularly hard was how these rows were ‘played out’:

I couldn’t handle going to my dad because my dad would say mean things about my mum whereas my mum would just cry. But either of those things are not good for a child to witness.

Dark clouds

Alongside this childhood backdrop two events came to mind. The first was when, aged seven, her paternal grandmother died. It was the only time she saw her father cry ‘and it was like one tear’. Diana insisted on going to the mortuary with him:

I can remember feeling this real responsibility, like I've got to look after my dad. Em, I dunno (small laugh), I was just like a weird child…and sort of seemed to try and take the world on my shoulders, em, and try and make things better for everybody and stuff.

The other memory was when her father was made redundant:

And all I've got is this image of him, like sitting in a chair. Basically, in hindsight he was depressed, he was definitely depressed.

Diana described the 'dark cloud' which had long hung over her father who was convinced he would die young as both his parents had died in their 60's. It was from family therapy that she became aware how this may have affected her:

That taught me quite a lot about my dad and how many issues he's got that, I never realised, em, then…so I suppose in some ways, yeh I never looked at it like being his carer before but yes I, yes I needed to look after him.

Shame and guilt about 'that time' and her subsequent illness remain dominant emotions experienced by her parents and herself:

I hate talking about this…like she (mum) would instantly blame herself and she did instantly blame herself and I don't like verbalising it because I would never blame my mum and she's been and still is, amazing with it all. But she, so they argued a lot, and, I just found that so hard (her voice cracks).

Stage two: Because of this

When exercise became a 'bit of a thing'

Diana placed where 'it' began around the time she was dating her 'first ever boyfriend'. She was fifteen and he lived about half an hour's walk from her home:

…and I'd like walk home from his house sometimes, and this became a bit, I can remember that becoming a bit of a thing, like I had to, like my dad would be like 'I'll come and pick you up' and it would be like no, <u>I can't</u>.

Diana thought her compulsion to exercise may have been connected to her boyfriend:

I had him on a pedestal, massively, I thought he was like amazing, em, and probably thought I wasn't like enough, good enough. But, but there's no reason to think that.

Later she reflected:

I don't think he treated me brilliantly…you know, I was happy, I thought I was happy for the time I was with him.

As for their break up:

So he like snogged another girl which was obviously huge when you're like fifteen, sixteen…she was what I felt, was everything I wasn't…she was <u>really</u> confident.

A new challenge

Whilst studying for her 'A' levels and exercising excessively Diana found a new challenge, each day she would eat less than the day before:

I always ate, I never starved myself totally. I obviously starved myself (small laugh) but I never didn't eat at all it was always the exercise…but the link wasn't there between burning off calories, it was just I need to do this…it wasn't until I was physically starting to, you know lose my body that I, that I sort of put those two things together.

What mystifies Diana today is how, a year earlier, when holidaying with a friend she had joked about being anorexic:

We were like 'oh my G-d I <u>so</u> couldn't do that' (not eat). I mean I was perfectly healthy then…y'know we were teenagers, we didn't do it, we said it…but that conversation still sticks in my head because it was like this thing that was so kind of I could <u>never</u> do…there was no *way I could ever starve myself, yeh, ever, and that's weird, em, I dunno, maybe that's not weird. I don't know if it's just a teenage girl… (Voice drifts off)*

And yet, she reflected wistfully:

The weight was really falling off…and no one really said anything to me.

This 'no-one saying anything' confused her further in relation to her mother:

She probably thought y'know, I'd probably grow out of it or… I dunno, you know you go to university and you sort of move on, it's a phase, those sort of things.

Diana never did go to university, after sitting her exams she became more depressed and her anorexic symptoms dominated her life:

I was pretending to be fine the whole time, because again, I didn't realise what was wrong with me, like I genuinely didn't…It was definitely about control, definitely… and yeh, I don't know if it was like I, I just don't want to exist anymore… I mean I was in it then, <u>definitely</u> in it, so yeh, maybe it was a cry for help, I dunno.

Diana's weight 'dived' and her now very concerned mother took her to the GP:

He told me there are starving children in Africa…I should appreciate food more and I should eat my mum's apple crumble…I think he probably thought, teenager, she's going through a phase, whatever.

Her mother nevertheless 'fought and fought' and Diana was referred to an ED psychiatrist who told her she needed to be admitted.

Stage three: And then

First admission – earning my place and confusion

Diana spent an unhappy month at home waiting for a hospital bed although family therapy started and she met with a dietitian. Whilst relieved to be told what was wrong having visited the ED unit and seen some of the in-patients, it brought about another challenge:

I thought right, if I'm going to go in there I'm going to have to get as bad as I possibly can…it felt like forever, just waiting and eating as little as I possibly can and doing as much exercise as I can…well they're anorexic aren't they and I'm not (we laugh)…and I'm not one of them…I've got to earn my place.

Diana described that first admission as confusing. She was relieved to have her control removed by the hospital, it was like 'being given permission to eat'. At the same time:

I did it because my mum and dad, my family, I did it for them, em, and, I didn't really want to do it.

Diana the '*proper people pleaser'* also felt annoyed at how some of the patients messed around with their food during meal-times and her thoughts shifted from:

OK this is what these people are doing, they're much better anorexics than me I'd better do that as well.

to:

I'd find being around people that didn't comply really difficult. Partly because, well, mainly because how dare they get away with something I'm not getting away with but yeh…how dare they not do the right thing?

It was a really hard time, having to eat to put on weight which she described as:

What they were trying to do to me.

Diana was discharged from hospital 'weight restored' but her mind was still in turmoil.

Stage four – Moving forward

Second admission

Within a year Diana's weight once again dropped significantly although she had few memories of what she did during that intervening year. It was following an out-patient appointment she was told she needed to be re-admitted:

…so when I was told I needed to go back into hospital I made sure I was worse again than the first time because obviously there's no point going in again if you're not going to be so, like… it had to be worse. So I did this and this second time it was like I'm ready to get well, not, I didn't feel like that at the time…it was a massive failing, that I hadn't, but, but on my family's part not on myself, like I'd let them down.

This second admission Diana described as absolutely necessary:

I wasn't convinced that I'd got as bad as I could be…and I needed to prove to myself that I could do it again if I wanted. That's the sort of thought that I've come around to thinking now, you know, afterwards …I had to do it twice to…to prove to myself and that, like, you know, box ticked, done… yeh, I needed it. So yeh, it did, it did have a purpose….I'm not particularly convinced of that now, but now I wouldn't need to, I don't need to, y'know, I can verbalise things.

Diana attributed the transformative elements of this hospital stay to the actions and words from various members of staff.

Her psychiatrist was a key component:

He's a one off really, he's just so lovely… His softly approach was just lovely and he was brilliant, and like brilliant with my mum and dad who were just floored by the whole thing and he was gently, gently with them, explaining it and he was just very personable.

There was also Caron, her psychologist, with whom she had worked with on her first admission:

It allowed me to sort of start and then finish it, well do you ever finish it…do the next bit. So I got a head start on that, em, I think it probably, it helped me to, or forced me to accept that I did have the illness. Not that I was in denial about it or anything…but to accept that was the right place for me and that I needed help.

A list, a tipping point and a new mantra

Diana pinpointed three significant changes in her thinking as she reflected further on this admission which were to have an impact on her then and today. The first emerged from an exercise set by Caron:

Caron asked me to write a letter to it (anorexia)…as my best friend and a letter to it as my worst enemy and that was a really useful exercise…

What Diana wanted most in her life was a partner, children and good, 'healthy' friends:

…all things I couldn't have if I maintained that life, you can't call it that can you, it's, it's just shit…I can't look the way I want to look and be healthy and have all the things I want to have and I want to have those things more than I want to look like, you know, emaciated. So that was a kind of tipping point…and that's obviously a <u>massive</u> *thing to come around to and that's something I still, almost like my mantra now… like I can't, I can't function properly unless I'm like this, because I've tried it and it doesn't work (small laugh). So I can't have babies, I can't have a relationship, have a job, all those things, just, you know… eat and drink and things unless I look like this.*

That was not to say her anorexia suddenly disappeared, it was a daily struggle however, having been in hospital, twice:

'…the other option wasn't viable'.

University life and confidence

Another significant change came from a supportive occupational therapist at the rehab house who encouraged and helped Diana apply to university. She opted for a university which enabled her to continue living at home:

I didn't trust myself to live away because that would, like so many people do that don't they and go to Halls and then go downhill.

Diana recalled how regimented her eating was during that first academic year ‘fresh from hospital’, staying closely to what she had eaten in hospital. By her third year life was opening up:

I was having all these new experiences.

The third significant change Diana attributed to reflecting more on how she might achieve her goals:

I think the more time you spend in hospital, I think you lose people. So people just think x is in hospital, they’re still in hospital; OK I can go and visit them…you know, there might be a bit of a novelty value at first, having an anorexic friend in hospital…then you realise they’re in a mental hospital in (town) and you don’t really want to go there and I do think you lose people.

Relationships

This new awareness led her to think about how she wanted to be seen differently by others:

Like if they don’t understand it they think you’ve got no push and no drive. Whereas if you have got drive, people admire you and that’s a nice feeling as well…I know some of my friends, and certainly my family think ‘bloody good job’ and that’s a much better feeling than being thin can give you.

During both hospital admissions Diana witnessed ‘revolving door’ patients, those people who yoyo in and out of hospital for much of their life:

And I just think (small laugh) which one do I want, it’s quite clear which one I want. So that’s motivation as well isn’t it…I suppose I could see people in there who were engulfed in it and obviously I was engulfed by it as well but it wasn’t <u>everything</u> that was me…there was more to me than that.

Diana reflected on how her first admission was to make her family happy, ‘*but it didn’t work’*:

I am doing it for my family now but that includes me. I am part of my family…and yeh, over the years it has become more for me in order to achieve that life that I want to have.

Diana's 'people pleasing' personality hadn't changed much '*which is annoying'*, however she became more adept at reflecting on things differently and felt more able to say what she thought. This she attributed to Caron who had encouraged her not to 'show' her unhappiness but to 'verbalise it':

Moral support

A relationship Diana valued was Julie, a friend she had been in hospital with who, like her, had found a taste for life. Going out to pubs and clubs boosted her confidence and in the presence of someone who understood and shared her nervousness and vigilance made it easier:

So obviously we'd have to have a salad for dinner, but the fact we were having pudding and wine…was a big deal. We would do that and obviously because she was ill as well it was OK; we were both doing it.

Marriage

Discharged from hospital and having finished her degree Diana began work, mentally holding on to the 'list' she had written to her eating disorder. About three years later Diana met her future husband, a young man who was very different to her previous boyfriends:

I wonder whether that's to do with, because he doesn't provide the self-esteem, but you know, so I have to produce it for myself.

Stage five: From SEED to 'normal'

Is the average girl really friends with salad?

Diana was aware that there remained a negative degree of control around what she ate:

Recovered to me means completely normal with everything, with food and exercise, just not having an issue with it. I mean I don't know how many women there are in the world that are like that anyway…

Diana's perspective of *the average girl* was that they knew they probably should exercise more, eat a little less chocolate, eat more salad, but they would rather have a burger and chips but, 'that's just not going to be me'. Diana was very aware of her vigilance and control around what she ate.

She wondered if it was possible to be 'recovered' when you have had the illness for so many years:

I think the majority of my friends are like that, like 'we're not friends with salad'…and if I'm honest, I've got no idea what I'd rather have, I know what I would have but I've got no idea what I'd rather have. Because I've spent so long…

Diana's own 'recovering' journey meant lots of things and incorporated numerous stages. One included her being able to introduce different foods from what she had eaten in hospital and discovering what she may or may not like. The subject of 'hunger' was a complicated one. She was aware how being hungry and then eating made her feel better, but then:

…because then I'm like, it's permission again, you know, I needed it… (laughs) I've always felt hungry, that's really sad. Well, it's sad as in that I felt as if I've been hungry for like twenty years or something.

Today Diana eats healthily however prefers not to describe herself as 'recovered' and argued it was not something an alcoholic attributed to themselves:

It's very hard to let it go…yes I'm at a healthy weight, yes I've held my weight for about ten years or whatever. So maybe my body's recovered but my head's not. So don't get me wrong, it is still something I struggle to let go of; you're almost maybe leaving yourself open and vulnerable if you say 'no, there's nothing wrong with me'…but I think, if you're sort of *open to it coming back, open to it still being there, not coming back but open to relapse, you're always on alert, which I think is a better state to be in than not. I worry that if you say that you're recovered, then you might get complacent…But yeh, I like the idea of being completely well, not 'well', but being, er, psychologically recovered…*

Stage six: Reflections: past, present and future

Re-thinking exercise

Having recognised that her relationship with exercise needed to change after her second discharge from hospital Diana did nothing more than gentle swimming. Her thinking at that time was:

I don't know how to exercise in a normal way, so I won't.

It was only after meeting her husband, watching him train for a marathon that she thought about how she could re-start exercising. Fearful that it could get out of control she found support from the owner of a local gym, told him of her ED history and asked him to keep an eye on her. Diana is aware that exercise and its link to her anorexic thoughts were not completely gone:

Don't get me wrong I am addicted to any exercise I do…But it's like a release isn't it…I can't, why I struggle with the whole recovery thing is because I can't, I can't see a time where I would go for a run and not be thinking about how many calories I'm burning…I've got to do something otherwise I can't justify eating.

