An Interpretative Phenomenological Analysis of the participants' experience of Anorexia Nervosa and what they feel aided recovery.

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Abbreviations: Anorexia Nervosa is also referred to as Anorexia or AN

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I would like to thank the research participants who were open and honest in sharing what had been a challenging time in their lives and for giving their time so freely.

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In memory of my parents, Joan, and Fred.

Abstract

Literature Review: The reviewed literature brings together, summarises and critiques the research that is available on Anorexia Nervosa, and provides a review of the nature, quality and extent of research in relation to the topic and gaps in the current research are then highlighted.

Rationale: the aim of the research was to understand the lived experience of those who had recovered from Anorexia Nervosa and to understand what they felt had aided their recovery with the hope that this could provide valuable information to those working with individuals who are experiencing the disorder.

Recovery is defined as no longer meeting the diagnostic criteria outlined in the DSM-5-TR (2022). The participants in this study had been in recovery for over three years; this duration was selected because most research focuses on recovery within the first twelve months post-treatment, during which relapse is most common. Consequently, insights were gathered from individuals experiencing long-term recovery.

Method: The data obtained from the interviews was analysed using Interpretative Phenomenological Analysis (Smith, Larkin and Flowers, 2015; Smith and Nizza, 2022), to look at the lived experience of the participants.

Findings: The main findings of the study are that the experience of Anorexia Nervosa had taken away the participants' hope of a life without the disorder and the eventual move to recovery became possible once they were motivated to make the necessary changes. The move to recovery was subjective to the individual but was found to be possible via early diagnosis before the disorder becomes entrenched; access to psychological treatment; the establishment of a good therapeutic alliance based on mutual trust and understanding; to instill hope, that they can overcome the disorder and to be helped by the professionals whose care they were in, to envisage a life outside of

the Anorexia Nervosa, where friendships are re-established, identity is recovered and a new life can begin.

Chapter 1

1.1 Introduction

Feeding and eating disorders (ED) are classified in DSM-5-TR (Diagnostic and Statistical Manual of Mental Disorders Text Revision: American Psychiatric Association, (APA) 2022) as a disturbance of eating or eating related behaviour that is intended to control weight (Solmi, et al., 2022) and when these criteria are no longer met the individual is said to have recovered (McDonald, et al., 2021). There are six diagnostic categories of ED, and these are Pica, Rumination Disorder, Avoidant/restrictive food intake disorder (ARFID), Binge Eating Disorder (BED), Bulimia Nervosa (BN) and Anorexia Nervosa (AN). According to the National Institute for Health and Care Excellence (NICE, 2017), more than 725,000 individuals in the UK are affected by an ED and in other research this estimate rose to 1.25 million people in the UK having an eating disorder (Beat Eating Disorders (BEAT) 2021). However, this may not represent the actual figure, as many sufferers may not be referred for treatment and individuals experiencing eating difficulties often do not seek support and try to hide their symptoms (van Eeden et al., 2023).

EDs have an impact on all areas of functioning (Palmer, 2014) and are often co-morbid with other mental health presentations (Andersson et al., 2023), and whilst all the eating disorders have similarities, they are also quite distinct from each other. The focus of this research is on Anorexia Nervosa (AN). One in 250 females will experience Anorexia Nervosa and 1 in 2000 males (NICE, 2017; Tabler and Utz, 2020). Whilst mostly females are affected the rate in males is estimated to be 5-10% (Artem et al., 2019). The reason that AN was chosen as the research area was due to its resistance to clinical intervention, the potentially life altering physical complications that can occur

(Cass et.al., 2020) and its destructive nature, as the mental health presentation with the highest mortality rate (Jansingh et al., 2020). The aim of the research was to understand the lived experience of those who had experienced Anorexia Nervosa and to understand what they felt had aided their recovery with the hope that this could provide valuable information to those working with individuals who are experiencing the disorder.

Anorexia Nervosa has an onset in adolescence or early adulthood with the average age for onset being reported as 16-17 and it has been found that there is a better prognosis for those with an early onset (13-18) and that the onset of the disorder is rare before puberty or after the age of 40, (Grilo et al., 2021). The mortality rate for AN is higher for those with a lower body weight during their illness and those presenting at the age of 20-29 years (Castellini et al., 2023). The onset of the disorder is often associated with a stressful life event. Other proposed causes for the onset of Anorexia Nervosa include the need for control (Fairburn, 2015), dysfunctional families (Wallis et al., 2018) and co-morbidity in families (Berthold, et al., 2022), if a family member has AN then other family members are more likely to develop the disorder, this likelihood increases by 10% (Steinberg, 2014) and twin studies have estimated the heritability to be 56% (Artem et al., 2019). Biological contributions may also play a significant role, and it has been suggested that there is an imbalance of neurotransmitters, in particular Serotonin, in those with Anorexia (Carr, 2015). It is also thought that eating disorder behaviour reflects difficulties with assertion and the identification and attribution of feelings (Thompson et al., 2023). Biology, psychology, family, and culture are all thought to contribute although cause and effect are not clear (Steinberg, 2014).

Those with Anorexia Nervosa fall into two broad categories: Restricting type (Harada et al., 2021) where food intake is restricted or binge eating/purging type (Gilon et al., 2018) where eating takes place but then sufferers purge by vomiting or taking laxatives, diuretics, or enemas, the ratio between the two is thought to be 50/50 (Gilbert, 2014). Chewing food and then spitting it out is also used. Individuals with Anorexia Nervosa often have an intense fear of gaining weight, and a distorted body image (BI) (Navas-

León et al., 2024). Those with Anorexia do not always lose their appetite but have an increased fear of eating and when a loss of weight is achieved the individual does not then stop but continues to avoid food and lose weight (Garcia-Burgos et al., 2023). Initially dietary restriction gives a sense of control and improves self-worth; however, this sense of control is soon lost (Fairburn, 2015). In addition to a reduction in food intake many of those with AN will engage in excessive amounts of exercise to burn calories and reduce weight (Harris et al., 2024).

There is a strong relationship between self-harm and Anorexia Nervosa (Kiekens & Claes, 2020). According to Cucchi (2016), this figure is 27.3%; 50% of those who binge and purge and 17% of restrictors. Self-harm is thought to be used as a response to negative emotional states and a release of anger and frustration (Claydon et al., 2020) and those with AN are 50 times more likely to commit suicide than individuals of the same age and gender in the general population. In a meta-analysis by Amiri, et al., (2023) they looked at 52 studies to determine the prevalence of self-harm, suicidal ideation and suicide attempts in those with an eating disorder and found that the prevalence of self-harm for those with AN was 40%; the prevalence of suicide ideation was 51% and the prevalence of suicide attempts was 22%. They conclude that there is a high prevalence of non-suicidal self-injury, suicidal ideation, and suicide attempts in those with AN. Anorexia Nervosa has the highest mortality rate of any psychological disorder (up to 15%) and the likelihood of death increases with the duration of the disorder (Castellini, et al., 2023); half of the deaths are from suicide and the others are from medical complications of the disorder such as starvation, electrolyte imbalance, and heart or kidney failure (Cass et al., 2020).

Of those who require inpatient treatment up to 50% require re-hospitalisation within one year of discharge (de Rijk et al., 2024), the initial aim of hospitalisation is to restore weight, however, this is only a first step and is most often insufficient to prevent relapse. The longer-term effects of AN can be bone growth retardation (Gibson et al., 2019) osteoporosis (Mehler, 2018) and neurological damage (Whitelaw et al., 2018). Fewer

than 50% of patients recover, 33% improve but do not recover and 20% develop chronic anorexia (Stedal et al., 2022). Recovery is defined as a return to non-restrictive eating, a lack of compensatory behaviours and a BMI (Body Mass Index) above 18.5 which is considered to be the lower limit of normal body weight and in research by Jacob, (2015) they report that psychological factors are not considered when assessing if an individual no longer meets diagnostic criteria for an eating disorder, however, good mental health is reliant on more than physical functioning (Zonnevylle-Bender et al., 2024).

Research that has looked at Anorexia Nervosa and recovery has mostly done this from the perspective of considering which treatments work best, and relapse research looks mostly at those who have been out of treatment for up to twelve months (Walsh et al., 2023). However, there is limited research that has looked at the experience of AN from the viewpoint of individuals who have experienced the disorder and been in longer term recovery and therefore there is a growing call for research that looks at the experience of the illness and recovery process from the perspective of those with first-hand experience of this, and that by seeking this insight this could have the potential to improve outcomes for those in treatment and add to the body of knowledge in this area (Sala et al., 2023).

The aim of the research which was to understand the lived experience of those who had experienced Anorexia Nervosa and to understand what they felt had aided their recovery with the hope that this could provide valuable information to those working with individuals who are experiencing the disorder. Recovery for this study was defined by the participants' self-report, as having not met the diagnostic criteria for Anorexia Nervosa for more than three years. This period was chosen as relapse occurs most often in the twelve months following initial recovery (Walsh et al., 2023) and many of the follow up studies look at functioning twelve months after discharge from inpatient treatment, (Olawale, 2018) but it has been shown that relapse can and does occur after this time (Zugai et al., (2024). This is a key area to study because if we can gain a deeper understanding of the journey through Anorexia Nervosa to recovery we may identify

where additional support can be given to those still battling the illness. It has been suggested that one way in which this knowledge can be gained is to ask those who have experienced the disorder, and maintained recovery, what the experience was like for them (Signorini, 2018 & Jenkins et al., 2019).The insight gained from those who have overcome the disorder could potentially inform treatment for those who are still suffering and practitioners working in the area. It is anticipated that the findings from this study will add to the body of knowledge in this field and will offer further insight into the experience of individuals who were previously diagnosed with Anorexia Nervosa.

The thesis will now continue with a Reflexive Statement, followed by Chapter 2 Literature Review, Chapter 3 Methodology, Chapter 4 Analysis, Chapter 5 Discussion and Chapter 6 Conclusion.

1.2 Reflexive Statement

As a scientist practitioner it was important to be aware of and to adhere to the Division of Counselling Psychology Professional Practice Guidelines, regarding engaging with the participants subjectivity, inter-subjectivity, values, and beliefs. It was important to empower the participants to allow them to share their experience and to not attempt to control the narrative but to show respect for the accounts of their experience that they brought, and to work in an anti-discriminatory way that is appropriate to the pluralistic nature of society today. From a pluralistic perspective we draw upon our knowledge of the world, and as Counselling Psychologists we are open minded to differing perspectives.

Pluralism is a philosophical and ethical tradition based on the idea that there is no single perspective or truth that is universally valid. The concept of pluralism is increasingly used to indicate the rich diversity of theory and practice in the field of counselling and psychotherapy. The pluralistic framework provides a means for empirical research to

directly inform practice. A key principle of a pluralistic perspective on research is an appreciation that all ways of knowing and sources of knowledge have something to offer (McLeod, 2021).

As Counselling Psychologists, we respect and value the lived experiences of the individuals with whom we engage, and we are able to reflect on our own biases, assumptions, and values in order to determine how they might impact our research. Through critical reflection and reflexivity, we can work mutually, with diverse clients to change our personal interpretation of their reality.

The ability to engage in reflectivity and reflexivity is essential to conducting research. As a researcher it was important to be mindful about how I might influence the research process by being reflective about my role as a researcher and being reflexive about the experiences of the participants (Mortari, 2015). The utilisation of reflectivity and reflexivity are valuable in allowing engagement with the participants in a safe space without judgment (Roulston, 2016). As Counselling Psychologists, we are encouraged to use reflectivity to develop a good understanding of ourselves and our identities and to become more self-aware of how we engage with others.

It was necessary to be aware of the power dynamics that could be in play in the research process, this can be achieved via self-reflection and a collaborative approach, recognising that each participant is an individual, and to adhere to the BPS guidelines by not assuming superiority of any one way of experiencing, feeling, valuing and knowing but to respect the diversity of beliefs and values. As Counselling Psychologists, we need to be aware of diverse life experiences and challenge those who pathologise based on sexual orientation, disability, class, racial identity, and religious and spiritual views.

Counselling Psychology encourages a pluralistic approach to knowledge and practice meaning that multiple models of psychological distress can co-exist and what this

means in practice is that one approach to treatment is not considered to be appropriate for all individuals. We are encouraged to value the individuality of our clients (McLeod, 2013). This view is supported by Cooper (2021), who says we need to value our clients and be responsive to their needs. It is therefore important as a Counselling Psychologist to consider different treatment approaches and their efficacy for mental health presentations. As part of this endeavour, I looked at the research into the different treatment approaches available for those with Anorexia Nervosa, to see what promised the best outcomes, and there was no single treatment that offered superiority (Frostad, 2018). When looking at the evidence base the treatment outcomes for Anorexia Nervosa were low with less than 50% of those with the disorder recovering following treatment (Fairburn, 2015). I felt compelled to understand more about the causes and treatments for Anorexia. I reflected on the idea that the onset of the disorder, is in part, young people striving for what they perceive as an ideal body shape and weight, as portrayed in the media, and individuals denying themselves the sustenance of life to conform to media expectations of the perfect body. I wanted to understand what led to women (as this is a disorder that primarily affects women) denying themselves the sustenance of life and as a woman I was able to reflect on the expectations that are placed on females in society. I then reflected on what I had been valued for whilst a young person and one of these things was conforming to media expectations of size and shape. I was valued by society for something over which I exerted no control.

Many individuals with AN had initially been praised for weight loss, but this had then spiraled into restrictive eating. It is difficult to comprehend the self-discipline that would be required to harm oneself in this way of restriction and / or purging to maintain weight loss and subsequently this leading to a loss of the sense of self and what is ‘normal’. This led me to want to understand more about an individual's experience of AN and what they felt had helped them to overcome this debilitating illness. This was best achieved via qualitative research.

Rankl et al. (2021), suggest that reflexivity is a core component of qualitative research.

We learn about ourselves by being reflexive and this enables us to then listen to others and not be self-focused in our research endeavours. As Counselling Psychologists, we learn to ‘bracket’ our experience to ensure that our processes do not impact on the therapeutic or research space, although Corbin and Strauss (2015), argue that this is not fully achievable. Bracketing is the setting aside of one's own beliefs and a priori assumptions to avoid misrepresenting a participant’s intended meaning, perception, or experience. It is necessary for a qualitative researcher to reflect on their position in relation to the research from both a personal and professional standpoint.

Bracketing refers to the researcher's identification of personal experience, assumptions and expectations that could influence how the obtained data is viewed. These fore constructions need to be bracketed, and what is meant by this is that belief and opinion must be acknowledged and set aside, as much as possible, to allow the experience of the participants to come through in the process (Thomas and Sohn 2023). Bracketing needs to continue through the interviews and the analysis. During the analysis new insight may change our previous belief if we are open to this and one must then bracket this new learning to allow a fresh view of the next transcript. Bracketing is, therefore, our initial identification of assumptions and the continuous re-examination and revision of findings (McGrath et al., 2024).

Bracketing is an iterative, reflective process whereby we acknowledge that it is not possible to separate ourselves from our assumptions. However, as researchers we must put aside these assumptions to allow the details of the participants' experiences to be reflected in the analysis and the writing of the work. McGrath et al., (2024), identified bracketing as a way in which the researcher can separate their own experiences from what is being studied. I do not have a personal shared experience of an eating disorder but have an interest from researching and working with those that do present with an ED and in particular Anorexia Nervosa. I wanted to understand the experience of those who had previously had Anorexia Nervosa and what had aided recovery.

In practice for this study, it was necessary to understand where any bias may lie and to recognise that I must allow the experience of the individuals to come through in the analysis. To this endeavour it was important that any frustration with the low recovery rates was not allowed to influence what was drawn from the analysis. A voice memo was made after each interview to identify the effect that the process had on me as the interviewer. Equal consideration was given to all the transcripts to avoid bias in reporting. If I felt drawn to a particular transcript it was important to reflect on why this was. The transcripts would need to be revisited multiple times to ensure that what was reported was drawn from the participants' experience. Co-coding was used to avoid or identify any bias in the analysis to ensure that what was reported was representative of the participants' lived experience.

As a Counselling Psychologist I remain disappointed that recovery levels, as reported in the literature, are not higher for those with Anorexia Nervosa and that young people are still struggling with this debilitating illness. From my reflections the individual had to find something that was more important (bigger) than the Anorexia Nervosa to aid recovery. From a professional point of view, I wanted to talk to those who had recovered to see what they found had enabled them to break free of the eating disorder. From a personal perspective, I chose this area to study as my empathy was with those who had experienced this illness, potentially, to achieve what society tells them they should look like. I wanted to look at the lived experience of individuals who had previously received a diagnosis for Anorexia Nervosa, to gain an insider perspective on this experience and to ask what aided recovery.

Chapter 2 Literature Review

This chapter will provide an outline of the systematic review and search methodology, followed by a consideration of the theoretical frameworks of Developmental Psychology, the Psychodynamic perspective, and Cognitive Behavioural Theory. The proposed aetiology of Anorexia Nervosa and some of the

presentations that can be co-morbid with Anorexia Nervosa will be considered, followed by a consideration of diversity and the impact of Anorexia Nervosa on minority groups and a review of currently available treatments.

Literature Review

A literature review serves to organise and interpret significant amounts of information pertinent to the current research. The aim of the literature review is to bring together, summarise, and critically evaluate the existing literature on the research topic. This process provides a comprehensive overview of the nature, quality, and scope of research related to the topic, enabling the identification of any gaps in the available research.

The literature review will provide information on the systematic review, the literature search methodology, followed by a presentation and critique of findings.

2.1 Systematic Review

Systematic reviews need to be methodical, comprehensive, transparent, and replicable. They involve a systematic search process to locate all relevant work that addresses the research questions, the results of the review are then presented. By reviewing and presenting substantial amounts of available research on the topic, this can help to minimise subjectivity and bias. A good systematic review will use the literature reviewed to develop a new theory or evaluate an existing theory.

The review must be explicit in explaining how it was conducted, include relevant material and be reproduceable by others wishing to engage with the topic. The current research has questions that it wishes to answer, relevant literature is then identified, the quality of the work assessed will be considered, prior to summarising the evidence and reporting on the findings.

2.2 Literature search methodology

A systematic review of the literature was carried out to provide a summary of the literature that was most relevant to the research question, both qualitative and quantitative studies were included if they appeared in peer reviewed journals. Books were also researched if they were relevant.

The key questions under consideration required a search for literature on Anorexia Nervosa that looked at the theoretical frameworks of developmental psychology, the psychodynamic perspective and cognitive behavioural therapy perspective, to ask what each of these perspectives contributed to our understanding of Anorexia Nervosa. The next question to be answered was to ask what is the perceived aetiology of Anorexia Nervosa, and to look at mental health presentations and self-expressed emotions that could be co-morbid with Anorexia Nervosa. It is also important to ask which treatments have been utilised and what were the outcomes, to include recovery and relapse rates, to understand what has been available to those presenting with Anorexia Nervosa. With the overarching aim of understanding what the potential contributing factors of Anorexia Nervosa are and the recovery and relapse rates, to look for any gaps in the literature that this research can then begin to address.

The following sources were used to find relevant literature: EBSCOhost; PsychINFO; PsycARTICLES; PubMed; ScienceDirect; Ingenta Select; Wiley-Blackwell Interscience; WorldCat; Elsevier; ArticleFirst; Wiley Online Library; Cambridge University Press and Google Scholar. These databases were searched from 2014 - 2024 to look for the most recent work and were chosen for their relevance to the field of psychological research into Anorexia Nervosa. In addition to on-line resources hard copies of books and journal articles relevant to the topic were also reviewed.

The keywords and phrases used in the search were: A norexia, recovery, treatment , relapse, medical complications, interpersonal relationships, identity, suicide and self -

harm, shame, perfectionism, self-esteem, anxiety, OCD, depression, and personality disorders. References used in the most relevant studies were also gathered and explored. The studies used met criteria that supported their inclusion. The inclusion criteria looked for research that reported on the prevalence and incidence of Anorexia Nervosa to gain an understanding of the rates of the disorder in the population: Work that reported on the treatment of Anorexia Nervosa, to understand what the available treatments are and to answer the question of what the relapse rates are following treatment. The literature review looked at research that had been conducted with both adolescents and with adults. Relevant research was reviewed on medical complications, mortality rates, suicide, and self-harm in those with Anorexia Nervosa. To answer the question on co-morbidities that occur with Anorexia Nervosa, literature was reviewed that had identified co-morbidities and included depression, anxiety, obsessive compulsive disorder, shame, perfectionism, low self-esteem, and personality disorders.

The criteria for exclusion were articles that were not in English or translated into English and articles that were not on Anorexia Nervosa or research methodology.

In qualitative work generalisability is not sought. However, it does provide quality information that can then inform quantitative work, which in turn can produce information that can be generalised (Hollin et al., 2020). Qualitative research can add depth and therefore be complimentary to quantitative work (Sardana et al., 2023). Qualitative and quantitative research were included, provided they had appeared in a peer reviewed journal, as both have value and can support the points presented. Non-peer reviewed articles were excluded as the evidence base is less robust (Ninci, 2023).

2.3 Introduction

The questions the research will seek to answer are: what was the participants' experience of Anorexia Nervosa; and what do they believe aided their recovery from the disorder? This would fulfil the aim of the research which was to understand the

lived experience of those who had recovered from Anorexia Nervosa and to understand what they felt had aided their recovery, with the hope that this could provide valuable information to those working with this population. For this study recovery was defined by the participants' self-report, as not having met diagnostic criteria for the disorder for over three years. This period was chosen as relapse occurs most often in the twelve months following initial recovery (Walsh et al., 2023). Many of the follow up studies look at functioning twelve months after discharge from inpatient treatment, (Olawale, 2018) but it has been shown that relapse can and does occur after this time (Zugai et al., (2024). To do this it is first necessary to understand the disorder.

The reviewed literature will consider theoretical perspectives, the aetiology of AN, an understanding of co-morbidity, as AN rarely exists in a vacuum, and a review of available treatments and outcomes. This will be followed by a consideration of recovery and relapse rates. It is necessary to gain this understanding, as having this knowledge, will enable engagement in the research process and a fuller understanding of the disorder prior to engagement with the current data and the task of understanding the journey through Anorexia for the research participants.

2.4 Theoretical Framework

Many theorists suggest a multidimensional risk perspective when considering the aetiology of an eating disorder (Stice et al., 2019). Considering this, the research will consider the theoretical perspectives of Developmental Psychopathology, Psychodynamic Theory, and the Cognitive and Behavioural Theoretical approach. The reason for considering these theoretical perspectives is that when treating those with AN it becomes apparent that there is not one defined cause (Vilhem et al., 2021), and these perspectives each offer an explanation as to the aetiology of AN and can contribute to an understanding of the development of this disorder. By looking at these perspectives, the interplay between risk factors that each theory suggests will be considered and the similarities as well as differences between theories, supporting the

idea of the multidimensional risk perspective (Stice et al., 2019).

The multidimensional risk perspective shares many of the principles of the Developmental Psychopathology Theory. The similarity is that the multiple risk factors for AN unfold over the course of the early lifespan and into adolescence, this is supported by the Developmental Theory (Moreno_Encinas et al., 2020). This theoretical approach is well supported and considers the interplay between genetics, the environment, and the family on the development of AN (Papini et al., 2024). A genetic predisposition is considered to be present, and this is triggered by the environment. Research into Anorexia has looked at the potential contribution that these developmental risk factors have played and whilst a genetic link has been proposed no specific gene has been identified. Similarly, dysfunction is often found in the families of those with Anorexia Nervosa (Rousseau, et al., 2022) but an atypical family has not been highlighted. So, whilst multiple risks are present exactly what these would look like is yet to be defined.

From a Psychodynamic Perspective it is argued that disturbed mother child interactions lead to serious ego deficiencies, leading to a sense of having no control or independence. This in turn leads to disordered eating. It is suggested that the mother has not attended to the needs of the child in an appropriate manner, offering food when comfort is required or comfort when food is required (Mirabella, et al., 2023). The child may grow up being unaware of their own emotional needs and unable to identify emotions, including those of hunger. Because the child is unable to interpret internal emotions, they then model the behaviours of other adults, not knowing their own needs. Those with AN rely on the opinions of others (Treasure and Cardi, 2017), they experience themselves as not being in control of their behaviour, needs, impulses, and not being in control of their own bodies. It is suggested that ineffective parenting leads the child to improperly label their internal sensations and needs, and they feel that they have little independence or control over their lives and take control of their eating. This distortion leads to a poor body image seeing themselves as fat even when the evidence is contrary

to this, and they then judge themselves on their shape and weight (Mitchell and Peterson, 2020).

This perspective fits well with our understanding of Anorexia Nervosa. The lack of control that the theory reports is evident in the literature and during treatment with those with AN. This need to control is then transferred to control of food when life feels out of their control. The lack of parental attention is not necessarily intentional, which starts to explain why within the Developmental Perspective the atypical dysfunctional family has not been defined (Rousseau, et al., 2022) and within the Psychodynamic perspective this is seen as needs not being met, (Treasure and Cardi, 2017), which provides a wider perspective on what this could entail, as need is not defined as a singular concept, but could be subjective to the individual.

Within the Psychodynamic perspective the difficulty in correctly identifying internal needs and emotions leading to dysfunctional behaviour corresponds with the Cognitive Behavioural perspective, where the interplay between, thoughts, emotions, physical and behavioural response, are seen to interact and can lead to dysfunction (Kennerley, Kirk and Westbrook, 2016). Distorted cognition is not necessarily the cause of Anorexia but can be a consequence (Klein and Attia, 2019). The ideas put forward by Treasure and Cardi, (2017) regarding the Psychodynamic perspective are compatible with the Cognitive and Behavioural perspective in that the perceived ineffective parenting can lead to distortions in cognition and dysfunctional behaviour.

Within the CBT perspective it is noted that it is not life events alone that affect the individual but their interpretation of them. It is argued that if one can identify the cognitions that are leading to psychological distress, then a change in cognition can be achieved (Beck, 2021). This is done by challenging the unhelpful thoughts and looking for an alternative perspective. This leads to cognitive restructuring and a revised view on the difficult thoughts that have affected the individual (Beck 2020). This theoretical perspective suggests that we do not need to change the past but to challenge and change

the unhelpful cognitions that are associated with events, to alleviate the behavioural symptoms that have ensued following this negative perception (Kennerley, Kirk and Westbrook, 2016). In terms of Anorexia this could be the anxiety that is present in relation to thoughts of eating and poor body image (Frisbie, 2020). This perspective allows an understanding of why similar situations may lead to different outcomes for individuals due to differing perceptions of events. It is compatible with a developmental perspective (Rousseau, et al., 2022) as negative perception of environment or family could lead to the development of maladaptive cognitions as reported in the CBT theory and within the Psychodynamic perspective, unmet need could lead to dysfunctional behaviour.

When considering the three approaches they are in effect complementary in enabling an understanding of the multiple factors that contribute to the development of Anorexia. Namely, genetics, family, and environment (Developmental: Rousseau, et al., 2022); family and needs not being met (Psychodynamic: Treasure and Cardi, 2017); and the interpretation of life events and the consequences of this (CBT: Beck, 2020). With these important perspectives in mind the review will further consider the aetiology of AN and in each of the critiques see how the information is supportive of these theories.

2.5 Aetiology of Anorexia Nervosa

Disturbances in the serotonergic and neurotransmitter systems have been found in those with Anorexia Nervosa, and these persist after recovery (Garg et al., 2024). Serotonergic neurotransmission remains high in those who have recovered from AN suggesting that the level may have been elevated before the onset of the disorder. These higher levels could have contributed to the development of the AN. It has also been argued that due to the frequent onset of AN at the time of puberty this could indicate that rising estrogen levels and the brains sensitivity to this could be implicated in the development of Anorexia Nervosa (Maciejewska, et al., 2024). The Developmental perspective would suggest that the predisposition was present and could be exacerbated

for example by the onset of adolescence. There is also evidence for altered brain structures in those with Anorexia Nervosa (Seidel, et al., 2024) however, cause and effect are not clarified.

Impaired hypothalamic function, a deficiency in insulin and reduced levels of leptin have all been implicated as leading to reduced appetite (Bigazzi, et al., 2024). People with Anorexia Nervosa under-eat, but whether appetite is lost is debated (Ranzenhofer, 2023). There is a reduced desire to eat and a premature feeling of fullness when food is ingested. Leptin levels fall when food intake is restricted but can return to normal once feeding is reintroduced (Bigazzi, et al., 2024). Therefore, there is some evidence for the contribution of reduced biological processes leading to reduced appetite.

Anorexia Nervosa is polygenic in nature whereby the disorder is the interplay of multiple genes and environment (Mitchell and Peterson, 2020). This fits with the Developmental Perspective (Rousseau, et al., 2022). Twin studies and family studies have been carried out to look at heritability and environmental impact on the occurrence of eating disorders. The risk of developing Anorexia Nervosa was 11.4 times higher for those with a family member with Anorexia Nervosa than for the control group (Oliva et al., 2020). The concurrence of AN has been found to be higher in monozygotic twins than in dizygotic twins with an estimated heritability rate of 70% this drops to 20% for non-identical twin pairs (Oliva et al., 2020). Although family and twin studies provide evidence for a genetic contribution to the aetiology of eating disorders the level to which genes contribute is difficult to quantify as non-shared environmental effects also appear to play a substantial role in the development of eating disorders (Del Casale, et al., 2023).

In addition to the proposed contributions of genes, biological and neurotransmitter influence, there is the interplay with psychological factors to consider (Kinnaird, et al., 2023). An eating disorder is said to be a deficit of the self, and a false self emerges. Individuals are considered to have difficulty in distinguishing between psychological

and physiological aspects of desire. Hunger may symbolically remind the individual of a painful psychological event that must be controlled to prevent the individual from being overwhelmed and this restrained eating keeps feelings at bay (Giles, et al., 2024). It is argued that eating restraint reflects an unconscious need to resolve past dysfunctional interpersonal relationships and the binging and purging behaviours serve to displace repressed impulses, release tension, and regulate intolerable affects (Biçaker, et al., 2024).

Another psychological contribution to the development of Anorexia Nervosa is thought to be that of attachment style (Cassioli, et al., 2022). Early development and relationships with the primary caregivers influence later attachment styles and interpersonal relationships (Nalbant, 2020). People form internal working models of the relationships that they have with others and if the primary caregiver is receptive to the infant's needs, then this can lead to a sense of self-efficacy and self-worth. If this important relationship is uncaring and unresponsive the infant can grow up believing that they are unlovable or unworthy of love (Nalbant, 2020). It is thought that if a child has one significant other to offer them care, then functional growth can follow, without this the predisposition to the development of an eating disorder could be triggered. Mantilla et al., (2019) found that insecure attachment is associated with an eating disorder and attachment to the ED exists as a separate entity. In a study by Holmes and Slade, (2018) they found that those with an ED reported feeling less supported by parents and felt responsible for parental happiness. The importance of early attachment to the primary caregiver is supported by the Psychodynamic Theory on the development of Anorexia Nervosa (Treasure and Cardi, 2017).

Those with anorexia may experience the eating disorder as being controlling and some talk of the anorexic voice (Pugh and Waller, 2016: Chua et al., 2022). It is suggested that the more powerful the 'voice' the lower the BMI (Hampshire et al., 2020). Mantilla (2018) talks of the need to externalise the eating disorder to oppose and disobey the voice if it is present. The anorexic voice, if present, is reported to be controlling and

authoritative by those who experience it. From a CBT theoretical perspective, it is proposed that disobeying and rebelling against the 'voice' may aid recovery and challenge how the client relates to the disorder (Pugh and Waller, 2016).

