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Mirror, Mirror on the Wall: Exploring the Experiences of People Suffering with Eating Disorders

By
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Submitted in fulfilment of the requirements for the degree of:
Doctor of Psychology

Department of Psychology
City University, London

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Mirror, Mirror on the Wall

Table of Contents

Acknowledgements	7
Declaration of Powers of Discretion	8
Section A: Preface	9
References	14
Section B: Research	15
‘An Interview Study to Explore the Subjective Experiences of Inpatients with Eating Disorders in an Inpatient Unit’	
Abstract	16
Introduction	17
Eating Disorders	18
Types of Eating Disorder	18
Potential Causes of Eating Disorders	25
The Treatment of Eating Disorders	28
Overview of Literature	31
Studies on Professionals’ Views of the Inpatient Experience	32
Quantitative Studies on the Inpatient Experience	34
Qualitative Studies on the Inpatient Experience	36
Motivation for Recovery	42
The Transition from Hospital to Home	43

	3
The Importance of a Study Investigating the Views of Inpatients	43
Personal Relationship with Research	47
Information on Clinic-ED	49
Methodology	52
Research Aim	52
Qualitative Design of Research	53
Qualitative Research and Counselling Psychology	53
Epistemological Underpinnings of Interpretative Phenomenological Analysis	54
Epistemological and Personal Reflexivity	56
Validity and Reliability	60
Semi-Structured Interviewing	61
Method	63
Sampling and Participants	63
Procedure	66
Recruitment and Preparation	66
Pre-Interview Discussion	67
The Interview Schedule	68
Post-Interview Debrief	68
Methodological Reflexivity	69
Ethics	71
Analytic Strategy	72
Researcher / Participant Relationship	75
Results	77
Overview	77
Master Theme 1: Rules	78
Rules: Unhelpful	79
Rules: Helpful	81
Flexibility	84

Master Theme 2: The Battle between Anorexia Nervosa and the non-Anorectic self	86
Split Sense of Self	87
What is my Anorexia Nervosa?	91
Master Theme 3: The Battle between Anorexia Nervosa and Clinic-ED	95
No control	96
Perception of Staff (Unhelpful vs. Helpful)	98
Perception of Treatment (Unhelpful vs. Helpful)	101
Master Theme 4: Peer Influence	106
Supportive impact of peers	106
Detrimental impact of peers	109
Master Theme 5: Distance from the 'Outside World'	113
Feeling saddened by distance from home	113
Feeling protected by Clinic-ED	116
Discussion	120
Discussion of Results	120
Master Theme 1: Rules	122
Master Theme 2: The Battle between Anorexia Nervosa and the non-Anorectic self	125
Master Theme 3: The Battle between Anorexia Nervosa and Clinic-ED	130
Master Theme 4: Peer Influence	134
Master Theme 5: Distance from the 'Outside World'	136
Specific Implications for Eating Disorders Clinics and Sufferers	138
Wider Implications for Counselling Psychology	140
Strengths and Limitations of the Study and Ideas for Future Studies	142
Conclusion	144
Reflective Statement	145
References	149

Appendices	174
Appendix 1: Correspondence to Clinics	174
Appendix 2: NHS ethical approval letter	176
Appendix 3: Flyer to Recruit Participants	178
Appendix 4: Participant Information Sheet	179
Appendix 5: Parental Information Sheet	181
Appendix 6: Participant and Parental Consent Form	183
Appendix 7: Interview Schedule	185
Appendix 8: Debriefing Form	186
Appendix 9: Table of Master Themes	187
Appendix 10: Summary of reflections on my relationships with participants	195

Section C: Critical Literature Review **197**

**‘The Media and Eating Disorders: Does the Media
Affect Adolescent Girls’ Eating Behaviours and Body-Concepts?’**

Introduction	198
Overview of Literature	200
Literature Suggesting the Media is not responsible for Eating Disorders	201
The Promotion of Eating Disorders in the Media	204
Pro-Anorexia Websites	208
Conflicting Messages within the Media	210
Summary of Literary Review	213
Discussion	213
References	219
Appendix: Examples of the content of Pro-Anorexia Websites	228

Section D: Client Study	230
 ‘The Use of Person Centred Therapy when working with a Client with a Negative Body-Image	
Introduction	231
Context of the work	231
Rationale for Choosing this Case	231
Summary of Theoretical Orientation	232
Background Information about the Client	233
Initial Assessment/Psychological Formulation	234
Negotiating a Contract/Therapeutic Aims	237
Development of Therapy	237
Beginning of Therapy	237
Middle of Therapy	240
End of Therapy	242
Discussion	244
Therapeutic Process/Changes in the Formulation	244
Difficulties in Therapy/Use of Supervision	245
Evaluation of Therapy	245
References	247

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This portfolio is dedicated to all of you...

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Section A: Preface

My journey of writing this thesis has taken place over the past three years. Yet, my journey in the involvement of eating disorders, the topic of this thesis, has taken place over nearly twenty years. From suffering with an eating disorder myself, to witnessing many of my school friends suffering with one, to working with eating disorder sufferers in both inpatient units and as a therapist, and to carrying out research on eating disorders, the subject has been a huge part of my life.

I was fortunate enough to lay my eating disorder to rest ten years ago. Yet, for those in the midst of their eating disorders, I recognise that they may sometimes feel that there is no way out. The uncertainty of whether one's eating disorder will last forever is often overwhelming. Luckily, I feel able to utilise the skills I learnt upon recovering from my eating disorder, and the journey I went through to get there, to support others. Furthermore, I feel my own experiences have allowed me to understand and empathise with those who are still struggling. This is what inspired me to carry out this research in the first place.

This doctoral portfolio is divided into three sections: firstly, a research component exploring the experience of being an inpatient on an eating disorders unit; secondly, an investigation of the impact of the media on eating disorders, carried out in the form of a literature review; and thirdly, a client study examining the therapeutic journey with a client I saw who was suffering with a negative body-image. The separate components of the portfolio are linked primarily by the overriding theme of eating and body disorders. Their potential effects upon individuals suffering with them are explored in the research and client study components. There are also recurrent references to the media's impact on eating disorders, both from a general viewpoint in the critical literature review (regarding the possible effects on people in general) and a more specific viewpoint (regarding its effect on the client observed in the client study).

The research study is the chief component comprising this portfolio. It explores the subjective experiences of inpatients in an eating disorders unit. Eight participants from one inpatient unit were interviewed in the study. All participants suffered from Anorexia Nervosa. Participants were asked about their experiences of inpatient life. A semi-structured

interview technique was employed, therefore as well as following a specific interview schedule, I asked additional exploratory questions such as “what was that like?” This was intended to allow as rich and expressive information to emerge as possible (Smith, Flowers & Larkin, 2009). Following the interviews, the qualitative research method of Interpretative Phenomenological Analysis was carried out on interview transcripts. This type of analysis observes each participant’s unique and individual experience of the meanings and intricacies of a particular phenomenon (Smith & Osborn, 2003). Once analysis has been carried out on each individual transcript, convergences and divergences between all participants’ accounts are then observed, and prevalent themes emerging from the narratives are explored.

