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## **ABSTRACT**

**Background:** Anorexia Nervosa is mental health problem which crosses both psychological and physical realms. It is also known to be a difficulty that often arises in adolescence. Unfortunately its prognosis is not favourable with elevated rates of chronicity and a higher mortality rate than any other psychiatric disorder in adolescence.

**Objectives:** This research set out to explore the experiences of young people about the early stages of Anorexia. It was anticipated that this would improve clinicians' knowledge in this area.

**Design and Method:** This study adopted a qualitative Grounded Theory design for the interviewing and analysing process. Eight participants took part in an interview on their experiences of the early stages of Anorexia. The participants were aged between 13-17 years old. The majority were female with one male participant. Interviews were transcribed verbatim and data were analysed using NVivo software. The process of analysis involved moving between the interviews and generating codes. Through this repeated process the themes emerged from and were validated by the data.

**Results & Conclusions.** Themes developed which illustrated the importance of the interpersonal context. Further analysis and conclusions were drawn from this and presented as this study's main findings. The main findings were that there is a strong emotional element to the experiences of the early stages of Anorexia; that the level of awareness into Anorexia is something that develops and finally that emotions and awareness impact on responses to interpersonal interactions. The results were considered in reference to literature and clinical recommendations were provided.

# **1. Introduction**

## **1.1 Anorexia overview**

### **1.1.1 Epidemiology**

Anorexia Nervosa is recognised as a serious psychological disorder. Although it is relatively low in its incidence, it is large in chronicity. Approximately 4 in 100,000 people who are aged between 10 to 39 years are diagnosed with Anorexia each year (Currin, et al., 2005). Furthermore, it is accepted to be a disorder that often starts in adolescence. According to the Royal College of Psychiatrists (2005), about 1 in 150 girls who are aged fifteen years old, have Anorexia. Estimates suggest 30-50% of patients go on to experience long-term chronic problems (American Psychiatric Association Guidelines, 2006). In addition, mortality rates are higher than other adolescent psychiatric disorders, with figures reported as high as 15% (Herzog, Rathner & Vandereycken, 1992) and a mean mortality rate of 5% (Stenhausen, 2000). The gravity of Anorexia led to me thinking that it was an area that warranted consideration.

### **1.1.2 Diagnosis**

Anorexia is identified and diagnosed according to guidelines. The Diagnostic and Statistical Manual of Mental Disorders Version IV (DSM-IV) and The International Classification of Diseases Version 10 (ICD-10) both outline criteria for diagnosing mental disorders. The criteria for this can be found in Appendices 1 and 2. They highlight that Anorexia is characterised by a refusal to maintain a minimally normal weight, fear of gaining weight, a distorted body image and the absence of menstrual periods. People with

Anorexia may reduce their weight by restricting what they eat, having a cycle of bingeing and purging, over exercising or using laxatives. In summary, eating disorders are explained as “an excessive concern with the control of body weight and shape, along with an inadequate and unhealthy pattern of eating” (Carr, 2006, p. 795).

In recent years a debate has developed over whether eating disorders can be considered in such a categorical manner. It has been highlighted that there can be limitations with this approach (Williamson et. al., 2002). The DSM –IV has developed a category of “Eating Disorder Not Otherwise Specified” (EDNOS). The diagnosis of EDNOS is given to eating disorders that are recognised to be clinically severe, but do not meet the diagnostic criteria for either Anorexia or Bulimia. However it has been shown that in outpatient settings, EDNOS is the most commonly diagnosed eating disorder (Martin et al., 2000; Ricca et al., 2001; Turner & Bryant-Waugh, 2004).

Given the difficulty of classifying patients within the main diagnosis and the large number of EDNOS, it has been suggested that this could be viewed on a more dimensional transdiagnostic manner (Fairburn & Bohn, 2004). Fairburn (2003, 2004) suggested that there are shared characteristics that lead to the development and persistence of the different eating disorders. It was therefore proposed that it would be more accurate to consider a transdiagnostic framework that encompassed a broader understanding. A study of adolescents (van der Han et. al., 1997) supported that patients did not meet traditional eating disorder diagnostic expectations and should be viewed as a spectrum rather than particular syndromes. This supports the position of psychology,

which views mental illness more fluidly as a constellation of symptoms understood by a comprehensive psychological formulation.

I considered that the prominent views of Anorexia are still defined by a medical model of looking for symptoms. While this is useful for providing a diagnosis, it does not fully represent the person with Anorexia. I therefore thought that it was important to consider the psychological understanding of Anorexia through the formulation approach.

## **1.2 Formulation of Anorexia**

### **1.2.1 Risk factors**

Anorexia is a complex, multifactorial problem that develops over time with some causative factors and others that emerge through life (Carr, 2006; Lask & Bryant-Waugh, 2007). As such, it can derive from numerous factors coming together. Some risk factors can be changed by intervention and are known as variable risk factors, whilst others are uninfluenced and are fixed risk factors. If a risk factor can change the onset or outcome of the disorder it is considered to be a causal risk factor. In addition, there are variable markers that cannot be changed (Lask & Bryant-Waugh, 2007).

In a review paper, Jacobi, Morris and de Zwann (2004) outlined over thirty risk factors for eating disorders that have been identified. These cover biological, psychological and socio-cultural domains. (See Appendix 3 for risk factors)The myriad of different risk factors can make it difficult to measure Anorexia, as risk factors can be correlated and

can evolve. It is thought that there is a lack of knowledge of the combination of factors that can result in the development of eating disorders (Cooper, 1995).

### **1.2.2. Formulation factors and models**

There are a number of factors to consider regarding what might predispose someone to develop Anorexia. It has been repeatedly demonstrated that there is a familial aspect to eating disorders. Family and twin studies have indicated that there is a genetic contribution to eating disorders (Strober et al., 2000). In addition, there are factors that are common to the predisposition of other mental health problems such as early life stressors including parental discord, bereavements, and abuse or neglect. Particular notice has been given to the effects of insecure early attachments; this theory was originally pioneered by Bowlby (1958). Evidence from literature reviews have supported that poor attachment was found in eating disordered populations, with connections to the main elements of eating disorders psychopathology (O’Kearney, 1996; Ward et al., 2000).

One of the main models used to understand the development and maintenance of Anorexia is the cognitive-behavioural model as originated by Beck for depression (1967, 1976). This has been developed to consider eating disorders. Vitousek and colleagues (1996) put forward multiple theories around the role of self-esteem, information processing, self-representation, personality variables and motivation. They suggested that core schemas promote the socially endorsed desire for thinness. These schemas drive the belief that thinness and weight loss will lead to a feeling of self-worth. Further developments have focussed on the importance of weight and shape, including models

explaining metacognitions and safety behaviours (Salkovskis, 1996) and the need for self-control being linked to self worth (Fairburn, Shafran & Cooper, 1998).

Particular psychological aspects around personality have also been highlighted as common to Anorexia. In particular perfectionism is upheld as being a contributing factor, with obsessional features such as rigidity, neatness, conscientiousness and preoccupation with rules also being widespread. If these characteristics result in a marked impairment of functioning, they could warrant a diagnosis of obsessive-compulsive personality disorder (OCPD) (Serpell et al., 2002). Another personality trait that can be associated with Anorexia is avoidant personality disorder (Gilberg et al., 1995).

The formulation approach is used widely in clinical practice but its intrinsic complex nature makes it difficult to research. It seemed to me that pockets of areas are researched and then combined in clinical formulations.

### **1.2.3 Anorexia within the context of adolescence**

Adolescence is viewed as a period of transition. As young people go through this stage they can be vulnerable to developing mental health problems. There are certain characteristics about the time of adolescence that can generally have an impact on the development of mental health problems and others that could activate Anorexia in particular.



Jacobs (2006) separated the tasks of adolescence into early, middle and late adolescence. In early adolescence primary tasks are sexuality and rivalry. The young adolescent has to adjust to physical and sexual changes of puberty. They are also involved in defining themselves within their peer group. In middle adolescence, the tasks are related to authority and independence; this involves testing boundaries and beginning to separate. In late adolescence the tasks are faith and responsibility. This involves further separation and identity formation.

Therefore, there are a number of maturational processes taking place during this time. Taking into account other risk factors, if life stressors are also occurring, it is understandable that mental health problems can emerge. Anorexia can develop as a means of avoiding the other challenges that adolescence evokes and instilling some control in their changing lives. Crisp (1980) wrote that Anorexia reflected the individual's fear and avoidance of growth, sexuality and independence.

A further common issue during the transition period of adolescence is perceived peer rejection. During adolescence the peer group is of high importance, as adolescents look to each other as points of reference. However, it is also known that this is a time when teasing, bullying and rejection can occur. If we consider this in light of the other risk factors such as low self-esteem; a perceived rejection by this group can be very damaging. In particular, if the individual perceives that their appearance or body is being criticised, this could trigger the predisposing factors around their body and self esteem and lead to Anorexia (Carr, 2006, Sassaroli & Ruggiero, 2005).

Finally, academic ability and achievement are highlighted and valued during adolescence by the education framework and formal assessments. If an individual has the risk factor of perfectionist expectations, a perceived failure during this time could be damaging. Anorexia could emerge as a means of exerting control and experiencing success (Carr, 2006).

### **1.3 Research on the Early Stages of Anorexia**

This study was interested in exploring individual's experiences of the early stages of Anorexia in adolescence. It was considered that this was an identifiable time period, in which people with Anorexia could have common experiences. In contrast young people's treatment and recovery journeys could be more variable. In reviewing the literature in this area it was discovered that the majority of research investigated the risk factors for developing Anorexia (Fairburn, et. al., 1999; Jacobi et. al. 2004). These studies predominantly aim to define the risk factors.

Fairburn et. al. (1999) set about firstly to identify risk factors for Anorexia, they then continued to conclude which of these risk factors were pertinent for people with Anorexia in comparison to other psychiatric disorders. They also aimed to compare risk factors for Anorexia against those for Bulimia. They hypothesised that there would be two main categories of risk factors, those that increased general psychiatric risk and those that increased the risk for dieting.

Jacobi et al. (2004) developed the literature on the risk factors for Anorexia by implementing a conceptual framework for a typology of risk factors which was outlined and utilised by Kazdin et al., (1997) and Kraemer et al., (1997). This moved on from using theoretical models to understand the development of the disorder and allowed an atheoretical approach to viewing risk factors. They therefore aimed to clarify some of the inconsistencies in the literature.

This systematic quantitative research has provided objective knowledge in the literature base on predicting the onset of Anorexia. It has also informed clinical practice by defining what to look for when assessing Anorexia. However, I observed that subjective research into the person's experience of the early stages of Anorexia is limited.

Recent studies have started to examine this area using qualitative methodologies (Nevonen & Broberg, 2000; Nilsson, et al. 2008). These studies explored patients' understanding of how their eating disorder emerged. Nevonen & Broberg (2000) found that the main reasons were interpersonal and weight related problems, in addition to dieting behaviours. Nilsson et al. (2008) discovered that causes were delineated to self, family and socio-cultural factors. Both studies focussed on the causes of eating disorders and resulted in their findings being in line with the results from risk factor literature.

While these studies added dimensional information to the quantitative research, they still focussed on the perceived risk factors for Anorexia. It was my impression that the literature still lacked information on the experience of developing Anorexia.

## **1.4 Importance of therapeutic alliance**

The lack of research on the person's experience of the early stages Anorexia indicates a subtle but important aspect that is missing from literature. It is my view that if we do not explore the individuals experience we may not fully appreciate their ability to engage with treatment interventions. In light of the severity and chronicity of Anorexia, I think engagement with treatment is an important area to be considered. The engagement with treatment is clinically acknowledged as being an imperative part of any therapeutic work. By considering therapeutic alliance in Anorexia I am adding aspects of clinical knowledge and investigating what is known about this in the literature.

It is widely acknowledged that there continues to be a limited evidence base for which treatments are effective when working with Anorexia. It is reported in both the National Institute for Clinical Excellence (NICE) (2004) and Quality Improvement Scotland (QIS) (2006) guidelines that there is a lack of powered efficacy studies of specific treatments and services for people with Anorexia. As the Anorexic population is small and can be long-term cases with complex formulations and mixed interventions, it is difficult to undertake randomised control trial research, which is viewed as the gold standard. The QIS development group stated that it used current clinical best practice within NHS Scotland to make consensus based recommendations for the management of Anorexia.

In consideration of the complexities that are involved in the development of Anorexia, it can be difficult to know which areas to prioritise for treatment. One upheld clinical opinion is that therapeutic alliance is of paramount importance for engagement with

treatment with young people (Kazdin, Siegel & Bass, 1990; Bickman, Rosof, Salzer, 2000). Adult based meta-analysis studies report that there is a moderate but reliable association between therapeutic alliance and positive treatment outcome (Horvath & Symonds, 1991; Martin, Garske & Davis, 2000). Subsequent meta-analysis studying children and young people in particular, found that the relationship between alliance and outcome is similar to adult studies (Shirk & Karver, 2003).

In addition, an argument has been put forward that the alliance is particularly important when working with children and young people, as their attendance is not always self-motivated but could rather be initiated by concerned parents or professionals (Bickman, et. al. 2004). Failure to develop a therapeutic alliance could be detrimental to adhering to treatment endeavors and also pose increased risk of termination of treatment. Estimates suggest 30-60% of young people terminate treatment prematurely (Armbuster & Kazdin, 1989). One of the prominent reasons parents and children give for this attrition is resistance to being in therapy (Kendall & Sugarman, 1997). Therefore, the clinician's ability to engage a positive therapeutic alliance may be more imperative (Shirk & Saiz, 1992).

The concept of therapeutic alliance was first developed by Freud (1913) who placed value on the analyst maintaining serious interest and sympathetic understanding of the client to permit the healthy part of the client to form a positive attachment. More recent research over last three decades has developed the pantheoretical concept of alliance, whereby it has consistently been discovered that different therapies produce similar

amounts of therapeutic gains (Luborsky, Singer & Luborsky, 1975; Smith & Glass, 1977, Stiles, Shapiro & Elliot, 1986).

Many researchers have interpreted these results as an indication that factors that are common to all forms of psychotherapy may be responsible for a large part of a client's improvement (Horvath & Luborsky, 1993). Bordin (1980) explained that alliance enhanced therapies, by making it possible for the patient to accept and follow treatment. He also defined alliance as the therapeutic bond with agreement on goals and tasks. The bond indicated a positive personal attachment between client and therapist. The tasks outlined the intervention behaviours and cognitions that form the therapeutic process. It was stated that both parties must perceive these tasks as relevant and efficacious. Finally, the goals of treatment pointed towards the targets of the intervention (Bordin, 1976).

A review by Ackerman and Hilsenroth (2003) provided a comprehensive examination of the therapist's personal attributes and in-session activities that positively influence the therapeutic alliance from a broad range of psychotherapy perspectives. Within the therapist's personal attributes, characteristics such as being flexible, honest, respectful, trustworthy, confident, warm, interested, and open were found to contribute positively to the alliance. Furthermore, they identified therapist techniques that were also found to contribute positively to the alliance. These included exploration, reflection, noting past therapy successes, accurate interpretation, facilitating the expression of affect, and attending to the patient's experience.

The outline of therapists' attributes and techniques relates to the work of Rogers (1957) who put forward the theory that the most important element in therapy was the quality of the therapeutic relationship. He outlined six conditions that were necessary for the therapeutic relationship to exist. Within this he suggested that it was imperative that therapist experienced an empathic understanding of the client, demonstrated an unconditional positive regard and that their interactions were congruent. The empathic understanding presupposes that the therapist is able to understand the client's feelings. An unconditional positive regard refers to an acceptance of the client. Furthermore, congruence refers to the ability to demonstrate openness to the client's feelings and actions. These qualities would facilitate a "helping relationship" (Rogers, 1961). Rogers work has greatly influenced therapeutic work and is the basis of therapeutic alliance.

## **1.5 Qualitative methods of research**

In recent years, there has been an increasing interest in utilising qualitative methodologies to broaden the areas that are able to be researched. Epistemology has recognised the benefits and limitations of the different approaches and there has been a move towards including qualitative methodologies (Willig, 2001).

### **1.5.1 Positivism, hypothetico-deductivism and social constructivism**

The positive stance proposes that there is a straightforward link between the world and our understanding of it. It states it is possible to describe phenomena accurately. It considers the researcher to be an outside, objective reporter without personal

involvement. The aim of positivist research is to produce objective knowledge. However, it has been criticised for being too selective and partial (Chalmers, 1999).

Most research now adopts a hypothetico-deductive approach. This suggests that instead of induction and verification, a process of deduction and falsification is more valid and reliable. This involves developing a hypothesis and testing it out to see if it can be upheld. Adopting a method of falsification allows the elimination process and the formation of more accurate understanding to occur. Nevertheless, it has been criticised for relying on existing theories to generate hypotheses, this can result in the research becoming restricted or elitist (Willig, 2001).

There has subsequently been an increasing interest in social constructivism (Burr, 1995). This contends that categories of knowledge and reality are actively created by social relationships and interactions. Willig (2001) describes social constructivist research as:

*“ concerned with identifying the various ways of constructing social reality that are available in culture, to explore the conditions of their use and to trace their implications for human experience and social practice.”*

*Willig 2001, p.7*

This approach explores phenomena and considers the various ways that they are constructed and made real and is normally undertaken in a qualitative manner. Parallels can be drawn between the social constructivist approach in research and philosophies on



the narrative. Foucault (1978) posited that narratives are used as a vehicle of ideologies. Narratives are viewed as a fundamental way of organising human experience and a tool for constructing models of reality (Herman, 2002). Utilising a research methodology based on narratives allows the exploration of ideologies and meanings to occur. The narratives from interviews provide rich and detailed information about phenomena.

Qualitative research is interested in meaning and how people make sense of their world and experiences. It attempts to understand what it is like to experience particular things. It tends to be concerned with the quality and texture of experience rather than cause and effect relationships. It therefore does not begin with predefined questions to test, but is open and participant led.

### **1.6 Aim of research**

It has been demonstrated that Anorexia is a complex problem. It has also been indicated that alliance is an important part of therapeutic work with Anorexia. Furthermore the early stages of identifying the problem and accessing services are crucial for forming a good alliance as these impacts on treatment adherence. Treatment adherence is particularly important for young people with Anorexia as they could be at serious physical risk and therefore are required to comply with treatment interventions. It has been demonstrated in other studies that a key part of alliance is that the patient is allowed to express their personal experience and feels understood, as this facilitates the therapeutic relationship being person centered and tailored to the individual. I was

therefore motivated to research patients' perspectives of the early stages of Anorexia to improve clinicians' knowledge in this area.

This research proposes to build on previous quantitative and qualitative research and add to the knowledge base. As this is an under-researched area, the interest of the research is to be an explorative study that identifies and interprets areas of importance to the participants. It aims to explore young people's experiences of the early stages of Anorexia. In this study the early stages is defined as the time from when they first began to recognise they had a problem with eating to the initial period of accessing specialist services. While it is acknowledged that in the early stages, the participants may not have used the label of Anorexia themselves, this terminology is used in this study for consistency and clarity. It was decided that this was appropriate as all the participants described symptoms and experiences that are congruent with Anorexia and were all given a diagnosis of Anorexia once they entered CAMHS.

This study aims to understand how the young people's eating difficulties emerged. It aims to understand how the recognition of Anorexia came about. This will be done by considering whether the individuals recognised the eating problems themselves and what biopsychosocial factors they noticed changed. In addition it aims to increase knowledge on what the experiences for the young people during the early stages of Anorexia are and how the early stages of Anorexia impacted on the individuals' daily lives.

As adolescence is known to be a time where interpersonal relationships are of high relevance, the study aimed to look more widely at the person's experience within their context. This could potentially include relationships with parents, siblings, friends, boy/girlfriends, wider peer group, teachers, GPs and mental health professionals. It aimed to explore who else was involved in helping them to realise they had Anorexia and how they did this. It aimed to understand the young people's perspectives on how other people responded to them at this time and how their responses affected the individual.

A further aim was to consider how their experiences and understandings of the early stages of Anorexia then influenced engagement with services. It aimed to understand the complexities of Anorexia from the individuals' perspective. It also aimed to explore how they experienced accessing services, including what they had found helpful and difficult.

The study will use a qualitative Grounded Theory design to match the research objectives. In Grounded Theory, the use of open-ended interviews allows the emergence of unexpected themes. Therefore, the stated aims of research are the initial aims and are intentionally broad to allow the participants to talk about what is relevant to them in this topic area. As is standard practice in Grounded Theory methodology, the aims and research questions will develop by what emerges from the interviews. They will also develop and become more crystallised through the analysis process. This enables the revised aims to be grounded in the narratives of the interviews from which they came. The process of the development of the aims of the research will be outlined in the methodology and the revised aims will be presented at the start of the results chapter.

It is anticipated that findings from this study will increase clinicians' knowledge on this area and will help them to understand the young people's perspectives in a more in depth manner than is possible from a clinical setting. This will then help to inform clinical practice by highlighting what is important to the young people during this time.