Re-thinking everything else

Diana remained unsure about why she had felt a need to 'punish' herself, perhaps she was 'just predisposed to it' or she was just 'a sensitive soul':

I don't think it's anything anyone said or done along the way. But that makes it harder then to know, your catalysts for it, you know…

She was aware that she had more work to do psychologically; that there remained an element of control around her weight however she was able to see how far she had come:

There's definitely still stuff that I could work on, but the way I see it at the moment, my, things are generally good so I don't want to, or I'm perhaps not ready to sort of do the next bit, yet.

Brief summary

Bettelheim considered fairy-tales illustrated inner human conflicts; they depicted an existential predicament, of mastering the psychological problems of growing up which included overcoming narcissistic disappointments, relinquishing childhood dependencies and gaining a feeling of selfhood. Below is a summary review set within the six-stage scaffold linking quotes from Bettelheim's 'Uses of Enchantments' (1976) with selected words and phrases spoken by the four participants.

<u>In the beginning</u>:

Participants: The world as a scary place; feeling powerless; "I'll be who you want me to be".

Bettelheim: 'the child is subject to desperate feelings of loneliness and isolation…more often than not, he is unable to express these feelings in words, or he can do so by indirection: fear of the dark, of some animals, anxiety about his body" (p10)

<u>Because of this</u>:

Participants: dysregulated affect; binary thinking; fragmented self-states, cut-off relationally; seeking specialness; ambivalence

Bettelheim: on ambivalence: “if the child is told he can get the better of someone like his parents this does offer a pleasurable thought, but at the same time it creates anxiety, because if that is possible, then the child might not be adequately protected…” (p32). “…the child is overwhelmed by these ambivalences within himself…since he cannot comprehend intermediate stages of degree and intensity things are either all light or all darkness…all courage or all fear, the happiest or the most miserable” (p74).

And then:

Participants: Finding a safe place; new relational configurations tested out; a toe in the world; varying degrees of containment

Bettelheim: “These tales tell him that by forming a true interpersonal relation, one escapes the separation anxiety which haunts him” (p11)

Moving Forward:

Participants: Taking in bite-sized emotional nourishment; “I can’t do this and have the future I want”; ‘sort of knowing’ feels more bearable

Bettelheim: “The child, as he develops must learn…to understand himself better (and) with this he becomes more able to understand others and eventually can relate to them in ways which are mutually satisfying and meaningful” (p3).

From SEED to Normal:

Participants: Re-covering and self-discovering; wondering about what are healthy choices; finding words

Bettelheim: “Only by going out in the world can the fairy-tale hero find himself” (p11)

Reflections:

***Participants*:** Being softer towards myself; I have more in my life now; taking responsibility for myself; it’s down to me; filling the gap where anorexia lived

Bettelheim: “Inner integration is not something that is achieved once and for all, it is a task that confronts us all our lives, in different forms and degrees” (p76).

Cross-case analysis of the data

The cross-case analyses in this study represents the ‘re-storying’ component as described in Stage 3: Storying and Re-storying’, whereby threads and tensions across the various narratives have been further scrutinised, acknowledging all the while the multiple interpretations and subjective meanings. It seeks to bring together commonalities and differences that may provide ways of understanding this study’s research question. This scrutiny led to three key words as seen in Figure 3, that of early years, a transitional place and integration which I then further elucidate for the reader. As previously discussed, whilst the key and sub-themes are placed in a boxes its design what to extract what I felt to be important and not privilege any one of these. I do not consider any of the themes to be operating in isolation rather they are intertwined and overlapping.

Figure 3: A relational trajectory in three stages

Stage One: Early years

Developmental

Insecure attachment/ Affect regulation

Self – unbearably vulnerable, others as unreliable

Control: Where the body enacts the unspoken

The binary structures of relational experiences

Concrete/ Black & white thinking

Come in and be perfect or stay out

Loss

Stage two: A transitional place

New, emergent relational configurations

Testing out possibilities of living

Can't do it for me but I'll do it for you

I'm still hollow, I need my label

Hope

Words

Thoughts that bump into each other

Caught between dread of the past and repetition in the future

Stage three: Integration

Seeing self parts work together

Trusting human relatedness

Mourning the past engaging in the present and future

Moving in and out of concrete and reflexive thinking

Being ordinary and special

Tolerating uncertainty

Finding a separate mind, Agency

Stage one: early years

Attachment configurations: Early years and acute feelings of unreliable human relatedness

Bella*: I'm sorry I have to tell you this background…"*

It was not only Bella who felt a need to begin her first interview with memories of past events accompanied by thoughts and feelings drawn from her childhood, Diana and Julie also began there. Only Carla began from a 'now' moment, of what 'recovered' and 'recovering' meant to her today, although it was not long before she too picked her way to 'back then'. It was as if all four women felt it was important to locate a position of '*this* was where it all began'.

From a calm, self-assured tone Julie became noticeably hesitant as she described her seven year old self and 'horrible family holidays'. It was as if old feelings of being unprotected and unseen both within her family and amongst her peers were being re-visited. From this position there appeared a fragmented self, on the one hand "*I wanted everyone to like me*", at the same time she considered herself unlikeable and as such *"just a very easy target"* for being bullied. Feeling unable to defend herself Julie sought ways to get rid of unwanted affect; what felt painful was her inner emptiness and discomfort with interpersonal relatedness. What she was seeking was a way to feel seen and above all feel special.

Bella's back-story began largely with what had 'horrified' her when growing up, including her mother's late pregnancy, her own changing body, numerous 'family secrets' and her family's embargo on emotional talk. Like all my participants Bella's 'people pleasing' did little to make her feel seen, understood or special so she made only enough room for one person at a time to befriend and when, inevitably, they did not measure up to her perfect ideal they were discarded, dismissed. Bella described herself as secretly rageful towards her parents, her mother's 'drudge' existence however provoked an increasing sense of disappointment and loss. What she longed for was emotional nourishment, instead she had to settle for physical closeness:

“We didn’t have any long heart-to-heart chats about things, it was all very practical. I was close to her…she was a botanist and so she sort of gave me a lot of attention about that”.

As Bella’s divided self shifted between ‘come close’ and ‘keep out’ it is possible that any hope for a different emotional outcome felt thwarted. From here young Bella turned to her family’s concrete ‘evidence’ as a reason for her imperfect life:

“I didn’t really like the way I looked”

From this messy place Bella found refuge in creating more rules and order in her life; cutting out food mirrored her cutting out others.

Diana’s depiction of a loving, secure family and *“normal upbringing”* were interleaved with narratives of having been an anxious child, “*just massively sensitive*”. As she reflected on her early life Diana’s emotional tone faltered, she recalled having been preoccupied and fearful that her parents’ arguments would lead to divorce. It is likely that Diana’s early compulsive behaviours were an attempt to quell her confused, inner world. Another ‘solution’ to manage her anxiety were her self-designated roles, Diana became ‘rescuer’, people pleaser and confident.

Carla like Diana, Julie and Bella projected an early divided self, she was ‘jolly Carla’ who comfort ate when ‘het-up’. Carla’s depiction of her family system was one of rigid expectations, particularly from her mother and like Bella emotions were rarely expressed. Carla struggled to distinguish between what were her thoughts and those of her mother, generating constant fear of getting it wrong. Confrontation for all my participants was something to be avoided at all cost and Carla’s ‘solution’ was compliance, ‘*doing what’s expected of me’.* Pleasing the other however left her feeling anxious about what she should be feeling which led to what she described as ‘*not happy, not sad, so you’re never disappointed’,* an anaesthetised emotion*.* Similar to Diana, Bella and Julie the narrative of not feeling good enough and not ‘fitting in’ became a preoccupation for Carla. It was from this place that compliance shifted to defiance as exhibited through her eating disorder.

Fonagy’s (2004, p 471) “object at the core of the self” describes the complexity that appeared to be taking place amongst all participants at this early stage. That is, from a fragmented self-state and fragile self-image, the child, too impoverished to communicate or make sense of human relatedness retreated to a world of ‘magical thinking’, a world of specialness, control and power.

Affect regulation

Control as an ‘idée fixé’

From immature emotional distress, with little understanding of why they felt the way they did all my participants described a need to feel in control of their lives. For Julie her body became the site of her control, offering a sense of power of what *she* could achieve that *they* (mother and girls at school) could not. From bingeing and vomiting, restricting and counting calories, measuring her physical self against others offered a sense of affective relief. Bella spoke of being ‘hell bent’ on staying at a weight below where her periods began alongside obsessional calorie counting and exercising; she ‘*needed’* to be in control. Diana *had* to walk, that was her ‘bit of a thing’ just as she needed to have a flat tummy, “*I need to keep doing this, to like get rid of this feeling*”. Carla’s obsessional thoughts were an attempt to quell her anxieties, which also became a war against her body played out via controlling food groups.

For all my participants their preoccupation whether of weight, calorie counting, alcohol consumption and exercising alongside the constant checking that went with these behaviours filled every waking hour. These thoughts, actions and behaviours chime with Janet’s (1889), idée fixe, whereby fixed ideas and subsequent behaviours originated from a failure to make sense of intense past experiences leading to “excessive and irrelevant responses" (Janet, 1889). Janet noted how time might pass between early disturbances and what he viewed as subconscious fixed ideas

"*The latency of expression is determined by the time required to perceive the inescapable reality of the event (s), the time necessary for the individual to expend useless efforts to fight the inescapable, and the occurrence of other stressful events that depleted the individual's last reserves" (Janet, 1889, cited in van der Kolk & van der Hart, 1989)*

From what appeared to be insecure, unreliable attachments (Bowlby, 1979) all my participants sought adaptations to regulate their affect and in particular interpersonal stressors. From a place of deep unhappiness they sought what McDougall referred to as "an addictive solution to psychic tension" (McDougall, 1998, p 8). Drawing from object relations and developmental theories McDougall argued that from anxiety arousing experiences and as a response to pre-existing psychic pain, usually originating in infancy, there arises "a child-like attempt at self-cure… "(McDougall, 1998, p 8). Coming from a place of immature maturity any attempt to control their lives however could only be construed in concrete terms and so certainty was not just compelling in their narratives it felt as if they were all describing a life-line.

Black and white thinking

Certainty/uncertainty: A shared narrative was of what was 'known' and 'not known' in relation to their thoughts, beliefs or actions. What was 'known', was invariably delivered with 'certainty' ('I just knew'; 'I could never do that'), suggesting a concreteness of thinking, a psychic mind that found difficulty accommodating a more flexible, reflective position for new thoughts and ideas to be entertained. From a NI perspective words such as 'never' were noticeably in tension with the hesitancy of the spoken delivery and it occurred to me that the narratives formed after the experience contained more terms of certainty and definition than the experience itself may have held at the time. Perhaps these retrospective narratives were their way of protecting themselves from their actions 'back then' and what was now 'too much' emotionally to bear thinking about. These 'knowing' discourses were also frequently linked to more 'uncertain' caveats. When for example I inquired of Julie about her mother's constant dieting, whether there was an element of her joining in she replied: "*I wasn't, at the time, I don't think I was, I think…I don't, I didn't really, no"*. Julie's delivery began with a degree of uncertainty, with broken short phrases that drifted away, as if reaching towards an answer that she could offer me in the moment whilst also inquiring of herself whether she 'joined in' with her mother's dieting. The sentence eventually reached a single word, an emphatic "no", as if through this process she arrived at greater certainty, with more 'voice'. These faltering narratives were evident at varying times with my other participants, Carla faltered when reflecting on 'jolly Carla', Diana was certain she never thought about dieting as a girl followed after deliberation with repetition of the word "weird", as she attempted to process her past thoughts in the present moment.

Powerless/powerful

The perception of power as being held by another was a dominant narrative expressed by all my participants and from this position they appeared to cast themselves as starting out from a position of feeling completely powerless, as if their very existence was in the balance. Bella's belief was of her parents being preoccupied with everything else except her, thus "*it seemed a bit pointless eating somehow*". Carla considered how "*the hold that my mum had on me*", led her to a powerless position where she began to question "*can I think for myself*?" When Julie spoke of feeling powerless in relation to her parents her speech lost momentum, *"I really got, I suppose, that, I got that it was about control, I got that thing that I was doing to my parents*". Yet, she reflected, even in the knowing it made no difference. The oxymoron 'I really got, I suppose" highlighted for me Julie's emotional difficulty of reconciling her parents' behaviours and I was reminded of a sentiment Julie had expressed as we began our first interview, whereby whatever you may 'know' it made little difference when you felt powerless to change anything.

Within these discourses was a relationship of what was being done to them and a need to reclaim power on their terms which reminded me of Benjamin's (2004) paper of 'doer and done to'. What followed I construed as disavowed, impotent rage leading to an attempt to claim power, to gain control. When Diana's GP told her she was not as thin as he thought she might be she recalled *"it just fuelled my desire to, to keep it going*". Carla's narrative was "*the power of being able to resist*", which included food and interpersonal relationships; for Julie anorexia was a massive "*fuck you*" to everything and everyone and Bella continued to 'cut off' everyone she considered as disagreeable and towards her parents "*this is what I'll do to you, I'll bugger off*". With all their control came manipulation, of their own and the others' emotions or actions. What they were describing appeared as expressions of rage, a rage that kept them alive and fed them as in turn they refused to be fed.

What became evident amongst all my participants was how their sense of power was not viewed as on a continuum nor something achieved over time, it was a black or white perspective, people who had power (them) and those that did not (me). Power I reflected required taking a position of agency, taking responsibility for ones actions and this appeared to be a struggle for all my participants.

Personal reflection –how any 'power as researcher' that may have existed was ameliorated

Replaying my conversation with Carla I recognised how I could be drawn in to their narratives from my own experience of the anorexic landscape. One such occasions was her reflecting on the power of the illness and powerlessness without the illness.

Carla: "I think in a weird way, well not a weird way, the illness said right, I had the power to get there, and I got there"

Renee: "Got where?"