My motivation in carrying out this research stemmed from my own experience of suffering with an eating disorder. I was not admitted to an inpatient unit myself, but I was curious as to what the impacts of admission, in conjunction with having to cope with such a debilitating illness, may be. I hoped this research would allow me to gain an insight into inpatients’ experiences. My overall goal in carrying out this research, however, was to give inpatients a voice, regarding what aspects of their treatment stood out for them, and what aspects they found helpful and unhelpful. Ultimately, I wanted to explore whether their voices could be utilised to identify future treatment practices in eating disorders clinics. I also hoped that being given the opportunity to reflect upon their feelings about inpatient treatment in a dedicated discussion space may allow them to clarify or process these feelings somewhat.

The second component of this portfolio is a critical literature review examining the potential effects of the media on eating disorders. This was motivated by an awareness of omnipresent, pervasive media messages that “thin is best” (Haggiag, 2000, p. 4) and a subsequent interest in understanding whether this may have an effect upon individuals who read fashion magazines and watch television programmes featuring skinny celebrities. Over the years working in eating disorder clinics, I have noticed many inpatients staring intently at supermodels in magazines, and poring over the pages providing tips on how to lose weight. Eating disorders can become all-consuming and the sufferer can become fixated with losing weight. Ideas on how to do so are readily available in virtually all types of media,

including magazines, television and the internet. Even for those not suffering from eating disorders, I wondered whether the media messages had any kind of detrimental impact. Essentially, this is why I chose this topic to conduct a literature review on; to satisfy my own interest about the potential effects of the media.

Finally, I have included a client study to demonstrate my abilities as a Counselling Psychologist. This forms the practitioner component of my doctoral portfolio, and is intended to show to the reader some of the work I have done with clients suffering with body-image difficulties. It illustrates my work in my chosen specialism, Person Centred therapy, and explores the valuable effects this may have upon clients. The client I have discussed had a negative body-image as a result of ascites caused by renal failure and consequent dialysing. Our therapeutic journey was, at times, intense and 'stuck', but the courage that she was able to draw from deep inside herself was admirable, and in the end, she showed immense strength at her acceptance of her situation. I felt this reflected the journeys of many of the participants in the research study; they too felt stuck and hopeless at times, but the strength they demonstrated in wanting so much to recover was remarkable. A powerful, all-consuming, eating disorder or a negative body-image is not easy to recover from, or even accept as something to be suffering from, but the client in the client study, and many participants in the research study, were able to find ways to keep trying, even when it seemed impossible.

I found it difficult to decide upon a title for the portfolio which captured everything I was trying to explain: eating disorders, eating difficulties, body disorders, body dissatisfaction, body-image disturbance. There are so many different features of eating disorders. In the end I felt that sticking to the collective term of 'eating disorders' was sufficient for the reader to grasp the essence of what the portfolio was about. Additionally, although I have solely explored the experiences of *females*, the title of this portfolio refers to exploring the experiences of *people* with eating disorders. The reason behind this was that I felt the portfolio should be accessible for all people – both male and female. Upon viewing the title,

I did not want males to feel in any way excluded from reading or using ideas raised in the thesis; simply on the premise that they were male.

Carrying out this research has been a very humbling experience for me. Anorexia Nervosa can be a very private illness (Claude-Pierre, 1997), yet the openness with which participants spoke was palpable. I feel fortunate to have been allowed this opportunity to explore the intricacies of the different effects eating disorders may have upon different individuals. Furthermore, I feel encouraged for the future of the treatment of eating disorders, having arrived at some conclusions for what may be done to support those suffering with eating disorders, eating difficulties, or body image difficulties.

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Section B: Research

**An Interview Study to Explore the
Subjective Experiences of Inpatients with
Eating Disorders in an Inpatient Unit**

Abstract

This thesis seeks to gain an insight into the subjective experiences of people with eating disorders on an inpatient unit. It explores the overall experience, as well as observing both challenging and helpful aspects of inpatient life and treatment. Eight female inpatients with eating disorders, aged twelve to seventeen, were interviewed. All participants were current inpatients at a specialist eating disorders clinic in a large city in England, and were nearing the end of their treatment. Participants' narratives of their experiences were analysed qualitatively, using Interpretative Phenomenological Analysis to identify common themes in the interviews.

My hope in carrying out this research is that participants will have benefitted from the opportunity to discuss and reflect on their time on an inpatient unit, and that the research may enable them to process their experiences. I also hope to enable the staff of inpatient units and eating disorder professionals in general to become more aware of their patients' experiences of being on an eating disorder unit. Furthermore, it is my wish that participants' narratives may be used to identify a treatment method which takes into account their views of what are beneficial and what are unhelpful elements of their experiences.

In order to protect the identities of those taking part in this study, the name of the eating disorders clinic in which the research took place will be referred to in this thesis as 'Clinic-ED' (Clinic-Eating Disorder).

Introduction

In writing this thesis, I hope to shed some light on what it *means* to be an inpatient on an eating disorders unit. I wish to provide an insight into the unknown, unspoken emotions behind the inpatient experience. Is it perceived as useful, challenging, painful, rewarding, sad, inspiring, traumatic..? Do inpatients come away feeling a sense of achievement and optimism, or do they feel a sense of sadness and hopelessness? Although each inpatient's experience is personal and unique, it is my view that their accounts can be indispensable in elucidating ways to make the time spent in an inpatient unit as helpful and as valuable as possible for others involved. Ultimately, I hope this thesis will provide a sense of understanding and clarification about the inpatient experience; not only for inpatients themselves, but for their carers, parents, friends, family and interested others.

I will introduce this study by initially providing a contextual overview of eating disorders and relevant treatments. Following this, I will present a review of current literature about the inpatient experience of being in an eating disorders unit. I will observe both qualitative and quantitative studies investigating the experience, and consider studies regarding the views of eating disorder professionals. I will also comment upon the motivation to recover from an eating disorder, and the transition period from inpatient unit to home in order to contextualise the current research study. I shall subsequently explain my rationale for conducting this thesis, including my own personal position within the research. Finally, I will demonstrate, in light of everything discussed, why it is necessary for a study such as this to take place.

It is my belief that those suffering from eating disorders should not be *defined* by their disorder. Thus in order to respect their individuality and identity, I will not refer to them as 'Anorexics' or 'Bulimics' in this thesis. Instead, I will use the term 'person with Anorexia or Bulimia Nervosa'.

Eating Disorders

Eating disorders are defined as a disturbed perception of body weight, shape or size, and a morbid 'fear of fatness' (DSM-IV, American Psychiatric Association, 1994). Sufferers typically regard themselves as obese, whilst in reality they may be extremely underweight. Those affected by eating disorders will attempt weight loss by a variety of means; starvation (Anorexia Nervosa), bingeing and purging (Bulimia Nervosa) and excessive exercise. Some may also use laxatives (DSM-IV, 2000) or appetite suppressant drugs (Department of Health, 2002) as a means of weight loss, whilst others may chew and spit out food without swallowing it (Walsh & Garner, 1997). These types of eating behaviours are commonly termed 'Eating Disorder-Not Otherwise Specified' (ED-NOS). Overeating and Binge-Eating Disorder (uncontrollably eating a large amount of food over a brief period of time) are also classed as eating disorders.

Eating disorders affect approximately one and a half million people in the UK (Lipczynska, 2005), and prevalence rates are highest amongst adolescent girls, aged fifteen (Calderon, 2007). Nonetheless, eating disorders can affect people as young as six (Ballard, Handy, McGibben, Mohan & Silveira, 1993), or as old as seventy (Mangweth-Matzek, 2006).

Types of Eating Disorder

Anorexia Nervosa and Bulimia Nervosa are the most common eating disorders recognised by medical classification schemes (such as ICD-10, 2007). Nonetheless, ED-NOS and Binge-Eating Disorder are becoming increasingly well-known (BEAT website, 2008).

