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Memories of life before Anorexia Nervosa: A qualitative retrospective study.

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Submitted in fulfilment of the requirements for the degree of: Professional Doctorate in Counselling Psychology

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Memories of life before Anorexia Nervosa: A qualitative retrospective study.

ABSTRACT

It has been shown that Anorexia Nervosa is associated with significant psychiatric morbidity and psychosocial impairment (Bodell and Keel, 2001) and that adherence to in-patient treatment and full recovery rates are poor (Gowers et al. 2007). Although there is substantial existing research and literature in this area, including issues related to the family and childhood, there is still much to be understood about the disorder. In particular, there is only a small amount of qualitative research looking at people’s childhood experiences before the onset of the disorder. The purpose of this research is to gain insight into the early experiences of those who have (or have had) Anorexia nervosa, prior to the onset of symptoms. The study uses thematic analysis to analyse and identify themes in the data, taking a critical realist stance throughout.

Semi-structured interviews looking at memories from childhood were carried out. Interview questions covered topics concerning family relationships, peer group experiences and how participants perceived themselves as children. 14 adults (13 female, 1 male) took part, who self-reported as having experience of Anorexia Nervosa. Participants ranged from 20 to 48 years of age and were at varying stages of recovery. No participants were receiving in-patient care at the time of interview. Analysis of participants’ retrospective accounts of their childhoods led to three main themes; issues relating to relationships within the family, in particular parental relationships, issues concerning challenge and adversity in childhood, and finally participant’s views of themselves.

The study aimed to give voice to those who have experience of Anorexia Nervosa; listening to and analysing descriptions of their childhood memories. By identifying themes in participants’ accounts of childhood and drawing on existing literature, it has been possible to gain a deeper insight into the perceived effects of childhood experiences with regard to Anorexia Nervosa. The discussion highlights identity development as being a significant underlying issue for those who go on to develop Anorexia Nervosa. It then goes on to
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explore implications for practice within Counselling Psychology and the treatment of the disorder generally, including the need to provide clients presenting with Anorexia Nervosa with a facilitating environment for identity exploration.

The researcher has personal experience of Anorexia Nervosa and is training as a counselling psychologist. Participants acknowledged finding it easier to volunteer for the study due to the insider-status of the researcher. The phenomenological stance of this study accepts that the subjectivity of the researcher always shapes the research, and therefore it is recognised that the personal experience and training of the researcher will have influenced the findings of the study.

During the process of conducting this study, I became increasingly aware of the trust shown to me by participants and how courageous and generous they had been to take part. It has therefore felt a huge responsibility to try and accurately reflect their voices in this work.
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Acknowledgements

Firstly, and most importantly I would like to thank the participants who gave up their time to take part in this research. Only through their openness would such depth of data have been obtained and I am aware of the courage and trust that participants showed me in order to achieve this. All showed a real desire to put their experiences to good purpose and collaboratively work towards a better understanding of Anorexia Nervosa.

I would also like to thank the B-eat organisation for their support in advertising this research study through their web-site and research participant pool.

Finally, I would like to thank the staff at the University of the West of England for their training and support; in particular, my two supervisors, Helen Malson and Zoe Thomas.
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Content and Index

The introduction outlines the aims and rationale and of the research. The literature review then gives an overview of the relevant literature surrounding the study, beginning with psychological theory from the 1960’s and 70’s, going on to look at more recent psychological research covering Anorexia Nervosa and the media, personality and attachment issues, emotion, stress, control and gender related issues. Finally, the literature review discusses childhood, adolescence and the importance of family, and concludes by discussing the importance of a greater understanding of Anorexia Nervosa to improve efficacy of treatment and therapeutic practice.

The analysis of the interview data, is broken down into three main themes; family relationships, adversity and memories of self. In the discussion themes are placed in the context of relevant literature, the discussion then goes on to show how identity is an underlying issue throughout the themes and how obstacles in identity development may be significant in both the development of and recovery from Anorexia Nervosa. Implications for practice and limitations of the study are then discussed.

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Introduction

“How does Anorexia enter a young woman’s life, impersonate her for a period of time before becoming her cruel ventriloquist?”

Epston, 1999 (pg 146)

Aims:

The aim of this study is to explore how people who have experienced Anorexia Nervosa perceive their childhoods. The objectives being:

1. To gain insight into the early life experiences of those who have (or who have had) Anorexia Nervosa and identify themes in participants’ retrospective accounts of their childhoods.

2. To draw on existing research literature to discuss whether these themes support existing views on Anorexia Nervosa and its possible causes.

3. To explore the implications of this analysis for practice within Counselling Psychology and the treatment of Anorexia Nervosa generally.

This research takes a critical realist stance and uses thematic analysis to analyse data obtained from semi-structured interviews. The interviews look at memories from childhood and cover topics concerning family relationships, peer group experiences and how participants perceived themselves as children. 14 adults (13 female, 1 male) take part, all of whom self-reported as having experience of Anorexia Nervosa and were at varying stages of recovery.

Rationale:

Anorexia Nervosa is associated with significant medical and psychiatric morbidity, and psychosocial impairment (Bodell and Keel, 2010). At over 5%, standardised mortality rates in Anorexia Nervosa were found by Signorini et al. (2007) to be the highest of any psychiatric disorder, with suicide being the most common cause of mortality (Birmingham et al., 2005). Whether this disorder is approached from a psychodynamic or clinical perspective, research makes apparent the detrimental effects of Anorexia Nervosa.
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NICE guidelines (2004) recommend psychological treatment to outpatients and psychosocial interventions for inpatient treatment for individuals with Anorexia Nervosa. Whilst the broad nature of their recommendation allows for autonomy and choice for professionals working in this field, it may also result in a lack of clarity or consistency for those seeking treatment.

A psychiatric perspective towards recovery appears to lean more heavily on the importance of weight gain and behaviours associated with it, particularly for those at a much lower weight. The American Association of Psychiatry Practice Guidelines (Yager et al., 2010) has weight restoration and the treatment of physical complications as its initial aims, followed by psychosocial interventions aimed at supporting weight gain and attitudes towards eating behaviours. The guidelines include psychological support for both the individual and their families, with a leaning towards CBT as well as interpersonal therapy and the use of medication for initial treatment, maintenance and relapse prevention. This approach is concurrent with the psychiatric approaches taken in other countries, such as New Zealand and Australia (Hay et al., 2014) and the UK (RC PSYCH, 2014).

This medical model does not give the same emphasis to psychotherapy that is seen within many psychotherapeutic settings. Here the emphasis leans far more heavily on psychological and emotional needs, rather than weight and physical factors. This supports the findings of Espindola and Blay (2009) showing that those recovering from Anorexia Nervosa view recovery as being complex and involving more than weight gain. The BACP (2008) promotes the importance of relationships in the recovery from Anorexia Nervosa, citing various research studies which state that therapy is more likely to prove successful for the disorder if increased attention is paid to relationships, expression of feelings and self-esteem. Studies such as the ANTOP study (2009) show the efficacy of focal psychotherapy (FPT) when working with people with Anorexia Nervosa. FPT concentrates on object relations, the function of symptoms and the therapeutic alliance within the therapeutic relationship (Dare and Crowther, 1995) rather than concentrating on individual’s eating problems.

Due to the complex interactions of medical versus psychological symptoms for Anorexia Nervosa (Bezance and Holliday, 2013) many clinical establishments opt to include elements
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of both approaches in their treatment strategy. Offord et al. (2006) found that participants believed services that recognised the emotional impact of weight gain, and addressed both the psychological as well as the physical aspects of the condition, were most helpful. This supports the work of Miller & Rollnick (2002), showing that adolescents with Anorexia Nervosa may benefit from an explicit exploration of both the psychological and physical benefits and drawbacks of recovery. Therefore, a collaborative approach that addresses the psychological and social elements of the disorder, contrary to the dominant medical view of anorexia, may benefit the therapeutic relationship most and promote engagement in the treatment process as a whole (Bezance and Holliday, 2013).

Wright and Hacking (2012) outlined the need to establish an authentic therapeutic relationship and reported clients’ suggestions of therapists’ empathy, acceptance and genuineness as facilitating factors. Data, from a study by Antoniou and Cooper (2013), also emphasised the importance of the therapeutic alliance for successful psychological treatment of Anorexia Nervosa; but was unable to show the underlying reasons for this association. This is collaborated by Antoniou and Cooper (2013), who found that clients with Anorexia Nervosa regarded therapists’ acceptance to be an important quality, associated with a strong alliance along with a non-judgemental and understanding attitude.

Within the psychological profession there is a lack of clarity as to the interventions with greatest efficacy (Berkman et al., 2006), a concern which is shared by many. What research studies appear to show is the generally poor outcome of available treatment. For instance, Gowers et al. (2007) conducted a study comparing treatments for adolescents with Anorexia Nervosa. General findings showed that full recovery rates were poor (33% at 2 years) and that adherence to in-patient treatment was only 50%. Likewise, Wallier et al. (2009) recorded dropout rates for patients with Anorexia Nervosa from specialized inpatient eating disorder programs from 20.2 to 49.6%.

As a Counselling Psychologist, I look to research in order to further my understanding of Anorexia Nervosa and guide my therapeutic formulation with clients. According to the BPS ethical guidelines (BPS, 2009) we have a responsibility to our clients to remain up to date with appropriate scientific innovations and we must acknowledge the limits of the methods we use, under the different circumstances that we may be applying them. The findings
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available from present research on Anorexia Nervosa are inconclusive in terms of the most efficacious form of treatment. The following literature review shows that, due to the complex nature of the disorder and the many variables that appear to be involved in its aetiology, there is as yet no clear understanding as to its cause or the maintaining factors. Without a clearer understanding of the disorder and relevant data on the efficacy of treatment we are, as therapists, working blind and risk attempting techniques with our clients that are at best ineffective and at worst harmful. In this retrospective study we look at how those who have experience of Anorexia Nervosa perceive their childhoods, in the hope that it will bring us one small step closer to understanding the disorder itself and how it should be treated.

Although there is a large quantity of research in this area, one of the dilemmas of relying on research for evidence based practice with Anorexia Nervosa is the apparent difficulties in conducting research in this area. According to Koruth et al. (2012) those with Anorexia Nervosa are relatively poorly represented as a research group, partly because they are considered to be difficult to engage in research. High rates of dropout from treatment studies make randomised control trials difficult to conduct and bring their validity into question (Rienecke et al., 2007). Mahon (2000), conducting research in this area, found that there were few controlled studies of treatment for Anorexia Nervosa and those that existed rarely addressed the issue of drop-outs. Although further studies have been conducted in recent years, it is still difficult to conduct experimental research in which a reputed causal factor can be manipulated. For instance, in the absence of control families, case studies of eating-disordered families, preclude any certainty about whether observed behaviours are unique to families with a member who suffers from an eating disorder (Polivy and Herman, 2002).

Other problems associated with research on Anorexia Nervosa, include the use of self-report responses for weight and height, often used in studies, which have been shown to lack sufficient accuracy. Gebremarium et al. (2014), who conducted a study with 13 year old adolescents, found that girls who reported trying to lose weight under-reported their BMI compared to girls who had not tried to do anything about their weight; those girls who perceived their weight as being too much under-reported their BMI compared to girls who thought their weight was reasonable. Meyer et al., (2009) also found that young women
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generally underestimate weight and overestimate height, affecting BMI calculations; and that this error is related to eating psychopathology, with a tendency of women with high levels of eating concern to overestimate weight. If these studies are accurate the use of self-report responses for weight and height in a study concerning eating psychopathology may introduce significant inaccuracies into the results. A number of researchers in the eating disorder field have highlighted the importance of focussing on sufferers’ perspectives in order to obtain a better understanding of both the disorder (Williams, 2009).

Early attempts to place eating disorders into social and cultural contexts concentrated upon family, media and fashion as the main roots for the cause of Anorexia Nervosa (Eckermann, 2009). Genetic and other biological influences and innate psychological characteristics have now also been suggested to confer vulnerability to the disorder, but according to Klein and Walsh (2005), it has proven difficult to disentangle factors that precede the onset of the disorder from those that are a consequence of it. The answer seems multi-factorial, a complex combination of factors that intersect differently for each individual.

Researchers, such as Ben-Tovim et al. (2001) believe that with a clearer understanding of the causes of eating disorders there may be more effective support for those suffering. A need to improve efficacy of treatments has resulted in increased research in this field, however, there is a gap in the literature looking at subjective perspectives of people who have experienced Anorexia Nervosa, on the aetiology of their own eating disorder. Yet to be fully explored are the personal perceptions of childhood; experiences of being parented, their feelings about themselves, how they felt about their relationships with their parents and their perception of how emotions were dealt with within the family. This study aims to contribute to a fuller awareness of these experiences. By doing so the hope is that psychologists and clinicians can use this knowledge to improve their understanding and support their work with those living with Anorexia Nervosa, thus aiding the development of future treatment.
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Literature Review

Anorexia Nervosa is a disorder with both psychological and physical effects, for which there are numerous definitions. Minuchin (1978) describes psychological symptoms, including a fear of gaining weight, distorted body image, a sense of ineffectiveness and a struggle for control. The DSM-V (APA, 2013) takes a more clinical approach and also includes physical symptoms to characterise Anorexia Nervosa, such as the restriction of food intake leading to weight below 85% of that expected. Miller et al. (in press) aim to link these physical and psychological symptoms by describing the co-occurrence of pathological thoughts and emotions concerning appearance and eating, with disordered eating behaviour, leading to alterations in the body. They label Anorexia Nervosa as a psychosomatic syndrome, with psychological and somatic functioning being inextricably intertwined.

This review now looks at a few of the main factors associated with Anorexia Nervosa, including the media, personality and attachment, emotion, stress and control, gender, childhood and adolescence, and finally the family.

The Media:

According to Wykes and Gunter (2007), the role of the mass media in influencing the development of an eating disorder has been investigated far more extensively than the media portrayal of eating disorders themselves. It was felt by some during the 1970’s that a resurgence in eating disorders may be due to a new expression of patriarchal oppression, as evidenced through media images (Spedding and Milton, 2013), showing how the media innately holds significant influence over society. Although, popular journalists often pursue an entertainment agenda for their reporting of health stories, in recent years greater prominence has been given to the medical views about possible causes of Anorexia Nervosa (Shepherd and Seale, 2010).

The discourse of thinness and the media has at times been used as the main rhetoric for discussing Anorexia Nervosa (Malson, 1998). In research looking at media exposure and its relationship to eating symptomology, the internalisation of socio-cultural pressures was found to be a mediating mechanism for the adverse effects of the thin ideal (Stice et al., 1994). The effects of exposure to the media in eating disorders, often implies that young
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people and adults are starving themselves to look like models and to acquire an ideal shape. For instance, the study by Tiggemann and Slater (2013) involving over 1000 teenage girls, found that time spent on the internet was significantly related to the internalization of the thin ideal, body surveillance and drive for thinness, with Facebook users scoring significantly more highly on all body image concern measures than non-users.

According to the study by Glauert et al. (2009), women’s perceptions of body norms and ideals are easily malleable by media exposure. They found that the more dissatisfied an individual was with her body, the greater the difference in her perceptions of what an ideal body should be compared to body norms.

**Personality and attachment:**

There continues to be evidence that personality variables are closely related to Anorexia Nervosa and may represent familial-based risk factors (Wonderlich et al., 2005). This is supported by a long-term study by Hartmann et al. (2010), who despite acknowledging the influence that severe eating pathology has on interaction with others (in terms of shame, withdrawal and guilt) suggest that the underlying personality may have an even stronger interpersonal pattern.

Studies have shown that narcissism is positively related to pathological eating behaviours (Campbell and Waller, 2010), with these behaviours and narcissistic defences serving a common function of emotion regulation in the presence of low self-esteem. This is supported by the work of Waller et al. (2008) who suggest that levels of body checking are associated with narcissistic defences in women with eating disorders. A further study by (Waller et al., 2007) supports the hypothesis that narcissistic defences and core narcissism are associated with eating pathology, but stress that defences rather than core narcissism are important in eating attitudes.

A twin/triplet study, by Eggert et al. (2007), goes on to show that personality characteristics may take a mediating role between insecure-resistant attachment style and disordered eating. They observed that individuals with resistant attachment are likely to exhibit disordered eating only if they have more neurotic personality characteristics and that this behaviour may serve the purpose of reducing negative feelings. It is important to remain
cautious in this area as personality variables may also be a consequence of Anorexia Nervosa, whilst others may influence the course of the illness without causal status (Wonderlich et al., 2005).

**Emotion:**

There are multiple studies concerning eating disorder and emotions, linking difficulties in emotion regulation to disordered eating (e.g. Lavender and Anderson, 2010). Data from a quantitative study by Wildes et al. (2010) lends support to the notion that emotion avoidance is salient to individuals with Anorexia Nervosa and that anorexic symptoms help individuals avoid aversive emotional states. This is not restricted to the processing of emotion but also the expression of emotion. In a non-clinical sample, negative attitudes toward the expression of emotion was found to be associated with increased levels of eating pathology (Meyer et al., 2010). Bydlowski et al. (2005) suggest that individuals with eating disorders not only have a deficit in emotion processing, but also in judging others’ emotional experience. They go on to wonder whether, as there is no correlation with the duration or severity of illness, these deficits predate the illness, potentially favouring its development. By studying early experiences, this research may shine some light on this theory.

Not all research agrees with the findings of Bydlowski et al. (2005) which implies emotional deficits in those with Anorexia Nervosa. Others, such as Joos et al. (2009), propose that there is no fundamental deficit in emotional perception with regard to emotions such as fear, sadness, anger and happiness for those with Anorexia Nervosa. Instead, it is suggested that they experience heightened emotions, such as fear, when confronted with stimuli, such as anger, and that increased emotion contagion (degree to which the emotions of one person affect another) may be positively related to increased risk of eating disorders in young women (Weisbuch et al. 2011). Findings from the qualitative study review by Oluyori (2013) point towards eating disorder behaviours such as restricting, being an attempt to control such unwanted negative thoughts and affect.

The suggestion that avoidance of other people’s emotions is used in Anorexia Nervosa to reduce affective states (Corstorphine et al., 2007) is supported by research, such as the in-patient study by Davies et al., (2011). Their results recorded an Anorexia Nervosa group
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showing less facial expression and looking away from negative film clips more frequently than a control group. Geller et al. (2000) offer the idea that, this behaviour may be a means of hiding expression to avoid feared negative consequences that occur as a consequence of showing negative expression.

Difficulties in emotional processing within eating disorders may be related to depression and anxiety (Gilboa-Schechtman et al., 2006). The most common comorbid psychiatric conditions in Anorexia Nervosa include major depression and anxiety disorders (Klump et al., 2009), the latter of which often predates the onset of the disorder (Bulik et al., 1997). Yackobovitch-Gavan et al. (2009) support the work of Bulik et al., with results showing that elevated lifetime anxiety can be considered as potentially predisposing to Anorexia Nervosa. Keel et al. (2005) shows an overlap in the hereditary tendency that influences anxious states on the one hand and Anorexia Nervosa on the other, so sharing common risk factors.

According to Raney et al. (2008) in there quantitative study on overanxious disorder, all women with Anorexia Nervosa displayed the characteristic personality profile expected in this disorder. They also found a robust association between anxiety and severity of eating disorder symptoms. It is suggested by Frank et al. (2012) that an intolerance of uncertainty may be a developmental factor contributing to anxiety and eating disorder behaviour in Anorexia Nervosa.

Many researchers question the origin of the attitudes towards emotions displayed by those with Anorexia Nervosa. Different emotional predictors have been investigated for associations with eating disordered behaviours. Potential predictors include perfectionism and shame (Meyer et al. 2010). Looking briefly at perfectionism and shame:

Perfectionism has been shown to be significantly associated with an array of disordered eating in women (Forbush et al. 2007), with the levels of perfectionism differing depending on the individual’s disorder and stage of recovery (Bardone-Cone et al., 2010). Bardone-Cone et al. found that when fully recovered perfectionism levels were significantly lower than for those who were partially recovered or active with an eating disorder. It was also found that perfectionism may be influenced by stress. Cain et al. (2008) found that decreasing personal perfectionism and interpersonal stress could contribute to reducing food restriction. Interestingly, according to Sassaroli (2005) the dimension of perfectionism
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influenced by stress, is parental criticism. However, self-criticism was also found to be associated with the over-evaluation of size and shape (Steele et al. 2011) and a strong predictor of eating disorders (Fennig et al. 2008).

*Shame* is described, in the qualitative review by Oluyori (2013), as an intense negative perception of self, and a perception of having what others will find unattractive. Oluyori (2013) found shame to be a contributory factor in the development of eating disorders. Skåderud (2007) aims to explain this connection by describing shame as a feeling of inferiority and self-dislike which can create an emotional and cognitive shift resulting in a change in behaviour. For the anorectic-to-be, the focus of coping and change is on body, weight and dietary control, i.e. emotional conditions are controlled via the concrete body.

The work by Troop et al. (2008) looks at shame in more depth, going on to differentiate between external and internal shame and their possible associations. They found a distinction between the types of shame with external shame being uniquely associated with severity of Anorexia Nervosa symptoms, while internal shame (shame as a measure of ‘feelings’) was uniquely associated with severity of bulimia nervosa symptoms. They therefore speculate that symptoms of Anorexia Nervosa are particularly sensitive not only to issues concerning social rank but, in particular, to low rank that is perceived to be imposed by others (rather than individuals simply perceiving themselves to be inadequate).

Although there is a wealth of research looking at emotional issues related to Anorexia Nervosa, very little can be found to identify the chronology of effects and separate causal factors from those factors caused by the disorder.

**Stress and control:**

As mentioned above, links have been made between anorexia, perfectionism and stress. A section of research looks at stress and stressful events in relation to eating disorders. Sexual abuse has been associated with a general risk of eating disorder development (Steiger et al., 2010), as has a wider range of childhood trauma (Smyth et al., 2008). The study by Sassaroli and Ruggiero (2005) showed the importance of the impact of stressful situations on the association between psychological dimensions and measures of eating disorder. They go on
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to suggest that stress may stimulate behaviours related to eating disorders in a predisposed personality.

Pliner et al. (2009) aimed to explain this suggestion by showing that high threat conditions increased motivation in participants to restore their sense of self-worth by successfully competing in an area unrelated to the original inferiority, therefore choosing lower calorie/more nutritious foods. These findings are supported by a related study by Cain et al. (2008). They suggest that increased dietary restraint was not only a way to establish sense of control in a domain in which they felt highly efficacious but also a way to try and resolve interpersonal stress.

The onset of Anorexia Nervosa is thought to occur when uncontrollable life events cause an individual to want to retain control (Bruch, 1978). Minuchin (1978) describes attempts at asserting control as a classic component of anorexia, “Her refusal to eat is a pathetic assertion of self against her conviction that she has always given in and that she will always be made to give in.” As well as being a possible factor in the development of Anorexia Nervosa, the concept of ‘control’ emerged as being central to understanding the process of drop-out from treatment services (Eivors, et al., 2003). The grounded theory study by Eivors et al. (2003) argues that drop-out is a means by which individuals can re-assert control over their perception of their eating behaviour when they are unable to see the disorder as dysfunctional or problematic.