## **2. Method**

### **2.1 Design**

This study adopted a qualitative Grounded Theory design to inform the interviewing and analysing process. This methodology was used as it is concerned with meaning and facilitates the process of discovery. Grounded Theory was developed by two sociologists Glaser and Strauss (1967) who argued that researchers needed a method that would allow them to move from data to theory, so that new theories could emerge. Since the original development of Grounded Theory, it has been build upon and revised. This study was informed by the original theory (Glaser & Strauss, 1967) as well as more recent developments (Charmaz, 2006; Strauss & Corbin, 1990).

Grounded Theory involves the process of category identification from the data. It provides guidelines on how to identify categories and make links between categories. Categories are formed by grouping together instances that share central features with one another. As this process progresses, higher conceptual categories are abstracted.

Grounded Theory is unlike other research methods in that it merges the process of data collection and analysis. The researcher moves back and forth between gathering data and coding and analysing it and then gathering more data. This is to facilitate the analysis being grounded in the data. The researcher continuously reviews earlier stages of the research and is open to change direction. This allows it to be more fluid and explorative.

The research starts broadly, with the aim of identifying the phenomenon studied; it then becomes progressively more focused throughout the research process. The advancement of a theory is shown through the development of the research. The research is said to reach saturation when repeated sampling produces the same emergent themes. At this point a set of categories and sub categories captures the bulk of the available data. The results from this provide an explanatory framework to understand the data.

In addition to this, Grounded Theory acknowledges the role of the researcher in the research process. It suggests that the researcher is not an external observer but must account for their role within the construction of the theory generated. The researcher therefore kept a reflective diary to document the experience of conducting the research.

### **2.1.1 Ethical Issues**

Ethical approval was sought and obtained from the Lothian NHS ethics panel. They considered this to be an appropriate research project. (See Appendix 4)

### **2.1.2 Participants**

The first inclusion criterion was that participants had a primary diagnosis of Anorexia. They were also required to fall into the age range of 12-18 years. Finally, participants should have a relatively stable physical status, whereby they were not at physical risk. People were excluded from taking part in the study if they were actively suicidal. A

further exclusion criterion was if they were at an early stage of contact with the service. This was to avoid interfering with the service delivery.

It was understood that the status and stability of this research group could be variable; therefore inclusion was also at the participants' therapist's discretion. The researcher liaised with the therapist to ensure participation was appropriate.

Eight participants took part and were currently attending the child and adolescent mental health service (CAMHS) of a city based service. They were receiving treatment from CAMHS, outpatients within Tier 3 and Day Programme and Inpatient Unit within Tier 4. The outpatient service within Tier 3 service is a multidisciplinary team that provides outpatient appointments for children and young people up to the age of 18 years. It provides individual, parent and family appointments as appropriate. This is most commonly on a weekly or fortnightly basis. The Day Programme service within Tier 4 is a multidisciplinary team that provides more intensive daypatient support for young people aged 12-18 years. This can consist of contact between two to five days a week. As well as individual and family work, they can provide daily support from key workers and the wider team, a variety of therapeutic groups, supported meals and school lessons. The inpatient unit within Tier 4 is a 12 bedded residential facility that provides intensive support for acutely ill young people aged 12-18 years. In addition to the services outlined in the Tier 4 day programme service, they provide 24 hour care 7 days a week and ensure that young people who are at risk -whether of self-harm, suicide, acting on delusions or physical risks of low weight- are kept safe.

### 2.1.2.1 Demographics of participants

The demographics of the participants are detailed in the tables below. It outlines the participants' gender, age, school year and contact with CAMHS. All of the participants were experiencing a first episode of Anorexia and none of the participants had previous eating disorders or received prior treatment from CAMHS. All participants were referred to CAMHS for a suspected eating disorder and were given a diagnosis of Anorexia following assessment by CAMHS. This diagnosis would have been given within the first month of contact with CAMHS; therefore the duration of Anorexia can be viewed as similar to the duration of contact with CAMHS which is detailed in table 4. In line with the inclusion criteria, all participants had a primary diagnosis of Anorexia and none of the participants had co-morbid diagnoses. While it is possible that participants experienced other mental health problems such as low mood or anxiety, these were not severe enough to warrant a diagnosis. In the recruitment stage, if potential participants had a dual diagnosis for example with Obsessive Compulsive Disorder, they were excluded from the study to help the research to have the most homogenous sample possible.

Table 1: Gender of participants

Gender	
Female	7
Male	1

Table 2: Age of participants

Age	
13-14 years	3
16 years	3
17 years	2

Table 3: School year of participants



School Year	
2 <sup>nd</sup> /3 <sup>rd</sup> year	3
5 <sup>th</sup> year	3
6 <sup>th</sup> year	2

Table 4: Duration of contact with CAMHS at time of interview.

Contact duration	
3 months	2
5-9 months	3
12 months	3

Table 5: All previous interventions with CAMHS by time of interview

Contact with services	
Outpatient only	1
Outpatient, daypatient and inpatient	2
Outpatient and inpatient	5

Table 6: Current involvement with CAMHS at time of interview

Current contact with services	
Outpatient - Tier 3	3
Daypatient - Tier 4	1
Inpatient - Tier 4	4

The tables show that most of the participants were female, with one male participant. The age range was from 13-17 years with the associated school years of 2<sup>nd</sup>-6<sup>th</sup> year. The contact with CAMHS was from 3 months – 12 months with a range of contacts with the different levels of services offered by CAMHS, including outpatient, daypatient and inpatient.

## **2.2 Procedure**

### **2.2.1 Pilot interview**

A pilot interview was conducted prior to the main data collection. The participant was a young person who had suffered from Anorexia and had just been discharged from CAMHS and was therefore a suitable interviewee. This person was initially approached by her therapist and then met with the researcher who obtained informed consent to participate in the pilot interview. It was outlined that her interview would not be used in the present study, but would help to shape future interviews. The pilot interview was used to aid the researcher in practicing the style needed for qualitative research interviews. The recording of the interview was reviewed with both academic and clinical supervisors and advice was given about adapting the interview manner to gather more detailed information.

### **2.2.2 Recruitment of participants**

A presentation was given to the Tier 3 and Tier 4 teams in CAMHS, outlining the research project. Staff members were asked to consider potential participants who would meet with the inclusion and exclusion criteria. A staff information sheet was distributed for reference. (See Appendix 5) The researcher had further discussions with the therapists about participants' suitability as requested. The therapist would then approach potential participants to introduce the research and provide them with a participant information sheet. (See Appendix 6) If the participant agreed to take part, the researcher met with them for an initial informal introduction. This allowed the researcher and participant to

go through the patient information sheet and discuss any questions. The participant was then able to give informed written consent. (See Appendix 7) A named professional was agreed, who could be contacted if there were any safety concerns. Lastly, a time and place for the interview was agreed, allowing at least a week for the participant to change their mind. It was made explicit that participation was voluntary and that the participants were free to decline to take part at any time without having to provide a reason.

### **2.2.3 Interview format**

All interviews began by asking the participants a few short questions about their age, stage at school and family set up. This was to gather some information on the participants' circumstances. Each participant was then asked the standard question of: "Can you tell me how your eating disorder emerged?". This opened up the interview to the area of research and allowed the participant to discuss topics that were relevant to them. The style of the interview followed the format of qualitative interviewing, which encourages the description of the details of events and the exploration of their meaning to the individual (Charmaz, 2006; Rubin & Rubin, 1995).

Through the process of the research the interviews evolved. The researcher adopted a social constructivist approach which acknowledged the pre-existing knowledge that was held by the researcher. This approach allowed transparency and identified the effect of the researcher in the research. The researcher considered potential areas that could arise in the interviews. Whilst recognising the researcher's pre-existing knowledge, these areas were only explored further if the participant initiated or responded to them. The interview style was flexible to adjust to each individual and the development of the theoretical

process. Initially, the first four interviews were very open and the participants were encouraged to direct them. In line with the Grounded Theory methodology, the subsequent interviews became more focussed on particular themes that had emerged. This was shared with the participants who were informed that the researcher may ask them to comment on their experience in comparison to what other participants had already expressed.

Participants were given a choice of where the interview was held, either at their treatment base or at the participant's home.

#### **2.2.4 Data management**

All interviews were recorded with a digital recorder. The recordings were then stored on a computer and erased from the digital recorder. Each interview was transcribed verbatim by the author, with para-verbals and the researcher's impression of affect also included. Identifiable information was either deleted or changed to ensure anonymity. The computer software NVivo was used to store and organise data.

#### **2.2.5 Analysis Process**

The transcribed interviews were analysed in line with the Grounded Theory principles of Strauss and Corbin (1998) whereby the interviews were considered in pairs. This allowed for themes to emerge and then become developed. The first two interviews were coded independently in an open explorative manner. Each interview was analysed line by line and codes were attached to each unit of meaning. A unit of meaning could be less than

one line or span over a few lines of text. It was therefore possible for each line to have several codes connected to it. Thus, an explosion of rich and detailed information that explored the potential interpretations was generated.

These first level codes were then clustered and organised at a second level to discover what broad themes had emerged from the initial interviews. These themes were kept in mind when conducting the third and fourth interviews, which continued in an open and explorative manner. The third and fourth interviews were also coded at a descriptive first level by using the existing codes generated from interviews one and two and adding codes specific to the individual interview. (See Appendix 8 for extracts with first level coding). The first level explorative codes amassed approximately 500 codes. These were grouped together by similar content and process themes and sub-themes. For example the over-arching theme of emotions, with sub-themes of the different emotions expressed; the over-arching theme of contact with services, with sub-themes of GP contact and CAMHS contact. This coding was done by the researcher and independently by the clinical supervisor to allow triangulation to occur. Furthermore, as is standard practice in Grounded Theory, memos were kept as a systematic way to document the development of the themes that emerged.

The main emerged themes were then organised to form an initial framework. This was developed from interviews one to four and incorporated many different aspects around the early stages of Anorexia. This included some of the risk factors of Anorexia, the cognitive and behavioural maintaining factors, the physical and psychological dynamics

of Anorexia, the emotional experiences and the interpersonal experiences. (See Appendix 9 for initial framework)

During this coding procedure the researcher repeatedly moved between the interviews and this was a central part of the Grounded Theory methodology. It allowed the discovery of which themes were repeated and how themes were linked. This means that the initial interviews influenced the development of the framework and the main emerged themes became clearer. At this stage it was decided to follow up the main themes of the effect on interpersonal relationships and emotional impact in relation to the identification and adjustment to Anorexia. As part of the Grounded Theory methodology, the aim of the research developed in light of the information gathered from interviews one to four. The aim became more focussed on understanding the interpersonal aspects and the individuals internal processing of the early stages of Anorexia as these were prominent themes that emerged from the data. The aim also developed to consider how these experiences impact on how the individual responds to interpersonal interactions.

#### **2.2.6 Development of main themes**

The overall framework of the main themes developed from interviews one to four was reduced to omit the themes that were not being followed up. Interviews five and six were then coded into this framework. (See Appendix 10 extracts with second level coding). This provided a means of validating the emerged themes as main themes as they were presented in additional more focussed interviews. From this rich data the researcher looked at the main themes that had emerged and how to present the information to give

an accurate reflection of the emerged themes that described the data as well as offering some interpretation.

It was decided that providing a framework that showed the stages of identifying Anorexia and adjusting to Anorexia would provide a description of the data, setting it in the interpersonal context from which it came. A detailed descriptive framework was developed which included minor themes such as interactions with wider peers and siblings. This allowed the breadth and depth of information to be presented. Links were also made around the interpersonal responses and the emotional impact and defences activated. (See Appendix 11). Interviews seven and eight were then coded into this developed framework and fine tuning was conducted to consolidate the information gathered. Again these subsequent more focussed interviews provided validation of the main themes that emerged. This framework was then reduced further to present the main themes from the descriptive section. It also presented the information in a way that embedded it in the interpersonal context.

Further analysis of the emerged themes was done to provide interpretations from the descriptive section and develop superordinate themes. This considered more conceptual themes that had emerged from the data. The emotional and defensive responses of the individual's were incorporated into the analysis section of the results. The information presented in the analysis section of the results is to be considered as the main findings of this research.

### **2.2.7 Saturation**

In Grounded Theory methodology, categories are said to be saturated when gathering more data does not create new theoretical insights or add new properties to the core theoretical categories. This means that the same patterns are found. Theoretical saturation, where categories are considered at a more abstract and general level is aimed for in Grounded Theory.

In this study, during the process of coding and analysis it became evident that some of the themes that emerged from the early interviews carried through all the interviews. It can be seen that all participants provided information on the superordinate themes, providing a range of responses and adding dimensions to the themes. It can therefore be shown that some validation was achieved.

### **2.3 Reliability and Validity**

Reliability and validity is an intrinsic part of the Grounded Theory process. In qualitative research it is standard practice that reliability and validity is demonstrated to the reader through conducting triangulation, providing an audit trail and being reflective and transparent in the research process (Willig, 2001).



### **2.3.1 Triangulation**

This study undertook a number of methods to allow triangulation to occur. Firstly, the themes developed were taken into the subsequent interviews. This is an integral part of Grounded Theory methodology and enables the participants to provide a means of validation and ensures that the themes are grounded in the data from the sample from which they came. They were found to be reliably validated by the participants to the point of saturation for superordinate themes. This level of saturation was considered to be met as interviews seven and eight did not provide novel information on the superordinate themes.

Secondly, both clinical and academic supervisors were utilised as experts to consult with throughout the research process. It is standard practice in Grounded Theory to consult others during the research process, to ensure that the interpretation was not done in isolation. The clinical supervisor was a Clinical Psychologist who is an expert on eating disorders and holds a Consultant position in a specialist eating disorder service. The academic supervisor is well experienced in both conducting and supervising qualitative research.

The clinical supervisor took on an additional role of being an independent rater of the early interviews and conducted an independent first and second level coding for interviews one and two. The clinical supervisor was provided with Word documents of the full plain transcription of interviews one and two. The clinical supervisor used the same methodological process as previously outlined, whereby detailed line by line coding

was conducted. These first level descriptive codes were then grouped into a secondary level framework. The secondary level frames of the researcher and the clinical supervisor were then compared. The clinical supervisor initially outlined their framework and then the researcher outlined their framework. This allowed for comparisons to be made between the researcher's understanding of the emerging themes and an independent expert's opinion. Memo notes were written to document this process.

It was found that there was a high degree of agreement between the researcher and the independent rater. For example, both the researcher and the clinical supervisor found prominent themes of conflict, the emotional impact of Anorexia, different interactions with different people, a changing level of insight into Anorexia, the participants changing identity. Further common themes were premorbid functioning, protective factors, the perceived triggers of Anorexia –including transitions and the cognitive and behavioural responses.

Any differences were discussed and incorporated into the overall framework that was developed for interviews one to four. For example, the clinical supervisor grouped together the coded defence styles that the participants gave an account of, which the researcher had coded but had not initially considered as a grouped theme. In addition, the clinical supervisor highlighted the importance of communication and thought it was important to demonstrate the different communication styles with different people in the coded framework. Finally, the researcher had used a timeline to group the coded framework into the initial phase of identifying Anorexia and then the subsequent stage of

adjusting to Anorexia. This was something that was clear from the narrative of the interviews and it was considered to be a helpful way to organise the emerged themes in relation to this time-frame.

The clinical supervisor also listened to interviews three and four to familiarise themselves with the data. At key stages where the framework was proposed and developed, both supervisors provided input and allowed triangulation to occur. For example for coding interviews three and four, the academic supervisor gave methodological advice about coding into the generated codes from interviews one and two and adding codes particular to each interview. This allowed rich descriptive interpretations to be generated and also enabled the range of nuances within emerging themes to be shown.

In the development of the initial framework from interviews one to four, themes emerged by looking for clusters from the codes. Themes were clustered together by similar content and process themes and sub-themes. Both supervisors were consulted about this framework to gather expert opinions on the grouping of themes. The supervisors were also consulted in deciding what areas to follow up in the subsequent interviews. While it was acknowledged that reducing the themes would narrow the interviews, this would also allow the research to explore these themes more richly. It was decided that the perceptions of interpersonal relationships during the early stages of Anorexia and aspects of the participants processing would be interesting and valuable areas to research further in this study.

The emerging framework was developed by reducing the codes and taking out irrelevant or minor themes. For example, accounts of risk factors were determined to be irrelevant to the more focussed aims of this research and were minor as they only emerged in the first four interviews. They were therefore omitted from the results. The omission of themes in the final results presented was agreed in consultation with supervisors.

The organisation and presentation of the framework in the results was developed by the researcher in consultation with the supervisors. Both supervisors provided input on the language used to describe the emerging themes, this helped to ensure that the headings used were both representative of the information from the interviews and were also clear to the reader. Finally, the supervisors provided advice on how best to represent the links between the interpersonal contexts and the individuals processing of this. This was originally shown by putting the emotional response and associated defences alongside the related contexts and was later incorporated into the analysis section of the results.

Thirdly, triangulation was carried out by referring to existing literature as themes were developed. During the different stages of the analysis, triangulation with the literature provided both top-down and bottom-up considerations. The top-down approach allowed the researcher to use knowledge that is available in this area to inform their coding. The grounded theory methodology states that the researcher should approach the analysis with an open mind but not an empty head. This allows the researcher to use their prior knowledge and literature base to help inform the development of emerging themes.

Triangulation with the literature was helpful in determining which areas to follow up, as

it allowed the researcher to be aware of what was missing from the literature base. Furthermore, in the later stages of the analysis a bottom-up approach of triangulation with the literature was taken. This allowed the researcher to compare what the participants had highlighted as important to them with the literature base. This is demonstrated in the results section, where literature is reviewed in relation to the emerging themes, to see what links or support could be found with the current research findings. This process of triangulation with the literature allowed the researcher to move between the data and the literature base and consider bottom up and top down aspects.

### **2.3.2 Audit Trail**

The development of the analysis was systematically recorded to provide an audit trail. This was done through the documentation of interview schedules, transcripts and chronological versions of coding. Furthermore, memo notes were consistently written to record and track how the analysis process developed, both during the individual researcher's coding and in consultation with clinical and academic supervisors.

### **2.3.3 Reflexivity**

In the social constructivist approach of Grounded Theory it is openly acknowledged that the researcher comes with pre-existing knowledge and experiences and actively participates in shaping the data. This is not a limitation of the research, but is rather upheld as an integral part of Grounded Theory methodology. In Grounded Theory this is accounted for by the researcher being reflexive and transparent about their role in the research.

In this study, the researcher informed participants of their experience of working with young people with Anorexia at the initial meeting. It was openly acknowledged that the researcher had some knowledge in this area, but was keen to learn more. The transparency of this is encouraged through the recording of the researcher's experience of undertaking the study (Ellis & Bochner, 2003). In this study, the researcher kept a personal reflective diary throughout the research process. This is detailed further in the discussion chapter to allow for transparency.

## **3. Results**

### **3.1 Researcher's position**

As previously outlined, the social constructivist approach of Grounded Theory states that it is important for the researcher to be reflective about their role in the research process. I am therefore acknowledging my pre-existing knowledge in this area before reporting the results from this study. Following my undergraduate degree in Psychology, I worked in an adolescent inpatient unit as a support worker for a year. This provided me with the opportunity to work with young people with Anorexia at its most acute stage. This gave me a great insight into what it was like to live with Anorexia on a day to day basis. My role required me to be involved in different aspects of their lives from supervising meal times, to going on short walks, to providing a listening ear. Through this experience, it became clear to me that Anorexia is a very complex problem and that many young people struggle with the conflicting feelings of wanting to recover whilst also feeling reliant on Anorexia. It has therefore been a disorder that has intrigued me since that initial experience.

In my clinical psychology training I have also worked with young people with Anorexia. Whilst carrying out this research I have also undertaken my elective placement with a child and adolescent outpatient team and have been the case holder and therapist for a young person with Anorexia. In assuming the role of the therapist with young people with Anorexia I have become increasingly aware of the degrees of resistance from the young person. It is my impression that they find it hard to admit they have Anorexia and

continually battle with submitting to the control of Anorexia. This can make therapeutic work more difficult and it became clear that having a good therapeutic relationship was important.

In my work with adolescents I have noticed that Anorexia can evoke strong feelings of anxiety in both families and professionals. As it manifests both psychologically and physiologically it is more visible when someone is very unwell. It appeared to me, that as professionals we are very concerned with risk factors and ensuring physical safety. While this is obviously a professional requirement I considered my thesis an opportunity to explore the individual's experience more fully. I was interested to know what was important to the individual about the early stages of their illness.

I expected that the young people would talk about how they came to know they had a problem with eating. This could lead to discussion on their thoughts as to what triggered their eating disorder, such as poor body image, low self esteem or feeling under some other form of stress. I also anticipated that they might talk about how Anorexia had impacted on their day to day life. This could include what physical, cognitive, behavioural and interpersonal effects it had. I also thought they might talk about what it was like facing up to the problem and who influenced that; whether it was themselves, friends, family or professionals. As I was working in CAMHS I was also interested to hear their thoughts and experiences of the service.



### **3.2 Development of framework**

As outlined in the methodology the framework outlined in this chapter was developed from moving between the interviews and the analysis. Through repeating this process the themes emerged from and were validated by the data.