The participants interviewed in this thesis all suffered from Anorexia Nervosa. Hence, although I will provide a more detailed description of this, I will also describe other types of eating disorder in order to impart the reader with an understanding of the distinctive features between different eating disorders.

Anorexia Nervosa is perhaps the most recognised type of eating disorder. It is a deliberate and sustained weight loss, driven by an intense fear of fatness. Those suffering with Anorexia Nervosa experience a distorted view of their body; even when they are extremely

thin, they will still perceive themselves as too fat (Santrock, 2005). Those suffering with Anorexia Nervosa commonly have limited insight into their problems with food (Park & Bell, 2008), and their eating difficulties may only be recognised and brought to professional attention by a family member or friend. They will often deny trying to lose weight, and try to hide their bodies by wearing baggy clothes (Kohn & Golden, 2001). They may feel anxious about eating socially and try to eat only when alone or unnoticed. They may also become highly active; walking, exercising and indulging in calorie burning activities for long periods of time. If it is not possible for them to purge or burn off calories following the consumption of food – even if only a tiny amount has been consumed – they may become panicked and agitated, and the thoughts of what they have eaten may consume their thoughts for a long time afterwards.

Those with Anorexia Nervosa typically weigh 15% or more below the expected weight for their gender, height and age. The body mass index (BMI) for a healthy adult should be 20 – 25 (calculated by the weight in kilograms, divided by the square of the height in metres). However, those with Anorexia Nervosa usually have a BMI of below 17.5 (Patient UK website, 2009).

The DSM-IV (2000) criteria for Anorexia Nervosa are illustrated below.

Box 1: DSM criteria for Anorexia Nervosa

- Refusal to maintain body weight at or above a minimally normal weight for age and height: Weight loss leading to maintenance of body weight below 85% of that expected, or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected.
- Intense fear of gaining weight or becoming fat, even though under-weight.
- Disturbance in the way one's body weight or shape are experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.
- Amenorrhea (at least three consecutive cycles) in post-menarchal girls and women. Amenorrhea is defined as periods occurring only following hormone (e.g. oestrogen) administration.

There are two sub-types of Anorexia Nervosa; Restricting type and Binge-Eating-Purging type. Restricting type involves the total restriction of food, without regular binge-eating or purging behaviour during Anorectic episodes (purging behaviour includes self-induced vomiting or the misuse of laxatives, diuretics or enemas). Conversely, Binge-eating-purging type involves the person regularly engaging in binge-eating or purging behaviour. Some individuals included in this sub-type may not binge-eat large amounts of food; they may purge after consuming only small amounts¹.

A variety of comorbid psychiatric symptoms may manifest in people suffering with Anorexia Nervosa. These include depressed mood, irritability, social withdrawal, insomnia and loss of libido (Cooper & Cowan, 2009). Obsessive-Compulsive tendencies are also common, including relentless thoughts of food, picking and pulling apart tiny portions of food and hoarding food (Loue, Sajatovic & Armitage, 2004). Anorexia Nervosa is potentially fatal, and may present a host of medical complications, such as cranial hair-loss, bodily hair-growth, osteoporosis, irregular heart-beat, poor circulation, fainting, coldness, kidney failure and low blood pressure, amongst numerous others (Somerset and Wessex Eating Disorders Association, 2009).

The most common onset age for Anorexia Nervosa is the mid-teens, with over 40% of newly identified cases appearing in girls aged fifteen to nineteen years old (National Eating Disorders Association, 2006). However, it has been observed to start at any age between six and seventy-two years (Somerset and Wessex Eating Disorders Association, 2009). Approximately 90% of those affected by Anorexia Nervosa are girls and women (Carlson, Eisenstat & Ziporyn, 2004), although the number of men affected is increasing (Swain, 2006). The duration of Anorexia Nervosa varies from person to person. Some may have a single, relatively brief episode, whereas others may experience problems until the end of adolescence (Kohn & Golden, 2001). Not everyone, however, will be so lucky as to fully recover from Anorexia Nervosa, and may experience dietary problems and body image

¹ The binge-eating-purging sub-type of Anorexia Nervosa is not to be confused with Bulimia Nervosa. What distinguishes the individual as suffering from Anorexia Nervosa is a BMI of below 17.5, typically restrictive eating behaviour, amenorrhea, and a fear of fatness.

disturbance into adulthood, or for the rest of their lives (Steinhausen, Rauss-Mason & Seidel, 1991). As Lamoureux and Bottorff (2005) assert; “with treatment, an average of 40% - 50% of individuals with Anorexia Nervosa completely recover, 30% improve, and the remainder are chronically affected or die” (p. 171).

Bulimia Nervosa is also a prevalent eating disorder. It is characterized by a cyclical and recurrent pattern of binge eating (uncontrolled bouts of overeating), followed by feelings of guilt and self-recrimination, and subsequent over-compensatory behaviours such as vomiting and excessive exercising. People with Bulimia Nervosa typically describe having ‘trigger foods’ which precede their binges. They may also have ‘binge foods’ which they tend to consume during binges. Many feel numb and out of control during episodes of bingeing. Hence, in an attempt to regain control, they will purge the food they have consumed. This leads to them feeling famished and empty, which may result in further bingeing and vomiting.

The DSM-IV (2000) criteria for Bulimia Nervosa are illustrated in Box 2.

Box 2: DSM criteria for Bulimia Nervosa

- Recurrent episodes of binge eating characterized by both:
 1. Eating, in a discrete period of time (e.g., within any two hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances
 2. A sense of lack of control over eating during the episode, defined by a feeling that one cannot stop eating or control what or how much one is eating
- Recurrent inappropriate compensatory behaviour to prevent weight gain
 1. Self-induced vomiting
 2. Misuse of laxatives, diuretics, enemas, or other medications

3. Fasting

4. Excessive exercise

- The binge eating and inappropriate compensatory behaviour both occur, on average, at least twice a week for three months.
- Self evaluation is unduly influenced by body shape and weight.
- The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

There are two sub-types of Bulimia Nervosa: Purging type and Non-purging type. Purging type involves regularly engaging in self-induced vomiting or the misuse of laxatives, diuretics, or enemas following binges. Conversely, Non-purging type involves principally using other inappropriate compensatory weight-loss methods, such as excessive exercising or excessive fasting following binges.

Bulimia Nervosa is a potentially life threatening condition. In addition to the medical conditions pertaining to Anorexia Nervosa (mentioned above), it is associated with dental decay, dry skin, bloodshot eyes, oesophagus problems (such as ulcers and ruptures) and a bleeding throat (Somerset and Wessex Eating Disorders Association, 2009).

The most common onset age for Bulimia Nervosa is late adolescence or early adulthood (Santrock, 2005). Similarly to Anorexia Nervosa, approximately 90% of those suffering with Bulimia Nervosa are girls and women (Carlson, Eisenstat & Ziporyn, 2004). More fortunate than those with Anorexia Nervosa, however, approximately 70% of sufferers will eventually recover (Garner, 2007).

Similar to Bulimia Nervosa is 'Binge-Eating Disorder'. This is a chronic condition which occurs when an individual consumes a large amount of food over a brief period of time; however, sufferers do not purge, fast, or engage in excessive exercise following binges. During binges, the individual feels totally out of control and unable to stop eating. People with Binge-Eating Disorder are usually overweight or obese, whereas those with Bulimia Nervosa are typically underweight, of normal weight, or slightly overweight (Kohn & Golden, 2001). Box 3

illustrates the typical characteristics of Binge-Eating Disorder (obtained from United States Department of Health and Human Services website, 2007).