Control must be considered when looking at interventions in this area, as self-control related variables powerfully predicted outcomes in anorexia (Birgegard et al., 2009). Again the qualitative study by Eivors, et al. (2003) found that research participants consistently highlighted the very ‘functional’ nature of Anorexia Nervosa. For many it was a means of survival when faced with limited options for (re)-gaining a sense of control in their world. Frank et al. (2012) also stress the importance of perception of control in eating disorder work. Anorexia Nervosa shifts the control of life and relationships to the control of eating and weight (Hartmann et al. 2010) and although becoming less submissive over the course of treatment can be seen as a positive change, unless issues of control are worked on effectively in therapy, patients may show indirect dominant behaviour in the form of dropout.
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Balancing these dominance-submission interactions, when control is required in relation to Anorexia Nervosa patients, is difficult. However, it is important due to the strong emotional effect of the anxiety provoking nature of self-starvation (Birgegard et al. 2009). This can be compounded by the self-criticism associated with Anorexia Nervosa, which may be compounded with staff’s frustration (Fennig et al., 2008). It has been demonstrated that there is substantially greater defensive pathology in eating disorder groups in comparison with control groups (Steiger et al., 1990), which compounds the difficulties of working with people suffering from Anorexia Nervosa.

Gender:

According to Malson (2009) it would be foolish to argue that the world would not be a better place without mass-media saturation of images dictating ‘ideals’ for women’s bodies; she bases this view on findings (such as Halliwell et al., 2005) that demonstrate the pernicious effects of such images (Malson, 2009). Feminist perspectives on eating disorders include the idea that they are developed within a sociocultural context that over emphasises thinness as beauty (Nasser et al., 2007).

However, anorexic subjectivities, experiences and practices cannot be adequately understood only in terms of a ‘hyper-conformity’ to a media generated idealisation of female slenderness (Coleman, 2008). Culture’s role in the production of eating disorders is far more complex, including the gendered power in-balance (Katzman and Lee, 1997) and lack of control afforded to girls and women in other areas of their lives (Lawrence, 1984).

Norms are produced and sustained by the circulation of discourses that define ideals about personhood (Guilfoyle, 2009). According to Guilfoyle (2009) discourses of personhood are currently arranged in such a way that the thin woman is given more room than her larger counterpart to inhabit culturally favourable identity positions, such as being hardworking or successful.

Psychologists have suggested that a reason for anorexia being more common in girls, is that girls continue to be subjected to a much greater degree of parental control during later childhood (Gordon, 2000; Palazzoli, 1985). The development of Anorexia Nervosa in girls
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has also be said to represent a pre-pubertal regression, whereby the child is able to literally annihilate the concrete physical signs of her emerging sexuality (Crisp, 1997).

Anorexia Nervosa was previously considered to mainly concern young women. Button et al. (2008) found that on average the proportion of male adults presenting at a specialised eating disorder unit was around 5%, supporting the general view that eating disorders predominately affects females. However, it is suggested that there is an increasing prevalence for the disorder in men (Soban, 2006).

Although there is a difference in the number of males and females presenting with Anorexia Nervosa, there is shown to be little gender difference in some factors relating to the disorder. Button et al. (2008) suggest that in adult presentation, there are few clinical differences between males and females with eating disorders. Lavender and Anderson (2010) found that males with disordered eating show an association with emotion regulation difficulties as with females, and that there was evidence that such difficulties also contributed to body dissatisfaction in men. Unsurprisingly, the number of studies that have examined the sociocultural influences on body image among boys are substantially more limited than those that have examined these relationships among girls (McCabe et al., 2007).

Anshutz et al. (2009) found no differences between boys and girls regarding the relations found between maternal behaviours and child restrained eating and body dissatisfaction. One of many concerns raised by research of eating behaviour in children, are results indicating that even at 4 years of age, boys and girls are focussing on their body size, and are attempting to alter their appearance to conform to the body ideal endorsed by society (McCabe et al., 2007).

Contrary to the research mentioned above that implies little difference between males and females with Anorexia Nervosa, there is also research supporting gender differences for this disorder. Striegel-Moore et al. (2009), found that there were significant gender differences in most behavioural symptoms of eating disorders, e.g. Men are less likely take part in body checking and body avoidance behaviours than women. Findings from research on men who have Anorexia Nervosa also highlight areas significant to this population. For instance, Aime et al. (2008) found that issues surrounding help-seeking appear to affect males.
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Men with eating disorders are likely to report other psychological problems, rather than their eating problems, more so than their female counterparts. Family and friend issues may also play a role in Anorexia Nervosa in men, with lower social status in a male population group with Anorexia Nervosa found to be four times higher than the general population and also a higher proportion coming from single-parent families (Lindblad et al., 2006). Comments from friends have also been shown to directly relate to eating pathology in men (Forney et al., 2012). As can be seen above, the extent and significance of gender difference in Anorexia Nervosa remains unclear. This may, in part, be because there are relatively few studies involving males with Anorexia Nervosa.

**Childhood and adolescence:**

Whilst the family may play a role in eating behaviour during childhood (discussed below), there are other significant aspects of childhood and adolescence which have been taken into consideration by researchers in this field. A study by Halmi et al. (2012) found childhood rigidity (an inability to adapt or respond effectively to change (Hollenstein et al. 2004)) to be a predominate feature that preceded Anorexia Nervosa and suggested it was a risk factor for the disorder, ahead of perfectionism. In fact there are a number of studies exploring autism (which commonly includes childhood rigidity) and anorexia. The quantitative study by Pooni et al. (2012) showed that participants with early onset eating disorders had elevated autistic traits of clinical significance, particularly repetitive and stereotyped behaviour and autistic social difficulties, as reported by parents of participants.

Dieting has been shown to be a risk factor for disordered eating in adolescence (Patton, 1997), with an association, between restrained eating and maternal encouragement to be thin, increasing with age through to late childhood (Anshutz et al., 2009). However, according to Steinhausen et al. (2005) many adolescents only show transient abnormal eating behaviour which does not significantly predict clinical eating disorders in young adulthood. Aime et al. (2008), in contrast, look at the non-transient nature for adolescent eating problems, associating them with other psychological problems, leading to longer-term impaired functioning.

Influence of peer group and friends is also significant during childhood and adolescence according to Gravener et al. (2008) who found significant associations between perceived
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peer dieting and drive for thinness. The longitudinal study by Linville et al. (2011) suggests that the development of eating disturbances, are influenced by mothers and peers reinforcing societal messages regarding the importance of thinness. The frequency of friends comments on weight and diet was shown to moderate the relationship between body dissatisfaction and eating pathology, with more comments strengthening the relationship (Forney et al., 2012). This association was strongest for women during adolescence and then decreased with age.

In a study by Nordbø et al. (2012), many of the participants described themselves as extremely sensitive to other people’s opinion about them. Heightened fears of negative evaluation may longitudinally predict an increased use of disordered eating (Gilbert and Meyer, 2005). Ahren et al. (2012) found an increased risk of Anorexia Nervosa among females who stated that they “often compare their future prospects with others”. Paxton et al. (1999) suggests the development of restrictive eating pathology may be an attempt to increase status among peers and therefore reduce the fear of negative evaluation. This view is supported by the work of Gerner and Wilson (2005), who found that girls who believed thinness would improve their friendships were more likely to be concerned about weight. Perhaps more importantly, they also found that poor acceptance by friends was a significant predictor of the belief that being thinner improves friendships.

Anorexia Nervosa and the family:

Psychologists have been trying to understand the causes of Anorexia Nervosa for decades. Going back to the 1960’s and 70’s, Bruch (1973) looked at disturbed mother-child interactions which, she argued, lead to serious ego-deficiencies in the child, connecting such a disturbance of self with the onset of anorexia. Bruch reasoned that Anorexia Nervosa had to be understood in terms of the total personality in the context of the family. This was supported by the work of Minuchin et al. (1978), who suggested that the family dynamics of anorexia, with a tendency to overprotect and prevent independence, was often excessively ‘enmeshed’ and fearful of the implications of individuality (Gordon, 2000).

Towards the end of the 1970’s, Palazzoli furthered this work on family structure and dynamics and the emphasis it takes over the individual (Palazzoli et al., 1978). According to Palazzoli (1985), in families with anorexia, resentment between parents can be covered by a
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façade of harmony and deflected through an excessive solicitousness towards the children, which becomes particularly inappropriate for adolescents who are seeking autonomy, which then leads to eating disordered behaviour.

However, there is significant literature criticising any rhetoric which simply ‘blames the parents,’ or worse, ‘blames the mother.’ Kalucy et al. (1977) believed these formulations leaned heavily on theoretical reconstructions of the early mother/child relationship, with many of the hypothetical constructs involved in the ‘mother blaming’ formulations not being observable and therefore un-testable.

Emotion regulation and avoidance in individuals with Anorexia Nervosa are mentioned above, but may also be considered in the context of the family. Le Grange (2011) found that parents of adolescents with Anorexia Nervosa tended to be remarkably lower in emotional expression than parents of healthy adolescents; especially true for negative feelings. Le Grange’s research supports previous work by Van Furth et al. (1996), who found that the levels of parental emotional expression at initial assessments were low in a study with adolescents with eating disorders. Interestingly, Le Grange’s study goes on to show that higher ratings of emotional expressivity for both mothers and fathers were related to better outcomes at the end of treatment, with parental warmth being a predictor of good outcome.

Canetti et al. (2008) sought to find a connection between the low levels of emotional responsiveness and anorexia. They reported that young women with Anorexia Nervosa saw their parents as being less caring compared to a nonclinical group and explained this by hypothesising that parents who fail to be responsive to their children will probably be perceived as less caring by the young adult. It is hard to ascertain whether parents actually do care less but as Parker (1983) points out, the perceived characteristics of parents are not less important than the actual ones in the development of psychological disorders.

Looking at control within the family, the study by Blodgett Salafia et al. (2009) uncovered a process wherein a psychologically controlling parenting style lowered the perceived self-competence of adolescents, affecting the development of bulimic symptoms. This does not appear to be restricted to adolescents with bulimia. A strong association between Anorexia Nervosa and increased paternal control was found by Wade et al., (2007) with high levels of
control from fathers being suggested as a unique risk factor for Anorexia Nervosa. Control, as a significant factor in Anorexia Nervosa has been discussed briefly above.

A study by Lam and McHale (2012) showed that when mothers reported less acceptance and fathers more conflict with their adolescents than usual, adolescents reported more weight concerns than usual in the following year. May et al. (2006) also show conflict between parents and daughters to be related to weight concerns across the course of adolescence. Besides conflict, children’s eating behaviour also appears to be affected by other parental problems such as under-involvement, critical comments by family members and critical life events (Hartmann et al. 2012), depression and lower marital warmth or intimacy (Sinton and Birch, 2005).

Further studies show that problems within the family can be associated with eating disorders. For example, a link has been found between the divorce of parents and body dissatisfaction in their children. Suisman et al. (2011) found that the heritability of body dissatisfaction was higher in offspring of divorced than intact families, and went on to show that divorce predicts an increased risk for the onset of an eating disorder (Suisman et al., 2011). They account for this by viewing divorce as a stressful life event, resulting in the accumulation of many negative events for offspring.

However, finding the link between the negative environment and resultant thoughts concerning body and eating behaviour is more difficult. According to McLean and Pasupathi (2012), parental divorce is a common and disruptive event that is important to an individual’s self-definition. It provides an opening for thoughts about the perceptions of relationships with one’s parents and other insights that might be drawn about the self. It is worth noting, however, that not all research concerning parental divorce found it to have detrimental effects on identity development. Grossman et al. (1980) found that, contrary to popular assumptions, divorce backgrounds did not predict levels of identity achievement.

A qualitative study by Loth et al. (2009), found that challenging times usually preceded the onset of eating disorders and that participants felt that changes within the family environment might have helped prevent their eating disorders from developing, e.g. increased family support.
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Food is a common tool for communication within the family. The dinner table is often the only place where families get together and can become the forum for sharing experiences (Ogden, 2003). In fact, Ogden proposes that meals, and the way in which they are prepared, can create a sense of group identity for the family. Orbach (1986) connects the significance of the role of food within the family to eating disorders by regarding eating disorders as a form of ‘hunger strike’. In the same way that a hunger strike may be a powerful way of regaining control over the political world (Wolf, 1990), eating disorders may be a way of gaining social or psychological control over the family.

Sinton and Birch (2005) state that, during childhood the family provides a critical context for the emergence of dieting and disordered eating. Even during the first year of life, the manageability of a child may interact with vulnerabilities of the mother, in such a way as to interfere with her empathic recognition of signs of hunger and fullness. This may lead to the child associating intense negative emotions with feeding (Ammaniti et al., 2010).

Rules around food at home are shown to have significance beyond these early months. Loth et al. (2014) found that parenting practices surrounding food, such as restriction of food and pressure to eat from parents, correlated to an increase in eating disorders in children. Effects do not appear to be limited to rules around food. After studying family-cohesion and children’s eating behaviour, Hasenboehler et al. (2009) hypothesised that too high a level of family cohesion could undermine a young child’s ability to self-regulate internal hunger and satiety signals. Karwautz et al. (2003) also found that in contrast to the perception of siblings without Anorexia Nervosa, affected siblings perceived themselves as less autonomous within their family and their family as more cohesive.

There is also a suggestion that imitation of maternal behaviours may have an influence. Children’s perception of maternal behaviours were found to be associated with child restrained eating and body dissatisfaction in preadolescent children, in a study by Anschutz et al. (2009). This is supported by Coulthard et al. (2004), who propose an intergenerational transmission of anxieties and concerns about food, through the exposure of children to unhealthy attitudes towards food by mothers with symptoms of eating disorders. However, in contrast, previous findings of a study by Pike and Rodin (1991) reject the notion that girls imitate their mother’s and suggest that the direction of effects may be in the opposite
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direction, with eating and weight disturbances in the child possibly increasing those patterns in the parent.

Some psychologists have suggested that family predictors for children experiencing Anorexia Nervosa are beyond the control of the family. For instance, patients with Anorexia Nervosa are less likely to be first born siblings and also less likely to have one or more brother (Eagles et al. 2005). However, an increased number of half-siblings was associated with a higher rate of eating disorder (Ahren et al., 2013). This study also goes on to suggest that parental education is considered to have an association with eating disorder, with higher parental education predicting a higher rate of eating disorders in females.

Genetic contribution from the family has also been considered, as the heritability of eating disorders is found to be similar to that of other psychiatric conditions, such as schizophrenia (Klump et al., 2009). Schur et al. 2010 found compelling evidence for a genetic contribution to restrained eating, although it was unclear from their study whether genes influenced restrained eating directly or through inherited mediators such as personality factors or body weight. Pieri and Campbell (1999) studied existing twin and family research and found that, taken together, it could be predicted that a substantial proportion of the predisposition to Anorexia Nervosa could be genetic. However, research by Collier et al. (1999) carried out around the same time, showed that the heritability estimates range from 41 to 72 per cent. This leaves plenty of room for non-genetic factors. The environment may play a much larger role than figures suggest if there is also a significant gene-environment interaction.

It is important to take into consideration the effect of Anorexia Nervosa on the family. Individuals coping with Anorexia Nervosa often rely on family members for economic, instrumental, and emotional support (Dimitropoulos et al. 2008). When compared to carers in other areas of mental health, it appears that parents of children with Anorexia Nervosa experience significant psychological morbidity, particularly anxiety, similar to or even greater than in the other areas (Kyriacou et al., 2008). An analysis of parents’ accounts of caring for someone with Anorexia Nervosa was conducted by Whitney et al. (2005). They found that carers felt helpless regarding control over the illness and pessimistic about outcome. It was concluded that these negative attributions may be linked to anxiety and depression in carers.
Whitney and Eisler (2005) argue that families of a child with Anorexia Nervosa often become reorganised around the illness. That is, they become stuck in unhelpful patterns of interaction, which impede their ability to fight the eating disorder and may in fact maintain the illness itself. Such is the importance of the effect of Anorexia Nervosa on the family that some studies, for example Sim et al. (2009), suggest that disruptions in family dynamics and emotional distress common in families with Anorexia Nervosa are secondary to the illness rather than the factors in its genesis. Ward et al. (2000) also conclude that many of the (family dysfunction) characteristics may be regarded as secondary to the presence of an ill family member, rather than caused by it.

Canetti (2008) poses some interesting questions when considering parent-child relationships. Does the eating disorder bias the individual’s perception of her parents or does the eating disorder change the parents’ behaviour so the parent becomes actually less caring? Does a lack of care contribute to the development of eating disorders? The controlling behaviour may be a distorted perception of the parent from the point of view of a defiant anorexic adolescent or it may be a new parental attitude resulting from the parents’ effort to cope with the adolescent’s illness. It is difficult to establish the direction of the parenting effects. Lam and McHale (2012) and Antoniou and Cooper (2013) emphasise the importance of parental involvement to identify and improve family processes which could possibly be encouraging or maintaining the disorder. Whitney et al. (2005) also propose that training parents in skills to manage the illness may improve outcome by reducing interpersonal maintaining factors.

As identity and sense of self have been shown to be a significant factor in Anorexia Nervosa and became an area for discussion in the findings and discussion below, the following paragraphs briefly outline the concept of identity, to give the reader a sense of the meaning of identity being used in this report.

**Identity**

There is some confusion concerning the definition and understanding of the word ‘identity’, often used interchangeably with the concept of ‘self’. According to Roeser et al. (2006) literature on self and identity is largely (and perhaps unnecessarily) separated. However,
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many psychologists use these words interchangeably, giving them similar meanings, as will be the case here.

Erikson (1968) described identity as involving a subjective feeling of same-ness and continuity over time. He suggested that in different places and in different social situations, one still had a sense of being the same person. In addition to this, he felt that others recognised this continuity of character, and responded accordingly to the person ‘they knew’. Forgas and Williams (2002) also define identities as being made up from one’s self-concept, what one believes is true of oneself. However, there is no implication in either case that these identities need be static over time. In fact, Erickson goes on to develop a theory identifying the various stages of identity experienced during a life span (Erikson and Joan, 1997), with alterations in identity corresponding to significant biological and sociocultural forces that occur during the life span.

Horowitz (2012) describes the significance of time with regard to identity by stating that, identity exists in past, present and future time frames, giving the notion that not only must identity have a fluid component, but that it is also dependent on the individual’s experience of all time frames. The idea of fluidity within identity has existed for many decades. Turner (1956) talked about identity and social identity theories describing the self as including both a stable set of evaluative standards and a fluid, ever-changing description in the moment.

Therefore, for the purpose of this study, it is assumed that identity consists of both stable and fluid components, which are based upon subjective feelings that may be influenced by biological and sociocultural forces and experiences.

A relational perspective

Counselling Psychology focuses on the significance of the helping relationship in psychotherapy and an increased questioning of the ‘medical model’ of the professional-client relationship (Woolfe, 1990). This includes the consideration of relational aspects of early childhood, which give a psychotherapeutic contribution to our understanding of the development of identity. This is significant in terms of gaining an understanding of disorders such as Anorexia Nervosa and also explains the relational perspective of the research study.
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Counselling Psychology focuses on the centrality of relationships in the development of identity from early childhood through to later life. Winnicott (1965) and Bowlby (1969) emphasise the significance of interpersonal processes in organising an individual’s internal world (Risq, 2010). Our sense of identity is developed in relationships, through the multiplicity of interactions with our early carers, and later with our peers and the significant adults (including therapists) in our lives (Gilbert and Orlans, 2011). Rogers (1959) believed that we need to be regarded positively by others in our relationships; we need to feel valued, respected, treated with affection and loved.

Fonagy et al. (2002) support this belief, saying that the self is equivalent to the aggregation of experiences of self in relationships. This supports previous work by Sullivan (1953), who suggested that identity is forged in interaction; so much so that the search for satisfaction via personal involvement with others led Sullivan to characterize loneliness as the most painful of human experiences. Johnson (1994) brings together the views of many contemporary theorists on this subject in his work on development. One of the underlying views represented is that identity development occurs as a consequence of the environment’s ability (or inability) to respond appropriately to the instinctual needs of the individual, and is therefore dependent on the interpersonal frustrations encountered. For a child these instinctual needs include attuned self-other relationships (Kohut, 1971 and Stern, 1985).

The significance of relationships throughout childhood can be seen in our interactions with our parents or caregivers. According to Winnicott (1964) this begins at the earliest stage of life between mother and baby, where a strong bond and sense of ‘holding’ needs to develop for healthy development. Winnicott goes on to say that, with age, the concept of holding expands from mother to the family, to the outside world, including school and social life.

Bowlby’s work on attachment goes on to highlight the importance of the proximity of a preferred attachment figure as being crucial to development (Bowlby, 1979). When children are young, they form a sense of themselves in relation to others through their primary carer. If early attachments are difficult in some way, this affects a child’s sense of their own and other’s behaviour, often leading to fear, distress and discomfort (Heywood, 2010).
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An example of this process is shown by Kohut (1984) when he talks about the importance of a child’s need to be shown that they are special and welcome by a parent. He goes on to discuss that if this message is sufficiently strong, then when the parent fails to provide it, the child is able to provide the message for itself and as such develop structure to the self. However, if the parent is deficient in making the child feel special and welcome the need is unfulfilled and may be repressed, leaving the person with a sense of insecurity and worthlessness. A necessary structure of identity can be inhibited (Kohut and Wolf, 1978).

Rogers (1959) also believed that feelings of self-worth developed in early childhood, and were formed from the interaction of the child with the mother and father. As a child grows older the interactions with significant others also affect their feelings of self-worth. This is in line with the early work of psychologists such as Bruch (1973), Minuchin (1978) and Palazzoli (1978) who looked at mother-child relations and family dysfunction as a means of understanding the cause of Anorexia Nervosa. In particular, Bruch (1973) connected the disturbance of self, caused by poor mother-child interactions, with the onset of Anorexia Nervosa. (Theory and research concerning Anorexia Nervosa and the family are discussed in greater detail in the literature review.)

Gilbert and Orlans (2011) remind us, that whilst severe early deficits in relational exchange can become ingrained and difficult to change, the plasticity of the brain allows for potential change which gives importance to relationships throughout the life span. Within the relational model of therapeutic practice these psychological changes occur within the relationship between therapist and client through their mutual recognition and a constantly shifting process of re-organisation and mutual repair (Benjamin, 1990). Hargaden and Schwartz (2007) describe it as a bi-directional process, leading to the co-construction of meaning.

This research has been conducted from a counselling psychology perspective, with the importance of interpersonal relationships being regarded as an essential part of the development of identity. In particular, when planning and carrying out interviews the views of Rogers (1959) on relationships were kept in mind; believing a person needs an environment that provides them with genuineness (openness and self-disclosure),
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acceptance (being seen with unconditional positive regard), and empathy (being listened to and understood).

In conclusion

The purpose of this research is to gain insight into the early life experiences of people who have (or have had) Anorexia Nervosa, to improve our knowledge and understanding of this disorder. This in turn may improve the effectiveness of therapeutic interventions and inform ways of reducing children’s vulnerability to Anorexia Nervosa.