The initial framework developed from interviews one to four included some of the factors that might have led to the development of the eating disorder as well as the cognitive and behavioural changes that were activated by it. It also reflected some of the dynamics between the physical and psychological aspects of Anorexia. However in consultation with supervisors, I concluded that these were areas where there is already some knowledge in the literature on the risk and maintaining factors of Anorexia. Therefore, it was determined that the other areas of the emotional impact of Anorexia in relation to interpersonal contexts would be focussed on in subsequent interviews. This was decided as the nature of conducting interview based research allows this more inter-related information to be gathered. Qualitative research allows the exploration of the complexities of interactions. It emerged that the early stages of Anorexia in adolescence is embedded in the interpersonal context and this evokes a number of emotions. It is difficult to research these intricacies in quantitative research and it was concluded that these were areas that were missing in the literature base. It was therefore more novel and interesting to explore these matters in this research.

In line with Grounded Theory methodology used, the aim of the research developed from the information that emerged in the initial interviews. The initial aim was intentionally

broad to allow the participants to express what was meaningful and important to them. The initial aim was to explore young people's experiences of the early stages of Anorexia. It aimed to consider how their difficulties came to light and how their experiences and understandings then influenced engagement with services. Through the Grounded Theory methodological process, the aim became more focussed on understanding the interpersonal aspects and how their processing of these impacts of the early stages of Anorexia; as this presented in the interviews and was missing in the literature. The aim was also to increase knowledge on how their experiences at the early stages would affect their responses to interventions.

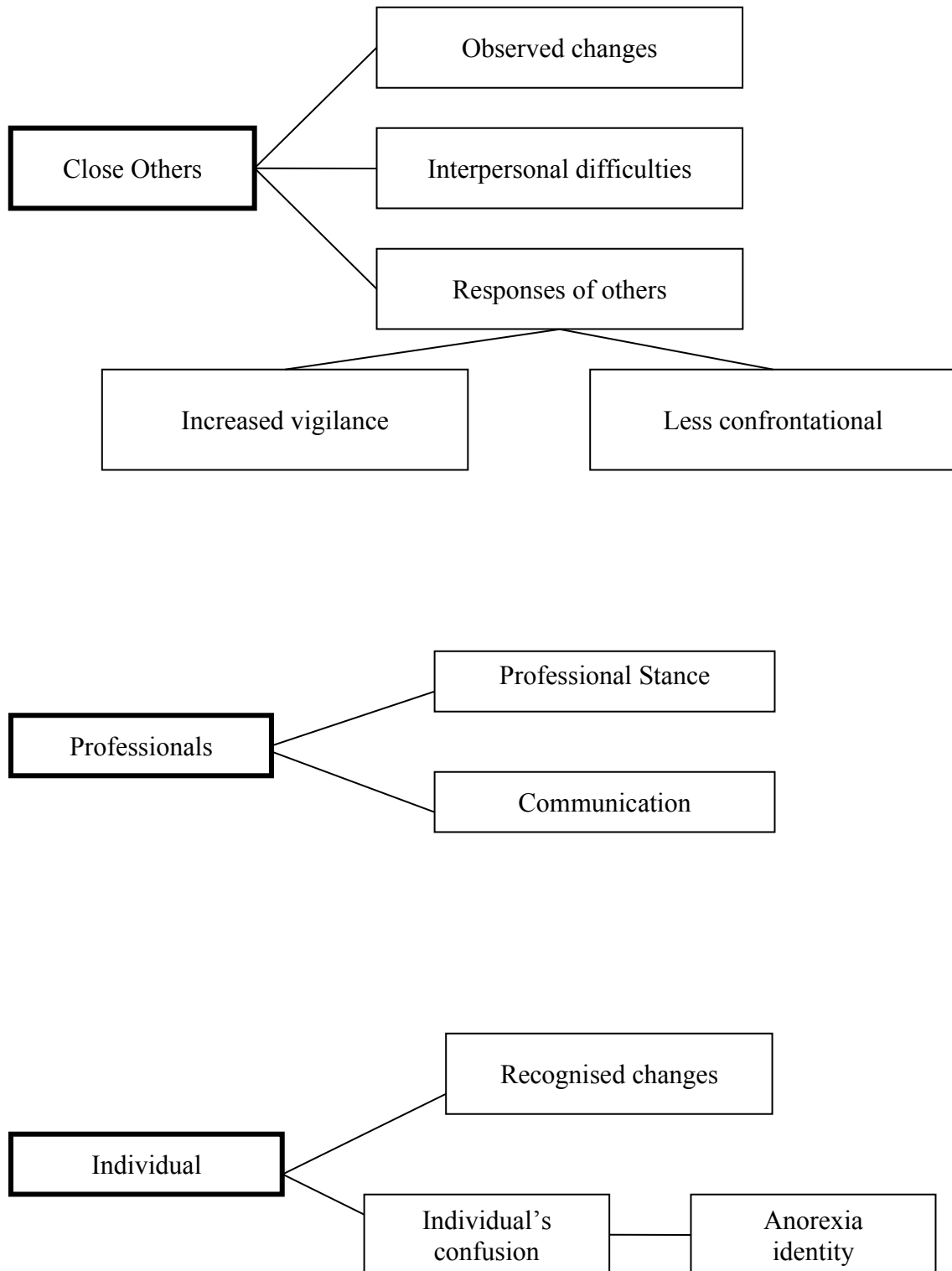
The process of conducting interviews progresses from being exploratory, to developing codes and themes, to confirming and shaping the overall frameworks that emerged. In this study, it became apparent that there were two main time periods that were described in the interviews. These were the identification of the problem, and then the initial adjustment to the problem. These two periods provided a natural primary framework to describe the data. They facilitated explaining the bulk of the data, as outlined by Grounded Theory principles. These periods have initially been reported as they allow the narrative from the interviews and the richness of qualitative research to be expressed. The purpose of the descriptive section is to set the emerged themes within the interpersonal context. This then informs the analysis section of the results, where a higher more conceptual interpretation is conducted and the main findings from the study are considered in more depth and with reference to literature.

### **3.3 Description of Results**

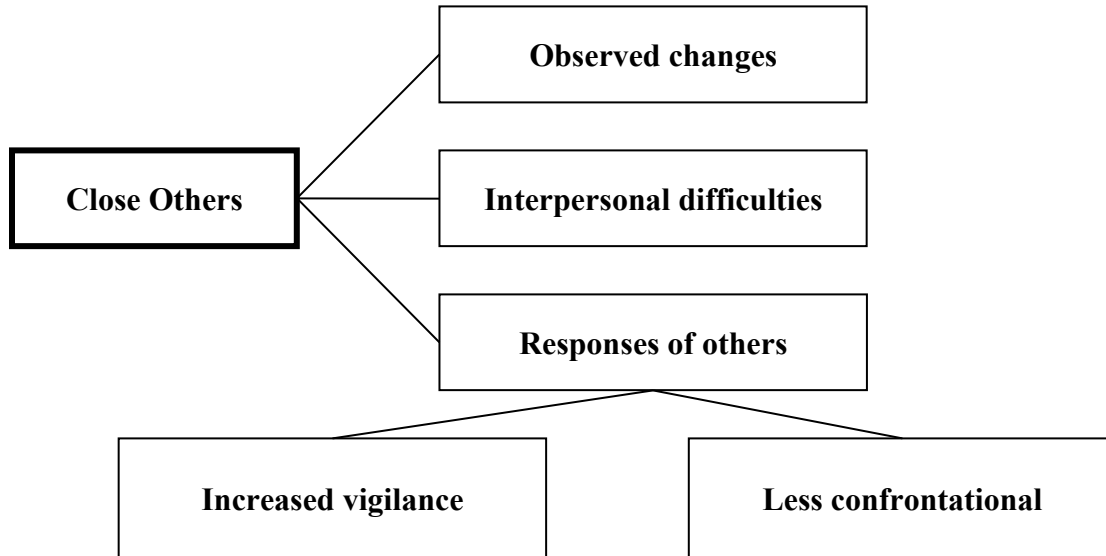
#### **3.3.1 Identification of Anorexia**

Participants' responses about the identification of their problem are outlined in Figure 1 on the following page. It encompasses the participants' views on the interpersonal context which they are part of. It outlines how the participants experienced how close others, professionals and the individual themselves came to identify the problem. Each of these groups will be explored separately as a means of providing rich information on the interpersonal context.

**Figure 1: Identification of Anorexia**



### **3.3.1.1 Close others' identification of Anorexia**



**Figure 2: Identification of Anorexia – Close others**

#### **Close Others**

The grouping of close others incorporated parents and close friends, as this was who the participants spoke most about. They also had a closer relationship with these groups than with siblings or the wider peer group.

#### **Close others' identification of Anorexia – Observed Changes**

Participants described that their close others were key people for observing Anorexia and were also noted to be worried about it. They identified some of the key changes

associated with Anorexia such as reduced intake of food, increase in exercising and reduced weight. The individuals described trying to minimise these changes and tried to make excuses about it. The participants expressed surprise that close others had noticed changes and said that close others comments were incongruent with how they saw things. It also appeared that the participants found this hard to hear, as they were coded as showing more hesitant speech and change in tone.

“Interviewer: would she {mum} ever comment that you were eating less?”

Participant 3: yeah

Interviewer: and when would she.. when would that be?

Participant 3: maybe at like teatime or something when she’s serving people, serving everything up and I was like (yeah) no I don’t want as much as that (yeah) and then and then she’d be like no but no but -look look at what we’re eating and then look at what you’re eating” [higher tone]

Participant 3

“because she’d {mum} always been aware that there was something not right and was always kindof worried that I was going to stop eating (ok) but em.. she just started getting worried about me cause I was only about 8 when I started thinking that I was overweight and stuff (yeah).. but em.. yeah so.. I kindof really self conscious.”

Participant 6

“Participant 1: Mm.. well all my friends commented that I was hardly eating at lunch, but I was like really defensive and I was like well I eat loads of breakfast so (ok)

Interviewer: So what would they say at lunchtimes?

Participant 1: They just just were like.. you should really be eating more and stuff.. and like are you not hungry hh.. i’m like no hhee he...”

Participant 1

“and I asked the people my closer friends and they all said they were a bit worried that I wasn’t eating enough but I .. and even people that I didn’t think would notice at all like guys were saying look are you eating enough we never see you eat... and you’re losing a lot of weight and you’re really tired and sad all the time and.. just kinda.. difficult to hear cause I still saw myself as what I was before..”  
[sounds slightly surprised at others noticing]

Participant 7

### **Close others’ identification of Anorexia – Interpersonal Difficulties**

It was repeatedly mentioned that during the early stages of identifying the problem, there was increased interpersonal difficulties with close others. In the home context the participants reported that the atmosphere at home changed and relationships became more strained. They described a general increased conflict within the family and high expressed emotions. In particular, there were arguments around food and their different views on it. The descriptions suggest that parents would try to shock the individual into understanding the problem and the individual would retaliate. The conflict involved having very heated arguments, which sounded emotive and intense. This was deduced by the descriptions of the language used whereby both the individual and their parents could use strong and emotive language. They also stated that the arguments would frequently involve shouting. These aspects of the conflict were repeatedly shown in the coding.

In the close friends’ context, participants reported that they felt more irritable and could find socialising difficult. This was partly due to concerns that food would be part of the social activity. In addition there was an element of not enjoying activities and finding it difficult to be around people. Overall, participants described trying to avoid socialising.

The nature of the interpersonal difficulties was also demonstrated through the coding of the paraverbals. Whereby, the instances where participants recounted conflict they would appear more emotional, some participants became more quiet and hesitant which was interpreted as pointing towards their shame in recalling these difficult interactions. In contrast some participants became more forceful in their speech adopting a more aggressive style that would reflect the conflict described. In the participants' descriptions of the conflict there were noted changes in their speech, whereby they were more hesitant and flat in tone. This points towards the emotive impact these interactions still held with them.

“Participant 2: well we had I had lots of arguments with my mum and dad. Em.. and my sisters well so (ok)... (3 secs)hm...[more quiet, flat tone]

Interviewer: ok what about ok with your mum and dad when would that happen?

Participant 2: em.. (2 secs) probably like em.. (3 secs) just like whenever if.. em like if I'd left quite a lot on my plate like my dad would like annoyed (mm hm) we had we had big arguments about that em..”

Participant 2

“like if I suspected her {mum} of like looking over my shoulder or something (right) at whatever if I was pouring out a glass of water or whatever like she wasn't actually but you know I would always be so paranoid (and what would you) I'd just turn around and start shouting at her (right) like oh no why are you looking over my shoulder like really actually shouting and she'd shout back and then.. she'd shout back no I wasn't don't be so paranoid (mm hm) and then we'd start swearing at each other then we'd just go away in a huff.”

Participant 8

“em.. well he'd {dad} get upset (mm hm) er.. and really angry and say stuff like.. I'm not going to your funeral or you're just killing yourself I'm not watching you kill yourself (mm).. and I'd get upset (yeah) and then he'd shout some more and then he'd get upset as well (yeah).. kindof the same every time”

Participant 7



“yeah.. well I think.. I wasn’t my usual self (yeah) cause I didn’t have any of the energy that I used to (uh huh) em.. and.. I was always really sad and... I used to.. I never used to go out for lunch with people or anything I always used to.. like.. during times when people would be eating like if it was.. considered unusual for people not to be eating that I would.. hide out in the classrooms or something but also cause I was too cold (right, yeah) to ever do anything (yeah) so I used to have to.. hide away all the time and I never felt like going out (ok) so.. I kinda felt a bit more isolated from my friends as well”

Participant 7

“em like em.. I remember a time when I was supposed to be going out with like two of my friends and they were just going out into town and stuff (yeah) but for some reason I just really, really really did not want to go. (ok) and like I was really looking forward to it like when we arranged it (yeah) but like on the day it was just like I can’t be bothered”

Participant 2

### **Close others’ identification of Anorexia – Responses of Others**

The participants described that they experienced a difference in how the group of close others responded to them at the stage of identifying Anorexia. They recounted that parents became increasingly vigilant of them, whereas peers were less confrontational in their approach.

### **Close others’ identification of Anorexia – Increased Vigilance**

Participants described that as their parents observed more of the changes associated with Anorexia, they also experienced increased parental vigilance. The participants described feeling that this was quite intrusive. It reflects that the time of adolescence is one during which both separation from the family and individuation is occurring. The participants seemed to experience this increased vigilance as imposing and discordant with their developing autonomy. It also points towards the function of the illness in increasing the

involvement required by the parents. While this causes conflict it also allows the task avoidance of separation.

“em.. I think well.. obviously because she {mum} was getting in an argument (yeah) and em that she... rai raised her voice or she used to get stressed or you'd see that she was worrying about me (mm) em.. she used to always ask how.. you know are you still eating and stuff she used to always ask you know how you doing (right) and are you eating and... I used to obviously lie and say I'm ok. (ok).. so eh... ”

[tone flat when saying what mum would ask and changed higher when said “I'm ok”]

Participant 4

“em... I don't know... my mum kept on.. like.. nagging me that I wasn't eating enough although I thought that I was and like I was eating like as I had done before (ok) and then that kindof was a bit irritating (yeah) and like my brother was getting to go out a lot and he was like completely kind of like he'd come into the house whatever time he wanted (yeah) and I wasn't really allowed to do that.. ”

Participant 1

“Participant 2: I was like leaving out all my rice and stuff I was taking everything out and.. my mum was watching me and she started making me have like some more rice (ok) and stuff like I was just get em I just got really annoyed at her (hm) and em.. [flat affect and tone of voice, also seemed bit nervous]

Interviewer: so how would she try and make you have more rice?

Participant 2: em well I was I was just like I stood up and I was just taking my plate into the kitchen and she wouldn't let me pass her at all, I was trying to get past but she wouldn't let me past.”

Participant 2

### **Close others' identification of Anorexia – Less Confrontational**

Within the close others grouping, a contrast was shown between how parents and friends responded. With close friends even if they recognised Anorexia they did not seem to force the issue. Although they would comment on it, there is more of a sense that they were less confrontational in their manner. The interviews illustrated that friends were

worried, but unsure about how to respond to Anorexia. It seemed that friends would not know how to follow up their concern.

From the responses, there is an impression that friends felt uncomfortable about asking too much. This is also reflected in the participants' unease at talking about this, which was repeatedly coded as hesitant and trailing off speech and flat tone of voice. It may have been awkward for the participants and friends at this time, before Anorexia was fully recognised. It was also reported that this led to the participants being uncertain about their friends' insight into Anorexia. It shows that the lack of openness about talking about it can lead to uncertainty about who knows what. This compounds the secretive aspect of Anorexia.

It was also reported that some friends either did not recognise the changes at all or did not see it as a problem. Due to the physical nature of Anorexia and the visible changes that occur, it could be that they avoided facing the problem. The interviews revealed that some friends may not have noticed the changes as being unusual. This highlights that we live in a culture where dieting and over-valuing thinness is prevalent. It is suggested that losing weight was accepted and even when it developed to Anorexia it could go unmentioned. This indicates that although it is known that there is a prevalence of Anorexia during adolescence, it is not always identified as being Anorexia within the peer group.

“Participant 1: Em well some of my friends when we went rowing they were like you’re really thin, but I was like oh no I’m not...

Interviewer: and would they say anything else?

Participant 1: I don’t know they kind of left it at that cause they just.. I don’t know...  
{{4secs}}

Participant 1

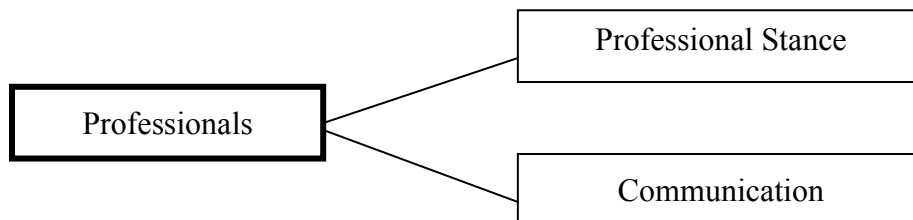
“em.. my friends did but.. they didn’t say anything, I think my friends did or.. didn’t.. you don’t know sometimes (yeah) and eh but they wouldn’t say anything they kept it quiet or (right) they just didn’t want to say anything really I think..”

Participant 4

“my friends obviously noticed that I was losing weight but I think cause I had a I had a holiday coming up well it was October that I was supposed to go on holiday (yeah) I think a lot of people thought that I was just kinda wanting to go to the gym em lots to get in shape for the holiday (ok) and if people asked I would just say I was fine so..”

Participant 5

### **3.3.1.2 Professionals’ identification of Anorexia**



**Figure 4: Identification of Anorexia - Professionals**

### **Professionals identification of Anorexia – Professional Stance**

The professionals refer to contact within general medical (GP) and specialist services (CAMHS). The participants described these interactions as more functional and following requirements, such as performing medical checks, assessments and referring to other professionals. The results reveal a focus on identifying and monitoring the physical signs of the illness. The participants reported that they felt that they were asked a lot of questions during their initial contact with CAMHS. Their descriptions gave the impression of feeling interrogated by the questions and the focus was on assessment rather than engagement. The participants reported being asked very personal questions that they did not always know the answers to. This came across as an unsettling experience that the participants found threatening.

“em.. (4 secs) em.. I remember like.. she {GP} took my height and my weight and em.. she showed me the BMI chart and said.. that it was low but not too low cause it was quite it was really early on (ok) so em and then... probably about a month afterwards I went back and then a couple of months after that I went back again”

Participant 2

“started to do.. ts therapy well sortof with me how how.. you know... just questions to me like.. make pretty much I think it was symptoms (right) of Anorexia that were, so tryin to uh em.. see if I did have it you know (ok) saying like em.. em.. how much do you eat or do you feel.. like em.. yeah .. low low energy stuff like that (hm) do you feel your hands and feet are cold a lot, stuff that was obvious that I had an eating disorder.”

Participant 4

“I think it was pretty difficult cause my dad was in the room at the time for part of it (mm hm) and just like the lady asked me like how many times I made myself sick and all these things that I was doing.. and just like all the kindof pills I was taking and stuff, I hated having to say that in front of my dad”

Participant 5

“I don’t know she’d just kindof write down how I was feeling but I’d already explained that to my mum like everything I’d said to them I’d already spoken to my mum about (uh huh) and I didn’t really feel comfortable talking to someone that I’d never met before about (yeah) how I was feeling (yeah).. I think that I didn’t see the point cause I spoke so much with my mum anyway (ok) about how I was feeling at that point I was quite clingy with my mum (mm) didn’t feel comfortable going out with my friends (mm) and I just wanted to stay close to my mum (ok) yeah”

Participant 6

### **Professionals identification of Anorexia – Communication**

The participants recounted particular things about the communication style of their interactions with professionals. They appeared to consider the GP to be quite blunt and direct about things. It could be that GPs are less experienced and lacking confidence in working with people with Anorexia as they did not seem to engage with the person’s experience. There is a sense of a lack of rapport which is highlighted by the repeated coding of the paraverbals of laughing or hesitant speech in this theme. It may also be that the participants are reluctant to engage at this early stage of service contact and their defences are more active.