As a young person moves into adolescence further pressure can be felt by the expectations placed on them by the media, where the portrayal of a thin ideal is put forward (Nawaz et al., 2024). This is also a time of growth and change both physically and psychologically as the young person moves towards adulthood and takes on an identity that is influenced by peers (Lotery et al., 2024). The pressure to conform to a thin ideal is felt at this stage and if the predisposition is present these environmental expectations could trigger the onset of the eating disorder (Wang et al., 2024). The media contribution to the onset of an eating disorder is thought to be significant (Naumann, et al 2016).

Having considered the aetiology of AN and the possible contributing factors co-morbidity will now be considered, in line with the recommendation from recent research that co-morbidities need to be considered if outcomes for those with AN are to improve (Rickerby et al., 2022).

2.6 The Co-morbidity of Illness and Self Evaluation Emotions

Berands et al., (2016) reported that it is important to consider the co-morbidities that could be present in those with AN as their contribution could hinder recovery and could help explain why relapse rates are high (estimated at 57%: Berands et al., 2016). Howard et al., (2023) built on this agreeing that it is important to consider co-morbidity existing with the eating disorder. Co-morbidity is defined as having more than one illness at the same time. In addition to the co-morbidity of illness it has been found that interpersonal problems and self-evaluation emotions (SEE) can also impact on the course of Anorexia Nervosa. A review of a selection of co-morbid mental health presentations and SEE in AN will enable understanding of how some of these co-

morbidities can contribute to the process of Anorexia Nervosa (Howard et al., 2023).

When considering co-morbidity depression has been found in those presenting with Anorexia Nervosa. Kahn et al., (2020), conducted a quantitative study with 56 adolescent females who had been admitted to hospital for AN. Depression levels were assessed at admission and one month after admission. From hospital records they found that those with a higher level of depression were later re-hospitalised and suggest that clinicians pay special attention to those with depression to facilitate remission. This is supported by Panero et al., (2021), of the 87 adult in-patients who were assessed in their study 22 had major depressive disorder. These patients required a longer in-patient stay and had a worse outcome (reported as weight restoration and limited calorie intake). They suggest that the presence of depression affects the length of hospital admission and efficacy of treatment.

One of the main co-morbidities that is found is that of anxiety (Dosal et al., 2024). There are many anxiety presentations, those that are found to have the highest co-morbidity with Anorexia Nervosa are Generalised Anxiety Disorder (GAD), (Rickerby et al., 2022), and Obsessive Compulsive Disorder (OCD), (Levinson, 2019). In a study by Lloyd et al., (2022) they suggest that anxiety is a central feature of AN and is at its highest prior to eating. In the study a lower base line anxiety score predicted a lower relapse rate after treatment. They suggest that anxiety disorders precede the onset of Anorexia Nervosa. It is suggested that anxiety responses and AN behaviour of not ingesting enough calories, are due to an irrational belief system, with dysfunctional behaviour tailored to this belief system. Avoidance of eating is then a response to avoid eating related anxiety, therefore, exposure to different foods is of benefit, and to feared food scenarios that evoke anxiety, learning how to tolerate this exposure without resorting to ritualising behaviours (Natali et al., 2024). This builds on the work by Simonazzi, et al., (2023), who conducted research with 144 participants and found food related anxiety, stemming from early aversive learning experiences, led to threat cognitions, in the psychopathology of the illness. It is argued that regular eating

alleviates the anxiety associated with eating (Sivyer et al., 2020).

Obsessive Compulsive Disorder (OCD) is often reported to co-occur and have overlapping symptomology with Anorexia Nervosa (Thomas et al., 2022). Research has looked at the co-occurrence of OCD and AN to determine if there are genetic risk factors between the two presentations (Cheng et al., 2020 and Yilmaz et al., 2020). Yilmaz et al., (2020) looked at 3,495 AN cases, 2,688 OCD cases and 18,013 controls. Whilst genome-wide significance was not reached they found a high correlation between OCD and Anorexia Nervosa. They report that their results confirm a shared genetic risk for AN and OCD. Thomas et al., (2022), looked at executive functioning difficulties in Anorexia Nervosa and OCD and found both similarities in behavioural and neuroimaging findings on set shifting, working memory, response inhibition, and response monitoring. These studies show a shared risk for the co-development of AN and OCD.

Another co-morbidity is that of personality disorder (PD). Müller et al., (2021) looked at the occurrence of Anorexia Nervosa (AN), OCD and PD and found that 25% of those with AN also had a personality disorder and 20% of those with OCD had a PD. They concluded that there is a high prevalence of cluster C personality disorders in those with AN. In a study by Kawada et al., (2023), they found the co-occurrence of PD with AN but in particular Borderline Personality Disorder (BPD), was found to be the PD that most often co-existed with the Anorexia Nervosa.

Those with Anorexia Nervosa often report problems in social interactions as seen in social anxiety (Chiu, et al., 2022) and can present as either submissive or hostile. It is argued that interpersonal difficulties with emotions or in relationships may be at the core of the difficulty and predict treatment response and the poorer the individuals interpersonal functioning the higher the rate of relapse. It has been suggested that those with AN tend to avoid conflict, competition and rivalry and put the needs of others first. Schmidt, (2018) agrees with this saying that emotions are bottled up to avoid upset or

conflict. However, the adolescent with AN will tend to dominate the family but see themselves as submissive. The wish to control life is transferred to control of eating and weight and an inflexible thinking style can be present, leading to anxiety in decision making and holding themselves to a high standard (Schmidt, 2018) leading to clinical perfectionism which in itself is problematic and high rates of this are found in those with Anorexia Nervosa (Shafran et al., 2018: Howard et al., 2023).

Perfectionism and shame, whilst not a disorder in themselves can co-exist and hinder recovery (Matos et al., 2015; Howard et al., 2023). Blythin (2020) found that research into Anorexia Nervosa often neglected emotional factors and found that shame is present in those with AN, but it is not clear if this is a cause or consequence, and the level of shame increases with the level of Anorexia Nervosa severity. Shame is a self-conscious emotion that occurs via self-reflection and fear of eliciting disgust in others (Blythin, 2020). It is suggested that those with an eating disorder view themselves as inadequate and perceive that others also view them in this way; internal shame of self and external shame of self by others (Malecki et al., 2023). A vicious cycle can develop whereby shame over body shape leads to a desire to control body image, striving for perfectionism to avoid shame and to fit in with peers, it is argued that this then develops into an eating disorder as praise is often given for weight loss in the early stages of the development of Anorexia Nervosa. Shafran et al., (2018), found it was necessary to treat the transdiagnostic constructs of shame and perfectionism to aid recovery from the eating disorder.

Howard et al., (2023) agree that it is important to consider co-morbidity existing with the eating disorder and in their study, they looked at the relationship between shame, perfectionism, and Anorexia Nervosa. They interviewed eleven participants and analysed the data using a constructivist-grounded theory methodology, they found a relationship between shame and perfectionism whereby to alleviate the feeling of shame the individual would strive for perfectionism and when this was not achieved it led to further shame. Shame could drive the AN via shame over body weight or shape and

shame over eating or not eating. The perfectionism could then be sought by being perfect at having AN. Another finding in the Howard et al., (2023) study was that early life trauma can lead to shame and the development of Anorexia Nervosa. Shame appears in DSM-V-TR (2022) as a diagnostic criterion for PTSD under persistent negative emotional states and Mares, et al., (2020) and Howard et al., (2023) found trauma was another co-morbidity that can occur alongside Anorexia Nervosa. The participants who had experienced trauma in the Howard et al., (2023) study, believed that trauma led to shame and that shame preceded their perfectionism. For those without trauma they were less clear on which had occurred first between shame, perfectionism, and the Anorexia Nervosa.

Self-esteem is the positive or negative view that someone holds about themselves. Perfectionism is thought to contribute to low self-esteem (LSE) (Rigoli and Martinelli, 2021). Those with AN often experience low self-esteem, holding a deficient view of themselves (Şenay et al., 2023). Rigoli & Martinelli, (2021) suggest that dissatisfaction with body shape and weight could lead to LSE. Monteleone et al., (2019) conducted research with 405 adolescents to look at the psychopathology and psychiatric co-morbidity of AN and concluded that LSE was prevalent in those with Anorexia Nervosa and should be treated along with any general psychiatric conditions as they contribute to the duration of the illness.

Interpersonal problems are a risk factor for AN in either the development or maintenance of the presentation. An interpersonal issue that can arise is that AN impacts on relationships with partners, it has been found that as an individual's weight lowers there is a corresponding loss of libido and this is accompanied by sexual anxiety (59.2%) (Price et al., 2020; Cassioli, et al., 2022). Cassioli, et al., (2022), found that the greater the weight loss the greater the loss of sexual function. Loss of libido and sexual anxiety lead to tensions in the relationship with two thirds of those surveyed being in a relationship without sex. The authors suggest that sexual intent should be assessed alongside the eating behaviour due to the potential impact on intimate relationships.

They suggest that libido does return with weight gain.

Finally, when considering social and interpersonal factors there is a large gap in the literature for males (Halbeisen et al., 2024), minority groups (Convertino et al., 2021) and those who are longer term recovered (Jenkins et al., 2019). Anorexia Nervosa is reported to be highest in white Western adult females however, there are some discrepancies in the literature and a growing body of research suggests that rates have increased in Asian populations and in males (Carr, et al., 2020).

Research has looked at the impact of eating disorders in diverse populations and it has been found that eating disorders affect individuals of all genders, ages, sexual orientations, ethnic, and socio-economic backgrounds. Males are an example of this as it has been found that 1 in 4 of those with an eating disorder are male (Beat, 2017), and yet Anorexia Nervosa continues to be known as a 'female' disorder, and it is argued that this association can deter males from seeking treatment. To prevent this Corcoran, Trainor, & Robinson, (2021) suggest that eating disorder treatment should not be 'skewed' towards any gender and that gender sensitive information should be available to raise awareness and reduce the stigma and isolation that is associated with males seeking treatment.

The prevalence of Anorexia Nervosa is also rising among ethnic and racial minority groups, and disparities persist in treatment seeking, and the effectiveness of treatment for those from these minority groups. Acle, et al., (2021) suggest that culturally sensitive interventions need to be implemented to address the barriers that prevent these individuals from seeking treatment. They argue that this can be achieved by working collaboratively to understand the clients from within their cultural context to understand the impact of culturally sensitive factors by being curious and exploring ethnic identity, acculturation, and family or social support. There has also been research that has looked at ways to increase the number of participants who take part in research looking at

Anorexia Nervosa from racial and ethnic minorities and that research should pro-actively explore the role of diversity in treatment (Halbeisen, Brandt, & Paslakis, 2022).

Research has shown that those from sexual and gender minorities including transgender individuals have an increased risk of developing an eating disorder when compared to heterosexuals and those who identify with their birth gender. It is thought that a contributory factor to this could be due to exposure to minority-specific stressors, such as discrimination and violence and gender minority stressors, such as gender-based victimisation and identity non-affirmation. These stressors can increase vulnerability to identity-based traumas and eating disorder behaviours can then be used as a coping mechanism. The lifetime prevalence for Anorexia Nervosa in transgender individuals is 1.7%, and diagnoses are higher among sexual minority adults compared with heterosexual adults who identify with their birth gender (Nagata, Ganson and Austin, 2020).

Stereotypes about who develops Anorexia Nervosa could contribute to disparities in treatment and outcome. It has been found that those from a white, higher socio-economic group are more likely to seek treatment than those from a lower socio-economic group, racial and ethnic minorities, males and gender minorities (Sonneville & Lipson, 2018; Fairburn et al., 2017) and that these groups of people may not recognise the need for treatment or may not be referred.

In some groups there is a culture of thinness for example with athletes, models, and dancers where there is pressure to conform to a thin idealised norm. Although for this group it is argued that a return to normal eating is possible (Carr et al., 2020). Parker and Harriger (2020) support the argument that those in the LGBTQ+ community are more likely to experience an eating disorder due to higher levels of stress caused by stigma and prejudice, leading to a higher incidence of mental health problems including eating disorders.

2.7 Treatment

Having considered three different theories and potential contributions to the development of Anorexia Nervosa and co-morbidities, available treatments will now be considered. For clinicians, the starting point is the NICE Guidelines (The National Institute for Health and Care Excellence), which recommend Cognitive Behavioural Therapy-Enhanced (CBT-E: Fairburn, 2015); the Maudsley Anorexia Nervosa Treatment for Adults (MANTRA: Wittek, 2021) and Specialist Supportive Clinical Management (SSCM: Schmidt, 2015) for the treatment of adults. If one of these treatments has not worked then one of the others can be offered or Focused Focal Psychodynamic Therapy (FFPT: Herzog et al., 2022). Family Based Therapy (FBT: Flütsch et al., 2021) is the treatment that is recommended by NICE (2017) for children and adolescents and if this does not work then individual CBT-E or Adolescent-Focused Psychotherapy can be offered (Kinnaird et al., 2023). Research has taken place into the treatment of eating disorders and the outcomes have shown Cognitive Behavioural Therapy, in particular CBT-E (Fairburn, 2015) and Family Therapy (Baudinet et al., 2024) to have had some success (Van den Berg E et al., 2019). For those whose weight is extremely low hospitalisation is required to restore weight to enable engagement with psychological therapy. The weight at which hospitalisation takes place is dependent on the policy of the CMHT (Community Mental Health Team) or CAMHS (Child and Adolescent Mental Health Service) operating in the geographical area.

Anti-depressants are sometimes prescribed to those presenting with AN as biological contributions have been considered and it has been suggested that there is an imbalance of neurotransmitters, in particular Serotonin (Carr, 2015) however, anti-depressant medication has not proved to be successful in the treatment of Anorexia Nervosa (Fairburn, 2015). The focus on the use of anti-depressants is due to the low mood that is found in some Anorexia Nervosa patients, in particular when they are underweight. However, the results from the use of anti-depressants is said to be disappointing, as treatment approaches that utilise the use of medication have not been shown to be

efficacious and Fluoxetine which is sometimes prescribed was not shown to reduce the risk of relapse in weight restored individuals (Walsh, et al., 2021). Some anti-depressants can produce side effects in patients who are severely underweight, in particular Selective Serotonin Reuptake Inhibitors (SSRIs) have been associated with bone loss and increased risk of fracture (Jones, 2013). Gilbert (2014) reports that one third of psychiatrists falsely believe that SSRIs are recommended by NICE for the management of AN. Another medication that has been trialed is Oxytocin (a hormone and neuropeptide) that controls eating behaviour, food consumption and emotion reactivity including stress, anxiety, trust, social interactions, and bond formation. The Oxytocin system becomes disrupted in Anorexia Nervosa affecting its level, and its use in RCTs (randomised control trials) has shown that whilst it does not improve weight gain it may reduce the stress associated with eating (Carr, et al., 2020).

Hospitalisation is often required for weight restoration in those who are severely underweight (Strand et al., 2020). However, lack of provision is often found with treatment being given on psychiatric wards for acute admissions, if a space is not available in a specialist eating disorder service (Sharpe et al., 2023). Hospitalisation is for the re-introduction of calories leading to weight restoration and to a rehabilitation of the consequences of malnutrition such as dehydration, bradycardia, hypotension, hypothermia, neutropenia, hypertransaminasemia, amenorrhea and impairments to growth and bone health (Parker et al., 2020). However, it is argued that an extended hospital stay may have an adverse impact on long term recovery (Carr et al., 2020), and in some areas, intervention can be late, only being offered once someone is seriously underweight. Because of this 40% of clients will seek treatment privately (Rance, 2017), which can be costly and therefore only accessible to those who can afford it, and for those who are hospitalised help is not always available in supporting them back into the community, due to the inequity in geographical distribution of available care and some GPs lacking in knowledge of Anorexia Nervosa (Tylec, 2014).

When someone has been seriously underweight, and re-feeding needs to take place

there are risks associated with this. During re-feeding the re-introduction of carbohydrates can lead to electrolyte, metabolic and organ dysfunction (Parker et al., 2020). Re-feeding syndrome lacks a consistent definition and is most often referred to as a severe electrolyte disturbance (mainly phosphate) which can lead to sudden death when food is introduced (Parker, 2020). In starvation the body is in a catabolic state and shifts from burning carbohydrates, to fat and protein utilisation, this leads to an altered insulin response and increased glycogen secretion (Parker, 2020). When re-feeding occurs the body changes back from catabolic to anabolic metabolism resulting in switching back from fat use to carbohydrate use, resulting in lower levels of phosphate, this can lead to circulatory fluid overload, respiratory and heart failure, and death. Hypophosphatemia is seen as the precursor to re-feeding syndrome (Parker et al., 2020). It is because of these potential life-threatening changes that medical monitoring is necessary in underweight individuals and when this is not carried out there is a risk to life as highlighted in the Parliamentary and Health Service Ombudsmen Report 'Ignoring the Alarms' (Behrens, 2017).

Following hospitalisation or for those who do not require inpatient treatment one of the therapies that could be offered is CBT-E which is a trans-diagnostic approach that looks at the over-evaluation of weight and shape, over-evaluation of control over eating, dietary rules and changes in eating patterns due to events impacting on mood (Jansingh et al., 2020). There is a 20-week model and a 40-week model (Fairburn, 2015). Low self-esteem and perfectionism, which are most often present in those with Anorexia Nervosa, are treated in the 40-week model. The extended version was designed following criticism that the 20-week model did not address the co-morbid difficulties that those with AN can be experiencing, the 40-week model is to allow time for this additional work to take place (Lock, 2019). The CBT approach aims to challenge the dysfunctional thinking and behaviours that are present in those with AN, to establish functional cognitions and behaviours, via a change in the belief system that is held regarding weight and shape (Sokol and Fox, 2020). The aim is to also work with any co-morbid presentations that may be present. Those with Anorexia rarely present

without additional anxiety or depression as often the Anorexia has been a response to other life events that have felt to be out of the individual's control (Grave and Calugi, 2020).

Empirical support for CBT-E is mixed with some studies being supportive of the therapeutic efficacy of CBT-E for AN and others suggesting its usefulness is limited; in a meta-analysis by Kaidesoja, et al., (2023) they looked at 44 studies and could not find sufficient data to support the use of CBT-E for those with Anorexia Nervosa. Whereas the systematic review by Dahlenberg et al., (2019) concluded that CBT-E was useful across the range of eating disorders but did not specifically report on AN. CBT-E has been found to be more beneficial than nutritional counselling in weight restored patients but not better than clinical management in underweight patients (Cowdrey, 2016).

Randomised Control Trials (RCT) of CBT do demonstrate efficacy (Poulson et al., 2014). Cowdrey (2016) suggests that CBT-E could be useful but found that patients had deteriorated at initial follow up and progress was only partially maintained at 8 months follow up. Grave, (2020) looked at CBT-E for adolescents and of those who had completed treatment 71% showed weight gain. In a further study by Grave (2023) it was suggested that CBT-E is the most effective treatment for adults and a suitable alternative to Family Therapy for adolescents. A reduction in body image concerns was found in a study by Calugi (2017), and this is supported by Frostad (2018) who found that CBT-E can be effective, however, drop-out rate is high and evidence from non-clinical settings is limited. Their study included 44 individuals in an outpatient hospital setting and 22 dropped out of treatment. In this study weight gain over a BMI of 18.5 at 12 months follow up was 77% in those who completed treatment. This illustrates the importance of keeping people in treatment to completion. Signorini et al., (2018) asserts that CBT-Es effectiveness in routine clinical settings needs further investigation. In their study 50% did not complete treatment and they conclude that CBT-E is effective but that the attrition rate is high. Whilst efficacy has been found in these trials all authors agree that there is room for improvement to enable higher recovery and maintenance

rates and wider access (Grave, 2023).

One criticism of the approach is that during CBT-E in session weighing takes place at each session and Whiteley, (2017) argues that this could be shaming for clients and jeopardise the therapeutic relationship and it has been found that a good therapeutic relationship aids engagement and therefore low drop-out rates and recovery (Zugai, et al., 2018). Whiteley, (2017) argues that with this approach to treatment, emotion is ignored in favour of cognitive and behavioural techniques to reduce symptoms (as measured by DSM-V-TR: APA, 2022) but what clients need is the opportunity to talk about themselves and their feelings and not be seen as another Anorexic. However, Fairburn, (2015) states that the interpersonal issues can be addressed in this treatment approach. Provision of the approach can be limited as in some areas CBT-E is not available. Haas, et al., (2023) conducted a randomised control trial of a mobile application that provides CBT to individuals who have been discharged from hospital, in an attempt to reduce the relapse rates for Anorexia Nervosa by increasing the availability of this treatment and it is anticipated that this would increase access to those wishing to receive CBT but do not have access to a clinician.

MANTRA (The Maudsley Model of Anorexia Nervosa Treatment for Adults) (Wittek et al., 2021) is another NICE recommended treatment and is a cognitive interpersonal treatment approach looking at intra-personal and interpersonal factors whereby the client and therapist define together what maintains the AN and how to intervene. This approach, as with CBT-E, is a 20–40-week protocol that utilises a motivational interviewing style (Jansingh, 2020). Carr et al., (2020), reported that CBT was comparable to MANTRA but in severe cases MANTRA was more successful. A multi-centre cohort study was undertaken with 92 patients between the ages of 13 and 21 to look at the efficacy of MANTRA with adolescents at twelve months follow-up, after completion of treatment (Wittek et al., 2021). The follow up study after 18 months found that MANTRA was a suitable treatment for adolescents with 46% being fully remitted compared to 16% in the treatment as usual group (Wittek et al., 2023).

A study comparing MANTRA and SSCM (Specialist Supportive Clinical Management) was carried out by Schmidt, Treasure and Alan, (2023) and SSCM was reported to be a suitable alternative to MANTRA. SSCM was developed as a control process to enable comparison to active treatments and was based on clinical management and supportive psychotherapy, with the idea being to normalise eating and restore weight. However, the approach was found to be useful in its own right and in a study by McIntosh et al., (2023) they found that it was as effective as the treatment it was a control to including CBT-E and MANTRA. It is argued that the core components of SSCM are sufficient to effect change (Jordan, McIntosh and Bulik, 2020). McIntosh et al., (2020) reported that SSCM had been found to be effective in the treatment of Anorexia Nervosa in six clinical trials and in their study178 SSCM therapy sessions were transcribed, providing an important level of data, and a key element to recovery was the normalisation of eating and weight gain.

Family Based Therapy (FBT) is a well-established treatment for Anorexia Nervosa in adolescents (Hass et al., 2024). The idea is that there are inter-generational coalitions, enmeshment, and lack of conflict resolution in the family unit. The approach aims to externalise the AN so that it is not a family 'fault' (Pisetsky et al., 2019). Chen et al., (2016) found that there were high drop-out rates for Family Based Therapy with 9 of the 22 patients in their study leaving and a further 3 did not attend the follow up appointments. Twenty sessions were offered with a mean of twelve being attended, however, despite the low attendance weight gain was achieved. Eisler et al., (2016) support the efficacy of FBT and in their study 60% achieved 'good to intermediate' outcome based on the Morgan-Russell Scale. Conit, (2017) reported that in FBT significant numbers drop out and this is further supported by Hay et al., (2017) and Simic et al., (2021) found that whilst FBT is the treatment that is offered to adolescents in the UK between 10% and 40% have a poor outcome and the mortality rate is reported to be 6-15%.

Winston, (2021) reviewed psycho-dynamic approaches arising from a Psycho-dynamic

Perspective (for example Focused Focal Psycho-dynamic Therapy (FFPT)) and reported that the idea is to allow the client to re-experience important developmental experiences in a healthier adult way, to develop competency where deficit previously existed in emotional development. The idea is to look at attachment and what the relationship is like with carers as a disruption in the attachment process can lead to difficulties and the development of Anorexia Nervosa (Zhu et al., 2020). Research suggests that FFPT is more effective than treatment as usual (TAU) but not superior to the NICE recommended treatments (Carr et al., 2020; Simmonds et al., 2020).

Other approaches to treatment have been trialed (Linardon, 2017; Miniati et al., 2018). However, none of the third wave therapies have an established treatment protocol. A more recent approach is CBT-T (Cognitive Behavioural Therapy-Ten), this is a ten-session protocol and whilst not suitable for all clients it has been designed for use with those who are motivated to change and not underweight (Waller et al., 2019).

Having considered some of the available treatments and their efficacy, further information on recovery and relapse will be reviewed.

2.8 Recovery & Relapse

Recovery from anorexia nervosa is difficult to define (McDonald et al., 2021) and there is no accepted definition of what recovery is (Walsh, et al., 2021). Much of the literature takes a medical approach to defining recovery as no longer demonstrating physical symptoms (Dawson, et al., 2014), from a physical health perspective this would be regaining weight to a BMI of 18.5 or above and no binging or purging behaviours. However, this is only the start and social, occupational, educational, and psychological domains need to also be considered (McDonald, et al., 2021). Recovery can be viewed as regaining a meaningful life however, the meaning of the word ‘meaningful’ cannot be systematically measured and then applied as it is subjective to the individual (Jacob, 2015). It is difficult to predict who will make a full recovery and

who may struggle during their life (McDonald, et al., 2021). Junne et al., (2016) say that if sustained recovery is to be achieved then behavioural and cognitive elements should be addressed, and Nilsen, et al., (2020) suggest that clinicians should ask the person with Anorexia Nervosa to define what recovery would look like for them.

In research by McDonald et al., (2021) they sought the views of service users and therapists on the definition of recovery as they agreed that it would be useful to have universally defined criteria. Those with experience of Anorexia Nervosa felt that a recovery model should include emotional coping and quality of life, and that recovery should not be seen as an endpoint but as a journey. The study concluded that there is a difference between academically derived recovery criteria and lived experience. Recovery may look different for each individual and in addition to regaining a minimal weight would include their perception on a meaningful life as suggested by Jacob, (2015). Stockford, et al., (2019), report that recovery is a complex psychological process and treatment needs to include the psychological components of self-identity as the study found that those recovering from AN were dealing with a fragmented sense of self, and needed to reach a point where they had insight into their illness and a commitment to recovery, this would be followed by reclaiming their sense of self through meaningful relationships, rebuilding identity and self-acceptance, this is supported in research by Croce et al., (2024).

Recovery can be aided by available treatment and when considering the recovery and relapse rates, Thomas et al., (2016), say that no treatment has shown superiority and Frostad, (2018), supported this reporting that no treatment was supported by robust evidence and Friederich et al., (2017) found that treatment outcomes are generally poor for adults and that there was a less favourable outcome and higher mortality rates for those who had been hospitalised. In addition to the high relapse rates, further studies confirm the high mortality rate for those with Anorexia Nervosa, a moderate recovery rate, and a large number remaining seriously ill, from these studies it has been suggested that early detection and retention in treatment, has been found to aid recovery (Di

Lodovico et al., 2024).

The transferability of clinical trials to real world clinical settings has limited research looking at efficacy (Murray et al., 2020). Research has been carried out to look at the experience of adolescents who have been discharged from inpatient treatment and they found that once weight is restored the patient is discharged but, in some cases, not provided with follow up treatment (Olawale, 2019). Walsh, et al., (2022) found that there was a high relapse rate in the first twelve months after discharge from inpatient treatment and that this risk decreased the longer someone stayed in recovery. Those who are hospitalised during their treatment have a poorer outcome than those who are not and, in the Wentz, (2023) study, recovery for Anorexia Nervosa was reported as 63%. This accords with the relapse rate found by Berands et al., (2016) of 57%. Sala, et al., (2023) conducted a meta-analysis of 35 papers to look at predictors of relapse rates and found that the more severe the AN in terms of restriction the higher the rate of relapse but those who were motivated to change had a lower chance of relapse. Recovery is most often defined as not meeting DSM-V-TR (APA, 2022) diagnostic criteria, however, if psychological factors were assessed and treated it is argued that relapse rates would be lower (Howard et al., 2023).

An essential aspect of care is considered to be a good therapeutic relationship and a comprehensive approach to individual treatment (Lev Ari et al., 2024). Zugai et al., (2024), suggest that a supportive therapeutic relationship and communication are thought to be fundamental requirements in aiding recovery. The therapeutic relationship is important as it benefits engagement and outcome and the lack of engagement with services by sufferers is a problem (Zugai et al., 2024). In a study by Signorini et al., (2018) they found that 50% of out-patients who attended for treatment dropped out before treatment was complete and suggest that follow up studies should take place after a longer period has elapsed following the completion of treatment. Karlsson et al., (2021) interviewed adolescents who had completed treatment to ask them what they had found to be most useful, and they reported that they needed to be motivated to make

the changes and to be treated as an individual not another case of Anorexia Nervosa. This supported the findings of Kotilahti et al., (2020), that a treatment that focuses on weight gain was viewed negatively by participants and their family and the therapy was seen as being less valuable. Zugai et al., (2024), suggest that qualitative research is required to assess service users' views of the treatment that was provided, and professionals need to be trained in the treatment of EDs as this raises the expectation of the clients. Jenkins et al., (2019), found that more needs to be done to maintain retention in treatment, improve access to treatment and improve drop out attrition, as good outcomes are reported for those who adhere to treatment.

2.9 The Current Study

There is limited research that has included the perspective of those who no longer meet the diagnostic criteria for an eating disorder (as defined by DSM-5-TR, APA, 2022) and have not done so for an extended period of time, to understand more about their experience of AN and what they feel enabled their recovery. From the review of the research, we can see that there are high attrition rates in therapy and high relapse rates post therapy while the treatment being offered is dependent on available support in the geographical location. Signorini, (2018), Jenkins et al., (2019) and Zugai et al., (2024) suggest that more research needs to take place that looks at the individuals' journey to aid further understanding of the disorder from those who have recovered.

The questions the research will seek to answer are: what was the participants' experience of Anorexia Nervosa; and what do they believe aided their recovery from the disorder? This will fulfil the aim of the research which is to understand the lived experience of those who had recovered from Anorexia Nervosa and to understand what they felt had aided their recovery, with the hope that this could provide valuable information to those working with this population.

For this study recovery was defined by the participants' self-report, as not having met

diagnostic criteria for the disorder for over three years. This period was chosen as relapse occurs most often in the twelve months following initial recovery (Walsh et al., 2023), and many of the follow up studies look at functioning twelve months after discharge from inpatient treatment, but it has been shown that relapse can and does occur after this time (Olawale, 2018).

The reason this research is important is that a deeper understanding of the disorder is required if we are to move beyond the high attrition and high relapse rates that are found in the studies. An important way in which to do this is to ask those who have experienced the disorder and maintained recovery what the experience was like for them, as suggested by Signorini, (2018), Jenkins et al., (2019) and Zugai et al., (2024). This is a critical area to study because if we can gain a deeper understanding of the journey through anorexia to recovery we may identify where additional support can be given to those still battling the illness. The insight gained from those who have overcome the disorder could potentially inform treatment for those who are still suffering and practitioners working in the area. It is anticipated that the findings from this study will add to the body of knowledge in this field and will offer further insight into the experience of individuals diagnosed with Anorexia Nervosa.

To enable this to happen one must consider the available methodological approaches and consider which could be utilised to fulfil the research aim.

Chapter 3: Methodology

3.1 Introduction

As Counselling Psychologists, we adhere to the BPS Code of Human Research Ethics with the intention of avoiding harm and the prevention of misuse or abuse to our participants, but also to wider society. During research we aim to maximise benefit and minimise risk, and as research Psychologists we ‘value the dignity and worth of all

persons, with sensitivity to the dynamics of perceived authority or influence over persons and peoples and with particular regard to people's rights' (Code of Human Research Ethics, 2018, p.5).

When adhering to the BPS code of ethics and conduct it is acknowledged that this is important at all stages of the research process from the inception to the final write up and beyond, and that to facilitate good psychological research there needs to be mutual respect and trust between the researcher and the participants. This can be achieved by respecting the participants accounts of their experience, their individuality, and differences, to include; culture, sexual orientation, gender, socio-economic status, race (including colour, nationality, ethnic or national origin), age, disability, and religious belief.