Carla: “…a pride that, rarely have I ever achieved anything in my life, but I achieved in-patient status with my anorexia. How perverse is that”

Renee: “I don’t see it as perverse at all, but I mean in an anorexic way (C: yes), there was a part of me that thinks, this is the one time that, being an anorexic with in-patient status that it says a) that you were good at it and actually b) you weren’t being a good girl. And I suppose it says something about how our illness allowed us to be ‘the naughty girl’ (C: yeh), and do it really well”.

What I was caught up in and influenced by were Carla’s words of “never achieving anything in my life”. It was a deeply uncomfortable thought that I had ‘forgotten’ so when spoken by another it took me by surprise. I was transported back in time and flooded with my own memories. I didn’t know how to be a naughty girl, or perhaps I dare not, for then I would be alone, unloved; yet I wanted to be naughty and loved. And from this place, at the interface of language and experience a co-created shared, intersubjective space opened up which Carla and I inhabited. I tentatively offered my interpretation of ‘perverse’, at the same time my mind sought to find order in the messiness I was experiencing, which may account for placing markers between my thoughts, (‘a’ and ‘b’). Anorexia had for us both provided a sense of achievement and permission, to do ‘naughty things, act like a child. Yes, its power was “perverse”; it was both toxic and an enabler.

Social construction

The body

All participants spoke about social, historical and cultural influences, particularly during the ascendency of adolescence. Within their discourses, whether losing significant amounts of weight as "*it's what you do*" as teenagers or Bella, reflecting on her mother's emotional distance as "*common in the '60's*", these retrospective thoughts could have been a strategy of 'normalising', making acceptable to themselves their thoughts and actions. With socially constructed beliefs absorbed, whether of a perfect body or relationships, their knowledge or sense of knowing, appeared to have been created with a degree of fantasy, a search for an 'ideal' structure. Once again there were echoes of black and white thinking, Bella for example spoke of needing perfect friendships, for Diana it was a perfect family, for Carla it was to be found in the other, "*if only I was her, y'know, and then my life would be perfect, my life would be amazing*", Julie sought the perfect flat tummy. From self-surveillance to self-correction as an attempt to fit in with socially and culturally constructed prevailing norms "a discipline of the self and the body" (Shipton, 2004, p16) was eventually turned to by all my participants. Shipton argued that the concept of the body emerged as a project, with "a promise of eternal plasticity and therefore endless possibility" (Shipton, 2004, p17). It appeared as if the 'project' Shipton referred to was something all my participants engaged in to deflect from their emotional turmoil. Malson (1998, p 31), described the body as constituted, regulated and resisted, becoming "a material site of power struggle", for all my participants the body became a tangible site where their internal anxieties were enacted.

Reflection: Extending Malson's (1998) perspective I am aware how even today human touch can as easily make me recoil as it can produce a desire to embrace the other. In the midst of anorexia I recall my therapist asking me about what it felt like to stroke my own skin, having experienced many years of therapy this had never been asked of me and I recall my shock that I could not do this simple task. Van der Kolk (1989) described flesh as the 'storehouse of subjectivity', with bodily sensations capable of being greatly affected by the quality of holding. I wonder if therapist's today help their client's decode and understand their somatic responses as a source of psychic pain or hold in mind how anorexia is a deeply somatic illness.

Within these political and socially constructed 'truths' their struggle to achieve power at any cost appeared to pacify them. Julie described her illness as satisfying *an escape from the world*, Carla viewed it as a place where she was in control, Bella stated how from being rigid around food she would become more relaxed and for Diana it was "*all about fading away…I was like broken, like only a teenager can be, you know.* The paradox was, that in an attempt to find autonomy and a sense of 'this is me', as anorexia took hold it fragmented their world even more for it required distancing themselves from others who interfered with their thoughts, feelings and behaviours rather than drawing them towards the other.

Narrative construction: Modifier (1)

The word 'just' was notable by its frequent use by all my participants. At times it was spoken as a shorthand for justifying something, Carla for example spoke of how *"I just started to lose weight*" (a phrase expressed by all participants). That something 'just happened' could act as a linguistic tool absolving the individual of responsibility or agency whilst defending their more fragile self against difficult thoughts; if something just happened there would be no need to feel guilty about it. There is an element within this word reflecting a level of secrecy, enabling the phenomenon to slip into the sentence whilst making it subordinate within the overall context of the narrative. 'Just' was also a vehicle for minimising interpersonal and/or intrapsychic conflict, of reducing rather than accentuating beliefs, thoughts or actions. Bella's self-perception for example of being "*just not special enough*" is a language of assessment, in this instance there was a reduction of enough-ness. For Diana *"it was just always going to happen*" provided a degree of inevitability, enabling an unconscious reluctance to think more about what factors may have influenced her troubled inner world. From deconstructing these narratives what I noticed emerging were narratives of confused self-representation, from this place ‘just’ was akin to a verbal ‘shrugging off’ of what the mind was resisting thinking about in greater depth, arguably to maintain a (false) sense of psychic equilibrium.

Narrative construction: Modifier (2)

Julie referred to anorexia as “*a bit of a power thing*”; Bella was fearful of being “*a bit like my mum”*; Diana’s need had been “*to shake this feeling off a bit*”; her obsessional exercising also became “*a bit of a thing*”. It appeared as if there was a gap between the experience and the re-telling that required modifying; where memories of ‘back then’ revealed an uncomfortable space that they were unable to account for. As such ‘a bit of a thing’ may have served to reduce and so pacify the self from potentially disruptive thoughts. Equally striking was how the narratives shifted in tense, between third and first person leaving me to wonder if this too came from a position of needing to further protect themselves from uncomfortable thoughts.

This modifier led me to reflect on anorexia as taking in ‘bits of’ food, looking at bits of the body, the opposite position being of taking in ‘too much’, which could result in wanting more. Within these thoughts there existed an interpersonal and intrapsychic dimension, the missing relational component being a hunger for relatedness as well as an intense fear that it may not satisfy their needs enough. Lacking the ability to self-soothe and regulate their internal experiences, with no container for their expressed feelings of guilt and shame they found a way “to survive the unbearable, both psychologically and psychophysiologically” (Petrucelli, 2015, p35) through their bodies.

Stage two: Transition

The Oxford English Dictionary defines transition as “the process or a period of changing from one state or condition to another” (OED, 1998). From extensive analysis of my participants’ narratives I have selected dominant themes that appeared across all my participants’ narratives to varying degrees and identified by them to be significant moments, thoughts or actions.

Testing out new possibilities of relating

From a place of constant vigilance, where relationships had once felt threatening a shift appeared in the narratives and delivery for three of my participants. Julie, Diana and Bella all spoke about a safe space (Winnicott, 1953), where new relational configurations were tested out.

When Julie and Diana spoke about their time in hospital and in particular the hospital staff their narratives conveyed a lightness and at times playful quality. There was a warmer tone as thoughts and memories came together and words were lingered over compared to the more faltering discourses of their childhood years. Whilst Julie had raged about being on the unit and her fears of being discharged after almost two years she had, over that time, learned how to articulate to the staff how she felt. Julie in effect was using words rather than showing her frustration through eating disordered behaviours. Whilst the staff had been experienced as both good and bad objects (Klein, 1931, p243) it was object constancy, the caring and consistency, their providing her with explicit messages meant Julie felt listened to. This in turn contributed to her holding the possibility that she was not being abandoned, again. Julie was also involved in what happened next as far as her treatment plan was concerned and expected to play her part in the programme. Being treated as an adult and the setting of boundaries were new experiences for her and whilst she did not fully play by the hospital rules Julie trusted the staff enough to comply:

"So, yeh, there was a transition and then they said right, no more, you're out and if you want it that bad you'll maintain your weight and you'll come back to do rehab. Yeh, so that's when that happened, em, and then, <u>that,</u> that was probably the most…and then <u>that</u> was definitely the next step forward".

Julie’s narrative and her repeated, emphatic use of the word *‘that’* contained an expression of certainty that was also hopeful.

Diana expressed a similar sense of feeling safe and cared for by the hospital staff. Her psychiatrist, Dr Green was singled out as ‘special’; he was a male authority figure who was also available, empathic and consistent. What she sought to convey was how impactful it had been to be understood and listened to when she felt so vulnerable.

From this dyadic relationship which felt safe enough Julie and Diana spoke of how their relationships with other patients changed over time. In the early days on the ED unit their behaviours generally mirrored their former patterns of relational configurations, of needing to please, wanting to be viewed as special and with degrees of grandiosity and competitiveness in relation to being the ‘best anorexic’. A different ethos prevailed when they moved to the rehab house where a new language was fostered by the staff, that of hope and an encouragement to taste the outside world experientially. This cascaded down and as Julie noted, it was ‘group led’. From this place she described how she could test out having fun:

“I can smile and I can laugh and I’m still getting the help and they still know that I still need help… they still know that this is a really difficult stage of recovery”.

Julie’s narrative interested me with her shift from past to present tense. Bruner (1990, p 94), writing about explication, that is, making the implicit explicit, argued that one reason the narrator may switch tense to “the timeless present tense” was to distinguish their story from other courses of events in the past. In this way Bruner suggested they became “not only logical, but lifelike as well” (Bruner, 1990, p 94). Julie, talking about laughing and smiling suggested a reinforcement of how her new containing relational interactions allowed her to behave differently. As she continued she reverted to past tense, faltering, Julie was articulating another stage of change:

And I think, things started to shift in that sense. And whilst, so I did, I did manage to, so I stayed for six months and I managed to get my weight to the weight they expected it to be…and… do alright"

Whilst Diana and Julie had experienced their time in hospital as a relatively safe environment Carla's experiences in hospital remained conflicted. Her dominant narratives were of her mother's visits and the critical tensions that were evoked from her mother's remarks which in turn fuelled her internal voice of not being good enough. Relationally Carla acknowledged how throughout her time in hospital she remained a 'push-over':

"I didn't have confidence, what I had was… (Pause for 3 seconds), I can't think how to put it in words, but, I'm a pushover to be accepted and at my lowest (weight) I didn't need to be accepted…if my friends had gone, they'd gone. Because I had all I needed from the illness".

Carla's comment of 'I can't think how to put it in words' linked to the hesitancy and pauses as she spoke suggested her continued and early struggle of verbalising difficult feelings.

Bella meanwhile chose a university 'as far from home as possible' yet little changed in her internal world, apart from geography. After university she worked abroad and later married however her need to control her relational world remained the same:

"*There were still loads and loads of underlying problems and I think that one of the big problems I had was relationships actually*".

For Bella it was group therapy, attended for over six years and designed specifically for eating disorder patients which made a significant and lasting impact on her. This became her safe transitional space:

"I can't tell you how it happened. I think it was just, I think it was really good being in a group because there was that interaction and sort of learning how to be with other people…It was very much to do with the way we related."

What Bella began to take in and digest was how her black and white view of relationship shifted as she was supported by the therapists to make her own connections of how her actions could have consequences which included how other people related to her.

Hope and containment vs existential emptiness

Across this transitional stage all my participants' narratives included themes of containment as being an important element for change. From consistency and positive reinforcement, often despite their best efforts to disrupt this, safe relationships emerged. All my participants received practical help and encouragement to consider new possibilities in relation to living their lives beyond their eating disorder. At the same time these supporters acknowledged their waves of despair, appreciated their stuckness and from this there emerged a capacity to reflect on new ways of being in the world. With more hope for the future there was a parallel feeling of trepidation. They all spoke of states of confusion and ambivalence as they looked at life without their eating disorder as being akin to existential emptiness. They were being encouraged to 'move on' but what this evoked was a sense of not knowing what if anything could take its place, they had after all experienced the illness for so many years.

Self-growth (1): Reviewing and configuring their sense of self

Across this transitional stage all the participants' narratives conveyed ambivalence which on closer examination held stories that described feelings of being caught between certainty, that the past would be repeated in the future and uncertainty, of what and how taking control of their lives might look like. Having experienced a period of feeling consistently attended to by others my participants very tentatively began to explore what it could feel like to relinquish the protection of the harmful defences they had erected. As a defensive system anorexia had filled a chasm and kept uncomfortable thoughts at bay. The narratives across this stage suggested new experiences and positive relationships were filling some of the missed psychological developmental stages. As they slowly faced the psychic pain derived in childhood their narratives oscillated between the fears of feeling emotionally empty and a struggle to achieve a sense of Agency.

Diana for example spoke about her second admission as conflicting, whilst she felt guilt about letting her parents down and aware of still being a people-pleaser there was a shift, she was thinking beyond her eating disorder. Rather than wonder if she was worse than others (weighed less) which had previously provided a sense of achievement she recalled being fearful of her future if nothing changed:

“And I was also quite scared, you know, because you’ve got the chronic people in there and you think ‘Oh my G-d am I going to be one of those revolving door people’?

Diana reflected on how attending university, meeting new people and having a social life which began when she moved to the rehab house did much for her self-confidence and motivated her to keep going:

“Yeh, I just thought, well they don’t know me, they don’t need to be speaking to me and they are.”

As Julie experienced life beyond the confines of the ED unit her positive thoughts bumped into her harsh, archaic voice of ‘what if’.

“*It was still not alright but it was sort of, there was steps forward…em, whilst I didn’t want to let go of the illness I was, I didn’t want to be ill anymore and that, was, em, was a huge shift”.*

It was more than ten years since Julie’s anorexic symptoms began and as she articulated her to and fro of contemplating a different life her expression became uneasy. What she wanted and what she allowed herself to hope for were still at this stage at odds:

I suppose you’re constantly trying to juggle both and I know you can’t do that, I know you, you can’t be, you can’t hold on to the illness and have a life really.