There were further accounts of the participants experience with professionals, whereby they felt dehumanised and treated like a case. There was a sense that assessment styles were not tailored to match the individual. Participants described that they felt they were being made to fit into pre-determined criteria. The paraverbals of more forceful and angry speech indicate that they were annoyed by this. They also experienced a relentlessness to the questioning that came across as insensitive and resulted in the participants feeling resentful.

“em my GP sent me here. (right) and she was kinda like well we’ve gone through everything else [laughing] (right) em and this isn’t putting like any labels on you or anything but just want to check out how and..”

Participant 1

“I’d .. I I’d I’d I didn’t know what to call or I (hm) I I once asked my doctor (yeah) em.. if I had Anorexia (uh huh) and she said something like -are you joking you look like someone in a prisoner of war camp.”

Participant 3

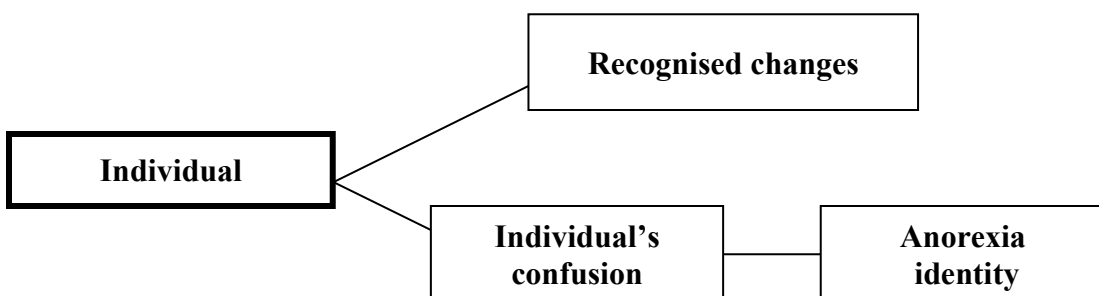
“and then and then yeah they just, I felt like I was being treated more as like.. I was treated as Anorexia, I wasn’t treated as someone with Anorexia. (yeah, ok) feel like (yeah) they like all the symptoms and things like they would think you’d have all of them, which you don’t [high pitch at end] (yeah) everyone’s different”

Participant 3

“Well she’d talk about quite personal things.. and she’d just keep repeating the word Anorexia (right)... which at that time was like the banned word in my house you couldn’t say that and even I remember I started to cry and they would still go on like repeating the question.. I I obviously couldn’t answer I couldn’t even talk I couldn’t even bear to look up (hm) and I felt bad because I I let them see me cry (ok) and I didn’t want that (yeah) and it sortof became a sortof hatred towards them because first impressions are everything in that sort of situation anyway.”  
[sounds angry]

Participant 8

### **3.3.1.3 Individual’s identification of Anorexia**



**Figure 5: Identification of Anorexia - Individual**

### **Individual's identification of Anorexia – Recognised Changes**

The participants all recounted how they first came to realise they had a problem. Most of them were able to recognise explicit changes for themselves, for example that they had changed their eating and/or increased their exercising. The participants gave similar accounts as the close others in that they noticed changes in how they behaved with food. They also mentioned exercise as something that changed. However, in contrast to close others, they were also very aware of other changes that were occurring at the time. They commented on emotional changes as well as physical ones. They gave an account of noticing that their mood changed and they felt more irritable, self-conscious and generally stressed.

“like I wouldn't .. like before I'd eat a lot of crisps and I totally I totally stopped eating crisps and then.. it was like all the other junk food like I wouldn't eat and em...and then it just kinda went down (yeah) so..”

Participant 2

“And like I really enjoyed Duke of Edinburgh as well (oh ok) I went on like a rowing training camp (right) this was like kindof about a month before I came here (oh ok) and straight after that I went on Duke of Edinburgh, but I really struggled cause like I could hardly lift my bag and stuff (ok) hm that was kindof when I realised that I really did have a problem”

Participant 1

“em... I just started to.. eh.. skip um like meals there.. eh.. you know... just make sure that... I was... just eating less really (yeah) just I I was I wouldn't have breakfast or lunch or (right) stuff like that or if I did I would only have lunch I would skip breakfast or something like that (ok) em..yeah so I would try to restrict myself eh.. if I em.. I wasn't doing much”

Participant 4



“em.. (8 secs) I don’t know, I can’t think of any.. and em... (4 secs) I guess it I do kinda remember before everything started like a little bit before I’d actually.. I’d been getting more worried and I’d been thinking about doing something but like em like just it kinda went away like for a month and then totally came back again. (oh ok) and yeah so..”

Participant 3

“and then I kindof one person said something to me and I remember til I was about 10 em I think that’s when it kindof began it kindof started in lot of exercise and stuff like that (ok) I remember feeling really self conscious (hm) and always hated going to changing rooms at (mm hm).. and stuff like that in case clothes were too tight for me even though my mum had taken me to the doctors a few times.. and I wasn’t at all over weight and I never had been (yeah) I just really thought that I was myself .”

Participant 6

“em well it was just thought it was really stressful (mm) you know eh... {2 secs} eh that that affected me in that I was stressed and (ok) I had to eh exercise more and think that eh to compensate what I was eating.”

Participant 4

### **Individual’s identification of Anorexia – Individual’s Confusion**

The participants described an unreal quality about their situation during the early stages of identifying Anorexia. They described being confused by what was going on and the comments that people made. This theme is considers the individual’s experience of this time. It seemed that while they were trying to minimise or deny they had Anorexia, they felt very confused. Considering this from the individual’s perspective adds a dimensional quality to the findings. It appeared that denial was more of a sub-conscious reaction that left the individual feeling bewildered by other people’s interactions with them. There is a strong indication that while there is a lot of focus is on them and their well-being at this time, the individuals’ experiences of this is that they feel confused by this and lost in the midst of it.

“Participant 5: I reckon I just I think I just kinda felt quite alone and didn’t really (hm) and didn’t want anyone cause everyone was telling me like my boyfriend was always telling me oh there’s something wrong and you should be going trying to get someone to help you and I was saying oh there’s nothing wrong [slight sigh] (ok)... yeah... [flat tone] (...)

Interviewer: and then what would you say if he brought something up?

Participant 5: I’d just kindof brush it off and say that everything was fine. [more quiet, sounds despondent] but then I didn’t think there was anything wrong”

Participant 5

“yeah like sometimes I’d get like these.. overwhelming rushes of confusion (hm) and they’d just make me cry (ok).. honestly I did a lot of I did more crying eh.. I’ve done more crying between February and now than I have done probably in my whole life (mm, mm-hm) so.. (yeah)”

Participant 7

“Interviewer: So what was it like going to the different places? What was it like going to the GP first?”

Participant 1: em I don’t know I just kindof like I had no idea like what was wrong with me or like why it had happened.”

Participant 1

“I think it was just a bit annoying cause I thought that everything.. in my head everything was ok and I didn’t understand why people were saying to me like, things like oh you’ve lost loads of weight and I didn’t think I had so (uh huh)... yeah...”

Participant 5

“Participant 7: basically my dad telling me that I was killing myself and that I was going to die which.. almost happened but that’s not quite the point (yeah) [sounds slightly sarcastic at end]

Interviewer: and what was it like for you hearing him saying that?

Participant 7: it was horrible cause I didn’t believe it (ok) I couldn’t see it and I couldn’t see what I was doing was wrong (yeah) or abnormal in any way so (ok)..

Interviewer: so what did it feel like?

Participant 7: hearing it ? (yeah)... it made me feel quite... confused (mm hm) cause I didn't understand what he was saying (yeah) or how he could think that (ok)...

Participant 7

“I don't know it was quite hard (hm) cause... but.. I'd been feeling quite low about myself for while at that point (yeah) so.. kindof like.... I just felt quite sad and alone (yeah). Cause I felt nobody knew how I was feeling..”

Participant 6

### **Individual's identification of Anorexia – Anorexia Identity**

It was demonstrated that the Anorexia illness starts to take over and dominate their identity. They begin to take on the identity provided by Anorexia, whereby they see it as part of themselves rather than separate to themselves. In the early stages participants recounted considering the features of Anorexia becoming more incorporated into their lives. Most participants recounted that this did not feel abnormal and they therefore did not notice the extent to which the Anorexia had taken over. It could be hypothesised that their confusion around the early identified changes then led to their Anorexia identity becoming more pronounced.

“...em (2 secs) I can't remember how I felt I just remember that I was just like... counting everything up quite a lot and like when I was going like if when I was going to bed I'd like I'd plan out exactly what I was going to be having the next day and I'd count it up everything that was in it (ok) so I knew exactly what I was going to be having (yeah) so...(3 secs)”

Participant 2

“yeah.. definitely... think because that's all we because that's all that I ever.. that was in my head cause I was just thinking about losing and weight and food and everything all the time so, I just kinda felt that the person I wasn't the same person anymore just that was all that was important to me.”

Participant 5

“...em I had a chest infection (mm hm) and with that I lost my appetite (ok) and.. then even after I recovered from that I never really got it back and then... over a while.. over a period of a few months I gradually started reducing what I was having (yeah) and then... had less and less and less (uh huh) to... until.. like just before I was admitted where I was living on... sortof maybe 20-50 calories a day if I was lucky (ok)... em yeah..”

Participant 7

Participant 4: em just started cutting down my calorie intake kinda.. trying to build on more physique (mm hm) em.. to look more muscular that I thought I had to cut down on my calorie intake (mm) rather than to eh increase it (mm hm) and eh I was I just really got it wrong (yeah) so I kinda was getting addicted to that feeling (ok)

Interviewer: what feeling was it that you got addicted to?

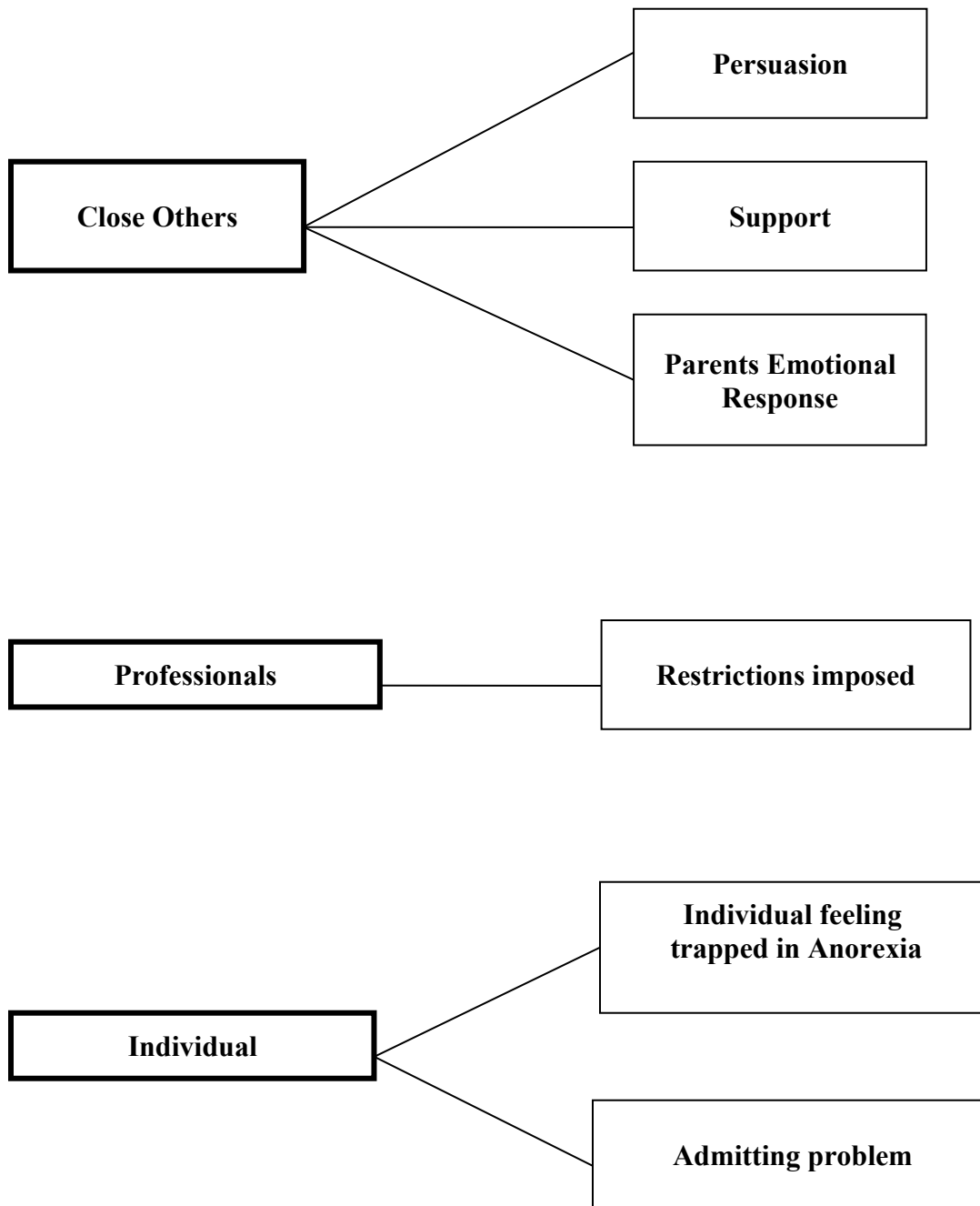
Participant 4: well I think it was em.. the sortof after you exercise the feel good factor (uh huh) after that em so it em adrenaline rush and the realise of endorphins and stuff so I got addicted to that (yeah yeah) hm..”

Participant 4

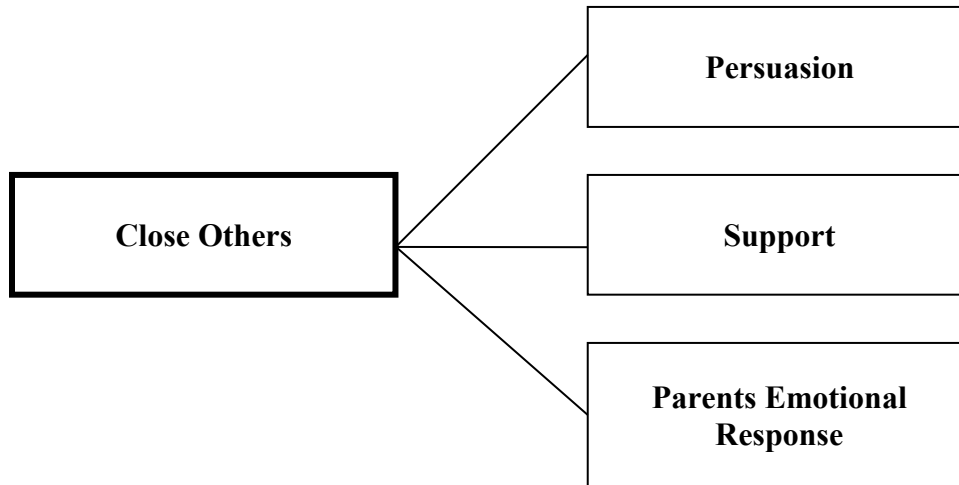
### **3.3.2 Adjustment to Anorexia**

Participants’ responses about the adjustment to their problem are outlined in Figure 6 on the following page. Again, it comprises the participants’ views on how close others, professionals and the individual themselves adjusted to the problem once Anorexia had been identified. Each of these groups will be explored separately.

**Figure 6: Adjustment to Anorexia**



### **3.3.2.1 Close others' adjustment to Anorexia**



**Figure 7: Adjustment to Anorexia – Close Others**

#### **Close Others Adjustment to Anorexia – Persuasion**

Participants described that their parents in particular would try to persuade them to eat more or reduce their exercise. They were found to demonstrate different methods of persuasion; through encouragement, enforcement or emotional manipulation. This shows the different tactics that would be undertaken to try and help the individual. In encouragement, parents would try to persuade the participants to eat. They seemed to inadvertently collude with the problem, rather than confront it. In contrast in parental enforcement, parents would be firmer with the participants and set boundaries. This was found to cause conflict between the individual and their parents. Thirdly, at times parents would use emotional manipulation to try and persuade the individuals to eat. This

highlights the emotional bonds within the family and that guilt could be used as a method of coercion.

“well they kept trying not to force me but they’d {parents} try and make me think (mm hm) about the food and stuff and saying that it’s not bad for you and stuff and then they would eventually get me to eat it and I think they would get quite upset with me when I’d stopped”

Participant 6

“em.. like say it was all low calorie and stuff and she {mum} wouldn’t use lots of oils or anything like that and it would just be vegetables and chick.. em.. if she didn’t think I’d have enough she’d say have a bit more (mm hm).. just be more gentle in her approach..”

Participant 7

“well.. they {parents} just kindof, they wouldn’t get really angry it was just they’d get more upset (yeah yeah) and they would try and get me to eat it and kindof.. they never actually forced me like force fed me ( uh huh) but they would like.. kindof get angry with me and say if you don’t eat this you’re not going here and you’re not going to do this if you don’t eat it (uh huh) and that.. em they would take things off me eventually (ok) but.. em.. they never got really mad at me (ok) yeah”

Participant 6

“and I remember there was like times in the middle of the night that she {mum} would try and get me to eat and I I was really scared like I knew I had to do it (yeah) but even when I did eat it might be something like half a banana (uh huh) but but I was really scared and and I was really sad how sad I was making my family (ok) so I had to do something about it.”

Participant 3

“em.. (2 secs) well there was one time that I can actually remember (yeah) quite well and like em I’d left like quite a lot well.. left some on my plate and em...my dad had recently really badly hurt his toe (ok) and em he’d had to get stitches and everything (hm) and it was really hurting him at the time (hm) and he refused to take a pain killer until I ate some and I felt absolutely horrible so.. em...yeah.. and but it was a massive argument that time (mm hm) so..”

Participant 2

“and I might be home at the weekend and things then.. [flat tone] my dad said something to me once.. cause my mum was getting quite stressed or upset and something (uh huh) I was in the car just with my dad (uh huh) and he was like “well can you not just eat normally for one weekend” [voice changed to imitate dad, pleading tone] or something like that (hmm) and I just thought “you have no idea do you” [laughing] you just can’t do that”

Participant 3

### **Close Others Adjustment to Anorexia – Support**

It was reported that once Anorexia had been identified and was no longer hidden participants perceived close others as more supportive. Participants described that their parents’ understanding of Anorexia changed. The participants also referred to their parents as supportive and people that they felt accepted and comfortable with.

In addition, the importance of close others in the peer group was evident. Participants reported that their friends were accepting of them with Anorexia. At a time when the peer group are of significance, this acceptance was interpreted as important to them.

There was an expressed anxiety about telling friends about Anorexia and how they would react. However, participants were pleased to find that most of their friends were supportive of them and interested in hearing about Anorexia.

Furthermore, friends provided a space where the participants felt they could just be themselves. They also provided reminders of a normal life without Anorexia and provided some escapism from Anorexia. This could either be by remembering what they were like before Anorexia or by talking about what life would be like again without Anorexia.



Initial parental response:

“Well they {parents} kindof like at first they didn’t like understand like what it was like (yeah) hmm.. I think sometimes my dad thought that I did it just to annoy them (ok) so.. or that I was being stubborn.”

Participant 1

And later, increased understanding and adjustment:

“I think it was how long it’ll take me to get better but they didn’t really know anything at that point and they recommended a book for my parents to read and after that my parents started to be like a lot more understanding and stuff..”

Participant 1

“she{friend} was trying to understand like she wanted to know all the details of like what I was doing in outpatients and who all the people were (yeah) and what exactly I was thinking or what exactly was going on for me (yeah)...em.. so she like I felt she was really.. good in that respect..”

Participant 7

“Particiant 1: They {friends} just kinda like were quite interes well not.. I don’t know if that’s the right word but like interested in it (ok) and just kinda trying to be really supportive and stuff and hm

Interviewer: So how would they show they were interested in it?

Participant 1: Well they just kinda like em.. like I don’t know [laughing] like we’d talk about it and stuff (ok) so.. and talk about what they had thought (ok) like quite a lot of them had kindof guessed so”

Participant 1

“I think most people who came to visit me... nobody really talked about anything to do with it and I tried not to talk about it, we’d just try and kinda talk about other things going on outside (yeah) just to try... cause that would be the hour that somebody came in the day or whatever, the thing that I would look forward to all day (yeah) so kinda.. get away from it for a bit”

Participant 5

“em.. just tell me that I have to keep on fighting the illness (hm) and just to keep on.. doing the hard work that I was doing in the inpatient unit (ok) em.. and. You’ll you’ll em..you’ll get back to school with us (yeah) and just all the good things that to get back to really (yeah yeah) it was quite nice just to hear from them.”

Participant 4

“.. and he {boyfriend} would always tell me like kindof he.. he. remembered what it was like before it got really really bad so he was kindof he helped me remember that that wasn't who I was and I would just always think this is who I am the only person who I am is the person who counts calories and thinks about food but.. he was kindof a reminder to me that..”