The questions the research will seek to answer are: what was the participants' experience of Anorexia Nervosa; and what do they believe aided their recovery from the disorder? This will fulfil the aim of the research, which is to understand the lived experience of those who had recovered from Anorexia Nervosa and to understand what they felt had aided their recovery, with the hope that this could provide valuable information to those working with this population. In choosing an appropriate research approach to answer the questions it was first necessary to consider whether qualitative or quantitative research would provide the vehicle by which to make the analysis (Ghafar, 2024). An overview of the considered approaches is given below.

Pérez-Hämmerle et al., (2024) suggests that the epistemological and ontological assumptions of research methods are rarely as fixed as they are thought to be and can hold common ground. The differences are thought to be that quantitative research takes a deductive process of constructing hypothesis and testing them via empirical research and a qualitative process is inductive. Both are repetitive (iterative) but quantitative research is seen to be objective and generalisable to a wider population but also simplistic and decontextualisng, whereas qualitative research is seen as subjective but

not generalisable and the researcher may show bias in the analysis of data (Silverman and Patterson, 2021).

Quantitative research is considered to be objective, and a good theory can be tested or falsified, and this testability of theory is key in quantitative research (Wallis, 2023). There is a reality that exists independent of our own thoughts and beliefs about that reality, and the purpose of science is to uncover and explain that reality, known as realism (Wallis, 2023). Quantitative research is concerned with collecting and analysing numerical data to find patterns, make predictions and to generalise the results to a wider population (Bhandari, 2022). Quantitative research looks for a cause and effect or relationship to be found in the data that is collected, and the majority of Anorexia Nervosa quantitative work looks at the recovery rates for those with Anorexia Nervosa after following a treatment protocol (Walsh et al., 2021), whereby the researcher and participants are independent of each other, with the researcher not having any impact on the data collected. Previous research has mainly adopted a quantitative approach to assess the efficacy of the different treatment approaches for Anorexia Nervosa and there is less research that has sought the experience of those who have overcome the disorder (Jenkins et al., 2019).

A qualitative approach was the appropriate choice for this research as opposed to quantitative as the participant's subjective experience of Anorexia Nervosa and what aided recovery was sought as opposed to having an idea of what contributed and then generating a hypothesis to be tested. When considering the different qualitative approaches that were available Discourse Analysis (Johnstone and Andrus, 2024), Thematic Analysis (Braun and Clark, 2023), Grounded Theory (Charmaz and Thornberg, 2021), and Interpretative Phenomenological Analysis (Smith, Larkin and Flowers, 2015) were considered.

Discourse Analysis (DA) (Paltridge, 2021) was considered as it is used to study the underlying meaning of the spoken work. It originates from sociology and is concerned

with the use of language in the construction of reality. DA is a critical realism approach in believing that there is a reality, 'out there' but viewed through a lens, and therefore reality is distorted. We try to get close to reality whilst accepting we will not reach that goal. DA looks to what is being said and the way that language is used at the broader level than a sentence or utterance and considers how we use language to interact with society and how it provides our identity and power relations and how these are created, expressed, and maintained (Howitt and Cramer, 2016). Hjelm, (2021) says that there is not a simple explanation of what DA is, but the analysis seeks to look at speech to see what the words 'do' to the speaker and hearer. Karimi and Niazi (2023), spoke of DA being an open-ended (or iterative) process and that DA rejects the idea that language is representational, in that it is not a representation of internal psychological states, and that language is designed to do something not to represent something (Nelson and Hardy, 2015). It was decided that this approach, (DA) would not have fulfilled the aim of the study, as it was anticipated that language could be representational of the participants psychological experience.

Thematic Analysis (TA), (Braun and Clark, 2023), was considered as a qualitative approach for the analysis of the data. The approach is underpinned by the ontology that there is an objective reality that can be tested and the epistemology that this knowledge can be gained via the interpretation of data. TA seeks to identify recurring patterns found within the data that is obtained from interviews. This could either be inductive (data led) whereby the researcher looks at the data and sees what emerges from the dialogue, or deductive (theory led), where the researcher has an idea of what they anticipate they will find and seeks this from the data. For this research an inductive approach would have been taken as the researcher was seeking to gain knowledge from the participants as to what their experience of AN had been and what they felt aided their recovery. The reason that TA was rejected is because it offers limited analysis (Howitt, 2016) and therefore it was felt that this would not offer the depth of analysis that was being sought, as whilst themes could emerge or be sought it does not allow for interpretation of the participants information. It was considered to be an important aspect of the work to be

able to bring a depth of analysis and interpretation to what the participants were bringing, to enable the researcher to phenomenologically review the transcripts and offer an interpretation of what was said.

Grounded Theories focus on generating or discovering theoretical ideas rather than these ideas being specified beforehand, they are inductive. A Grounded Theory is one that is inductively derived from the study of a phenomenon it represents (Cullen, et al., 2021). Grounded Theory has an established reputation for the study of human behaviour and for making knowledge claims about how individuals interpret reality (Charmaz and Thornberg, 2021). The purpose of GT is to develop an explanatory theory of a social process and currently reflects the analytic approach of Corbin and Strauss, (2015).

Grounded Theory discourages a review of the literature prior to conducting the interviews to minimise presuppositions that might distort the research (Charmaz, 2014). Sampling and recruitment can occur at several stages of the project. An initial sample may be recruited and interviewed and based on preliminary analysis of their data a further sample can then be defined to address emerging issues. This is best known as theoretical sampling (King et al., 2019). The process continues until ‘saturation’ occurs (Cullen and Brennan, 2021), saturation has occurred when no new themes are emerging (Cullen and Brennan, 2021).

This method is often used when the researcher aims to develop a conceptual model of the phenomenon under investigation to generate theory in an under researched area (King et al., 2019). The idea of the current study was not to generate a hypothesis in an under researched area but to deepen our understanding of a homogenous group of people with shared characteristics. As Howard et al., (2023) said if you have an idea in mind then this is not suitable for GT.

In brief, Grounded Theory’s central aim is theory building, rather than theory testing. It is a suitable design when a theory does not fully explain a process (Thornberg and

Keane, 2022; Walsh, 2022). The current study did not aim to build a theory but to look at the lived experience of individuals who have previously received a diagnosis for Anorexia Nervosa, to gain an insider perspective on this experience and to ask what aided recovery.

To achieve this aim, after consideration of the other research approaches Interpretative Phenomenological Analysis (IPA) Smith et al., 2015; Smith and Nizza, 2022) was chosen. IPA is a qualitative approach that is concerned with how individuals make sense of their major life experiences.

The aim of IPA is to explore experience in its own terms acknowledging that there is no ultimate or objective truth but to understand the subjective experience of the individual. IPA is a qualitative approach that is concerned with how individuals make sense of their major life experiences (Smith et al., 2015). IPA is informed by three key philosophical areas – phenomenology (the study of experience), hermeneutics (the theory of interpretation) and ideography (concerned with the particular, not nomothetic) (Eatough and Smith, 2021). These philosophical areas will be considered to demonstrate how they inform IPA and how IPA is applicable to the research aim.

3.2.1 IPA and Phenomenology

Individuals have experiences, and these become significant when life takes on meaning for specific events. Phenomenology is the study of experience and what it is like to be human. To do this it is necessary to study an individual's lived world. Phenomenology is concerned with an individual's perception, awareness, and consciousness and this is key in IPA research as the researcher seeks to understand the participant's lived experience (Smith, et al., 2015).

Consciousness makes possible the existence of a significant world (Montague et al., 2020), and intersubjectivity refers to our engagement in the world. Intersubjectivity is the concept that aims to describe this relatedness and to account for our ability to

communicate with and make sense of each other (Sturgess, 2022). As Counselling Psychologists, we seek to "engage with subjectivity and intersubjectivity, values and beliefs (…) and negotiate between perceptions and world views but not to assume the automatic superiority of any way of experiencing, feeling, valuing and knowing" (British Psychological Society [BPS], 2005, p. 1-2). We are in a world with objects, relationships and language, and our being in the world is always in relation to something else and the interpretation of people's meaning making activities is central to phenomenological enquiry in Psychology and the IPA theoretical approach (Eatough and Smith, 2021). This study seeks to understand the participants intersubjectivity and this can be achieved via the IPA analysis.

Knowledge is gained from experience and perception in the world. Our experience of another is never the same as their experience, as for us it is secondary and for them it is lived (Sides, Pringle and Newson, 2024). We can be empathic with another, but we cannot fully share their experience, being personal to the individual who had the experience, (sometimes referred to as *mineness* and *aboutness).* Our perception of the world is shaped by others, our perception of the world is altered when others are around. As we explore the lived experience of the participants utilising IPA this will always be via our subjective perspective (Fischer, et al., 2019).

Experience in the world determines how people act and how they act determines who they become. This is relevant in Anorexia Nervosa as the action leads to a 'being' that is less than an accepted version of a healthy way to be in the world (Scarpina et al., 2022). As researchers we then attempt to make sense of this activity and its meaning to the participants. IPA will be how the researcher attempts to make sense of the participants experience in the world at a time when they were experiencing Anorexia Nervosa (Smith and Nizza, 2022).

3.2.2 IPA and Hermeneutics

Hermeneutics is the theory of interpretation, IPA is engaged in a double

hermeneutic with the researcher making sense of the experience whilst the participant is also making sense of the experience of Anorexia Nervosa (Howitt and Cramer, 2017). The participant (1st order) making meaning and the researcher (2nd order) making sense (Smith and Nizza, 2022). Interpretative work is used to draw out the meaning of the experience for the research participants (King et al., 2019). In IPA, the researcher stands alongside the participant for a unique perspective, aiming to understand the phenomenon both personally and analytically.

The Hermeneutic Circle is the dynamic relationship between the part and the whole at various levels, to understand the part we look to the whole and to understand the whole we look to the part (Montague et al., 2020). To understand the period in the participants' life when they were experiencing AN we will carry out an interview and from there we will pay attention to the single words, then single extracts and then the whole text. This will then shed light on the whole of the person's life that is under the spotlight and the complete narrative for the research project. In IPA the process of analysis is iterative, we move back and forth within the text while seeking meaning, we then offer a perspective on the transcript that the participant cannot (Smith and Nizza, 2022).

We seek meaning from the phenomenon as it shows itself (Murray and Wilde, 2020), this will be done by analysing the text to look for what is apparent and what is not. Bracketing will need to take place as we bring our prior experience, assumptions and pre-conceptions, we then look at the experience of our participants in the light of our experience (Behal, 2023), this is our fore-experience and could be an obstacle to interpretation. We need to 'bracket off' our fore-conception to enable us to see the meaning from a non-judgmental stance. However, it is acknowledged that this is not fully possible and what we can then aim for is to be open to differing concepts as they arise from our participants' narrative to ensure that the researcher's pre-conceptions do not prevent the lived experience of the participants from being seen and reported during the interpretation of the transcripts (Fischer and Guzel, 2023).

We may not realise what our pre-conceptions are until after we start the analysis. Then

our fore-conceptions can subtly alter as we engage with the text and we then project an altered perception onto the text, a projection of meaning, the movement of understanding and interpretation. This is a process that can subtly change the researcher's perception of the participants lived world and the future engagement with the research topic (Fischer and Guzel, 2023). We need to be aware of our bias and allow what has been said to present itself (Smith and Nizza, 2022). The aim is not to relive but to learn anew in the light of the present, in understanding the text and then the meaning. The idea here is that phenomenon will influence our interpretation, this will then exert an influence on our fore-structure, which in turn will influence our further interpretation. Therefore, bracketing will need to continue throughout the process in relation to both previous knowledge and new understanding. This is done by being aware of bias and prior knowledge, to put this to one side, to allow the lived experience to come through in the interpretation, and Smith et al., (2015) suggest that this is achieved by ensuring that our focus remains on the words of the participant.

3.2.3 IPA and Ideography

IPA has an ideographic focus, which means that it aims to offer insights into how an individual, in each situation makes sense of that situation (Nizza, Farr and Smith, 2021). Ideography is concerned with the particular, not nomothetic which is concerned with making claims at the group or population level and establishing general laws of human behaviour. Particular in the sense of detail and depth of analysis and how the phenomenon is then understood from the perspective of the participant and the researcher. Ideography can be commitment to the sole case in its own right, the individuals' personal unique perspective on their experience and how the phenomenon appears (Smith et al., 2015). We build a picture from individual experiences as by looking at the particular this leads to the universal. In IPA qualitative research we look at the individual's experience and anticipate that this will shed light on the phenomenon and the experience of others. Parts connections and common meaning emerges when an everyday event becomes significant in and of itself, we then utilise IPA to make

sense of what the participant is making sense of (Behal, 2023).

IPA is concerned with when the everyday experience becomes an experience. When an individual sees the episode as significant and reflects on this to make sense of it. People reflect on the world and add meaning (Nizza et al., 2021). To achieve this an in-depth review of the lived experience from the participants will be sought to gain their perspective, and to interpret what they are saying via the utilisation of IPA (Smith et al., 2015) to answer the research question of what was the participants experience of Anorexia Nervosa and what do they believe aided their recovery from the disorder? This would fulfil the aim of the research which was to understand the lived experience of those who had recovered from Anorexia Nervosa and to understand what they felt had aided their recovery, with the hope that this could provide valuable information to those working with this population.

Utilising IPA, the aim will be to capture the experience as experienced by the research participants (Smith and Nizza, 2022). The participants will be invited to reflect on their experience of Anorexia and of the recovery process. Intentionality will be present where thinking on purpose is required of the participant, and the researcher will aim to put aside their pre-conceptions and what they take for granted in the world to concentrate on the current perception of the reported lived experience of the participant (Smith et al., 2015).

The experience and perception of lived processes will emerge from the analysis of the interview data. An interpretative process with an idiographic commitment to exploring the details of a participant's account of a significant life event, before moving on to making more general claims about the population under investigation. IPA was the most appropriate approach for this research.

3.3 Participants & Recruitment

IPA has a focus on the richness of the data collected from the participants not on the quantity of participants recruited. Therefore, a small number of participants is appropriate (Smith and Nizza, 2022).

Table one shows Pseudonyms and the approximations for demographic information relating to each participant.

Table 1

Participants and Approximations:

Pseudonym & Age	Age at onset / diagnosis	Age when treatment ended	Duration	Years in Recovery
Lilly 40-45	11/12	16-18	4 years	20-25
Rose 45-50	15/17	20-25	8 years	20-25
Jasmine 30-35	14/15	20-25	7 years	10-15
Poppy 35-40	11/12	25-30	15 Years	5-10

As the study aimed to recruit individuals who had been 'recovered' for a minimum of three years it was not possible to recruit via eating disorder services as this would potentially attract those who were still experiencing Anorexia Nervosa. Therefore 'insider' assistance was sought with the recruitment process (King et al., 2019). This was achieved via email and word of mouth to professionals working in mental health who may have worked with individuals who had previously experienced Anorexia Nervosa or who were known to them professionally. In addition, the intention of the research was communicated verbally to mature post graduate students, to ask if they

were aware of anyone who had previously been diagnosed with Anorexia Nervosa and met the criteria of having been recovered for over three years.

After ethical approval was obtained from the Research Ethics Committee, four participants were recruited: Initially six were sought but due to the difficulty of recruiting those who were in longer term recovery this was not possible in the time limit. However, on reflection the wealth of information that was obtained from the four interviews was extensive. This is in line with the recommendations by Smith et al., (2015) who suggest that small homogeneous numbers of participants allow for a more in-depth analysis of data than if larger numbers of participants are recruited. It has been suggested that qualitative studies advance knowledge via their small but detailed studies due to the bonding relationship that is able to develop between the researcher and the participants, and IPA gives researchers the opportunity to understand the innermost reflection of the 'lived experience' of the research participants. Phenomenological analysis allows the research participants to express themselves in the way they want to (Alase, 2017; Williams, 2021). Smaller numbers in IPA enable a deeper focus on the data and with the lived experience of the participants (Barton, 2020), and the smaller numbers allow for a more specific understanding that may not be available in larger studies (Alase, 2017). It is therefore the depth of information that is gathered via the interviews that will determine the quality of the study as opposed to the sample size, and IPA is better suited to smaller numbers (Smith and Nizza, 2022).

The inclusion criteria for the study were that the participants were all English speaking with a previous diagnosis of Anorexia Nervosa and had been in recovery for over three years. The exclusion criteria were those diagnosed with a different eating disorder or no eating disorder, participants who did not speak English and those who had not been in recovery for the required length of time. The participants were all female. It is acknowledged that the participants who took part in the study may not be representative of all of those who have experienced Anorexia Nervosa.

3.4 The Process

Once potential participants were identified and had agreed to have their email address passed to the researcher, they were sent a Participant Information Sheet (Appendix 3) via email (Appendix 2). A follow up email was not sent as this allowed time for them to consider if they wanted to participate or not, with no pressure from the researcher. Having read the participant information sheet, if they wanted to participate, they could contact the researcher either by email or phone and the consent form (Appendix 4) was then sent via email to the participant and an interview date and time was set up to take place in a private room, in a public place such as a university or local library. For Participants who wished to be interviewed in their own home a risk plan was put in place whereby the interviewer would notify a colleague of the place of the interview and agree to contact them 90 minutes after the start time of the scheduled interview appointment. If contact had not been made in this time, then the colleague would call the interviewer and if a response were not received the local police would be called. It was not necessary to enact on these precautions.

Before the interview, the consent form was signed, and participant consent was confirmed. The ethical application was updated to allow remote interviews via secure platforms like Microsoft Teams or Zoom, which were free for participants. Both platforms offer end-to-end encryption. Zoom was used for video recording the remote interviews. Participants received and returned the consent form via email before recording began.

All participants were advised of their right to withdraw up to the point of data analysis. They were notified that this would take place within four weeks of the interview. After this time the data would have been anonymised and analysed. No participants asked to withdraw.

Every effort was made to ensure that the participants were in stable mood both during

and following the interview. A SUD (subjective unit of distress) rating was taken at the start and end of the interview, to ensure that their subjective emotional state was at the same level at the end of the process as it had been prior to the interview. In addition, due to the ordering of the questions this naturally led them through the experience to recovery. Whilst the participants were all recovered the recollection of past events had the potential to lead to distress and it was therefore essential that relevant contact details (for example BEAT), were available for them on the debrief form (Appendix 5) in case they became distressed following the interview, and also time was taken over the interview so that the participants did not feel rushed at any point.

3.5 Interviews and Data Analysis

The first two interviews were conducted in the participant's home at their request and both proceeded without any concerns. These interviews were voice recorded. The following two interviews were conducted remotely via Zoom and these were video recordings.

The interviews started with a preamble of neutral questions to allow the participants to relax and get use to the researcher's style. Participants were advised that if there were any questions that they did not want to answer that this was fine, and they could decline. This was done because the researcher was sensitive to the context of the questions and the impact they could potentially have (Yardley et al., 2021) however, all questions were answered.

The researcher was interested in the lived experience of those who had experienced Anorexia Nervosa and to understand what they felt had aided their recovery with the hope that this could provide valuable information to those working with individuals who are experiencing the disorder.

This was achieved by carrying out semi-structured interviews with the participants. Up

to 50% of the questions naturally emerged from the dialogue with the participants, allowing the researcher to offer some structure but also to follow the participant's train of thoughts and feelings as memories were recalled. All participants were able to share the detail of their experiences and the perceived route to individual recovery for each of them.

The questions the interview would seek to explore from the perspective of the participants included what they saw as the starting point of the Anorexia Nervosa and to ask what was happening in their lives at this time with the hope of gaining an insight into their lived experience. The questions will then move to asking about their time with Anorexia Nervosa and what they feel enabled them to break free of the disorder or if they feel it is still part of them. It is anticipated that via the participants self-reflection we will gain a deeper understanding as to the experience of Anorexia Nervosa and what aided recovery. The full list of open-ended questions that were used to guide the interviews can be found in Appendix 7.

The interview schedule acted as a guide to the questions that could be asked whilst recognising that some of this information would occur naturally, during the interview (Silverman, 2022). Questions were designed to align with the research aim, to understand living with and recovering from Anorexia Nervosa. All questions were open-ended, with prompts provided if needed to delve deeper into participants' experiences (Smith and Nizza, 2022). The supervisor and peers reviewed the questions to ensure their relevance to the study's aim.

Towards the end of each interview the flow was more conversational to ensure that the participant was bought back to the present day prior to ending: Although the ordering of the semi-structured interview questions naturally allowed this progression from the past to the present to happen (Smith et al., 2015).

At the end of the interview participants were given a Debrief Sheet (Appendix 5) with

the contact details for the researcher, the research supervisor and organisations that could be contacted should they feel vulnerable having recalled past events. They were thanked for their participation and further neutral questions were asked to ensure they were back in the present day and at ease with what they had discussed. This is in line with the recommendations for IPA research (Smith et al., 2015).

After each interview, the recordings were transcribed. This was a lengthy process, but it did enable full immersion into the words of the participants. Initially the transcripts were read and re read whilst listening to or watching the recordings. This enabled the researcher to be reminded of any utterances and inflections. The transcription noted any gaps in speech with dots (...) and any unclear dialogue was noted as 'unclear' the removal of other identifiable information is indicated by () the rest of the transcribed recording was verbatim. Following this stage paraphrasing of what had been said was noted. Description of thoughts and experience was noted along with linguistic comments of how they spoke, and then conceptual comments that included personal reflection on what was being reported to ensure that pre-understanding did not bias the emerging understanding of the participants world (Williams, 2021). The aim was to move from description to interpretation from 'what is the participant saying' to 'what do they mean.' The meaning of what was being said was interpreted from the perspective of the researcher, whilst acknowledging that pre-conception should be identified to prevent this, as far as possible, from influencing what was seen to be emerging. This is achieved by acknowledging previous knowledge and expectations, my pre-conception had been a disappointment with the low recovery rates for Anorexia Nervosa, so this knowledge needed to be put to one side and then to focus on the data to allow the participants accounts to come through in the analysis (Alase, 2017; Montague et al., 2020). It was interesting to note that the participants, whilst presenting a chronological account would then return to specific incidences and report in more detail unprompted.

Personal Experiential Statements (Smith and Nizza, 2022) emerged during transcript

analysis. Initial annotations were made on hard copies; later interviews were analyzed manually on a computer without software to ensure full researcher immersion into participants' lived experiences. Following IPA's epistemological approach, each interview was broken down into parts (Personal Experiential Statements), embodying the hermeneutic circle to create a new whole. These statements were reviewed, clustered, and irrelevant ones were removed through abstraction. Some statements became Personal Experiential Themes (PETs) via subsumption (Motta and Larkin, 2023). Initially, a theme on relationships was included but later removed, as relevant statements fit better into other themes like 'Losing Me'.

After the first interview had been analysed the researcher then moved onto the next interview and started the process again. Bracketing was used which is consistent with IPAs ideographic commitment (Fischer, 2023) so whilst the fore-structures of the researcher had potentially changed the emergence of new personal experiential statements was still possible. Once each individual transcript had been analysed and personal experiential themes had been identified the transcripts were then looked at again to look for convergence and divergence and from this, group experiential themes (Smith and Nizza 2022) started to be defined. A table of group experiential themes (GETs) with supporting quotes was then created, followed by the reporting of the findings from the analysis.

The researcher was sensitive to Yardley et al., (2021) criteria for quality in qualitative research, whereby one is sensitive to context, and that sensitivity is shown to the research participants and their data, and an awareness of relevant literature is evident. Reflexivity is also important as it enables reflection on the process. Another criterion is commitment to rigour, which refers to giving attention to the topic under investigation, choosing an appropriate sample and conducting the analysis in line with the requirements of an IPA study. Commitment to rigour is demonstrated by learning more about the research approach and taking time and care over the analysis to look in detail at the participants accounts and discussing the work with the supervisor and peers. The

process is then reported in detail to demonstrate coherence and transparency, and Smith et al., (2015) say that coherence refers to the level of consistency with the research approach and the work carried out, and that transparency is achieved by clearly describing the process in the final write up.

King et al., (2019) Suggest that as a researcher we are accountable for ensuring the work presented is valid and reliable. Reliability is how accurately a variable is measured. Reliability is not considered to be strong in qualitative research as the researcher's subjectivity shapes the research process. Therefore, it is important that the detail of the process is included to allow for transparency in how conclusions were drawn, and the account produced must be credible (Smith et al., 2015).

Validity in quantitative research is achieved by paying close attention to the data and questioning if this measures what is says it will measure. Validity in qualitative research is also concerned with how well the analysis fits the data. The data is seen as valid and therefore it is only the analysis that is in question. As the interpretation was a subjective exercise the initial personal experiential statements were shared to validate the process and the personal experiential themes that emerged. Justification of analytic claims is the phrase used to describe this process (Howitt and Cramer, 2017). Validity of the group experiential themes via inter-rater reliability (Seale and Tonkiss, 2018) was sought, by sharing the themes with the Research Supervisor who provided feedback, commenting on both description and interpretation to ensure that the analysis was credible. The full analysis was shared and discussed at length to check that the conclusions drawn made sense from the data obtained. The work was then reviewed by a second supervisor who provided feedback on the GETs and the supporting personal experiential statements.

All data has been kept securely (locked box for hard copy and computer password protected for soft copy) with transcripts being stored separately to any identifying demographic information. This is in accordance with the Data Protection Act (2018)

and GDPR requirements (2018). The data will be destroyed once an award has been conferred by the Exam Board at London Metropolitan University. Participants were advised that any identifiable information would be removed from the transcripts and that whilst extracts from the interviews would be used within the thesis that these would not contain any identifying material and that every effort would be made to maintain confidentiality and anonymity, although there is always the slight risk of a participant being identified via the extracts even when these precautions have been taken.

3.6 Reflexive Statement Part Two

Prior to the first interview I reflected on my thoughts and whilst no single emotion was at the fore there were several key thoughts that were present. These were an expectation that it could be either good or bad, respect for the participant who was giving their time, and a concern for 'getting it right.' I approached each interview with an element of excitement and anticipation at what would be shared. During the interviews, the participants all presented as relaxed and engaging. Whilst they were all informed that they did not have to answer any questions where they felt uncomfortable to do so, all questions were answered.

During the initial interview, the temptation was to act as a therapist and therefore feedback would have resembled the initial paraphrasing one would make of the transcript and then to make therapeutic interventions. Once I recognised this, I was able to follow my remit as a researcher. Following this initial interview, I felt I had experienced a reminder of the difference between counselling and interviewing and was able to carry this forward to the rest of the interviews. The information that was shared during all the interviews was in depth and intimate and my gratitude is with the participants for sharing so freely this information about themselves.

The analysis took a long time, because the information shared was engaging and then to narrow this down to what would be reported was difficult as I wanted to capture the full essence of what they were sharing. Again, this could be in part due to working as a

Counselling Psychologist where there is the opportunity to go back to what was shared and work with this. For the research, the responsibility was to report accurately on what was being shared from this one opportunity. I do believe that I have been able to capture the essence of what was shared and what seemed important to the participants during the analytical process, whilst recognising that this was done from my perspective, and another researcher may have put more emphasis on other experiential statements.

Following the process reported the final analysis was made and is reported below.

Chapter 4 Analysis

Psychology is phenomenological in origin with a desire to understand experience. This analysis aims to understand the participants view of their experience at a time when they had Anorexia Nervosa and what they felt enabled them to overcome this. It is acknowledged that this is a subjective interpretation of the transcripts as seen from the interpretative viewpoint of the researcher and that another researcher may have decided to present the themes differently (Smith et al., 2015; Smith and Nizza, 2022).

Depth of analysis must be thorough with an emphasis on the meaning that each individual brings to the phenomenon under investigation (King, Horrocks and Brooks, 2019). The researcher aimed to honour the individual experience whilst also seeking to find any similarities. There was a wealth of information that was shared and the group experiential themes that stood out for the researcher are presented here.

4.1 Group Experiential Themes

From the Personal Experiential Statements, Personal Experiential Themes emerged, and this led to the formation of Group Experiential Themes. Four final Group Experiential Themes are presented. These are: Group Experiential Theme 1. Losing Me, with the sub themes of: Experiencing Fear, Taking and Losing Control, Perceptions on the Family and Sense of Self. Group Experiential Theme 2. Dark Days, with the sub

themes of: Loss and Hopelessness, Depth of Despair and A Sense of Belonging. Group Experiential Theme 3. Empowered, with the sub themes of: Something Bigger, Regaining Life and Support. And Group Experiential Theme 4. Journeys End, with the sub themes of: Sexuality and Finding Me, What Remains and Reflections.

Table 2

Table of Group Experiential Themes

Group Experiential Themes	Supporting Personal Experiential Statement
1 Losing Me	
1a Experiencing Fear	My whole life was so, outside of school it was horrendous. And in school, I didn't like school, I was bullied a lot, but I loved music, and I loved dance and that's, I threw myself into that. (Rose 130-133)
1b Taking and Losing Control	I was much bigger than I am, and I was the fat one.... I had this kind of almost conscious decision, it was like, oh, okay that's actually something you can do something about (Jasmine 154-159)
1c Perceptions on the Family	I think there were issues with being the middle child at times which I found I wasn't the eldest or the youngest and maybe being three girls that made it harder. (Lilly 98-101)
1d Sense of Self	There was nothing, as I say I was 100% anorexia, there was no me, there was no hope of me (Poppy, 1054)
2 Dark Days	

2a Loss and Hopelessness	I vividly remember my parents leaving me in London and thinking 'Oh my God I'm not going to see them for four weeks' I wasn't allowed to I had to wait and I remember being really scared. (Lily 871-874)
2b Depth of Despair	I saw the consultant psychiatrist, who I really don't like, and he said to me, "It would be irresponsible for me not to tell you that you're dying." (Rose 344-346)
2c A Sense of Belonging	They get you in to get you better but then you go back into a world where you don't feel you belong, you don't feel as if anyone cares, you don't feel the same anymore, you know? (Poppy 728-730)
3 Empowered	
3a Something bigger	I did some incredible things went like, went off with my cousin for a while. And, um, went, like swimming with dolphins and bungee jumping and all just like really off, which gave me the kind of experience with actually life can be quite good. Jasmine 1047-1050)
3b Regaining life	I didn't, I didn't care if I lived or died, I really didn't care, but once you get a life, you do care, you really do. (Poppy 683-684)
3c Support	we'd have a chat, and she was kind of my key worker and she, she knew every game I was playing, she would challenge me on everything. But I really built up a good relationship with her. (Rose 689-692)
4 Journeys end	
4a Sexuality and Finding Me	I was with men in my teenage, in my twenties and then I ended up in a relationship with a woman, urm, and again it was about developing me and actually, I think, it was important for me but really hard. (Poppy 1234-1239)
4b What remains	I don't believe you're ever like fully recovered, but I think it's, but yeah, I kind of don't. I think it's always there to an extent (Jasmine 1164)
4c Reflections on Recovery	I mean to try and find a positive in themselves. I mean it's hard isn't it if you're that low but there is always

	something in somebody that their good at so to hold onto those things that their good at (Lily 664-668)

The personal experiential statements that emerged during the analysis of the transcripts reflect the participants experience of the illness and their reflections on this experience and eventual recovery. Whilst there are similarities in narratives there are also very subjective experiences unique to each individual and these are also captured in the reporting of the group experiential themes.

It is acknowledged that another researcher may have reported the experiences differently and could have arrived at different personal and group experiential themes. When deciding on the themes they initially followed the experience of the participants from the start of their time with Anorexia Nervosa to recovery, but they were then reassessed to look for deeper meaning and personal experiential themes that spanned their time with the illness. During this process new group experiential themes emerged. These will be looked at in turn with personal experiential statements to support each group experiential theme.

The removal of identifying information is indicated by ()
Gaps in the narrative are indicated by .....

4.2 Group Experiential Theme 1. Losing Me

The participants experience of their perception of being in the world is captured here, through thoughts that were expressed on their lives during the journey with Anorexia Nervosa and beyond. This elicited many emotions but also perceptions on how they took control when life felt difficult, their view on some of the things that influenced them and how they felt about themselves. These themes are not mutually exclusive and complement each other.