It seems important to highlight here that the nature of Anorexia Nervosa itself may make recovery harder to initiate and maintain. One element to consider is that of the ambivalence experienced by those with the disorder. According to the qualitative study by Nordba et al. (2006) which looks at participants perceptions, ambivalence is a central feature of Anorexia Nervosa, which leads to psychologically purposeful behaviour. Meanings that participants attributed to these behaviours ranged from avoidance of negative emotions through to death. In a meta-synthesis of international literature, Espindola and Blay (2009) also found that patients with anorexia recognised various positive aspects of the disorder including security, protection, power, control and a feeling of being different. These findings indicate the presence of factors that justify the presence and maintenance of Anorexia Nervosa for the individual, which can then frustrate treatment. It is suggested by Jappe et al. 2011, that treatment needs to be focused on engaging the individual’s own motivation to accomplish long-term recovery.

Researchers, such as Ben-Tovim et al. (2001) believe that with a clearer understanding of the causes of eating disorders there may be more effective support for those suffering. Oluyori (2013) also argues that a greater understanding of emotional phenomenology of eating disorders is of clinical value in improving treatment interventions. This literature review only touches upon the wealth of research that already exists concerning Anorexia Nervosa and yet as shown above there is only limited success in treating the disorder.

This study will look retrospectively at experiences of individuals who have, or have had, the disorder before they recall the onset of symptoms. The greater the insight into the experiences of individuals prior to the onset of Anorexia Nervosa, the more likely we are to
identify vulnerabilities and risk factors for the disorder (Koruth et al., 2012). Research into people's experiences supports collaborative working between those who need support and those who aim to provide it, shaping service development. It is time to look more closely at the experiences encountered by those who go on to suffer Anorexia Nervosa and improve understanding of the aetiology of the disorder.
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Methodology

This study takes a qualitative approach aimed at gathering rich contextual data concerning childhood memories of individuals who have had experience of Anorexia Nervosa. Qualitative methods can be used to improve understanding of psychological conditions and may provide an understanding of clinical realities missed by quantitative studies (Malterud, 2001). According to Smith et al. (1999) a qualitative approach is appropriate for an in-depth exploration of participants’ lived experience.

Recruitment:

Participants were recruited through the national B-EAT organisation web-site, which provides information and support for those with eating disorders and their carer’s. (B-EAT supported the pilot research to this study.) Permission was sought from this organisation once ethical approval had been granted by the University of the West of England. An advert was written which was then posted on their national website. The advert outlined briefly the purpose of the study, what participants would be asked to do and the researcher’s status as an insider researcher, with contact details should they wish to respond (see Appendix 2). The local B-EAT representative was also contacted, who agreed to advertise the project at support group meetings in Bristol.

Prospective participants responding to the B-EAT advertisement were sent, via email, the participant information and consent form (see Appendix 3), with an invitation to contact the researcher if they wished to participate. Once a participant confirmed their wish to proceed a mutually convenient time and place was found for the interview.

Inclusion criteria: Participants for this study were to be adults i.e. 18 years old or above, with personal experience of Anorexia Nervosa. Participants needed to self-identify as having experienced Anorexia Nervosa, a formal clinical diagnosis was not required. Participants could be currently suffering from anorexia, in recovery or fully recovered. As there are a range of eating disorders which are thought to have different influencing causes and identities (Ben-Tovim, 2001) only participants who self-identified as experiencing Anorexia Nervosa at the onset are included, although other eating disordered behaviours, such as bulimia, may have occurred at a later stage. Participants needed to be fluent English speaking.
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Ethical considerations:

This study carried risk due to the vulnerable nature of the participant group. In order to gain insight into experiences from childhood, questions that were included in the interview would have possibly invoked negative memories and associated uncomfortable emotions, e.g. Participants were being asked to describe their early memories of their parents, who in some cases may have been abusive. This could cause emotional distress.

Due to the nature of the project, participants had had or still had a mental health condition and were therefore classed as being vulnerable. As is appropriate for research with any participant group the BPS (2014) ethical guidelines were adhered to throughout the research process, but with special regard to advice given concerning vulnerable participants. Some of the measures taken to ensure ethical research practice are outlined below:

- Participants were given information describing the nature of the study and fully outlining their role should they decide to take part. Researcher contact details and Supervisors details were included on the participant information sheet in case of queries or concerns.
- A list of help-lines was included in the information should they need support at any point during the research process.
- Fully informed consent was sought from participants prior to the interview, ensuring that they understood the nature of their participation and their ability to withdraw at any point up to data analysis.
- It was felt that an adult (rather than a child) sample group would reduce risk to participants. Those under the age of 18 would be more likely to be living with parents and any issues arising from the interview may have had an impact on those relationships. (Similar issues may still have impacted on adult’s relationships with parents and this age restriction would not eliminate risk and participants were reminded of the contact details of organisations offering support included in the participant information.)
- Prior to and during the interview, participants were advised to only answer questions they were comfortable with. The researcher made an effort throughout
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the interviews, to be aware and sensitive to the participants’ distress and their choice to terminate the interview at any time, e.g.

In the case of 1 participant issues of child abuse were mentioned by the participant, who then became upset but appeared to feel it was necessary to disclose more information for the sake of the research. As it was not appropriate to cause further distress I reassured the participant that this wasn’t necessary and stopped the interview for a period until she asked to continue. We moved on to different aspects of her childhood. This type of intervention was required in a number of interviews, showing the emotional vulnerability of this sample group, the great desire of the participants to help and the need to support them during the interview process so that no advantage was taken of their vulnerability.

- It was made clear to participants that the interview was a research interview and not counselling.
- Confidentiality was outlined, noting the anonymity given to all data, i.e. by anonymising transcripts and by using of pseudonyms.
- Prospective participants who were in-patients at the time of interview, were excluded and any still receiving treatment on an out-patient basis were asked to discuss their involvement in the research with their lead clinician, prior to taking part. The same guidelines were also applied to anyone receiving treatment for co-morbid conditions, such as depression. Participants all needed to be English speaking to ensure that the studies intention to gain insight into experiences was not impeded by foreign language constraints.
- I was aware that participants would have varying degrees of support in the community and were at different stages of recovery. Effort was made during recruitment to ensure acceptable levels of support and a sense of safety, e.g. the interview for 1 participant was delayed by over 6 months as she had recently left in-patient care and it felt sensible to ensure she felt emotionally stable living at home prior to taking part. Another participant’s interview was postponed whilst she dealt with a physical illness which, whilst it would not prevent her attending the interview, may have added significant emotional stress.
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By putting safeguarding at the forefront of the process, participants were able to take part in the interview process with a maximum level of safety; this sense of safety would possibly have an added benefit of facilitating fuller responses to the interview questions.

Participants:

A sample size of 14 participants was achieved through the recruitment process. It was felt that this was a suitable number, as saturation of the data seemed apparent by this point. (It was found by Guest et al. (2006) that a sample size of 12 allowed for saturation of themes when using thematic analysis, although basic elements for meta-themes could be present as early as 6 interviews.)

Participants were all Caucasian and of British origin, with 13 out of 14 being female. Gender was not specified in the recruitment information, however, only two males responded to the advert and only one of these attended an interview (the other failing to attend on the day). This sample ratio of female to male is approximately in line with statistics concerning the ratio females to males with eating disorders in the UK population. Button et al. (2008) give 5% as the average proportion of males presenting at a specialised ED unit and The National Institute of Health and Clinical Excellence (2004) estimated around 11% of those affected being male. It would therefore be expected that in a sample of 14, 1 or 2 participants would be male.

Although the inclusion criteria only required participants to be self-identified as having experienced Anorexia Nervosa, all but one of the participants who took part had been clinically diagnosed with the disorder. Only 2 saw themselves as being fully recovered, 4 as partially recovered and the remaining 8 as not being recovered. 2 participants are recorded as recovery being ‘unknown’ as they preferred not to say. As explained in the recruitment section, no participants were receiving in-patient treatment at the time of interview, however, 5 participants were either receiving or waiting to receive some form of therapeutic intervention in the community.

The age range for participants was 20 to 48 years old, with a mean average age of 29 years. Pseudonyms were chosen for each participant.
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<table>
<thead>
<tr>
<th>Participant Pseudonym</th>
<th>Age</th>
<th>Gender</th>
<th>In recovery as defined by the participant</th>
<th>Data collection method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ruth</td>
<td>31</td>
<td>F</td>
<td>Partial</td>
<td>Face-to-face interview</td>
</tr>
<tr>
<td>Yvonne</td>
<td>23</td>
<td>F</td>
<td>Y</td>
<td>Face-to-face interview</td>
</tr>
<tr>
<td>Beth</td>
<td>48</td>
<td>F</td>
<td>Y</td>
<td>Face-to-face interview</td>
</tr>
<tr>
<td>Jane</td>
<td>46</td>
<td>F</td>
<td>N</td>
<td>Face-to-face interview</td>
</tr>
<tr>
<td>Mary</td>
<td>20</td>
<td>F</td>
<td>N</td>
<td>Face-to-face interview</td>
</tr>
<tr>
<td>Tina</td>
<td>21</td>
<td>F</td>
<td>N</td>
<td>Email</td>
</tr>
<tr>
<td>Wendy</td>
<td>21</td>
<td>F</td>
<td>N</td>
<td>Face-to-face interview</td>
</tr>
<tr>
<td>Sally</td>
<td>22</td>
<td>F</td>
<td>Unknown</td>
<td>Email</td>
</tr>
<tr>
<td>Liz</td>
<td>23</td>
<td>F</td>
<td>N</td>
<td>Face-to-face interview</td>
</tr>
<tr>
<td>Helen</td>
<td>44</td>
<td>F</td>
<td>N</td>
<td>Face-to-face interview</td>
</tr>
<tr>
<td>Cathy</td>
<td>23</td>
<td>F</td>
<td>Unknown</td>
<td>Email</td>
</tr>
<tr>
<td>Jo</td>
<td>30</td>
<td>F</td>
<td>N</td>
<td>Email</td>
</tr>
<tr>
<td>Lee</td>
<td>26</td>
<td>M</td>
<td>N</td>
<td>Face-to-face interview</td>
</tr>
<tr>
<td>Lucy</td>
<td>32</td>
<td>F</td>
<td>Partial</td>
<td>Face-to-face interview</td>
</tr>
</tbody>
</table>

NB: "Unknown" indicates the participants who were not clear or did not want to define the status of their recovery.

There was no wish on the part of the researcher to encourage participants to label themselves as being at a particular stage in recovery if they did not want to do so; it was felt that this could be detrimental to them. People who have mental health problems are perceived by some members of society to belong to a lower status group (Hall & Cheston, 2002) and can experience stigmatisation and discrimination (Crisp et al., 2005). Stigma can be personally, interpersonally and socially costly (Biernat & Dovidio, 2000) and can greatly exacerbate the experience of mental illness (Corrigan, 2007).

Labelling a participants stage of recovery, as with labelling a person with a diagnosis, may be unhelpful to recovery. Labelling can contribute to a sense that a person is just an illness or has something ‘wrong’ with them, with little else as part of their identity (White 2007). It can also prevent them from pursuing treatment in an effort to avoid being labelled (Corrigan, 2007). Whilst acting as a guide to clinicians as to the symptoms being experienced, a diagnosis (or label) can in itself become self-fulfilling and can bias the way clinicians and the public see a person (Kennard 2013). It was therefore with reluctance that it was deemed unavoidable in order to recruit participants for the study, to use the diagnostic term Anorexia Nervosa as a means of clearly defining the recruitment criteria.
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Data collection:

Face-to-face, semi-structured interviews with participants were used for data collection where possible. Semi-structured interviews are shaped by an interview schedule which can be used as a guide, in response to what is said by the participant (Runswick-Cole, 2011), to give an informal conversational style of interview. The benefits of this style of interviewing include allowing participants the opportunity to present unanticipated issues (Smith, 1995).

The interview itself included questions that were aimed at accessing participants’ memories of childhood experiences, focussing particularly on family and relationships, with parents, and siblings. Questions also referred to memories of relationships with peer groups and how participants perceived themselves. Further questions, more specific to participants’ experiences of food and eating were included, such as a question around mealtimes. (For the Interview schedule see Appendix 1a).

For those people who wished to take part but who were unable to travel to a suitable meeting point the interviews were conducted by email. This allowed potential participants from more widespread areas and those who found travelling difficult, to take part in the study. It did not seem beneficial, either to volunteers or to the research study, to restrict those in these two groups from participating.

E-mail has strengths and weaknesses as a communication medium for research interviews (Meho, 2006). In this case it has provided easy access to otherwise unreachable participants (Selwyn and Robson 1998) but this may have affected the data of received. In e-mail interviews the interviewer is not able to read facial expressions, body language, make eye contact, or hear the voice tones of the participants. It is therefore possible that visual or nonverbal cues are missed that would be observed during a face-to-face interview (Selwyn & Robson, 1998) and that could be used to guide the interview process. Evidence gathered by email is often seen as a less accurate reflection of a respondent’s thoughts than verbal data (Hodder, 1994).

However, Selwyn & Robson (1998) argue that e-mail interviews reduce some of the problems associated with face-to-face interviews, such as the interviewer/interviewee effects that might result from visual or nonverbal cues between the two (e.g. gender, age, voice tones, dress) and eliminate errors introduced through incorrect transcription; the data
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is analysed exactly as the interviewee wrote it. Importantly in the case of this study, Kim et al. (2003) explain that e-mail may safeguard against possible shame for some people when they describe potentially sensitive events, experiences, or personal characteristics (e.g., difficult relationships with family or abuse). In many cases e-mail can facilitate disclosure of personal information (Bowker & Tuffin, 2004).

There were two main concerns about conducting the interviews by email in this study. Firstly, that to receive a long list of questions of a personal nature may feel overwhelming or intimidating to participants and, secondly, that the participants may be vulnerable and could be affected by the questions. These points were addressed by dividing the interview into three sections (see Appendix 1b) that were emailed consecutively only after the previous section had been returned, thus reducing the number of questions at any one time. Prior to the initial section being sent, a dialogue was set up with the participant (alongside the usual consent form and participant information) ensuring that the participant was aware that they could email for more information and guidance if needed, were aware of support networks and most importantly could stop at any time, miss out questions, only write what they felt comfortable with and withdraw completely from the research if they wanted to. The length of time to complete the full interview by email varied from around two weeks to two months. (No participants reported feeling distressed by questions, however, two participants needed reassurance when they felt unsure they were answering questions correctly.)

As outlined above, thematic analysis was used to analyse the data to identify any themes within the data set obtained in this research. This form of data collection, using semi-structured interviews is compatible with thematic analysis.

Runswick-Cole (2011) stresses the importance of the researcher in qualitative interviewing, with the researcher reflecting on aspects of their lives that might influence their conduct during research. Critical realism assumes that complete detachment of the researcher from their research participants is impossible (Ackroyd and Karlsson, 2014). As an insider researcher, (one who shares the characteristic, role, or experience under study with the participants (Dwyer and Buckle, 2009) this has been an important aspect for me to consider, both in terms of the overall research and for interviewing. I informed participants that I had
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Anorexia Nervosa and have been fully recovered for a number of years. Participants have made comment, that it was easier to respond to the invitation to take part in this research, knowing I have insider knowledge. The disclosure of insider-researcher status can influence the rapport with participants (Runswick-Cole, 2011); this does appear to be the case so far.

The interview started with a general discussion about the research and participant information form, ensuring the participant understood the information. Written consent and a pseudonym were obtained prior to the start of the interview. *(For the participant consent form, see Appendix 3).*

**Analysis and theoretical framework:**

Data was transcribed verbatim leading to the production of a rigorous orthographic transcript, which included relevant non-verbal sounds and pauses, whilst retaining the original nature of the data (Edwards, 1993). The transcription code used to transcribe data was a simple convention that took a few basic notations from Jefferson (2004). It is based upon standard keyboard symbols and common conventions (Wiggins and Potter, 2008). The following codes were used:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>(pause)</td>
<td>Indicated a pause in speech</td>
</tr>
<tr>
<td>[ ]</td>
<td>Between adjacent lines of concurrent speech indicate the onset and end of a spate of overlapping talk.</td>
</tr>
<tr>
<td>(inaudible)</td>
<td>Indicates speech that is difficult to make out. Details may also be given with regards to the nature of this speech (e.g. shouting).</td>
</tr>
<tr>
<td>?</td>
<td>Indicates a question.</td>
</tr>
<tr>
<td>Under</td>
<td>Underlined fragments indicate speaker emphasis.</td>
</tr>
</tbody>
</table>

The transcripts were analysed using Thematic Analysis within a Critical Realist framework. According to Guest et al. (2012) Thematic Analysis focuses on identifying and describing both implicit and explicit ideas within the data and is a flexible method for identifying, analysing, and reporting patterns (themes). This approach does not identify causal relationships per se, but allows the identification of themes which, in the case of this study, relate to how the lived experience (or individual subjectivity) of childhood is represented in participants’ accounts. This is in accordance with counselling psychology’s preference of maintaining a phenomenological focus, which includes the important feature of inter-subjectivity (gaining an understanding of the social world through an on-going process of
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exchange and interaction with others (Lawthorn and Tindall, 2011)). The themes obtained are then interpreted and discussed to identify their broader meanings and possible significance, making use of previous literature and research, as suggested by Patton (1990). This allows the present study to discuss how these experiences of childhood might relate to eating difficulties.

Research epistemology guides what can be said about data, and informs how meaning is theorised (Braun and Clark, 2006). According to Braun and Clark (2006), Thematic Analysis can be used across a range of epistemologies, making it suitable for use within a critical realist framework. As a counselling psychologist trainee, maintaining a phenomenological focus is of importance.

Critical Realism

This study takes a critical realist stance as defined by Bhaskar (1978). According to Mingers (2000) the original aims of critical realism were to re-establish a realist view of being in the ontological domain whilst accepting the relativism of knowledge as socially and historically conditioned in the epistemological domain. An important characteristic of critical realism is that it maintains a strong emphasis on ontology, with its foremost tenet being that the world exists independently of what we think about it. Danermark et al. (2002) add that what we think about it (the knowledge gained) depends on what problems we have and what questions are asked. Importantly, this leads us to accept the fallibility of our knowledge and the possibility of getting things wrong (Zachariadis et al., 2010). It also contends that differences in the way an individual perceives and experiences concepts and phenomena are inevitable as they depend upon an individual’s beliefs and expectations (Bhaskar 1978), which in turn are mobilised by cultural values and ideas.

One rival perspective to critical realism in the social sciences is social constructionism. Looking briefly at constructionism and realism:

According to Campbell (1998) two of the more conventional constructivist components are that knowledge is constructed by individuals and society and that a reality exists independent of the observer. In the case of social constructionism a major focus is to uncover the ways in which individuals or groups participate in the construction of their
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perceived reality. According to Elder-Vass (2012) the subsequent consequence of this focus is that if something can be socially constructed then it can be constructed differently and therefore result in change.

Realism is viewed in a number of differing ways (Hunt, 2003). If we take Speed’s (1991) definition of realism then reality exists and can be discovered by people in an objective way and therefore determine what we know, i.e. reality exists independent of the observer (Casti, 1989) and can be experienced by everyone in the same way (Osborne, 1996). For realists the social world, like the rest of the natural world, is driven by causal processes, and therefore social science is partly concerned with seeking to explain the causal interactions that produce social events (Bhaskar, 1998). Bhaskar (1975) differentiates between critical realism and empirical realism by distinguishing between the “real”, the “actual”, and the “empirical”. Even though critical realism accepts that there is one “real” world it does not follow that we, as researchers, have immediate access to it or that we are able to observe its every aspect (Zachariadis et al., 2010).

Both critical realism and social constructionism have ties to positivism. However, according to Cruikshank (2011), critical realism is concerned with the positive development and application of knowledge, whereas social constructionists claim that knowledge is uncertain and consists instead of constructions of reality that are imbued with power. Critical realists assume that there is a real world out there. However there is no way that such an assumption can ever be proved or disproved, as social constructivists may argue. However, critical realism takes the approach that we behave as if it was true, as if the world was real. In general this supposition works, especially for the physical world (Easton, 2009).

According to Sayer (1992) social science must be critical of its object. In order to be able to explain and understand social phenomena critical evaluation must take place. The most fundamental aim of critical realism is explanation; finding answers to the question of what caused those events to happen (Easton 2009). It is evident that critical realism does not commit to a single type of research but rather endorses an extensive variety of research methods which are chosen according to the type and aims of the study, to answer questions such as the causes of events (Zachariadis et al., 2010).
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The critical realist stance assumes that each individual forms their reality through a process of perception and communication (Eatough and Smith, 2008). This study therefore sees participants as experiencing their own reality, according to their perception of events, and the context in which they have experienced them. This provides the study with access to their reality. Sayer (2000) argues that what can be observed may make us more confident about what we think exists, but existence itself is not dependent on it. In fact, observable events that are being generated by complex interactions, can give information on the existence of unobservable entities. This makes it possible to understand how things could have been different if these interactions had not taken place (Zachariadis et al., 2010). In more simple terms and in relation to this research, by observing and analysing, it is possible to gain an understanding of participant’s experiences and, in turn, improve knowledge into what may create change if different interactions were to take place.

Whilst this study is not using interpretative phenomenological analysis (IPA), as developed by Jonathan Smith, it shares with the IPA approach the acknowledgement that it is not possible to access an individual’s life-world directly, because there is no clear and unmediated window into that life (Smith and Osborn, 2003). The researcher must therefore play a role in the analysis of data, taking a responsive position and acknowledging their own impact on the research (Larkin et al., 2006). This is supported by Willig (2012) when discussing critical realism, stating that rather than assume data directly reflects reality, it needs to be interpreted in order to gain access to underlying effects and motivations. This leads to a dual process in which the participants are trying to make sense of their world whilst the researcher is trying to make sense of the participants trying to make sense of their world (Eatough and Smith, 2006).

As an insider-researcher I was aware of my own personal experience of Anorexia Nervosa, which would undoubtedly play a role in the analysis process of the study. I would, as discussed above, only be able to see the data through the eyes of my own reality. This could lead to greater emphasis being given to certain meanings that resonate with my own or an unconscious avoidance of meanings that either did not resonate or that may have caused emotional discomfort.
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The methodological choices made in planning this study, were aimed at taking these issues into account. The use of Thematic Analysis allowed an objective approach to the coding process, reducing the need for the interpretation of data, hopefully leading to a closer representation of the participant’s views than I may have achieved using IPA. By taking a Critical Realist stance, I am supporting the view that I hold in my role as a counselling psychologist; that the participants will recall their subjective experiences as they remember them, which may alter from other’s views of that reality. This stance also means that the study accepts that the researcher plays a role in the research process and will have had an impact on the research findings.

From a critical realist position there appears to be a gap in the literature concerning subjective perspectives of childhood, of people with Anorexia Nervosa, and how this may relate to their eating disorder.

Reflexivity

In line with the critical realist approach of this study (as outlined above), it is important to recognise how research is influenced by the context in which it is conducted, and also the impact of the researcher through a process of personal reflexivity. The context for this research includes its purpose to extend knowledge in the field of Counselling Psychology and its role as a Doctoral Thesis for the professional development of the researcher. In both cases it situates the research firmly in a therapeutic context that questions the medical model of care for those with mental health issues.