[sounds more hopeful, tone a bit higher]

Participant 5

### **Close Others Adjustment to Anorexia – Parental Emotional Response**

As well as expressing their own emotions, the participants were aware of the emotional impact on their parents. This in turn affected the individuals, which will be highlighted in process elements. This helps us to consider the interpersonal and family dynamics that come to light when Anorexia arises. The main emotions that were recognised in parents were anger, worry and sadness. Participants recognised that the situation was frustrating for other people as well and they commented on anger in their parents. There was also the awareness that parents were worried about the participants. Some people reported that their parents would tell them they were worried, while others said they could see worry in their parents. Finally, there was a sense that parents experienced sadness and despair about their child's eating disorder and the seriousness of the problem.

“em.. my dad has quite a temper so he would often get cross with me and my mum got annoyed as well.”

Participant 1

“yeah and that sometimes.. they would get quite angry with me and try and get me to eat it because we'd been like walking about all day in New York and stuff (right).. and that I hadn't eaten anything for lunch some days and had just really cut back..”

Participant 6

“em.. I think well.. obviously because she was getting in an argument (yeah) and em that she... rai raised her voice or she used to get stressed or you’d see that she was worrying about me”

Participant 4

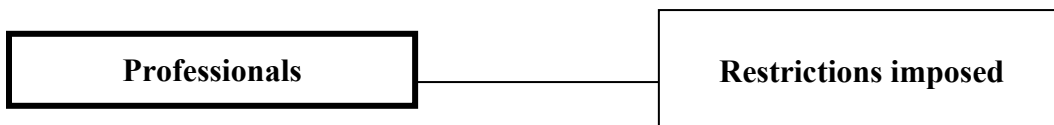
“think he was just really sad about everything he had I think... he hadn’t realised how bad it was until he came here and he was almost crying when they were telling him all these things about how it was really really serious and (mm hm) and how they needed to wait on all these kinda results before they were to see whether I needed to get admitted or not (ok)... think he was just really sad about it”

Participant 5

“I couldn’t sleep and I was in a lot of pain and um I was like got really upset and worried about things I can’t remember what (hm) but there was a lot of crying and then and then.. um.. my mum would come sit with me and then she would be upset too”

Participant 3

### **3.3.2.2 Professionals’ adjustment to the Anorexia**



**Figure 9: Adjustment to Anorexia – Professional**

### **Professionals adjustment to Anorexia – Restrictions Imposed**

Once the participants were receiving treatment from the CAMHS the main descriptive theme was of having restrictions imposed. It appeared that there were numerous limits put in place for example around their weight, the level of activity they were allowed to do

or what they should eat. Results indicated that this was a time where they were made to face consequences. Participants' experience of this indicates that this was felt to be imposed upon them rather than collaborated on. It seemed that they viewed professionals as quite strict authority figures that they had to adhere to.

“I can't really remember... (3 secs) I think... (2 secs) they wanted me to change lots of cause there was like one night.. it was something like they'd said “if she's lost more weight again when she gets weighted then we'll have to take her into inpatients” things about like what I ate and stuff”

Participant 3

“it was more I didn't mind coming to the hospital (mm hm) it was what I was told to eat (ok) but now that I think back the nutritionist was being really fair I just didn't like her instantly because I thought she was the one that had to tell me what I had to do (yeah) so I really didn't like her for it”

Participant 6

“Participant 1: Yeah and then they were all like well we don't think you should sit the rest of your exams but I was like no I'm sitting the rest of my exams [laughing] so...

Interviewer: And what happened when you said that?

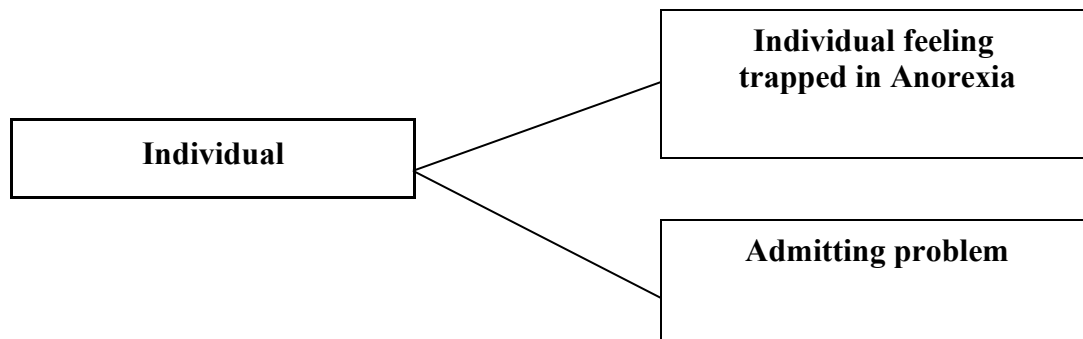
Participant 1: em I think they were like well I don't think that's a good idea and would it not be better not to and I was like no hh (hmm) and then.. hm.. I can't remember what happened really after that...”

Participant 1

“and I think because I hadn't eaten for so long as well to have to eat and like half a sandwich was like such a big deal... just felt that everything was really difficult (yeah)... think like when they [staff] had tried to get me to eat things like eating one grape which was like 2 calories seemed like loads to me so to come over here and to think oh my god I'm eating 200 calories was like massive..”  
[very quiet throughout, sounds upset]

Participant 5

### **3.3.2.3 Individual's adjustment to Anorexia**



**Figure 10: Adjustment to Anorexia – Individual**

#### **Individual's adjustment to Anorexia – Individual feeling trapped in Anorexia**

Once the Anorexia illness had become more established it seemed very hard to relinquish it. Participants described how as time progressed they became more aware that Anorexia had become a big part of their identity. Participants reported feeling trapped or stuck in a difficult situation. There is a clear tension between beginning to recognise they have a problem and not wanting to give up Anorexia.

“hmm... yeah I think just kindof had a kindof an idea in my head that if I was if I lost a lot of weight I would be happier so (mm hm).. but then it couldn't I couldn't stop it I didn't know when to stop and (yeah).. couldn't really...”

Participant 5

“it wasn't as if I thought... em..like..oh maybe I should think about what they're what other people think about this nah I'll just leave it (yeah) it just like it never came into my head (yeah) at all cause... cause just.. I was like so stuck in other things (ok)... and also worrying and things.. (2 secs)”

Participant 3

“I think I just felt so stuck with everything (yeah, yeah)...I think because.. cause everything had just got worse and worse and it just got less and less and I was having to.. at that point it just I couldn't eat anything at all so (hm) so kindof tired all the time and I couldn't do anything else and just felt.. stuck”

Participant 5

“em depended what kindof mood I was in (yeah) I'd go through phases.. like some days I'd be like.. ok eating (mm hm).. I would have a few things she [mum] would suggest (yeah) but other times I wouldn't and I ... just wouldn't.. I just... refuse to eat most of what she would say..”

Participant 7

### **Individual's adjustment to Anorexia – Admitting Problem**

The findings showed that as time progressed there came a point where the individuals realised the seriousness of Anorexia for themselves. They seemed to begin to adjust to having Anorexia. For some people this was a gradual recognition that happened slowly over time and for others it seemed to have a revelatory quality to it. In addition, Participants were found to feel the emotions of worry and fear in relation to adjusting to the problem themselves. They were concerned about both relenting to Anorexia and facing up to it. This put them in a quandary and led to feelings of fear.

“but I really struggled cause like I could hardly lift my bag and stuff (ok) hm that was kindof when I realised that I really did have a problem”

Participant 1

“em... {2 secs} just think I'd kindof.. I think I remember one time cause I hadn't ever, when I looked at myself I thought I still looked in my head like massive and it was not until one time I remember being.. in \*\*\*\* and having a shower and kindof looking at myself and thinking.. oh my god I actually look so thin (yeah) and I hadn't ever really seen that before and even thought people had been saying it to me for so long.. I just didn't realise it really properly til then.”

Participant 5

“Interviewer: Do you think.. it sounded maybe that you’d come to terms with it.. a bit more?”

Participant 4: Yeah I think I was.. that I recognised that I was I wasn’t right the way I was feeling I knew that my friends.. knew they didn’t feel the same weren’t going through the same things so (yeah)... I knew I needed help...”

Participant 4

“because I really wanted to do something (yeah) even though it really upset me the fact that I had to.. (ok) and felt horrible afterwards (yeah). It wasn’t so much the eating it was how I would feel afterwards (mm ok) yeah”

Participant 6

“and then I went again and you know it was a big em.. thing.. cause I was in a lot of stress then (ok) it must have been I don’t know if it was.. at boiling point but it was oh.. you know I think I have a problem here (ok) em.. this has become a little bit overwhelming for me (right ok) hm”

Participant 4

### **3.4 Analysis of Results**

The descriptive level of results was further interpreted to see how the themes interrelated and related to higher level concepts. Diagram 11, on the following page shows the relationship between these themes. This section of the results presents the main findings of this research. It found that there is a strong emotional element to the individual's early experiences of Anorexia; that their awareness of Anorexia is something that develops; and that these factors influence their interpersonal interactions. Each of the areas will be explored in turn and the relationship between the three main themes will be considered in the discussion.





### **3.4.1 Emotional impact**

The first main finding of this research is that there is a strong emotional element to the individual's experiences of the early stages of Anorexia. There was an array of emotions expressed in the interviews. In the initial coding of the first four interviews, a number of different emotions were identified. The emotional aspect of their experiences was explored further in interviews five to eight to gain richer information about the character and qualities of the emotions. It evolved that the emotional impact formed a large part of the emerged categories. It was found that the expression of emotions was over-represented across the interviews and was therefore taken to be an important theme to consider.

#### **3.4.1.1 Emotions Experienced**

It is evident that the early stages of Anorexia developing were a difficult time for the individuals. The participants' accounts also provide valuable information on how they processed these experiences. The interviews indicated that strong emotions were evoked by the different situations and interactions participants encountered. The richness of the data provided by interviews further allows us to consider the significance of the way in which things are described. Whereby, if a participant was emotive in describing something in the interview it is likely that it holds importance with them. This section will consider the emotions that were most repeatedly coded from the interviews. It will cover frustration, guilt, shame, fear, worry, loneliness and low mood.

### **Emotions Experienced - Frustration**

The frustration expressed linked to the interpersonal difficulties experienced and in particular the conflict at home. Furthermore, the individuals found the increased vigilance and imposed restriction from parents and professionals frustrating. This seemed to result in reduced autonomy which the participants found emotionally difficult. They also described feeling frustrated that others did not fully understand their experiences. The coding of the paraverbals associated with the emotion of frustration showed that they were coded as being more forceful in their tone and could talk more quickly. This seemed to echo the hostile aspect of the emotion they were expressing.

“not that great for me either (no) cause it’s like you’ve got all the different rage kinda (yeah) and you didn’t know why and it wouldn’t take much to set (mm hm).. to set you off (yeah).. so it was...quite confusing as well (mm hm).. and then you’d feel bad because you know.. like.. you know they di didn’t deserve it.. but that would just make you angry again.. so..”

Participant 7

“Interviewer: So would that what would that feel like for you just having the same arguments again and with the same people?”

Participant 2: just really frustrating and stuff so (hm hm) (5 secs)”

Participant 2

“just the same as with everything else just felt angry with it (hm).. people were just.. being annoying about things..”

[quiet, blurred words]

Participant 5

“It was kinda really awkward (yeah) like I’m kinda used to it now with family meetings and stuff (sure) but then it was.. I don’t know I really hated it..”

Participant 1

“I think they just kindof like the way that they {CAMHS staff} spoke to me (ok) and the way that they, well the first woman that I got she was really nice and didn’t at all (mm hm) but it was just she the other woman just really like.. spoke to me like I was 2 year old (ok) and the things she made me do like colour pictures and stuff like that I just found that really annoying (ok) cause at that point I was 13 (mm) and I just thought oh for goodness sake I’m too old to be doing this (ok) so...”

Participant 6

“I used to get really frustrated with like \*outpatient worker name\* and \*outpatient worker name\* because they were telling me all these things they were telling me I should do all these things (uh huh) and.. I just think it was such a pain or ridiculous”

Participant 7

“not really I think I just got really quite upset and my mum and dad would like try and calm me down (yeah) and get me to eat it eventually, and sometimes I got really mad and just stormed off to my room but eventually they’d get me down (ok) so quite stupid”  
[tone higher and slight laughing at end]

Participant 6

“just cause I had such strong craving for cheese (yeah) and then aw no she said to me the next day -even if it is just eating a bit of cheese- and that made me angry cause I thought well you don’t understand cause if you understood or cared then.. you’d know that I wouldn’t eat cheese (ok) or anything mm... it’s silly now but.... Just felt like if people didn’t remember me then they didn’t care and that just made me feel more lonely”

Participant 7

### **Emotions Experienced - Guilt**

Participants also described feeling guilty about the impact their problems were having on other people. This was shown by a reported conflict between feeling guilty and responsible for their effects, and also not being able to change the situation. In the interviews, the participants appeared more emotional when recounting situations when this was evoked. The paraverbals that were coded repeatedly showed that participants

were either sadder in tone with frequent hesitations or more incongruously light-hearted. These features were found more frequently in the theme of guilt and it may be that guilt is a more difficult emotion to admit to.

“I.. I felt more like em cause some people when something’s said about them (hm) they’ll really take it to heart or some people get really aggressive (yeah) and I took it more to heart (uh huh) and I thought well maybe it is my fault (ok) so.. like I knew it wasn’t but it just made me questions myself (ok).. felt guilty.. (yeah) {2 secs}”

Participant 3

“I think I felt guilty about what I was doing to other people as well.. just guilty about what I was making other people sad and stuff... think it was really difficult because I knew that the things I was doing was bad like I knew.. I shouldn’t be taking diet pills you shouldn’t be taking laxatives you shouldn’t be doing you shouldn’t be making yourself sick and everything but just couldn’t stop it so... {2 secs} it’s like you wished that you could you wished you could eat food and be normal but be thin like you want to be (yeah) but realistically.. the kindof thin you want to be you would never be that if you ate properly so...it was hard..”

Participant 5

“since I could upset them {parents} that I’d upset them so much that they didn’t really feel close to me anymore (ok) cause some of the things I’d said when I was really ill and didn’t want to eat something (yeah) I said some hurtful things and (ok) some things that I wouldn’t be able to take back and they just thought that maybe that is what I thought about them”

Participant 6

“well I’d just felt really guilty like like if they got angry I felt guilty, if they got sad I felt guilty, [jokey/lighter tone] (ok) like I just felt I never I felt like I’m such a pressure on them (yeah) but just wanted to.. like get rid of it.. but I couldn’t do anything about it... [getting quieter and quieter] (5 secs) and can’t remember much more”

Participant 3

“Well he was just like I can’t believe this has happened. Like.. almost as if it was my fault.. (ok) hm {{3 secs}}”

Participant 1

“I think I felt guilty about what I was doing to other people as well.. just guilty about what I was making other people sad and stuff... think it was really difficult because I knew that the things I was doing was bad like I knew.”

Participant 5

### **Emotions experienced – Shame**

Participants expressed shame and embarrassment about Anorexia and wanted to keep it hidden. These emotions and the secrecy they provoke were repeatedly found throughout the research in the different interpersonal contexts. The recurrence of these themes across situations infers that it is of importance. It can be seen to relate to the perceived stigma around mental health problems and the individual’s fears of being discovered and made an outcast.

In the close others interpersonal context these feelings are linked to friends identifying changes and the individual trying to minimise Anorexia. Initially the feeling of shame was connected to having a mental health problem and the participants expressed apprehension about others identifying Anorexia. This became a growing concern and they described feeling worried about how other people would react. There is a different element to this feeling with the peer group as it has an added worry about what other people would think of them. They had worries that other people would think they were “weird” or “mad”. The derogatory connotations of these words again emphasises the stigma experienced around mental health problems. This draws our attention to the self-consciousness and self-criticism that can be present in people with eating disorders. This

can often be masked by their high achieving status and perfectionistic and at times even apparently arrogant stance. This concern was less present in the family context where the participants were less self-conscious and where the problem was most manifest. However it was also found in interactions with professionals, whereby they seemed to feel that their lives were being intruded and this resulted in them feeling ashamed about their situation.

“I don’t know cause I think it made it more real if you said it out loud (hm) and I was a bit embarrassed about it at points I didn’t want people to know if they thought that I was weird or something (ok) like that, other people at school I didn’t want them to know..”

Participant 6

“I just found it easier sometimes just to be.. cause i.. stay away from.. well I don’t know.. cause cause it could be people asked me like “oh how are you and stuff” (yeah) I didn’t want to tell them cause it felt that’s really private (hm) that’s part of me (mm hm) I don’t want anyone to know (mm hm) and also sometimes.. I just felt well I’m so down and I can’t make myself happier.. and I felt bad being down around other people (yeah) cause they might feel that they... need to do something to try and help me get happier or something or they might think I was attention seeking or things (ok).. didn’t really see people much (ok)... (2 secs)”

Participant 3

“I don’t know cause I think it made it more real if you said it out loud (hm) and I was a bit embarrassed about it at points I didn’t want people to know if they thought that I was weird or something (ok) like that, other people at school I didn’t want them to know..”

Participant 6

“I was kinda worried about what their reactions were going to be...(...) em.. that they kinda like wouldn’t want to be friends with me and stuff or like that they would take it the wrong way like...”

Participant 1

“or they might be like she’s just been big headed she just wanted to lose weight (right) and like be vain (right) and I always worried that like people would think that of me (ok) em things like that.”

Participant 3

“just really bad because it’s... been.. had all your kindof.. it’s kindof felt you’d had all your dignity taken away in a way because you’d you couldn’t do anything yourself you couldn’t eat anything well they were telling you what to eat you couldn’t go to the toilet yourself you couldn’t have a shower yourself you couldn’t do anything like that so (yeah) ...”

[very quiet at start and throughout, sounds upset]

Participant 5

“I felt awful like I wasn’t proud of it, cause I know some people are proud of it... I was extremely ashamed and still am... and when it’s a problem like that I don’t want people to know.. and like all these people knowing was just awful.”

Participant 8

### **Emotions Experienced – Fear and Worry**

As their problems progressed and they came into contact with professional services the participants described being scared by being in a new situation and having to confront their problem. The results gave the impression that they were worried about meeting new people and having changes made for them. They described being scared at having to give up something that they had clung on to and how they would do this. In the interviews they were repeatedly coded as quite hesitant when explaining this. This may have been more difficult for them to express as although the research was independent to their treatment they were still receiving care from CAMHS.



“Interviewer: So were you quite quiet (yeah) yeah. And do you remember how you felt when you were there?”

Participant 2: I just felt really uncomfortable and (hm)... just ner nervous and stuff (yeah) so yeah hm....”

Participant 2

“It was quite nerve wracking cause I kindof like I sort of knew that like I wasn’t eating properly but I didn’t want to see I wasn’t really sure and then we went to all these different places and like they kindof didn’t really know what to do so yeah.”

Participant 1

“but I felt when I got weighed the next day I felt like “oh I should have put on weight” or at least like stayed stable like (yeah yeah) but then it went down again.”  
[emphasised *again*, sounds disappointed]

Participant 3

“Participant 1: but I don’t know it was ok but I didn’t really enjoy it though cause of like eating and stuff I was like still a bit traumatised by coming here (ok) em

Interviewer: What do you mean by traumatised?

Participant 1: Oh [laughing] I don’t know [laughing] (laughing) I just I was just kinda was still trying to accept it all (yeah yeah) and stuff it was quite hard and like that I was on a meal plan and stuff I still found that quite hard so..”

Participant 1

“Participant 4: em I was emotional I think then (yeah) eh I think eh cause.. you know if.. they were they were asking questions and I think.. I was.. going to show an eating disorder (ok) so I was quite emotional I think (ok)

Interviewer: so was that (yeah).. do you think that was going through your mind at the time that you were thinking..? (yeah) maybe I’ve got an eating disorder (yeah mm) ok... and what.. emotions do you think you felt?

Participant 4: eh.. just upset (yeah) em.. and... aw worried as well actually (yeah).. just how I would if I would ever recover from it (hmm) and how I would ever get better really... {2 secs}

Participant 4

### **Emotions Experienced – Loneliness and Low Mood**

This was also a time when the individuals indicated that they felt low and that others did not fully understand their experience. They therefore found it hard to be in interpersonal settings and withdrew. This was coded as a lonely emotional experience for the individuals as they repeatedly said that they did not enjoy retreating but found it too hard to be around other people and felt lonely or alone. The repeated coding of low mood and loneliness together seemed to indicate that they were associated.

“think any time I was at home as well I just stayed away I just stayed in my room at stuff (hm) because... I didn’t like being around people who were eating things as well, so if I was downstairs and someone was eating in the living room or anything that really annoyed me so it was just easier if I just kept myself in my room (yeah)... {4 secs}”  
Participant 5

“I don’t know.. I was like sad a lot of the time so (yeah) I kinda got a lot quieter {{3 secs}} and I didn’t want to go out as much..”  
Participant 1

“I I didn’t want to let any of my feelings out (hm) I remem I used to be like everything I kept [emphasised] like absolutely everything to myself (uh huh) I wouldn’t tell anyone not even like my mum or there was no one that I felt I could speak to..”  
Participant 3

Participant 7: Just felt like if people didn’t remember me then they didn’t care and that just made me feel more lonely (ok)

[sounds quite annoyed]

Interviewer: quite strong feelings then...