Box 3: characteristics of Binge-Eating Disorder

- Experiencing absolute lack of control over the consumption of food.
- Eating an unusually large amount of food at one time – more than a normal person would eat in the same amount of time.
- Eating much more quickly during binge episodes than during normal eating episodes.
- Eating until feeling physically uncomfortable and nauseous.
- Eating when depressed, sad, or bored.
- Usually eating alone during binge eating episodes, in order to avoid the discovery of the disorder.
- Often eating alone during periods of normal eating, owing to feelings of embarrassment about food.

Currently, the DSM-IV does not distinguish Binge-Eating Disorder as a distinct disorder; instead categorising it under ED-NOS. Since it affects an estimated 2% of adults in the UK (Disordered Eating website, 2008) it would seem that more research on this disorder is required.

Eating Disorder-Not Otherwise Specified (ED-NOS) has become progressively more recognised in recent years, and has in fact recently been shown to be more prevalent than Anorexia and Bulimia Nervosa (BEAT website, 2008). ED-NOS refers to disordered eating which does not meet the criteria for Anorexia or Bulimia Nervosa, (or any other specific eating disorder). The DSM-IV (2000) criteria are as follows:

Box 4: DSM criteria for ED-NOS

- For female patients, all of the criteria for Anorexia Nervosa are met except that the patient has regular menses.
- All of the criteria for Anorexia Nervosa are met except that, despite significant weight loss, the patient's current weight is in the normal range.
- All of the criteria for Bulimia Nervosa are met except that the binge eating and inappropriate compensatory mechanisms occur less than twice a week or for less than three months.
- The patient has normal body weight and regularly uses inappropriate compensatory behaviour after eating small amounts of food (e.g., self-induced vomiting after consuming two biscuits).
- Repeatedly chewing and spitting out, but not swallowing, large amounts of food.

People diagnosed with ED-NOS may frequently switch between different eating disorders, and may meet some, but not all, of the criteria for Anorexia and Bulimia Nervosa at any given time. Essentially, ED-NOS is a 'catch-all' term for eating disorders which do not fit within the parameters of Anorexia and Bulimia Nervosa criteria.

Grave and Calugi (2007) state that ED-NOS is the most common eating disorder diagnosis made in outpatient settings. It is feasible that ED-NOS may represent a manifestation of contemporary cultural practices and associated weight-related discourses such as "keeping in shape" and "calorie counting"; thus, in a sense it (and other eating disorders) may have become 'normalised' by today's cultural standards. Therefore it may be understandable that an increasing number of people are developing ED-NOS. Nonetheless, ED-NOS is fairly unheard of and there are few studies researching its treatment. Fairburn and Bohn (2005) propose that this may be due to the 'not otherwise specified' label suggesting that it is not as important as other 'specified' disorders. Even so, the risks associated with ED-NOS are

just as serious as with Anorexia and Bulimia Nervosa, as the people suffering with it engage in the same damaging behaviours prevalent in specified eating disorders.

Essentially, all the aforementioned types of eating disorders are psychological illnesses, all present physical dangers and complications, and all may cause a great deal of emotional turmoil to those suffering with them. Every type of eating disorder is distressing and potentially life-threatening, thus it is crucial that the individuals suffering are treated in a way that respects and works best for them. Eating disorders, however, are not simply about symptomatology and treatment, and the aetiology behind them must be taken into consideration.

Potential Causes of Eating Disorders

In some cases, what starts as a 'harmless' diet escalates into an uncontrollable fixation upon staying thin (Freeman, 2002), and the sufferer will be unable to recognise when they have gone too far. As Patton, Selzer, Coffey, Carlin and Wolfe (1999) assert, females who diet at moderate levels are five times more likely to develop an eating disorder than non-dieting girls. However, eating disorders are generally precipitated by underlying psychological disturbances. Kohn and Golden (2001) state that "Anorexia Nervosa is a biopsychosocial disorder and undoubtedly individual, familial and cultural factors all contribute to its development" (p. 92). Here I will outline just some of the potential causes which have been more frequently discussed in eating disorder literature.

Low self-esteem has commonly been linked with negative body image and eating disorders. Self-esteem relates to the perception of the self, and the sense of worth as a person. Correspondingly, body image is the perception of the physical appearance. If a person has a poor perception of themselves in general, it may follow that their perception of their body may also be poor. Indeed, many studies have shown that people with low self-esteem are at significantly greater risk of developing an eating disorder (Button, Sonuga-Barke, Davies & Thompson, 1996; Button, Loan, Davies & Sonuga-Barke, 1997; Dykens & Gerrard, 1986).

Further research has shown how striving to find a sense of self can contribute to an eating disorder (Polivy & Herman, 2002). Entering into adolescence (the most prevalent onset age of eating disorders) can be an immensely stressful time, and teenagers may be under a great deal of pressure. The pressure to develop 'who they are', compounded by the pressure to conform to society's unattainable 'ideal' body may lead them to believe that if they are thin, they will be accepted (Stice, 1998). Adolescence can be confusing and scary, and those who find it difficult to deal with may develop an eating disorder as a means of coping.

A great deal of research has also been conducted on the association between eating disorders and perfectionism (Bastiani, Rao, Weltzin & Kaye, 1995; Castro-Fornieles, Gual, Lahortiga, Gila, Casulà, Fuhrmann, Imirizaldu, Saura, Martínez & Toro, 2007). Perfectionism may involve the setting of and striving for unrealistic personal standards and critical self-evaluation if these standards are not met. Those with an eating disorder may equate thinness with perfection; therefore the desire to be thin becomes so strong that no clothes size is ever small enough, and no weight is ever low enough. Indeed, the societal link between thinness and perfection is ubiquitous, for instance in the media images of skinny celebrities with 'perfect' lives. These images convey the message that if people are thin, they too can have a perfect life, wearing perfect clothes and attracting positive attention from others. This is compounded by omnipresent media messages endorsing thinness and discouraging adiposity (Posavac & Posavac, 2002).

One factor closely linked with this perfectionism is control (Kubersky, 1999; Strober, 1982; Surgenor, Horn & Hudson, 2003; University of Cambridge, 2008). When individuals fail to meet the impossibly high standards they set for themselves, they look for a part of their lives they can control: for some, this may include food and weight. Many adolescents may feel totally out of control. Adolescence is a time when many are trying to find a sense of self, and some may feel pressures from school, peers and family (Peterson, Paulson & Williams, 2007). Thus, they may thrive from the feelings of control afforded by restricting their food intake and losing weight. Unfortunately, for those suffering with eating disorders, what starts as a bid to gain control over their food intake ends up controlling them.

Some researchers have posited that eating disorders and the desire to be thin may represent an avoidance of assuming adult roles and responsibility (Bruch, 1979; Byrne, 1987). This may occur for many reasons. For some, the thought of being an adult may simply cause fear and anxiety. Others, alternatively, may have felt unloved or uncared for as a child, and wish to compensate by staying in the body of a child, hoping that this will cause others to care for them as a child may be cared for (Strober, 1997). Essentially, starving the body prevents or reverses physiological maturity and keeps the body in a pre-pubescent state.