What motivated her was being amongst people who were unaware of her eating disorder history, what did not help was her role as a service-user within a mental health charity, here her split thinking came in to her story:

“I wanted meaningful service user involvement… But I was also equally going fuck, that’s my job, that’s the label I need. I can’t move away from that because I don’t know anything else”.

Carla’s struggle for control of her life was markedly different with her mother continuing to have a presence across most aspects of her life. Her significant moment presented itself whilst in hospital when she wrote to and received a letter back from a young man she worked with:

“And he wrote back, he wrote back and that was a real big deal. That was like, wow, do you know what, actually, someone, someone does care.”

Carla’s repetition of words and at times whole phrases evoked a sense that she remained baffled by the idea of being held in mind by another. Carla’s certainty that people could not always be trusted however began to marginally shift as she continued to date the young man (who she later married), however it was not, she reflected, completely for herself that she sought change:

“(I was) just wanting to be accepted by him I think…I look back now and I can say I probably didn’t let myself enjoy it, it was a, a process that I had to go through.

Unfortunately across this transition period Carla was informed that local council funding and boundary changes meant she no longer had access to the support of the hospital. This she recalled was a “*huge loss*” for her.

Bella’s journey across this second stage was succinctly described:

“I was an anorexic that could eat, but I never ate enough”.

Bella’s transition was of starting to take in new experiences. She moved to London, travelled overseas, married and had a baby, yet none of these experiences nourished her enough emotionally. Bella's difficulty was of being unable to contain feelings of goodness for any length of time. Bella spoke about her experience of group therapy on more than one occasion and the containing feeling it evoked:

"*Just having a very strong therapy relationship where, em, with a much more compassionate voice from the therapist really."*

What Bella was taking in was a less harsh, self-attacking way of being, one that she slowly learned how to do for herself.

Self-growth (2): flexible, reflective thinking

Detected within this transitional stage was a degree of self-speak that was less self-punishing. Their discourses suggested that their thoughts and subsequent actions came from a less polarised position, one that included hope for the future. This more flexible way of thinking was in contrast to when they were in the midst the illness. Back then a rigid either/or thought structure dominated; what was wrong or missing in their lives led to an inevitable conclusion, they would undoubtedly fail or get it wrong. To leave this place was a risk for it included being responsible for one's actions. What was changing incrementally and supporting these shifts in thinking was their reflective capacity to think beyond binary options.

Julie described the length of time it took for her to 'shift gear':

"…because you've got all these incentives and things in your life that gives you reasons to stay well, em, yeh, and (speaks more thoughtfully and quieter), to take your own responsibility for that I suppose…"

Later she elaborated further:

"When I went into rehab, the second time, I didn't need to be friends with the people in hospital…because I had a life outside to hold on to whereas before, I hadn't built that life yet."

As Julie reflected on what ‘could be’ I detected a less ‘knowing’ discourse, a more thoughtful self in-action. This was exampled when describing her loss in weight after being discharged and the subsequent letter she wrote to her psychiatrist. Julie’s awareness that she did not need to be ‘rescued’ reflected her ability to take in her emotional experiences, her ‘subject self’ (Kohut & Wolf, 1978)

“I’d realised that there was a lot that I hadn’t actually worked on, about myself, really, at that point, my self-esteem and, em, who I was beyond the eating disorder.”

Another story which incorporated a reflective capacity was told by Diana. When her psychologist recommended she wrote one letter to anorexia as her friend and another as if it was her enemy for Diana the letters became important catalysts for change and represented containers for her unspoken, out-of-control feelings. From a starting position of fantasy and omnipotence whereby she was in control of herself and others she began to reflect on what could be gained without the illness in her life. Diana desperately wanted to have a family of her own and it was from this place she asked herself a different question ‘*what do I need to do to look after myself?’* Additional ‘tipping points’, which is how she referred to her changes in thinking, came from being able to take in the belief meaningful others had in her and her capacity to move forward with her life. This was not a smooth process however her ability to reflect on the choices that lay ahead demonstrated more flexible thinking. An example was when her brother complimented her:

‘*You’re a grown woman Diana, you can manage it’. And that’s was the first time he’d said that to me. And that’s a weird feeling as well because I’m like, ‘oh, why doesn’t he care, why isn’t he worried, is it because, y’know, he thinks I’m well, kind of thing. But also, OK, yeh, that’s good, he’s not worried or anything”.*

Carla’s narratives within this stage held less moments of positive reflection; her thought-processes tended to revolve around food choices and the exhaustion of pleasing family members and friends. Evidence of her world opening up incrementally came primarily through accessing a more relational world which she described as ‘allowing more people in’:

“It’s just that I have more in my life now”

Within these few words I detected an expression of Carla minimising or reducing her life. Like her eating, it remained unexciting; even though she took in new foods it was just not quite enough to make a difference.

Carla’s self-concept appeared to have remained similar to stage one. Bromberg, in ‘Hidden in Plain Sight’ (2013) suggested reflectivity was part of a journey between two people “as self-state permeability increases so does openness to state-sharing” (Bromberg, 2013, p1). It was from this growing sense of a ‘we’ he argued that allowed the individual to expand on their ’self-experiences’. Carla’s ‘I can’t do it for myself’ changed little in stage two and unable to generate it for herself she continued to seek approval and affirmation from others.

Bella was aware that her reflective and reflexive thinking across this transitional stage was strongly influenced by her studying to work as a counsellor and her involvement with mentalisation programmes:

I realised I hadn’t learned to mentalise and that (work) was really helping me to do that….there were so many things that I’d never thought about before. And there was nobody really in my family who would be remotely interested in having these kind of conversations.

As Bella reflected on her family she spoke more about her ‘self-speak and in particular in relation to her parents:

“They weren’t always critical, that voice that you’d internalised, that critical voice, is actually a version of them, but it isn’t really them. And starting to notice that I was far more punitive in my head than the people I thought the voice belonged to.”

Finding a way forward was long and hard for all the women and turning at times towards their eating disordered thinking and behaviours played a part in their journeys forward.

Bromberg’s (2013) description of ‘resistance’ felt pertinent here, “It is a ‘marker’ that structures the patient’s effort to arrive at new meaning without disruption of self-continuity during the transition, and gives voice to opposing realities within the patient’s inner world that are being enacted in the intersubjective and interpersonal field” (Bromberg, 2013). This appeared key for all the women and the time taken to disinvest with their illness spanned years.

Stage three: Integration (1)

Integration in this context describes, in part, how various delayed psychological developmental achievements came together to varying degrees over an extended period of time for all participants. An integral aspect was the “integration of multiple self-states into a coherent experience of the self” (Siegel, 1999, p 310) this in turn influences a person’s subjective experience leading to “the ability to reflect upon one’s own childhood history, to conceptualise the mental states of one’s parents and to describe the impact on one’s own personal development” (Siegel, 1999, p 312).

Interpersonal and subjective pathways open up

Compared to Stage One where a largely binary structure of relational experiences existed (resulting in a poorly integrated sense of self) the stories of their expanding world contained more subjective and interpersonal meanings.

Julie’s speech when reflecting on her rounded life after leaving hospital was punctuated with pauses. Listening to her spoken delivery it appeared more floating, less certain, as if she sought to find coherence, a way to organise her internal experiences in words. She had studied for a degree, established new friendships, forged a career and started dating, externally all was good except that it brought new, uncomfortable, existential dilemmas:

I had no idea, like, what am I interested in, what do I like, you know, who don't I like, what don't I like and all that sort of stuff. It started to creep in …Like nothing major, just stuff that people deal with every day, but I still hadn't really".

Making sense of or '*dealing with the everyday'* was echoed by Bella who also became aware that she had an 'inner world' that was not always consistent. Within this stage Julie, Bella and Diana looked more towards the future than their past which now contained notions of having the capacity to shape their own lives. Julie described a different kind of control, one where she felt responsible for herself and her actions. This sense of agency and autonomy was spoken about when she reflected on her relationship with her partner:

And actually, with the relationship with David, I really wanted it to be, you know, as two individuals, where I'm looking after myself, I'm an independent woman, I can look after myself, where I don't need a carer.

Julie was not saying all was fine or that her illness was relegated to the past, what I construed was her holding a less idealised view of the present and future. Julie had acquired an ability to look at her life and her relationships with a growing recognition that the future was less certain. Whilst these feelings were not always comfortable they appeared to have been more tolerated; her reflections were grounded in reality and the uncertainty expressed was not attached to a catastrophic outcome:

If he left me tomorrow, I do, I think that… that would be a huge impact on my life, em, that would be massive. Like would, would suddenly that impact on my recovery? I don't know, I don't know. Could I take that and would I, would food become my coping mechanism if that bit of my life fell apart, possibly, I don't know. But that's because that's sort of slightly different, that's something quite horrible in my life and that's massive. Rather than it being because I need him to make sure I'm (small laugh) eating every day, y'know"

Diana reflected similarly in relation to her partner:

"He doesn't provide the self-esteem for me. You can't provide self-esteem, so I have to produce it for myself."

In contrast Carla described her husband as important in that he provided her with a more balanced perspective of herself and her life that she could not generate alone. In contrast to her mother she was 'laid back' in his company *"I was in a position to relax and allow myself, and look around and see everybody else".*

This looking around at the world and recognising she was not alone was an important component for Carla although for the greater part her needing to please others remained relatively unchanged.

Holding uncertainty and disinvesting from concrete thinking

Bella added another perspective, one voiced by my other participants, of appreciating how she had come to find a less polarised way of thinking:

"… (I was) *getting to the point where I can actually see the grey, and see the pros and cons of different points of view at the same time."*

Julie commented similarly, that she had to remind herself of her old 'black and white me' and how it could appear from time to time:

And that, I, I still struggle with that to be honest, that, that I suppose that messiness of it, I suppose, and, and allowing…yeh, just keeping it contained and not allowing it to spill in to the next day and the day after that and moving on from it. Because that…yeh, not…I suppose not having…not having it all neat and tidy like it doesn't fit with that, I suppose, my kind of black and white. But I think, for me, unless I started to accept that there will be that grey in between I was never going to be where I am".

Julie's hesitant speech was not only a recognition of her subjectivity, 'what *I* have to do' her relational position was key, she was one amongst others and to carry on with life meant living in the grey area with others, even if it felt less safe at times. Life for these women as they talked about this period was viewed as less linear and more on a continuum that they could move back and forth and that was good enough.

Finding a less harsh inner voice

All four women were aware of how their ‘critical voice’ could be self-attacking when under stress and in those moments anorexic thoughts and feelings could emerge. Bella described this as her ‘angry voice’ ready to put her down. What was different was her conscious awareness of these thoughts and of being more compassionate towards herself:

“I’ll sort of catch myself and think why am I doing that, why am I punishing myself like that and I think when I had the eating disorder that would have got played out in the arena of food, em,…and I think that somewhere along the line I moved away from doing that, I think there was an awareness of what I was doing”.

Bella’s remark of how shifts in thoughts and behaviours came about ‘somewhere along the line’ captured how some changes in thoughts and feelings were experienced very gradually whilst other changes were much more conscious acts. The latter was exampled by Diana when reflecting on the letter she had written to herself in hospital. In stage two this was experienced as her holding on to a hopeful outcome, a form of wish fulfilment, in the integration stage of emotional growth there was a different quality of thinking, one that incorporated how she needed to be more active to achieve what she wanted:

“I need to do something about this…I’m going to need to try and put on weight and that sort of thing and that was nine years down the line”.

And later:

“Well, I could, I suppose (not eat), but like why, why would I do that. I just, it doesn’t make sense anymore, it doesn’t make sense for the life that I’ve got”.

Although Carla was not as robust as the other three women she was able to reflect on the positive movement in her life although these tended to be expressed with caveats. Her eating disorder may be channelled elsewhere but she added, she was happily married, had two children and lived a healthy, outward facing sociable life and most importantly the occasional eating disorder thoughts did not take over her life:

I can go out and enjoy a meal out. Do I enjoy it as they do? No, no but from where I was twenty years ago it's a healthier, I don't turn invites down…

Diana similarly described her 'small mechanism of control' then and now:

"That makes me realise how far I've come…how the intensity of how you felt and although you may feel, you know, now, I might feel guilty about eating, the intensity of that guilt was, oh magnified by millions, wasn't it…I almost can't remember…oh G-d, how everything is, it's just your world isn't it…"

All these conversations led to a question each woman reached at this juncture in their life, of whether they perceived themselves as being 'recovered' or perhaps the word was 'recovering'? Whatever the word it was filled with uncertainty. On the one hand they were all living their lives and taking in new experiences in a way they never imagined was possible some fifteen to eighteen years earlier, yet doubt existed on a daily basis.

Integration (2) Residues from SEED-AN

Being ordinary - a relational, social and cultural dilemma

The doubt of 'how well' my participants were willing to ascribe themselves to was attached to *a different form of integration*, one that was present in all their narratives. Less researched it related to the 'enduring' element of SEED. Having been ill across an extended period of time and now at a different life-stage the question of what were 'normal' and 'acceptable' thoughts and behaviours and what may be derivatives of their eating disorder became confusing, contradictory and at times intertwined. Integration of how they lived their lives, including conversations about how many times was acceptable to go to the gym, discussions about what size clothes they wore or what they ‘really wanted to eat’ was a challenge for them all. Listening to the chatter of other women it was hard at times for them to know what was socially and culturally acceptable which in turn led them to doubt whether they were ‘recovered’.

Carla for example recounted an incident of being out with friends when her order for a plain hamburger was served with melted cheese. What, she wondered, should she do, should she scrape off the cheese?