As an insider researcher, I clearly have personal experience related to the research aims, and pre-conceptions of the possible causes of this disorder. Having been in training as a Counselling Psychologist for five years I also have some professional experience working with those trying to recover and their carer’s. In particular, I have found myself working with mothers whose children are attempting to recover from Anorexia Nervosa. They not only wanted to find ways of supporting their child’s recovery, but they have searched for an understanding of why their child succumbed to Anorexia Nervosa.

It has been essential that, during the course of this research, I have acknowledged and reflected upon my existing thoughts, feelings and value systems related to the data. I have
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experienced the physical and emotional pain of Anorexia Nervosa, and also the frustrating ambivalence associated with recovery; the intense fear that comes with deciding you want to fight it, only to discover you cannot face the emotions that have been hidden by starvation. Throughout the planning and carrying out of this research I have been mindful that my own experiences will be playing a role in the process. I have also been aware that my on-going training as a counselling psychologist is equally significant in driving my motivation and actions. Due to the critical realist stance of this study it feels important to briefly outline some of the reflective processes that have taken place.

My own experience of Anorexia Nervosa and the many years of personal therapy that followed have led me to a personal understanding of my own illness. The combination of the vulnerabilities generated by caring but strict, demanding parenting and trauma during early adulthood led to the onset of what became a debilitating coping mechanism; a way of controlling what happened to me and in some ways who I was. Although I do not cast blame on my parents who I know were doing the best they could with the parenting knowledge, time and energy they had, I am aware that they were not able to emotionally or psychologically prepare me for the life that was to come in adulthood. Combined with the many similar stories I heard whilst on eating disorder programs and living in psychiatric hospitals, I arrived at this research with a growing belief that childhood experience plays some form of role in the development of Anorexia Nervosa.

I was also aware of the huge chasm that opened up in my life when I began to move away from the disorder and the wealth of emotion that flooded into that void. Not only did I struggle to view myself as a worthwhile person, a female with views and rights, but I found it difficult to re-establish my identity whilst contending with the overwhelming emotions, particularly fear, that came with the freedom to exist.

During the interviews and data analysis I was aware of these memories and emotions and how they may be impacting on my interpretation of the data. At all times I attempted to compare and contrast the memories of participants (rather than look for confirmation of my own experiences) and notice the variations and convergences in the experiences recalled by participants. During the analysis I made use of my scientific background to approach the data analysis as a mathematical process, looking for evidence, frequency of occurrence and
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noticing any anomalies. By pushing the emotional aspects aside at this point, it became easier to keep the participants’ voices at the forefront of the coding process.

Participants made it clear to me both during and after the interviews that my status as an insider-researcher had made it easier to volunteer for the study and also to talk openly during the interviews. Their reasons for this included a reduced fear of being judged and a sense that I, the researcher, would be able to understand more easily what they were talking about and were therefore less likely to be misrepresented.

I also received many positive comments about the manner in which the interviews were conducted and an appreciation of the openness that I showed concerning my experiences of my illness. (I had made the decision prior to commencing data collection to only mention my experiences of Anorexia Nervosa and my recovery if participants asked specific questions about it.) One participant, in particular, wrote to thank me many months after her interview, as she felt the research experience as a whole had aided her recovery, giving her hope and motivation.

Reflection on the literature review:

Literature was collected by searching for and reading studies related to Anorexia Nervosa from relevant journals such as the European Eating Disorder Review and the International Journal of Eating Disorders. Texts by significant psychologists in the field of eating disorders and material recommended by other specialists were also included. There has been no attempt to take a critical stance to the literature review, however where studies or theories have been found to be conflicting this has been highlighted, e.g. the section on gender comments on contradictory findings relating to males and females with Anorexia Nervosa.

It became clear, as I wrote the literature review, that I was not including any of my own beliefs or opinions as part of the writing, as would perhaps be expected. I have wanted to present the existing research much as I have read and received it and so it became a conscious decision on my part to present the review in an impersonal manner. Much of what I have read on Anorexia Nervosa over the past few years, although rich in theory and relevant findings, has felt clinical and distanced from the individual. I feel that this is reflected in the style of literature review I have written here. I hope this study redresses the
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balance slightly by keeping the individual at the forefront of the study, allowing their voice to drive the analysis, discussion and conclusions made.

Reflection on the interviews:

Throughout the interview process I was aware of a sense of vulnerability surrounding the participants to varying degrees. I wanted them to feel safe and in control of the interview process, however, I realised that, even with their full consent, there may be aspects within the process that may have applied control over their attendance or willingness to answer what may have been challenging questions, e.g. thoughts about not letting me, the researcher, down or not wanting to feel beaten by the past, etc.

It feels important to highlight here the intense sense of their shame I experienced whilst listening to participants talk about the criticism they experienced as children. This was a particularly strong sensation when they talked about issues relating to ‘not being good enough to belong’. With reflection I am able to recognise similar sensations from my own childhood which may have heightened my reaction to these responses. However, even after taking this into consideration, there felt a clear sense of shame and sadness associated with the participants themselves, which they were still experiencing as adults whilst recalling their childhoods.

When listening to participants talk about their experiences of parental aggression or abuse, it was difficult to sit with the sense of anxiety and insecurity that I felt in the room. I found myself feeling frustrated and even angry, during these moments; angry on behalf of the participants because they had not received what they needed, and perhaps the internalised anger of the participants themselves which they were unable to acknowledge or could not justify verbalising.

During the analysis process, the increasing awareness of the struggle participants were voicing concerning their inability to express emotion as children, made me question the scope of the interview process in terms of its ability to gain insight into the emotional experiences of participants. The majority of those taking part had struggled to express emotions vocally during childhood, which may have made it difficult for them to talk about
their emotional memories. I was aware of the intense level of emotion that I could feel in the room as we spoke, but much of this was never verbalised by participants as they talked.

I noticed over the course of the analysis process that I felt increasingly indebted to the participants. The more I listened and read their words, the more involved I became in their memories and the greater the realisation of how courageous and generous they had been to take part. It has therefore felt a huge responsibility to try and accurately reflect their voice in this work.
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Analysis

*The stories from the insiders are incomparable to the stories written about them by outsiders.*  
Epston, 1999 (pg 149)

The aim of this research is to gain insight into the childhood experiences of those who have suffered from Anorexia Nervosa, looking in particular at their experience of their families, peer group and their perception of themselves. The results are necessarily retrospective and consist of memories that participants chose to share.

Due to the large amount of material obtained from the semi-structured interviews, the process of analysis began by dividing the data into 5 main topic areas. These topic areas simply grouped related interview questions together to make the coding process more manageable. There was no intent to predict emerging themes by this division and a large overlap between topics was inevitable at this stage. Topic areas consisted of:

- Family relationships
- Adversity
- Feelings and descriptions of self as a child
- Rules during childhood
- Opinions concerning Anorexia Nervosa

The data was then coded, identifying the semantic content of the data. After this initial coding period three data-driven, emergent themes became apparent across the complete data set. These were as follows:

1. Perception of family relationships and parenting styles
2. Experiences of adversity
3. Memories of self
Collated extracts from each potential theme were considered, with further coding where necessary, leading to sub-themes for each area. After several iterations these sub-themes became the best possible fit with the coded data, for the complete data set.

Each theme looks at retrospective accounts of participant’s childhoods from a different perspective. Theme 1 concentrates on their remembered experiences of their parental relationships, in terms of how participants felt parents communicated with them and the parenting styles experienced; reporting participant’s remembered experiences of these relationships in terms of emotion, affection, control and criticism. Theme 2 looks at specific childhood experiences and how participants felt these experiences had affected them. Finally, theme 3 looks at how participants felt their childhood experiences affected their view of themselves. The three themes therefore look at recalled childhood experiences from an inter-relational perspective, as adverse external events with associated effects and from an individual internal perspective.

**Theme separation and overlap**

It is clearly apparent from the research mentioned in the literature review above that Anorexia Nervosa is associated with many different variables, e.g. self-esteem, depression, trauma, childhood rigidity, emotion regulation, to name but a few. However, there is difficulty isolating these variables due to the developmental nature of the variables, particularly over the course of childhood, and also the many associations that exist between variables.

For instance, if we look at some of the research discussing the influence of the family on Anorexia Nervosa we can see the dilemma faced by researchers in this field. Canetti (2008) found that participants with Anorexia Nervosa experienced parents as being less caring, whilst Wade et al. (2007) found parents of those with the disorder to be more controlling. Other researchers, such as Suisman et al. (2011), found associations between eating disorders and stressful life events in the family, including parental divorce and trauma. Parallel to this is the work of researchers such as Skåderud (2007) and Troop (2008), both finding shame to be a contributory factor in the development of Anorexia Nervosa. What is left unclear is whether the lack of care, over control or trauma faced in childhood is the cause of, related to or exacerbated by the shame experienced by those who have the
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disorder. Add to that the many other variables shown to be associated with Anorexia Nervosa by the vast array of research that exists and we are left in confusion.

There appear to be so many variables associated with Anorexia Nervosa, many of which often inter-relate. The associations can be observed, but the direction of these associations is harder to prove. In order to use research to guide clinical practice having a full understanding of the aetiology of Anorexia Nervosa is important and yet to be achieved. The many individual variables and associations that have been found so far by research in this area, have yet to be assembled in a form that allows us to see a clear picture of the aetiology of the disorder or develop an effective form of support for those trying to recover.

This study has been no exception to the difficulties posed by multiple variables that appear to overlap and link together. This has led to problems sorting the data obtained, leading to an unavoidable degree of overlap between the emergent themes and sub-themes of the findings. However, in this study, rather than try to separate these variables, the themes attempt to view issues from different perspectives, to give a clearer view of how participants experienced their childhoods. For example, an issue such as ‘parental child abuse’ will appear in different forms within all three main themes. Each theme looks at that parental abuse from a different perspective. Theme 1 concentrates on the remembered experiences of the parental relationship with the participant, in terms of how participants felt parents communicated with them and the parenting styles experienced. Although child abuse is not specifically discussed in Theme 1 it plays a role in this theme as it will have impacted on the participant’s experiences of their relationships with parents. However, the theme itself reports participant’s remembered experiences of these relationships in terms of emotion, affection, control and criticism. Theme 2 looks at the abuse as an experience in itself and the perceived effects felt by participants. Finally, theme 3 looks at the participant’s memories of how they perceived themselves as a child and how they felt their childhood experiences affected their view of themselves. Therefore the issue of child abuse as experienced by the participant is being represented from an inter-relational perspective, as an adverse event with its associated effects and from an individual internal perspective.

By looking at the issues discussed by participants, from the different aspects of each theme, this study seeks to represent the overall picture of how participants experienced their
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childhoods. It also looks at their perception of how those experiences affected them and their sense of identity. From a counselling psychology perspective, the variables seen to be associated with Anorexia Nervosa in other research, need to be approached from a developmental perspective; rather than looking at variables in isolation it looks at how childhood experiences may have affected the overall development of the self during childhood.

In the sections that follow, each individual theme will be represented by a thematic map and the findings from each individual theme shown, with supporting data from participants provided as evidence. Finally, an overall thematic map shows all three main themes and how they relate to Anorexia Nervosa through the concept of identity. This will then be the focus for debate in the following discussion section, making use of relevant literature from other research.

Theme 1: Perception of family relationships and parenting styles

This theme gives an overall sense of participants’ perception of the relationships that originated at home, particularly with that of the main care givers. It gives emphasis to the emotional significance of the relationships to the participants and also the perceived effect of certain behaviours, such as parenting styles. ‘Perception of family relationships and parenting styles’ was one of the largest main themes, driven in part by the emphasis of the questions in the first half of the interview. However, family and in particular parental relationship issues were regularly mentioned throughout the interview and appear to play an important part in participants’ experiences. Although there was some mention of relationships with siblings, grandparents and other relatives in the data, this theme only includes parental relationships, or another main care giver, due to the significance given to these relationships by participants, in comparison to the wider family. (Sibling relationships are, however, mentioned in theme 2 in relation to adversity and aggression.)

The four sub-themes that developed, came from data received across the entire interview for each participant and include Communication of emotion, Affection, Control and
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Criticism.

Each of the four sub-themes is discussed in turn below:

1. Communication of emotion

When reading through the data concerning emotional interaction between participants and their parents, it appeared that nearly all participants perceived there to be an underlying level of difficulty with these interactions, with some parents seeming to lack the capacity to talk on an emotional level with their child.

Jane: *I can’t even begin to imagine sitting down with my Mum and explaining how I was feeling, or my Dad. No, no, emotions weren’t discussed.*

This felt difficulty was not just on the part of parents, with some participants also noting that they in turn believed they had not learnt how to share their emotions.

Beth: *Everything just got bottled up inside me, erm, and I didn’t know that you could talk about emotional stuff.*

Some participants were clear in that they felt close to one or both parents and that their relationships were positive, but still perceived there to be a limit to their emotional communication which was hard to overcome.

Jo: *They were always very loving and supportive and now I look back I know I didn’t use them how I could have done, I never talked or shared anything with them, and I feel bad for that and I think they regret not pushing me more to talk to them.*
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Le Grange (2011) carried out a study with adolescents and their parents looking at expressed emotion and Anorexia Nervosa within family based treatment. It was found that parents of adolescents with Anorexia Nervosa tended to be ‘remarkably’ low in emotional expression. This supports the sense of difficulty described by participants in relation to the emotional communication with their parents.

Liz: *I always did things with Mum, we could talk about not really emotional stuff but I would sort of complain about something happening at school, as long as it wasn’t like really emotional she’d sort of listen…..* With my Dad, [I] *always felt like I had to talk about intellectual things….I enjoyed that but it meant that I couldn’t really talk about just what I wanted to talk about.*

For other participants, emotional expression appeared to be actively discouraged by the response of parents. Lee imitated his Dad in a demeaning voice, as he recalled his Dad’s words:

Lee: *We don’t talk about feelings, don’t, don’t be a poof…*

Sally also found that expressing emotion was met with derision and appeared to see the long term effects of this on her relationship with her parents.

Sally: *I learnt that crying wouldn’t get me any care and so I didn’t do it….. I now have issues of hugging my parents as I just think it’s all fake and I resent how I have been made to feel when things are wrong.*

Haslam et al. (2012) found that an invalidating childhood environment (one in which the child’s emotional experiences are not validated and expression of emotion may be met with punishment or neglect (Linehan, 1993)) is associated with adult eating disorder symptoms and cognitions. In the cases of Lee and Sally as quoted above, there is a sense of parents failing to respond positively to the needs of children, who want to talk about their feelings and receive a validating response.

These were not the only the negative consequences that participants felt deterred them from sharing emotions. For some it was the strength of the parents’ emotional responses, as experienced by participants, and the perceived inability of the parent to handle certain feelings, making emotional communication difficult.
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Mary: *She [Mum] can’t hide or suppress emotions and I think it almost made me more scared of doing that [sharing emotion]. I think I became quite scared of emotional extremes in any situation.*

Wendy: *I think a lot of the time you don’t know what my Dad’s feeling until he snaps….and then it’s anger, anger and upset, and it’s scary.*

Experiences relating to expression of emotion appear to have altered some participant’s confidence in managing strong emotions. Other research shows that women with eating difficulties may relate displaying emotion with negative meaning. For instance, Meyer et al. (2010) carried out research with a non-clinical sample and found that women concerned with their eating believe that displaying emotion is a sign of weakness and that emotions should be kept under control. The women in Meyer’s study also felt that others might be rejecting or damaged should they themselves display their emotion.

It appeared that many of the participants had a real need to support or at least understand their parent’s behaviour. Whilst recognising the shortcomings of a parent in terms of their emotional availability, participants also showed a need to understand why the parent was like that. There seemed to be an enormous amount of compassion and understanding towards parents.

Helen: *I don’t think she [Mum] was aware, really, of what she was doing. Her personality was such that she wasn’t aware of the effect of her behaviour on people around her.*

Helen shows an awareness and understanding here of her Mum’s difficulties and tries to justify her Mum’s abusive behaviour towards her. During the interview, Helen would talk about her Mum in an angry voice, but then switch to a more compassionate tone when explaining why her Mum behaved a certain way. Such ambivalent feelings towards parents were common amongst participants.

There was an overriding sense from the data, that most participants perceived the sharing of emotion in childhood between themselves and their parents as difficult. This was still often the case for those who reported a good and close relationship with at least one parent. Some participants appear to perceive a loving relationship with a parent, but emotion was still seen as being avoided. However, this is in stark contrast to
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other participants who describe relationships with parents that were full of derision and fear, and greatly lacking in affection.

2. Affection

Participants talked a great deal about their memories of their relationships with their parents. They were able to articulate that they felt there was a difference between ‘love’ and ‘care’ and could also remember, in most cases, what they felt they had received and what, if anything, was missing.

Jane: I think it was a case of ‘I loved my Mum deeply’. So from that place of love, yes, I felt close to her. But close as in our relationship, no, I didn’t. I felt completely unloved by her and pushed away...... if I kissed her goodnight, which I did every night, I remember just feeling that I made her feel dirty.

Jane gives an example here of a lack of emotional communication between her and her mother; she felt her mother could not communicate love or affection.

Some participants described a far more affectionate relationship with one parent than the other. Lee was close to his mother but found the relationship with his father more difficult:

Lee: Being with Mum she would....give me lots of hugs and cuddles, and talk about anything and everything..... I love my Dad hugely and I know that he loved me and I’m fully, fully aware of that, but the way he showed it was just fucking awful...

(Lee is referring to the verbal and occasionally physical abuse carried out by his Dad when he was naughty.) By talking about his father in this way, Lee gives an example of a perception of being loved whilst understanding that the parent lacks the ability to behave in a way that communicates this love to the child. This was a common feature amongst the relationships described by participants.

Going back to the early 1990’s, Humphrey (1992) found that the parents of children with Anorexia Nervosa were more affectionate, but also more neglectful (both parent) and controlling (fathers only) relative to families of children without an eating disorder. This research also went on to discuss how fathers of daughters with Anorexia Nervosa combined pseudo-affection and control (i.e. loving and controlling). Participants in this
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study give a mixed range of descriptions of the types of relationship dynamics that existed with their fathers and there was no clear pattern within the styles of relationship such as those found by Humphrey. For instance, Sally was close to her Dad:

Sally: *I was always and still am a daddy’s girl...we used to do a lot together.*

Cathy who on the one hand felt close to her parents, but also found her mother in particular quite exacting, appreciated the comfort her Dad gave when she was crying:

Cathy: *I have a particular memory of crying and my Dad coming to comfort me. I used to quite like having an argument, because cuddles were nice when we made up....*

Jane, who felt close and loved by her Dad also describes her Dad as lacking in affection.

Jane: *I wouldn’t call him cold with us as children, um, but I’m also aware that he didn’t really give affection.*

Some, of course, experienced challenging paternal relationships, such as Beth:

Beth: *My father was such a big dominant force in the family, you know, that’s all I can really remember, is what he was like and his unpredictability and his temper.....my father was just a bit of a dictator.*

Beth, along with four other participants, gave a description of a controlling and affectionless father. These descriptions support more recent research by Horesh (2015), who suggests that difficult father-daughter relationships have a direct influence on the development of and maintenance of an eating disorder.

For some participants there was an awareness that the distance felt in the relationship between them and their parent may have been generated by them as much as by their parent.

Liz: *It was always very awkward, like, we didn’t really do hugs and things like that..... but I can’t remember whether it was me not liking it or them.*

Participants appeared to want to present a clear view of their relationships with their parents. They felt it was important to discuss the love they received from their parents as well as the difficulties they experienced in the relationships.
3. Control

It is difficult to establish how issues concerning emotion relate to eating symptomology. Meyer et al. (2010) speculate that a lack of emotional control may be perceived, by those with eating difficulties, as reflecting a total lack of control. It is generally accepted that ‘control’ plays a role in the maintenance of anorexia nervosa (Hartmann et al. 2010; Frank et al. (2012); Birgegard et al., 2009). The data obtained in this study shows that participants perceive that issues surrounding control were apparent, in most cases, well before the onset of the disorder and in a variety of forms. This links to the first theme concerning parental relationships, as one way in which control was felt to be significant was in the form of a controlling parent.

Lucy: *I wasn’t allowed to do this, I wasn’t allowed to do that, I wasn’t allowed to do the other…. I wrote [my diary] in German because the one thing about having a paranoid mother is you know she reads your diary.*

Lucy gives a powerful sense of feeling controlled by her mother, even to the extent of losing control over her privacy.

Sometimes parental control through the threat of anger appears to have influenced the behaviour of participants and other family member’s.

Cathy: *He [Dad] would get very angry because he thought I should take more responsibility and Mum turned into my protector, helping me to meet his high standards before he got home from work.*

Cathy felt her father came to have increased control over both his daughter’s and wife’s behaviour through his aggression. Fathers of daughters with Anorexia Nervosa have been found to be more controlling in a number of studies (Canetti et al., 2008; Humphrey, 1992), not necessarily through aggression, but through other means, such as being over-protective, encouraging dependency and limiting freedom of choice. However, controlling figures were not seen to be confined to parents. Jo was affected by her grandmother’s behaviour:

Jo: *I spent a lot of time with my grandmother, who I now detest, and cannot stand to be around because she is a controlling, manipulating bitch if I’m honest.*

Cannetti et al. (2008) also found that grandparent parental characteristics may play a role in the development of eating disorders in granddaughters.
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Another way in which control was felt to feature during childhood was participants perceiving themselves to not have enough control over their lives. Lucy felt that her mother’s form of discipline resulted in her losing control of aspects of her life, as her mother would take away her possessions or stop activities, leaving Lucy feeling powerless.

Lucy: [I was] terrified anything could go, completely no control of anything in my life that I enjoyed.

Participants believed that these various forms of loss of control, often led to methods of seeking control in other specific areas of life.

Mary: I hated colouring in books and things where they’d already drawn for you. I wanted to do it all by myself. Erm, so I guess maybe [I was] quite controlling.

And at a later age:

Mary: I think I was quite protective and possessive over my friendships...

Many participants believed this finally led to seeking control through anorexia nervosa.

Jane: Anorexia for me was a way of coping with events at home, feeling unloved and feeling out of control.

Participants in a number of qualitative studies have described how Anorexia Nervosa has provided them with a sense of control that they felt they could not obtain in other aspects of their life (Dignon, et al. 2006; Lamoureux and Bottorff, 2005; Reid et al. 2008).

In this study, control appears to be a significant factor in participant’s lives before they perceived themselves to have symptoms of Anorexia Nervosa. That control was usually a result of their parent’s or caregiver’s parenting style, and gave participants both a sense of control being put upon them, as well as having control taken away from them. Participants voiced the opinion, that it was the feeling of being out of control that resulted in them seeking control in other areas of their lives.

4. Criticism

Some participants felt that critical parenting created difficulties for them during childhood. It was not unusual for participants to feel they had one or more critical
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parent, causing them to feel ‘not good enough’. Helen grew up with a sense of not being able to get things right at home.

Helen: [Dad was] difficult to please, nothing was ever right or good enough.” And then talks about her Mum, “I was damned if I did [try] and damned if I didn’t, really. Yvonne reflects on her Mum’s efforts to help, which unfortunately made her feel inadequate:

Yvonne: She [Mum] was always, like, erm, trying to be helpfully critical which always made me feel like it was never good enough.