The family environment can also play a large part in the development of an eating disorder. Martinez-Gonzalez, Gual, Lahortiga, Alonso, de Irala-Estevez, and Cervera (2003) found that individuals whose parents were separated, divorced or widowed were at higher risk of developing an eating disorder. Nonetheless, even if the family environment is extremely close-knit, the individual can develop an eating disorder following an attempt to gain a sense of individuality (Thompson, 1996). Crucially, eating behaviour is learnt by watching parents around food. If parents are weight or body conscious, the individual may come to attach great importance to weight and appearance (Thompson, 1996).

Eating disorders may also occur following a traumatic event (Smyth, Heron, Wonderlich, Crosby & Thompson, 2008). This may include anything from physical or sexual abuse (Wonderlich, Crosby, Mitchell, Roberts, Haseltine, DeMuth, & Thompson, 2000) to bullying at school (Sweetingham & Waller, 2008). Eating disorders may develop following an attempt to regain control, to block out painful feelings and emotions, or as a form of self-punishment, particularly if the individual blames themselves for what has happened.

New research has also shown that Anorexia Nervosa may be linked to the insular cortex, the part of the brain which aids interoceptive awareness of body states (Agrawal & Lask, 2009). This research suggests that due to an insular dysfunction, some people may be more predisposed to develop Anorexia Nervosa in reaction to the potential life events mentioned above. People without this dysfunction may not develop eating disorders after experiencing similar life events.

Ultimately, there are numerous reasons why an individual may develop an eating disorder, not all of which will have been covered here. To observe every potential cause of eating disorders, however, would require an enormous body of work. What I hope is to have simply provided an overview of this, in order to contextualise some of the issues that the participants who took part in this study may have experienced.

The Treatment of Eating Disorders

Recovering from an eating disorder is often extremely challenging. Frequently, sufferers portray their Anorexia or Bulimia Nervosa as a friend or guardian, and the only ‘thing’ they can trust (Serpell, Treasure, Teasdale & Sullivan, 1999). They often describe ‘becoming’ their Anorexia Nervosa and losing their own sense of identity (Cozzi & Ostuzzi, 2007; Suarez & Kerr, 2007). Furthermore, those suffering with an eating disorder may find that *every* aspect of their lives is affected – not simply their ability to eat food. A huge proportion of their time may be taken up by worrying or thinking about food (Garner, Vitousek & Pike, 1997), and calculating what calories or fat content has or has not been consumed (Fairburn, 2008). Their friendships, relationships, school, work and daily activities may all suffer as a result of their eating disorder (Siegel, Brisman & Weinshel, 1988). Thus, the process of recovery is far more complicated than simply gaining weight and learning to eat again.

There are many treatment options for people suffering with eating disorders. The most suitable approach depends on the individual and their specific symptoms, issues and strengths, as well as the acuteness of the eating disorder. Essentially, effective treatment should address both physical and psychological aspects of the disorder (Kohn & Golden, 2001). This involves attending to any pressing medical or nutritional needs first and foremost, and subsequently promoting a healthy relationship with food, whilst educating the individual about constructive ways to deal with life in the future.

Kohn and Golden (2001) assert that those suffering with eating disorders should not be treated by individual professionals and “are best managed by the ‘team approach’. The team usually comprises a physician, nutritionist, psychologist or psychiatrist and sometimes a social worker” (p. 96).

Eating disorders are frequently treated in outpatient settings (Costin, 1997). This may involve individual psychotherapy (most commonly Cognitive-Behavioural therapy; Fairburn, 2008), group psychotherapy, support groups and nutritional counselling. Psychotherapy is useful in allowing the individual to explore issues underlying their eating disorder. It may also teach them to respond to stress in healthier ways. Group psychotherapy and support groups can be useful in providing a space for the individual to discuss their concerns with people who have previously suffered or are currently experiencing similar issues to them. Group psychotherapy is facilitated by one or two professionals, whereas support groups are commonly peer- as opposed to professionally-led. Group psychotherapists often administer exercises designed to elucidate the understanding and exploration of eating disorders. Nutritional counselling deals solely with the 'food side' of the eating disorder, helping the individual to design meal plans, accomplish dietary goals and achieve a healthier weight. It may also involve educating the individual about basic nutrition and the consequences of eating disorders.

Depending on the severity of the eating disorder, outpatient treatment may be insufficient or contraindicated. When symptoms are uncontrollable and significant medical risks are involved, such as low blood pressure, weakened liver and kidney functions, and heart problems, treatment in a more structured setting such as a hospital or inpatient unit may be necessary. This is intended to give those suffering with eating disorders the opportunity to concentrate on recovery in a more focused atmosphere.

The number of sufferers admitted to eating disorder wards is increasing. It has been reported that "1,484 patients with Anorexia were admitted to wards in 2006/7 compared with 1,338 the previous year; an increase of 11 per cent" (Levy, 2008). Inpatient care entails twenty-four hour care in a hospital setting, offering medical and/or psychiatric intervention. In this setting, trained eating disorder professionals will design a 'care plan' or treatment programme to treat an inpatient's eating disorder.

Admission to hospital for eating disorders can involve going to a general hospital ward, a non-specialised psychiatric unit or a specialised eating disorders unit. Ellis-Ordway (1999) states that "people with eating disorders tend to get better faster on specialised inpatient

units” (p. 190), as they offer more specialist treatment protocols unique to eating disorder sufferers.

There is widespread variation in the types of treatments and services offered in eating disorders clinics across the UK (Gowers, Edwards, Fleminger, Massoubre, Wallin, Canalda, Starkova, Hannesdottir, Almquist, Aronen, Scholz, Hoerder, Skarderud, & Boyadjieva, 2002). These range from structured ‘refeeding programmes’ to intensive individual, family and group therapy, using a variety of therapeutic approaches. Inpatient units generally provide an array of recreational activities for their inpatients, for both enjoyment and therapeutic purposes. These usually include both indoor and outdoor activities, and will incorporate exercise orientated ones for those who are at a high enough weight.

Essentially, all eating disorders inpatient units are different. Some may insist on room and bed rest, whereas others allow inpatients to stay on the main ward, but maintain that they sit down and relax. Some argue that the staff and inpatients should eat together to promote a more normalised eating atmosphere, whereas others state that staff should supervise inpatients whilst they eat in order to focus fully on them and monitor any ‘foul-play’ (such as subtly flicking away or hiding food).

Nonetheless, the ultimate goal for eating disorders units is weight restoration. Some units may prioritise the inpatient’s motivation to recover and engagement with treatment over simply monitoring their weight gain (Gowers et al., 2002), but all units aim to bring their inpatients to a healthier weight. Usually, small treatment goals are identified with the inpatient, and these are worked towards throughout their admission. For instance, inpatients may be given smaller portions of food at the start of their inpatient stay, and given increasingly larger portions over time. Inpatients may be weighed a number of times per week, and their weight-gain measured in stages.

For a description of the treatment provided in Clinic-ED, the inpatient unit where this research study took place, please refer to the ‘Information on Clinic-ED’ section on page 48, at the end of the introduction chapter.

Overview of Literature²

As Vanderlinden, Buis, Pieters and Probst (2007) point out, the majority of existing research on inpatient life and treatment has, remarkably, neglected to consider the views of inpatients. Research in this area preponderantly focuses on the opinions of eating disorder professionals and therapists (Jarman & Walsh, 1999). It seems fairly short-sighted that the views of inpatients – those who are able to provide a personal account of their experiences – have been somewhat overlooked.