“…and it was that kind of anxiety, and panic, for a moment, which I think if I, if I hadn’t have had the illness, I mean from a rational perspective, anybody else would have been ‘oh I don’t really like that’…whereas for me I felt I couldn’t. I mean none of them know…”

Diana’s narrative, similar to Bella was her quandary surrounding food when pregnant. Would she, she wondered have had more cravings, she answered her own question with a note of resignation “*you just don’t know do you*”.

Body size was another concern and came with a degree of attempting to normalise how they saw themselves, as Bella pointed out it was a common female preoccupation and one she constantly questioned…”*it’s so hard to know*”.

Julie reflected another sentiment common to all the women which was that she could not remember a day where food was not an issue and later added how this changed to

“…where the fear of being too thin becomes frightening, I, yeh, I relate to that now, I never thought I would”.

Summary

Integration as a transformational journey

The statement “*what the fuck is normal*” voiced by Julie and similarly echoed by Bella, Carla and Diana encapsulated a further necessary psychological developmental stage. By looking at themselves as one amongst others they were also relinquishing their position of specialness, something that was desperately needed in their formative years when their self was so fragile. This Integration stage encompasses a configuration of the self as a psychic structure within a relational matrix (Aron, 2000). Observed within their narratives was a sense that people could be interesting and interested in them; there was a capacity to recognise that what had been damaged through relationships could also be healed through relationships.

Discussion

Underpinning this narrative inquiry or ‘puzzle’ (Clandinin, 2013, p 42), has been the word ‘how’; how did four women all of whom experienced anorexia nervosa for over ten years transition away from the illness, how were their lives impacted and transformed? In the spirit of my chosen methodology this discussion does not seek to offer key themes rather to open a dialogue that will provide fresh insights to counselling psychologists and psychotherapists through exploring the experiential narratives of my participants. This study seeks to further stimulate and evoke a deeper curiosity in relation to working with SEED-AN clients as well as providing additional intelligence for existing eating disorder training programmes, sufferers and carers. Drawing on examples with my participants and from my clinical experience I discuss what alternative meanings may sit beneath their words and ask of the reader ‘how else may we listen to our clients’?

Contributions and Implications for therapeutic practice

The therapeutic relationship –anchoring an environment of hope and trust

This study has explored in-depth stages two and three of my cross-case analysis, that of transition and integration. Within these stages weight may not be life-threatening however they continue to have fluctuating anorexic cognitions with its intensity or 'loudness' being varied and reflective of their emotional state. Having suffered with anorexia for many years it is highly possible that, like my participants they have had therapy in the past and possibly on more than one occasion, as such they will have formulated in their mind its merits or otherwise. From professional experience when asking a new client about previous therapy their narratives can shift between placing its 'ineffectiveness' on themselves ('it's my fault, 'I'm useless, unfixable') to describing the previous therapist as 'wrong for me', (she/he didn't understand me, didn't listen' 'just wanted to put weight on me'). Whatever their 'truth' I am mindful my clients may experience varying degrees of mistrust when sitting with yet *another* therapist.

Alongside feelings they may harbour of failure, shame and guilt it is likely that in the early days of therapy our clients present a highly defended self. Constructed in their early years its external appearance in the therapy room can be one of being guarded, appearing unreachable and highly ambivalent. When Bella spoke about her first therapist, how his probing questions felt quite intrusive and left her feeling unsafe she went on to reflect how years later her experience of psychoanalytic group therapy was very different. It is possible she experienced a higher degree of personal readiness nevertheless of significance was how she described being in the group. From initially being "*very stingy about myself*" which may have reflected the difficulty she had investing in herself she began to take in the compassionate voices from the therapists. Over time Bella was able to manage this herself which in turn led to her finding ways to regulate her affect.

Carla’s dominant memory of the therapist in the community practice was of being questioned about eating lunch and *“the last thing I was going to talk about was when I was going to have my lunch*”. What Carla elicited was a therapist who exhibited no interest in how she was feeling. It was the anorexic symptoms that the therapist focused on and any sense of being a person for Carla was absent. Carla left after one session and I did wonder if she was considered a difficult or ambivalent patient by the practice. Ambivalence is a word that can at times appropriately describe the thought processes of our clients however it also leads me to wonder whether what our clients may also be ambivalent about is yet more therapy, after all in their eyes it has not helped them to-date. It is possible that the person Carla met with had, in the moment, lost sight of what is important for all our clients, the uniqueness of the person not the label or summation of her illness.

Therapy as a playground for testing out new relational configurations

This study makes a contribution to professional knowledge by illuminating the crucial role, particularly in the early days, for the therapist to be the keeper of hope until our clients are able to hold and keep this alight for themselves. For this to be possible trust in their therapist as well as a sense of containment and consistency are key components in this therapeutic endeavour. For Diana, Carla and Julie their narratives across their time in hospital and later as out-patients illuminated an appreciation of the consistency of staff; Bella had the same psychotherapists across the years she attended group therapy. All the women used similar descriptors in relation to the therapeutic environment, it worked because it felt a ‘safe place’ to explore their feelings. Whilst I appreciate the difficulties of providing long-term therapeutic support within the NHS this developmental, relational illness requires an engagement with our clients beyond the symptoms which in itself can be difficult for our clients as it is an illness that has long been word-less. This research study has highlighted how professional reliance on physical symptoms as an expression of wellness is simplistic and fosters mistrust by the sufferer. What this study has further shown from lived experiences was how nurturing and emotional nourishment became a significant enabler for the person to replace the space where their symptoms had resided. A characteristic of anorexia is what I refer to as being akin to the childhood game of ‘show and tell’, their difficulty in finding words to describe their thoughts can signal a dissociation from complex early trauma and from this place they show significant others their distress in concrete form, via their body. As the discourses from all the participants attested from experiencing consistent, safe attachments within the therapeutic environment it provided a springboard for testing out new ways of being in the world. From ‘the body articulating the unspoken’ (Petrucelli, 2015, p 15) words were encouraged to replace uncomfortable corporeal feelings. From clinical experience I view a fundamental part of the therapeutic work as supporting clients to become active explorers of their internal and external world. From encouragement to think out loud knowing that they are being heard we become explorers together and by so doing demonstrate what may be for our clients a new relational configuration, of being interesting and having something of importance to say that can be shared and provide positive self-affirmation.

Beneath the words: Attending to the subjective experience

This study highlighted a narrative shift by all the participants from concrete thinking to a more reflective and reflexive way of taking in information as they moved across stages two and three. An example from Carla was her bemusement when a person said ‘*eat what you like’* she laughed, “*I’ve got no idea what I’d rather have”.* For Carla having a choice about what food she liked had once felt impossible as was her ability to reflect on how this may mirror how she saw her life. It was only as her life began to have more form, or shape that she could reflect on the parallels of starving herself and being shape-less and of not letting in what may nourish her physically and emotionally. When a psychiatrist commented to Julie on her first hospital admission how self-aware she was Julie described how only later was she able to reflect that he had been right however back then her self-awareness was very superficial. She *knew* it was about control and an attack on her parents *“…but I never bloody well did anything about it*...” from feeling powerless nothing changed, having a sense of what could be was a catalyst that enabled her thinking to shift.

In both these examples within stage one of the cross-case analysis Carla and Julie would likely have felt mortified for these words fuelled their fragile sense of self and entrenched negative self-beliefs; further proof of not knowing what was being asked of them. Within stage one all the participants described binary thinking and by extension displayed a desire for knowing and certainty. From this place there were just two relational positions, idealisation or denigration, something that therapists need to be alert to in the transference and countertransference. A further implication for professionals to consider is how much attention in any session they place on physical symptoms and how much is placed on day to day living and exploring their intra and interpersonal challenges.

Harnessing reflectivity and reflexivity

The question of weight when working with a person with a history of an eating disorder is understandable. The participants' narratives on this subject were similar to what I frequently hear in my clinical practice, a fear that if their weight was to 'normalise' they would be perceived as 'recovered' by their loved ones and professionals. Abandonment again. It would appear that weight is an issue for professionals and for our clients, ideas of what 'success' means for these two groups though are at odds. This study highlighted how dangerous it felt to acknowledge moving away from the illness and how this was successfully navigated by the participants. Small shifts came with the encouragement from an array of professionals who encouraged new thoughts to emerge that in turn affected their sense of self. From here the participants began to ask different questions such as how their life might be experienced without anorexia; who were they without this label? What they were grappling with was that of 'what kind of future could there be for me''. This newly acquired developmental achievement demonstrated their capacity for 'reflective observation (Gerson, 2004) as well as a reflexive self, of experiencing oneself as both subject and object (Aron, 2000). Whilst stage two described a transitional period that included exploring alternative ways of life to their illness I assert integration as suggested in stage three incorporated acquiring a confidence that strengthened their sense of Agency, it enabled them to take in new ways of looking at themselves and the people around them. For men and women who have experienced SEED the additional dilemma as witnessed with all the participants was that they were living and participating in a life stage far away from where the symptoms manifest. This study reinforces the importance of working with our clients to explore their relational world. Training should include working with SEED-AN clients with an appreciation of mentalisation and how their world can shift between hope and fear, of trepidation as they look around at their peers ‘just getting on with life’ knowing that they have the opportunity to ‘be’ part of life anew. It is a time, as described by all the participants, where familiar eating disorder behaviours can re-surface as their familiar way of seeking control under stressful conditions.

Relapse holds a message for therapists

‘Relapse’ is a word that needs further exploration and appreciation. I argue that this is not about failing or going backwards, rather I position this as a communication by our clients of unresolved therapeutic work. From this place our clients may return to the concreteness of ‘show and tell’. It is important that therapists are alert to and not influenced by ‘cliché interpreting’ (Casement (1990, p 17). Casement argued that recovering a freshness of insight required not looking to stereotyped interpretations for in doing this one loses sight of the individual, “we cannot always avoid interpreting in ways that have been frequently used before…” however without such clichés “the patient will frequently lead us to insight that is more specific and often quite new” (Casement, 1990, p17). Moving forward and voiced by all the participants we heard how unhealthy ED cognitions later became flags, not something to be acted on but an alert of unprocessed emotional tensions.

Linking symptoms to emotions: words and interpersonal meanings

Julie described how in the rehab house she started to use the therapeutic space differently, psychotherapy became less about reflecting on the past, it was thinking about the present and integrating her different self-states. Diana described how time with her psychologist during her second admission was a much valued reflective time. For Diana, Bella and Julie their lives were expanded in part by their psychotherapy sessions becoming a place of emotional exploration, it stretched them to test out how else they may challenge their self-beliefs. It was unfortunate that Carla was unable to maintain the links with the team she had worked with due to council funding changes and this element was not available for her.

From pseudo-solutions and concrete thinking this study has highlighted how supporting our clients to make links between their feelings and emotions and the loudness of their eating disorder voices requires reflection and it is from this place that more nuanced ways of thinking can be experienced. When a client describes ‘feeling fat’ I view this as opening a space for a reflective conversation, that as ‘fat’ is not a feeling what else may be going on for them in their inner world. I agree with Halsted (2015) that these expressions convey “affective experiences, longings and views of the self, poorly integrated into a confused expression of bodily appearance saturated with negative affect mislabelled as ‘fat’” (Halsted, 2015, p 79).

As Julie’s weight stabilised she spoke about how therapy changed in tone and content, she appreciated how the ‘here and now’ was far more important. From being encouraged to go out and return to talk about ‘normal things’ over an extended period of time she appreciated how as new relationships emerged in her life there was “less room for your eating disorder”. Similarly Bella described a shift from her black and white world, of always looking for a solution or certainty as being challenged by her therapist who encouraged Bella to sit in uncertainty, “to stay with it a bit more”. In my clinical practice I encourage my clients at this stage to connect the discomfort they feel whether about their bodies, or eating or their obsessive need to exercise as a useful place for them to be curious about what they may have either walled off, dissociated from? This capacity to reflect on what may be taking place, what the other person may have been saying and what negative self-beliefs may have been evoked creates a space for a sense of autonomy to develop.

Clinical implications and national policy

When I began this study the most recent guidelines from the National Institute for Health and Care Excellence's (NICE) for eating disorder was published in 2004. In 2018 NICE updated the standards for assessment, treatment and care for eating disorders which included statements on recommended treatments, treatment waiting times and co-ordination of care. Having reviewed this long overdue document whilst holding in mind that this study focuses on people who have experienced anorexia over a prolonged period of time (SEED-AN) I argue that it does not sufficiently address this group of people. To highlight a few of the anomalies I have chosen a selection of NICE (2018) recommendations in relation to psychological treatments and link these to the narratives within this study as well as reflections from my professional practice.

Excerpts from NICE Guidelines (2018)

Treating anorexia nervosa

1.3.2 "When treating anorexia nervosa be aware that helping people to reach a healthy body weight or BMI for their age is a key goal…"

Psychological treatment for anorexia nervosa in adults

1.3.4 For adults with anorexia nervosa, consider one of:

- Individual eating-disorder-focused cognitive behavioural therapy (CBT-ED)
- Maudsley Anorexia Nervosa Treatment for Adults (MANTRA)
- Specialist supportive clinical management (SSCM)

Detailed guidelines related to each of these treatments follows this list, its emphasis being one of physical maintenance and duration of treatment. CBT-ED consists of up to forty sessions over forty weeks and the clinician is encouraged to promote healthy eating and explain the risks of malnutrition and being underweight'. MANTRA includes intra and interpersonal maintaining factors and treatment which typically consists of twenty sessions, weekly for the first ten weeks and flexible thereafter. It recommends up to ten extra sessions for those people with complex problems. This treatment ‘encourages the person to develop a non-anorexic identity’ and ‘to understand their condition and the problems it causes and the link to the wider social context’. SSCM consists of twenty or more weekly sessions and aims ‘to help people recognise the link between their symptoms and their abnormal eating behaviour’, it aims to restore weight and provide psychoeducation and nutritional education and advice. The guidelines then continue with three other treatments should the above be ineffective all of which are similarly time-limited.