Participant 7: yeah it was like nothing was ever just like a niggle (mm) it was there or it wasn’t..”  
Participant 7

“I felt so lonely that there was no-one there (uh huh) and I felt that I was always terrified and always on edge about being alone (ok) and I just felt like em.. I was completely on my own and no-one felt the same way as I did (yeah) and that nobody understood how I was feeling (hm) when they did but I just felt that they didn’t (yeah) yeah”

Participant 6

“em.. {3 secs} I think the hardest thing there was a couple of things I think one of the hardest things kindof feeling like I’d just feeling really alone feeling the person I was wasn’t really who I was anymore”

Participant 5

“yeah.. kinda...sad and lonely.. cause... I didn’t understand I felt like I was kindof isolated and I also became.. really reclusive (ok).. like.. em.. that started back in February I started to.. like be alone a lot more and I never used to feel like going (ok).. and so.. I’d js.. be really reclusive so I would be.. I would literally be alone a lot of the time (mm but I also felt.. kindof alienated cause I was the only one that thought I didn’t have a problem (ok) so... it was like I was in my own wee hole (yeah, yeah)...”

[very broken, hesitant speech, low tone]

Participant 7

### **3.4.1.2 Overwhelming emotions**

It is evident that this was a very emotionally turbulent time for participants. Participants would experience a number of difficult emotions in their interpersonal contexts. It also became clear that the experience of these emotions was that they were very profound.

Participants described that they would feel these emotions intensely. This was viewed to be an over-arching theme to the emotional impact. Some said that they could not imagine a worse thing that could have happened to them and they felt very overwhelmed.

“I felt so lonely that there was no-one there (uh huh) and I felt that I was always terrified and always on edge about being alone (ok) and I just felt like em.. I was completely on my own and no-one felt the same way as I did (yeah) and that nobody understood how I was feeling (hm) when they did but I just felt that they didn’t (yeah) yeah...”

Participant 6

“yeah cause I didn’t really notice what I was doing and then.. I then got worse.. like I get.. I was quite low as well (yeah) and it was sortof like a hole and.. as I got further and further down.. the disease started to take over as well so (ok) I didn’t see what I was doing...”

Participant 7

There were also some accounts of participants experiencing acute levels of distress. Some participants acknowledged that they found it difficult to relate to other people and would “snap” or have “tantrums”.

“em.. (4 secs) well I did actually notice that I was always really angry with my friends for some reason.. like they’d say something that was just perfectly reasonable and I’d just get annoyed with them (right) and just snap at them for absolutely no reason. I didn’t associate that with anything but I just think I did think that I was getting a bit over the top.”

[sounds ashamed]

Participant 2

“and I wouldn’t eat certain things and I would make take tantrums if I had to and they would try and get me to eat as much as possible (ok) and try and get me out of that habit (yeah) but eventually it just kindof got really bad and just rapidly went downhill.”

Participant 6

In addition, some people reported having an emotional breakdown as a result of their level of anguish and confusion. They described feeling besieged by their emotions and finding this a frightening experience.

“em.. I don’t know just kinda scary (yeah).. what’s going on [quieter].. and it would just get so out of control be crying and crying I don’t know what and then like you’ll, if you’ve ever been crying and like you get sortof tired (mm hm yeah you do) but I’d sort of push myself to keep crying and crying and then em and they.. I’d.. there were sometimes like I sometimes used to go for a drive in the car with my dad [quieter] (hm) and once I tried to open the door and get out the car when it was moving and [very quiet] .. stupid things like that cause just felt like I’ve had enough I want to end it (hm) but I would sortof chicken out...which I’m sortof glad now [slight laugh] (yeah) but..”

Participant 3

“And then that night just total kindof broke down everything it was just kindof all of that but it was so strong yeah (ok)..

[tone very sad]

..hm.. I think it was probably cause, I think because I’d been told all that stuff the day before and it was just all happening (mm hm) so quick and everything (mm hm)...

(...)

like.. when I’ve spoken to my dad about it now he said I was just like... crying for like 3 hours and kindof like hitting myself against the wall and everything and I totally can’t remember that thinking about it now (ok) but... I think my dad just didn’t know what to do at the time”

Participant 5

“that day I just rushed home at first I was just really really really annoyed (uh huh).. I remember picking up a coat hanger just throwing it at the wall and then turning up my music really really loud (yeah yeah) and then just smashing a lot of things throwing things tearing down posters (yeah) and then.. that anger.. turned into.. anger to myself (yeah).. and then that.. turned into really really sad..”

Participant 8

In light of the emergence of the significance of the emotional impact and the interpretation that these emotions could be experienced as overwhelming, I thought it was important to consult the literature base to determine what is already known about emotions in Anorexia. This acts as part of the triangulation process.

Bruch (1974) first wrote about the emotional impact of Anorexia. It was stated that as well as having difficulty discerning hunger and satiety, people with Anorexia experienced emotions as bewildering. It is my impression that Bruch’s findings led to more investigations into Anorexia and emotions.

Recent literature on emotional regulation in Anorexia has considered that alexithymia is prevalent. Alexithymia describes when people have “no words for emotions” and refers

to a poor capability of recognising and verbally expressing emotions. It has been shown that this feature was also present in adolescents with Anorexia (Zonnevijlle-Bendek et al. 2002, 2004). The studies showed that there was a specific emotional deficit rather than cognitive problems.

This study has shown that the participants all experienced a degree of emotional turmoil. Although they were able to comment on this in the interviews, many of them said that at the time they did not understand their emotions. In their experience of emotions being overwhelming, they described being more aggressive and displaying their emotions through snapping at people or having tantrums rather than articulating their distress. Furthermore, when they recounted the most acute emotional experiences their language was more jilted and lacked clarity. They described an inability to express themselves vocally and resorted to more behavioural responses of risk taking, self-harm and destroying their belongings to express their distress. The paraverbals of these descriptions indicated that they were emotive in reciting these experiences as well. It has also been shown that people with Anorexia are more prone to silencing negative affect and this may be accounted for by excessive anticipation of distress (Geller et al. 2000). In light of this, it is paramount that therapy acknowledges the intensity of emotions that may or may not be explicit.

Further research in affect regulation and Anorexia has considered the lack of emotional insight. In a trilogy of papers Skarderud (2007a, b, c) explored the concept of reflective function in Anorexia. Reflective function refers to the psychological processes

underlying the capacity to make mental representations (Fonagy, 1989). It refers to the ability to understand oneself and others as a part of affect regulation. In Anorexia, emotions are concretised in a physical way and people with Anorexia are viewed as having impaired reflective function. This could partly explain how participants described the emotional difficulties in this study. As they found it difficult to understand their emotions and this became overwhelming for them. Again, it has been suggested that interventions should focus on rehabilitation from using the body to represent mental states to expressing emotions successfully.

### **3.4.2 Awareness of Anorexia**

The second main finding of this research is that awareness of Anorexia is something that develops. Diagram 11 shows the relationship between the overwhelming emotions and awareness of Anorexia. This will be expanded on in the discussion. It has been outlined in this study that there are different interpersonal contexts in which the individual lives. However, attention has also been drawn to how the individual experiences the early stages of Anorexia themselves. In reviewing the identifying and adjusting stages, the main themes that emerge from the individual's perspective that hold some density are around feelings of confusion, the Anorexia identity, of feeling trapped in Anorexia. These themes were over represented across the interviews and were viewed to be charged with meaning.

In the interviews the participants sounded quite despondent and confused when talking about the start of Anorexia. There was also a sense that they had succumbed to it without

full awareness. By taking a developmental perspective of the illness, the interviews and the categories that emerged demonstrated how this came to change. It is important to try to understand how this change progressed as it could potentially help to inform treatment interventions. These themes can be linked to the idea of awareness of Anorexia, whereby people are able to identify and attribute their difficulties as Anorexia.

#### **3.4.2.1 Lack of Awareness of Anorexia**

Referring back to the identifying stage in the descriptive section of the results, participants described feeling very confused by the concern that other people were expressing about their developing illness. They seemed unable to see what other people saw and they also depicted their Anorexia identity developing. They recounted some of the cognitive and behavioural changes that occurred with the progression of the illness. The accounts given were that this was not initially attributed as Anorexia, and was not thought to be atypical. They appeared to be so preoccupied by these elements, that it could be said they couldn't see the wood for the trees. This can be interpreted as the participants displaying a lack of awareness of Anorexia.

“but.. so.. I was still like it's hard to think how serious it is or it isn't (hm) cause it like happened to me so you never really think that it's serious if it happens to you”

Participant 3

“I thought it was a bit ridiculous.. cause I thought it's a bit of fuss (ok).. cause I kept passing it off that I was just tired I was just tired (ok).. and.. then.. I thought she was being a bit stupid or hypochondriac mother (ok) I think”

Participant 7



“and when people were telling me things, even when he was saying do you not realise that.. and he was saying oh look at all these signs of people who have anorexia and (mm hm) you’ve got all those things. And I was just kinda saying no that’s not true and..”

Participant 5

### **3.4.2.2 Awareness of Anorexia developing**

Referring to the adjustment phase in the descriptive section of the results, it was shown that the participants began to increase their awareness of Anorexia. As the controlling nature of the illness advanced, they felt very trapped in the illness. As well as observing the detrimental affects of the illness, they still felt compelled by it.

However, it can also be seen that the participants started to see a different perspective, this enabled them to begin to acknowledge they had an eating disorder. This can be understood as a change in awareness. While previously they were very detached from recognising the illness, as their awareness progressed they were able to admit it for themselves. Participants reported different ways of gaining awareness. Some participants described quite a sudden realisation, whereby they were shocked into recognising Anorexia. Other participants described that they were conscious they had a problem and once someone else had identified it as Anorexia they were able to agree with them. Finally, some participants described a more gradual change of awareness of Anorexia. As they received treatment they began to recognise the degree of the illness more.

“and that I’d seen um um in history and things we’d seen all these people that were like..em.. like how like in war world war 2 or something (yeah) they’d all been starved and things and then I thought -I look like that [tone sounds astonished/disbelief] ohh [louder, laughs] this is like getting serious (ok) and I think I I started to realise that like well I’ve lost a bit to much weight here (ok) and I’d I wanted it to stop (hm) but once you’ve got into that you just can’t stop (yeah) it just it just kept going and em..”

Participant 3

“yeah well with the switch being flicked on it was like all the connections (mm hm) could now be finished (mm hm).. cause before it was like the thoughts could get into my head so far and I would start to sortof logically process them (yeah) but then they’d be hitting off this brick wall (yeah) and they couldn’t finish (ok) but then.. they was suddenly able to finish.. so then I looked in the mirror.. and I saw.. every bone in my body sticking out (mm hm) and... I saw my hair.. thin.. and.. all the physical things (ok) and then I felt kinda all the things as well.. I felt the incredible fatigue and... jst.. hunger.. and I saw what everybody had been saying about how.. that I was getting out of hand I saw what a recluse I had become as well (ok) and how lonely I’d kinda made myself (yeah) and that’s kinda hard”

Participant 7

“Interviewer: ok.. and how did it come.. that.. it was kindof recognised as being a problem did you recognise it yourself (no) or was it more your parents?”

Participant 6: my mum and dad did (yeah) and I kindof eventually when they mentioned it I knew that something wasn’t right. (right) and then that’s when they took me to the hospital..”

Participant 6

“so eh.. well.. he... well I sortof... well I admitted that I had an eating disorder or I think I had a problem I said (yeah) I don’t know what I think... you know I was feeling really stressed.. so I just thought.. I had to voice it out (yeah ok) em..”

Participant 4

“but I think as time went on and I.. did start eating and then cause kindof my well my brain I think my brain was working a bit more properly and I started to think a bit more rationally about things and I thought... I just need to keep going with this... even though I was really unhappy with things, my size.. just thought this is what I’ve got to do so..”

Participant 5

Awareness into Anorexia can be linked to their motivation to address their problem. Whereby if they lack awareness, they are unmotivated and as awareness develops so does motivation. This led me to think about the theories on what leads a person to obtain awareness and motivation. Referring to the literature facilitates triangulating my findings.

Prochaska and DiClemente's (1983) transtheoretical model of change is a useful framework to consider how awareness plays a role in Anorexia. The transtheoretical model of change proposes that behaviour change involves stages of change. The stages are precontemplative, contemplative, preparation, action and maintenance. The model has been applied to a number of health behaviours and has been assessed for its applicability with eating disorders. Hasler et al. (2004) found that stage of change is an independent dimension that is relevant for treating eating disorders. A study involving 115 people with Anorexia found that 80% were in a pre-action stage of change at the start of treatment (Rieger et al., 2005). This seems to be congruent with the description of participants' limited awareness of Anorexia in this study.

In engaging with people with Anorexia it is important to assess their awareness into the problem and motivation to change. It is then possible to tailor the intervention to suit the individual. If they are at a precontemplative, contemplative or preparation stages the first task of the intervention might be consciousness raising and enhancing motivation. Touyz et al. (2003) recognised that Anorexia is a functional illness that has some adaptive advantages which the individual does not want to relinquish. They distinguished that if the stage of change and the goals of treatment are incongruent, then resistant will occur.

Therefore, they devised a day programme that aimed to meet the needs of the different stages of change. This seemed to be a more robust service that accounted for a patient's stage of change and how that would relate to individual treatment.

### **3.4.3 Responses to interpersonal interactions**

The third main finding of this research is that the impact of emotions and the awareness of Anorexia influences how the participants responded to interpersonal interactions, as illustrated in Diagram 11. This will be interpreted further in the discussion. It is known that adolescents belong to a number of different systems. Their primary system is the family system, then the peer group system, school/college system and wider society. In addition, once they enter into mental health services, they are also part of the National Health Service system. While they are experiencing the early stages of Anorexia, how they respond to these systems can be seen through the interpersonal interactions. In this study interpersonal interactions refers to the individuals interactions with the close others and professionals, as was outlined in the descriptive section of the results.

It has been demonstrated that there is substantially greater defensive pathology in eating disorder groups in comparison to controls (Steiger et al. 1990). In this study it was found that the participants would respond in a defensive manner to interpersonal interactions. Their responses are also linked to the participants' awareness of Anorexia and stage in the model of change. As when they lacked awareness they used more primitive defence styles such as denial and deception. Once awareness is starting to change, but the illness

still has a strong hold, the defences triggered are more active and involve control and resistance.

Participants' level of awareness of Anorexia can also be seen to be connected to their ability to engage in interactions with people in general and also treatment interventions; whereby the greater the level of awareness, the more able they are to engage. The interviews provided information on the range of responses that people have around engagement. The categories that emerged from the interviews showed that the participants responded to interpersonal interactions in different ways. Some of the responses demonstrated an impaired ability to engage with others. In addition some accounts were given of being able to comply or collaborate with others. Finally, some responses indicated that participants tried to oppose interactions with others. These areas will be considered in turn.

#### **3.4.3.1 Interpersonal Interactions – Impaired ability to engage**

A theme that emerged was that some participants felt unable to engage at all. They described feeling detached from reality. The impaired ability to engage in interpersonal interaction was shown through coding of examples of denial throughout the research. In interpersonal interactions there was a clear inability in seeing Anorexia even when it was blatantly pointed out. This could be seen in different settings. For example, with close others and professionals they reported hearing other people telling them about the seriousness of Anorexia but being too unwell to take this on board. They depicted that

they would immediately refute what they heard. This then led to their feeling that they could not answer questions or engage with treatment.

“I don’t think I really at the time understood anything (yeah) it’s not, I don’t really think it’s until quite recently like even until the last couple of months that I’ve started (ok) to look at it a bit more and kinda reflect on it a bit more and kindof understand things (mm hm) mm.. and what was going on at the time I think because maybe because I wasn’t eating.. that just made me... basically like a zombie and not remember things...”

Participant 5

“I just didn’t really think about it.. it just felt normal like the thing to do (ok) and like I noticed that I stopped thinking about things... like I had a very em... strict way of thinking like one.. sided you know (yeah) and usually you know my personality is not like that”

Participant 8

“em... (3 secs) sometimes not a lot but just like she was crying and she could feel all my bones and things (ok) [tone flat] and there was once when... she I found her really upset (hm) and she said she didn’t want to lose me... (hm) and I felt a bit like.. “nah I’m alright” [tone higher, jokey] (uh huh) you know but “ah no I’ll be ok, bit underweight you know but” [tone higher jokey, slight laugh] but I’d got like skeletal [laughing] (laughing) yeah (ok) so I just people being upset”

Participant 3

“em.. it was quite upsetting talking about it (yeah) cause... really I didn’t understand what he [dad] was saying (ok) or see how true.. em... and he used to get.. upset because I couldn’t see it (yeah).. and ... so..”

Participant 7

“Participant 2: em (4secs).. there was a time when I used to go like I used to go to a basketball club (right) and usually in the break all my friends would go outside and just chat and stuff but em I used to stay inside and I used to keep running around the hall so it was just everyone thought I was being a bit stupid and stuff so (hm) (...)

Interviewer: and did you think it was funny that you were staying in or what did you think about it?

Participant 2: (3 secs) um I didn’t think it was weird.. but like I was the only person there apart from a couple of guys who played football (ok) and the coach so.. em..yeah(4 secs)”

Participant 2

“I reckon I just I think I just kinda felt quite alone and didn’t really (hm) and didn’t want anyone cause everyone was telling me like my boyfriend was always telling me oh there’s something wrong and you should be going trying to get someone to help you and I was saying oh there’s nothing wrong [slight sigh] (ok)... yeah...”

Participant 5

“it’s like when I was in outpatients em.. the guy that was working with me told me that this disease had a 30% mortality rate (ok) and my mum was so scared and she was so upset but I just.. just like so what...” [more quiet when saying “so what”]

Participant 7

The participants also described using deception as a way of avoiding interpersonal interactions. They seemed to find interacting with people very difficult and at times felt unable to engage in interpersonal interactions. In the family setting, the deception was mainly around restriction of food. Most participants described trying to hide what they had eaten from the family. In the peer group context the deception was primarily to avoid socialising although avoidance of food was also apparent. Participants expressed actively making excuses to try and hide Anorexia or avoid interpersonal interactions. The participants provided many examples of deception and this adds to the secretive aspect of the disorder.

“Participant 4: and I I was I’d just kinda say I’d try to lie to them and just say I was alright (mm hm) em.. and.... I think all of a sudden I’d think they’d believe me but they sortof had to take their wor my word for it (yeah..ok).. hh

Interviewer: and what was it like um.. lying or trying to make excuses about things?

Participant 4: em.. {2 secs} it was quite hard to make certain lies up and to always have to lie to my parents about it cause you did you did sortof want it.. voice out and say you did have a problem but again you didn’t want to admit it (hm) or you just you didn’t know what to say.. I don’t know why, but it’s really secretive (yeah it is) mm illness so eh.. I ju I just I thought I would get quite upset that I I had to lie all the time (ok) {2 secs}”

Participant 4

“Think cause I was like taking like diet pills and all these things as well I was trying to hide all that from everyone and make sure kindof (yeah) people didn’t know that I was doing that (yeah). So I felt like kinda bad cause I was hiding everything from everyone but it was kinda like my thing that I had (mm) that no-one else knew about (mm-hm mm-hm) so it was like that.

Participant 5

“em..i’d just say I had to go somewhere with my mum with my mum (ok) or just lie basically (ok) and usually I was quite busy in the weekends anyway.. well I had my football game on the Sunday (uh huh) and.. I used to go watch... football games on the Saturday (ok).. so I was quite hh”

Participant 4

“yeah at the time I would sometimes I would even make excuses not to go with them {friends} if there was any food involved.”

Participant 6

“em...think it..was...was very difficult sometimes (yeah)... you just had to make a lot of excuses all the time (mm) and you kinda had excuses set in your head (mm) if someone asked you if you wanted something to eat you’d say no I’ve already had something or I don’t like that or (mm hm).. something like that (yeah)...”

Participant 5

It could be that there is an impaired capacity to engage with others, whereby when people are low in mood they can find it difficult to concentrate. However, the accounts given seem to indicate a different quality to their incapacity. The literature base was consulted as a means of triangulating my findings.

Recent research in the neuropsychology of Anorexia has supported the clinical observation of poor cognitive flexibility. For example, they have been found to have a rigidity of thought and demonstrate poor performance in set-shifting tasks (Treasure et al.



2007a). Thinking style can be considered as a core component to the pathology of Anorexia and it can be relevant to the development and maintaining cycles of Anorexia (Lena et al. 2004; Schmidt & Treasure, 2006). This cognitive deficit can also be an obstacle to patients benefiting and completing psychological treatments. Tchanturia et al (2007) suggested that it would be useful to undertake neuropsychological profiling as part of the assessment process. They also recommended utilising cognitive remediation therapy to improve the thinking processes rather than the content. Their study suggested that cognitive remediation therapy may be beneficial for acute and treatment resistant Anorexia patients.