4.2.1 Experiencing Fear:

A pattern emerged in the personal experiential statements, primarily of fear. These are encapsulated in this section and collectively presented.

> *I think it was when I was 12 and that was, I remember being absolutely terrified. Because I was on a psychiatric ward ..... on an acute ward and it was really strict and rigid and the first few weeks mum and dad weren't allowed to visit and I was 25 miles from home in () and that was really scary really, really scary and you get quite you know you can imagine being on a psychiatric ward it was quite hard I found I was quite scared.* (Lilly 127-136)

Lilly uses the word '*scared*' multiple times and the phrase '*absolutely terrified*' seems to convey the depth of emotion that is recalled. This fear could have been evoked by being away from her family and from finding herself in hospital on a psychiatric unit. The use of the word '*acute*' could be Lily conveying how those she was treated with, appeared to her to be severely unwell. It could also be an attempt to distinguish herself from those she saw as having mental health problems and not seeing them as being like her. The strict routine, being away from her family, without being able to see them, and being around people that are seen as not being like her could have added to the sense of fear and perhaps a fear of what could become of her. Lilly seems to find herself in unexpected circumstances being separated from her parents in a strange, and for Lily a frightening place. There is an image presented of a vulnerable child separated from anything familiar and placed in what appeared to her to be a strange and scary world.

> *I was around eleven or twelve ... I was afraid to eat because I had this sickness bug....my mum went to work... But I do kind of think that was a triggering point, shall we say, but I just didn't start eating again really.* (Poppy 54-62)

In this personal experiential statement Poppy expresses a fear of eating for fear of being sick. Poppy presents the image of a frightened child and in describing her mother's return to work as a '*triggering point*' it is possible that Poppy felt that at that time of sickness that her needs were not met and the return to work could symbolise that she felt that her mother had limited time for her, as when poppy was sick and in need of attention her mother returned to work. This then led to a fear of eating for fear of what would happen while she was alone. Poppy goes on to say:

> *I was definitely really sick because I was hallucinating, I was scared. (Poppy 159) I just remember being petrified; I was on my own* (Poppy, 180)

Scared, petrified, Poppy expresses her emotions at a time when she was unwell, alone, and afraid. There is a sense in her words that she is trying to convey how unwell she was and that she was not getting the care that she felt she needed, leading to further fear at that time. Food was then seen as the potential catalyst to further illness.

Fear is expressed by Lily and Poppy perhaps due to the level of parental care that they felt was needed not being available but for Jasmine, the felt experience was discomfort in the presence of her father.

> *My relationship with my dad's quite difficult. (Jasmine 167) Cause he's got a real temper. He has been aggressive in the past (Jasmine 172). So, it was me and my mum during the week normally, and then me and mum joke now, because I mean, we did talk very openly about it and we do have very serious conversations, but, um, it's like the NSPCC advert where like, he used to like call. When he was on the airplane like literally, like the second he landed he used to call, and it was like this dark fog coming over the house.* (Jasmine 180-187)

There is a sense of dread in Jasmine's words at the impending arrival of her father at home. This in itself gives a sense of the foreboding that seems to be felt but when this comment is viewed again in the light of Jasmine and her mother having '*serious conversations'* about this now, this adds to the feeling that there was a level of fear at his arrival home and perhaps the fear of aggression. The idea of the serious conversation would appear to suggest that the feelings from childhood are still present although perhaps evolved. There could be an implication that Jasmine feels her mother could have done something to alleviate this difficult relationship at the time.

Rose's felt experience of life both inside school and in her home life, was not portrayed as being good:

> *My whole life was so, outside of school it was horrendous. And in school, I didn't like school, I was bullied a lot, but I loved music, and I loved dance and that's, I threw myself into that.* (Rose 130-133)

It seems that for Rose life was difficult and she indicates this using the word '*horrendous'* when referring to life outside of school, (abuse was present) perhaps Rose is trying to impress on the listener the extent of how she felt about her home life. The language used for her time in school is less emotive but still reported as not being liked. The bullying is mentioned, but then Rose moves quickly on to what had helped. Perhaps to avoid the memory or not dwell on a time when life appears difficult. Solace appears to have been sought through music and dance perhaps acting as a distraction from her experiences at home and the bullying at school, providing an outlet for her emotions.

There are different emotions expressed in this group experiential theme but are demonstrative of some of the felt experience of the participants during their time with Anorexia. For Lily feeling alone and afraid, there appears to be no respite as this is in the hospital situation, so change was not possible in the short term. Whereas for Poppy the fear was alleviated by not eating and whilst not a constructive response was seen as

constructive in the circumstances. Jasmine shares her feelings of discomfort at the prospect of her father's arrival home. For Rose, there are two substantial aspects of life both home and school, that lead to the felt experience being summarised using the word '*Horrendous*.' Different words are used to express their emotions but for each of the participants we can gain a sense of the difficulties they are conveying.

4.2.2 Taking and Losing Control

This sub-theme considers control and how this affected the participants. Anorexia is often about trying to take control of food when life feels out of personal control.

Lilly expresses a sense of having no control when she was away from home, on a student exchange visit from school to another country, she reported feeling uncomfortable in a new place that felt strange to her:

> *I remember being quite homesick and not liking the food. And I didn't really like the dad he was a bit creepy, and I remember getting on with some of the others, but she and I just didn't click for whatever reason. And that for me I think was possibly when it started and then from there, I remember feeling uncomfortable about the food and being in a strange country when I remember I wasn't eating perhaps as well.* (Lilly 30-38)

Lily was separated from her family for the first time and experienced discomfort around the father and no emotional attachment to the student. This is recalled as a time of discomfort and a reduction in food intake, that could then have become associated with the food representing change, and loss of control over her environment. It seems that Lilly is feeling a lack of control being away from home and in a family where she is not comfortable, where as an exchange student she does not feel she can leave. Therefore, feeling uncomfortable and not liking the food potentially led to a sense of being out of control, or trapped. The use of the word '*creepy'* adds to a sense of discomfort and the isolation from anything familiar being absolute. The reference to the

‘*others’* conveys an image that there are people outside of this environment that she could relate to but in the exchange home the feeling of being separate and of having no control of this is exacerbated by this knowledge.

Lily felt as if she did not have control, this is different for Jasmine. Initially Jasmine had chosen to take control of her food intake as a means of taking control over her body image.

> *I was much bigger than I am, and I was the fat one, but I thought but I like buried it, which is what I probably still do with a lot of stuff. I just like buried, ignore, ignore, ignore. And so, when I had this kind of almost conscious decision, it was like, oh, okay that's actually something you can do something about, I felt stupid or whatever. I felt like, um, at like family stuff or whatever it was it was kind of a bit like, oh, those bits aren't changeable and actually that's something that's really changeable.* (Jasmine 154-161)

In sharing her thoughts, we see the combination of self-perception, avoidance and realisation and it is at this point that an ‘*almost conscious decision*’ is made to take control of her weight. One can question what is implied using the term ‘*almost,’* perhaps a decision without the knowledge of consequence. It is interesting to note that Jasmine talks of burying her perception of how she sees herself and we cannot know if this self-perception of being bigger is borne out in reality or if this is a distorted view. The reference to the *‘family stuff’* appears to be her comparison to others at family gatherings and a consideration of what she had the power to change.

> *I just don't remember it ever, just being this healthy thing that got out of hand. I remember it being quite destructive and, um, maybe a bit, not even self-harm. I dunno. It just was always quite destructive.* (Jasmine 350-352)

There is a recognition that this was a strategy that was damaging and is considered in relation to self-harm. The restriction was not seen as healthy and is acknowledged as

being destructive from the start. There is a progression from control over food intake to loss of control over the illness. The comment that it was always quite destructive raises the question of why Jasmine embarked on this behaviour when the consequences are already potentially known to her. Perhaps Anorexia is already prominent at this point as opposed to this being the starting point, or the desire for a thin self was more powerful than the fear of the destructive nature of restricting. We later see that this control is lost:

> *If I eat, I don't have to feel guilty because the alternative is you're going to put cream down a tube and I'm going to be like, have this big bulging, like cream tummy, whereas if I eat, I'm probably going to have a few less calories and it's going to be kind of better nutrition.* (Jasmine 998-991)

Jasmine moderated the feelings of guilt that she felt when eating by rationalising that if she ate, she would ingest less calories than she would if she refused to eat and had to be tube fed. The word '*cream*' that is used to describe the food that will be put through the tube conjures up the image of something thick and unpleasant. The bulging tummy is then the image that she presents of herself, which potentially is something that she wants to avoid, not only as a feeling but as an image too, so she goes for the option that feels more bearable to her. It appears that eating is then rationalised to be less calories and better nutrition, and this rationalisation is potentially made to enable her to alleviate the feeling of guilt and to eat, when in reality choice has been removed, and Jasmine is aware of that.

> *I didn't like myself. I remember feeling like that definitely. And that control, yes that's it isn't it anorexia you have that I guess you're trying to control how you are as a person. I guess it doesn't matter I guess the things like self-harm or drugs or whatever it is, it's all how you choose to. Yes, I remember not liking myself definitely. (329-339 Lily)*

Lily talks of dislike of self and control, and for Lily control is seen as a means of

tackling this dislike of herself by taking control of food to try to counteract how she viewed herself as a person. This control is likened to self-harm and drugs as a potential choice in the process of change. Control over food is chosen '*How you choose to'* to alleviate the dislike of self but ultimately this leads to self-destructive behaviour and the development of the Anorexia Nervosa.

For Poppy the approach to keeping control over food whilst hospitalised, manifests in purging and exercise:

> *There was like four of us, it's like cult behaviour. But urm, we'd have four toilets and bathrooms and we'd all exercise and we'd all spend hours making ourselves sick after the meals, it was terrible. But they didn't even know, they only knew once all the drains started blocking up.* (Poppy 522-527)

Poppy and her fellow patients were able to purge and exercise after eating and this appears to have not been initially noticed by the hospital staff during their inpatient stay. '*Cult behaviour'* could refer to the competitive nature and collective behaviour of Poppy and her fellow patients, all engaging in the same routine with the aim of avoiding weight gain. Poppy uses the word '*terrible*' to describe their behaviour when reflecting on it now, but at the time they appear to have been intent on purging everything from their systems, as portrayed in the comment that this behaviour would continue for '*hours'*. The severity and duration of the purging is implicated by the drains eventually blocking up. Poppy and her fellow patients appear to be demonstrating a strong resistance to the re-feeding treatment that was in place, with a concerted effort to continue to exercise and not gain weight and this behaviour further contributes to the comment that this was '*cult behaviour.'* They had not relinquished control over the disorder at this stage, to enable them to engage with treatment.

For Rose, control was taken over food as control could not be taken to avoid the harm

that was taking place in her personal life:

> *When I was a child, I was abused and then rewarded with food.* (Rose 64-65)

Food was the silencer and became associated with the aftermath of abuse.

> *I was very much on self-destruct, I hated myself, I thought the less of me there was, the less there'd be to hate, and I wouldn't take up too much space in the world, that's how it felt.* (Rose 234-237)

Rose's self-perception appears incredibly low, manifesting in a hatred of the self, arising from the abuse, and a desire to disappear, perhaps to prevent further abuse, by reducing her visibility in the world. This could also be a way of trying to let people know that something was wrong. It seems that already on self-destruct, and a feeling that there would then be less of her to hate, Rose took control of food, away from the abuser, as a way of controlling her life, when the abuse could not be controlled.

For all the participants there was a poor sense of self from both internal and external factors and control was taken of food as a means of trying to control self-perception or life. Whilst this initially may have given a sense of achievement it led to the development and continuation of the disorder. Control is taken but then it is lost and what had felt constructive became destructive.

4.2.3 Perceptions on the Family

Family is seen as being important at all stages of life. It is the environment in which one grows and gains a sense of what the world is like. The participants were able to see how familial relationships had played a part in their experience or development of Anorexia Nervosa.

> *I remember my grandparents favouring () being the eldest grandchild and at*

times they made that quite obvious I would say. My grans sister um favoured () with being the youngest and I think that that is probably the reason why I haven't had three children. I think there were issues with being the middle child at times which I found, I wasn't the eldest or the youngest and maybe being three girls that made it harder. (Lilly 94-101)

Lily reflects on her position in the family and considers how she found this difficult. The use of the word *'issues'* implies that being the middle child was difficult for her. There are reasons put forward for this, such as not having the position of oldest or youngest a sense of not being special as the middle of three girls, that is supported by the thought that both her elder and younger sisters were seen by Lily as being favoured. From the extract we cannot see if this perceived favouritism was seen by Lily prior to the onset of the disorder. There is a sense in her words of isolation from her siblings and elder relations. This feeling of familial relations being '*hard*' appears to have perpetuated into her adult life and her decision regarding her own family unit.

The family relationships were complicated for Rose. Her parents' attention was often diverted to her sister who had a long-term physical illness:

My sister, was very, very ill as a child, so my mum and dad spent a lot of time with her, so kind of me and my brother, were kind of left on our own devises. (Rose 135-139)

Rose reports her sister as being '*very very ill*' which is an interesting reflection by Rose as when a family member has Anorexia Nervosa they are usually perceived as the unwell family member, Rose wants to impress how unwell the sister was compared to herself at this time. There is a sense in her words that she and her brother were unable to gain an equal amount of attention due to the illness of the sibling. Perhaps this is a contributing factor to the Anorexia Nervosa and that this illness could redirect some attention to Rose's needs and what was occurring in her life when her parents were

attending to her sibling. For Rose it appears that she did not gain sufficient parental attention as they needed to be available for the unwell sibling and she and her brother were '*left to their own devises.'*

From an earlier extract we saw that Rose was abused and it was during this time when her parents spent *'a lot of time'* with the sibling that the abuse started, and Rose was then holding the secret that the family member in whose care she was placed was harming her. Interestingly this did not become known in the family via Rose sharing but by her mother gaining access to her medical notes:

> *she said," I've read your hospital notes, it says that you've been abused by a member of the family, who was it?" Because you can imagine my mum's sitting there thinking, "is it my dad, is it my brother?" And she said, I was white as a sheet, and I said it was, I said, "it was (()," it was awful. Yeah, but my mum to this day believes that if she didn't, if that hadn't come out, I probably wouldn't be here. (Rose 223-229)*

Rose tells us that her mother has strength in the conviction that holding this secret had maintained the Anorexia and that recovery would not have been possible without it being revealed. Rose does not say if she shares this conviction but could be implied via her recalling her mother's words. The use of the words '*it was awful*' could refer to being challenged unexpectedly and having to disclose. For Rose's mother the abuse appears to be seen as the contributing and maintaining factor.

Poppy recalls a time in the family where she reflects on her behaviour:

> *Your child's trying to kill themselves, literally, and I was terrible, like I used to, when I was around fifteen, I used to engrave things on their windowsill like, "fuck off and die," I was horrible, I was awful. And I used to throw cans of beans at my Mum and, particularly when I was at the early stage of*

> *college, I used to just slam the door, I went through like teenage years like, I was just horrible to her. And that's really affected our relationship because she was an adult, she remembers that, whereas you kind of escalate through your teenage years and you forget how evil you were.* (Poppy 1164-1173)

Poppy starts the recollection by saying that she was trying to kill herself but does not expand on this here, but moves onto self-deprecation using the words '*evil', 'horrible'* and '*awful*' to describe herself during her teenage years, Poppy is potentially trying to convey how she now sees her behaviour whilst unwell, and as an adult is reflecting on the effect that this potentially had on the perceived attitude of her parents towards her as an adult. Perhaps there is regret that she behaved in this way towards them as implied by the multiple use of self-deprecating words directed at herself, or perhaps her annoyance is also towards the Anorexia Nervosa and the effect that she feels this had on her behaviour. Poppy appears to believe that her behaviour then, has created a lack of connection with her parents now. There is a sense that she behaved, at the time, in a way that was her discomfort with life coming through in her actions, and that as she moved to recovery these actions subsided, but on reflection they are now seen as her being '*evil',* and that whilst she has moved forward there is a belief that her parents will still recall these times and that they could be having an impact. There is also the possibility that this is Poppy's fear that her behaviour then has affected the relationship now.

For Lily she felt that her parents were supportive:

> *As I say, mum and dad never showed favouritism between any of us, never so I don't know I don't think there was ever anything from them and they were so supportive when I was ill. I mean Mum bless her I know she had a really tough time it was hard, it makes me cry thinking about it. I mean what I put them through she you know, it was really hard for them and as a parent now you realise.* (Lily - 338-348)

Previously Lily expressed that she felt her grandparents showed favour to her siblings but here she is pointing out that this was not something that she experienced from her parents and that they were supportive. As an adult Lily reflected on how difficult her illness must have been for her parents and it seems that being a parent herself now, she is able to see her own parents' perspective and how much they helped her. The comment '*bless her*' and when she further on says '*makes me cry thinking about it,*' possibly indicate empathy and appreciation towards her mum for her support. Lily does not seem to have had this insight at the time, perhaps due to the nature of the illness being all-consuming, but as an adult she has reflected on how it may have been for her parents.

Jasmine reported a difficult relationship with her father, although at the time, whilst she hated the behaviour, she took it to be normal as friends also had difficult relationships at home.

> *I remember at a really early age, and I don't think this is intentionally cruel, actually. I think it was just like his lack of awareness. Like I remember being at the park and he'd put me on the monkey bars and kind of left me dangling there for ages, like kind of pushing too far, but really like sticks in your mind as being kind of terrifying. (Jasmine 217-221)*

Jasmine made many references to her father's behaviour and the impact that this had on her. The sense of hanging from the monkey bars and then being left there '*dangling for ages*' evokes a sense of abandonment, lack of care, as well as punishment. All these could potentially contribute to a sense of unrest for Jasmine, which could have been a factor in her Anorexia Nervosa. It could be that the reference to '*pushing too far*' seems to be perceived as abusive by Jasmine.

In contrast Jasmine does report a good relationship with her mother during the week when her father was working away, and her brother was at boarding school:

Mum, and I grew really close so Yeah so, we had like lovely times during the week ..... And then at the weekend, my brother and my dad would come home. (Jasmine 261-268)

A good relationship is described between Jasmine and her mother, but this was not enough to buffer against the advent of Anorexia Nervosa.

From the personal experiential statements, we can see some support within the family environment but also the potential for unintended contributing factors to the onset of the illness.

4.2.4 Sense of Self

One could gain a sense of how the participants experienced themselves at the time of the illness. When Poppy talked of how she felt at the time one can sense the seriousness of her condition:

As the anorexia just got worse and worse and worse and from about the age of fourteen I don't think there was any of me there. I think I was the eating disorder, which is really, really sad. Urm… but I, I used to keep a diary every day and literally if you read back six years, it will be the same thing, "I was told to eat this today, I am fat, I am disgusting, I shouldn't be alive, I want to die," all of these things. And that was me. (Poppy 977-984)

As can be seen from this personal experiential statement Poppy seems to have lost her sense of self and by the age of 14 feels she had become the '*eating disorder*'. The emphasis on the word '*really*' perhaps demonstrating the depth of her sadness and her view of this time in her life. At this stage, her disgust in herself seems to be absolute. The comments are all self-deprecating and this is over an extended period, where Poppy

is full of self-loathing, with a misconception of body image, the role of food and the impact that this will have on her. '*I shouldn't be alive*' conveys a different message to not wanting to be alive. The '*shouldn't'* makes this sound as if it is essential, not a wish or desire.

> *There was nothing, as I say I was 100% anorexia, there was no me, there was no hope of me.* (Poppy, 1054)

Poppy's sense of self is lost, '*I was 100% anorexia*' is the extent to which Poppy felt in the grips of the disorder and who she had been or could be appears to be gone.

> *I was very much on self-destruct, I hated myself, I thought the less of me there was, the less there'd be to hate, and I wouldn't take up too much space in the world, that's how it felt. (Rose 234-237)*

Rose's words seem hopeless and lack any self-compassion. There is a recognition that the current behaviour is detrimental to the self but without the intention of stopping. The idea of wanting to disappear could be an attempt to eradicate herself from further harm or a continued need to not be seen to prevent this harm. There is a sense in her words that her situation was too much to bear.

For Lily, the misconception of the impact that eating will have on the self is borne out:

> *I can remember thinking as soon as I eat something I'm going to get fat, you know, you just have this really disproportionate view, you know, I'm going to put on five stone, I think in a biscuit. (*Lily 1019-1022)

Whilst Lily is aware now of her distorted view of her shape and weight this insight was not available to her at the time. The belief is that any food intake will lead to a significant increase in size and then a dislike of self. With hindsight Lily is now able to

see that this view was distorted through the comment of '*you have this really disproportionate view*.'

The disproportionate view is shared by Jasmine:

> *Then it's really embarrassing cause I'm going there with eating issues and then they've weighed me, (yeh) you know? Yeah, she's just meeting the criteria or whatever. So, then I went on a bit of a mission. I remember that being really hard period, where there was no, intervention really in between.... Yeah. well not to prove I had an eating disorder just to, just to prove that I wasn't like just cause I was so embarrassed of my weight, I felt like God, if they weigh me and I weigh what I weigh now. Um, yeah, it's just, it's just be so like humiliating.* (Jasmine 471-482)

Jasmine is waiting to be assessed for an eating disorder but here we see her self-belief is that she is overweight and will find it humiliating for her current weight to be seen by the professionals. This leads to her determination to lose weight. Her sense of self is that she is overweight and there is no consideration of the fact that if this were true, she would potentially not be referred for an ED assessment. The fear that she presents is that when weighed the professionals will think she is fat. There is the mention of the criteria that needs to be met if she has an ED but then disputes that she is not trying to 'p*rove she had an eating disorder*' but was genuinely embarrassed by her weight. There could perhaps be a concern that she will not be unwell enough to access treatment so needs to ensure that her weight is reduced further, or her self-image could be so distorted that a correct sense of self is lost.

From these personal experiential statements, we have seen how the participants had lost sight of who they were and had a distorted view of their shape and weight affecting their sense of self, and how they viewed themselves, or how they thought others would view them regarding body image.

4.3 Group Experiential theme 2: Dark Days

4.3.1 Loss and Hopelessness

When the participants spoke of their experience there was a sense of loss and a feeling that things would not change, leading to hopelessness.

> *When, particularly when they took away, they'd already took away running and friends and family, when they took away school, there was nothing to live for. And I took a massive overdose of paracetamol, urm somehow that didn't kill me, and I slashed my wrists and that didn't kill me, I ran across London in front of cars, that didn't kill me, so I was a bit invincible at that point, but I really didn't want to be here. I hit rock bottom.* (Poppy 1055-1063)

There is a sense of hopelessness in Poppy's words and her portrayal of how life was for her at this time. There is a sense that all of the things she loved are lost at this stage. Poppy is expressing that with the removal of everything that had made her life feel good, this had led to her first suicide attempt. For Poppy there seemed to be no recognition that the Anorexia had become so entrenched that there was a need to remove activity due to the risk to physical health, but only a sense of loss. Following the first suicide attempt there is almost a sense of surprise at her survival, and this is then followed by further attempts to end her life. Poppy lists off the different methods that she tried as if they are everyday occurrences, perhaps to distance herself from the seriousness of what she is recalling. The comment on being invincible could be Poppy trying to make light of a time when she was seemingly beyond help or as if she feels that somehow, she could not even manage to kill herself. There is a sense of resignation that everything has been taken away from her and she cannot even end her life. '*I hit rock bottom*' feels like the final recognition that things could not get worse and ending her life had not been possible with an acceptance that she is still alive.

> *I vividly remember my parents leaving me in London and thinking 'Oh my God*

> *I'm not going to see them for four weeks' I wasn't allowed to I had to wait and I remember being really scared. I can't remember isn't that awful how you forget but I do remember them not being able to visit me for a while and you had to write and that being really really scary and as I say hearing all these people banging down the corridor.* (Lily 871-881)

For Lily there is a sense of hopelessness and fear as she is separated from her home, family life and from her parents. Whilst some of the memories are forgotten, being left in London is reported as vivid. The idea of not seeing her parents for four weeks is shared as a frightening experience for her at the time. The '*banging down the corridor'* refers to other psychiatric patients who would '*kick off'* (162). Adding to the sense of separation and fear. Four weeks feels like a long time for Lily to not see her parents and for the only communication to be by writing. Being left, thinking this would be for a long time, and then hearing other patients, all leading to the sense of fear that is expressed and perhaps loneliness. This is a time when hopelessness appears to be present for Lily.

Rose spoke of the regime in the hospital and the loss of privileges:

> *I was given my own room, and it had a sink in the room, but I was told that if I didn't eat, or if I lost weight, they would urm move me to the dormitory, where I had to spend time with other patients. I still didn't eat, I wasn't allowed visitors, and it got to the point I wasn't allowed to shower, you weren't allowed to do this, we're not allowed to do that. And I spent the first couple of weeks leaving my bed from one room to the other, it became a joke, it became an absolute joke* (Rose, 398-405)

We see here that if Rose ate, she had her own room but to not eat meant time on a ward with other patients. The sink is mentioned and seems significant, perhaps symbolic of having her own space. The movement from the room to the ward is referred to ironically

as a joke and we can sense the frustration that this evoked in Rose. Once again, we see that there is a loss of contact with the outside world as visitors are not allowed. The routine was not seen as helpful:

> *So, you can't do therapy, that would be abuse in itself. However, I felt that the privilege, punishment treatment programme they had was just reinforcing the abuse on another level, does that makes sense? And it kind of, the negative emotions you have about yourself, are reinforced.* (Rose, 531-535)

For Rose, who had the experience of food being used as a reward by her abuser, the privilege and punishment regime enforced the idea of food being used by a third party to exact what they needed.

> *I was just getting worse and worse and worse um, my weight had dropped down to like thirty eight kilos and I was about the height I am now um, and I was having signs of liver failure and I already had a real serious liver damage and my thyroid wasn't even showing as being a thing anymore and I'm starting not to walk and things like that. And so the consultant at the time, ... basically said to mum, I'd never seen the consultant before, they basically said to mum, she's got about two weeks to live at the moment if this carries on.* (Jasmine 901-910)

Jasmine's health had deteriorated and there was a serious risk to life. The internal organ damage that is reported is unseen but when presented with the image of someone too weak to walk this gives the impression of the apparent hopelessness of the situation and that physical well-being is now severely affected.

For each of the participants we can sense the hopelessness that each of them felt regarding their situation and the impact that Anorexia Nervosa was having on their physical health.

4.3.2 Depth of Despair

The Anorexia had taken all of the participants to a dark place where physical health had deteriorated to such an extent, loss of life was seen as imminent if a change did not occur and there was also the risk to life from themselves.

> *I was very low in weight they were worried I wasn't going to survive because I was my stomach had just got to the point where I think that I'd you know my body was bad I had to go on a drip and be you know and that was really scary when I first went in there and that was really really scary.* (505-511 Lily)

Lily's health has deteriorated to a point where survival may not be possible. The drip is recalled, and fear is present as it often is when Lily recounts her experience.

> *I can remember that we were in this room and there was a lady in particular who I remember, and we weren't allowed to leave the table until everyone was finished their food and we were sat at the table for hours. I remember and they locked the door because they worry about people kicking off. (163-169 Lily)*

Lily recalls one lady but does not expand on why she is remembered. Perhaps this was someone who took time to finish and is recalled when considering the time spent at the table. The door being locked does not add a sense of security as it would seem that any '*kicking off*' would be in the room where they were eating and waiting. Instead, there is the image of insecurity.

For Rose the hospitalisation was her low point, she was placed on a general psychiatric unit not a specialist eating disorder service and Rose struggled being around patients who she viewed as being different to her, more unwell.

> Yeah so, *I went in, I had no choice, went in, oh god, () it was awful, they put me on ward seventeen which was like a square and for a seventeen-year-old girl, being put on a unit with people that has schizophrenia,*

> *psychosis, urm bi-polar it is really frightening. And it's in a square, and you just walk past, it reminded me a bit of, have you ever watched One Flew Over the Cuckoo's Nest?* (Rose 367-373)

The comment that Rose '*had no choice*' could indicate that due to the severity of the illness hospitalisation was required and that this was no longer negotiable. Rose then uses emotive words to describe her experience of being with other patients with severe, non-ED, mental health presentations. The inclusion of the ward number and her age add to the impact of her words in the recollection of the event. Rose mentions twice that the ward was '*in a square*' and *'you just walk past it'* this could allude to a lack of privacy. The reference to the '*One Flew Over the Cuckoo's Nest,*' could be a reference to the fact that the main character did not see himself as unwell but was with those who were. Rose indicates potentially that she sees the fellow inpatients as frightening and not like her.

Jasmine considers her experience of being on a psychiatric unit compared to being in a specialist unit.

> *Yeah, it was a mental health hospital. I don't know how I feel I did feel eating disorders should be separate personally. There's been pros and cons. You know, I met some people along the way, but I was also exposed to a lot of violence, lots of serious self-harm. Um, somebody committed suicide.* (Jasmine 853-856)

Here Jasmine is reflecting on the treatment environment and moves from not knowing how she felt about her time on the psychiatric unit to believing that EDs should be treated separately. Jasmine considers the pros and cons of her stay on the psychiatric unit, and it is implied that some of the people that she met were the pros but the self-harm, violence, and suicide that she was '*exposed to*' were the cons.

Jasmine also talks about a suicide attempt and the realisation of how unwell she was.

> *I also had quite a serious suicide attempt. Like I took a shed, load of painkillers and all sorts. And um was resuscitated, actually my heart rate was like 12 or something ridiculous or 15 or something. I was really unwell. I remember my brother coming in to say goodbye to me.* (Jasmine 900-903)

The word '*serious*' is used to emphasise the gravity of the situation at the time. Here we see that life was almost lost as Jasmine is resuscitated due to her physical deterioration. The use of the word ridiculous about her heart rate, could be inferred to her physical condition and the attempt on her life but also to the recognition of the severity of her illness. The visit by her brother is also a reminder that the end of life was potentially seen as imminent.

> *My Mum, she was so… she was – I can still hear her screaming, urm… and I don't know how many I managed to take, but I had like eight boxes in their bathroom, and they broke the door down and they took me to the hospital, and I had my stomach pumped and everything like that. Urm… but… it wasn't just a cry for help, you know. Like I, when I was at, (), I think the depression really took hold because I wasn't getting fed up and pushed out the door, there was no hope of getting out, yet I didn't feel supported to find an end point. So, I used to self-harm quite a lot and cut my arms and things and… it was just, that was a really dark place* (Poppy, 1160-1170)

The memory of her mother '*screaming'* is still clear. We then see what is taking place behind the closed bathroom door. Poppy points out that this was not '*a cry for help'* implying that the desire to die was very real. She then takes us on to understand why this may have been. The feeling that there was to be no end to the illness and therefore no escape except to escape life completely. Poppy feels that there is no support to effect change and recover and therefore she is in '*a really dark place.'*

A further illustration of this '*dark place*' is seen when Poppy talks of her fellow

inpatients:

> *I don't think my treatment was necessarily ideal, but I had treatment and I survived. Urm, and of those, those four of us, I'm the only survivor. They all died and in fact, seven people I knew from that, my journey, they're no longer here. And only, maybe three of us are well enough for people not to know.* (Poppy 1698-1700)

Poppy expresses that her treatment was not ideal but is then able to acknowledge that she did have treatment and potentially this contributed to her survival, whist her three fellow inpatients from the time all died. The fact that she says, '*I survived*' and then '*I am the only survivor*' indicated the acknowledgement that she was the lucky one. It is interesting to note that she then says that '*maybe three of us are well enough not to show*' potentially bringing up something that is important for Anorexia Nervosa survivors, or at least for her. That it is not only about surviving but not showing signs of the illness either. By saying '*And only*' possibly Poppy considers this a real achievement. Poppy is possibly aware at this point of how her journey could have had a different outcome.