Additionally, the majority of existing research has been largely quantitative. Whilst qualitative research seeks to understand the meaning and complexity of an individual's world through the analysis of their personal account of events and experiences, quantitative research seeks to classify the features of a phenomenon, count these features and conduct statistical tests upon them in an attempt to explain what has been observed. Thus, in a sense, the richness of participants' words and embellishments is not overt in quantitative studies. Yet, when exploring participants' perceptions of a phenomenon, as this study has done, these embellishments are what may enhance and enrich the researcher's and readers' overall understanding.

Due to the broadness of the topic of eating disorders, there is a large amount of literature making some reference to the inpatient experience. I have selected to review the literature included here as it has specifically observed the area of the inpatient experience with more focus than some of the more general eating disorders studies.

³ The literature reviewed for this research study was obtained via psychological, psychiatric and medical search engines, such as PsycINFO, Senate House Library Serials Catalogue, Medline and MBase. Key words used to attain journals and articles about the topic were 'eating disorder', 'Anorexia Nervosa', 'Bulimia Nervosa', 'inpatient experience', 'inpatient treatment experience', 'inpatient view of eating disorders unit', 'Interpretative Phenomenological Analysis', 'qualitative research' and 'quantitative research'. Journals reviewed were predominantly from the last ten years, although the search engines contained journals from the last hundred years, which were also reviewed if relevant to the study. The principal journals reviewed in this study were the 'European Eating Disorders Review', 'International Journal of Eating Disorders' and 'Eating Disorders'.

Studies on Professionals' Views of the Inpatient Experience

Many of the studies carried out on the inpatient experience have been from the perspective of eating disorder professionals, including nurses and psychotherapists. Here, I will outline just a few of these studies, and comment on their limitations. My reasons for selecting these studies stem from the fact that I felt that they best represented the broad variety of professionals' views regarding the inpatient experience, and highlighted the need for more studies investigating the views of inpatients themselves.

In 2009, Lievers, Curt, Wallier, Perdereau, Rein, Jeammet and Godart conducted a study whereby they analysed the structured clinical charts of three hundred inpatients on an eating disorders unit, to identify aspects of the inpatient experience which may have influenced their length of stay. They found that variables such as whether the individual had been tube-fed during their stay, their accomplishment of the therapeutic weight contract, the duration of the eating disorder prior to admission, and the presence of a comorbid disorder all affected inpatients' length of stay. They stated that their study could help clinicians to optimise and individualise treatments and increase inpatient and family compliance. Whilst undoubtedly a useful study, Lievers et al (2009) appear to overlook the views of inpatients themselves about whether they felt the above variables played a part in their length of stay. Moreover, it disregards the emotions which inpatients may have felt about these variables. Surely, evaluating these emotions would provide a broader overall perspective on how to optimise and individualise the treatment which Lievers et al. (2009) hoped to achieve.

Similarly, in their 2007 study, Masson, Perlman, Ross and Gates investigated potential factors relating to the inpatient experience which may have influenced dropping out prematurely from an inpatient eating disorders unit. They performed statistical analyses on retrospective charts of one hundred and eighty-six inpatients in order to obtain information on the rates, timing and predictors of drop-out. Again, however, their study neglected to investigate the views of inpatients themselves on why they may have dropped out prematurely.

Rockwell, Ellinwood, Dougherty and Brodie (1982) stated that good basic nursing care was the most essential ingredient in the process of treating eating disorders. Ryan, Malson, Clarke, Anderson and Kohn (2006) explain how nurses define this good basic care. Ryan et al. (2006) interviewed fifteen nurses about nursing children and adolescents with eating disorders. After analysing the interviews using discourse analysis, they found that nurses considered 'loving' or empathic support, the surveillance and disciplining of inpatients, and constant and ever-present care to be essential elements in nursing care. However, Sansone, Fine and Chew (1988) found that eating disorder nurses demonstrated progressively less favourable impressions of their patients over time, and progressively lower levels of job satisfaction. Indeed, the level of burn-out for nurses in eating disorder clinics is believed to be high (Rubel, 1986). It is questionable how nurses can deliver good basic nursing care if they are feeling pressured and potentially harbouring negative feelings about their patients.

Many studies on professionals' views of inpatient eating disorder care have reported inconsistencies between the views of staff. Allen, Deering, Buskirk and Coyne (1988) found that there was minimal concordance amongst the views of various disciplines regarding the relationship between staff and inpatients. Furthermore, Davies, Parekh, Etelapaa, Wood and Jaffa (2008) conducted a study investigating the views of staff on the management of physical activity in inpatient units. They found that the forty-three units they investigated shared little consensus on how exercise should be managed, and there was a significant lack of a consistent approach. It is somewhat concerning that if staff cannot agree amongst themselves about the management of their inpatients, what message they then convey to the inpatients who are supposed to rely on them to help them recover.

Lieberman, Von Rehn, Dickie, Elliott and Egerter (1992) argued that inpatients were far more likely to comply with treatment if there was a good working alliance between them and staff. Yet, Gallop, Kennedy and Stern (1994) found that inpatients' perceptions of the therapeutic alliance with staff were different to the views of staff. Indeed, these perceptions may be highly subjective; what nurses may believe is helpful behaviour towards their inpatients may be perceived by inpatients themselves as unhelpful. As Gallop et al. (1994) state:

“That early differences in patients’ perceptions of the alliance are associated with premature discharge suggest that staff should consciously seek assessment of the patient’s subjective experience of the treatment programme if they are to help the patient stay the course” (p. 409).

Indeed, this study consciously seeks inpatients’ subjective perceptions of their experiences, and also goes one step further by exploring whether these experiences can be used to identify optimal ways in which eating disorder professionals can work with their clients.

Quantitative Studies on the Inpatient Experience

A number of studies assessing inpatients’ perceptions of treatments have used quantitative methods of research, predominantly via the use of questionnaires. I found the following studies to be particularly pertinent in highlighting the shortcomings of using this type of quantitative research when assessing inpatients’ needs, views and ideas regarding their treatment. Additionally, the studies mentioned here demonstrate how some quantitative research has a propensity to observe one category of a phenomenon, neglecting to focus on the full experience. For example, Zeeck and Hartmann (2005) conducted a questionnaire study in which they measured inpatients’ perceptions of individual therapy. Yet, they did not focus on other aspects of inpatient treatment, stating that other influences on the inpatient were too complex to evaluate. Yet surely, it is these other influences which essentially comprise the whole inpatient experience. Without reflection on such influences, the study seems somewhat limited.

Similarly, Wiseman, Sunday, Klapper, Klein and Halmi (2002) investigated staff and inpatients’ preferences of Cognitive-Behavioural therapy over Psycho-education on an inpatient eating disorder unit, and Wade, Frayne, Edwards, Robertson and Gilchrist (2009) evaluated whether motivational interviewing improved eating pathology in inpatients. These studies all focus on therapy specific components of the inpatient experience, disregarding the overall experience.

In the same vein, Vanderlinden, Buis, Pieters and Probst (2007) conducted a study comparing inpatients’ and therapists’ views on helpful and unhelpful elements of therapy.

They found that therapists and inpatients essentially shared similar views. Both considered learning how to improve self-esteem, learning how to improve body experience and identifying problem solving skills to be key aspects of the process of therapy. Once again, however, this does not account for the general, therapeutic milieu of the inpatient unit, instead focussing solely on the therapeutic process.