To avoid criticism and a sense of deficiency, some participants remembered trying to be good all of the time.

Liz: I can’t remember a time that I was told off for not doing something....I generally think I just did everything that I was expected to do...

Sally felt that the critical stance she experienced of her family caused her to feel like she didn’t fit in, because she was always told off for doing things wrong.

Sally: Everything was seen to be perfect about my family and I often remember feeling like I didn’t fit that mould and was always wrong..... I could have tried to help with something but done it wrong and I wouldn’t be told thank you for trying but instead just told off for doing it wrong.

Shame is discussed in Theme 3, however, it feels important to highlight here the intense sense of their shame experienced by participants in association with the criticism they experienced as children. This was a particularly strong sensation when they talked about issues relating to ‘not being good enough to belong’.

Listening to the participants talk about their experiences often gave me a sense that they felt invalidated by one or other of their parents. According to Winnicott (1986), a facilitating environment is necessary for the development of self, and without it being good enough, the maturational process (in the emotional sense) weakens or wilts. Criticism appears to be one factor that made it hard for some participants to gain a sense of validation and feel that they were ‘good enough’. Mary often felt that she couldn’t do things right but now has the reassurance from her mother that she didn’t imagine the criticism. She has found this validation reassuring in adulthood.
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Mary: I often felt, erm, criticised and she [Mum] thinks now that looking back that maybe she didn’t, erm, she wasn’t encouraging enough.... She criticised us when we weren’t doing well enough.

Criticisation appears to have played a role in the lives of the majority of participants prior to the onset of symptoms of Anorexia Nervosa. This was most common as a result of critical parenting, which left participants feeling inadequate and invalidated. One of the effects for participants who perceived themselves to be overly criticised was a sense of shame, particularly when the criticism made them feel like they did not belong.

In summary, theme 1 gives voice to participant’s sense of difficulty communicating with parents on an emotional level. Whilst most participants remember feeling loved by at least one parent, this love was not always effectively communicated in the form of affection. Some parents actively discouraged emotional communication. Both controlling and critical parenting featured in responses by participants, leading them to feel at times out of control, invalidated and ‘not good enough’. A number of participants remember feeling a sense of shame due to the criticism they received.

Theme 2: Experiences of adversity

Theme 2 concentrates on the experiences of adversity discussed by participants when recalling their experiences of childhood. The findings show that many participants often felt vulnerable at home, in some cases due to the neglectful or abusive nature of parents; for others, issues such as poverty, a death in the family or frequent house moves led to a sense of insecurity. Rather than their needs being met, participants felt they had to have concern for and accommodate the needs of the parent. Some participants felt a sense of isolation as a result of this. Although love was often experienced in the home by participants, it was often co-experienced with levels of anxiety and sometimes fear. Challenges were also faced outside of the home, with bullying being a significant adverse experience for a number of participants.

To give an overview of the data, concerning the adversity experienced by the participant group, the main sources of difficulty discussed by participants are shown in the table below:
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<table>
<thead>
<tr>
<th>Source of adversity discussed during interview</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poverty</td>
<td>2</td>
</tr>
<tr>
<td>Frequent house moves</td>
<td>1</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>3</td>
</tr>
<tr>
<td>Abuse by parent (physical or sexual)</td>
<td>7</td>
</tr>
<tr>
<td>Neglect by parent</td>
<td>1</td>
</tr>
<tr>
<td>Abuse by family friend/baby sitter</td>
<td>2</td>
</tr>
<tr>
<td>Abuse by sibling</td>
<td>3</td>
</tr>
<tr>
<td>Sexual assault by stranger</td>
<td>1</td>
</tr>
<tr>
<td>Rejection of child’s sexuality</td>
<td>1</td>
</tr>
<tr>
<td>Bullying</td>
<td>5</td>
</tr>
<tr>
<td>Death of parent during childhood</td>
<td>1</td>
</tr>
<tr>
<td>Parent with diagnosed mental health issues</td>
<td>3</td>
</tr>
</tbody>
</table>

(With 14 participants included in the study, it can be seen from the table that some participants spoke about experiencing more than one form of adversity during childhood.)

It is worth noting that a significant proportion of participants had experienced a form of child abuse during childhood from a parent, family friend or acquaintance. Others reported being witness to verbal conflict, aggression and sometimes violence between parents. For some the trauma of assault or bullying occurred outside of the home. In the majority of cases when listening to participants describe these situations, there was an overriding sense that parents were perceived to be impotent or ineffective in their attempts to help.

The theme divides into four sub-themes which look in turn at the challenges surrounding the experiences associated with having parents with mental health issues, experiencing forms of child abuse, aggression within and outside of the home, and the perceived effects of adversity felt by participants.
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1. Experiencing parents with mental health issues

Although only 3 out of 14 participants had parents with diagnosed mental health issues, over half described one of their parents as having undiagnosed difficulties or behaviours they believed indicated such a problem. Ruth, talks about her Mum’s depression:

Ruth: *I remember her being very gentle, but vulnerable and sad, erm, but also very, like, soothing and nurturing, you know, erm, but I do remember really early on her being sad.*

Whilst Cathy remembers:

Cathy: *Mum had quite severe OCD and post-natal depression, so I remember her as being quite anxious...*

These parental difficulties appeared to be significant to participants in a variety of ways. Some participants, who had parents with mental health difficulties, spoke of memories of feeling fearful and vulnerable at home. For instance, Lucy, talks about her Dad who had Asperger’s:

Lucy: *But I just remember thinking ’my Dad can’t protect me because he doesn’t know what’s real and what’s not. Instead I feel very scared.*
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When listening to Lucy, I could sense her anxiety when acknowledging that her Dad was unable to protect her. She clearly described one of the early occasions when her Dad had been unable to separate an abstract idea from reality and the fear that this invoked in her. Lucy also went on to describe how she feels her Dad’s difficulties affected her behaviour:

Lucy: *He has Asperger’s and he’s on and off had depression and social anxiety….I was quite loud in class and I could be quite disruptive, again, I wanted to be noticed…… A lot of people thought it was just me kind of looking down on them rather than, like, seeing that something was mentally wrong at home.*

Lucy wanted to be noticed, she wanted people to know that something was wrong and this resulted in a change in her behaviour.

Beth was also affected by her mother’s mental health. She felt that her understanding of size and weight had been affected by her perception of her mother’s history of Anorexia:

Beth: *My mother had Anorexia. You could say it runs in the family…. I remember saying, I couldn’t understand why I was bigger than her because she was in her thirties and I was in my teens.*

This, as with Lucy, then resulted in a change in her behaviour; in Beth’s case changing behaviour related to her relationship with her body and food. However, it was not clear in the interview with Beth whether this change of behaviour was a direct desire for people to notice her and the difficulties she was having, as it was with Lucy.

Mary describes being affected by her Mum’s anxiety:

Mary: *I was quite scared by the way that my Mum was, erm, breathing and she would… she’s quite anxious generally…..and it suddenly became something that would worry me…..I’d sort of get quite cross with her for panicking.*

Mary showed in her recollections of her mother the dichotomy that was often experienced by participants whose parents had mental health issues; an awareness of worry and concern for the parent combined with the sense of anger or fear associated with the parent not being able to parent them.
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This sense from participant’s responses of needs not being met by parents, who were perceived as struggling with difficulties of their own, is shown in an example from Helen’s interview. She felt her emotional needs went unseen because of her mother who was diagnosed with a personality disorder:

Helen: *I think sometimes my mother was so unstable, or maybe unwell herself, she wouldn’t be aware of maybe my needs,..... I just wasn’t allowed to have [emotions] or if I did dare say something, there would be a negative consequence.*

As well as struggling to have her needs met, she also often appeared to feel a high level of concern for her Mum and a desire to accommodate her needs. Helen often had to care for her Mum, leading to conflicting emotions of guilt and anger:

Helen: *I feel guilty saying so but there were parts of her that were cruel.... Her personality was such that she wasn’t aware of the effect of her behaviour on people around her.... It was normal for her to threaten that she would kill herself and I would often find her unconscious having taken too many things.*

When Helen talked about her Mum her ambivalence towards the relationship she had experienced with her became apparent. Anger would shift to sympathy and understanding, with enormous guilt for talking badly about her Mum.

The need in some participants to care for parents, shows the level of empathy and emotional sensitivity that they appear to be capable of. Beth remembers trying to protect her Dad who had depression:

Beth: *I have seen unemployment damage Dad’s self-esteem, I have been cautious not to make him feel disliked or singled out in arguments because I already know he feels quite worthless as a person.*

Although it is impossible to know from the data whether Beth’s Dad felt worthless or had low self-esteem, what is clear is that Beth felt that these were his experiences and tried to modify her behaviour and communication with her Dad to accommodate him.

The mental health of parents of a number of participants influenced their perception of security in the home, with an increase in feelings of vulnerability, anxiety and insecurity due to their parent’s difficulties. Some participants remember feeling their parent’s needs had to be put ahead of their own at times, which created a conflict for
participants who wanted to help their parent but also recognised that their own needs were being neglected.

2. **Experiencing forms of child abuse**

A wide range of childhood traumas, including sexual abuse, has been associated with a general risk of eating disorder development (Smyth et al., 2008; Steiger et al., 2010). In this study, over half of participants recall experiencing a form of child abuse during childhood from a parent, family friend or acquaintance. Beth:

Beth: *He [Dad] was quite a strict disciplinarian, erm, with the children which involved using whips to punish us, erm, and using demeaning exercises...if he thought we were being naughty.*

Helen had kept her memories of abuse secret from her family and friends until she was in treatment:

Helen: *I was able to disclose some things. It was actually stuff, I, um, I ended up being interviewed by the police for, so we’re talking of a serious nature of neglect and trauma, growing up.*

Unfortunately, some participants are still struggling with uncertainty, making it hard for them to resolve their emotional responses. Jane is in this situation concerning her father:

Jane: *When I was 21, um, I had what supposedly are memories of sexual abuse...These surfaced in response to some things that my Mum said....I’ve lived in this horrendous place of not knowing whether it did or didn’t happen.*

Difficulty in memory recall of physical or emotional trauma in early childhood is a common experience (Rothschild, 2000). Victims of trauma may be unable to address traumatic childhood events because of memory gaps that, in the past, have helped them cope (Brown et al. 1999). Jane’s discomfort was palpable when she discussed the uncertainty of not knowing whether her memories were accurate.

The following response from Lucy allows a glimpse at the emotional effects experienced by participants when coping in these environments where abuse is taking place. Here she is talking about how good it was being away from home:
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Lucy: ...knowing I wasn’t going to be yelled at for no reason at all or manipulated....even if there was no one else around, like, just knowing [laughs] that I could just breathe.

Sometimes memories of abuse in the home did not involve parents; instead siblings were recalled as the source of difficulties. The sense of isolation caused by this can be seen in the quotes from participants.

Ruth: My sister used to get angry, so she used to kind of hit me and stuff like that. That got worse when I was a teenager but I just froze and just, it was like I wasn’t there, so just lie there...

Wendy’s brother would make fun of her and if she tried to stand up for herself he would become physically aggressive.

Wendy: So he’d [brother] keep going until you snapped......I think most of the time I felt like they [parents] couldn’t help.

Often in the case of sibling abuse (or bullying) participants felt that parents were impotent or ineffective in their attempts to help. When Wendy talked about her parent’s response to her brother’s behaviour, there seemed to be a sense of futility surrounding the situation. She clearly had wanted their help but didn’t see them as being able to help.

3. Experiencing aggression

In 3 of the participants’ households there was reported to have been domestic violence. However, many other participants also reported significant conflict between parents. This ranged from subtle verbal arguments, creating a tense atmosphere, through to physical violence witnessed by participants. Liz remembers being aware of the parental conflict, even though her parents did not argue directly in front of her:

Liz: I noticed that probably from the age of nine or ten, but they weren’t sort of overt arguments. It was just atmosphere really, I guess.

In contrast, Beth recalls the unconcealed aggression of her father. She felt she lived with the fear of her father’s anger on a daily basis:

Beth: My father was a drinker and had a temper.... Everything got resolved through my father, erm, through his dictatorship and his violence and his aggression.
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Jane also recalls being aware of parental hostility, although she was not witness to it at the time. Her sense of the hostility was only validated in adulthood when her Mum disclosed the physical violence that had taken place:

Jane: Dynamics were quite, um, difficult in that my parent’s marriage was very tempestuous. It was a very unhappy marriage, very hostile….which was very hard for my sisters and I. She’s [Mum] told me since he was physically violent to her because he would accuse her of, um, seeing other men.

Yvonne talked about the root of her anxiety when witnessing her parents argue and the occasional violence that accompanied some of the arguments. Combined with the discomfort of seeing the aggression between her parents, she remembers fearing the loss of a parent which left her feeling insecure.

Yvonne: Erm, very, very volatile arguments [between parents], screaming, shouting at each other, erm, I have witnessed the occasional violence but that’s, that’s only, like, two or three times….. I was worried one of them would leave and not come back again.

Experiencing aggression in the form of bullying was also mentioned by five participants, in relation to other children at school or outside of school (a further three participants were affected by bullying from a sibling in the home as mentioned above). Lee, who was bullied for being overweight, describes school life with an expression that I experienced as disgust in his voice:

Lee: I mean it was a merciless, horrible environment school was; it was akin to torture of sorts...

He found the verbal abuse of other children to be humiliating and degrading. Yvonne who, as shown above, also experienced violence in the home, felt that how she saw herself in childhood, was affected by her experiences of being bullied by other children. This in turn affected her ability to ask for help or challenge what was being said:

Yvonne: I don’t think I talked to anyone about being bullied at the bus stop because I was ashamed about what he was saying... because I thought it was true... I started really hating myself, ‘so and so’s called me fat, so I must be ‘fat’.
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This adaptation of both internal thoughts and external behaviours were common for participants experiencing aggression from those their own age. They felt that they often adapted their behaviour to reduce the risk of bullying and also to try and fit in with their peer group. For instance, Beth recalls:

Beth: *I remember thinking I need to be friendly with certain people because, if I wasn’t, if I didn’t ingratiate myself to them then they would bully me.*

As with Yvonne, a number of those reporting experiences of bullying outside of the home were also subject to abuse, or witnesses to abuse, within the home.

Conflict and aggression were frequently experienced by many participants during childhood, ranging from actual physical violence through to a perceived atmosphere of tension. These various situations often left participants feeling fearful and anxious. For some there was an added sense of insecurity at the perceived risk of losing a parent. Aggression could also be an issue outside of the home with around a third of participants being bullied by other children, leading to feelings of humiliation and shame. Both within and outside of the home, many participants recall altering their behaviour to try and reduce the risk of aggression.

4. Experiencing the effects of adversity

As can be seen in the previous sub-themes, many challenges were reported to have been experienced by participants during their childhoods. Their sense of the impact of facing such adversities included a sense of feeling unprotected and vulnerable, accompanied by emotions including anger, anxiety and in some cases fear. For example, Jo remembers feeling anxious, with a sense of perceived potential danger generating the emotion.

*Jo: I do have memories of being laid in bed and being scared of men in the house.... And fearing the dark.*

Due to her father’s behaviour, Beth describes her home as:

*Beth: ...an unstable environment. Erm, my father, you know, was unpredictable...He just had breaking points and we didn’t know what they were...*

She felt that living in such a chaotic, abusive household had affected the way she perceived life and her whole world as a child:
Beth: *I was quite frightened by the world, by world news, erm, that used to impact on me.*

When talking to participants like Jo and Beth it felt as if the insecurity and anxiety that appeared to be generated by adversity in one setting became a more general sense of anxiety that infiltrated other areas of their lives.

During the interviews participants often talk about perceiving themselves to have been anxious or worried as a child or having others report that they were anxious at a young age. When asked, participants rarely had any sense of why this was so.

Mary did not recollect her worry directly, but recognised the emotion when she saw images of herself:

*Mary: I was quite worried but I didn’t feel worried at the time. Erm, but looking at photos and videos I constantly had a worried expression on my face...*

Wendy, talks about remembering feeling anxious whenever the family left the house together:

*Wendy: I’d just burst into tears, erm, and they’d be like ‘Why are you crying?’ I wouldn’t say....but I knew it was because I was worried that they were going to leave without me.... I thought if I left the room to go and get my shoes on and, in that instant, they were all going to go and forget that I was in the house.*

This appears to show a high level of anxiety in a young child based around a fear of abandonment. Although Wendy appears to have recognised her fear as a child, she felt unable to communicate her emotional difficulty with her parents at the time.

Yvonne is the only participant who appears to directly relate her anxiety to a physical difficulty with eating:

*Yvonne: I don’t remember the anxiety as much as my Mum tells me but I do remember I did always say I felt sick all the time.....It was a struggle to get me to school....I remember at lunchtimes not being able to eat, not being able to swallow, erm, which obviously is some kind of anxiety in my throat closing up.*

As with some other participants Yvonne does not appear to directly remember being particularly anxious, however, she has a clear recollection of nausea and difficulty swallowing. She also talked openly about her dislike of school and not wanting to
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attend, which she relates to the eating difficulty, but it is her mother that gives anxiety as the causal factor joining the two issues.

During the interviews, I was struck by the strength with which participants felt the effects of experiencing adversity influenced the way they perceived themselves. Jane spoke with what felt like great sincerity and sadness, about how her Mum had left her feeling:

Jane: I felt I was a bad person, I was unlovable, that I was dirty, um, that nobody could possibly like me if my Mum didn’t like me......

Jo also remembers the way she thought about herself at a young age:

Jo: I remember feeling my parents looking at me and thinking, ‘We wish she was better and like other girls’.... I remember feeling like the odd one out...

In this instance we cannot know what Jo’s parents felt or thought about Jo, but it is Jo’s perception of their thoughts that seemed to be causing her to feel like she was different and not good enough. Cathy also felt ‘not good enough’ as she compared herself to her sister; Cathy was hit by her parent, whereas her sister wasn’t.

Cathy: I don’t think I thought anything particular about it because it was just what happened. Although I do remember feeling like I was the ‘naughty’ child and my sister was the ‘good’ one.

Lee also felt that his perception of himself was affected by the comments and behaviour of those around him. He sums up this sense of adversity affecting self-perception, as he describes himself:

Lee: No self-esteem at all, absolutely none, erm, because eventually I think if you’re told by enough people that are close to you, that should tell you the opposite, that you are worthless of who you are, you take that upon yourself as a, as a given fact.

Participants felt there were also positive effects of adversity and it appears to be important to many participants that their struggles and survival should be seen in terms of success and appreciating what they may have learnt from their experiences. For some participants there is a sense that going through difficult events has fostered coping strategies and a resolve to survive.
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Mary feels that she has been shaped by her experiences in childhood and even though those experiences were challenging she is still able to retain a positive stance towards the effects they produced in her.

Mary: *I feel like there are certain aspects of my personality that have been shaped by those experiences which I am grateful for*...

Lucy describes the perseverance and resolve she remembers having to sustain in order to find ways to fit in with her peer group.

Lucy: *I didn’t really fit in any group and I was on my own a lot….There was no-one who said, ‘This is what you can do, this is how you can solve it,’ but I just had to keep trying things until it worked*.

Helen also appears to be able to see her negative childhood experiences as part of the process that has developed her qualities as an individual now. When she talked about this in the interview, there was a sense she needed there to be a positive outcome from all that she had been through, but that she also genuinely believed that some good had come out of her experiences.

Helen: *I suppose I see that it is because of my experiences it’s made me who I am…..It’s made me a person that doesn’t judge anybody, which has to be a positive*.

These thoughts are echoed by a memory of a conversation Lee recalls when he was talking to a friend. Lee was smiling as he recalled:

Lee: *A friend of mine once said that ‘if these things hadn’t happened to you, you wouldn’t be the person I love’; which is the one saving grace that I do have from this to be fair*.

Researchers have focused on moments of challenge and have seen them as potential opportunities for learning about the self (Mansfield et al., 2010). Many comments made by participants show this aspect of self-learning. These often included the care of children through parenting or teaching. Liz, looking from her role as a teacher describes:

Liz: *I [as a teacher] have a lot of empathy for the children that a lot of other teachers don’t*.

Sally feels that she has tried not to repeat the mistakes of her own parents:
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Sally: I think I learnt how I would deal with my own children, or more how I wouldn’t deal with things I feel that my parents did with me, that I never found helpful. Like I never felt listened to or like I wasn’t good enough.

Jane has also tried to use her own childhood experiences to guide herself as a mother:

Jane: It’s hopefully made me a better mother because I’m so aware of the damage that verbal abuse, physical abuse, um, not giving love to your children, um, not praising them, um, how damaging that is to a child.

There is a sense with these statements that participants have wanted children in their care to experience a more compassionate approach than they experienced as children. Participants have attempted to use their sense of ‘not being good enough’, ‘not being listened to’ and ‘not being loved enough’ to inform their behaviour with children in their care, in the hope that those children won’t experience the same emotional pain. As well as showing the empathy and kindness that these participants appear to be capable of, it also perhaps highlights the extent to which they themselves must have suffered, in order that these issues are of such importance to them with their own children.

When reading through the full scripts from the interviews, there is a real sense of the participants’ strength and commitment to endure. Although some of the coping strategies that were utilised by participants were destructive, their will to survive is clearly apparent.

One recollection that I found particularly poignant was from Helen, who describes a time when the fear that she often felt due to her Mum’s behaviour, was softened by the presence of a friend.

Helen: I once had her [friend] around to stay at my place and I remember we were top to toe in my bed and listening to my mother outside the bedroom door completely off her head on booze trying to say the alphabet and I remember us giggling about it.

Helen said these words with what seemed like such mixed emotion. She was smiling as she spoke, but it looked like a smile of embarrassment and her voice sounded sad rather than happy.
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Theme 3: Memories of Self

All of the sub-themes that became apparent in this third theme ‘Memories of Self’ can be directly related to issues that have been discussed in themes 1 and 2. However, this theme looks at each of the issues from the perspective of the participant in terms of their internal experiences and resultant behaviour, e.g. The second sub-theme looks again at issues surrounding emotion, which is similar to theme 1 ‘Parents and emotion’, but instead of looking at the communication of emotion within the family, this section focuses on how participants felt they experienced and managed their emotions. ‘Self-view’ is divided into four sub-themes:

1. Sensitivity

During the interviews, participants expressed a wide range of feelings towards themselves and the type of people they felt they were. These descriptions frequently held them in positions of deficiency rather than strength. For many there was a sense of being easily worried or anxious, relating this to a greater sensitivity to external conditions. Sensitivity in this context relates to participants apparent tendency to respond to emotional stimuli even when it is at a low level. A high proportion of participants made comments concerning their childhood view of themselves as being highly sensitive or easily upset by things, often comparing their level of emotional reaction to that of others. Tina gives an example of this, comparing herself to her sister, saying:

Tina: *I suffer more than most others from nerves and embarrassment...... I recognise that I am unusually sensitive to emotion as my sister did not feel the same distress.*
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Mary felt that her sensitivity to emotion could leave her feeling easily overwhelmed by strong emotions.