Rose on the other hand talks about how the words of a psychiatrist about her condition had an effect.

> *And I saw the consultant psychiatrist, who I really don't like, and he said to me, "It would be irresponsible for me not to tell you that you're dying." And he said, "unless you stop this now, or we do something else, you are going to die, your heart is suffering,"* (Rose 344-349)

Rose tells us the words of her consultant psychiatrist rather than telling us this in first person. Perhaps she is trying to put distance between the illness and herself. What is presented in his words is the severity of her condition to the point that death is seen as a serious possibility. '*Stop this*' gives the impression that to do so would be easy

whereas '*do something different*' could be seen as a need for everyone to make changes. What is clear is that Rose can recall his words and so perhaps internalised the message that change was needed to prevent further physical deterioration.

4.3.3 A Sense of Belonging

This Group Experiential Theme looks at the participants' sense of belonging. In the narratives there were times when they had felt part of something good and at others feeling separate from those they tried to interact with.

All of the participants had lost out on external friendships due to hospitalisation and felt unprepared to return to their previous life when discharged.

> *no one cares. ... and it was that you didn't feel the same when you came out as well. So, it felt like a lot of… yeah, they get you in to get you better but then you go back into a world where you don't feel you belong, you don't feel as if anyone cares, you don't feel the same anymore, you know? (Poppy 726-730)*

The absence from school appears to have impacted Poppy and her sense of belonging. It seems that Poppy had certain expectations of how she would feel after coming out of hospital. The comment on not feeling the same could be an expression of the change she felt in herself after being in hospital and away from her school and friends and she possibly had expectations of how things would be once she returned. There is a sense of not fitting in that could then have led to the assumption that she was not cared for *'no one cares'*. There is also a sense of separation in her words, a disconnect from her reality is conveyed when she says *'you don't feel you belong'* where her world of illness and hospital were not compatible to the world she then re-entered once she was considered to be well enough.

This feeling of no longer belonging meant that school was seen by Poppy as better in hospital as they were in a shared environment, being educated together, without the

need to seek out individuals for friendship. This took the pressure off Poppy and gave an automatic sense of belonging and care.

> *but I wonder whether I actually quite… felt better when I'd been admitted there because I had, I always made friends there, there was always lots of different people that cared and, school was better there because it was just a small group of us and I didn't have to try and belong, you were put with people.* (Poppy 412-418)

In hospital for Poppy the effort needed to form friendships was removed, making life seem easier, the desire to belong was fulfilled and the care that was thought to be missing was found here. A sense of belonging comes through in Poppy's narrative as she talks of schooling being better in hospital as they were in a shared environment, being educated together, without the need to seek out individuals for friendship. This gave Poppy a sense of belonging but may not have been an incentive to change, as change would mean a return to the world where she did not feel cared for.

Lily was also aware of this difference in treatment by peers after hospitalisation and on returning to school.

> *I think people were probably wary of me at school I think probably. At secondary school I think the last year I was there more so, but it did make it hard probably to build up friendships.* (Lily 435-438)

Lily uses the word '*wary*' and in this we see the perceived disconnect from friends and peers because of the prolonged separation from them due to inpatient treatment. There is tentative language used in '*I think*' and '*hard probably*' perhaps this is a consideration of what made the formation of friendships hard. Potentially friends were '*wary*' of forming a relationship in case Lily was absent again, and a consideration that if an individual is absent from school for any length of time or is intermittently absent then

this can be disruptive to friendships.

Rose initially talks of a different kind of belonging, that of closeness to her siblings.

> *I'm not as close to her as you see some sisters are. And that saddens me because it would be nice to have that, but we're not. And my brother, interestingly he just split up with his wife and my relationship with him has really, really built quite well. So that's, that's good. But at the time, the relationships were awful, I lost friends, obviously, because your friends are seventeen, they're going out, they don't want to go to a psychiatric hospital* (Rose, 1066-1074)

Rose is considering the impact that her illness had on her sense of belonging to family and friends. The implication is that there has been an opportunity to improve this with her brother as an adult due to a change in circumstances but that when younger there was perhaps no opportunity for the development of close relationships with her brother or sister, in part, due to the time spent away from them in hospital. Rose expresses how this saddens her as something that was lost and has not been fully found. This leads to thoughts of friendships and an understanding of why these were lost. Whilst there is understanding now this could have been painful at the time and contributed to a sense of separation from those outside of the hospital.

For Jasmine, the sense of belonging altered over time and experience:

> *So a girl I went to primary school with, ... she did stuff to me. .... but when I got away from her, um, because she didn't pass her 11+, I was really happy at school the first few years and had a good friendship group. And then in year nine, she was let in and that was really hard. .....Yeah. I think her then coming in and interfering with the friendship group and she made lots of comments. I really, not massively, used to laugh it off and bury it quite deep, so it didn't make me feel awful but something about her being there, just, yeah, it did feel horrendous. I*

mean, that massively that massively impacted on friendships and in years I don't keep in contact with anyone from that school really now. (Jasmine, 597-624)

In Jasmine's words we see the feeling of escape '*I got away from her*' and the formation of friendships at her new school. Then this changed in year nine when the girl who '*did stuff to her'* joined the same school. We see that Jasmine tried not to allow the comments to hurt her but the feelings that are present allow us to see that this was difficult when she talks of trying to bury her reaction to alleviate the way it made her feel. '*Massively'* is the word that is chosen to describe the impact that Jasmine feels this had on the formation of friendships and how these friendships were ultimately lost or not kept. There is discomfort in her words, and this gives the impression of how difficult this experience was for Jasmine and the distance from these relationships that have been put in place, perhaps to protect her feelings in the present.

After spending time in a specialist eating disorder unit, it was time for Jasmine to return to school:

When I realised that going back to school without having been educated for two years was not my best idea. I just said to mum, look this isn't working. Why don't I get a job so I got a job at () and I just loved it. Like I had a really cool group of friends. Um, I got a lot of positive feedback, and I got promoted almost immediately I just had a laugh with it I liked being around the kids so we could joke being really Silly. (Jasmine 1179-1184)

Jasmine takes the decision not to return to her school and the reason given is due to the 2 years that she had missed. But could there also be some avoidance here of the girl that she had previously '*escaped from'* and her experience at the school, with the disruption to friendships, influencing her reason for not returning. The time taken out of school to work appears to have boosted her confidence via the formation of friendships and positive feedback for her work.

Jasmine then started at a new school:

> *I've always had friends, always not had any problem connecting with people, but it was just nice to, I think it was nice to have like a different group of friends and you know, I'm friends now got a lovely group of friends about 12 of us, we've all known each other since school.* (Jasmine, 1196-1199)

Here we see a change in that these relationships seem comfortable and have been maintained. The past was left behind and a sense of belonging is established. This different group of friends had not been part of her journey with Anorexia Nervosa, perhaps enabling a fresh start in her recovery.

> *when my mum went on, when they went on holiday, I remember, without me, I was really upset, and I was stuck in hospital. They went on holiday. I was, remember being, but I think, you know, it was hard because. You know, it must've been hard for them because I think they thought, oh, they go on holiday with your parents as well. Then I was stuck in hospital and then they were, oh, we don't, you know, but it's hard because it was their summer holiday* (Lily 1341-1351).

There is a sense of abandonment in Lily's words and the feeling of separation, both physically and emotionally from her family, is conveyed. Initially 'blame' is placed on mum and whilst Lily is able to reflect that her siblings and parents needed time to enjoy the summer this does not prevent the sense of loss coming through in her words. '*It was hard*' refers to both her and the family but the word '*stuck*' gives the feeling that the person who was missing out was Lily. The sentences are partially formed as Lily recalls her feelings at the time and her reconciled thoughts on them now.

From the PETs it can be seen that the participants experienced a sense of loss in close relationships and sought belonging in the friendships that they formed and were able

to recognise when a disruption to this formation had taken place.

This theme has shown us some of the challenging times in the participants' journey with Anorexia. From hopelessness and fearing that recovery is not possible, the loss of friendships and the times when loss of life was seen as imminent, or the hopelessness was so absolute that an attempt to end life was made.

4.4 Group Experiential Theme 3: Empowered

Self-actualisation emerged in the narratives of the participants when they talked of their recovery from Anorexia and the change, they experienced in themselves that enabled them to regain life from what had been lost during the illness.

4.4.1 Something Bigger

During the illness, the participants had all experienced a reduction in previously enjoyed activities but had felt unable to make the changes needed to regain this life. Then for each of them something changed, and they became able to change the behaviours that they had become entrenched in and started to move towards recovery.

> *Yes, I remember that* (being on a drip in hospital) *and thinking maybe, maybe something clicked, and I thought, come on you know I don't know, you can't carry on like this you know but yes, yes. There was a cycle there yes definitely but to break that cycle.* (Lily 505-509)

There is a realisation by Lily that the cycle would perpetuate unless she opted for change. The use of the word '*but*' could imply a recognition that this could be difficult. With the comment '*I remember thinking*' there seems to be a self-realisation of the desire for change and to break free from the cycle she had been trapped in. There is a recognition of the patterns of behaviour that she was engaged in and how this would perpetuate unless she made significant changes. This feels like a moment of choice, to continue the cycle or take the necessary action to change.

For Jasmine she had found the return to her old school too uncomfortable and started at a new school, whilst still being monitored for weight loss. The desire to belong motivated her to change:

> *It just wasn't worth it anymore. So again, it just, it totally freed me of guilt Cause it's like, well, if I don't, if I lose weight, I'm gonna spend my whole weekend in () on 4,000 calories, restoring the weight and then I go back to school on Monday, my new school and you know, they'll have a lovely weekend. and I'll pretend I had a nice weekend too, I hadn't told anyone.* (Jasmine, 1054-1058)

The maintenance of the Anorexia is seen as a hindrance which is implied by *'just wasn't worth it anymore*.' Jasmine appears to rationalise that she could let go of the guilt she felt when eating, as weight loss was now seen as a hindrance, because being in hospital at the weekend was stopping her from engaging with life and was also perpetuating her having to pretend to new friends that she had *'a nice weekend too'*. Being freed from guilt to avoid being hospitalised appears to have helped her to engage with food. The idea that Jasmine had not told anyone at the new school could imply that there was a sense of shame over the illness she was trying to recover from or perhaps a desire to move away from that aspect of herself, she has left her old school, which could be symbolic of wanting to leave the Anorexia behind, she has become able to engage with food and feels freed from guilt and has a desire to engage with new friends.

The establishment of friendships at a new school had enabled Jasmine to engage with life and therefore food. For Poppy it was not a good relationship that initially empowered her to effect change, this came later:

> *the lead nurse - she wasn't very nice – she sat down with the three of us who'd stopped eating and said, "the chances of people like you who are this*

> *entrenched with Anorexia is… 90% of you will die by the time you reach your twenties, you need to get a grip, and you need to do what you're told to do." Urm but actually for me I thought, do you know what, I am going to prove her wrong.* (i.e not die) (Poppy 1030-1037)

Poppy recalls this moment and whilst this was a harsh comment Poppy says it inspired her to prove the nurse wrong. She reports the nurse as not being nice but is also able to recall her words, showing the impact that this information had on her at the time. '*Get a grip'* and '*do as you are told*' is what Poppy then did but recalls this as proving the nurse wrong, perhaps showing that the part of the message that resonated was that 90% of those who are entrenched with Anorexia Nervosa will die and this was what Poppy proceeded to disprove. There seems to be a sense of determination that comes from Poppy, perhaps a rebellion against being spoken to harshly if realistically. The way Poppy conveys that the nurse speaks to them is as if she considers them incapable, somehow infantilising them, which is something that motivates Poppy and could potentially be seen as a turning point to her making changes

> *I went back to her once I'd recovered and I said, "oh look what you said to me," she couldn't remember and I said, "please don't say that to anyone else, it did work for me, but it probably won't work for anyone else.* (Poppy 1124-1128)

Here we see the recognition that for Poppy the comment had motivated change, but she can still see that for others it may not have the same effect and could be demoralising.

As Rose started to recover, she had a desire to help others:

> *I started to, I was really, really getting better and really wanted to do something to help people with eating disorders, and I remember the thing that absolutely switched it for me was I got two choices here, I remember () bringing to hospital a cut out of an article on the (), and it was on (), and it said, "() weighs just three*

and a half stone, she feels like she takes up too much space in the world." My God, that's how I feel. (Rose 828-835)

Rose read the words of someone who was experiencing Anorexia Nervosa and felt a connection having felt the same herself before her journey towards recovery. Here we see that to 'witness' the plight of another who was still in the depths of Anorexia Nervosa prompted Rose to want to help those who were experiencing an eating disorder. We later to see that from this point Rose takes the decision to work towards recovery:

okay, I'm really going to give this a go, and work with them or work with () (Rose 891-892)

The choice to change has arrived and Rose sounds empowered.

For each of the participants there came a point where something or someone in life motivated them to make the changes that they needed to make to get better. Once the journey to recovery begins, they are empowered to continue by their own strength and commitment.

4.4.2 Regaining Life

Jasmine's desire to belong once she started the new school and gained new friendships led to a charge in mindset on what she saw as important:

I think life just suddenly became more and more important. (Jasmine 1127)

This feels like a key comment in Jasmine's journey, the point at which life is seen as worth living and therefore more important than Anorexia Nervosa. School was not the only thing that Jasmine engaged in, leading to the sense that life was being regained from what had been lost.

> *I did some incredible things went like, went off with my cousin for a while. And, um, what, like swimming with dolphins and bungee jumping and all just like really off, which gave me the kind of experience with my actually life can be quite good.* (Jasmine 1023-1026)

There is a sense of excitement in her words at the things she was able to do and a sense of freedom that she can engage in activities and that '*life can be good*.'

> *I think the thing that saved me really is choice and taking responsibility. Because as a child, you have no choice. And going to uni as well, that was, my parents were petrified, because my plan was go as far away from home as possible, I like applied to like () and () *laughs* and in the end I went to () which was quite a compromise really, but I met the nicest group of girls possible, and we lived together.* (Poppy 740-751)

Poppy takes responsibility for her life in this extract by choosing her university. Something simple that is seen as significant as she has a choice which is something that had been missing in her life. It is interesting that having spent a long time away from home Poppy is also opting for a university that is not close to home. Perhaps this was to try to establish independence, which had been lacking in her life. Poppy can meet new people at university and in describing them as '*the nicest group of girls possible'* we gain a sense of closeness and feeling cared about for who she was and being able to live independently would have been a new experience.

Poppy expressed that once life felt as if it was being regained it became important to hold onto this:

> *I didn't, I didn't care if I lived or died, I really didn't care, but once you get a life, you do care, you really do. (Poppy 683-684)*

For Poppy, her previous disregard for life is overtaken by a desire to engage with life.

When Lily was well enough to leave hospital and return to school it was embarrassment that led to a change in her behaviour towards food.

> *And one thing I absolutely hated when I started going back to school was my dad drove over from () where he was at work, bless him, to sit and have lunch with me,....and I absolutely hated it because I was different to my friends and that worked because I didn't like the fact my dad turned up. You know it was a bit embarrassing. You know ..... because I needed to be supervised when I started back at school then he'd go back to work and I absolutely hated it.* (Lily 943-9 60)

'*Bless him*' appears to show that this is recognised as a good thing that her father is doing but does not detract from the '*hate*' that she expresses at still being different to peers due to the need for supervision and this being provided by her father. The word '*hated*' is used multiple times showing the depth of this feeling at the act of being supervised. It appears that the embarrassment motivated her to want to eat unsupervised, either to fit in with her peers or to avoid feeling embarrassed.

For Rose her absence from daily life and friends was not always absolute. Rose spoke of several occasions when she had been able to leave the hospital unnoticed:

> *I did get a friend to get a runaway car for me. A runaway car, I went out, I said take me out for the night to the pub, just take me out, so she came in, got her sister in the car, again I sneaked out. I went out for the night, came back, nobody had known I'd gone. And then it came to medication, in those days I had Lambrusco and it would knock me out, I had some Lambrusco, and I was all rosy cheeked enjoying and happy, and nobody noticed.* (Rose 1076-1085)

Rose was able to stay in contact with friends whilst an inpatient and whilst absconding

would not have been ideal for her health, perhaps it gave Rose a sense of normality in a life that was not then normal. It is interesting to note that she had not been missed by the hospital staff even though she had been out for the night or that the alcohol was not detected on her breath at the time of medication. For Rose there was some connection to her previous life that could have buffered against the effect of the illness. Perhaps for Rose this was a reminder that life was there to be regained.

Whether life was regained, or never totally lost, this link to the world outside of hospital was important to all of the participants and perhaps a contributing factor to recovery.

4.4.3 Support

The participants spoke of those who had supported them, be it family, friends, or professionals, during their time with Anorexia Nervosa and how this helped on the road to recovery.

A nurse with an interest in eating disorders was the turning point for Rose:

> *My last visit, okay so it's probably one of my worst nightmare visits in terms of my health, I, what happened, there was a nurse on the ward, called (), and she had specialist interest in eating disorders. So, she set up an evening group, self-support group with patients who were actually outpatients who used to come in, because I was an in-patient, we'd go into this, and just have like a meeting, like self-support and we were all over eighteen we'd yeah, normal.* (Rose, 718-726)

From Rose's initial comment we see that this was her last hospitalisation and that at this time her health was poor. But this is also the visit where things changed for her in terms of recovery, and we make this assumption because it was her '*last'* time as an inpatient. It would seem that the treating nurse had experience of working with those with an

eating disorder and managed to engage Rose. The engagement with those attending the outpatient support group allowed Rose to see that there was the possibility of recovery or at least of managing her Anorexia Nervosa well enough to also be an outpatient.

> *we'd have a chat, and she was kind of my key worker and she, she knew every game I was playing, she would challenge me on everything. But I really built up a good relationship with her. It's the first professional I actually started to trust.* (Rose 689-693)

Here was someone who engaged Rose by building a good therapeutic alliance. The change for Rose appears to have happened via this engagement through conversation and the nurse taking an interest in Rose. By saying '*she knew every game I was playing*' shows that here was someone who was knowledgeable of the behaviours that those with anorexia could engage with to avoid eating and weight gain and would then challenge Rose on her thinking and behaviour. Whilst the nurse '*challenged her on everything*' this did not prevent the establishment of a good therapeutic alliance. There is perhaps an element of respect for the nurse's knowledge and therefore being challenged felt acceptable. The use of the word '*actually*' hints of a slight disbelief that this has happened with a professional.

> *She never tried to force feed me, in fact she got me to eat more than anybody else without even trying. Because she'd kind of sit with me at mealtimes and just natter about things. We'd have a laugh about things and I'd eat sometimes without realising. It's very clever.* (Rose 916-920)

Here we start to see the importance to Rose of having someone who would sit with her and engage with her whilst trying to eat. The idea that she was not '*force fed*' appears to have relaxed Rose, perhaps taking her off guard and instead of the re-feeding being a medical intervention this became a supportive intervention that enabled a change in behaviour. The idea of the '*natter*' could have enabled the focus to be taken away from

what was being ingested, and the '*laughter*' lifts the mood. '*It's very clever*' could be the acknowledgement that this approach allowed for the eating to become part of the process of engaging with another individual, instead of food being the only focus. There seems to be something about a sense of normality implied in that it felt more like two people having a chat over a meal. The reference to the '*chat'* and this feeling *'normal'* gives the impression of a relaxed atmosphere. The relationship with the nurse shows a recognition that this was someone who understood the nature of the Anorexia Nervosa and the behaviours that could be engaged in. This trust potentially led to further engagement with another professional:

> *I went to see an amazing psychologist, called (), I had two years with her, I think..... Yeah, and she was absolutely amazing. Yeah, I really haven't looked back since.* (Rose 924-932)

Lily also recalls support from a health care professional:

> *I had a very good Dr there and um I think she was pretty hard on me looking back she really was, but I think I probably needed that, I needed that and like. The family therapy wasn't nice to go through and for any of us really it was quite a hard experience I think but I don't know whether, whether something just finally clicked in me. I do remember her being really strict with me and I wasn't allowed to do certain things when I was in hospital and yes whether that treatment just something worked better or I don't know whether I was just working through my teenage, I don't quite know really but that I do remember that sort of working, working better for me.* (Lily 463-473)

Lily reflects that the doctor was '*very good',* but this had been a difficult process at the time for herself and the family, a '*hard experience*.' There appears to be a contemplation in the moment as to what had helped. There is the possibility that the therapy worked but Lily seems uncertain about this, and the reflections seem to suggest that time had

played a part in her being ready for change when she talks of working her way through her teenage years. We see here that the regime was '*strict*', and this meant that Lily was closely monitored during her treatment, not being allowed to engage in certain activities. When she says '*that worked better for me*' it is unclear if this was family therapy, the strict routine, or the progression of time.

Support can come in different guises:

> *Yes, I think at school I would throw my sandwiches in the bin in a paper towel I can remember doing that and Jogging in the toilets and I had a couple of friends who would go and tell the teachers. Then of course I'd be cross with them and the matron at school would erm be watching, she kept an eye on me. I remember being cross with my friends, they were trying to help me and even now I've got one friend from school I still see, ... and to this day she'll say we were really worried about you. You were a massive problem* (Lily 268-277).

The support in the guise of friends watching Lily and reporting her if she was not eating or she was exercising was not seen as helpful at the time but could show that her friends cared enough to risk the friendship perhaps in an attempt to keep her safe. Lily can recall that she was cross but can now see that they were trying to help. There is also the matron at school who tries to monitor her behaviour. The jogging in the toilets and throwing away her food allows us to see what Lily was trying to do to avoid eating and weight gain. Whilst this support is not cited as facilitating change it is potentially a positive presence in Lily's life.

Poppy was supported by a nurse who worked with her collaboratively:

> *she said,* (the nurse) "*look, what we're going to do is you're going to start going home, urm but I really want you to try and get to thirty-eight," and she said, "but it needs to be up to you this time." And they worked with me, as an outpatient for*

a year, and I managed to get to thirty-eight kilos on my own terms. And whilst still doing sport and going back and doing my A-levels. And then I went to uni. (Poppy 684-690)

There is a sense that the nurse is handing some of the control for eating and weight gain to Poppy by making the decision to increase food intake, and increase weight, a collaborative process. Feeling involved in the process could have moved the re-feeding from something that was being done to Poppy to something that she was actively involved in, and the additional incentive was being allowed to go home after a prolonged stay in hospital. We then see that Poppy starts to engage with school and activities again which was something she had been unable to do and had missed.

I started seeing a lady called () .....and that made a massive difference. Um, Um, yeah, so I saw her not for not for like that long, uh, but that really did make a difference. For me to understand it better and understanding that cause so many books portrayed, eating disorders as like you've got to, it like talks to you. And it's almost like with some people it's described as being another voice, but I came to understand, okay, it is still my voice and it's still my thoughts, but it's a set of thoughts and behaviours. And it's my fault still because it's my thoughts. But I came to view it like a bit differently. (Jasmine 1141-1153)

Jasmine is helped to see her Anorexia in a way that enabled her to have a deeper understanding of her thoughts and behaviours. The move from reading about EDs in books to relating this back to herself and reaching her conclusions on the theory and how it applied to her sounds empowering.

Within this group experiential theme, we see hope starting to be instilled and the facilitation of a desire to engage and change. For Rose we saw the importance of the relationship with the nurse, Jasmine, wanted to engage with her new life, Poppy chose to prove she would not be one of the 90% and Lily decided to break the cycle. Putting

this together we see how the participants became empowered to make changes and work towards recovery.

4.5 Group Experiential theme 4: Journeys End

This group experiential theme captures the experience of discovering aspects of themselves, considering how the participants feel in relation to the AN now and reflections on what could have helped them or could potentially help others.

4.5.1 Sexuality and Finding Me

The participants talked of significant relationships and the impact of Anorexia on these when in adult life. For three of the participants, they talked of their sexuality and trying to find who they were following their recovery. The Anorexia had taken from them their teenage years when individuals are becoming aware of their own desires:

> *I was with men in my teenage, in my twenties and then I ended up in a relationship with a woman, urm, and again it was about developing me and actually, I think, it was important for me but really hard because I think I, got confused, confused isn't the right word and I think sexuality is fluid, urm, and in many ways that, I had two relationships with women actually, so one was relatively short lived and I was really uncomfortable with it .....So urm yeah, so that wasn't very easy.* (Poppy 1234-1246)

There is a sense of uncertainty and confusion and a sense of discomfort in all that Poppy is expressing and that is reflected in how she talks about having sexual relationships early on with men and then women and how generally relationships have been '*really hard*.' She mentions the word confused, and then talks of sexuality being fluid, but the overarching feeling is that there is something difficult and uncomfortable about relationships. She also seems to be processing it there and then and is possibly contemplating how she feels about these past relationships when she was on a journey

to discover who she was. There is a sense of confusion overall for Poppy as she tries to understand her experience of '*developing me'* Poppy is trying to convey her experiences at this time and her own uncertainty and confusion about her needs once she was engaging with life.

> *I think I probably didn't realise that I was gay because of that experience (*sexual assault by a girl at school*) that for a long time I probably would have realised before, but the idea of being anywhere, like having a relationship with a woman another teenage girl, and just felt like, Ugh, like that's revolting.....So I think that that delayed my realising I was gay because I have this horrible link.* (Jasmine 646-651)

Here we see that recognition of sexuality was delayed due to '*revulsion*' at what had happened to her at the hands of a female at school, leading to confusion over her sexuality in later life, as repulsed at the thought of a female relationship. Jasmine uses the words '*horrible link,*' to convey what had made her shy away from any female relationship. There is strong felt emotion that is attached to the recollection as demonstrated via '*ugh*' mirroring her use of strong words '*revolting*.' It would seem that the strong feelings are still present when the girl is recalled. This led to confusion over her feelings towards females in general, compared to her feelings towards the girl who she says '*did stuff*' to her.

Rose had hoped for 'normality' via her sexuality.

> *It's just, sorry, it's just the whole, I remember going through that thinking, why do I have to be gay as well. I was like why? Why can't I just be normal? And I have no problem with being gay. It's not something I advertise but I don't think you should advertise what sexuality you are, it doesn't matter, does it.* (Rose 752-756)

The implication here is that Rose is not happy with being gay and does not view it

as ’normal.’ ‘*As well’* could imply that Rose, having spent years with Anorexia Nervosa had a desire to ‘conform’. She is saying that sexuality does not matter whilst putting forward a strong view to the contrary. There is a sense that this is less about who she is attracted to and more about a need to ‘fit in’ to not be the Anorexic and to blend with wider society and heteronormativity.

These three participants each needed to find who they were when they were able to engage with sexual relationships. For each of them there was an element of indecision and discovery that eventually led them to finding themselves.

4.5.2 What Remains

This group experiential theme looks at how the participants feel about themselves now regarding weight and shape:

Although Jasmine is in recovery, she still holds some negative beliefs with regard to eating and body image:

> *Even now I don't weigh myself I couldn't weigh myself. Um, it would be, it just feels so humiliating. The only way I describe it to my partner, sometimes I'd rather like do a poo on the beach in front of everyone, than I would stand in front of the scales in front of anyone. Like, it just feels that like, Ugh.*
> (Jasmine 481-484)

Jasmine is still conscious in a negative way about her shape and weight. Jasmine compares the idea of being weighed with something that others would equate as being disgusting to emphasise the impact that this would still have on her. It could be inferred that the idea of putting herself on the scales carries trauma for her, where she anticipates negative criticism from herself or from others and/or to be emotionally distressed.

> *I won't, I'll never look in the mirror like ever.* (Jasmine 1267)

For Jasmine it is as if she avoids obtaining any knowledge of her weight or shape for fear of further humiliation and the fear of a negative body image seems to still be present. Recovery for Jasmine is an ability to eat and work and generally function, but the fear of negative shape and weight is still present with avoidance of knowledge and avoidance of mirrors, possibly for fear that the conception that she is 'fat' will still be present. It seems that physical awareness of oneself is still extremely hard for Jasmine and potentially distressing.

The idea that some of the Anorexic thinking remains is borne out in the following extract:

> *I don't believe you're ever like fully recovered, but I think it's, but yeah, I kind of don't. I think it's always there to an extent* (Jasmine 1164)

An interesting reflection with the recognition that some of the Anorexia Nervosa remains.

Poppy is aware of her shape and weight in the present time, but her view is different:

> *As I got more of a more normal life, that it was a bit negative being called anorexic or underweight or skinny. And actually, I get quite cross with people, because I am still small, but when they go, "oh my god, you're so thin," I'm like, "you've no idea!"* (Poppy 1046-1051)

As 'normal' life started it felt negative for Poppy to be called skinny. This difference in perception could relate back to self-concept and Poppy is aware that she is small but to be smaller would be dangerous.

This was not the perception of all the participants.

It's another life it's a long time ago for me so I suppose its not something that effects my life now really, not really much at all. I mean if I see people, it brings it back to me definitely. And I'm naturally, if there's a programme on telly I watch it I can relate to that and I remember feeling like that but it's not something that affects me really. (761-767 Lily)

Lily talks of the Anorexia as a thing of the past but the comment '*not really much at all*' could indicate that whilst it is gone it is not forgotten as it was part of a considerable proportion of her teenage years. However, her words do seem to convey that generally she is able to engage with life with limited interference.

This is the experience for Rose, and we see the contemplation of what remains:

I think because I had it so long, I think I'd be lying to say I don't have the odd thought when things are.... (trails off) (935-937 Rose)

That's the hardest part. So, urm, I might sometimes, usually when I'm due on I'll kind of get the old, "oh I'm so bloated," like the hormone imbalance. I get nightmare PMS, not great, and I feel a bit big. But I don't do anything about it. (1007-1012 Rose)

Here we see that the mind will sometimes slip into body image concerns but in her recovery, Rose is able to recognise this and accept the thoughts but not act on them. It could be that these thoughts are comparable to other females who have not experienced Anorexia Nervosa but could also be the remaining remnants of the eating disorder.

The remaining impact of the Anorexia Nervosa in the lives of the participants is varied from appearing to be present regarding body image with Jasmine and not wanting evidence that she may be large, that contrasts with Poppy's view on her body image and not wanting to be too small. We then saw that for Lily and Rose the interference is less

with occasional thoughts of the Anorexia Nervosa and its effects.

4.5.3 Reflections on Recovery

All the participants spoke of the need to instill hope in the person with Anorexia, that change is possible and that there could be something that was more important to them and therefore, worth the change.

> *It's all about having hope and something to live for. Like if I think, if I didn't want to live, I didn't have anything to live for, really. I should have done, I should have had my family. Urm, but I couldn't see that, and no one seemed interested in that and no one identified that. But that's what it was all about really.* (Poppy 1528-1535)

Poppy reflects that she needed help at the time to see that a future was possible and that there could be things in her life that were worth living for. '*I should have done*' implies that she feels she should not have lost sight of this. The '*I should have had my family,*' could indicate that Poppy felt that either they should have been there for her, or that she had lost sight of the fact that they were still there for her. Poppy is expressing that she needed external help to enable her to see who was there for her and to instill hope, and enable her to see that a different future, which she had lost hope of having, was still possible.

Hope was also the key message that Jasmine wanted to convey and simply put:

> *don't take away people's hope.* (Jasmine 1441)

The idea that hope was taken away implies that Jasmine feels this was something that was done to her and not within her control. Jasmine sees hope as being important to recovery and potentially providing the mechanism for change.

Lily shares this belief and feels that to give others with Anorexia hope, is a key ingredient to recovery.

> *I mean to try and find a positive in themselves. I mean it's hard isn't it if you're that low but there is always something in somebody that their good at so to hold onto those things that their good at.* (Lily 664-668)

Lily reflects that if you can find someone's strength and encourage them to focus on this it could help to foster change; if someone is seen as an individual with strengths that can be harnessed. There is a sense of hope emitted from Lily's statement, that at no point should one believe that all is lost Her belief here appears to be that each person is good at something worth holding onto and by finding out what this could be may foster the change that is required.