Some questionnaire studies, nonetheless, do account for the whole inpatient experience, but the information provided is limited. For instance, Newton, Robinson and Hartley (1993) sent postal questionnaires to former inpatients of eating disorder units, enquiring about their inpatient experiences. Of the inpatients whose admissions had been compulsory, Newton et al. (1993) did not mention how many felt negative or ambivalent about their experience, although they did say that “half felt, in retrospect, that the [compulsory admission] had been a ‘good thing’” (Newton et al., 1993, p. 19). The quantitative nature of the study, however, does not allow for elaboration on such statements, thus limiting the readers’ understanding of why participants experienced their admission as a ‘good thing’.

A further example of how quantitative studies can be limited is illustrated in Rosenvinge and Klusmeier’s (2000) study. They conducted a questionnaire study investigating inpatients’ satisfaction with their treatment on eating disorders units. They found that individuals who experienced staff as competent on eating disorders reported higher treatment satisfaction. However, upon reading this, the audience is not provided with a sense of what this really means. What constitutes a competent staff member in the views of inpatients? Why and how does this result in higher treatment satisfaction? Indeed, questions such as these are effectively lost in quantitative studies.

Bloks, Spinhoven, Callewaert, Willemse-Koning and Turksma (2001) conducted a questionnaire study to assess how inpatients’ coping styles affected their recoveries. They found that although coping styles changed in a favourable direction during the treatment process, predominantly negative coping styles were still used at the end of inpatient treatment. Specifically, these included increased preoccupation about their situations and decreased inclination to seek social support. Participants also tended not to approach their problems from different angles, work in a goal-oriented way, or feel confident in solving

problems. Essentially, it may have been beneficial for inpatients to have been given the opportunity to discuss some of their feelings around why they used such coping styles, and what they feel could have been done to promote more positive coping skills. However, in quantitative research methods, such analyses are not addressed.

Another questionnaire study was conducted by Halvorsen and Heyerdahl (2007). They compared former inpatients' perceptions of inpatient life and treatment with their parents' perceptions. They found that parents reported having an overall positive perception. However, reports from former inpatients were significantly more negative than those from parents. Whilst useful in highlighting the differences in views between those directly involved with the inpatient experience (the inpatients) and those slightly removed from the intensity of it (the parents), this study does not allow for an examination of the richness and complexity of the inpatient – or the parent – experience.

Essentially, this is a limitation affecting most quantitative studies – they tend to allocate meaningful experiences to categories. Ultimately, it is questionable how much information concerning feelings and emotions can be extracted from a questionnaire – fundamental elements when assessing issues such as the inpatient experience. Indeed, it appears that more research is needed which will explore the meanings behind inpatient experiences, using qualitative analytic strategies.

Qualitative Studies on the Inpatient Experience

Upon researching this area, I was only able to identify two significant qualitative studies evaluating the inpatient experience on eating disorders units. These were conducted by Offord Turner and Cooper (2006) and Colton and Pistrang (2004). Both studies interviewed inpatients of eating disorders units and carried out Interpretative Phenomenological Analysis on these interviews.

In their 2006 study, Offord, Turner and Cooper explored young adults' experiences of their inpatient treatment for Anorexia Nervosa during their adolescences. They also enquired about their experiences of discharge and the impact that their admissions had had on issues of control and self-esteem. Offord et al. (2006) conducted semi-structured interviews with

seven former inpatients of three different general, non-specialist adolescent psychiatric units. All were female. The interview questions covered topics such as perceived helpful and unhelpful aspects of treatment, the balance between physical and emotional needs, the perception of the hospital environment, the degree of control experienced in hospital, views on being around inpatients with and without eating disorders, the impact of admission on the individual's sense of self, relationships with friends and family outside the hospital (during and post-hospitalisation), views on the discharge experience and management and adjustment issues following discharge.

Offord et al. (2006) used Interpretative Phenomenological Analysis to identify themes in participants' accounts. Four superordinate themes emerged from these accounts, including:

- 1) Removal from normality versus connecting with the outside world
- 2) Being treated as another anorexic versus as a unique individual in distress
- 3) Control and collaboration
- 4) The importance of peer relationships.

Offord et al. (2006) stated that participants experienced their hospitalisation as both negative and positive. Many factors contributed to this. For instance, when participants felt perceived as a unique individual, they reported much more positive accounts of their experiences. This included being valued and supported with psychological as well as other forms of treatment, and extended support being offered to participants' families. Conversely, those who experienced it as negative described it as controlling, unsupportive and unhelpful.

Participants in Offord et al.'s (2006) study experienced some practices as empowering and an incentive to co-operate with treatment, such as being afforded responsibility over the pace of weight gain. Nonetheless, as Offord et al. (2006) state:

"Over-controlling, rigid programmes and staff assumptions about patients with [Anorexia Nervosa] could also result in patients feeling out of control, powerless and under-valued as individuals, whilst practices such as withholding

age-appropriate activities and group/individual psychological input were often experienced as compounding one's sense of being a bad person deserving of punishment" (p. 385).

Participants placed a great deal of importance on supportive relationships with fellow inpatients. They talked about the sense of community in the inpatient unit, and stated that having the opportunity to identify with others and learn positive ways of coping was helpful. Nonetheless, they also described having to eat separately from non-eating disorder inpatients as stigmatising and unhelpful.

It would seem that there are many strengths to Offord et al.'s (2006) study. They effectively describe in depth both the helpful and unhelpful, and positive and negative perceived elements of treatment, and suggest ways of utilising participants' accounts to inform future treatment. For instance, they explain how creating individualised and collaborative approaches to care can minimise some of the otherwise negative effects of hospitalisation.

Additionally, interviewing participants from different inpatient units provides a broader insight into different treatment methods and participants' views of what they find helpful or unhelpful. Offord et al. (2006) do not provide a comparison between the different units, however, which may have been helpful for units who employ similar treatment methods. Basing research in non-specialist adolescent psychiatric units also provides a useful opportunity to investigate whether being in close proximity to both similar and different peers is helpful in diffusing negative effects such as competition (with other eating disorder inpatients), or unhelpful in hindering positive effects such as learning valuable coping mechanisms from one another.

Whilst informative about the inpatient experience, this study does have some limitations. Firstly, participants are interviewed two to five years after discharge. Although the authors argue that this allows for a more reflective account, it is important to consider how time and distance away from a situation can distort a perception or memory of that situation (Paz-Alonso & Goodman, 2008). In contrast, by conducting interviews prior to discharge, one

may receive accounts which are more accurate and somewhat clearer in participants' minds.

Additionally, the study tends to focus too specifically on particular topics, thus in some sense, directing the flow of conversation onto what the authors want to know, without allowing participants to simply discuss whatever comes into their minds about elements of the inpatient experience. For instance, by bringing up the topic of self-esteem, the authors alert the participants' attention to this. Thus, even if this had not been a key part of the individual's inpatient experience, it is brought to their attention and focused upon; entailing another, more significant part of their inpatient experience may consequently be overlooked. Furthermore, by combining discharge and inpatient experiences in the same interview, the participant is not given the opportunity to focus fully on one or the other, which may entail that all topics relating to each experience are not covered. It may have been of more benefit to conduct two separate interviews, in order to allow additional, complementary information to emerge regarding each experience.

Another key study assessing inpatients' experiences of inpatient life and treatment was conducted by Colton and Pistrang (2004). In this study, they interviewed nineteen participants on two specialist inpatient eating disorder units. All were female and between the ages of twelve and seventeen. The interview questions covered topics such as what participants found helpful and unhelpful about their treatment, the extent to which they were trusted and given responsibility on the unit, relationships with unit staff, opinions on being with similar others, feelings about being separated from their outside lives, and their experiences of Anorexia Nervosa.