Do NICE guidelines meet the needs of SEED-AN individual’s?

This rigorous narrative inquiry identified how the participants did not need help understanding their condition, *they* were the experts. They, like so many who meet the SEED-AN criteria are fully appreciative of the dangers of malnutrition, they have intimate experience, neither at this stage did they need dietary advice they knew ‘logically’ what foods were good for them. The NICE guideline describe anorexia nervosa in its generality what it does not take into account are the wide range of symptoms and psychological implications across different stages of the illness. Whilst the medical model prevails and professionals continue with models of treatment grouped together this illness will not effectively support those that meet SEED-AN criteria. With the dissemination of this study my hope is that professional support across the spectrum will be re-examined and reviewed to take this into account.

In my clinical practice clients I regularly hear stories of previous experiences in therapy, of being told what to do or how to behave. An example within this study came from Carla as she recalled telling her psychologist about a friend who always told her what she *should* be doing and thinking. The psychologist’s response was to keep her friend at a distance, this kind of friend was not helpful at all for her, to which Carla responded “*but she’s all I’ve got”*! It is possible that in the transference Carla had been talking about her therapist.

A similar story was provided by Bella who made the link between being told what she should be doing by her mother, she gave her ‘practical solutions’ but never thought about her inner world’.

Julie’s narrative articulated this succinctly:

And obviously in therapy they always try and pull you to that (the past) but that wasn’t’ where my head was. And I wasn’t, you know, like, how I was feeling about myself when I was out with friends and how I felt about myself at work and, like the fears I had”.

The NICE guidelines’ medicalised focus of evidence-based outcomes, behaviours and provision of time-limited support for an illness that likely began its trajectory in the individual’s early years in my experience deepens resistance for support and strengthens the person’s sense of ‘failing at therapy’. For those people who have a long history with this illness providing the space and supporting them to become narrators of their lives and seek out alternative ways to navigate complex relationships cannot be time-limited. This study has highlighted how complex the process of moving forward can be and how outcome measures do not capture this complexity. As a contribution to knowledge this study has demonstrated how greater attention needs to be placed on interventions that support the person’s self-development, of mentalisation and reflexive skills alongside consistent multi-disciplinary services being more accessible in the community.

There remains a postcode lottery in relation to frontline resources for NHS eating disorder services, as highlighted in a report by the charity B-eat (2018) published in response to the updated NICE guidelines. (www.beateatingdisorders.org.uk/news). My hope is that this narrative inquiry, which highlights the experiences of long-term sufferers of anorexia will add to the qualitative and quantitative studies of SEED and in turn provoke earlier support across the country.

Social and cultural dilemmas

Discursive confusion abounded for the women in this study in relation to what was normal, acceptable and/or non-anorexic behaviours, thoughts and emotions? How did ‘normal’ people think about what or when to eat; what was the normal amount of times people visited the gym or exercised in a week? For all the narrators this was a major part of their journey as they transitioned away from stage one. Fraught with contradictions their body image was fused with feelings of inadequacy, their relational self shared a discourse with their harsh internal self.

From analysing the narratives of the participants it shines a light on time and place which are key component of Clandinin’s narrative inquiry (2000); it was therefore with interest that I absorbed a leading Market Research Company’s study.

A year before the interviews for this study took place market research Company, Mintel, (2014) published a report titled ‘Dieting in 2014? You’re not alone’, statistical findings included

- 55% of British people (29 million) attempted to lose weight in 2013
- Only 5% of women and 17% men never think about weight (no indication of age).
- By 2017 diet foods and supplements were expected to have a global value of £220 billion.

It is hard to ignore the fact that in the 21st century, particularly in the Western world the female body is discursively constructed in a way that emphasises the ‘body beautiful’ as slim. Print and social media similarly perpetuate the idea of the thin body as bringing happiness, popularity and success. If one was to follow this train and consider that these messages singularly influence our clients one could, by extension argue that every weight-watcher was a potential anorexic. This is of course untrue however when a person has a fragile sense of self and finds a vehicle that sells success and acceptance through the body then it can be extremely potent. What the narrators in this study provided was a strong subtext, the relational and developmental struggle. Anorexia nervosa expressed the fantasy of a controlled body and a controlled life, when relationships with the people around them and their sense of self is experienced as being out of control they each found a way of being special, being better than and in turn this became the ultimate disrupter for thinking.

Food and its role in culture and religion, a personal reflection

Food in my family and the Jewish community I grew up amongst was more than sustenance, it was part of our identity. There are rules of what you can and cannot eat and when certain food can be eaten. Jewish festivals have an associated food attached, a symbolic representation; Jewish food shops both separated and connected us from others. Food was another word for family, it powerfully represented our ancestors and heritage through handed-down recipes. To say no to food was to upset the balance of the family. I still recall my eighteen year old self sitting at the dinner table on the Sabbath staring at my plate and refusing to pick up my knife and fork. My parents were at a loss. I felt powerful, at last. Whilst I bring my own personal reflection I am aware how other cultures and religions also hold food to be a central tenet in their lives. From this place eating disorders can represent denial and attack without a word spoken.

Strengths, limitations and future research

To my knowledge this is the first study to explore and analyse narratives from people who experienced severe and enduring anorexia nervosa, who no longer required medical or psychological support and is written from an insider-researcher perspective. From this vantage point a strength was the close bond forged between researcher and participants. All the participants described being able to openly talk about their experiences in a way that they may otherwise have felt more constrained, fearing being perceived as ‘not recovered or good enough’. It was a strength of this openness that led to a revision of this study’s direction and title, as described in the introduction.

I am also aware how these bonds can inform and influence the data. The mutual connection with all my participants meant there was a ‘knowing’ that flowed between us. I could share with them for example how I was nervous about what I should wear when we first met, what would they think of my (body) size, did I look ‘normal’? They each laughed and all the participants said that this had been their concern too. There was an insider ‘speak’ just as across each of their stories there was humour, black humour and at times less need for talking about their emotions, a nod or silence, a ‘y’know’ sufficed. Later as I analysed the data I wondered if this knowing position meant I did not dig as deep as perhaps someone might have done who had not had these experiences. Was I more accepting and less curious? Burrowing deeper in my own thinking I came to appreciate how my attempts to measure responses was a reductionist approach which was at odds with this narrative inquiry. Narrative inquiry is a philosophy and a methodology, what emerged was neither right nor wrong, what emerged from all our narratives was a story of note and importance.

Because it is difficult to find people who have not received professional support for a number of years it was my connections with professionals in this specialist area that enabled me to be put in touch with the women who were to become my participants. The question of whether this was potentially a weakness in that they may have been invested in talking positively about their treatment and experiences with the psychiatrist that connected us has been touched upon elsewhere. My perspective having further analysed the data in detail is that this study does consider the influences of treatment, how it may have influenced the participants was nevertheless one component in the process of how they moved forward with their lives. Furthermore it highlighted certain elements that may not have been helpful such as lengthy time as in-patients as well as evidences good practice by the staff including the positive impact of their collaborative efforts.

The choice of only women in this qualitative study has already been explained in that they are representative of gender ratio. There was a range of ages across participants as one would expect with SEED-AN. Future research which I believe will be of importance is pregnancy and mothering for women who have experienced anorexia across a long period, of how it impacts them and their families. This study provided a snapshot of the narratives that included experiencing change of body shape, eating during and after pregnancy and exercise, I believe this will become a useful springboard for future studies.

A strength of this narrative inquiry has been that it comes from lived experience thus offering professionals deep insight of the transitional stages and how they integrated more complex relationships around them. The range of psychological therapies received by the participants was varied and included one-to-one psychodynamic psychotherapy and psychoanalytic group therapy. Whilst the participants spoke about their experiences this study may be limited by not having looked at this in greater detail. With the NICE (2018) guidelines being more specific in relation to treatments I anticipate more research will continue to take place in the future.

A limitation of this study has been that the question of exploring more deeply the terms ‘recovery’ and ‘recovering’. What this meant to the participants was touched upon but not explored in depth; to do so would be a detour and possibly a distraction from the research question. The material from the interviews being both rich and dense led to my decision that to offer a quasi-response would not do justice to this weighty subject. It is my intention to research this further at a later date.

Conclusion

"It has often seemed to me that if human beings have not been given what they need at the appropriate stage in their development, they are left with a compulsive hunger which drives them to try and obtain what is missing". (Storr, 1990, p 92)

From analysing the narratives of the participants, which encompassed their individual life trajectories up to the point of interviews for this study and included key influences such as significant others and social and cultural environment, what emerged from the data are three key stages (see Figure 3). This study has specifically sought to understand SEED-AN experiences and what factors were significant in their moving on with their lives, the 'how'. From the dominant discourses in stages two and three (**Figure 4**) this research study has demonstrated a core narrative as being the importance of the individual recognising their legitimate place in the world relationally. All the participants expressed how as their world expanded the perception of themselves and others shifted, their sense of emptiness was replaced with emotional nourishment. Equally, affect dysregulation played out through their body and the rules that filled their mind over time were transformed as they took in new, more interesting experiences.

"Long-term recovery requires something more subjective than simply symptom relief"

(Petrucelli, 2015, p 18)

This study has highlighted how a broader approach is required by healthcare professionals, with greater attention placed on helping our clients build and expand on the multiple meanings of what it may mean to have feelings of emptiness, of being 'too much'; to make links between what they experienced in the past and how it may influence how they see the world in the present. This study has brought to the fore the importance of the therapeutic relationship, of the two-way relational interaction of listening, taking in what is being said, what themes may sit beneath the words and an appreciation of this as their truth. Instead of debating about how clients can be treatment resistant we need to make meaningful connections with our clients, providing a secure space which allows them to make connections with their internal and external world.

Figure 4: key transformative narratives

Stage Two: A transitional place

- Caught between dread of the past and repetition in the future
- New emergent relational configurations
- Testing out possibilities of living
- Finding words, trust and hope
- Thoughts that bump into each other

Stage Three: Integration

- Trusting in human relatedness
- Self-development/a more complex self-concept/identity
- Finding a separate mind/thirdness/Agency
- Reflective/reflexive thinking
- Mourning the past, engaging in the present/future
- Tolerating uncertainty and life’s ambiguities
- Being ordinary and special

This study has demonstrated a trajectory of self-discovery as linked to the developmental achievement of experiencing a relational thirdness (Gerson, 2004). Gerson described this as a movement from a narcissistic form of relating towards acceptance of relating to the needs of others whilst recognising that they have needs of their own. This maturational process for all the participants was evidenced through their narratives as life took shape and new experiences provided a sense of being part of something more, where acceptance and living trumped their eating disorder. This shift allowed a process of recognition, one that legitimised their fears and concerns whilst allowing for a new set of thoughts to fill them.

Along the way my hope is that this study has shone a spotlight on how the person's emotional deprivation, their sense of emptiness carved out literally through starvation can be replaces with emotional nourishment.

I do not believe that there is a moment when a person decides to recover, rather from transformative experiences in a person's life over time there emerges new possibilities and the work of psychotherapy is to harness this. What was witnessed through the narratives and made an impact on all the participants was the encouragement by trusted others, for three of the participants this began within a multi-disciplinary setting, for one it was a group setting which had a strong professional lead. Each new experience provided a brick that enabled them to build a stronger self-structure in their lives and enabled them to slowly dismantle their defensive walls. Possible selves, representing what they might become became, over time, a future that was in relation to and with others.

Closing reflections

Research journal entry: My reflexive process as I near the close of this research

A constant companion throughout this research journey has been the words from my mentor who remarked ‘It will get messy and when it does try stepping back and look at your processes. ‘And then’? I asked, ‘You breathe and step back further’. It was and has remained good advice.

I recall interviewing my participants as being a comfortable exchange, not at all messy. Between the narratives there were silent reflections where we momentarily returned to ‘that place’. We laughed, we remembered those people who had died and mourned lost years.

Ambivalence. As I think about this word today I enter a state of reverie. I am struck by a parallel process that may be at the heart of where I am now, what has changed within me as this study draws to a close. The narratives of my participants contained strong threads about struggling from a need for self-imposed control because the world felt such a dangerous place, towards testing out a different way of being. It encompassed appreciating how fears of abandonment and loss were not gone but perhaps felt less painful. From this deeply personal research question, born in part out of my not knowing whether I was recovered enough I have recognised that the question was all wrong, it was messier than that and in this knowing I have felt a sense of liberation. For today I may have doubts about what I am eating but I don’t act on these thoughts, I notice them and wonder what I may be disturbed about. I recognise that having suffered with anorexia for over twenty five years these thoughts are not surprising, I must befriend them more for what they are nudging me towards, my self-growth. I had never thought about it in this way, with such clarity as I do now. This I appreciate is the power of narrating one’s own story and being witness to others as they tell their own. Intuitively I think I sort of knew this, it is perhaps why I encourage my clients to begin by telling their life-story in their own time. I have been reminded through this narrative inquiry how we are “composing and constantly revising our autobiographies as we go along…we begin in the midst and end in the midst of experience” (Clandinin, 2013, p 43).

To my colleagues I close with an addendum in relation to SEED as a growing area of discussion. My concern is that practitioners and researchers may lose sight that SEED is an acronym not a ‘condition’. SEED is *not* an illness, the illness is anorexia nervosa. That it is severe and enduring is a travesty and our continued research and cumulative knowledge and understanding of this illness is vital.