Mary: *I think both emotionally, any emotional extremes always scared me.*

Recent research on emotional sensitivity (a tendency to orient, discriminate, and respond to emotionally relevant stimuli at a low threshold), shows that individuals with Anorexia Nervosa, as with the participants in this study, tended to be more sensitive to emotion, and to also have higher levels of emotional contagion (be easily affected by the emotions of others) (Harrison et al., 2010; Davies et al., 2011). Ruth recognises how affected she felt by others:

Ruth: *I think I've always been really shy and...really over sensitive. I remember just always being very affected by things socially and by other people.*

Wiesbuch et al. (2010) connects this increased emotion contagion to eating habits, finding that young women who were likely to experience emotion contagion were especially likely to exhibit unhealthy eating attitudes in response to an emotionally negative family environment.

Like Ruth above, other participants link a sense of being shy or timid to their sensitivity. Jane jumps from talking about her shyness to her perception of herself as a sensitive child:

Jane: *I think I was quite timid, I think I was quite shy...I was a very sensitive child.*

However, there is no clarity concerning the reason for this link. Participants did not seem to differentiate between these characteristics and it was unclear as to whether they felt the sensitivity may have been connected to or been a cause of the shyness.

Participants felt that a consequence of their sensitivity was expressed in the form of increased worrying and anxiety during childhood. Helen remembers worrying a great deal when she was younger:

Helen: *All I kind of remember is being a child that worried excessively....worry about what was going to happen next, what was going to be around the corner next time.*

Wendy shows in this statement that not only did she perceive herself to be easily worried, but she remembers others around her also being aware and noticing her reaction:
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Wendy: They [parents] knew generally that I was a bit of a worrier and would get upset reasonably easily.

Overall, many participants saw themselves as being highly sensitive and easily affected by the emotion of those around them. They felt this often left them feeling overwhelmed by emotion, and worried or anxious about life generally. Previous research shows that individuals with Anorexia Nervosa make greater use of behaviours surrounding food to avoid and control overwhelming negative emotions (Dignon et al., 2006; Wildes et al. 2010; Federici & Kaplan, 2008 and Serpell et al., 1999).

2. Managing emotion

During the analysis for this study, it became clear that difficulties in the understanding and expression of emotion were felt to be important aspects of participant’s lives when remembering childhood experiences. Direct statements relating to the significance of emotion were frequently given, as well as references to emotional issues within other answers. Although two interview questions asked participants directly about the expression of emotion, much of the data related to this theme came from other parts of the interview.

Difficulties surrounding the expression of emotion were commonly reported by the majority of participants, in different forms and with different levels of awareness. For instance, Yvonne is aware of her loss of ability to feel excitement but is unaware when or how this occurred:

Yvonne: At some point though, I don’t know, I have repressed excitement, which I’m not sure where that comes from.

Jane relates her changes in behaviour to her inability to express how she felt about things:

Jane: I was doing things, using behaviours that were extremely damaging to me and to my family, but I didn’t know how to verbalise what I was feeling. And I think that’s really important.

The area of emotional expression broke down into three main ideas; participants’ reasoning for wanting to repress their emotions, how they chose to repress them and
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how they chose to express emotions. Looking first at their reasons for emotional repression, participants remember responding to their parents’ reaction to emotion. Sally describes how her perception of her parents’ reaction to her tears deterred her from crying:

Sally: *I would hide my feeling and emotions as I grew up from the age of about 10 I would say. It wasn’t worth being told I didn’t have the right to cry as ‘it’s not that bad’.*

Jane, describing her departure on a school trip, remembers her Mum directly telling her not to cry:

Jane: *I was told very strongly by my mother that I mustn’t cry. I wasn’t to cry….. There was no affection. I was told not to cry.*

Some participants also remember wanting to avoid embarrassment or a negative reactions from others, as well as the sense of disturbance they felt within themselves, all of which were felt to be caused by showing emotions. Embarrassment often played a key role in this process.

Wendy: *Erm, it felt wrong [to share emotions]. I was embarrassed that say they knew the reason I was upset that they’d think that was a silly reason to be upset.*

Jo: *I was almost embarrassed about showing excitement or enjoyment or anything like that.*

Beth preferred to avoid expressing negative emotions around others, as she felt it led to feelings of failure or weakness. Her inability to understand her own feelings appear to have compounded her discomfort.

Beth: *I felt like I was a failure, erm, if I talked about things I wasn’t sure about or talked about my insecurities……I may not have known what I was feeling. I may just have felt it and been disturbed. I used to get quite disturbed by my feelings but I just don’t think I understood them.*

As participants felt a need to repress emotions, it makes sense that they appear to have been resourceful as children in finding ways to avoid expressing emotion through distraction and avoidance. These avoidance strategies covered a wide range. Lee acknowledged that he used laughter to cover up his true feelings when with his friends.
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Lee: *I think comedy becomes a mechanism to cope with the fact you’re not happy, erm, so you just carry on making jokes at your mates...*

Jane bravely admitted, with obvious embarrassment and shame, that she used to lie to avoid openly expressing her unhappiness and worries. By lying she felt she was able to bring attention to herself at a time when she felt unable to ask for the help she needed.

Jane: *If I could make something up, I didn’t actually have to feel anything....I told some pretty bad lies....they were made up, but they were not lies in that they were drawing attention to some pretty horrible stuff that was going on at home.*

Some participants appear to have learnt to predict and manipulate the likely emotions they would experience, for instance Yvonne managed her expectations to avoid disappointment:

Yvonne: *So I was always expecting the worst to happen......I’d expect it to be not that good and then be pleasantly surprised when it’s good or just have my expectations met if it wasn’t that good.*

As well as finding ways to repress unwanted emotions, participants also appeared to be creative at finding alternative ways to express emotions when they felt they needed to. Techniques participants found constructive included diary writing, music, films and reading. Some created imaginary worlds for themselves.

Yvonne: *My Mum would be the person that I would talk to if I was upset, erm, if I was happy I’d probably express that to Mum, my friends, write in my diary, wrote, yeah, wrote everything in my diary.*

Diary writing features for a number of participants, as a way of safely talking through feelings and venting stronger emotions.

Tina: *I kept a diary and religiously documented my thoughts.....the diary writing stopped about age fifteen but it definitely helped me to vent my anger.*

Helen also kept a diary which gives her an insight into how she felt as a child:

Helen: *I kept a diary since I was about nine, and reading it I obviously do have a little bit of feeling about me. I was probably a very frustrated, unhappy, deeply unhappy soul.*
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Besides diary writing, the use of creative outlets in the form of music, film and books are shown to have played a part in the lives of participants.

Jo: *We watched a lot of films, which have become a big part of my life and how I work through feelings and emotions to get through to the other side....... I still watch these films as a safety, if I’m feeling anxious in anyway, I use them to feel safe...*

Ruth: *If I was upset....I’d listen to music, I’d read books....I didn’t talk to people.... I played out a lot of things through books.*

Jane remembers finding music particularly useful and continues to do so:

Jane: *Listening to sad music was a way of getting in touch with my feelings... I used to love to write and I still do and that’s a huge release for me.*

Lucy took this creative strategy in a different direction through the use of her imagination. She remembers creating a whole world where she felt more comfortable existing:

Lucy: *I had a complete imaginary community, erm, with different families and different people...I’d just live in that when I wasn’t at school...Somewhere they cared.*

Yeah, it was like where I wanted to be.

In each of these cases, it appears that where participants were unable to express their emotions verbally they looked for and found an outlet, using different creative mechanisms.

What are usually perceived as destructive behavioural strategies for coping with emotions were also mentioned by participants, prior to the onset of eating disordered symptoms. These included self-harm, such as cutting and other violent or damaging behaviour towards self or others. Beth gives an example of how she dealt with her feelings through self-punishment.

Beth: *Hurting things that were part of me or which are related to being part of my family. It was just my way of dealing with my emotions.*

These destructive forms of expression were not always physical; for some it was their use of verbal behaviour that they felt allowed them to express emotion. Mary tries to explain this by recalling how she would become argumentative over unimportant things, unrelated to the actual emotional triggers she was struggling with.
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Mary: I suppressed quite a lot and then I think often it would come out in arguments over very trivial things....other things that I felt like I had a rational reason to be upset.

Over the course of the interviews, it became clear that all the participants were aware of themselves as ‘emotional beings’ during childhood. They were all able to remember and acknowledge their emotions, even though they had frequently found it hard to express or understand them clearly at the time. They also felt able to consider others’ emotions and empathise with others, particularly their parents. At times it appears that these qualities have perhaps been too effective and left participants, in childhood, feeling overwhelmed and incapable of dealing with the levels of emotion they faced.

3. Shame

Research looking into the issue of shame in respect to eating disorders has shown that there is a link between eating disordered behaviour and shame (Saftner et al., 1995; Troop et al., 2008; Skårderud, 2007); in particular external shame is related to Anorexia Nervosa (Gupta et al., 2008). Memories of feeling shame were prevalent throughout the different sections of the interviews. Shame was experienced by participants who felt, for various reasons, not ‘good enough’. Lucy recalls the sense of not being good enough to be trusted:

Lucy: If I went out at night, I wasn’t allowed a house key....so quite often, like, you’re stuck in the garden because you can’t get in but it was more important that I didn’t lose the key than I didn’t sleep in the garden.

Whilst talking about aspects of their childhoods connected to not feeling good enough, some participants looked embarrassed. This was most apparent in the interview with Helen, who had experienced years of childhood abuse and had come to view herself as worthless as a result. Although the word shame was rarely used in any of the interviews, it was implied in what was said and the felt existence of it was most apparent.

Helen: I never had a sense that I deserved an existence..... I could do nothing or be nothing that would be acceptable.
Shame (in the form of an intense negative perception of self, and a perception of having what others will find unattractive (Oluyori, 2013)) was reported to have been experienced by the majority of participants during childhood. This often took the form of memories of feeling different from others and therefore not belonging.

Jo: *I can remember wanting to be like others I thought were ‘more popular’ and better than I was. I can’t remember hating myself as such, but I can remember wishing I was different – physically and mentally.*

Ruth: *I felt ashamed if, because, I had quite a hard time socially and my younger sister had loads of friends and I always felt quite ashamed of that….. I just remember really wanting to fit in.*

Beth and Lucy both felt that their sense of being different existed, not just in friendship groups, but within their families.

Beth: *Erm, I felt very different to my family. I felt like I didn’t belong.*

Lucy: *I feel like an extrovert in a family of introverts…*

Unfortunately, this sense of feeling different appears to have lead on to further negative experiences for participants, such as loneliness and anxiety.

Helen: *There was a deep sense at school of alienation…. I somehow became a person that was different and not great to be around.*

Wendy: *I think I was a bit anxious and embarrassed, erm, because I knew I wasn’t like other people.*

When reflecting on childhood memories and the desire to belong, participants reported resultant changes in behaviour to gain approval, hide characteristics and avoid displeasing others. Amongst the different behavioural strategies recalled by participants, was ‘people-pleasing’, either by doing what others wanted or avoiding doing what others did not want.

Beth: *I was a groupie to the popular girls and I used to do anything that they asked me to do because… I could cope with the idea they might want me around because I was useful to them.*

Wendy: *I never [paused] tried to do anything for someone to make them like me or anything like that, it was more just I tried to not do certain things to make them not like me…*
These ‘people-pleasing’ behaviours sometimes appear to have manifested themselves in ways in which participants would prevent aspects of their character’s showing through to others. For instance, Tina was aware of only showing certain emotions to people outside of the family:

Tina: I think people who know me (excluding family) would still call me happy-go-lucky but this is definitely a front I put on to please others.

And Wendy remembers preferring to conceal her more forthright characteristics in order to please others:

Wendy: ...I did have this side of me that was quite large and outspoken, but I kept it back just in case they wouldn’t like it...

During the interviews, it was noticeable that participants felt able to rationalise and explain how external influences had had an effect on the way they saw themselves as children. Lee had been greatly disturbed by the words of a teacher who he felt had undermined his sense of self.

Lee: One of my earlier teachers said I should be a road sweeper....that still makes me angry now...

He had found this to be a degrading experience, which diminished his self-view and made him feel ashamed of himself. As an adult he still carries anger concerning this interaction. There is a real sense when reading through some of the interviews that participant’s external worlds had greatly influenced their internal sense of self.

4. Physical Self

During the interviews, there were surprisingly few references made by participants concerning fat and weight with regard to appearance. In fact, only three reported being concerned about being overweight prior to the onset of Anorexia Nervosa, Lee being the most clearly concerned. Having been overweight for much of his childhood, resulting in bullying at school, he remembers making a conscious decision to control his weight:

Lee: But at one point I decided that I wasn’t going to be fat and I wasn’t going to be stupid and I was just going to push and push and push and I know that was a really big influence...
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However, other aspects of appearance were mentioned more frequently, often in relation to bullying. Some participants felt that the negative comments of others in their peer group, relating to appearance had altered their perceptions of themselves.

Tina: *I was bullied for my appearance for a number of years....I started to dislike the way I looked in my late teens even though I was not overweight.*

Yvonne also remembers comments that she feels clearly affected the way she felt about herself:

Yvonne: *One of my friends said I didn’t have good enough legs for a skirt, erm,...just things like most teenagers go through, but that obviously affected me a lot more.*

It was not just the comments from friends or peer group outside of the home that participants felt affected how they saw themselves. Some felt that parental comments were also unhelpful. Beth was affected by comments made by her father and his friends:

Beth: *What I heard was that the colleagues go ‘You’re a big girl’ and my father saying, ‘Yes, isn’t she’. Now I don’t know if that’s a true memory or not but it impacted on me and I felt this again, this sort of humiliation came across me, erm, you know that I was fat.*

Participants’ views of themselves did not stand in isolation from the rest of the world; instead they appear to be based in the context of the world around them. Issues surrounding appearance were based on participant’s views of others and how they perceived themselves in relation to them. Sally notices her fixation on size but is unable to explain the significance:

Sally: *I wasn’t always the smallest that could have affected it, like I was always second smallest in the class and dance school; but why I feel the need to be the smallest I still don’t know.*

Liz: *I remember always feeling awkward....because I was taller than everybody else as well like......fat’s the wrong word but kind of just awkward and clumsy and stuff.*

Outside influences, from the media were also mentioned by two participants as having an influence. Ruth recalls there being an emphasis on being thin in the media, however, to her this became an issue of shape:
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Ruth: ...there was a lot of kind of emphasis in the media.....it was more like just being very, very thin but still, erm, kind of having breasts.....I just remember wanting to change my proportions which was obviously impossible but I just got preoccupied...

Participants recalled the behavioural consequences of the negative feelings they experienced towards their appearance. However, some participants were able to connect certain thought sequences that they felt were significant during childhood. Firstly, Jo describes a behavioural consequence, as she recalls struggling to attend school:

Jo: I can remember not wanting to go to school at all because I hated the way I looked....comparing myself to others around me all the time and feeling very jealous of other girls around me.

Secondly, Ruth and Yvonne link their ability to change their appearances with how they felt they would see themselves. Ruth traces a sequence of thought from changing her appearance, to her being more acceptable as a person, leading to her life being better.

Ruth: I became quite fixated on this idea that, if I could [pause] look right [pause] things would be better and, like, I’d be acceptable.

Yvonne appears to have associated her ability to change her appearance with feeling better about herself because she felt able to be good at something:

Yvonne: When I decided to start changing my appearance, erm, that made me feel like I was good at something because I was exceptionally good at it.

These memories of both behavioural and cognitive links to appearance gave a sense that participants weren’t necessarily associating thinness with looking better per se, but instead prior to the onset of Anorexia Nervosa there were a variety of psychological mechanisms in place relating appearance to a sense of self and self-worth in the context of the family, peer group and society in which they were living.

In summary, the third main theme shows how participants expressed a wide range of feelings towards themselves and the type of people they felt they were. These descriptions frequently held them in positions of deficiency rather than strength. For many there was a sense of being easily worried or anxious, relating this to a greater sensitivity to external conditions. Not only did participants feel that family relations played a role in how they saw
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themselves, but many also felt that their relationships within peer groups were also significant. There is a real sense when reading through some of the interviews that participant’s external worlds had greatly influenced their internal sense of self, including relating issues of appearance to self and self-worth.

Both during the interviews and throughout the analysis process the questions concerning self and identity have emerged as an underlying issue for all the participants involved. Experiences in childhood appear to have disrupted participants’ sense of who they are, and during recovery they have had to address this. The discussion below looks at how the three main themes may connect to this issue of identity and the significance this may have to the development of and recovery from of Anorexia Nervosa.
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Discussion

“Anorexia’s power is so treacherous, so insidious in fact, that it has a young woman torture and violate themselves while it remains in the shadow of their lives stalking them.”

Epston 1999 (pg 146)

I wanted to begin this discussion with Epston’s quote, as it eloquently describes the strength of the force with which Anorexia Nervosa appears to control the behaviour of those who experience it. His portrayal of the disorder seems to externalise the power and influence of Anorexia Nervosa, as if it ‘happens’ to someone rather than being a consequence of the person’s own self. From a therapeutic perspective, Epston’s approach allows a person to form a new narrative of themselves as part of the recovery process. The image, he offers, of ‘external power and influence’, mirrors a significant issue found within the analysis of this study; that of the external forces that may have driven the disorder for the participants. These forces appear to be the varied challenging experiences of childhood, which in turn may have led to internal issues relating to their perception of themselves.

The following discussion looks at the issues outlined in the analysis, in the context of relevant past research. The primary aim of the discussion is to allow the participants’ voices to be heard by concentrating the discussion on the experiences that were most commonly discussed by participants during the interviews. These include the emotional communication, control and criticism they experienced with parents; the adversity they faced; their perceived sensitivity to emotion and the shame they experienced; issues related to their peers; and their view of themselves in terms of personality and appearance.

The secondary aim of the discussion, is to show how these issues may be linked to their self-view and identity; a concept that appears to flow beneath the surface of all three themes. By showing a connection between the childhood experiences discussed by participants and identity issues, it may be possible to more fully understand the role in which identity has long been said to play in Anorexia Nervosa (for instance, Bruch 1982; Weaver et al. 2005). The final aim of the discussion is to reflect in the findings of the study and look at the possible implications for counselling psychology and therapeutic practice in general.
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The discussion is summarised by the diagram below. *(For a full thematic map please see Appendix 4)*

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**Discussion of the issues identified in the main themes:**

As can be seen from the analysis, a number of issues emerged from the data that were significant to the participants when recalling their childhoods. These included parental and emotional concerns, adversity and trauma and how participants perceived themselves prior to the time they recognise as being the onset of their symptoms.

**Emotional communication**

Analysis within Theme 1, showed that some participants felt their parents did not have the ability to talk easily with them as children about emotional issues, such as their own or their child’s feelings. Many participants recalled that during childhood they needed and desired greater emotional communication with their parents. In some cases parents appear to have actively discouraged emotional expression or deterred their children from discussing things by failing to safely manage their own emotional response. The issues of emotional expression and communication between parents and children have been discussed in a number of studies (Le Grange, 2011; Humphrey, 1992; Canetti et al., 2008) all of which give an emerging view of difficulty in emotional communication within families where a child has or goes on to have eating difficulties. This implies that there may be detrimental
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consequences associated with an environment lacking in emotional communication or validation (Winnicott, 1986), which may result in eating disordered behaviour (Haslam, 2012; Linehan, 1993; Meyer et al., 2010).

Participants appeared keen to point out to me, that whilst there were difficulties in emotional communication with parents, there was often still some form of affection shown to them. It seems important to recognise that love and affection may have been present whilst validating parenting was seemingly deficient in other ways. Humphrey’s (1992) research reported similar findings, with parents of children with Anorexia being more affectionate and also more neglectful or controlling.

Control and criticism

Psychological theories of Anorexia Nervosa suggest that a need for control in the person’s life as a key precipitating and maintaining factor for the disorder (Fairburn et al., 2003). Issues surrounding control featured regularly in the analysis for this study, with participants perceiving matters concerning control to be apparent long before the onset of Anorexia Nervosa. Participants often reported feeling out of control during their childhoods, which they felt led them to seek control in specific areas of their lives. Some participants were even explicit that their eating disorder was a means of communication and control. These findings are in line with previous studies relating control and eating disorders (Humphrey, 1992; Canetti et al. 2008). A study by Malson (1998) found that for participants the thin body symbolised self-control because by controlling weight and food the person with Anorexia Nervosa felt in control of their life.

One way by which participants felt parents had exerted control was through criticism. The interviews showed that it was not unusual for participants to have one or more critical parent causing them to feel ‘not good enough’, giving them reason to adapt and control their behaviour as a result. Research suggests that families of individuals with Anorexia Nervosa are more prone to being over-involved, hostile, critical, and invalidating of an individual’s emotional needs than families of individuals without eating disorders (Polivy & Herman, 2002). As the need for control is often intrinsically linked to a person’s sense of self (Duker and Slade, 2004), it is possible that these kinds of invalidating responses can
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affect how individuals with Anorexia Nervosa respond to and experience themselves (Haynos and Fruzzetti, 2011).

According to Winnicott (1986), a facilitating environment is necessary for the development of self, and without it being ‘good enough’ the maturational process (in the emotional sense) weakens. Theme 1 showed that participants in this study, frequently recalled experiencing emotionally invalidating environments, where deficiencies in emotional communication, and issues of control and criticism existed (by varying degrees). Yardley and Honess, (1987) put emphasis upon the adequacy of the caretaking environment with respect to rendering intelligible and acceptable the fragile emerging self of the child, in order that the individual may be firmly and happily anchored in a positive experience of self. This allows speculation that the family environments experienced by participants may have contributed to difficulties in a positive sense of self.

Adversity

The analysis of Theme 2 discussed the adversity participants recall experiencing during childhood. A qualitative study by Loth et al. (2009), found that challenging times usually preceded the onset of eating disorders. In this present study, the difficulties recalled by participants included trauma, such as bullying, child abuse, parents with mental health difficulties, domestic violence and aggression in the home. Some participants remember often feeling vulnerable at home, without their needs being met, resulting in a sense of isolation. They also felt there to be a sense that they were required to meet the needs of their parent(s) before their own.

The mental health of parents appears to have played a role in the adversity faced by some participants during childhood. There is little research available showing direct relationships between Anorexia Nervosa and parental mental health, however studies show possible relationships between eating concerns of children and borderline personality disorder, narcissistic, histrionic and psychopathic traits in parents (Steiger et al., 1996). Brunton et al. (2005) also found there to be a link between parental mental health issues and restrictive eating behaviour in children, in the form of paternal maladaptive narcissism. A family history of eating disorder emerged as a specific risk factor for eating disorders in children, in research by Machado et al. (2014). However, it is unclear in these studies as to how these
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Parental mental health difficulties were bringing about the eating concerns and restriction in children.

Unfortunately a larger than average number of people with Anorexia Nervosa, have been subjected to some form of sexual abuse. Mullen et al. (1993) found that histories of childhood sexual abuse correlate with an increased risk for a wide range of mental health problems even when allowance is made for the effects of family dysfunction. In particular, for those with eating disorders, histories of sexual abuse in childhood are obtained more frequently than would be expected in psychiatric patients (Oppenheimer et al. 1985). In a study carried out in an eating-disorder unit 50% of anorexic and bulimic patients had suffered sexual abuse (Hall et al. 1989). In England around 49,000 children were identified as needing protection from physical or sexual abuse in 2014-2015 (DfE 2015). With over 11 million children under 18 in England the average number of children identified as being abused is therefore well below 1%. In this study, as with the study by Hall et al. mentioned above, well over half of the participants reported having experienced either sexual or physical abuse, far higher than the national average.