Similarly, Rose suggests:

> *I think the key in all of this is getting the person encouraging the person not to tell someone what to do, it's never going to work.* (Rose 1258-1260)

The message from Rose is to engage with the individual and collaborate for change, but most importantly in an encouraging manner. The comment on '*telling someone what to do won't work*' and '*it's never going to work*' could have come from her own experience. Encouragement that perhaps comes from a good therapeutic alliance could enable working together towards change. Perhaps the implication is that this encouragement could also come from a partner, friend, or family member.

As Poppy reflects on her experience, she emphasises the need to 'catch it early'. This reflection could come from the consideration that hers was not initially identified and the Anorexia Nervosa became entrenched.

> *You have to catch it soon enough, before it gets entrenched.... Well, if you can tap into finding out why they're behaving the way they are, that way you can help them ..... But it's about understanding what used to be or what could be important to them, and what gives them hope and something they could see that could replace the eating disorder.....It's a real sad place to be.* (Poppy 1495-1500)

Poppy presents ideas that she sees as necessary for change. Poppy then suggests that seeking the cause could potentially enable the professional to help the person with Anorexia Nervosa to move forward; she then elaborates on this suggesting that there is a need to look for what was, or could be important to the individual. There is a suggestion that if this is found then this could replace the eating disorder. With hindsight Poppy is in a position to contemplate what she needed which at the time she may not have been aware of. Again, the idea of offering hope is seen as important to recovery. The final words give insight into Poppy's view of the disorder and the depth of sadness that is recalled.

> *Yeah, and actually, anorexia's really sad like although it was all I had, urm and I was so afraid of giving it up, but I really would say to myself that life is better without it.* (Poppy 1568-1570)

Here we see the sadness that Anorexia Nervosa brought to Poppy's life but also how difficult it became to let go when it was seen as all she had. There is a sense of loss but also the feeling that to regain life this loss would have to be made. The fear of giving it up could imply a journey into the unknown of what life would be like without Anorexia Nervosa and the reassurance that she gives to herself with the words that 'l*ife is better without it.'*

Chapter 5 Discussion

5.1 Overview

The aim of the research which was to understand the lived experience of those who had recovered from Anorexia Nervosa and to understand what they felt had aided their recovery. This will provide an insight into how participants who were previously diagnosed with Anorexia Nervosa have experienced the disorder, and what they feel enabled them to overcome the disorder. This chapter will look at the research findings and consider them in relation to the previously reviewed literature in chapter 2 and additional literature in light of the findings.

Four participants who met the inclusion criteria were interviewed. Although this is acceptable, for an IPA study, six participants were initially sought but due to the intended research population, recruitment was difficult. The interviews were transcribed verbatim, and the qualitative data was then analysed via, Interpretative Phenomenological Analysis (Smith and Nizza, 2022) this method was utilised for the analysis to enable an understanding of the lived experience of the participants. During the analysis personal experiential statements, became personal experiential themes (PET) for each participant, and this developed into four Group Experiential Themes (GET).

The four group experiential themes are: Group Experiential Theme one: Losing Me, which encapsulated the perspective of the participants regarding how they view their experience of who they were. The sub-themes are: Experiencing Fear, Taking and Losing Control, Perceptions on the Family and Sense of Self. Group Experiential Theme two: Dark Days, when the participants recalled challenging times during their experience of Anorexia Nervosa where feelings of hopelessness arose, times when life felt too difficult to continue, and a loss to their sense of belonging. These experiences are captured under Loss and Hopelessness, Depth of Despair and A Sense of Belonging.

The third Group Experiential Theme is: Empowered, where we gain a sense of how the participants began to see that there was ‘something bigger’ than the Anorexia Nervosa and this enabled them to regain their life from what had been lost and the support that encouraged this change. The sub-themes are, Something Bigger, Regaining Life and Support. The final Group Experiential Theme is Journeys End, this GET looks at how the participants rediscovered themselves and their reflections on the recovery journey. The sub- themes are, Sexuality and Finding Me, What Remains and Reflections on Recovery. These will each be considered.

5.2 Group Experiential Theme One: Losing Me

5.2.1 Experiencing Fear

Whilst emotions are shared at every stage of the participants' experience there were times in the transcripts where emotions stood out as being strongly recalled and are presented here.

The emotion of fear was expressed by Lily, this was in response to finding herself on a Psychiatric unit, a long way from home, with people who she saw as being unwell. Meule et al., (2021) suggest that psychiatric inpatient care shows good outcomes, but that relapse can be high. Considering the extreme emotions that were experienced by Lily and the fear of being with adults with a non-eating disorder presentation could be one reason for placing those with an eating disorder into specialist services as found by Mac Donald et al., (2023). Whilst the fear of being away from home would still have been present for Lily there would not have been the additional fear that arose from sharing the ward with patients presenting, with what was perceived as frightening presentations. This is not reported by Lily as an acute admission but perhaps a placement in a specialist ED inpatient service was not possible in the required time. There is reported to be a shortage of inpatient ED services available, and this will add to the requirement for those with acute presentations to be referred to non-speciallised

ED services (Sharpe, Adams and Smith, 2023).

Poppy also expresses fear but for her this was in relation to being unwell and then being afraid to eat for fear of being sick when her mother needed to return to work. This felt emotion appears to have then contributed to the onset of the Anorexia Nervosa and could be construed as an inappropriate response to feelings and fits with a Psychodynamic perspective on the potential development of the disorder, in that when carer, child interactions are disturbed this can lead to ego deficiencies and a sense of not having control (Nalbant, 2020). This would not fully explain the development of the disorder as Engel et al., (2022) did not find a difference in the need for control between those with Anorexia and healthy controls.

It is argued that if a child's needs are not appropriately met by an adult during childhood, then they may be unable to identify and respond to their internal needs including those of hunger (Treasure and Cardi, 2017). The idea that the child's needs have potentially and perhaps unintentionally not been attended to, is supported in the narrative by Poppy, who felt alone when she was unwell and afraid. It could be said that Poppy needed her mother to identify and respond to her internal needs (Cassioli, et al., 2022). This was not possible, and when internal needs are not met the Anorexia can provide a visible external need (Mitchell and Crow, 2019). From a Cognitive and Behavioural Theoretical perspective, it could be suggested that being alone at a time when Poppy's felt experience was one of fear, that this feeling, that is strongly expressed, could then lead to dysfunctional behaviour such as not eating (Klein and Attia, 2019).

The onset of the disorder is often associated with a stressful life event (Steinberg, 2014) and for Jasmine one of the emotions that was expressed was that of stress, this was recalled at the prospect of her father arriving home and her uncertainty around his mood towards her. In a study by Racine and Wildes (2015), emotional abuse was strongly related to Anorexia Nervosa severity, and they suggest that emotion dysregulation as a consequence of emotional abuse could precede the onset of the disorder. Whilst abuse

is not being cited as present, the predominant felt experience for Jasmine was a keen sense of fear and foreboding at her father's return. In a study by Grogan et al., (2020), they found that non-abusive but adverse family situations could also be found in those presenting with Anorexia Nervosa. As an adult Jasmine reflected that her father's behaviour could be construed as abusive and at the time it was seen as a difficult relationship, that evoked strong feelings of discomfort, this is supportive of the research by Grogan et al., (2020), who suggest that abusive or adverse family environments could contribute to the onset and severity of Anorexia Nervosa. For Jasmine, the feelings she had towards her father produced strong felt emotions and in addition to the felt emotions of fear and foreboding there was also the sense of uncertainty of what to expect.

For Rose her home life was described as horrendous as abuse was present in her life and there was also a dislike of school, meaning that a place where she felt safe was not available, for some individuals inpatient care can then offer this 'safe place' (Thabrew et al., 2020). There was a strong felt experience when recalling past events and a sense that these feelings added to the perception that her world was not a pleasant place for her to be. Kearney-Cooke and Striegel-Moore (2018) found that childhood sexual abuse can become a route to the development of Anorexia Nervosa and an eating disorder may become an adaptive effort to defend against self-regulatory deficits resulting from abuse. It could be inferred that the abuse was a contributing factor to the development of the Anorexia Nervosa for Rose and the main cause of her emotional response. Chuku et al., (2023), found no direct association between childhood sexual abuse and the development of Anorexia Nervosa, however, Lyons (2023) found that childhood sexual abuse led to a higher susceptibility to the development of an ED. Rose expressed that she felt the abuse was the reason for the onset of her Anorexia Nervosa and her felt emotion was described with words that portrayed a depth of feeling that was associated with the experience.

For each of the participants there was a life event or series of life events that contributed

to the development or maintenance of the Anorexia Nervosa and led to a felt experience, of fear.

5.2.2 Taking and Losing Control

Anorexia can be a response to life events that have felt to be out of the individual's control (Fairburn, 2015). In line with previous research (Grave and Calugi, 2020), the participants were each in situations where they were unable to control certain aspects of their lives. What the participants then have in common is the wish to control life was transferred to control of eating (Grave and Calugi, 2020). The sense of control that was initially felt by the participants was soon lost, as the disorder became entrenched and where restriction was initially the means of control (Harada et al., 2021) this morphed into purging (Gilon et al., 2018) where eating took place but then three of the participants purged by vomiting or taking laxatives. Initially the participants were all restrictors and Gilbert, (2014) estimates that this is the case for 50% of those with Anorexia. The purging and use of laxatives became prevalent in the later stages of the disorder rather than at the outset and the misuse of laxatives has been shown to increase the incidence of suicide and self-harming behaviours in those with Anorexia Nervosa (Lengvenyte et al.,2020).

Lily was away from home and feeling estranged from anything familiar, and she then talks of the discomfort around the food that was experienced whilst abroad. This is in line with the research by Grave and Calugi, (2020) who found that Anorexia Nervosa could be a response to individuals being unable to control aspects of their lives. Lily was unable to control the situation as she was away from home and staying with a family with whom she felt uncomfortable. Lily later goes on to say that she disliked herself and we see that she took control of food as a way of controlling aspects of her life and self-perception. This could be supportive of the multi-dimensional model of Anorexia Nervosa as there were multiple factors at play in her life that could have contributed to the onset of the disorder (Stice et al., 2019).

In addition to a reduction in food intake many of those with Anorexia Nervosa will engage in excessive amounts of exercise in an attempt to burn calories and reduce weight (Morrison et al., 2022). This was seen in comments by the participants, and is demonstrated in the extract by Poppy, that whilst in hospital she and her fellow inpatients would purge and exercise for hours. Exercise was one of the things that had been removed from the participants life due to the weight loss and the risk to life that further exercise could cause (Harris et al., 2024). Again, it can be seen that whilst initially control was taken over food intake this was eventually lost as control over life and calorie intake was taken away from the participants but in an attempt to maintain some control the exercise continued.

Individuals with Anorexia Nervosa may have an intense fear of gaining weight, and a distorted body image (BI) (DSM-V-TR: APA, 2022). When present this distortion leads to a poor body image and Jasmine saw herself as fat and then judged herself on shape and weight (Pugh and Waller, 2016; Mitchell and Peterson, 2020). This thin ideal may not extend to their view of others as Brockmeyer et al., (2020) found that those with Anorexia Nervosa do not value thin in other females, perhaps due to the perceived competition and the need for them, not others, to be thin. When Jasmine started to restrict, she felt good about the change to her shape and weight. Initially this dietary restriction gave a sense of control and improved Jasmine's sense of self-worth, until what was seen as within her control began to control her (Osler, 2021).

As a young person moves into adolescence pressure is felt by the expectations placed on them by the media, where the portrayal of a thin ideal is put forward. Jasmine recalls feeling larger than her peers and not eating was an effective way to address this. This then led to the vicious cycle whereby shame over body shape, led to a desire to control body image, to avoid shame, and to fit in with peers (Blythin, 2020). Initially Jasmine was praised for this weight loss which incentivised her to continue. The pressure to conform to a thin ideal was felt, and these environmental expectations potentially

contributed to the onset of the eating disorder (Blythin, 2020). From the previous literature it can be seen that shame and poor body image can be addressed in some forms of treatment (Fairburn, 2015; Matos, 2015) and a transdiagnostic approach is recommended to deal with any co-morbidity that could present and Panero et al., (2022) recommend the development of treatments that can specifically address shame in those with Anorexia Nervosa.

Rose's experience is supported by the findings of Grogan et al., (2020) who found that abuse could be a contributing factor to the development of Anorexia Nervosa. Friederich, (2023) suggests that from a psychodynamic perspective, there can be a feeling of ineffectiveness and loss of control. Rose experienced herself as not being in control of her own body and took control of food away from her abuser as a means of exercising some control over this aspect of her life, when in effect this was not possible at the time. It is argued that disturbed mother child interactions lead to serious ego deficiencies, leading to a sense of having no control or independence. For Rose the relationship could be seen as disturbed due to her mother's attention needing to be diverted to an unwell sibling. This unavoidable absence unwittingly enabled the abuse to take place and then to disordered eating. This would support the theory of Kearney-Cooke and Striegel-Moore (2018), who found that childhood sexual abuse can become a route to the development of Anorexia. It is argued that when a child's needs are not met in an appropriate manner this can lead to an inappropriate response (Treasure and Cardi, 2017). For Rose her mother was unaware of what was happening and so was not able to protect her from this harm.

For the participants, the need for control was transferred to control of food when life felt out of their control. The need for control and then the loss of this is also evident in the literature on Anorexia Nervosa (Friederich, 2023; Kearney-Cooke and Striegel-Moore 2018).

5.2.3 Perceptions on the Family

The participants all recalled difficulties in family dynamics, preceding their experience of AN which is compatible with a developmental perspective (Rousseau, et al., 2022; Wallis, et al., 2018) as Anorexia Nervosa is considered to be polygenic in nature whereby the disorder is the interplay of multiple genes and environment (Mitchell and Peterson, 2020). A predisposition is considered to be present, and this is then triggered by life events. This is in line with the Developmental Psychopathology Theory which considers the multiple risk factors for Anorexia Nervosa and the part that the family play in this. Multidimensional risks occur during the early years and into adolescence (Moreno_Encinas et al., 2020), this was supported by the current study with the participants recalling what they perceived as difficult events in childhood and adolescence. Once the multidimensional risks have triggered the Anorexia Nervosa, maladaptive cognitions ensue which is then compatible with the CBT perspective (Calugi et al., 2024). There is the interplay between genes and environment leading to or contributing to the disorder and the establishment of maladaptive thinking regarding food, shape and weight as found in this study.

It could be argued that the early relationships that the participants experienced with the primary caregivers for example Poppy's mother, Jasmine's father, Rose's grandfather and Lily's position in the family, could have had an effect on their attachment styles and interpersonal relationships and contributed to the development and maintenance of the disorder however, Treasure et al., (2021) recommend involving the family in treatment to improve the outcome. It could be argued that the participants experiences led to a low sense of self-efficacy and self-worth and from a Cognitive and Behavioural perspective this can lead to distortions in cognition and to dysfunctional behaviour such as not eating (Grave, et al., 2020). The distorted cognitions are not necessarily the cause of the Anorexia but can be a consequence (Klein and Attia, 2019).

For Jasmine, whilst she was fearful of her father her mother offered a buffer to this, and

if a child has one significant other to offer care, then functional growth can follow (Lucas et al., 2022). However, for Jasmine the predisposition to the development of the eating disorder was still triggered and this significant attachment did not provide a buffer against the development of Anorexia Nervosa. This could be seen as supportive of the multi-dimensional risk model where in addition to the family dynamics other factors could also have contributed, such as her desire for a thin ideal (Stice et al., 2019).

All the participants reported interpersonal difficulties, with emotions and in significant relationships. Tauro et al., (2022) found that those with Anorexia Nervosa often report problems in social interactions and can present as either submissive or hostile. Poppy spoke of being hostile towards her parents during her illness and was able to reflect on this as an adult and believed it had affected her relationship with them now. The idea that difficulty in social interactions can then continue into recovery is supported by Keeler et al., (2022). Those with Anorexia Nervosa tend to dominate the family (Fjermestad, et al., 2020) however, Rose felt that it was her sister's illness that diverted attention from her and her brother. This was an interesting reflection by Rose, as when a family member has Anorexia Nervosa it is often the siblings who report feeling that the attention was diverted from them to the sibling with Anorexia Nervosa (Fjermestad, et al., 2020).

As we have seen difficulties within the family, even if unintentional, could be influential to the onset or maintenance of the disorder (Monteleone et al., 2024). However, they can also be instrumental in recovery (Monteleone et al., 2024). Each of the participants were supported through their hospitalisations and on their returns home by their family. This familial influence was present in their lives prior to the onset of the Anorexia Nervosa, during their experience of illness and in recovery, perhaps showing the potential importance of these relationships and perhaps they could be utilised to aid recovery as suggested by Treasure et al., (2021).

5.2.4 Sense of Self

Monteleone, et al., (2021) said that an eating disorder is a deficit of the self and a false self emerges, this is supported by Croce et al., (2024). They argue that identity is thought to be central to the aetiology of Anorexia Nervosa as a weakened sense of self is thought to impact on perception of body image leading to a lack of an integrated sense of self. The individual identifies as Anorexic more than anything else as the Anorexia Nervosa acts as a compensatory form of identity (Oldershaw et al., 2019). Conti et al., (2020) looked at treatment experiences of those with Anorexia and found that across fourteen qualitative studies, individuals with Anorexia Nervosa reported experiencing a significant identity conflict. This identity conflict was characterised by a struggle to determine if Anorexia was separate from, or a part of, their own identity. This was supported by Broomfield et al., (2021) who found comparable results as participants were divided on the belief that Anorexia was a part of their identity or was an external controlling force. Poppy felt she had lost her sense of self and become the Anorexia, the illness was all consuming and she felt that nothing of who she had been was left, this could be representative of the false self emerging as also found by Monteleone, et al., (2021). The idea that hunger may symbolically remind the individual of a painful psychological event that must be controlled to prevent the individual from being overwhelmed, could relate to all of the participants who were dealing with what for them were painful psychological events that gave us an insight into their experience of the disorder and the impact that this had on their sense of self (Moccia et al., 2022).

For Rose her identity conflict led to her wanting to disappear and the eating restraint could reflect an unconscious need to resolve the difficult situation that had been experienced, the idea of the desire to disappear is supported in the work of Fuchs, (2022). The disturbance in self-concept is believed to be a maintaining factor in Anorexia Nervosa and a change in this disordered identity is thought to aid recovery (Croce et al., 2024). In research by Amianto et al., (2016) they found that it was

important for those with Anorexia Nervosa to achieve a sense of identity and suggest that this should form part of treatment. This is supported by Conti, (2018) and Croce et al., (2024) who suggest that those with Anorexia Nervosa may lack a sense of identity and for recovery to take place they need to let go of the Anorexia and form a new or reclaimed sense of self. For each of the participants a sense of self separate from the Anorexia was sought in recovery.

Mitchell and Crow, (2019) say that the negative sense of self that can be present in those with Anorexia Nervosa leads to a poor body image, seeing themselves as fat even when the evidence is contrary to this, and they then judge themselves on their shape and weight. In line with research by Mitchell and Peterson (2020) there were shape and weight concerns expressed by all the participants. Interestingly, with one exception, the participants did not see themselves as fat but had a fear of becoming fat. This belief is demonstrated by Lily's disproportionate view that eating a biscuit will automatically lead to weight gain. Rigoli and Martinelli, (2021) suggest that dissatisfaction with body shape and weight could lead to low self-esteem. Self-esteem is the positive or negative view that someone holds about themselves. For each of the participants they were dissatisfied with their weight and shape and held what appeared to be a distorted view of themselves as found in the research by Şenay et al., (2023).

The study found that there was a negative self-perception held by the participants with regard to shape and weight but also a detrimental view of themselves as a person was present. A positive sense of self had been lost during their experience but whether this loss was present beforehand is undetermined.

5.3 Dark Days

5.3.1 Loss and Hopelessness

For each of the participants there was a sense of loss, separation and hopelessness.

The loss was for the life they had experienced outside of the hospital, the ability to exercise, see friends and attend school, and the feeling that this was gone forever. In this section the serious effect that the Anorexia Nervosa had on them both physically due to the threat to life and mentally with the loss of hope is seen. In a report by Elwyn, (2023) They found that if an individual with Anorexia Nervosa is told that there is no hope this can act as a maintaining factor and add to the feeling that recovery is impossible, leaving the individual feeling unprepared or unable to change. They identified that a turning point for recovery can be having a clinician instill hope, and feeling understood was also identified as a key feature in the road to recovery. During the illness the participants identified little hope of a life beyond the Anorexia.

Anorexia Nervosa has the highest mortality rate of any psychological disorder (up to 15%) the likelihood of death increases with the duration of the disorder (Amiri, et al., 2023). Half of the deaths are from suicide and the others are from medical complications of the disorder such as starvation, electrolyte imbalance, and heart or kidney failure (Cass et al., 2020). Each of the participants experienced a physical life-threatening experience due to the effects of starvation and required re-feeding. When re-feeding occurs the body changes back from catabolic to anabolic metabolism resulting in switching from fat use to carbohydrate use, resulting in lower levels of phosphate. This can lead to circulatory fluid overload, respiratory and heart failure and death, as the re-introduction of carbohydrates can lead to electrolyte, metabolic and organ dysfunction (Parker et al., 2020). The effects of starvation are seen in the participants accounts, as Rose and Jasmine both went into heart failure; Rose, Jasmine and Poppy were told directly that they would die due to the physical effects of the Anorexia, and Lily was so low in weight that the staff felt she too may not recover. 60% of deaths in Anorexic patients are via sudden cardiac arrest, organ failure or suicide (Fairburn, 2015). These high death rates explain why the first line of treatment has to be weight gain but whilst the hospital stays were vital for sustaining life they provided limited psychological input and this is considered to be necessary to contribute to psychological recovery (Kästner et al., 2021). Whilst hospitalised the participants lost

hope of regaining what had been lost to the illness (Abber et al., 2024).

The risk from suicide is six times higher in those with Anorexia than in the general population (Sharpe et al., 2023; Elwyn, 2023; Gaudiani, Bogetz and Yager 2022; Abdi et al., 2020). In the present study two of the participants had attempted suicide and for Poppy this was on multiple occasions. The reason given for this was that the Anorexia Nervosa had taken away from her everything that she felt was important, family, friends, school and exercise. During the illness, due to the risk to physical health, it can become necessary to restrict what activities the individual can engage with. School is removed meaning that access to friends mostly stops, exercise is removed and all other physical activity is restricted. When considering recovery from Anorexia Nervosa it would seem important to compensate in some way for what has been lost and to offer hope for its re-installation. This could help to alleviate some of the hopelessness that was found in this study and in a study by Kern et al., (2020) they suggest that instead of removing all activity that an adapted form of activity should be included in treatment.
There appears to have been a sense of hopelessness and little hope for recovery being offered and this is seen as an essential requirement in the treatment of those with Anorexia Nervosa (Elwyn, 2023).

5.3.2 Depth of Despair

Anorexia Nervosa is resistant to clinical intervention with potentially life altering physical complications that can occur due to its destructive nature, (Cass et al., 2020). Multiple hospital admissions were reported as the participants were discharged once weight was restored, prior to psychological treatment being received, and the overwhelming emotion that was expressed on initial hospitalisation, was one of fear. Many of these hospital stays were in psychiatric wards and not in a specialist ED unit. Both Lily and Rose considered the other non-ED patients to be frightening and Jasmine reports witnessing serious self-harm and there being a suicide whilst in the psychiatric unit. The stay in a psychiatric unit could be due to the limited number of beds available

for the inpatient treatment of Anorexia Nervosa (Sharpe et al., 2023). Eventually three of the participants were placed in a specialist unit and in Lily's case moved onto a children's ward.

These extended hospital stays whilst essential to physical health (Parker et al., 2020) may have an adverse impact on long term recovery as was the case for all of the participants who were unwell for an extended period of time (Carr et al., 2020). Certainly, the participants in this study needed weight restoration but then remained entrenched in the disorder. During the time of this inpatient care it felt as if the participants were in the 'thick' of the disorder. Sharpe et al., (2023) argue that there is a need for high quality care in the treatment of those with Anorexia Nervosa and that what this looks like needs to be defined, as if this is achieved it could lead to shorter hospital stays.

When considering the previous research into hospitalisation the findings are supported by this study, namely that when the participants were first discharged from inpatient care, following weight restoration, they were not provided with follow up treatment (Olawale, 2018) and subsequently there was a high relapse rate with all participants returning to hospital. This was also the finding of Croce et al., (2024) who found that relapse rates within the first twelve months following discharge from hospital were 40% and this indicates that better follow-up care in the community is required to ensure the maintenance of gains and the need for psychological treatment to be available. This is possible once weight is restored, and essential for long term recovery (Sharpe et al., 2023) and could have benefited the participants in this study.

There is a strong relationship between self-harm and Anorexia Nervosa (Kiekens and Claes, 2020) as found in the current study. According to Cucchi, (2016) this figure is 27.3%. Self-harm is used as a response to negative emotional states (Claydon et al., 2020) this was supported in the current study with self-harm being present for Jasmine and Poppy. In a meta-analysis by Amiri et al., (2023) they looked at 52 studies to

determine the prevalence of self-harm, suicidal ideation and suicide attempts in those with an eating disorder and found that the prevalence of self-harm for those with Anorexia Nervosa was 40%; the prevalence of suicide ideation was 51% and the prevalence of suicide attempts was 22%. They conclude that there is a high prevalence of non-suicidal self-injury, suicidal ideation, and suicide attempts in those with Anorexia Nervosa. With these figures in mind the current study found that three of the four participants had attempted to take their life and 50% had self-harmed. This was done at the point in the Anorexia journey when it felt as if they were in the 'thick of it' and this was the response to the situation they found themselves in. Conway-Jones et al., (2024) believe that due to the high rate of self-harm in those with AN there is a need for them to be closely monitored.

5.3.3 A Sense of Belonging

This Group Experiential Theme looked at the participants sense of belonging. In the narratives there were times when they had felt part of something good and at others feeling separate from those they tried to interact with. This forms part of the GET as the disruption to the sense of belonging was most acute during their transitions between inpatient and outpatient care.

Friendship can function as a motivator to change and therefore aid in recovery, helping to improve intimacy and self-validation (Malmendier-Muehlschlegel et al., 2016). All of the participants had lost out on external friendships due to hospitalisation and felt unprepared to return to their previous life. From Poppy's narrative there was the feeling of not being the same since her hospitalisation and a sense of not belonging when she returned to school. Lotery et al., (2023) suggest that there is an important difference between home friendships and those formed in hospital and whilst the hospital friendships can have some negative effects as those with Anorexia Nervosa can learn detrimental behaviours from each other, they can also be close as these relationships are with those who have an understanding of what is being experienced, and can be

supportive of recovery. During inpatient treatment Poppy did form close friendships with other patients and a sense of belonging and understanding was found. However, there were also disadvantages of being placed with other people presenting with Anorexia, as this is a competitive illness with people striving to be the best Anorexic and learning from each other, as with Poppy and her friends where there was the '*cult*' behaviour of collectively purging and exercising (Osborn, 2023).

Those with Anorexia Nervosa can experience challenges in the formation and maintenance of friendships due to viewing friendships negatively with only 17% of those with Anorexia Nervosa reporting that they viewed friendships positively (Data et al., 2021). For Poppy it seems that less effort was required to form the inpatient relationships and the friendships that were formed in hospital felt caring compared to her experience on her return home (Lotery et al., 2023). This was not the same for Jasmine who said that she always made friends easily. It would appear that it was Jasmine's choice to not return to her old school and friendship group, but this could have been to avoid the girl who she saw as abusive. New friendships were formed and in line with previous research (Malmendier-Muehlschlegel et al., 2016) did appear to aid recovery as the desire to fit in with peers motivated Jasmine to continue with her changes in eating behaviour, once her recovery journey started. The new friendships that were formed were potentially instrumental in her recovery as found in research by Nilsson and Hagglof, (2016).

Treasure, (2024) suggests that the support of family and friends can be a critical element in the management and recovery from Anorexia Nervosa. When Lily returned to school, she felt that her peers were wary of her and her perception of belonging was challenged. Thibault, Pascuzzo and Pesan, (2023) found that the greater the sense of alienation was from friends the more severe the Anorexia Nervosa, they suggest that peer interactions have an impact on psychological well-being for those with Anorexia Nervosa as also found in this study.

The sense of belonging that Rose spoke of was a regret that she and her siblings were not closer. It is not unusual for these relationships to be disrupted, in particular when a sibling has spent time away from home as an inpatient (McGrath, Wilson and Buckmaster, 2024). Rose had also spent time away from her sister due to the illness that the sister experienced. This would have increased the time apart as both spent time in hospital and added to the feeling that the relationship was not close. The needs of siblings need to be considered when treating those presenting with Anorexia Nervosa to mitigate against this loss of contact (Matthews, Peterson and Lenz, 2021)

Lily spoke of a time when the family went on holiday while she was in hospital and she recalls feeling upset. Family life can be disrupted when a sibling is hospitalised and care should be taken of the non-ED siblings well-being (McGrath et al., 2023). For parents they must balance the needs of the unwell child with that of their other children. Heneghan et al., (2023) found that fragmentation in family relationships can occur and suggest that it is important that the needs of the well siblings are considered. In taking Lily's siblings away it could be a means by which some 'normality' was preserved for these children who were well.

The sense of belonging was lost for some of the participants and challenged for others. Research has found that peer relationships can have an impact on symptom severity and recovery (Thibault, Pascuzzo and Pesan, 2023: Treasure, 2024). For the participants these relationships with friends and siblings were rekindled, strengthened or new friendships began, once the journey towards recovery started.

5.4 Empowered

5.4.1 Something Bigger

Each of the participants recall a change in cognition 'something clicked' at the point when they opted for change. For each of them the conveyed experience was unique,

perhaps highlighting the need to see each patient as an individual, who will be motivated to change, by something that is important or at least meaningful to them. This supports the idea by Conti et al., (2020) who concluded that treatment should be tailored to the individual and it is possible that within this process what is meaningful to the client, that could effect change, could be elicited.

Lily recalls the moment when she was in hospital on a drip and the recognition that this was a cycle that would continue unless she opted to break this. For Lily, there appears to have been reflection, leading to insight, and then the decision to change, which is supportive of the mechanisms found in the study by Pascual-Leone and Yeryomenko, (2017) where from the point of deciding to change Lily made significant gains. In a study by Brockmeyer et al., (2023) they looked at sudden gains in therapy and in particular CBT and Focal Psychodynamic Therapy they found that a sudden gain was predictive of a good, sustained outcome.

When Jasmine changed school, she had a desire to belong and to not share with her new friends that she was an inpatient at weekends. What we potentially see here is a rebuilding of identity outside the anorexic identity. This rebuilding of identity was found in the study by Conti et al., (2020) they concluded that the therapist could help the individual in recovering a sense of identity that was separate to the Anorexia Nervosa. This was also found by Croce et al., (2024) and appears to have been a contributing factor in recovery for Jasmine.

Poppy did not talk of a good therapeutic relationship, or initially treatment aiding recovery but a desire to prove the nurse wrong who had told her and her fellow patients that they would die unless they made the necessary changes. In a study by Rankin et al., (2023) they concluded that there could be factors other than treatment that led to a motivation to change and this seems to have been the case for Poppy. Enhancing motivation is considered essential for improving outcomes (Rankin et al., 2023) and whilst the motivation that Poppy took from the nurse was perhaps unique, it does

demonstrate that motivation can come in unexpected ways. There is the recognition by Poppy that whilst this comment had motivated her to change, this was perhaps not the best way to motivate everyone, and she did convey this to the nurse in her recovery. It has been suggested that diverse ways to motivate and support clients need to be found (Rankin et al., 2023) and this is supported in this study.