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Appendix 1: Participant information sheet

Research title: How do women with a history of SEED-AN experience navigating their lives away from and beyond their illness – A narrative inquiry

Researcher: Renee Botham

You are being invited to take part in a research study. I have outlined below why I believe this research is important as well as some information to help you decide whether or not you wish to take part. Please take your time to read this information and discuss it with your friends or relatives if you wish. Do please contact me if there is anything you do not understand or, if you would like further information. Thank you for reading this.

What is the purpose of this research?

The purpose of this research is to achieve further understanding about how women, who have suffered with Anorexia Nervosa over an extended period of time, make sense of their own recovery and what recovery means for them.

This study is undertaken by me, Renee Botham, as part of my Doctorate in Counselling Psychology & Psychotherapy by Professional Studies, at the Metanoia Institute. The part of the project in which you are being invited to participate, will take place between October 2014 and June 2015.

Why have I been chosen?

This collaboration of shared experiences involves four participants who each meet the following criteria:

You are female, over the age of 18 and were clinically diagnosed as suffering from anorexia nervosa. You have endured this illness in excess of five years and identify yourself as being recovered for over two years.

Do I have to take part?

It is completely up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part in this study?

I will invite you to meet with me for two interviews that will each last for approximately an hour and a half with a space of about a month between the two meetings. What I am hoping we will achieve together is a conversation that provides a space for you to reflect on and convey *your* story of how you moved further away from the clutches of anorexia, how you experienced this; your personal meaning-making of recovering from anorexia nervosa. The interview will take place at a location you find convenient and comfortable. The interviews will be recorded on to an audiotape as part of the research.

Please note that in order to ensure quality assurance and equity this study may be selected for audit by a designated member of the research committee. This means that the designated member can request to see signed consent forms. However, if this is the case your signed consent form will only be accessed by the designated auditor or member of the audit team.

What are the possible disadvantages and risks of taking part?

While there are no known risks that can be foreseen in participating in this study sometimes, discussing your personal experiences can affect your emotions. You can stop at any point or end the interview if you do not feel you want to continue further.

What are the possible benefits of taking part?

Although participating in the study will not be of any clinical benefit to you, the information you provide may help the treatment and care of others with anorexia nervosa in the future.

Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you which is used will have your name and address removed so that you cannot be recognised from it. All data will be stored, analysed and reported in compliance with UK Data Protection legislation. While there may be quotes of what you have said I will make sure that you cannot be recognised from these.

What will happen to the results of this research study?

This study will be published as part of a postgraduate dissertation. A copy will be made available to you on request. Condensed articles will also be submitted for publication in psychology and psychotherapy journals and specialist eating disorder journals. At no time will you be identified.

Who has reviewed this study?

This study is reviewed by the Metanoia Research Ethics Committee

Contact for further information:

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Thank you

Appendix 2: Consent Form

Participant Number:

Title of Project: How do women with a history of SEED-AN experience navigating their lives away from and beyond their illness– A narrative inquiry

Researcher: Renee Botham

		Please initial box
1	I confirm that I have read and understand the information sheet dated……for the above study and have had the opportunity to ask questions	
2	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason. If I choose to withdraw, I can decide what happens to any data I have provided.	
3	I understand that my interviews will be taped and subsequently transcribed	
4	I agree to take part in this study	
5	I agree that this form that bears my name and signature may be seen by a designated auditor	

………………………….. ……….…. …………………………………

Name of participant

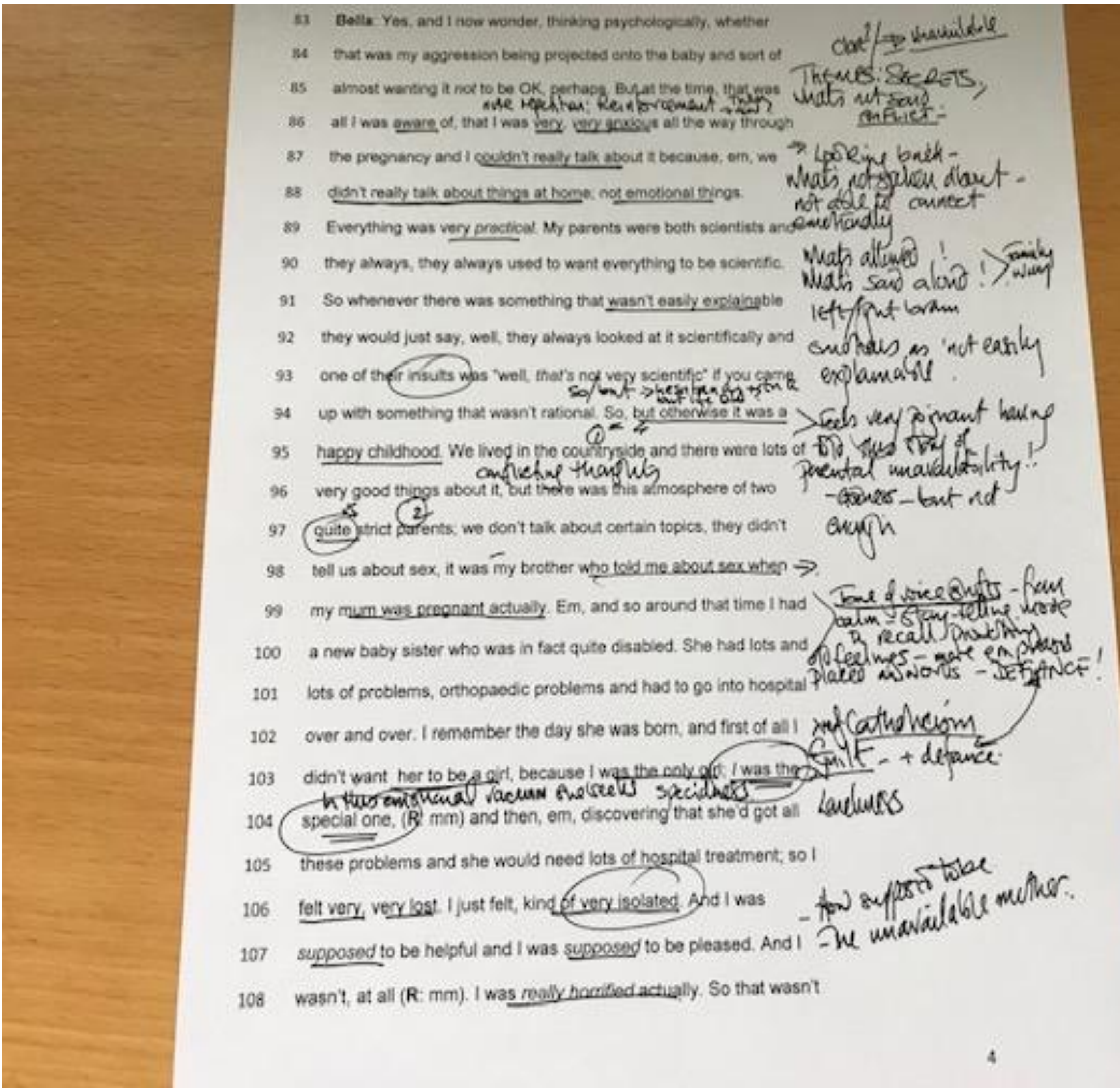
Date Signature

…………………………. ………….. …………………………………

Name of person taking consent (if different from researcher)	Date	Signature
……………………………..	…………...	………………………………….
Researcher	Date	Signature

I x copy for participant; 1 x copy for researcher

Appendix 3: Examples of line by line analysis



Bella: Yes, and I now wonder, thinking psychologically, whether that was my aggression being projected onto the baby and sort of almost wanting it *not* to be OK, perhaps. But at the time, that was all I was aware of, that I was very, very anxious all the way through the pregnancy and I couldn't really talk about it because, em, we didn't really talk about things at home; not emotional things. Everything was very *practical*. My parents were both scientists and they always, they always used to want everything to be scientific. So whenever there was something that wasn't easily explainable they would just say, well, they always looked at it scientifically and one of their insults was "well, *that's* not very scientific" if you came up with something that wasn't rational. So, but otherwise it was a happy childhood. We lived in the countryside and there were lots of very good things about it, but there was this atmosphere of two quite strict parents; we don't talk about certain topics, they didn't tell us about sex, it was my brother who told me about sex when my mum was pregnant actually. Em, and so around that time I had a new baby sister who was in fact quite disabled. She had lots and lots of problems, orthopaedic problems and had to go into hospital over and over. I remember the day she was born, and first of all I didn't want her to be a girl, because I was the only girl; *I was the special one*, (**R**: mm) and then, em, discovering that she'd got all these problems and she would need lots of hospital treatment; so I felt very, very lost. I just felt, kind of very isolated. And I was *supposed* to be helpful and I was *supposed* to be pleased. And I wasn't, at all (**R**: mm). I was *really horrified* actually. So that wasn't

4

Over/[illegible] unavailable

THEMES: SECRETS, whats not said, CONFLICT –

over repetition: Reinforcement [illegible]

→ Looking back – whats not spoken about – not able to connect emotionally

Whats allowed! Whats said aloud! > family way

left/right brain

emotions as 'not easily explainable'.

So/but → [illegible]

> feels very poignant having [illegible] this story of parental unavailability! – [illegible] – but not enough

① ②

conflicting thoughts

Tone of voice shifts – from calm – story-telling mode to recall [illegible] of feelings – more emphasis placed on words – DEFIANCE!

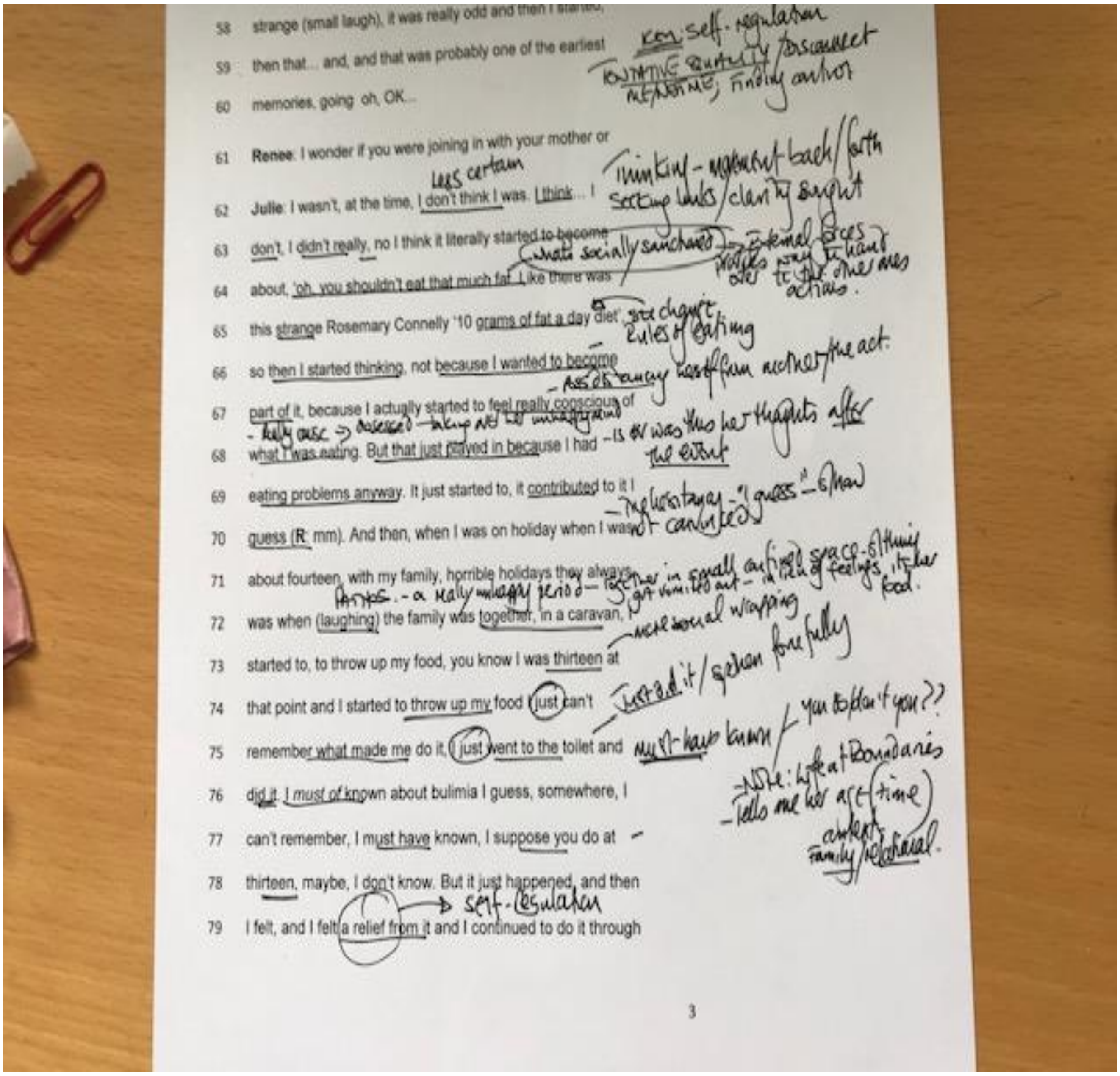
and Catholicism

Guilt – + defiance

in this emotional vacuum she seeks specialness

Loneliness

– how supposed to be – the unavailable mother.



strange (small laugh), it was really odd and then I started, then that... and, and that was probably one of the earliest memories, going oh, OK...