According to participants, one of the effects resulting from the various forms of adversity experienced by participants was a sense of feeling unprotected and vulnerable, sometimes leading to memories of feeling anxious in childhood. A number of participants remembered that at times these feelings lead them to alter their behaviour to cope with their experiences. According to Machado et al. (2014), factors associated with the experience of disruptive events (such as trauma, etc.) are risk factors for general psychopathology but not necessarily risk factors for Anorexia Nervosa in particular. Their research concluded that no specific life event acted as a proximal trigger for Anorexia Nervosa. This implies that adversity may relate to psychological issues for an individual, but that the link to the aetiology of Anorexia specifically requires further thought.

Sensitivity to emotion

The analysis of Theme 3 gave emphasis to the importance of certain aspects of the how participants viewed themselves and how they felt others viewed them. The analysis showed that many participants believed themselves to be highly sensitive to emotion and easily upset.
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“I am afraid of myself: I am afraid of the feelings to which I am defencelessly delivered over to every minute.”

(Ellen West in Binswanger, 1958, pg 148)

I have included this quote from Ellen West, who talks about herself when experiencing Anorexia Nervosa. She describes the same sense of being overwhelmed by the feelings that were reported by many of the participants in this study over 50 years later. Participants appear to have been coping with strong, sometimes conflicting emotions during childhood (the love versus the fear of a parent, for instance) with inadequate means of expressing these emotions. As a result they looked for alternative means of expression.

The high levels of emotional sensitivity reported to have been experienced by many participants in this study has also been shown in other research on Anorexia Nervosa. Both increased levels of emotional sensitivity and higher levels of emotional contagion appear to be experienced by those individuals with Anorexia Nervosa. For instance, the study by Harrison et al. (2010) found that individuals with Anorexia Nervosa displayed signs showing that they may be more sensitive to emotionally relevant signals, such as social stimuli like an angry face. As discussed in the literature review, Davies et al. (2011) recorded a group of people with Anorexia Nervosa looking away from a negative film clip more frequently than a control group, suggesting a need for greater avoidance of emotion. These findings support the reported experiences of many participants in this study, who felt they were ‘over-sensitive’ as children and easily upset by events or people around them.

According to Haynos and Fruzzetti (2011), both quantitative and qualitative research studies support the hypothesis that a variety of eating-disordered behaviours function to regulate emotion; with the control of food being seen as a means of reducing distressing feelings (Dignon et al. 2006). Wildes et al. (2010) indicated that patients with Anorexia Nervosa showed levels of emotion avoidance that exceeded community controls. This was supported by findings from Federici & Kaplan (2008), Serpell et al. (1999) and Dignon et al. (2006) which all provide support for the idea that the symptoms of Anorexia Nervosa function to help individuals avoid and control overwhelming negative emotions. A small number of participants in this study remember directly relating their control of food as a means of altering how they felt or to gain a sense of control over their situation. Restriction and excessive exercising, may also function to regulate overwhelming emotional
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experiences by increasing access to positive emotional experiences (Haynos and Fruzzetti, 2011).

Interestingly, emotion regulation difficulties, recorded by those with the disorder, appear to remit when an individual recovers from Anorexia Nervosa (Harrison et al. 2010). This implies that emotion dys-regulation may either be a function of the disorder, or that it is a predisposing factor of the disorder and recovery involves the improvement of emotion regulation skills. In the case of this study, participants clearly remember feeling sensitive and emotionally vulnerable before they perceived themselves to be showing symptoms of Anorexia Nervosa. If emotion dys-regulation is a predisposing factor then it raises the question of whether those vulnerable to Anorexia Nervosa experience these difficulties due to either personality aspects, factors due to adversity or a lack of learnt emotion regulation skills? Many participants in the present study remember feeling ill equipped to manage their emotions, but also recall feeling highly sensitive and easily affected by events. They perceived it to be their personality or character which caused their response to emotion, but also recognised that increased support from others (particularly parents) in learning to express and manage emotions would have helped, particularly at times of adversity.

Personality

In this study some participants stated that they saw their sensitivity to emotion as part of their personality. As discussed briefly in the literature review, there continues to be evidence that some personality variables are related to Anorexia Nervosa (Wonderlich et al., 2005). Narcissism, in the form of narcissistic behaviours in particular, has been positively related to eating symptomology, as a means of emotion regulation (Campbell and Waller, 2010 and Waller et al., 2007). Others, such as Haynos and Fruzzetti (2011), suggest that it is exposure to pervasive invalidating responses from the social or family environment, in combination with high emotional vulnerability, which may result in emotion dys-regulation. This supports findings from Theme 1, that show that for many participants invalidation was experienced on a familial level. However Weisbuch et al. (2011), points out that the precipitating role of families in the development of eating disorders may well depend on the adolescents' susceptibility to emotion contagion. Until there is a clearer picture concerning
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the point of development of emotional sensitivity and dys-regulation it is difficult to
distinguish cause from effect.

Shame

The emotion of shame featured frequently in this study, associated with a sense of
participants feeling that they did not belong, or perceived themselves as being different to
others. A number of participants felt that they altered their behaviour as a consequence of
these feelings. Previous literature has described connections between eating disorder and
feelings of shame, as factors causing and maintaining Anorexia Nervosa; with the feelings of
inferiority and self-dislike leading to a change in thoughts and therefore behaviour
(Skårderud (2007) and Sanftner et al. (1995)). Gupta et al. (2008) who also found that
chronic shame predicted eating disorder symptoms over and above general negative
emotions. More specifically, Troop et al. (2008) found a unique association between
external shame (perception that others perceive the self as inferior) and the severity of
Anorexia Nervosa symptoms (in particular the degree of weight loss). Certain participants in
the present study reported remembering feeling concerned about how others saw them in
relation to the family or peer group. Participants that experienced others as seeing them as
being different, or not as good as them, reported going on to feel shame and anxiety.

As shame has been characterised as an emotion that is felt upon the loss of self-esteem
(Deigh, 1983), it seems unsurprising that self-esteem is also a well-researched area in
relation to eating disorders, as well as a concern for the majority of participants in the study.
Silvera et al. (1998) demonstrated an association between low self-esteem and eating
disorders. What is particularly significant to their research is that factors, such as rejection,
relating to poor self-esteem were apparent before the participants experienced eating
disorders. The experience of the participants in the present study also point towards issues
relating to low self-esteem being apparent prior to participants acknowledging eating
disordered behaviours.

Ansari and Qureshi (2013) showed a relationship between parental acceptance-rejection
and negative self-esteem. This adds evidence towards the role of parents, in terms of
acceptance and self-esteem, being significant to eating disordered behaviour. A number of
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Participants in the present study reported feeling criticised or rejected by their parents. This combined with the possible tendency to experience external shame and its effects, may explain the sense of low self-esteem discussed by some participants.

Peer group
However, it is not always within the family context that issues occur. For some participants in the study, a desire to belong within peer groups was strong and they reported that the rejection they felt resulted in significant changes in their behaviour. In general, the peer group holds significant value, particularly during adolescence, for identity development.

According to Forthun et al. (2006), the orientation toward peers that generally occurs during early adolescence is crucial for the behavioural and cognitive autonomy that emerges throughout adolescence. Seeing all that is good (or bad) about the self, reflected in the eyes of one’s friends provides a source of validation of one’s own subjective reality.

Guilfoyle (2009) represents here the view of many researchers, who consider norms in society as being produced by the circulation of discourses that define ideals about personhood; so there is a set of social rules regarding what kind of identities we can legitimately inhabit. He gives the example that enculturated persons are predisposed towards seeing a thin woman as being self-disciplined, healthy and attractive. In the case of adolescent peers, Gerner and Wilson (2005) found the belief that thinness improved popularity and acceptance; and that those who perceived themselves as having poor peer status also believed that being thinner improves friendship. This supports previous research by Tiller et al. (1997), which found that women with eating disorders also perceived themselves to have lower social support. Keel and Forney (2013) added that personality guides who adolescents select as peers, and that peers form an important micro-environment that can either contribute to or protect against the development of eating pathology. This exposure to peers who reinforce the cultural thin ideal through their own behaviours may contribute to the internalization of the thin ideal.

Physical appearance
When looking at references to physical appearance during the interviews, there were surprisingly few references made by participants concerning fat or weight. Some research shows that patients with Anorexia Nervosa are more concerned with eating than with
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weight or appearance, unlike those with Bulimia Nervosa (Cooper and Fairburn, 1992). However, there is little research into body satisfaction (or the importance of appearance) prior to the onset of Anorexia Nervosa, for those who go on to experience it.

In this study, comments by participants concerning appearance tended to refer to the effect of views expressed by friends or family. This relates to the findings of Troop et al. (2008) discussed above that stressed the importance of external shame and the view of others to those with Anorexia Nervosa. Participants often judged their appearance in comparison to others, with the perception that others saw them as inferior or inadequate in some way. Participants were often able to rationalise that external influences had had an effect on the way they saw themselves during childhood, but it was not clear that they had this awareness at the time.

Anorexia Nervosa and Identity

Epston and White (1992, pg 141) write about a client ‘Amy’ during her process of recovery from Anorexia Nervosa:

“She had construed her participation in activities in the subjugation of her own life as liberating activities……. The ruse was exposed, and the practices of power were unmasked. Instead of continuing to embrace these practices of the self, Amy experienced alienation in relation to them. Anorexia Nervosa no longer spoke to her of her identity.”

In this extract Amy’s destructive behaviour is described as giving her a false sense of freedom prior to treatment, but then goes on to imply that by separating Amy from these practices she was able to form a different sense of her identity. This infers a distinct relationship between behaviour and identity and allows us to consider the possibility that aspects of Anorexia Nervosa, including behavioural aspects, may be linked to issues of identity.

Hilde Bruch (1982) argued that Anorexia Nervosa is caused by the failure to develop a diverse set of identities or self-definitions. This is supported by a more recent study by Weaver et al. (2005), in which participants showed a belief that their development of Anorexia Nervosa was a result of them not knowing who they were; the implication being
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that the eating disorder becomes a means of defining oneself in the absence of a clear identity (Koski, 2008 and Maisel et al., 2004).

Anorexia Nervosa may therefore hold different meanings in terms of identity for different people and the body may be used to support these particular identities, such as self-discipline demonstrated by a thin body (Malson, 1999). Research by Eckermann (1994) involving young women with eating disorders found two conflicting aims in the constructions of their identities. The first was a quest for selfhood (the body as a project of the unique self) and the second a quest for sainthood (goodness by denying or degrading the body).

Identity has also been identified as a factor involved in recovery from Anorexia Nervosa. Bulik and Kendler (2000) carried out a case study on a client who was trying to recover from Anorexia Nervosa; she described her belief that she would have no identity if she gave up the eating disorder.

Anorexia Nervosa can be seen as the only thing the person can be good at (Maisel et al., 2004). For instance, people with Anorexia Nervosa were regarded by themselves and others as having a high level of self-discipline and control (Giles, 2006), suggesting that the eating disorder dictates one’s identity as successful or failure. This may make it more difficult to give up the disorder because it can feel like giving up an identity of being successful. There is therefore a need for individuals to find alternative ways of fulfilling this part of their identity. Matoff and Matoff (2001) and Weaver et al. (2005) both found that participants felt that increased autonomy and individuality allowed them to define their own identity, as part of the recovery process.

The participants in this study reported a broad range of experiences during childhood that they often felt influenced the way they perceived themselves and the world around them, leading them to alter their behaviour. Hogg (2006) found that contextual effects impact on identity, including parenting and early life experiences, and also the psychological implications of the situations one is in. The remainder of this discussion goes on to look at the experiences voiced by participants and consider how they may be linked to identity issues during childhood, possibly leading to an increased vulnerability to Anorexia Nervosa.
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The first main theme concentrated on family and family relationships. Participants spoke about all stages of childhood, however adolescence featured predominantly in answers during the interviews. Young adulthood is a crucial period for identity development and an unclear sense of identity has been associated with negative psychological outcomes (Bosch et al., 2012 and Samoulis et al., 2015). As children tend to remain living at home during adolescence and emerging adulthood, it is not surprising that there is a significant amount of research looking at parenting styles and the connection to identity formation.

A number of researchers give insight into connections between parenting style and identity, with a consistent pattern of results emerging (Dunkel et al., 2008). In brief, relevant findings include a link between diffuse-avoidant identity processing style (defined by a tendency to postpone dealing with identity issues as (Berzonsky, 1990) and intrusive psychological control or limited expressiveness within the family (Adams et al. 2006; Soenens et al. 2004). Whereas, an informational identity processing style (active searching and evaluation of identity relevant material) was associated with authoritative parenting and parents who showed interest in their adolescent children (Berzonsky et al., 2007; Berzonsky, 2004). (Note that, authoritative parenting involves legitimate control and reasonable supervision, exercised within a context of warmth and acceptance, as opposed to authoritarian parenting with little warmth and strict control (Baumrind, 1971).)

In the present study, many participants had experienced parents who were controlling and occasionally intrusive in parenting style. They also frequently spoke of difficulties in emotional communication and expression between themselves and their parents. Using the findings discussed above, it is reasonable to question whether the parental relationships experienced by participants, during childhood and adolescence, would have affected their identity processing style.

Berman et al., (2004) say that identity development is said to go through a challenging process of identity exploration so that individuals eventually reach a point of satisfactory developmental change. This process of exploration involves the assimilation and rejection of different identifications (Erikson, 1968). Dunkel et al. (2008) suggest that the diffuse-avoidant identity style may be associated with an absence of this process. Some young
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people experience a degree of identity distress during this identity exploration (Samoulis et al., 2015), particularly if there is a lack of appropriate support for a young individual.

In order for this process of identity exploration to take place, there therefore needs to be appropriate support from parents for the child’s autonomy, as without support for autonomy, rejection of identifications by the young individual becomes difficult (Berman et al., 2004). When parental support for autonomy and independence is present there is increased likelihood of an informational style of identity processing for the child (Soenens et al., 2004). Meaningful exploration was associated with emotionally supportive parenting (Forthun et al., 2006). The implication is that for people who experience a lack of emotional support at home there may be a detrimental effect on this meaningful exploration. A number of participants in this study may therefore have experienced an added challenge to the process of identity formation as they voiced memories of feeling restricted and controlled by parents.

Theme 2 concentrates on the experiences of participants related to adversity and trauma. The wealth of existing research concerning trauma and identity development suggests that trauma exposure and stressful life events may negatively affect identity development (Scott et al., 2014 and Anthis, 2002). Compas et al. (2001) also found that trauma during adolescence may also undermine the young person’s ability to cope with other stressors that are present. Some suggest that trauma exposure may promote a premature ending to identity formation causing greater identity concerns than would be developmentally expected (Dugan, 2007).

Evidence to support these theories comes from studies showing greater identity problems among adolescents exposed to violence and sexual abuse (Bailey, Moran, & Pederson, 2007; Idemudia & Makhubela, 2011). In general, this points towards trauma survivors, such as many of those in this study, as having greater difficulty in identity formation (Scott et al., 2014). According to Weeks and Pasupathi (2011), in order for adolescents and young adults to integrate negative events within their sense of selves, they need responsive listeners to support the identities they offer in this process (Weeks and Pasupathi, 2011). Many of the participants in this study reported a high degree of trauma and adversity during their
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childhoods, whilst also feeling they lacked the support, in the form of responsive listeners, that they needed to cope with such adversity.

Oyserman (2007) suggests that the endorsement of one’s identities by others also matters; what is possible, what is important, what needs to be explained all come from social context. Therefore being a self requires others who endorse and reinforce one’s selfhood. So much so that people will change their behaviour to get others to view them as they view themselves (Oyserman, 2012). It is not surprising then that themes of being accepted or left behind by others, appear to be prevalent identity concerns among many early adolescents (Kroger, 2007). Initially that acceptance lies with the family, but later the peer group is essential to the process of one’s identity formation.

In both Themes 2 and 3 of this study, the importance of the peer group and challenges surrounding peer relationships can be seen. In particular, participants discuss issues surrounding the need to belong, and remember the sense of not being accepted by others causing significant emotional distress during their childhoods. There was a sense of ‘not being good enough’ throughout many responses during the interviews. To fit in with a social identity one must be congruent with it and therefore people act to increase similarity to particular social identities (Oyserman, 2012). This is in accordance with participants in this study who remember altering their behaviour to please others, when trying to gain a sense of acceptance.

“because you’ve spent your whole life pleasing others that you lose your identity....” Jane McLean and Pasupathi (2012) and Schwatz (2008) and stress the importance of social contexts, such as peer groups, for individuals who are in the process of ‘trying out’ identities such as self-views.

Identity may refer to how a person is socially regarded and therefore the cultures, or family environment in question may say whether that regard is positive or negative, making the person feel pride or shame (Horowitz, 2012). Feelings of shame and a lack of self-esteem have been shown to be common features in the lives of participants in this study, prior to the perceived onset of Anorexia Nervosa. These were frequently linked to perceived negative peer group experiences, as well as family dynamic challenges. It is possible that
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the identity issues, generated by various family and social relationships, are connected to the sense of shame and low self-esteem experienced by the majority of participants.

Within Theme 3, aspects of personality and emotional sensitivity were discussed by participants, with some participants describing themselves as having personalities that were over anxious or sensitive. According to Lounsbury et al. (2007), an individual’s sense of identity has multiple connections to personality traits. In fact, Costa and McCrae (1994) state that personality traits are important contributors to identity formations and may serve as expressions of identity. Van Lieshout & Haselager (1994) and Berger (2001) discuss the issue of cause and effect, they concluded that identity issues emerge primarily in adolescence, whereas personality traits have been reliably recorded for children as young as age 3; therefore surmising that personality traits precede a sense of identity.

If personality plays a contributory role in identity formation, it might also explain the role of personality in the development of Anorexia Nervosa through its influence on identity. Participant’s often viewed their personality as a contributing factor in their difficulties during childhood, including their sensitivity to emotion, which they felt may have increased their susceptibility to Anorexia Nervosa.

In summary, Lam (2005) places responsibility for identity formation firmly within the family, stating that a cohesive and well-functioning family environment, including involved and supportive parents, is associated with a positive and coherent sense of self and identity. Looking both at the analysis of this study and the other relevant research discussed above, it appears that those who have experienced Anorexia Nervosa may have experienced growing up in various challenging environments, often lacking in emotional expression or validation, and which did not fully facilitate the freedom of autonomy that allows an individual to develop an informational identity processing style. This in turn may have prevented them from establishing a positive and coherent sense of self.

Looking specifically at the experiences of the participants in this study, a number of identity related issues can be identified. Firstly, the lack of emotional communication and expression within many participants’ families, as well as the controlling and intrusive nature of some parents, may have reduced participants’ ability to effectively develop their sense of self and cope with the distress often experienced during identity development. Secondly,
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the trauma and abuse experienced by some participants may have affected identity formation, particularly when emotional support was unavailable. Thirdly, some participants experienced difficulties within their peer groups making development of social identities challenging and leading to a negative self-view.

Oyserman (2012) describes how identity influences what people are motivated to do; motivating behaviour in both positive and self-undermining or even self-destructive ways, depending on their situation and self-perception. That being the case the construction of a clear sense of identity (a good sense of self) will have implications on an individual’s choices and behaviour. Likewise, a deficient sense of identity may have a detrimental effect on behaviour. In order to gain a clearer view of the aetiology of Anorexia Nervosa and its associated eating disordered behaviours it seems important to gain further insight into identity issues prior to the onset of symptoms, for those who go on to develop Anorexia Nervosa. With greater understanding we may find ways of both reducing the risk of developing the disorder and improve the quality of care and recovery for those who succumb Anorexia Nervosa.

Implications for practice and further questions

“I took ‘suffering’ to be the designated ‘problem’. And by doing so, ‘suffering’ more or less becomes everyone’s problem.”

Epston, 1999 (pg 140)

Although this quote from Epston relates to the care of chronic physical illness, it also feels applicable to those of us who work with clients recovering from Anorexia Nervosa. It is easy to be blind-sided by the physical aspects we are presented with, but it is the underlying psychological suffering of the individual that impacts them, those who are close to them and their therapists in turn.

Counselling psychology as a discipline aims to use research to improve the insight and understanding of therapists working with clients. The findings of this research are one small step towards a fuller understanding of Anorexia Nervosa and therefore an opportunity to improve the effectiveness of treatment. More traditional treatment models for Anorexia Nervosa include re-feeding programs, with the expectation of a consistent change of behaviour for the individual leading to weight maintenance. Research shows that present
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treatment models, that also often involve family interventions, are still proving relatively ineffective, with recovery rates around a third and drop-out rates from treatment being between 20 and 50% (Gowers et al., 2007; Wallier et al. 2009). Long-term behaviour change in those trying to recover from Anorexia Nervosa appears to be difficult to establish. A qualitative study by Malson et al. (2004) showed that participants felt professionals concentrated on the eating disorder rather than the person experiencing it.

A discourse based on pathology, that focuses solely on eating disorder symptoms and behaviours rather than including contextual factors, can contribute to identity concerns (Koski, 2008). If during the process of recovery individuals are treated for their behaviours alone, they may come to understand the eating disorder as an individual illness and solely a problem from within themselves, potentially leading to an identity encompassed by the eating disorder and resistant to change.

Oyserman (2012) allows us to rationalise and understand the disinclination to change behaviour by relating identity to motivation and therefore resulting behaviour. Whilst someone with Anorexia Nervosa maintains the sense of identity intrinsically linked to the development of the disorder, they will be motivated to maintain associated eating disordered behaviours. Re-feeding is contrary to the immediate motivations and will therefore be resisted due to the discomfort and loss that must be endured for change to take place (Harmon-Jones, 2000). Whichever identities come to mind in the moment and whichever behaviours are easily linked to them are the ones a person will pursue (Higgins, 1998). This means that for behaviour to change motivations need to alter, and therefore identity development would need to take place.

As a Counselling Psychologist, this leads me to the conclusion that just altering behaviour during recovery from Anorexia Nervosa (either eating behaviours, or social behaviours in the family) may not be enough. Individuals will perhaps need the space, support and encouragement to identify issues of identity that may take them right back to their earlier years when the process of identity formation normally begins.

Taking the findings of this study and relevant existing literature, we can see that there are a number of ways in which findings can guide the way in which therapists work with those recovering from Anorexia Nervosa. Participants felt their childhood experiences had
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Influenced the way they perceived themselves and the world around them. In particular, they often spoke of controlling and occasionally intrusive parenting, as well as difficulties in emotional communication. Parenting styles such as these have been linked to identity development issues (Dunkel et al., 2008) and, in turn, an unclear sense of identity has been associated with negative psychological outcomes (Bosch et al., 2012). Therefore, when working with clients with Anorexia Nervosa, it would seem likely that therapists may need to provide an environment where further identity exploration can take place, allowing for the assimilation and rejection of different identifications (Erikson, 1968) that may not have been encouraged during childhood. Clients could experience the support and validation they need to experiment with their sense of identity and autonomy.