#### **3.4.3.2 Interpersonal Interactions - Compliance and Co-operation**

Some participants described that they knew they had to adhere to what people were suggesting. In the early stages this tended to be a response from younger participants and may refer to their level of maturity. Their responses showed that they felt they had to comply with what other people requested from them. This indicates a degree of acquiescence. This compliant aspect of Anorexia is supported in the literature, which outlines that people with Anorexia can minimise their own needs in order to preserve close relationships (Geller et al. 2000). In addition, it was reported by other participants that as their awareness changed they were more able to engage with services. This led to them to being able to have more of a collaborative therapeutic relationship and co-operate with treatment.

“just get really upset but eventually I would end up doing it again, my mum.. I would just give in (ok) but em... it was... em.. I would be like there’s no way I would do that I would never do that I’d never eat that (yeah) there’s no way I would eat that (Yeah) and then eventually I would just give in and end up doing it anyway so there was no point fighting it and it got to the point that (yeah) it was pointless cause I was going to end up having to do it anyway”

Participant 6

“She would just standing there (right) and basically just walk in my way totally (oh ok) and I was just getting really annoyed and em.. she said just have one more and I sort of I was saying no way and then like em eventually cause like we were standing there for absolutely ages arguing (really) so eventually I had like one more grain {of rice}.”

Participant 2

“like even all through my outpatient thing and the doctor {GP} thing \*outpatient worker name\* used to say.. oh well you’ve done one thing at least you’ve come here but I used to think that’s so stupid my mum brings me [slight laugh] (slight laugh) it’s not like I’m coming myself if it was adult then I could go out and make my own way there and stuff (yeah) then perhaps it is a big step to go to an outpatient department (yeah) but if you’re mum’s taking you and like practically taking you by the hand (ok) to get you through the door then.. it’s kinda just what you do.. also.. I’ve not always been obedient but I norm.. like I do what I’m told (yeah ok) so..i think it’d probably part of my schooling as well like the way I’ve been brought up (ok) and so.. I thought it was a bit weird that people were making these comments.”

Participant 7

“Participant 6: they {GP} didn’t say much (uh huh) they just knew in some way that something wasn’t right and they told me.. that I had to go to the hospital

Interviewer: ok and what did you think about that?

Participant 6: I was quite upset about it but (hm) I knew myself that something wasn’t right at that point and that maybe I’d feel better about myself if I did go...”

Participant 6

“Participant 8: It felt like she {CAMHS professional} got what I was talking about... she said some things that I would agree with basically...”

Interviewer: What would she say?

Participant 8: Well she'd say well your mood has changed... she'd just point out things (ok)... but I would actually listen to her... actually listened a wee bit.

Participant 8

“We got the phonecall I was.. I was relieved actually (ok).. that I was going to the inpatient unit (right) yeah.. cause I knew I was going to get help and intensive care (ok) I knew I was going to get back so (hm.. ok)

(...)

but i.. I just said to them I think this is the best thing for me (ok).. so... eh.. so I was agreeing that I want to go hm..”

Participant 4

### **3.4.3.3 Interpersonal Interactions - Opposition**

Lastly, it was interpreted that some participants would use defensive processes to oppose interpersonal interactions. They spoke about actively resisting engaging with people and professional services in particular. This can be linked to when they are gaining awareness, but are also holding on to Anorexia. They described feeling under attack by both the level of vigilance of parents and the intrusive questioning of professionals. Considering the secretiveness of Anorexia and its hold over their identity, the participants' defences were set off and they would resist engaging in interpersonal interactions through different means.

### **Opposition with Family**

In the family context, participants were found to use control as a defensive response and can be seen as retaliation against the enforcement of others. The process of control is paramount in Anorexia and will be outlined by triangulating this study's findings with literature on Anorexia and control. Control can be understood as a psychological

response to the intense emotions that they were feeling and the unsettling context of adolescence and adjusting to admitting that they had Anorexia. As well trying to control their eating and exercising, participants described trying to maintain a feeling of control over other aspects of their life. During this complex and emotional time, participants said that they were unable to express themselves rationally and clearly. They would therefore control their behaviour as a means of communicating their emotional distress. There is a sense of the individuals feeling more anxious and attacked which results in them becoming more defensive.

In addition, the participants showed opposition through resistance. This was shown through not taking on board close others' attempts at persuasion or resisting interpersonal interactions in general. The responses indicate that it also evoked a strong determination within the individuals. This again highlights the participants' feelings of desperation and clinging to their defences.

“I didn't like it I think that part of the thing was to get the control over what it was (yeah) cause a lot of things I didn't like about myself and I hated the way I looked (hm).. stuff like that and I think that was one thing [referring to eating] that I knew I could change (ok) so that's why I thought so much about that..”

Participant 6

“that was one of the worst things just realising that you were kindof.. so alone with everything and (yeah).. you couldn't tell anyone (yeah).. I think as well the other bad thing was just feeling so guilty all the time about everything (hm) just.. feeling.. feeling like you had to do things like you had to go to you had to go to the gym and you had to go out for a run (yeah).. and you thought that you were in control of everything when really it was in control of you (mm hm)...yeah...”  
[emphasised “had”]

Participant 5

“em.. she would try and encourage me to eat and stuff like (uh huh) when I first.. was getting really.. rude with my eating (yeah) and I started to get really controlling and I’d only eat stuff that I’d made myself”

Participant 7

“it was quite hard cause I was really close to them at that point (yeah) I’ve always been close to my mum and dad (yeah).. but.. we were just arguing a lot more and stuff because I think the fact that they were making me eat something, everything else was kindof even if it was something like tidy your room (yeah) I’d go mad because they’d already told me what to do with the eating so (yeah yeah).. cause I thought that they had so much control over everything that I did (uh huh) and I wanted some control back”

Participant 6

“I think that the hardest things was having to eh..em.. like eat and stuff.. actually being told what to do (yeah) I hated that part of it that I had no control over what I had to do (ok) cause usually I’d just do everything by myself (yeah) and be quite independent (yeah) but I had to have that completely taken off me cause I wouldn’t be allowed out em for my lunch and stuff in case I wouldn’t have something unless people were watching me (yeah) like close friends or em.. relatives stuff that I wouldn’t be able to say if I hadn’t eaten.”

Participant 7

“I think when stuff like that happened as well it’d make me want to eat less (hm) like i.. I wouldn’t do it at all.. would just think... them actually getting angry at me about eating made me not do it (yeah).. because that was a way of me getting back at them, cause they were just kinda you’ve got to eat something you’ve got to eat something.. and then getting angry at me about it and the more they got angry at me about not eating the less I’d have because (yeah).. that was the way of making them more angry”

Participant 5

“Well I kindof didn’t want to spend as much time with her (ok). Cause otherwise it she usually ended up commenting about food or something (ok) hm”

Participant 1

“again they’d just argue with me and ss try to eh see how how many people have told you about.. eh.. you know this.. that you’re doing too much exercise and I just again wouldn’t listen (ok) hm... I’d just say -yeah I accept it- but wouldn’t listen to them, just to stop the argument.”

Participant 4

### **Opposition with Professionals**

The participants also described being more resistant in interpersonal interactions with professionals. This could be done in an active way by deliberate resistance or in a passive manner through avoidance or being unable to respond. Participants recounted using a number of means such as lying, leaving the session, changing the topic or distancing themselves from the questioning. They were found to have increased determination and continued to demonstrate trying to maintain control over their lives as it provided them with something to focus on and a feeling of accomplishment, which improved their feelings of self worth.

“em.. well I told I told my dad that I wasn’t going to speak because it was him that had the problem and not me so when I came into the doctors and they said what’s wrong I was just saying I didn’t think there was anything was the problem so then the doctor was confused and was like.. ok...”

Participant 5

“I I probably would cut back at times and I would just kindof change the subject almost [lighter laughing tone] (laughing) (ok) but em I didn’t find it helpful at all cause I would have just talked to my mum about that and.. things that I already knew and I didn’t find it helpful to talk to someone (yeah) that I’d never.. talked.. met before, things that I already knew.. and that I’d already brought up (ok) so I didn’t find that overly helpful”

Participant 6

“oh I got really upset sometimes and (mm hm).. there was a couple of times that I walked out (right) and just waited by the door (yeah) but that made it worse”

Participant 6

“.. I remember half thinking I probably lied about some of the things cause I kindof thought well if I just.. lie about it then it’ll be alright... {4 secs}”

Participant 5

“no.. I well at the first meeting with them I thought I didn’t think it was going to be any help at all and sortof went in with the view oh it’ll be interesting to see how all these things work [higher tone] (ok) it was more me finding out how they treat mental health in the NHS than anything else (slight laugh, ok)..”

Participant 7

“I think that once I came over here I just wanted to get out so badly (hm) that I thought I’m just going to do this and in my head I thought och I’ll just do it and I’ll.. eat I’ll eat everything until they.. til I’ve put on weight and then I’ll get out of here and then I’ll just do it again and then this time I’ll be more careful that people won’t realise”

Participant 5

“just really the nutritionist I really didn’t like cause she was the one that now looking back on it I think the reason I didn’t like her was cause she was telling me what to do and I like having control over things (yeah) and being able to choose what I could do and what I couldn’t do”

Participant 6

“Participant 8: It just felt it was always something that I was accomplishing (ok) cause I don’t really accomplish things I start something but then I think I can’t be bothered..

Interviewer: So it gave you a feeling of accomplishment?

Participant 8: Yeah and just I think it all started cause I was a bit sad.. I know a lot of girls could start cause they want to lose weight or they feel fat... I was just a bit down.”

Participant 8

“em... {2 secs} I think I just remember at the doctors and here getting like blood taken and everything (ok) and people telling me.. like lady this lady was telling me that what I was doing was.. so dangerous and like you could was so close to easily dying [“dying” emphasised] and everything and (right) all your kindof...organs are being destroyed and I just kinda thought in my head I don’t I don’t care about that I’d rather.. I’d rather keep doing this and be thin than be.. have to eat anything I’d rather do anything else than have to eat. (ok) so I didn’t care I didn’t care that all these people were telling me that I could die (mm) and that you were really ill (mm) and stuff (mm hm)... {2 secs}”

Participant 5

It is widely upheld that exerting control is a central feature of Anorexia. The literature on Anorexia and control puts forward that the perceived need for control can be understood

in light of the perfectionistic qualities and low self esteem of people with Anorexia, whereby control provides an improved feeling of self-worth. In the early stages of Anorexia, it has been found that there could be a need for control in general and people with Anorexia may try to control various aspects of their lives. This then develops into prominently controlling weight and eating (Fairburn, Shafran & Cooper, 1998). Slade (1982) proposed that controlling food provides a direct and immediate evidence of control. This is not necessarily possible in other areas that could potentially be controlled, which could be more under the influence of other people.

It has also been proposed that exerting control within Anorexia can have a powerful effect on others in the interpersonal context, particularly when pre-existing dysfunctional relationships exist (Fairburn et. al., 1999). In addition, considering Anorexia in adolescence it is important to acknowledge that this is a complex time of transition. Control through Anorexia may provide a means of stopping or reversing puberty and halting the tasks of adolescence (Strober, 1991). Feeling in control can therefore be viewed by the individuals as an advantage of Anorexia (Lask et. al., 2007).

The theme of opposition again highlights the importance of taking into account individuals' level of awareness and readiness to change. If there is discord between the individuals' stage of change and the treatment intervention, then resistance will occur. This led me to review what barriers are known to prevent treatment adherence in Anorexia.



An upheld barrier to treatment engagement in Anorexia is social anxiety (Goodwin & Fitzgibbon, 2002). It has been demonstrated that social anxiety and Anorexia can be co-morbid (Halmi et al, 1991). If someone is socially anxious, they fear humiliation and rejection and this could then impact on their interpersonal interactions. It has been demonstrated in this study that at the early stages of Anorexia, participants found interacting with people more difficult. This was across the contexts of peers, family and service. They recounted feeling more self conscious and coped with this through avoiding people and isolating themselves. In considering this, it is likely that beginning treatment could activate social fears of evaluation and result in resistance.

The physical nature of Anorexia has led to some research into people who refuse treatments (Goldner et al., 1997). However, there is less attention to treatment resistance. As some degree of treatment resistance is prevalent in Anorexia, this raises the ethical issue of to what extent intrusion of a patients' autonomy should be made (MacDonald, 2002). This consideration is often made in light of the individuals' degree of illness and refers to their levels of awareness and resistance. I believe that this is an area that is often overlooked when working with people with Anorexia. It is my impression that working with Anorexia evokes repeated ethical dilemmas, which warrant some reflection throughout therapeutic work.

## **4. Discussion**

### **4.1 Researchers reflections on research process**

During the research process I kept a reflective diary of my thoughts whilst conducting the research. This was mainly in relation to undertaking the interviews. In addition the memos helped me to reflect upon and evidence how my interpretation of the data developed. I have also considered the impact of researching **the early stages** of Anorexia in adolescence alongside working in this area. Each of these aspects will be considered in turn.

I reviewed my reflective diary and noted themes from each entry. Overall, the reflective diary demonstrated the process of becoming more confident in conducting the interviews. In the early interviews I noted uncertainties about achieving the balance of asking questions to gather rich information, without directing the interview. In the pilot interview I was more passive and as a result gathered quite surface level information.

As the interviews progressed and I had started coding, I was more aware in the interviews of the themes that were being repeated. Once a preliminary framework had been developed this was openly taken into interviews five onwards. I felt more capable in carrying out the interviews and became more aware of what would constitute a “good” interview with detailed information. While this helped me to feel more confident about asking for the details of their experiences, it also created a slight anxiety about the consequence of the interviews providing me with my data. I was also aware of the

importance of the research in terms of it being a requirement in my Doctorate of Clinical Psychology training.

As my confidence in the interviews improved I noted feeling more able, which in turn helped to set a relaxed tone for the interviews. In addition I felt that all of the participants spoke freely about their experiences. I think it helped to have a discussion about participants' suitability prior to approaching them. I also think it was useful to have an initial meeting with each of the participants to help them feel at ease. In general I felt that the participants were very open in the interviews and generously spoke about their experiences.

It was interesting to observe the different quality to conducting interviews compared to clinical work. Although the coding of paraverbals has been helpful in interpreting the nuances of the interview I was struck by how the participants spoke about difficult times but never became overly upset to the point of crying. From my experience of clinical work with young people with Anorexia, if this were a clinical session I would have expected to see more expressions of distress. This illustrates the protective distance of an interview setting. In contrast to clinical sessions, I noticed that the participants felt freer to explore different areas as there was less of a structure. The interviews also seemed to provide a space which allowed the participants to vent some of their frustrations about the early stages of Anorexia. In my reflective diary I also observed the differences between the participants. This related to their age, gender and stage of illness. These individual differences will be considered further in the discussion.

The coding procedure raised similar thoughts and feelings on gaining competence. As this is the first Grounded Theory research I have undertaken, throughout the research I relied on repeatedly referring to literature and my supervisors' guidance. I think this made me ensure that I was being thorough in my coding and documenting the process of coding as evidence of the development of the final framework. Again as the process progressed I became more confident in my abilities. I feel that as well as producing a final piece of work I have also learnt a great deal about using a Grounded Theory methodology.

Lastly, I was aware of the mutually influential effects of conducting research in an area I was concurrently working in clinically. It was expected that my clinical experience will have influenced the research and also that the research would have an effect on my clinical work. It is likely that my clinical psychology training has helped me to use open-ended questions to shape interviews but not pre-determine them. My training has also meant that I am familiar with exploring topics to uncover the meaning they have for the individual. However, I was also aware that I had to be self-disciplined to not adopt my usual therapeutic mode.

It is also probable that my clinical experience impacted on my perception of themes that emerged in the research and it was useful to consider my pre-existing knowledge and expectations of the research prior to starting the interviews. This allowed me to be mindful of my biases throughout the research process and ensure that my interpretations were grounded in the interviews.

As the themes emerged and I began to see similarities across interviews, I also noticed parallels in my clinical work. During the course of conducting the research, the young person with Anorexia I was working with entered the Tier 4 Day Programme service. I therefore had less of a case managing role, as this was held by the Tier 4 team, and I took on a more reflective role. The research findings were useful in cuing me to consider some of the complexities of the interpersonal and emotional impacts of Anorexia in a therapeutic way. I observed that in sessions with the young person, I began to frequently facilitate the exploration of her interpersonal interactions. I would also help her to learn to identify and tolerate her emotions more. Furthermore, I anticipate that in the future I will be particularly mindful of the findings from this research when assessing and initially engaging young people with Anorexia.

I also noted in my reflective diary that it was interesting in the interviews to have a distance from addressing Anorexia. As I was not in a therapeutic role I did not need to formulate or challenge things as they arose. This provision of space to explore the early stages of Anorexia more freely was a valuable aspect to undertaking interviews alongside clinical work in this area.

## **4.2 Participants**

### **4.2.1 Age of participants**

A factor that that emerged as important to consider was the age of the participants. As has been outlined in the introduction, the period of adolescence is a time of transition and

development. Furthermore, it is a time when the peer group is more fluid and identities evolve. As progression is made through adolescence, the peer group become more significant. It was clear from the interviews that the age of the participant played a role in how they described the importance of their family and peer group. Younger participants spoke more about the family as their main interpersonal context and were more emotive when talking about interactions with family members. They spoke about peers as a system of which they were a part, but one that had less importance. In comparison, older participants spoke about both family and peer groups at length. The peer group took on a greater role and those relationships had more depth.

It is also important to acknowledge that as Anorexia is both psychological and physiological, it necessitates increased supervision from parents and professionals. Some participants could be viewed as seeking this increased interaction from their parents, in the context of having enmeshed relationships and stalling developmental progress. However, others were more humiliated by this level of supervision. It therefore might be useful to not only consider the age of the participant, but their level of maturity.

#### **4.2.2 Developmental stage of illness**

It also became clear that their stage in the illness was important to consider. It impacted on how they understood and reflected on their experience of the early stages of Anorexia. Some participants were still relatively near the beginning of treatment, having had approximately three months contact with professional services. They commented in the interviews that they were only beginning to understand how Anorexia had developed. In

contrast, some patients had been receiving interventions for approximately one year. While they were able to think back to the early stages of Anorexia and remember accounts of things that happened, they tended to add a more contemplative dimension.

In addition, at the time of interview some of the participants were receiving Tier 4 inpatient services. While the interviewer ensured suitability with their clinician and gained informed consent, it may be that participants at the more acute end of Anorexia recounted their experience in a different manner to the participants who were currently less controlled by Anorexia. I observed that participants that were currently in the Tier 4 service were generally more flat in tone throughout the interview, whereas other participants were more expressive in giving their accounts.

### **4.3 Interpretation of findings**

There was a wealth of information and interesting findings in this study. The descriptive section of the results in particular outlines a number of themes. Unfortunately it is beyond the realms of this study to interpret the details of all the aspects of the interactions within the contexts of the close others and service contact. I have therefore drawn out the themes that were of most prominence and present them as explorative interpretations from this study's sample.

#### **4.3.1 Descriptive results interpretations**

The main purpose of the descriptive section of the results was to provide information on the context from which the main results were found. However, it is also possible to offer some interpretation on this section, by considering common themes. It was evident that there were some themes from the descriptive section of the results that were repeated across the interpersonal contexts. The first one was that the participants frequently gave accounts of finding interactions difficult. In the close others context this was mainly shown through conflict with family members. In addition with peers they described feeling more irritable and finding socialising difficult. In light of the struggle they expressed in contexts that were familiar to them and where they were known and accepted; it is understandable that they also found interactions with professionals difficult.

The descriptive themes also indicate that the participants experienced interpersonal interactions as threatening. This can be seen in the close others context through the theme of vigilance and in the professional context with the theme of restrictions imposed. These themes suggest that the individuals were dependent upon Anorexia at this time. This is associated with the defensive stance that is repeated through the descriptive section. It also compounds their feelings of loneliness and supports the position that people with Anorexia are scared of sharing their emotions (Geller et al. 2000).

It is also interesting to note the visible aspect of Anorexia that is different to other mental health problems. Whilst the individuals tried to conceal Anorexia, it was demonstrated



that different people observed the explicit changes that occurred. Once Anorexia had been identified, the participants were less able to conceal it and this came across as being potentially frightening for the individuals. This illustrates the incongruence of hiding an illness which is so physically visible.

### **4.3.2 Analysis of results interpretations**

The analysis of results illustrated in diagram 11 indicates the relationship between the main themes found. It shows that the array of emotions and participants' experience of them as overwhelming is connected to their level of awareness. This then has an impact on their responses within interpersonal interactions. These are the main findings of this research.

#### **4.3.2.1 Analysis of emotional impact and awareness of Anorexia**

It is my impression that during the early stages of the Anorexia when it is initially being identified and adjusted to, is an emotionally confusing time. In considering the emotional impact I deemed it important to consult the literature on the theoretical understandings of emotions. It has been outlined that the function of an emotion within a system might be to communicate to another person. The cognitive model of emotions places emotions midway between constructivism and realism. Whereby, emotions are partly formed by mental representations and partly through experiences in reality. (Power & Dalglish, 1997) This study has demonstrated the range of emotions that were experienced. In

interpreting these emotions, I considered that it would be helpful to regard the main emotions expressed in reference to literature.