Renee: I wonder if you were joining in with your mother or

Julie: I wasn't, at the time, I don't think I was. I think... I don't. I didn't really, no I think it literally started to become about, 'oh, you shouldn't eat that much fat'. Like there was this strange Rosemary Connelly '10 grams of fat a day diet', so then I started thinking, not because I wanted to become part of it, because I actually started to feel really conscious of what I was eating. But that just played in because I had eating problems anyway. It just started to, it contributed to it I guess (R: mm). And then, when I was on holiday when I was about fourteen, with my family, horrible holidays they always was when (laughing) the family was together, in a caravan, I started to, to throw up my food, you know I was thirteen at that point and I started to throw up my food I just can't remember what made me do it, I just went to the toilet and did it. *I must of known* about bulimia I guess, somewhere, I can't remember, I must have known, I suppose you do at thirteen, maybe, I don't know. But it just happened, and then I felt, and I felt a relief from it and I continued to do it through

3

Key: self-regulation
Tentative quality / disconnect memories; finding anchor

Less certain

Thinking - movement back/forth
setting links / clarity sought

what's socially sanctioned → External forces - [illegible] over to the other ones actions.

strict diet
Rules of eating

- [illegible] from mother / the act.

- really consc → obsessed - taking note [illegible]

- is or was this her thoughts after the event

- [illegible] - 'I guess' - [illegible] contributed

Parties. - a really unhappy period - together in small confined space - filthy - got vomited out - in lieu of feelings, it was food.

- more social wrapping

Just did it / spoken forcefully

must have known / you do don't you??

- Note: life at Boundaries
- tells me her age (time) context
Family / relational.

→ self-regulation

Food FOR THOUGHT -

How life experienced
How understood

Sub Themes/Threads

Humour, conflict, tone, metaphors, WTFIN, sentence construction (using I/you etc) paradox, Discrepancies/inconsistencies
Vulnerability,
Reflections - to expand understanding

Appendix 4: Example of bubble diagram

APPENDIX 5 EXCEL SHEET		
Bella		
Key themes	**Sub themes**	
Early years:		
Developmental: attachment/affect regulation, interpersonal, self/other	Insecure attachment, I was an anxious child	
	Parents preoccupied and dismissive of emotions- feelings of not being validated, anger, envy	
	I was the good girl, always did what I was told	
	Couldn't empathise	
Conflict	But otherwise it was a happy childhood	
Parental influences/**what may have been internalised - LOSS**	Parents' past sitting in the present: history (wartime lives), cultural, economic, social	
	Mother as typifying unhappy womanhood 'a woman's lot' - never having a mind of her own	
Shame, secrets, confusion	What gets covered up - dad's disability, poverty, emotions denigrated/invalidated in favour of rational/scientific thinking - 'I didn't know what my feelings were about'	
	Father's 'shame' leading to his mistrust in others (poss 'eaten whole' by Bella/internalised)	
	developing body, periods - mortifying, disgust	
Rage	Sister born - how I was expected to be	
Guilt and harsh super ego managed through control	Control, self-punishment, hugely critical of myself for not being the way I thought I ought to be, not having the family, friends - so I attacked myself	
	I would eat, but not a lot, preoccupation with calories (concrete)	
What's not said	what parents didn't say - re-assurance, love, don't go to Europe, validation from others	
Relational - only room for one perfect other	Only room for one person at a time; perfect other or denigrated and discarded;	
Black and white world	safety in certainty, uncertainty as dangerous;	
Fragmented self	Powerful vs powerless - this is what I will do vs what done to me	
	Being a good girl, people pleaser,	
Keep out' vs come in , look after me	I'm self-sufficient or a failure, battling with a desire to be seen as fragile and frail (needing to be taken care of)	
Self: Special or invisible	you are special and singled out **o**r ordinary 'a blob with no defined shape or form', the latter being mundane, invisible, uninteresting	
Relationships	relationships as scary	

Diets and calories as an emotional regulator**/Control: 'everything had to be concrete'**	From confused emotions to taking control of body shape, periods - that's concrete, easily measured	
	Anorexia for me was about not wanting to take anything in	
	Parents remain preoccupied - reinforced unseen, unheard, invisible	
Early professional support	Unhelpful GP, fuelled desire to be better at it, one session of counselling - do it alone	
University		
Relationships, terrified and excited	Naïve self, picking up how to be from others,	
	Obsessed with boyfriend -cuts-off from others	
Affect shifting between hyper and hypo	Relaxed vs hyper vigilant, scared and anxious	
Living in London - how do I need to be?	How I needed to be - toughen up, less naïve, watches others - 'it was all miserable'	
Under-nourished as physical and emotional	I was an anorexic who could eat but I never ate enough - not being able to take in enough goodness to sustain her	
A transitional space opens up, experiential but not relational	Moves abroad with friends - 'an angry move'/attack on parents but new experiences presented themselves. Unchanged sufficiently was her relational world	
	Swopping idealised parents to friends - look after me, nourish me	
Leaving home - not necessarily a move forward	Turning my back on the past; denigrating parents - closing the door on any goodness, so there was little left to work with when I was gone	
Starting married life - emotionally unprepared for adult life	Trapped, depressed, not ready to be a grown up; nurture me, nurture me!	
Pregnancy, motherhood and ED resumes	Doing it differently to my mum; feeling isolated, empty/ 'hollow'; 'my life had been hollowed out into him' and there was nothing inside of her	
Counselling - one to one	Feeling intruded upon; all about him; too probing - but, starting to understand something of relational dynamics	
The world of work	Don't be too successful, life is meant to be a struggle	
Integration - a new chapter	**So instead of being very fragmented all the different (self) parts somehow work together**	
Group therapy: an open space for self growth	They were interested in my emotional world; 'a bit of re-parenting'	

	A container, helped me make sense of my inner world, for emotions to be talked about; a safe place.	
Relational shifts	They (therapists) offered a more compassionate voice; showing me empathy - until I was slowly able to do it for myself	
Learning how to be with myself and others	Group therapy: From wanting the therapist as a mother-child might, to negotiating a more adult way of relating, 'To fill in a lot of the missing bits of information; we all began by wanting our own slice of the therapists	
	Starting to take responsibility for myself; from needing constant reassurance to learning how to self-soothe, tolerating what can feel uncomfortable emotionally	
	I have power over the way I relate'	
	Taking the idea of change being gradual vs instant gratification	
	Struggle with 'good enough' but better	
	I have an inner world' and I can be a feeling person	
Mentalisation as a revelation - how I relate has consequences!	How I related to myself, others, the world and making links with my eating disordered behaviours	
	Recognising I was far more punitive in my head than the people I thought the voices belonged to	
Recovery from an eating disorder or a process of self-development - so it never ends	As long as I was fragmented in my self life was always a struggle - realisation that it doesn't have to be that way	
What is 'full recovery? It's complicated	Is it that anorexic cognitions are hardly ever there, where food is not key focus? Is it about body image	
Kick-starting the self-development process; AN as a blessing, what it forced me to do	Recovery as multi-faceted process, out of a crisis (ED) you sort of collapse and moving forward viewed as putting yourself together in a different way	
ED so early, no idea about what is my normal weight	Anorexic as teenager, still growing, what is right shape - it's so hard to know	
Lots of people worry about body	I struggle with body image, but so do others; preoccupation is it ED or normal, no urge to stop eating if feel big; perhaps, maybe more aware what goes into my mouth than other people	
Can't see myself going back to it, but can't say never	I don't feel tempted to go back, if I see red light I wonder what it is communicating to me - I have other ways of coping now	
Constantly questioning whether I'm OK	Making little calculations - it's our culture	
Reflecting on my self	Being more self-aware, it's gradual	
	Having a right to express emotions - I have a right to be angry; catching my thinking - tolerating the idea that I may not be special	

Is 'normal' actually desirable?	Culture is visual, air brushed images,	
Learning to embrace I have a woman's body	Being a woman doesn’t have to be dangerous, not trapped; sex is not about being invaded	
Learning about myself anew	It developed when so young, with no sense of self, then finding a solution in the illness, then I had to work through that solution and out the other side.	
	Moving from black and white extreme thinking to seeing the grey; that the blackness I can still feel will pass.	
Integrating early experiences, **less black/white**	Can see the patches of goodness growing up - 'but there wasn't very good connected tissue'	
	Moving from black and white extreme thinking to seeing the grey; that the blackness I can still feel will pass.	
	You can't do it all on your own	

Diana

Key themes	Sub themes
Early years	
Relational: Unreliableness of human relations	Attempts to **normalise conflicting human experiences:** Happy family, my parents argued a lot, feeling ineffective, anxiety and fear of their separation
	People pleaser - try and make things better for everybody
Attachment	Insecure, anxious, preoccupied, fear of potential loss/abandonment, shifts between passivity and ambivalence
	Compliant, merged position; separation anxiety
Affect	Anxiety, control - G-d problems, OCD, feelings all intense -
Loss	Self, time, identity
Internal conflict; divided self	We were a happy but they (parents) argued a lot'
	Poor sense of self
What was 'known' spoken as 'certainty'	I had to go for a walk; 'that was when it started'; I couldn't not exercise'
Mid teens - self	I thought I was happy; not good enough; always been like that, apparently
	Normalises back-story in cultural/social - 'what teenagers did'
Mid teens self-other relationships	Others as more confident, better, prettier
Concrete/black and white thinking	Powerless - powerful; know -not know; you have the illness or you don't
	Sense of ineffectiveness countered by intensity of the illness 'it was my entire world' nothing else mattered
Loss	
Connecting and disconnecting	Control body shape, periods and emotions -
	I'm fine, in control
	making connections with exercise/food restricting as in control vs out of control
	Being special vs being ordinary
Exercise and body shape - I never saw myself as fat	Had to - 'to get rid of something'; concretised to 'seeking a flat tummy'; **weight** viewed **as a mechanism of control**
No one said anything	All those enactments all that - control, went un-noticed -
GP	Think starving children in Africa

Hospital - first admission and ambivalence	**Enactments** - no words: need to be as bad as I can (see me, help me, hear me) having to 'earn my place'. They are anorexics, I'm not one of them **Relief**: - control removed, given permission to eat **Anxiety**: Wanting to be special (via the illness) yet others better than me in here; not a good enough anorexic **Conflict**: people pleaser vs how dare they get away with stuff Caring staff - Dr Green, softly approach, like a dad, felt seen, heard, understood
Self - invisible	I'm in here and will do it for them (others)
Relapse	Insufficiently nourished - emotionall
Hospital - second admission, I can do it again; it had to be worse than before	Its purpose; box ticked; prove I can do it again if I want (in control), but worse (more special than before) Also - I failed, let people down and fear of being a revolving door patient
TIPPING POINTS **A new phase began; trusting relationships that were joined up**	Staff - continuity; caring, personable, felt heard Others getting on with their lives - I can't achieve any of that in here!
A new space to test out different ways of being and becoming	Still people pleasing but a different attitude
Finding words/a letter to my anorexia - black and white	**The letter** - helped to find words not enactments, seeds as planted and nourished in safe environment; see the split - AN as friend or enemy - more as a friend, keeps me from getting fat Making more conncetions
Therapy	Talked, a lot, unresolved experiences; shift to 'it was inevitable, always going to happen (AN) Family therapy - helpful, understanding more about father's history, parental dynamics how this may have been internalised by her It never ends Valuable - 1st admission - start the work, 2nd admission- do the next bit - trust, acceptance (of help and more open to support)
OT support	Helping her wirh future plans, uni application

Self/others and new kinds of relationships	A new boyfriend - he had me on a pedestal 'what I needed at the time' Awareness of isolation from others - you lose people, they get impatient with you (special vs not special) shift to 'wanting to get well for me' from pushing others away to new possibilities
Discharge	Confidence, new thoughts,
Needing hospital regime as template	Food as per hospital - couldn't trust myself Moral support from ex patient - understanding and appreciating the challenges
Reflective	**I can't look this way(emaciated) and have what I want.** Ability to prioritise for the future and think about what she wanted for herself
	From reflection of can I exercise healthily seeks healthy relationships to support her
INTEGRATING NEW IDEAS - LIVING NOT EXISTING	You have to take ownership of your illness because it is always fighting with you; feeling like you're worth it
Today I have words and balance in my life	Still has to do some kind of exercise 'I've got to do something to justify eating'
Self-esteem and	Husband not know me when in hospital - he doesn't provide the self-esteem for me - I have to do it for myself, better, healthier. More emotionally literate; I can laugh
Life on a continuum	Maybe my body's recovered but my head's not. I do like the idea of being completely well, psychologically recovered - Recognition work to be done
Taking in caring 'adult' relationships	Really caring friends, husband, family - she takes control of her life - but doing this for me now Elements of doing lots for others/people pleaser but more self-aware
Can hold uncertainty	Taking in new thoughts, introducing new experiences
Recovering/recovery	An alcoholic can be 'in recovery' and that's OK!
Being vigilant	If you're open to it coming back, to a relapse then you're always on alert If say you're recovered you can get complacent
There is no normal!	Recovery means completely normal with food and exercise, have no issues but how many women in the world are like that? I know what I'll have but I have no idea what I'd rather have - I've just spent so long saying no to pastry!

Different stages or points of recovery - contemplating a different future	Time frame of illness has a bearing; ability to think about future - allow yourself periods, possibility of having a family/getting pregnant
	Acceptance of my body as it needs to be in order to be healthy
What's hard - not knowing why/catalysts!	There's no one reason you have anorexia and there's no one reason why you move away from it
Achieving the life I want means eating	Not eating - it doesn't make sense any more for the life that I've got
Guilt	What have I done to them (family)?
Acceptance	I'm here and all that hard work, it's what I have to do!

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