Many participants in the study also reported a high degree of trauma and adversity during childhood, without the sense of feeling supported or listened to in a way that allowed them to cope. Trauma exposure and stressful life events may negatively affect identity development (Scott et al., 2014) by causing a premature ending to the developmental process (Dugan, 2007). Time may therefore need to be given by therapists to listening and providing validating responses to the trauma stories offered by these clients, to allow them to integrate these negative events within their sense of selves (Weeks and Pasupathi, 2011).

Finally, participants often felt they were unaccepted by others, within families or in their peer groups. This caused significant emotional distress to many participants and frequently left them feeling ‘not good enough’, shameful and with a sense of low self-esteem. Acceptance has been shown to be an essential part of identity formation (Kroger, 2007) initially within the home and, during later childhood and adolescence, within the peer group. Osyerman (2007) suggests the endorsement of one’s identity by others aids identity development. This endorsement may be able to begin within the therapeutic relationship, before attempts are made to broaden out into a wider social context.

However, the findings also identify potential difficulties that may arise within the therapeutic relationship, causing frustration for the therapist and slowing client progress. According to King and Turner, (2000), those diagnosed with eating disorders are described as uncooperative and challenging to work with in recovery and their resistance to recovery
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may lead to feelings of failure, frustration and emotional turmoil for the clinician (Ramjan, 2004).

Carl Rogers (1959) believed that humans have one basic motive, the tendency to self-actualize - i.e. to seek to survive and fulfil one's potential. However, he also recognised that a person with low self-worth (an issue for many participants in the study) may avoid challenges in life, not accept that life can be painful and unhappy at times, and will be defensive and guarded. It is these avoidant, defensive and guarded behaviours that the therapist must be actively aware of and make use of the counter-transferential responses that result. The therapist's determination to tolerate and reflect upon this countertransference will support their understanding of their client's conflicts.

The self-destructive behaviour associated with Anorexia Nervosa (and shown in the findings of this study) may be enacted in the therapeutic relationship. The high levels of anxiety, also described by participants, may be aroused in the therapist by clients, as well as a sense of feeling controlled; the therapist is likely to find themselves in the painful grip of countertransference feelings of helpless fear and anger (Hughes, 1997). Understanding the nature and origin of these intense emotions will aid the therapist in both coping with their response to clients, but also using these experiences to further the therapeutic work with the client.

It feels remiss that NICE (2004) makes recommendations for research which concentrate only on the efficacy of treatments and the validity of screening for Anorexia Nervosa, but as yet, make no mention of further research into cause or prevention of the illness. Importantly perhaps, with better understanding, we may improve support for children both within the family and in schools to reduce their vulnerability to disorders such as Anorexia Nervosa. With a clearer understanding of the extent to which identity development is significant to the aetiology of Anorexia Nervosa strategies may be put in place within childcare, education and parenting settings that encourage positive identity formation in children.

Winnicott (1986) believed that there is one particular idea that needed to be fed back into the medical practice, that care-cure is an extension of the concept of holding. What appears to be meant by this is that clinicians are able to provide a continuation (or perhaps
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the beginning) of a facilitating environment, for those in their care, which allows personal growth and the maturational process. In the context of this study the facilitating environment could allow and support the development of identities which may have been prevented or discouraged during earlier years of development.

With the above in mind, further research on the significance of identity development on the aetiology of Anorexia Nervosa is needed. Ideally larger qualitative studies that allow participants to voice their experiences of childhood, would further the exploration into the aspects of identity development most significant to increasing a child’s vulnerability to Anorexia Nervosa. There is also room for greater understanding concerning how society might be better placed to support children in their identity development, particularly for those living in challenging home environments. There is an increasing significance being given to the therapeutic relationship in the treatment of Anorexia Nervosa (Gulliksen et al. 2012 and Vrabel et al. 2015), and an understanding of the effectiveness of differing styles of therapy may be improved by further research. This in turn may provide evidence for the most efficacious way for therapists to work with those recovering from Anorexia Nervosa, providing a facilitating environment for clients who may need to further their identity development.

Strengths and Limitations

This study has a number of restrictions, due to the nature of the research and the means by which it was completed. These include limited participant numbers due to the qualitative style of research (with limited time and resources). Although the sample size for this research was of a size recommended for thematic analysis (a sample size of 12 allows for a saturation of themes (Guest et al. (2006)), the number of participants in this study invariably limits the ability to generalise findings to the wider population. The study sample was also entirely Caucasian and would not necessarily be representative of all individuals with Anorexia Nervosa, either in the UK or abroad. This is not unusual for a qualitative study, which aims at providing an in-depth study within a specific area.

Although the research was advertised on the national B-EAT website and emailed to over 400 people who had agreed to consider taking part in research supported by the B-EAT
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organisation, the uptake was low, taking over 6 months to recruit the 14 participants who took part. Possible reasons include:

- Potential participants may have felt reluctant to discuss their personal experiences. Due to the presentation of someone who has experienced Anorexia Nervosa, there is an increased risk of them having fears, such as, feeling they may be judged or criticised and feelings of shame.
- Potential participants may not have wanted to talk about (or feel they were at risk of criticising) their parents.
- The wording used in the advertising may not have sufficiently described the research, to make it accessible or appealing to take part.

Although a suitable participant sample number was achieved, the long recruitment time gives cause for concern. If the reasons above are applicable, the participants who took part may have only represented a particular portion of the population of those who have experience of Anorexia Nervosa and may have had substantially different experiences or personalities from those who felt unable to take part. It may have been beneficial to recruit participants through various therapeutic service providers, to ensure participants have a space to talk about their potential fears.

The researcher for this study has personal experience of Anorexia Nervosa. The unique perspective of an insider researcher inevitably makes a difference to the research (Costley et al., 2010). Insider researchers may be seen to lack objectivity and compromise the validity of studies, if validity corresponds to an objective world (Rooney, 2005). The insider-status of the researcher in this study would have affected the findings, due to personal experiences influencing the way in which data was heard by the researcher. The counselling psychology training and therapeutic work completed by the researcher may also have affected the analysis of the study. However, as discussed previously, the epistemological approach taken accepts that data is seen through the ‘reality’ of the researcher and the participants (Eatough and Smith, 2006). This Critical Realist stance means that the study accepts that rather than assuming data directly reflects reality, it must be interpreted in order to gain access to underlying effects and motivations (Willig, 2012). Therefore all
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researchers play a role in the research process and will have an impact on the research findings (Larkin et al., 2006).

Advantages to insider researcher include the wealth of knowledge they bring to a study that an outsider is not privy to (Tedlock, 2000). There is also evidence that it allows interviewees to talk more freely and comfortably with the researcher (Tierney, 1994). This appears to be the case in this study where participants acknowledged finding it easier to volunteer for the study due to the insider-status of the researcher, and reported feeling comfortable with the interview process.

Data was retrospective in nature and may not equate exactly with events as they occurred in reality. Flaws in retrospective accounts are well recognised, such as the effect of current mood on recall (Widom, Raphael and Du Mont, 2004). The accounts show, however, how participants remember and make sense of their experiences, which is in line with the critical realist approach of the study, giving the participants description of their reality. There has also been concern that current psychiatric disorders, in particular depression, may lead to selective recall of negative experiences and an exaggeration or misrepresentation of the presence of childhood adversity (Brewin et al., 1993). However, Brewin et al. go on to say that, based on their literature review, this is not the case, with 'patients' memories being in as much agreement with external criteria as controls', whether the criteria be siblings' memories or independent records'.

Quality concerns should be an integral and explicit part in qualitative research (Bergman and Coxon, 2005). In particular, according to Spencer et al. (2003), in order to be of good quality, qualitative research should show credibility, with findings being supported by both the data collected and resonating with other sources, such as existing research. The quality of this study was ensured by selecting an appropriate methodical approach, maintaining a rigorous analysis process whilst sorting and coding data. (Each level of the sorting process was repeated twice to ensure a consistent outcome and check that data had not been missed or wrongly allocated to a theme.) All findings were corroborated by data from the interviews to ensure that participants’ voices were accurately represented. On completion of the analysis process, the findings of the study were found to resonate with existing literature and research.
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Only data obtained during the recorded interview was included in the analysis process. Information or participants’ views voiced before or after the interviews, were omitted from the analysis, although they have been mentioned as points of discussion particularly when looking at the strengths and limitations of the study.

Prior to the interview commencing, one of the participants mentioned existing research literature that they felt linked Anorexia Nervosa with ‘abusive parenting’. She wanted to make it clear to me that she felt she had had a good childhood with loving parents, and that not all people who had had Anorexia Nervosa would have experienced abusive parenting. Comments such as these lead to speculation as to whether participant’s knowledge of findings from existing research may have affected their response to questions in this study. For instance, participants may have felt the need to make overly supportive comments about their parents if they felt their parents may have been prejudged.

The majority of participants taking part had struggled to express emotions vocally during childhood, which may have made it difficult for them to talk about their emotional memories. I was aware of the intense level of emotion that I could feel in the room as we spoke, but much of this was never verbalised by participants as they talked and could therefore not be used as part of the data within the analysis process. By using Thematic Analysis to analyse data, only the written words, as spoken by participants and transcribed verbatim, are used in the coding process; emotional communication through transference and countertransference are therefore lost. The personal account of participants is also lost, as it is not possible to retain a sense of continuity and contradiction through any one individual account (Braun and Clarke, 2006). It is also not possible to identify causal relationships. However, the nature of this research meant that the data set covered a broad range of topics, leading to a rich set of data that allowed an insight into the childhood experiences of participants who had gone on to suffer from Anorexia Nervosa.
In Conclusion

This study allowed insight into the childhood memories of those who have experience of Anorexia Nervosa. The findings showed that the majority of participants recalled challenging issues in childhood that included difficulties with emotional communication with parents; controlling, or over-involved parenting; adversities such as child abuse and bullying. These challenges often resulted in them perceiving themselves to be ‘not good enough’ or that they did not fit in, to the extent that they would try to alter themselves and their behaviour.

When the findings were discussed alongside previous research and theory, the concept of identity development featured strongly in the understanding of the role in which childhood experiences may have affected participants. The varied events such as trauma, abuse, bullying and inadequate parenting styles reported by participants, have been shown to affect identity development in children (Scott et al., 2014; Dugan, 2007; Kroger, 2007; Oyserman, 2007), which may in turn lead to negative psychological outcomes (Dunkel et al., 2008 and Bosch et al., 2012).

For therapists working with those recovering from Anorexia Nervosa, it may therefore be important to provide a facilitating environment which allows for further identity exploration as part of the therapeutic process, allowing for the assimilation and rejection of different identifications (Erikson, 1968). Time may also need to be given by therapists to listening and providing validating responses to trauma, allowing events to be integrated within a client’s sense of self (Weeks and Pasupathi, 2011).
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Appendix 1a – Interview schedule

Interview Schedule

The interview will ask you questions about your personal experience from your childhood. Some of your memories will be clearer than others, don’t worry if you cannot remember details, talk about what you can and only the details you are comfortable including.

1. Could you start by helping me get an idea about your family? Who are the different members of your family and what was home like when you were a child?

2. I’d like you to describe your parent(s) to me, from when you were a child, starting from as far back as you can remember.

3. How was your relationship with each of your parents?
   Prompt: Do you have any particular memories that would illustrate this?

4. How did you feel about yourself as a child?

5. How do you remember your parents or other people seeing you?

6. What did you do when you were emotional when you were young?
   Prompt: Do you remember what would happen when you were happy?
   Do you remember what would happen when you were upset?

7. How were good and bad behaviour dealt with in your family when you were a child?
   Prompts: Can you describe what would happen when you were successful?
   Can you describe what would happen when you were naughty?
   How did you feel about it at the time?

8. How close did you feel to your parents?
   Prompts: Were you ever apart from your parents?
   How did it feel? What did you do?

9. What were meal times like at home? Perhaps you could describe a typical meal time that you can remember, including how people behaved?

10. Are there any other aspects of your early experiences that you think might have had a negative effect on you or that you feel set you back?

11. What do you see as the possible cause of your eating disorder? Or is there something you feel may have prevented it?
   Prompt: Do you think your childhood experience had anything to do with later
experiences with food and weight?
Do you think anything else influenced this?

12. Is there any particular thing you feel you have learned from your own childhood experiences? Something you might have gained from the childhood you had?

We are going to conclude this interview soon. Are there any other comments that you would like to make, which you feel may have been missed by these questions?
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Appendix 1b – Email interview schedule

Research Questions – Section 1

These research questions are about your personal experience from your childhood. Some of your memories will be clearer than other. Don’t worry if you have difficulty remembering; write as much as you can, but only details you are comfortable including.

If you do not feel comfortable answering a question, please miss it out.

13. Could you start by helping me get an idea about your family? Who are the different members of your family and what was home like when you were a child?

14. I’d like you to describe your parent(s) to me, from when you were a child, starting from as far back as you can remember.

15. How was your relationship with each of your parents?
   *You might like to include particular memories that would illustrate this.*

If thinking about any of these questions has caused you any distress please use the participant information sheet to find numbers for support groups.

Research Questions – Section 2

As before, these research questions are about your personal experience from your childhood. Some of your memories will be clearer than other. Don’t worry if you have difficulty remembering; write as much as you can, but only details you are comfortable including.

If you do not feel comfortable answering a question, please miss it out.

1. How did you feel about yourself as a child?

2. How do you remember your parents or other people seeing you?

3. What did you do when you were emotional when you were young?
   *Do you remember what would happen when you were happy?*
   *Do you remember what would happen when you were upset?*

4. How were good and bad behaviour dealt with in your family when you were a child?
   *Can you describe what would happen when you were successful?*
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Can you describe what would happen when you were naughty?
How did you feel about it at the time?

5. How close did you feel to your parents?
Were you ever apart from your parents?
How did it feel? What did you do?

If thinking about any of these questions has caused you any distress please use the participant information sheet to find numbers for support groups.

Research questions – Section 3

As before, these research questions are about your personal experience from your childhood. Some of your memories will be clearer than other. Don’t worry if you have difficulty remembering; write as much as you can, but only details you are comfortable including.

If you do not feel comfortable answering a question, please miss it out.

1. What were meal times like at home? Perhaps you could describe a typical meal time that you can remember, including how people behaved?

2. Are there any other aspects of your early experiences that you think might have had a negative effect on you or that you feel set you back?

3. What do you see as the possible cause of your eating disorder? Or is there something you feel may have prevented it?
   Do you think your childhood experience had anything to do with later experiences with food and weight? Do you think anything else influenced this?

4. Is there any particular thing you feel you have learned from your own childhood experiences? Something you might have gained from the childhood you had?

5. This is the end of the research questions. Are there any other comments that you would like to make, which you feel may have been missed by these questions?

If thinking about any of these questions has caused you any distress please use the participant information sheet to find numbers for support groups.

Thank you so much for your time taking part in this research. If you would like I can send you a summary of the results when the work is complete (this will be in around a year’s time).
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Appendix 2 – Advert for B-eat

Construction of childhood: A thematic analysis of Anorexia Nervosa sufferer’s retrospective accounts.

Would you like to take part?

The aim of this research project is to find out about the early lives of those who have experience of Anorexia Nervosa, in particular, looking at their childhood experiences before the illness began. The research hopes to build our understanding of the experiences of those suffering with this disorder.

Participants need to be 18 years or over and speak fluent English. You need to have suffered from Anorexia Nervosa but may now be in recovery or fully recovered.

The interview will consist of open questions asking you about your childhood. For instance, you will be asked to describe your parents, how you felt about yourself as a child and about how you felt you and your parents interacted at certain times. I am hoping to interview between 10 and 15 people for this study.

You do not have to answer all the questions and you can give as little or as much detail as you wish. You may skip any questions you find difficult or distressing.

There is detailed information for you to read before consenting to take part. This can be sent to you by post or email. If you would like to contact me to discuss taking part or request information, here are my details:

Sarah Pitt: Sarah3.Pitt@live.uwe.ac.uk

I am what is sometimes called an ‘insider researcher’ in this area, as I recovered from Anorexia Nervosa myself a number of years ago.

The results of the research will be submitted to BEAT and may be published in a research journal or submitted to a research conference. No participants will be identified in any publication and the aim of publication is to improve understanding of people with anorexia and thus to improve treatment approaches.

It is up to you to decide whether or not to take part; participation is entirely voluntary and a decision not to take part will not impact on any service from BEAT you receive now or in the future.

Thank you for taking time to read this Information and for considering taking part in this study.
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Appendix 3 – Participant information and consent form

University of the West of England


Participant Information Form

Construction of childhood: A thematic analysis of Anorexia Nervosa sufferer’s retrospective accounts.

My name is Sarah Pitt and I am a student on the Doctorate in Counselling Psychology course at the University of the West of England. Research is an important element of the course, contributing to knowledge and understanding within counselling psychology. I have chosen to look at Anorexia Nervosa as my research topic and I am inviting you to take part in my research study. Before you decide whether to take part, it is important for you to understand why the research is being done and what it would involve. Please take time to read the following information carefully and discuss it with others if you wish.

Contact me (details below) if you would like to take part, if there is anything that is not clear or you would like more information. Your participation is entirely voluntary. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the research about?

The aim of this research project is to find out about the early lives of sufferers of Anorexia Nervosa, in particular, looking at their childhood experiences before the illness began. The research aims to contribute towards our understanding of the experiences of those suffering with this disorder. To take part you need to be 18 years or over and speak fluent English. You may have Anorexia Nervosa or may now be in recovery or fully recovered.

What does the research involve?

If you decide to take part in this study, you will be asked to give informed consent by signing a consent form and answering a few demographic questions. This confirms you understand the purpose of the project, what you will be asked to do, your rights as a participant and that you would like to be involved. You will then be asked to take part in a face-to-face interview, lasting around 1 hour, which will be audio recorded. The recording will then be analysed in detail. If it is difficult to meet, the interview may be conducted using email.
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The interview will consist of open questions asking you about your childhood. For instance, you will be asked to describe your parents, how you felt about yourself as a child and about how you felt you and your parents interacted at certain times. I am hoping to interview between 10 and 15 people for this study.

You do not have to answer all the questions and you can give as little or as much detail as you wish. You may skip any questions you find difficult or distressing.

Even if you consent to take part you are free to withdraw at any time during or after the interview and without giving a reason, until the data is analysed. For instance, you can stop the interview at any time. **Should you wish to withdraw please inform the researcher using the contact details below.** You will have been given a pseudonym when agreeing to take part in the research. This is a word you choose to identify your data so that your real name is not directly held with your data. You will need to quote this pseudonym word when you contact the researcher to withdraw.

**What happens to your data recording?**

The recording will be transcribed word-for-word, taking care to remove or change any details that might identify you. The analysis will then be conducted using the anonymised scripts and short quotes from this data will be used to illustrate my findings.

I will publish my findings as a dissertation; the results of the research may be submitted to BEAT for use on the research section of the website. Findings may also be published in a research journal or submitted to a research conference. A bound copy of the dissertation will be stored securely at the University of the West of England and kept indefinitely. **No participants will be identified in any publication.**

It is up to you to decide whether or not to take part; participation is entirely voluntary and a decision not to take part will not impact any service from BEAT you receive now or in the future.

All information will be treated confidentially. Recordings will only be accessible by the researcher and will be stored on my password-protected, encrypted laptop computer until approximately 6 months after the study is completed, at which point these will be destroyed. Anonymised transcripts of full interviews will also be seen by my Academic Supervisors.

**What are the benefits and risks?**

I hope that you might find it interesting to take part in this research. By completing this study I am hoping to increase understanding of the lives of people that go on to develop this eating disorder. By increasing knowledge it is also hoped clinicians will be better informed and treatment approaches may improve.
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This research topic is of a personal and sensitive nature and you may find the information or interview itself cause you distress or raise uncomfortable issues. If this is the case please seek support from any of the organisations listed here:

**BEAT** – 0845 634 1414, help@b-eat.co.uk

**Mindline** – 0808 808 0330

**ANAD** – anadhelp@anad.org

If you are receiving treatment for your eating disorder you will be asked to show this information sheet to your lead clinician and seek their agreement that participating in this study would not contradict the treatment plan you have in place.

This study has been designed to reduce any risk to you the participant (and BPS ethical guidelines have been followed). The University of the West of England has given ethical approval for the undertaking of this research. However, should you feel you have been harmed in any way by taking part, you have the right to pursue a complaint and seek resulting compensation through the University of the West of England who are acting as the research sponsor.

**Further information:**

*If you would like to take part* or you need any further information at any stage during the study you can contact me directly using the details below, or you can contact my academic supervisor, Dr Helen Malson (details below). Unfortunately, as this study is self-funded, I cannot refund any expenses.

**Researcher details:**

Sarah Pitt: Based at the University of the West of England, Professional Doctorate in Counselling Psychology Programme. I am what is sometimes called an ‘insider researcher’ in this area, since I recovered from Anorexia Nervosa myself a number of years ago.

**Contact details:** Sarah3.Pitt@live.uwe.ac.uk

*If you have any further questions, or concerns, you can contact:*
Helen Malson (supervisor), University of the West of England, Frenchay Campus, Coldharbour Lane, Bristol. BS16 1QY or Tony Ward (Director of studies) at the same address.

Remember, you do not have to take part and you may withdraw up until the point where data is analysed.

*Thank you for taking time to read this Information Sheet and for considering taking part in this study.*
Participant Consent Form

Do you give consent to taking part in this research project, looking into the early lives of sufferers of Anorexia Nervosa? Read the statements and sign at the bottom of the page if you understand and agree with each statement.

- You understand why the research is being done and what it involves.
- You understand participation is entirely voluntary and you may withdraw at any time until the data is analysed.
- You are agreeing that the information you provide can be used in this research project, including the use of direct quotes in the dissertation report and publications of this research. All names and place names will be altered to protect anonymity.
- You may make use of support contact details and the details of the researcher or supervisor if you need to, at any time during the study.
- You understand you do not have to answer all the questions and you can give as little or as much detail as you wish.
- You may skip any questions you find difficult or distressing.
- If you take part and then change your mind you can withdraw up until the data is analysed. If you wish to withdraw, you can do so without giving a reason. Please inform the researcher using the contact details on the information sheet, and quote your pseudonym.

I GIVE MY FULL CONSENT TO TAKE PART IN THIS RESEARCH

Signature: ........................................... Date: ..................................................

Name (print): ...................................... Pseudonym: .........................................
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Demographic Information

This information is used to gain an overview of the group of people who participated in this research. It will not be used to identify you personally and you do not have to complete these questions if you do not want to.

Age: ............................................
Gender: ............................................

Do you have or have you had Anorexia Nervosa? ............................................

Do you see yourself as recovered? ............................................

If yes,
   a) How long did you suffer from Anorexia? ............................................
   b) How long have you been recovered? ............................................

If no,
   a) How long have you been suffering with Anorexia? ............................................

Are you trying to recover?
The full thematic map above shows the three main themes identified during the analysis, with their relevant sub-themes outlined in the boxes above. All three main themes are seen...
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to be feeding into the concept of identity which became increasingly apparent during the writing of the discussion section. This overview of the study highlights the idea supported by existing research, that the experiences of childhood, as recalled by the participants, may have played a role in affecting their identity development.