One of the primary emotions expressed in this study was frustration. It was decided that it was more appropriate to code this emotion as frustration rather than anger as it was more frequently described at a lower level than anger, although some angry outbursts were also reported. Berkowitz (1962) formulated that frustration leads to anger which then drives and heightens the probability of aggressive behaviour. While this framework has been developed since its original conception, I think it provides a useful outline in understanding the process involved in frustration developing into anger.

In this study it seemed that participants were less inclined to express anger. This is an interesting finding as anger is considered to be a key feature in Anorexia, with people with Anorexia having a higher state anger (Waller et al., 2003). However, they have also been found to have higher rates of anger suppression (Horesh et al. 2000; Waller et al., 2003). It could therefore be considered that the participants were repressing their anger. Another possibility is that they were recounting a time of emotional confusion and were unable to express their emotions clearly. Furthermore, it has been shown that anger is more likely to be directed at another person (Averill, 1982). It is my impression from this study that the participants felt guilty about the impact they were having on other people and could have therefore wanted to minimise their expression of anger in the interviews.

This leads onto the emotion of guilt, which was repeatedly coded alongside the emotion of frustration. It has been found that there are significantly higher rates of guilt in adolescents with Anorexia (Berghold & Lock, 2002). Minuchin et al. (1978) pioneered the conceptualisation of young people with Anorexia being particularly loyal and protective of their parents in expense of their own autonomy, and guilt was viewed as the motivator behind this conduct.

In the literature, loneliness is considered to be an aspect of low mood (Harrington, 2002). However, in this study loneliness was coded as distinct to low mood as it was emerged as being a prominent theme. The literature suggests that with individuals experiencing low mood there is a preoccupation with an over-invested role or goal (Power & Dalgleigh, 1997). With Anorexia the perfectionistic standards can lead to feelings of inadequacy when expectations are not obtained. In this study it was noted that loneliness and low mood were repeatedly coded together. It could be that as the participants felt more isolated and lonely they also criticised themselves for not being the same as their peers. This could then impact on their mood. It is also widely held that a reduction of social activities can have a negative influence on mood (Fennel, 1989) and this could have also contributed to the findings in this study.

Additional emotions that arose in this study were fear and worry. It has been theorised that these emotions can be inter-related. Borkovec et al. (1986) suggested that worry can be viewed as a cognitive attempt to anticipate and avoid a myriad of possible future outcomes. Eysenck, (1992) proposed that worry had the functions of acting as an alarm

that introduces information on threat-related materials, a prompt to bring this information to awareness and a preparatory function to allow anticipation of future situations. In this study it can be seen that both fear and worry were related to facing up to the reality of Anorexia and the possible consequences of this.

Finally, the emotion of shame emerged from the study. Shame has been recognised as a central aspect of eating disorders (Goss & Gilbert, 2002). Shame is viewed as an adaptive reaction that protects against an invasion of the self which allows the preservation of relations as well as the person's sense of identity. However, it has also been recognised that too much shame can be self-destructive and result in withdrawal (Skarderud, 2007d). Studies on shame in people with eating disorders have found that they have elevated rates of both internal shame, whereby they have a negative self-evaluation, and external shame which indicates feelings that others look down on them (Goss & Gilbert, 2002).

In a recent qualitative study, Skarderud (2007d) found that people with Anorexia experienced shame about having an eating disorder. This was partly related to shame of having problem associations with food, but also considered the shame of having a psychiatric illness, which was also found in this study. The shame and secrecy of Anorexia was a prominent theme in this study, which is also upheld in the literature as part of the nature of Anorexia (Haller, 1992). This is connected to the stigma of mental health problems and Anorexia in particular. A community survey (Stewart et al., 2006) found that people with Anorexia are perceived as most to blame for their condition and were thought to be seeking attention. This concern was partly found in the participants'

responses in this study. In addition, they held self-persecutory worries that having a mental health problem would lead to them being considered mad. In light of the widespread perfectionistic standard that people with Anorexia hold, this could be an understandable fear. In this study they also expressed strong feelings of self-consciousness which may have intensified their experiences of shame and perceived stigma. Given that people with Anorexia find it difficult to understand and express their emotions and difficulties, (Zonnevillle-Bendek et al. 2002, 2004) they may view disclosing Anorexia as admitting personal flaws.

Further research has shown that people with Anorexia have inhibited expression of emotions. It has been suggested that they avoid expressing thoughts and feelings that are in conflict with those of others and prioritise other people's feelings over their own (Geller et al. 2000). Given this studies findings on the array of emotional experiences within interpersonal contexts, it is concerning that these emotions are repeatedly suppressed.

In addition, it has been shown that this study offers some support of the literature base for alexithymia in Anorexia (Zonnevillle-Bendek et al. 2002, 2004). Whereby, participants recounted that they found it difficult to understand their emotions during the early stages of Anorexia. This lack of understanding about emotions also impacts on the lack of awareness into the illness. I considered that the degree of emotions experienced and the level of awareness of Anorexia links to the individual's ability to respond to interactions. As previously stated, it emerged that participants found this a difficult interpersonal time.

If they were experiencing profound emotions but had a poor awareness of this, they responded in a defensive manner.

#### **4.3.2.2 Analysis of responses to interpersonal interactions**

During the early stages of Anorexia, it emerged that participants found interpersonal interactions difficult. They responded to this in different ways, some participants described an impaired ability to engage with others, some participants felt able to respond to interactions and a distinction was made between complying in an acquiescent manner and beginning to engage collaboratively. However, even as their awareness of Anorexia and its emotional impact improved, many participants still demonstrated opposition. This was described in both the family and professional contexts through control and resistance. Bearing in mind that one of the tasks of adolescence involves questioning and challenging authority, it could be important to consider what is normative age appropriate resistance and what is part of Anorexia. In this study, resistance can also be viewed in light of the early period of the start of Anorexia that was covered in the interviews. The research set out to explore the experiences of the early stages of Anorexia and at this time it is unlikely that the participants would have come to a point of acceptance of Anorexia. This is more likely to be something that would evolve through the therapeutic process. It is my impression that awareness of Anorexia alone does not infer a readiness to change. At this early stage it is apparent that participants were still holding on to their Anorexia identity.

It is evident that the early stages of Anorexia are a complex time. This can make gaining therapeutic alliance more difficult. A recent qualitative study (Tierney, 2008) explored young people's reflections of being treated for Anorexia. The main themes found were about accessing appropriate treatment, balancing physical and psychological care, identifying qualities required in professionals, and commenting on help from non-professional routes and perceived progress.

Some of this study's findings are in agreement with Tierney (2008). Tierney found that participants found accessing services difficult, particularly when they were treated with a lack of understanding and more focus was placed on the physical aspects. It was reported that participants valued therapists who understood the different dimensions of Anorexia and who challenged them in a non-judgemental manner. This relates back to the importance of establishing a therapeutic alliance with this client group and what is necessary for this to occur (Shirk & Karver, 2003). Furthermore, in a study regarding patients' perspectives on what aided recovery, it was found that supportive relationships, therapy and maturation were the three most commonly stated factors (Tozzi, et al. 2003). This links with the therapists' personal attributes and techniques that were documented to aid alliance (Ackerman & Hilsenroth, 2003). The current study suggests that it is imperative that professionals consider the emotional experience and level of awareness during the early stages of engagement.

Further parallels can be drawn between Tierney's (2008) research and this study.

Whereby, Tierney found that participants appreciated non-professional support and drew

out family support. This study supports this and has considered both familial and peer support. Finally Tierney also noted the importance of wanting to recover, which is linked to this studies views on the benefit of employing the stages of change model. Hasler et al. (2004) proposed that self-referral, emotional involvement and the presence of several change processes may be indicators of motivated patients. They suggested that therapeutic work should focus on the expression of emotions, to reinforce patients' readiness for change. This study would support this proposition as the results have shown that it is an emotionally confusing time which has an impact on people's awareness of Anorexia. Helping young people with Anorexia to acknowledge and identify their emotions may also facilitate their ability to move through the stages of change.

In recognition of the widespread resistance that is characteristic of eating disorders, in recent years there has been increased interest in utilising motivational approaches. Motivational therapeutic work was initially developed in substance abuse populations where people were found to struggle with motivation to change. Lask et al. (2007) outlined the benefit and use of these practices with eating disorders. The main premise is that the individual holds the power for bringing about change. It also posits that resistance is not a trait, but rather an interpersonal process. This has been demonstrated in this study by resistance in different interpersonal contexts. Motivational approaches acknowledge that trying to change behaviour in someone who lacks motivation will result in increased resistance.



Lask et al. (2007) outline the benefits of using motivational interview to draw upon values, motivations, abilities and resources for change. It is influenced by the client centred approach and outlines that the therapist should take a motivational stance. This involves them providing empathy, honesty, acceptance, humility, curiosity, flexibility and low investment. There is a clear overlap between these characteristics and the ones outlined in the introduction as important for therapeutic alliance (Ackerman & Hillsenroth, 2003). It therefore further promotes the importance of having a good therapeutic alliance prior to a focussed intervention. This allows the individual to feel safe to explore both the incentives and disincentives of recovery and to move through the stages of change. Motivational approaches are also beneficial as they can complement other therapeutic approaches which could be introduced later.

### **4.3.3 Interpretations on interpersonal difficulties**

This study has outlined the individuals' experiences of interpersonal difficulties around the early stages of Anorexia. It has been shown that this crosses contexts of close others – encompassing family and peers- and professionals.

#### **4.3.3.1 Interpretations on peer group**

In considering the peer group, a number of studies have suggested that there is impairment in psychosocial functioning of individuals with current eating disorders. The sharing of friendships is often found to be difficult for people with Anorexia (O'Mahony & Hollway, 1995; Tiller et al. 1997). While this was apparent in this study that

participants found interactions with peers difficult at times, it was also found that peers provided a means to escape their Anorexia identity. The importance of the peer group during adolescence and the facilitative role they play in maintaining an identity that is separate to Anorexia, may provide protective factors. It has been shown that when Anorexia becomes more entrenched the task of individuation and separation can fail to be achieved (Stern et al., 1981). If this task is not accomplished, then adults with Anorexia would be expected to have a restricted social network.

Another study (Deter et al., 2005) investigated predictors of favourable outcomes in Anorexia. They found that when severe social impairments were present there was a delayed recovery compared to people with minor social problems. Furthermore, people with minor social difficulties have a weaker recovery if they are not integrated into a job situation. It has been noted that psychosocial functioning and clinical recovery are highly interdependent (Strober et al., 1997). The clinical implication of this is that it is important to encourage the maintenance of social relationships and consider social skills training for people with poor social functioning.

#### **4.3.3.2 Interpretations on family**

Foulkes (1948) was one of the early writers on the importance of the interpersonal context. It was put forward that individuals are born into a network of communication processes which affect their nature throughout their lives. It is my impression that this premise led to the development of considering people within systems. It also facilitated

viewing the affects on people within interactions. Foulkes' contribution to the literature laid a theoretical framework for family therapy. In this study a contrast was seen between the peer and family context, in that it was not possible to ignore Anorexia in the family setting and it seemed at its most pronounced here. Many etiological studies have outlined the role of disturbed interpersonal and family functioning in the development and maintenance of Anorexia (McIntosh et al. 2000).

In particular, I considered the work of Minuchin et al. (1978) to be of relevance. They identified key characteristics in their work with families of people with Anorexia. These were enmeshment, over-protectiveness, rigidity and lack of conflict resolution. They proposed that Anorexia represents a maladaptive attempt at autonomy and control in an enmeshed family. All of these aspects were found in this study. These factors are seen to have an impact on failing to provide a "holding environment" and limit the individual's development (Strober & Humphrey, 1987). Whilst this study supports the existence of these processes, it is the acknowledgment of the accompanying negative emotions which enables a more empathic stance.

Recent research has considered the role of close others within a cognitive-interpersonal model (Schmidt & Treasure, 2006). It has been found that high expressed emotion is a predictor of relapse across psychiatric disorders generally (Butzlaff & Hooley, 1998). Furthermore, it has been reported that the main purpose of high expressed emotion is to assert dominance in an interpersonal struggle for control (Wuerker, 1994). In line with findings from Schmidt & Treasure (2006) this study found that in Anorexia this control

battle usually arises around meal times when the issue of food is unavoidable and increased conflict occurs.

Schmidt & Treasure (2006) also proposed an alternative explanatory function of the high expressed emotion interaction. This views its purpose as to elicit comfort and reassurance from the caregiver. This creates a mutually reinforcing cycle of care eliciting and overly involved care giving which can be linked to enmeshment. This premise was also found in this study.

Finally, consideration of the effects of Anorexia also emerged from the interviews in this study. Participants were aware of the distress they caused their families. It was shown that their siblings were less involved, but still experienced the affects of Anorexia. Participants mainly commented on the emotional effects their parents experienced. This finding has been found in other studies. Caring for a person with Anorexia has been associated with psychological distress and poor life quality of carers (Kyriacou et al. 2008). Schmidt & Treasure (2006) stated that high levels of expressed emotion in the family related to distress in parents and siblings. This is influenced by the family's experienced burden of care (Treasure et al., 2001) and particularly by their uncertainty of how to help (Haigh & Treasure, 2003).

The Maudsely Hospital in London has been at the forefront of developing family based interventions for Anorexia in adolescence. They found that with the recent onset of

Anorexia, family based therapy is superior to individual therapy (Russell et al., 1987) and this is sustained at five-year follow up (Eisler et al., 1997).

A family based treatment manual which outlines the approach has been developed and made available (Lock et al. 2001). It considers the over-protective nature that is apparent in parents of people with Anorexia. The family based treatment initially places the parents in charge of the weight restoration process and considers that the family is the best resource for the resolution of the disorder. Only after significant improvement is made is the adolescent supported to gain independence with food and symptom management (Lock & Le Grange, 2001). This method of therapy represents a combination of treatment models, including family meals as used by Minuchin et al. (1978) in their structural family therapy. Since the dissemination of the manual, its effectiveness has been evaluated and gained support as an intervention for adolescents with Anorexia (Le Grange et al., 2005; Lock et al., 2005, 2006). Treasure et al. (2007b) have recently added to the Maudsley method for working with eating disorders. They have written a skills based book which provides practical information and strategies for caregivers to use in the context of the Maudsley treatment.

#### **4.4 Limitations of the study**

The strength of undertaking qualitative research of gaining participants' subjective perspectives can also be its weakness. In this study as I was exploring the early stages of Anorexia, it is possible that the reports are subject to retrospective bias. The memory of

this time will have been influenced by the subsequent events of how Anorexia developed. It is difficult to regulate this and it therefore highlights a limitation of this study.

Additional limitations about the sample are that they presented a relatively heterogeneous group and it may have been beneficial to have been more selective in recruitment of participants. However, this is a poorly researched population who are considered to be difficult to engage. There was also only a small potential sample size from which to recruit participants from. It was therefore difficult to impose further restrictions around recruitment. If there was further time or recruitment from other geographical sites was possible, this could have helped address this limitation. However, this was beyond the possibility of this research.

The limitations of this are that there were differences in the sample. As previously considered in the discussion, the range of ages and maturity of participants influenced how they spoke about their relationships with the close others group of family and peers. It could be that if this research was carried out with more participants that these differences would have emerged as being more prominent and relevant to the findings.

It could also be viewed as a limitation that only one male was included in the research sample. It could be that he provided atypical findings to the females. It might have been better to have not included him. Alternatively, if time allowed and participants were available it would have been good to interview more males. It is generalised that males with Anorexia tend to over exercise more than restrict their food intake. This study found

that the male participant recounted that his eating disorder began by over exercising and then developed to include restricted eating. However, this was a development that some of the female participants also said. Overall, the coding of his interview produced similar findings to the other participants and supported the emerged themes. One difference that was found was that the interview style of the male participant was different to the females in that he tended to give shorter responses. However, this could just be an individual preference, rather than because he was a male per se.

Furthermore, as is the case with all qualitative research there is an element of subjectivity in the research. It is standard practice to account for this through the researcher being reflexive about their role in the research. I would therefore direct the reader to the sections on the researcher's position and the researcher's reflections on the research process. In line with qualitative methodology, the interpretations from this study are presented as explorative hypotheses that are based on the data from the interviews, rather than as an absolute truth. While it is possible that other interpretations could be found, the Grounded Theory methodology is rigorous in how the interpretations emerged and this has been documented in this research.

Some limitations can be highlighted about getting participants to validate the findings. Although the coding and grouping of themes was performed by an independent rater, it may have been beneficial to perform a reliability check with the participants. It is possible that interpretations could have been made that were different to what the participants meant by their statements. This limitation could have been resolved by

presenting the transcripts and coding to the participants for review. However, I thought that this process could be potentially detrimental to the participants. As they were still receiving treatment from CAMHS, they were still in a potentially vulnerable stage of Anorexia. Furthermore, as people with Anorexia are known to have perfectionistic standards, I did not want to impose the notion that the interview was something that they had to “get right”.

A further possibility would have been to enlist a young person who had recovered from Anorexia to perform an independent check on sections of transcripts with coding, to see if they made sense to them. Alternatively they could have been given groups of quotes and headings and asked to put them together. This would have allowed the researcher to see if other people would form the same groupings. However, it would have been difficult to recruit a suitable young person to perform this task as in this research setting young people with eating disorders routinely engage in group therapy. I did not want to risk confidentiality of participants being risked. In addition, I would also be concerned that using a young person would potentially put undue pressure on them to provide “the right” responses.

As this was an explorative study it started by asking a broad question. It is clear that this research produced a great deal of explorative results. It could be that it would have been better to start with a narrower question to begin with. This would have reduced the research area. However, I was keen to not be too restrictive in my opening question and



allow the participants to talk about what was relevant to them. Furthermore, using a Grounded Theory methodology allowed particular areas to be followed up in more depth.

However, there are also limitations with using a Grounded Theory methodology. In Grounded Theory an active decision is made to follow up particular themes. This evidently means that other areas that arose as relevant to the participants in the first four interviews were not explored further. While this is a limitation of Grounded Theory, it means that more in depth information is gathered on the themes that were developed.

Finally, although themes emerged and were validated through the repeated emergence of themes, there were some themes which had a minority of alternative responses. This was presented in Appendix 11 framework as adding different dimensions within themes. In this study the descriptive results are presented to set the context of the main findings which are presented in the analysis of results section. It was found that saturation was achieved for the superordinate themes presented in the analysis section. Saturation was felt to have been met for these superordinate themes as they were followed up in more detail in interviews five to eight, which ensured that the areas were able to be explored to the maximum. Furthermore, the coding showed that no novel themes were found in the final interviews seven and eight. However, if this research was continued with more participants either the themes presented would be given more support or alternatively it could be that different themes would have emerged. It could be that with further interviews the minor themes could be found to be more prominent. This is an overarching limitation of conducting qualitative research within a limited time frame; it is

always possible that additional interviews would produce different results. Therefore, the findings presented in this study only reflect the responses of its participants.

The generalisability of findings from qualitative research should also be considered. With a small sample size it is not anticipated that findings are presented as facts. They are rather explorative hypothesis that can be used to inform clinical practice or to be researched further. In this study the findings would be most generalisable with a similar population of adolescents with Anorexia. However, findings could be useful for adolescents with other eating disorders, in particular the increasingly growing population of EDNOS. In addition, it may be that findings are relevant to adult populations with Anorexia or EDNOS.

## **4.5 Clinical Implications**

The findings from qualitative research are among the many forms of research that may be useful to practitioners. The main findings of this research are that there is a strong emotional element to the individual's early experiences of Anorexia; that their awareness of Anorexia is something that develops; and that these factors influence their interpersonal interactions. The generalisation of findings from any research is not straight-forward and depends on the similarity between the research context and the clinical context. Optimal clinical decision making is based by balancing research evidence, clinical judgement and patient preference (Newman et al. 2006). It is within this understanding that recommendations from this study are put forward.

- In order to enhance therapeutic alliance and treatment adherence it is important to take account of the person's experience of Anorexia. One of this study's main findings showed that it is important to consider the emotional impact of the experiences of the early stages of Anorexia and this will vary from person to person. Furthermore, the individuals may have difficulty accessing these emotional concepts and its part of the therapist's role to facilitate this.
- In considering this research's main finding that awareness of Anorexia is something that develops, it is also recommended that the stages of change model is utilised to shape understanding of the individuals readiness to change. This will

allow interventions to be adapted to fit with people's stage in the process. The emotional work will also reinforce their readiness to change.

- This research's findings on awareness of Anorexia and responses to professionals also suggest that a motivational approach could be beneficial in working with young people with Anorexia as it allows an exploration of their motivation and ability to progress with treatment interventions.
- The descriptive section of the results and the main finding on interpersonal interactions highlights the importance of acknowledging the interpersonal contexts that young people are part of. The maintenance of peer relationships should be encouraged to preserve an identity separate to Anorexia.
- The role of the family was also shown to be significant in the descriptive section of the results and the main finding on interpersonal interactions. Family based interventions have been shown to be effective in not only helping to address the Anorexia, but also to aid progressing through the tasks of adolescence and achieving maturation through separation and individuation.

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