For Rose the point of change had started with a good therapeutic relationship whereby she had felt that she was treated as an individual (Hagar et al., 2024). This was then further enhanced by the desire to help another person with Anorexia Nervosa, as once she read the words that had been written by this individual, she felt a connection and a desire to help. This represented something outside of the disorder that was worth the continued change and again supports the idea that there can be factors outside of treatment that could motivate the individual to make these changes (Abber et al., 2024). Rose's motivation came from a desire to help others who had experienced Anorexia Nervosa, to help them to accept the possibility of recovery.

Interestingly for the participants the desire and motivation to change preceded psychological treatment. They each reported psychological input in the journey to recovery but could also highlight a point before this input when the decision to change was made. Again, we see the multifaceted things that lead to the motivation to change, perhaps presenting a challenge in treatment as to finding what will motivate the individual to start the journey towards recovery. Recovery can include the need to let go of the disorder and is seen as a key element in the process of recovery (Conti, 2018; Williams et al., 2016). It has been found that this letting go needs to be an active decision with a recognition that the Anorexia is harmful (Conti, 2018). Initially this can feel like a loss of identity and therefore having something to replace this lost identity can help the progression to recovery (Croce et al., 2024; Broomfield et al., 2021; Conti, 2018; Williams et al., 2016).

For each of the participants they found something that made the move to recovery feel

worthwhile and possible. At this stage of their experience there starts to be a desire to change.

5.4.2 Regaining Life

For Poppy, as weight was restored the control that had been taken away was carefully returned and she was allowed to engage with sport and to return to education (Grave and Calugi, 2020). At this point Poppy can take back control of her decision making and over her life choices, which had not been possible whilst unwell. Previously this control had been taken away and Poppy reported feeling the loss of what had been important to her but as her journey with Anorexia Nervosa progressed and she moved towards recovery important activities and relationships were restored and Poppy continued in her journey towards recovery and regaining her life. Kinnaird and Cooper (2024) found that these personal gains were an important aspect of recovery.

This was similar for Jasmine, when she was able to engage in activities outside of the hospital, life became worth living and change began (Kinnaird and Cooper (2024). Initially when Jasmine spoke of engaging with life and activities her journey towards recovery was at the preliminary stages but as she experienced new activities this inspires her to continue on her journey. For Jasmine the establishment of new friendships was also seen as a contributing factor in recovery (Malmendier-Muehlschlegel et al., 2016 and Westwood et al., 2016). Jasmine is establishing a new identity without Anorexia Nervosa as supported in research by Croce et al., (2024).

The Anorexia Nervosa may have become a form of identity for Jasmine that had provided a false sense of self (Oldershaw et al., 2019). The new friendships could then have enabled her to build an authentic identity to move on from the illness. Conti, (2018) argues that the individual may experience a sense of loss when they let go of the disorder but for Jasmine it felt as if she needed to move on and establish herself as an entity without Anorexia Nervosa. This reclamation of the self involves the active

exploration and rediscovery of one's authentic identity, resulting in the creation or reformation of an identity that is independent from Anorexia Nervosa (Williams et al., 2016). Amianto et al., (2016) suggested facilitating the development of identity should be a key focus of treatment in order to achieve recovery and reclaim the non-AN-centric self.

A contributing factor to change for Lily was embarrassment at her father attending school at lunchtime. It can be a painful process to let go of the Anorexic identity (Broomfield et al., 2021) as it becomes the dominant part of the individual, but to remove the need for her father to be at the school it became necessary for Lily to relinquish this aspect of herself to engage with her friends and regain the school aspect of her life (Conti, 2018). Change occurred for the participants when they found something that they wanted to change for and for Lily one of these things could have been that she disliked being different to her friends (Rotenberg and Edwards 2017).

Rose does not appear to have lost contact with some aspects of her pre-hospitalisation life and absconded on a couple of occasions to see friends. It could, therefore, be suggested that some aspects of her life were maintained, if non-conventionally and this link to life could have been a contributor to change. As seen previously for Rose the desire to regain life was also in part a desire to help others, perhaps enabling a new identity, separate, but not too far removed from the personal identity with Anorexia Nervosa (Conti, 2018).

As weight was restored the participants were able to engage with activities that had been removed and a desire to regain their life emerged. Key elements appear to have been engaging with activity, returning to education and redefining oneself, (Croce, et al., 2024) as motivating factors to change (Aber et al., 2024). This would support the study by Rankin et al., (2023), who looked at CBT and in-session motivation to change. They found that factors independent of treatment may facilitate tipping points to change as also found by Lev Ari et al., (2023).

5.4.3 Support

All the participants displayed treatment interfering behaviours as also found by Nalbant, (2020). It can be argued that early development and relationships with the primary caregivers can influence later attachment styles and interpersonal relationships. An individual's attachment style could then have implications for therapy, as the attachment dynamic may be reactivated in the therapeutic process and interfere with treatment (Holmes and Slade, 2018). This notion is supported in the present study as the participants all found it hard to engage with treatment and relapsed on numerous occasions. Three of the participants were able to abscond from hospital while seriously unwell without this being noticed, highlighting the need for the professionals who are caring for them to be more aware that deception, in many forms, can and does take place (Rotenberg and Edwards, 2017). Poppy was able to continue to exercise and purge whilst an inpatient, and exercise has been found to reinforce the continuation of the disorder (Coniglio, et al., 2022). Rose was able to access laxatives for which long term use can lead to kidney problems (Kondo, Yoshiya and Sakakibara, 2024) and Jasmine's weight continued to drop. Only Lily appears to have been closely monitored for detrimental behaviours whilst an inpatient. They were all in situations where support was available but did not always take advantage of this.

Family Based Therapy (FBT) is the treatment that is recommended by NICE (2017) (Dahlmann et al., 2020) for adolescents. (Cursor, 2020; Chen et al., 2016; Conti, 2017; and Hay et al., 2017). This study found that this form of therapy was offered to three of the participants. Lily says that she did not find it helpful at the time but feels that her relationship with her sisters is better now because of this. There is a recognition that the passage of time may also have contributed to the reparation of the sibling relationship. The approach aims to externalise the Anorexia Nervosa so that it is not a family 'fault' (Pisetsky et al., 2019), however, this is not always achieved. Whilst Lily's perception of the family therapy was mixed, she did find support from someone who she described

as a good doctor who was strict. Lily found the strict routine hard but helpful, this is supportive of the study by Renee et al., (2023) they found that for those who recovered, involuntary hospitalisation was seen as beneficial but for those who continued to have difficulties, they reported a negative outcome of the involuntary hospitalisation. Support was available to the participants, but they needed help to motivate them to engage with this support. Counselling Psychologists can look for ways to encourage this engagement with the available support and it is argued that this may be achieved via empathic engagement and a concern for the individuals health in a non-pathologising interaction (Woolfe, 2012).

At the start of the illness the participants had attempted to hide what was happening from their friends, and this deception is supported in the study by Rotenberg and Edwards, (2017) who looked at trust in close relations and found that those with elevated symptoms of Anorexia Nervosa were less likely to trust friends and more likely to deceive them. Lily had friends who tried to monitor her behaviours, and when concerned reported her to the teacher. At the time, the friend's behaviour was not seen as helpful, but on later reflection the fact that her attempts to deceive had been thwarted, was seen as supportive action. Friends can have a contribution to make in the process of recovery (Datta et al., 2021) and for Lily her friends attempted to discourage the exercise that took place at school and were vigilant towards her throwing away her food (Nilsson and Hagglof 2016).

The therapeutic relationship is seen to be important as it benefits engagement and outcome, (Robertson and Thornton, 2021) it was the formation of an alliance that enabled the start of psychological recovery for the participants in the current study. This supports the work by Tierney et. al., (2020) who also found that individuals need to be motivated to change and not treated as another case of ED. Kotilahti, (2020) supports this saying that a treatment that focuses on weight gain is viewed negatively by participants and this was the case in this study whereby the participants did not always feel they were seen as an individual.

This study found that a supportive professional enabled change to progress, this supports the argument that to normalise eating and provide supportive psychotherapy can lead to change (McIntosh and Bulik, 2020). For Rose this was initially a nurse with an interest in eating disorders and then outpatient treatment with a psychologist. Rose felt that she was able to trust the nurse who had been working with her on the ward. Trust had been missing from her life and here it was found. In psychological terms a good therapeutic alliance was formed (Werz, Voderholzer and Tuschen-Caffier, 2022). Sibeoni et al., (2020) also found that a supportive therapeutic relationship and communication were the fundamental requirements in aiding recovery and when Poppy was encouraged to work collaboratively with a nurse, she felt that she was given some control over her weight gain and began to engage, as she felt included in the treatment planning.

Rose recalls her time with a psychologist as being important in her recovery. Jasmine also reports that it was her time with a psychologist who specialised in treating those with Anorexia Nervosa that helped her to overcome the disorder and the same was found for Poppy. This highlights the importance of psychological therapy, if we are to effect long term recovery in those with Anorexia Nervosa. Weight restoration, while essential is not sufficient. Robertson and Thornton (2021) suggest that qualitative research is required to assess service users' views of the treatment that was provided, saying that the building of a good therapeutic alliance could be the key to change regardless of treatment approach. The current study is supportive of these findings and found that treatment with a psychologist was seen by the participants as aiding recovery.

This study supports the ideas of Conti et al., (2018), who found that individuals with a lived experience of Anorexia Nervosa preferred supportive treatments that felt tailored to their individual needs; and therapists who treated them as a person and had the skills and capability required, to support them through recovery, even when times were difficult, and helped them to rebuild suitable and preferred identities outside of the

Anorexic identity.

5.5 Journeys End

5.5.1 Sexuality and Finding Me

Parker & Harriger (2020) argue that those in the LGBTQ+ community are more likely to experience an eating disorder due to higher levels of stress caused by stigma and prejudice leading to a higher incidence of mental health problems including EDs. This is in part supported by the current research, with two of the participants eventually identifying as lesbian and one as bisexual but this was discovered in recovery as part of the journey into finding out who they were without the Anorexia Nervosa (Conti, 2018).

Jasmine felt that the recognition of her sexuality was delayed by the female abuse she experienced, leading to confusion over her feelings towards other females in her life (Malecki et al., 2022). Maseroli et al., (2023) found that unwanted sexual events can lead to a disturbance in sexuality as was the case for Jasmine who recalled the idea of a female relationship as one that was distasteful to her. Brown et al., (2024) suggest using a treatment that is specifically for those from a sexual minority, however, even if this had been available at the time of treatment there is no guarantee that it would have been offered as Jasmine was in denial or unaware of her sexuality prior to recovery.

Poppy engaged in relationships with those who identified as males and females while trying to find herself. The time in hospital had taken away her teenage years and as an adult she is discovering her sexuality. This did not sound like a series of comfortable relationships but a time of uncertainty and confusion. Karountzos et al., (2023) found that those with Anorexia Nervosa have fewer sexual experiences during their time with the illness and this could in part explain why Poppy was uncertain of her sexual orientation, they also found that some dysfunction can be present, which could then lead to the discomfort that Poppy experiences when engaging with sexual relationships.

Cassioli et al., (2020) suggest that this is due to discomfort with closeness, and Karountzos et al., (2023) suggest that this improves following weight restoration however, Price et al., (2020) found that whilst weight did have some effect on sexual functioning that this was not the only consideration, and that other psycho-social aspect could also be playing a part.

Rose, having been unwell for several years, had initially struggled to accept her sexuality, wanting to conform to a heterosexual norm and did initially have a heterosexual marriage. This could be symbolic of a false self (Monteleone, et al., 2021) as considered in GET one. Rose needed time to allow her true self to emerge (Moccia et al., 2022) to enable her to engage with her new life free from the Anorexia Nervosa. Croce et al., (2024) found that a change in disordered identity aids recovery and for Rose to move to recovery perhaps it was necessary to accept her sexuality and to accept her newly found identity.

Cao et al., (2023) found that those from a sexual minority group were more susceptible to Anorexia Nervosa than heterosexual controls. For these three participants there was a continued journey in recovery as they discovered, and for some, came to terms with, their sexual orientation in the process of ‘finding me’. This could support the idea of Parker and Harriger, (2020), that additional stress, even in recovery, was associated with non-heterosexual sexuality. The establishment of good sexual relations is considered to be an important aspect of recovery (Castellini et al., 2020) and on the journey to finding and defining themselves without the Anorexia Nervosa, in addition to establishing a new or rekindled sense of identity, they were also able to establish close relationships.

5.5.2 What Remains

Recovery from Anorexia Nervosa is most often based on physical measures such as weight gain and behavioural measures that include no binging or purging (Nilsen, et

al., 2020; Jenkins et al., 2019; Signorini, 2018). Cognitive recovery could be defined as the absence of body image concerns, the absence of eating related guilt or shame and no fear of weight gain. Social, occupational, educational and psychological domains need to also be considered when thinking about recovery (McDonald et al., 2021).

Whilst Jasmine is in recovery, she still has body image concerns and Junne, (2016) would argue that this is not full recovery. For Jasmine, the shame that the thought of weighing evokes is palpable, even in recovery. Jasmine is still unwilling to view herself in a mirror or to weigh herself for fear that this will lead to shame cognitions (Blythin, 2020) and her sense of self is still influenced by her time with the disorder. However, Jasmine feels that she is recovered, suggesting that there are various levels or different interpretations of what defines recovery. This is supported in research by Kinnaird and Cooper, (2024) who looked at the personal perception of recovery for those who had experienced Anorexia Nervosa as opposed to a consideration of symptoms. Recovery can be viewed as regaining a meaningful life and whilst this cannot be systematically measured and then applied, as it is subjective to the individual, it could be that what Jasmine reports is that she has a life that is meaningful to her and therefore she views herself as in recovery (Jacob, 2015).

For Poppy there is a shift in identity where previously there was a desire to be thin this is now seen as a potential problem as she now has the knowledge that to be too thin would be detrimental to health. Croce et al., (2024) suggest that a change in identity could be key to recovery. This was also the finding of Broomfield, Rhodes and Touyz, (2021), they suggest that moving on from the Anorexia Nervosa is difficult as it has become part of the individual's identity and Poppy is now recognising that the thin ideal is something that she needs to let go of to enable her continued recovery. This contrasts with Jasmine who appears to still have weight and shape concerns but is avoidant of information to confirm or deny this.

As previously reported recovery does not have an agreed definition (Walsh et al., 2021)

and when considering the experience of the participants it can be seen that the personal perception of recovery is not the same for all of them as although there are some shape and weight concerns, the depth of these concerns is markedly different. It is difficult to predict who will make a full recovery and who may struggle during the course of their life (McDonald et al., 2021). Junne et al., (2016) say that if sustained recovery is to be achieved then behavioural and cognitive elements should be addressed. When considering recovery and what this looks like, there is a possibility that potentially the disorder is never completely gone (Kinnaird and Cooper, 2024). Lily and Rose both feel that they are free of the Anorexia Nervosa but also share that people or situations can bring back thoughts that feel part of what was experienced during their time with Anorexia Nervosa. Some of the anorexic thinking appears to remain for all of the participants.

5.5.3 Reflections on Recovery

Nilsen, et al., (2020), Jenkins et al., (2019) and Signorini, (2018), said it is important to ask what is effective from the viewpoint of the individual who has experienced Anorexia and treatment for this. Therefore, the participants were asked directly what advice they would give to those with Anorexia, their carers and health care professionals.

Jenkins et al., (2019) found that early detection could aid recovery, and that retention in therapy would be helped by this early detection. Poppy felt that the delay in diagnosing her Anorexia allowed it to become entrenched prior to any intervention taking place and once treatment for the Anorexia Nervosa was available Poppy was resistant to change. Jenkins et al., (2019) suggest that more needs to be done to recognise the disorder, leading to timely access, adherence to, and retention in treatment, before it becomes chronic, and that access to treatment needs to be improved, as good outcomes are reported for those who can access and adhere to treatment. This is supported by this study as the participants all appear to have been dealing with Anorexia

Nervosa for an extended period of time before diagnosis and by the time it was diagnosed they required hospitalisation. It could be inferred that early detection leading to treatment could have prevented the need for hospitalisation as also found by Parpia, Spettigue and Norris, (2023).

O'Connell, (2021) suggested that the AN-identity can be inadvertently reinforced by treatment. He proposed that restrictive treatments such as inpatient hospitalisation, encouraged identification with Anorexia Nervosa, this in turn reinforced the disconnection from their previous life. It was proposed that this increased identification with Anorexia Nervosa led to worsening symptoms, and the need for further treatment, that kept the individual away from a life outside of the disorder. This in turn deepened the connection to an Anorexic identity (O'Connell, 2021). This appears to have been the process for the participants in this study and contributes to the suggestion that early detection could enable treatment prior to the enmeshment of the disorder and the establishment of the Anorexic identity above any other self-perception. The participants in this study had started to identify themselves as the disorder and on reflection feel that this may have been avoided by early detection.

Another idea that was shared with a view to aiding recovery was seeking the cause of the Anorexia as this would enable the professional to help the client to move forward, this idea is supported by Vilhem, (2021). Again, this would need to be done early before the initial contributors have been lost to the Anorexia. As this study found, once the disorder is entrenched, it is difficult to recall the pre-anorexic life. Finding the potential causes alongside discovering what was lost or what could be found now to replace the eating disorder, are all elements that the participants felt could effect change (Carpinelli and Watzlawik, 2023).

Croce et al., (2024) found that those with Anorexia Nervosa had difficulty in defining how they would like to be as a person and were overly critical of themselves, struggling to feel effective and worthy. The participants in this study questioned who they would

be without the Anorexia as they had lost sight of who they had been or could be (Bulik and Kendler, 2020). Poppy felt that she needed help to identify the aspects of her life that would encourage recovery such as family, friends, and the return to what had been lost such as education and exercise. To do this Poppy felt that she needed the help of the professionals to be able to identify what was available to her other than the Anorexia. The participants spoke of the difficulty in letting go of the Anorexic identity as it felt that this defined who they were as a person, this is supported in the research by Broomfield et al., (2024) and the recommendation is to help those with Anorexia Nervosa to consider who and how they want to be without the disorder.

A key theme that came out of the research was the need to instill hope in the individual that things can get better, and that life can be regained. This could potentially be achieved by finding something that the individual is good at and then give them the clear message that it will be possible to do ‘this’ again, or alternatively to allow them to see that what has been lost such as sport or access to education can be regained. This is supported by Acharya and Agius, (2017) who looked at the role of hope in treatment and found it to be the vehicle for change and a way in which a better future can be imagined. The participants all felt that they needed help to envisage a life without Anorexia Nervosa and to instill hope that this was achievable for them.

The installation of hope could come from the establishment of a good therapeutic alliance as a collaborative relationship could lead to change, and the belief that a better future could be established. Rose felt that it was important to build collaboration and to encourage the individual to make their own decisions to enable them to feel that they were being seen as an individual, this was important in the research by Bray et al., (2024). Rankin et al., (2023) also found that there were factors other than treatment that could lead to change and within a collaborative relationship what this could be, could be explored. During this process any fear associated with giving up the Anorexia Nervosa could be considered, and this may enable something to be identified that could replace the disorder. This study found that a good relationship, trust and hope for the

future were all required in the recovery process.

In summary what the participants felt could have aided their recovery or was part of their journey to recovery was the need to detect early, identify where possible, the cause, treat the individual as an individual, build a good therapeutic alliance based on mutual trust and understanding, instill hope that they can overcome the Anorexia Nervosa, look at what was lost that could be reinstated or look for something new that could replace the disorder, help them imagine a life where friendships are established, education is recovered and a new life can begin.

As Poppy said, 'life is better without it.'

Chapter 6 Conclusion

6.1 Consideration of the Findings in Relation to Clinical Practice

The study was an opportunity to look at the lived experience of individuals who have previously received a diagnosis for Anorexia Nervosa, to gain an insider perspective on this experience and to ask what aided recovery, with the anticipation that the insights achieved, could inform current understanding of this disorder and a deeper knowledge of what may be required to aid recovery.

What the study found was that there is a need to identify the signs of an eating disorder, so that early diagnosis is possible. This would address one of the points raised by the research, in that early detection could enable intervention to take place early on, in the course of the Anorexia Nervosa and potentially prevent the entrenchment of the disorder, as it has been found that early recognition is crucial to long term prognosis (Neilson, 2020). Additional training in the detection of Anorexia Nervosa should be provided to health care professionals and ideally treatment would be undertaken by those with specialist training in eating disorders as also, found in the study by Zugai, Gill and Ramjan, (2024) who report that adequate training should be provided to all people who

work with those with an eating disorder.

This study found that the Anorexia Nervosa was not diagnosed early, and that once detected, inpatient care was required for weight restoration. During inpatient treatment there is reported to be an imbalance of power between the staff who are caring for those with Anorexia Nervosa and the patient (Zugai et al., 2024). Zugai et al., (2024) suggest that a re-balance of power could be achieved by working collaboratively. Counselling Psychologists are aware that there can be a perceived power imbalance but that this can be ameliorated by seeing the client as an individual and providing empathic engagement.

What was found was that whilst the hospitalisations had been essential for the physical health of the participants, they were experienced as distressing, evoking a strong emotional response, of fear and the separation from family and peers. Whilst in hospital there was a sense of loss, as contact with family was reduced, education stopped, leading to a loss of friendship and the feeling that all that was left was the Anorexia Nervosa (Bulik and Kendler, 2020). Psychological treatment was not initially offered due to low weight and the ability to engage with cognitive treatment being impaired because of this (Seidel et al., 2024). Once physical danger had passed, they were discharged often without arrangements being made for continuing care, this contributed to the need to return to inpatient treatment and the continuation of the disorder, this supports the findings of Kalindjian, Hirot and Stona, (2022) who cite the necessity for early detection and treatment of the disorder. This is further supported by Jenkins et al., (2019) who found that detection and access to treatment need to be improved. If hospitalisation is required then continuity is required at discharge ensuring that outpatient care is in place (Rienecke and Wallis, 2021). This continuity could be difficult unless sufficient numbers of adequately trained professionals are available in each geographical area as Anorexia can be a complex disorder to work with (Zugai et al., 2024).

All of the participants were initially treated in psychiatric units, which was shared as a

frightening experience, being placed with patients who they saw as being unwell. However, this could be due to the limited availability of inpatient ED services (Bailey-Straebler et al., 2024). As the disorder progressed hope of recovery was lost for the participants, and they had lost their sense of self and who they would be without the Anorexia Nervosa (Conti, 2018). The eventual move to recovery was supported by the re-installation of hope that a 'normal' life was possible. To instill this hope, the individual with Anorexia Nervosa and the Counselling Psychologist or other health care professional need to work together to define what maintains the Anorexia and how to intervene, this would then allow the individual to have some control, and this was seen as important to the participants and a facilitator of change (Jansingh, 2020). The belief that what had been lost could be rekindled or that new opportunities did exist, was a factor that helped to maintain the movement to recovery, and to promote hope that recovery is not only possible but desirable, as found in the current study.

Those caring for and treating the patients with Anorexia Nervosa can offer hope for a better future without Anorexia and that life can be worth the change. For this motivational shift to occur it was necessary to identify what had been, or could be important to the participant (Conti, 2020). A good collaborative therapeutic relationship provided this motivation for the participants and Counselling Psychologists can offer this opportunity to change.

From the reflections of the participants the implications for clinical practice and in particular for Counselling Psychologists, are to identify the disorder early, where possible discover the main contributing factor, treat early and collaboratively, engage the individual in the process of treatment to instill the feeling that control is not completely lost, offer hope that what has been lost can be regained and that life can be good. The contribution to the field of counselling psychology is the need to continue to offer empathic engagement to clients, the continued recognition that to achieve the above points there is a need to engage in a helping relationship and to not pathologise the individual but to work with them towards their recovery.

6.2 Limitations and Evaluation of the Current Study

Small sample sizes can be seen as a disadvantage but are a requisite for IPA studies. The small number of participants allowed for an in-depth exploration of the personal experience of the participants (Smith and Nizza, 2022). This does mean that the work is not generalisable to a wider population but can potentially form the basis for further research and add to the current research into the experience of Anorexia Nervosa and recovery.

This study looked at those who had been well for over three years. This made recruitment challenging as access is more readily available to those in treatment or recently discharged (Ambwani et al., 2024). Recruitment did yield four participants, and whilst initially more participants were sought, on reflection this would have detracted from the depth of analysis that could have been reported.

It is acknowledged that the group experiential themes that were arrived at are from the perspective of the researcher and another researcher may have placed more value on other aspects of the data, (Smith and Nizza 2022) as there was a wealth of information that could have been presented. The process followed has been fully reported, along with the interview questions, to demonstrate transparency and to allow for replication. It is noted that the information gathered is pertinent to the participants in this study and not necessarily to the full population of those with Anorexia Nervosa but is intended as an insight from which we may learn (Smith and Nizza, 2022).

Much of the information shared came from the time when the participants were very unwell however, once the journey to recovery began the participants spoke of spending time in therapy and how this enabled the continuation of the recovery process. A strength of the work is sharing the viewpoint of those with experience of AN and what they feel could have helped them on their journey, this includes the need for early detection and the instillation of hope.

During the process, the literature has needed to be updated to keep abreast of current research. Due to the wide spread of research areas into Anorexia Nervosa it is recognised that not all aspects may have been included in the review of the literature or the discussion.

6.3 Conclusion

During this study the focus was on those individuals who had been in recovery for an extended period, as the previous literature, as reviewed in Chapter 2 mainly looked at those who were relatively new to the recovery journey. The IPA analysis (Smith and Nizza, 2022) provided four Group Experiential Themes, these were: Losing Me; Dark Days; Empowered and Journeys End. The findings were that this had been a long journey to recovery for all the participants, with a focus on re-feeding, with limited early psychological input. The experience of being on a general psychiatric ward was viewed as a frightening aspect of the experience. Psychological treatment was not initially offered due to low weight and the ability to engage with cognitive treatment being impaired because of this. When weight gain was sufficient for discharge from inpatient settings there was limited continuity of care for the participants who all deteriorated and returned to inpatient treatment on multiple occasions.

The study found that the participants lost what was important to them such as family, friends and activities and hope was lost of these being regained, and of having a future without Anorexia. There was also the fear of what would replace the Anorexia Nervosa and enable them to re-engage with life as the Anorexia Nervosa had become part of their identity. The participants each needed to be motivated to seek a life outside of the disorder and the continued hospitalisation. What motivated each participant was unique to them but with the common theme that there was life outside of Anorexia Nervosa that was achievable and worth engaging with. Counselling Psychologists could aid in recovering this hope of regaining what was lost via the establishment of a good

therapeutic alliance, to see the patient as an individual and to promote hope that recovery is not only possible but desirable and achievable.

Future research could focus on what training is given on the recognition and treatment of eating disorders to those who work with people with an ED in the hope of promoting better understanding of the needs of this population, to seek a deeper understanding of the mechanisms of motivation and how to instill hope.

The implications for Counselling Psychology are the need for clinicians to engage in the work with this client group. To ensure that adequate training is given to all who work in this field, to ensure early diagnosis and the establishment of a good therapeutic alliance, to engage and maintain the client in psychological treatment, to offer hope of recovery and enable them to find what is 'bigger' than the Anorexia Nervosa and worth making changes for.

The message that as professionals we must convey is that 'life is better without it'.

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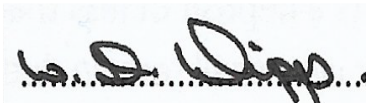
Appendices

Appendix 1

Evidence of Ethical Approval

	Name	Signature	Date
Student	**Wendy Whipp**		**11-02-20**
Supervisor	**Angela Loulopoulou**		**12.02.2020**
Principal Investigator			

PSYCHOLOGY: REVIEW

Reviewer

Enter **X** in correspondence with one and only one of the following statements:

C	Clear without amendment.	**X**
M	Clear conditional on the requested changes being made (minor modifications).[1]	
R	Revise and resubmit (major modifications).[2]	

Comments (required for M and R referrals).

[1] The project must be revised. The revised project has to be approved by the supervisor **only**. The revised project, signed by both student and supervisor, must be submitted, for auditing purpose, via the **Minor Modifications Archive** submission link.

[2] The project must be revised, signed by both student and supervisor, and resubmitted via the ordinary submission link as if it were a new submission.

	Name	Signature	Date
Referee	**Dr Raffaello Antonino**		**14/02/20**

Final judge (if one was appointed)

Enter **X** in correspondence with one and only one of the following statements:

C	Clear without amendment.	
M	Clear conditional on the requested changes being made (minor modifications).[3]	
R	Revise and resubmit (major modifications).[4]	

Comments (required for M and R referrals).

	Name	Signature	Date
Final judge			

Feedback from Ethics Review Panel

	Approved	***Feedback where further work required***
Section A	Yes	
Section B	Yes	
Section C	Yes	
Date of approval		17/2/20
NB: The Researcher should be notified of decision within <u>two</u> weeks of the submission of the application. A copy should be sent to the Research and Postgraduate Office.		
Signature of RERP		Professor Mark Wheeler

[3] The project must be revised. The revised project has to be approved by the supervisor **only**. The revised project, signed by both student and supervisor, must be submitted, for auditing purpose, via the **Minor Modifications Archive** submission link.

[4] The project must be revised, signed by both student and supervisor, and resubmitted via the ordinary submission link as if it were a new submission.

chair	

Appendix 2

Email Invite

Anorexia Nervosa & Recovery

I am conducting a piece of research and would like to interview individuals who were previously diagnosed with AN but have not met the diagnostic criteria for three + years

My interest is to understand the onset and recovery process from the point of view of people who have experience of this. The hope is that this could inform clinicians who are currently working with those who are experiencing AN.

If you would like to participate please email me on: wendywhipp@icloud.com for further information.

I look forward to hearing from you.

Wendy

Appendix 3

Participant Information Sheet

Anorexia Nervosa

Perceptions of living with and living without Anorexia Nervosa

This participant information sheet contains information about this study, so that you are able to make an informed decision about whether you wish to take part.

- This project is being conducted by Wendy Whipp. Wendy is a Chartered Counselling Psychologist, an Associate Fellow of the British Psychological Society and a BABCP Accredited Therapist, Trainer and Supervisor. The research is being undertaken as part of her 'Top Up' Practitioner Doctorate in Counselling Psychology.

- You have been invited to participate in this research because you were previously diagnosed with Anorexia Nervosa (but no longer meet the diagnostic criteria) and so could provide personal insights into what you believe were the contributing factors to the problem and what you feel helped you to overcome it.

- The aim of this research is to explore what it was like for you living with Anorexia Nervosa and what aided your 'recovery'. I am also interested to understand if you feel that anorexia plays a part in your life and relationships now and if so how? To answer these questions you will be asked personal questions about your life both past and present. If you do not wish to answer any of these questions then you will not be pressed to do so.

- The research will involve an interview (a link to participate on line will be sent) that could take approximately one hour

- All your responses are anonymous and confidential, and you are free to withdraw at any time prior to the interviews being analysed.

- Should you decide to participate then signed consent forms will be stored separately from the interview recordings and the transcribed information. Recordings will be pass word protected and transcripts will be stored in a secure box to which only the researcher has access. Extracts from the interviews will be used in the written work and you will be invited to choose a name by which to be known.

- It is anticipated that the findings from this study will provide insight into living with Anorexia Nervosa, contributing factors to the disorder, protective factors and longer term effects to better inform current treatment approaches.

- The study has been reviewed and approved by the London Metropolitan University Psychology Ethics Committee.

If you have any additional questions regarding this study, or if you would like to participate please contact:

Wendy Whipp at:
wendywhipp@hotmail.com or
wdw001@my.londonmet.ac.uk

Should you feel distressed but do not wish to talk to the interviewer then please contact:

Mind: www.mind.org.uk or
Beat: www.b-eat.org.uk

MIND: are a national mental health charity that accept self-referrals from the public for counselling or
B-EAT: an organisation that specialises in providing information and help to those with an eating disorder.

Appendix 4

Consent Form

Anorexia Nervosa
Perceptions of living with and living without Anorexia Nervosa

Please tick the appropriate boxes

I have read and understood the participant information sheet..... ☐

I have been given the opportunity to ask questions about the project..... ☐

I understand that taking part in the project will involve participation in a recorded interview with Wendy Whipp

..... ☐

I understand that my taking part is voluntary; I can withdraw from the study at any time prior to analysis of the data and I will not be asked questions about why I no longer want to take part ☐

On this basis I am happy to participate in the project.

Name of Participant ..... Signature.....
Date.....

Name of Researcher..... Signature.....
Date.....

Appendix 5

Debrief

Anorexia Nervosa

Perceptions of living with and living without Anorexia Nervosa

Thank you for taking part in this project. Your time and insight are greatly appreciated.

The aim of this research was to gain a greater understanding of Anorexia Nervosa from the perspective of someone who had first-hand experience of living with Anorexia Nervosa and recovering from this. Your personal experience of overcoming Anorexia Nervosa will allow us to gain an insight from a personal perspective; this will enable us to consider the best way forward in treating those who are experiencing this eating disorder now.

If you feel concerned by your recollections then please share this will the researcher, Wendy Whipp and if you have any questions please contact Wendy:

Wdw001@my.londonmet.ac.uk

or the research supervisor:

Angela Loulopoulou

A.Loulopoulou@londonmet.ac.uk

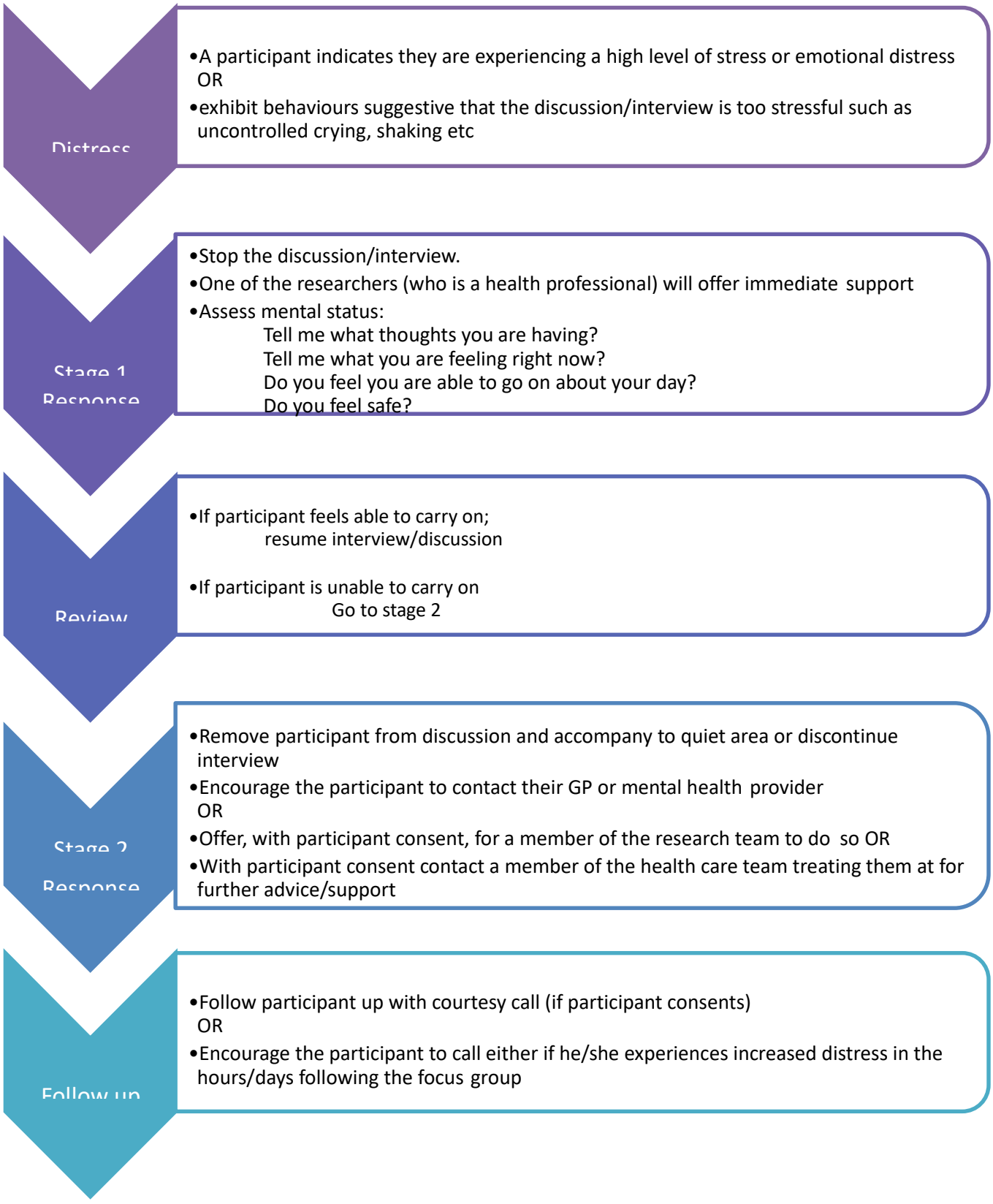
The following charities can also be contacted if you feel you have any further concerns that you do not wish to discuss with Wendy or Angela.

Mind: www.mind.org.uk or
Beat: www.b-eat.org.uk

Thank you again for your time.

Appendix 6

Distress Protocol



Appendix 7

Interview Schedule

Interview Schedule

Pre-amble to put participants at their ease. This could include comment on the weather or how long it took them to get to the interview (assuming they travelled).

Participants will be advised that they can stop the interview at any time without having to give a reason.

1. How old were you when you were first diagnosed with Anorexia?
    a. How long before this did you realise that you may have a problem?

2. What was happening in your life at this time?

3. Were you offered any form of treatment?
    a. Was this voluntary?
    b. What was it?
    c. How long did it last?
    d. How effective was it?

4. What was your eating behaviour like while you had Anorexia?
    a. Were you trying to hide your eating behaviours?
    b. Did friends or relatives comment on your eating?
    c. Did anyone comment on your weight?
    d. How did this make you feel?

5. How did you feel about yourself?
    a. How did others make you feel?
    b. Was this helpful?

6. What do you believe was the main cause of you developing Anorexia?

7. What do you feel helped you to overcome Anorexia?

8. Can you describe your recovery process?

9. Do you feel completely free of it now?
    a. If not how does it affect you?
    b. What is your eating behaviour like now?

10. Would you say there has been an enduring psychological impact?

11. Has Anorexia affected your relationships as an adult?

12. What would your advice be to someone with Anorexia?
    a. Or to their carer?

13 What would you want to say to your anorexic self now?

Check the SUD rating (subjective unit of distress): Thank participants for taking part and end with a neutral question.

Appendix 8

Transcript Extract for Lily

P um I think, I think one of the things for me was I was on a French exchange trip and each, Its funny actually I was only looking through the photos last, I found the albums in the loft the other day and I was just nearly 12 I'm a July birthday and it was May or June and I did a French exchange and I didn't get on with the girl unfortunately and we went to her house and then she came back to ours, you know a few weeks later

R yes

P I remember being quite homesick and not liking the food And I didn't really like the dad he was a bit creepy and I remember getting on with some of the other my friends but she and I just didn't click for whatever
reason and that for me I think was possibly when it started and then from there I remember feeling uncomfortable about the food and being in a strange country when I remember I wasn't eating perhaps as well and then I do remember a couple of comments that people I was never fat I was never particularly but I do remember you know I don't know you know what children are like sometimes with comments and whether I took that to heart and then I began to think this is something I can control and then it sort of escalated from there.

R so it sounds like a combination then

P I do remember going on that French trip and feeling quite unhappy

R so really if someone sort of said to you what would you say was the main cause?

P Yes that and I think being one of three, three in the middle girl of three I've got

two sister

R Oh ok

P and we're all very close in age there's only four years, mum has three of us under four so there is only sixteen months between me and() my older sister and 23 just less than two years between me and (). She had three of us under fours so I mean yes but its different she didn't work. I don't know I just um that was the way it was but I think that I didn't like being the middle child and looking back at the time I think there may have been a little bit of that there having two sisters and all being, not that we all went to the same school because we didn't but secondary schools we went to separate schools which was obviously good

R That's interesting so when you look back what would you say was sought of happening in your life at that time?

P umm as I say I think maybe I was just coming toward teenage years at that age and maybe there was a bit of anxiety about growing up maybe and then as I say I went on this French thing which I didn't enjoy erm and whether I was just a bit sensitive to comments and I think yes it was just me at that age

R It sounds like several different triggers doesn't it?

P I don't think there was one thing

R No

P But I mean I remember my grandparents favouring () being the eldest grandchild and at times they made that quite obvious I would say. My grans sister um favoured () with being the youngest and I think that that is probably

the reason why I haven't had three children, I think there were issues with being the middle child at times which I found I wasn't the eldest or the youngest and maybe being three girls that made it harder

R Yes, three girls together it can be difficult

P1 and when your all of a similar age. Yes, so I don't know really, whether that was.....

R Did you feel competitive with your elder sister because that bit about the grandmother favourites and..

P1 mum and dad weren't ever, I mean they were never favourites so I didn't ever feel it from mum and dad but I think. Yes I do remember when they use to come and feel and even to this day you know my Grans still alive my grandfather isn't which is I* mean you know we still used to call her the old golden girl you know and perhaps I was a bit sensitive to that.

R Yes, maybe, so it all adds to it. So I was going to say what sort of treatment were you offered but you said you were hospitalised.

P1 I was hospitalised, well a few times between 12 & 16 which is when I was ill in that period really. I first, I went because I don't really think that there was anything really in () in that area and the () hospital in London was, I think a sort of, may be a trial of you know where they seemed to know a bit about anorexia so I was put in hospital there at age I think it was either the summer I was 12 or the summer I was 13. I think it was when I was 12 and that was I remember being absolutely terrified. Because I was on a psychiatric ward and had a room within a ward and there were, I think there were six beds on an acute ward and it was really strict and rigid and the first few weeks mum and dad weren't

allowed to visit and I was 25 miles from home in London and that was really scary really, really scary and you get quite you know you can imagine being on a psychiatric ward it was quite hard I found I was quite scared.

Appendix 9

Transcript Extracts for Rose

23-25 P: Well I was first hospitalised at the age of eleven. Urm, they believed I had meningitis and ended up giving me a lung puncture, which was awful.

29-31 At that point, weight was not an issue to me, it didn't matter what my size was. It was just my relationship with food, I hated food. 34-36 and I know why, because when I was a child, I was abused and then rewarded with food. So, by rejecting the food-
54-58 I started losing weight and then really becoming obsessed with the weight. Then I was hospitalised, then was given the diagnosis of anorexia. Urm and then when I was seventeen, I was hospitalised in a generic psychiatric unit which is never the best placeIt was horrendous
It's the nature of the illness, so you put together six or seven on an inpatient basis, anorexia clients, they're going to be very, very competitive. I did it, there was a couple on the ward when I was in the hospital, it just becomes this big game 75-78
83-4 I was very angry all the time, didn't want to be in hospital,
89-92 An absolute magician, I could sit there and somebody would think I've eaten a whole meal and it would be up my sleeves, I'd half swallow so they'd make me open my mouth to look, and it would be sitting there,
115-119 I was just into my dance, because my whole life was so, outside of school it was horrendous. And in school, I didn't like school, I was bullied a lot, but I loved music and I loved dance and that's, I threw myself into that.
122-126 my sister, was very, very ill as a child, so my mum and dad spent a lot of time with her, so kind of me and my brother, were kind of left on our own devises. And then when Lisa's in hospital, we'd be sent to our grandparents
165-167 So, my mum and dad, all their energy really was taken up looking after
233-236 I was very much on self-destruct, I hated myself, I thought the less of me there was, the less there'd be to hate and I wouldn't take up too much space in the world, that's how it felt.
270-272 I was probably seventeen when I was admitted, at sixteen I was starting to have really, really bad problems with it, I think I went down to about fifty calories a day
276-7 mum got the GP out and he said, "you are really ill," he said, "we're doing an urgent referral to psychiatric
309 Then it became a battle
324 Because the control, the person with anorexia has, I mean, and they know it

330-332 I don't feel you're as aware of it, but the more you get into it, the more manipulating you become and the more deeper the disease becomes entrenched

341 I just can't eat this, I've got to lose weight, I've got to, it's an absolute obsession, you're driven by that

356-7 I saw the consultant psychiatrist, who I really don't like, and he said to me, "It would be irresponsible for me not to tell you that you're dying.

359-65 unless you stop this now, or we do something else, you are going to die, your heart is suffering," because I think my ECG was really low and-

P: -stuff like that. "We want you to come into hospital," and he said, "it's best that you come in of your own accord, urm, but if you refuse we have ways and means of getting you in without your say-so

380-385 it was awful, they put on ward seventeen which was like a square and for a seventeen-year-old girl, being put on a unit with people that has schizophrenia, psychosis, urm bi-polar it is really frightening. And it's in a square, and you just walk past, it reminded me a bit of, have you ever watched *One Flew Over the Cuckoos Nest*

393-5 I begged my mum and dad to take me home, I said, "please take me home, I promise I will eat, I promise I will eat." But they couldn't.

499-500 I guess the only thing it did do, it stopped me dying. Although I did go into heart failure

504 when I was in hospital, I overdosed on laxatives

532-535 I felt that the privilege, punishment treatment programme they had was just reinforcing the abuse on another level, does that makes sense? And it kind of, the negative emotions you have about yourself, are reinforced. Because they would punish you if you didn't eat

567 If I didn't gain weight, then I couldn't go out and get married

587 I OD on laxatives 593-596 my parents went to the general, were called in and said, "I'm probably not going to make it. through the night." Because my heart had gone into failure, and they had to pump me full of stuff. But I did.

621-2 Andy said about the fishing weights, and they searched all my room and everything and found them.

710-713 Yeah, so and then I went through a stage of chewing food and spitting it out, so you don't have to swallow. And at that point not realising that a lot of calories are absorbed through the saliva.

719-21 there was a nurse on the ward, called Lorna, and she had specialists interest in eating disorders. 729-733 we'd have a chat and she was kind of my key worker and she, she knew every game I was playing, she would challenge me on everything. But I really built up a good relationship with her. It's the first professional I actually started to trust.

742-755 I just got my coat, got my bag, crawled past this thing, and then ran out. I ran around the field several times, to burn some energy, thought, "sod it, I'm going to the pub," so I went into the pub, had a vodka and coke, meanwhile they probably realised they've got a patient missing because she hasn't half been in the toilet a long time. And think I walked to my friend's house who lived the other side of Dunstable, knocked on her door, "hi!" She's like," hello," she said, "are you out?" I went, "kind of."

R: Yeah.

P: She said, "does Andy know you're here?" I went, "no, not yet, can I come in?" She said, "well come in, and have a cup of tea," she went out and rang Andy, Andy rang the ward and then I was

picked up and taken back.
793-797 I remember going through that thinking, why do I have to be gay as well. I was like why? Why can't I just be normal? And I have no problem with being gay. It's not something I advertise but I don't think you should adversities what sexuality you are, it doesn't matter, does it. 812 I think the whole thing was me trying to just fit in some normality, society.
880-884 Because it, it just makes no sense, you're on this mission and you don't think about anyone, you become very, very selfish with it, very. You don't think about anyone else, you're just in your bubble, and nobody is going to take that control away from you.
909-913 I worked with Lorna a lot on the eating side of things and, which was hard, but actually the more you did it, the easier it became. And then you realised that actually, don't have scales, they're not helpful, it's reassurance seeking, it doesn't work, you know, all of that kind of stuff
924 And then I went to see an amazing psychologist, 934-937 she was absolutely amazing. Yeah, I really haven't looked back since. Urm, I think because I had it so long, I think I'd be lying to say I don't have the odd thought when things are.
965 she treated me as a person (Lorna)
967-971 She never tried to force feed me, in fact she got me to eat more than anybody else without even trying. Because she'd kind of sit with me at mealtimes and just natter about things. We'd have a laugh about things and I'd eat sometimes without realising. It's very clever
076-7 She got it to the point where she allowed the kitchen staff for me to go and make my own dinner. I was allowed to do that every night. And so because I'd made it, I was in control so I was more likely to eat it 980-1
1005 you can't abstain from it. 1009 That's the hardest part. So, urm, I might sometimes, usually when I'm due on I'll kind of get the old, "oh I'm so bloated," like the hormone imbalance
1023-5 If I want chocolate, I'll eat chocolate, which is quite frequently. I do like veg and things like that, but I'll eat what I want to eat and when I want to eat
1066-71 I'm not as close to her as you see some sisters are. And that saddens me because it would be nice to have that, but we're not. And my brother, interestingly he just split up with his wife and my relationship with him has really, really built quite well. So that's, that's good. But at the time, the relationships were awful, I lost friends, obviously,
1074 Because your friends are seventeen, they're going out, they don't want to go to a psychiatric hospital
1080-86 I went out, I said take me out to the night to the pub, just take me out, so she came in, got her sister in the car, again I sneaked out, I went out for the night, came back, nobody had known we'd gone. And then it came to medication, in those days I had Lambrusco and it would knock me out, I had some Lambrusco, and I was all rosy cheeked enjoying and happy, and nobody noticed
1102-5 my mum worked at the hospital, my mum would come every day to see me. She'd come every lunch time, she'd come every evening to see me. Urm, but she just didn't know what to say.
1109-12 She was forever having a go at the doctors, saying that you know, "what are you doing for her? it's clear she's playing a game, why are you letting her know when she's being weighed?
1132-34 I thought, "oh I did like her," and I felt completely comfortable, oh damn. Yeah, and it was literally, "oh damn,"
1186 I lack confidence, a lot
1223 obviously the earlier you catch it, the easier it is to treat
1237-39 Okay so then we look at, if you weren't doing this, what would you be doing? So how do

we get there? How do we move you to that
1337-8 But I think the key in all of this is getting the person encouraging the person not to tell someone what to do, it's never going to work.

Appendix 10

Jasmine: Consideration of the Personal Experiential statements

Age 15 struggling for a while Taking control of weight CONTROL
A conscious decision to take control
Progressed slowly until discovered then rapid
Comments on weight loss seen as positive
Not caring once secrecy was gone
Felt like the fat one
ignore bury
Then realised that change was possible
From a secret to no point hiding it now
Sees herself as different to other ANs
Restriction seen as healthy to start.
Weight loss not a concern to family
But noticed the mood change
A desire to lose weight before she was weighed
Distorted view - felt fat but knew to hide her weight
Embarrassed that the hospital staff would think she was fat
Referral made, weekly checks, further loss, guilt after eating
Still aiming to lose
Weight restored but monitored weekly
Did lose weight and readmitted
Uncomfortable with appearance and thought weight loss would help
Lost weight for cousins wedding
Fear of looking bigger
Didn't want to look fat anymore
Want to be thin
From you look great to you need to stop
Embarrassed by her weight then and now (poo)

External motivation to change to start with via restraint slowly moving to self motivation
The illness had an intentionally destructive element as knew what she was doing
Needed everything to stop
Once school stopped started to exercise excessively
Seen by the GP but a wait for treatment

No safe place Abuse at home and at school / **no safe place** / suicide
Difficult relationship with father

Has come to terms with this R (father)
Still a trigger point (dad)
Dad aggressive, narcisistic
Dad's return like a dark fog
Recalls being pinched by dad and bruising
Dad was in control
His temper would flare
Recalls being afraid by her fathers actions
Some memories are still difficult to discuss
Brother spared from the treatment
Did not share with brother what happened
Dad shouts, brother a wind up
Mistaken reason (dad's absence) attributed to the development of the ED
Family looked good
Home life was seen to be normal
Dislike of dad still evident
Not aware at the time that Dad's behaviour was inappropriate.
Never told anyone what he did as normal for her if unpleasant
Abused by a girl at school, escaped, then she came to the same school
Interfered with friendship group
Had told mum
Did try to talk to the girl as an adult
Delay in coming out due to what she described as a horrible link
Questions why mum did not intervene with dad's behaviour
Some anger toward mum
Tolerates father but has a plan to escape when she visits
Talks of respecting herself more than putting herself in a position where she could be hurt by him tolerates him
Mum as a support
Saw a family therapist but reports that they were mistaken in the belief that she missed her father

Parents help others Mum
Close to mum and a family friend
Mum had a catering business so more proud that she starved herself

Lost friends
But made ED friends and had fun
Intimate R with those in hospital due to a shared understanding

Health deteriorated and was admitted to a psych ward five days per week
Not eating while an inpatient **Dark days: Inpatient experience / Suicide**
Staff not speaking English
Got worse
Limited care, poor inadequate care

No obs of a patient who was suicidal. Walked out
Four walkouts, from a secure unit with people on section there
Further weight loss getting worse
Serious Physical health deterioration liver failure
Suicide attempt
Dr. Who could refer away but no beds anyway
5 months with NHS
Parents distraught about what to do
Sought private treatment
Private hospital given a goal to work towards
Draconium harsh regime
Tube fed for two weeks
Did not want to be tube fed.
Still playing tricks to avoid eating
Hard to cope at home at the weekends
One nurse was helpful
Told she had no future
Cousin had weight concerns and committed suicide
Better to have an ED than be suicidal
His death a secret
Secrecy around MH
Suicide seen as an option
Feels his death is relevant to the start of the ED

Intended to re lose weight but thinking had changed Moving forward
Life felt good Life taking on meaning
Had fun
Got a job, left school. Life became more important than the ED
as life changed
Life changed, work, education, and friends all regained
A more interesting life led to the feeling that being ill was not worth it! Freed from guilt
Wanted to engage with life again so being away every weekend was not worth it and having a reason removed the guilt over eating
No option get on and eat. And no guilt. Life or ED so no longer worth it
Started to understand the AN. Thoughts and behaviours that are hers so within control
My voice my thoughts my fault
Compensated due to neglect
Does not use the compensation money

Relays it like a script now
Concerns re telling others
Fear of judgement now and repercussions

Feels that she would not be employed if people knew
Distance from then and now, a story
Questions what is normal **Fear of judgement**
Fear of Judgement is still present
Would work in MH but not with ED
Worry of her past being discovered
Believes the ED prevented her from getting a job
Will not disclose in the future
No need to tell people her secret
Feels unable to disclose
Feels others might be able to
People should not be made to disclose
Feels guilt that she did not report it
Secretive re her illness
A strong reaction to disclosure

Some body image insecurities tells self to suck it up and get on with it WEIGHT
Wants to accept that no matter what size she is will think she is fat so accept how she is
Some BI concerns but won't diet
Keeps herself in check e.g., no exercise for fear of becoming obsessed
AN thoughts still present described as cruel
To see her weight may trigger her now
Won't look in a mirror even now, finds it upsetting

Education hard and still afraid she is stupid and will be found out Education
Procrastinates regaining what was lost
Does not strive for fear of failure
Would not engage with education for fear of being found out to be stupid
Wanted more
Back to education and worked hard to achieve but knowledge gaps cogs impaired
Pressure at school may have contributed

Never fully recover, always there Is it over?
Recovery is a long process
Some strong reactions remain so thought about therapy
Feels for her mother's experience of a daughter with AN
Meals out not weird now
The cool one

Offer unconditional care What now? Perception of the experience now
Girl died and felt angry with her can no longer see why you can't stop
Uncertainty over take away or not re control
Do not stereotype
Ok is ok no pressure to achieve just don't want to feel stupid

Formed friendships felt cared about an equal not an ED
Allowed to experience life and loved it so look for PF not just risk
Some triggers for the abuse at school still present.
Painful but don't pick the scab
Still on ED group chat
Those with a similar experience will understand but choose a wider circle of friends
Help is good until you can take back control
Treat ED seperately
Helped to challenge her thoughts before she could do it for herself
treat as an individual. See the person not the disorder
One friend makes a difference at the time of crisis

Good relationship says lose boundaries but harsh regime
Therapist innapropriate
Next therapist good
Therapy not good enough
Focus on re-feeding

Appendix 11

Transcript Extract for Poppy with initial comments

P4: Well, if you can tap into finding out why they're behaving the way they are, that way you can help them. Urm but the problem is is how long it's been there with in term so whether that's actually a problem now or whether it's more, it's thinking about habit, isn't it, and how entrenched that behaviours become. Find out why they are behaving the way they are
There is a sense here that her Anorexia was not detected early and that the ongoing problem becomes entrenched and a separate entity to the onset reasons. But it's about understanding what used to be or what could be important to them, and what gives them hope and something they could see that could replace the eating disorder. I think that the thing it's the void. What could be important to them and gives them hope and could replace the ED
Poppy needed to help to identify that a future was possible and that their could be things in her life that were worth living for. Urm, because if someone had told me that, as I say when I was a 100% anorexic, that I one day could urm… I don't know be in long term relationship get a job, get all these qualifications, enjoy competitive sport again, have all these things that I think make me happy. Would not have believed that she could have her life back
Hope for a future without AN is not present or seen as possible at this time
And yeah, I struggle with my mood and urm, things like that, but I think a lot of that

is the fact I was given antidepressants when I was about thirteen years old, so I don't think that helped my brain growing, nor did the eating disorder. Still struggles with her mood but feels this is due to anti-depressants at a young age and the ED
Mood fluctuations are given multiple causes perhaps not wishing to have sole responsibility for this due to AN but to share responsibility with those who treated her with medication. But, on the whole if you can find things that give you fulfilment in your life then that would replace the eating disorder. Find a replacement.
Interestingly the replacement is at hand as if Poppy eats she can resume sport and education. It's a real sad place to be because urm… you're basically wasting all those years of your life, not intentionally but they're just passing you by Wasting life.
Current perception on what the ED took away. and they're times when you can have like a fulfilling experiences and things that actually bring you joy. And it is possible to change these habits, but it takes a long time, like I'd say… probably took me about fifteen years Change is possible but it takes time, took her 15 years to get to the point of, not being free of it, as, I thought I was free of it a few years ago but getting to the point where you live with a very small, and that percentage changes doesn't it, but a small percentage of food related behaviour. Urm, that allows you to function normally in a life that's fulfilling. Still lives with a small % of food related behaviour but functions in a life that's fulfilling.
Not / never 100% gone

R: Yeah. That makes sense. It's almost like back to that hope thing as well, isn't it?

P4: It's all about having hope and something to live for. Good comment Like if I think, if I didn't want to live, I didn't have anything to live for, really. I should have done, I should have had my family. Urm, but I couldn't see that, and no one seemed interested in that and no one identified that. But that's what it was all about really. Nothing to live for. Should have been family but feels this was not identified

'I should have done' seems as if she feels she should not have lost sight of this, and 'should have' in relation to her family, implies that they should have been there for her, or that she had lost sight of the fact that they were still there for her, and the idea of someone being 'interested' and 'identifying' that would have been offering her the hope of a different future that she had lost hope of having.

R: What would you say to your anorexic self now? .....

P4: Probably the things that I've just said to you really, that there is hope urm, Their is hope
Again the idea of offering hope is seen as important to recovery.
that I will be able to enjoy the things that I want to, urm and that you can certainly build a balanced life with sport again, because sport was such a huge part of me, urm, and it was taken away. You can have sport back

Again we see the idea that seeking what was previously important to them and what has been lost from the pre Anorexic life or what could be found now to replace the

eating disorder are all elements that she feels could effect change.
But actually, I can do that in a healthy way, and and I think building friends as well. Like I don't think I had any true friends at that age, that understood me, Friends are important, none at that stage that understood
When someone is very unwell and cognitively impaired they often cannot see that they are cared for and that change is possible.
but now I've got, I think I went through a stage where I tried to build a really big friendship group to almost compensate for that, but now I've just got a handful of key friends who I know that I can say anything to, urm. Has key friends now with whom she can be honest

R: That's what counts, isn't it?

P4: Yeah, and it's important to be able to talk about feelings and identify them early, and it's not good to shut them away. Good to talk about feelings

R: Yeah.

P4: You know?

R: It doesn't work.

P4: Yeah, and actually, anorexia's really sad like although it was all I had, urm and I was so afraid of giving it up, but I really would say to myself that life is better without it. AN is sad but afraid to give it up, life is better without it

Here we see the sadness that Anorexia bought to Poppy's life but also how difficult it became to let go when it was seen as all she had.
Like as I've said over the last few weeks of these, things that I didn't ever expect to be, I won't call them triggering that's old terminology, but yeah. I just, I actually don't, before I think if I talked to you a few decades ago, I'd be like, "oh right it's coming back that's great, a bit more of this back in," but I'm afraid of that, that is not a happy place, like as soon as you identify something you're like, "I want that to go." I need to identify it, sort it out and move on back to my normal life. Afraid of it returning, looks out for it. Perhaps a recognition that she needs to be vigilant to avoid missing the onset of a return.

Table 3

Personal Experiential Statements for Jasmine (Sample)

Emergent Themes	Transcript 3: Jasmine	Initial Comments
Onset / Perception Self destruct	60-62 almost like, like a conscious decision to something to get an eating disorder. But I almost remember it being like a little bit of a like idea of like, Oh, that would be a way to do this quickly 342-344 I never wanted to do it in like a healthy way. It was almost, I think for me compared to some people, I know it has always been quite self-destructive. So I think what came first for me was maybe being a bit depressed.	Conscious decision Feel the ED was intentional Not knowing where this would lead A sense of control Knew what she was doing but didn't care Depression led to restriction, knew for a while it was a problem
Deception Sexuality / abuse	67-68 I kept it kind of hidden for a long while and that stopped it progressing quite so quickly. (646-649) I think I probably didn't realise that I was gay because of that experience that for a long time I probably would have realised before, but the idea of being anywhere, like having a relationship with a woman another teenage girl, it just felt like, Ugh, like that's revolting.	Progressed slowly until discovered Deception of family and friends of perhaps to herself Recognition of sexuality delayed Feeling of discomfort and confusion

Good relationships with friends	1434 They cared about me and I formed friendships with them	Felt like a person who was cared about and had friendships
Treatment / re-feeding	1682-1684 it'd be interesting. I'd imagine so many people did not actually get good enough therapy, to be honest, like majority of people I've spoken to through the years are it's kind of like ooh therapy, no, the focus was on re-feeding me.	Therapy not seen as good enough Focus on re-feeding
Psychological input	(846-850) There was only one specialist eating disorder, woman and actually she used to be able to come in and managed to get me to eat. I didn't even have a relationship with her, but she just used to kind of say, like, I know what you're hearing right now, is not to eat it, but actually just listen to my voice and we're just going to get this eaten and then we're going to be distracted. (846-850)	Being heard and helped Understanding
Serious threat to health	835-838 and then my weight was really dropping and I started to have signs of liver things and potassium being all over the shop, it's getting kind of dangerous. Um,	Health issues. Getting dangerous. Admitted

Serious risk to life	and then they said they needed to admit me five days a week. I also had quite a serious suicide attempt. Like I took a shed, load of painkillers and all sorts. And. Um, was resuscitated, actually my heart rate was like 12 or something ridiculous or 15 or something. I was really unwell. I remember my brother coming in to say goodbye to me. (Jasmine 900-903)	Perhaps a feeling that she could no longer contend with the AN
Cognitive change via behavioural change	1023-1026 did some incredible things went like, went off with my cousin for a while. And, um, what, like swimming with dolphins and bungee jumping and all just like really off, which gave me the kind of experience with my actually life can be quite good.	Had a great experience Realisation of life can be good
Visualise a better future without AN	1053 that kind of leads onto the getting better. Cause it just wasn't worth it. 1420 making sure people are treated as individuals. 1442 don't take away people's hope	A more interesting life led to the feeling that being ill was not worth it! See the person not the disorder Give hope

End of Thesis.