Following interviews, Colton and Pistrang (2004) added a quantitative component to their study, asking participants to fill out a stage of change and readiness to change questionnaire. The questionnaire sought to ascertain at which of four stages participants viewed themselves: precontemplation, contemplation, preparation or action (the fifth stage of the model of change, maintenance, was thought to be irrelevant to the *current* inpatient sample, thus was omitted). The questionnaire also included an eight-item scale measuring respondents' readiness to change specific Anorectic behaviours and attitudes.

Upon analysing the interviews using Interpretative Phenomenological Analysis, Colton and Pistrang (2004) identified five superordinate themes:

- 1) What is this illness that I have?
- 2) Do I want to get well?
- 3) Being with others: support versus distress,
- 4) Being an individual versus just another anorexic,
- 5) Collaborating in treatment versus being treated.

The questionnaire data showed that with reference to participants' stages of change, three were in the precontemplation stage, six were in the contemplation stage, one was in the preparation stage and nine were in the action stage.

Regarding the interview data, although most participants expressed simultaneous positive and negative views of their inpatient treatment, Colton and Pistrang (2004) report that their narratives were characterised by conflicts and dilemmas. Most respondents indicated conflicts about recovering from their eating disorder; even those in the 'action' stage of change expressed a desire to change but did not yet feel ready to relinquish their Anorexia Nervosa. Many referred to a conflict between perceiving their Anorexia Nervosa as a friend versus an enemy. All expressed mixed feelings about their close proximity to similar others; feeling that whilst peers could support and understand each other, competition was rife and witnessing distress was unpleasant. Additionally, most participants struggled to understand their Anorexia Nervosa and the associated emotions. Similar to Offord et al.'s (2006) study, Colton and Pistrang (2004) found that respondents were more likely to collaborate with treatment when it was experienced as supportive, and less likely when it was experienced as punishing.

Colton and Pistrang's (2004) study displays many strengths. Adding a quantitative component to the qualitative data may add weight to their findings and enrich the data (Polit & Hungler, 1999), for example, it may clarify whether different stages of change affect an individual's experience. Additionally, interviewing participants in two eating disorder

clinics elicits a broader variety of inpatients' experiences and different treatment methods used. Obtaining data from nineteen respondents is also a major strength, adding further weight to their findings.

Nonetheless, a significant limitation of this study is that the duration of each participant's time on the units varies greatly. For instance, the study integrates the views of a participant who had spent three weeks on the unit, with one who had spent twenty weeks on the unit. It is questionable whether the participant who had been there for three weeks had the same degree of insight as participants who had been inpatients for longer periods of time. Additionally, similar to Offord et al.'s (2006) study, the questions asked in the interviews are somewhat directed towards obtaining information which the authors want to know, rather than allowing a more open, flowing narrative which may produce information that is more meaningful and correspondent with participants' experiences.

Overall, the two above studies provide a significant insight into the inpatient experience and raise some important points. Both Offord et al.'s (2006) and Colton and Pistrang's (2004) studies recognise that participants feel it is important to be treated as an individual. In order to nurture this individuality, it may be helpful to explore which aspects of treatment exacerbate their awareness of not being treated as an individual, with a view to subsequently modifying them to produce different treatment methods which take into account all inpatients' needs. A further theme emerging from both studies is the participants' difficulties in collaborating with treatment. It follows, however, that if inpatients' needs are not being met in treatment, then they will be less likely to collaborate!

It would appear that more research is needed on the inpatient experience to add weight to the above studies and to rectify some of the limitations of their studies, for instance, interviewing current inpatients who have been on the unit for similar periods of time, and who are nearing the end of their treatment, in order to give a more reflective view. Additionally, it would be beneficial to ask questions which are not so directed towards particular elements of treatment (such as relationships with staff), but to ask more general questions about the overall experience and allow participants to raise specific topics which epitomise their experiences.

Motivation for Recovery

“Participants spontaneously (and unanimously) expressed the view that the key to recovery was their own desire and readiness to get well: without the motivation to get well, they would not benefit from the treatment” (Colton and Pistrang, 2004, p. 313).

This statement supports the majority of literature on the recovery process. The most common view is that individuals are motivated to recover not because of a beneficial treatment experience, but because of personal reasons.

Lamoureux and Bottorff (2005) state that many inpatients recover as they are “sick of being sick” (p. 177). Similarly, Rorty, Yager and Rossotto (1993) claim that many are motivated to recover by the desire for a better life, or being weary of having an eating disorder dominate their lives.

Yet Rieger (2000) reports that twelve weeks after admission to inpatient units, only an estimated 66% of inpatients feel ready to actively change their symptoms. Thus, a fundamental question to consider is: What can ward staff or eating disorder professionals do to aid the motivation to recover? It seems that by providing staff with an insight into what inpatients say have helped *them*, their awareness of the needs of their inpatients may subsequently increase.

Effectively, there is a paucity of research reflecting on the role of treatment in motivation for recovery. Surely, if the treatment experience was beneficial and helpful, the plight of individuals suffering with eating disorders would end much sooner, and they would not have to wait until their natural instinct of *wanting* to recover kicked in. In order for this to occur, far more research is needed on the inpatient experience, to confirm and add weight to both Colton and Pistrang (2004) and Offord et al.’s (2006) studies.

The Transition from Inpatient Unit to Home

As Stein (2007) indicates, the transition from an inpatient unit to home can be extremely challenging. Research has indicated many possible reasons for this. Bloks et al. (2001) has reported that, upon discharge, inpatients may fear that people will assume that they have completely recovered and that they will be able to cope. Stein (2007) discusses the fear of failure and inpatient concerns regarding “how they are going to take the new skills they have developed during treatment home, and...maintain their new motivation and commitment to staying well” (Stein, 2007, p. 1). This may be compounded by the fact that, upon returning to their home environment, individuals may be faced with the same issues that predisposed their eating disorders in the first instance.

Alternatively, some inpatients will have been in inpatient units for over a year, witnessing significant changes in their home environment upon their return. Offord et al. (2006) comment on inpatients’ discharge concerns, describing how many feel they do not ‘belong’ anywhere. The prospect of discharge can feel extremely overwhelming for some inpatients, and potentially even reduce the incentive for moving on with their lives. This can frequently result in relapse (Carter, Blackmore, Sutandar-Pinnock & Woodside, 2004). Indeed, Gustavus-Jones (2007) discusses the importance of adequate ongoing local support from Child and Adolescent Mental Health Services, suitable school provision and the identity of the individual within a peer group, as the lack of an adequate support system can be detrimental to an individual’s recovery (Burke & Stets, 1999).

Ultimately, it seems that if inpatients were given the opportunity, prior to discharge, to discuss and reflect upon their feelings about inpatient treatment, they may be provided with an enhanced recognition of helpful techniques. Thus, they may feel more comfortable about discharge, and the transition from hospital to home may be facilitated somewhat.

The Importance of a Study Investigating the Views of Inpatients

As aforementioned, the majority of therapeutic treatment models have mostly been developed by researchers in their ‘psychological laboratories’ or by therapists in their

‘therapy rooms’ (Jarman & Walsh, 1999). Many eating disorder clinics tend to use one preferred treatment method, usually designed by the clinics themselves, and neglect to consider what inpatients might find beneficial and instrumental to their recoveries. Perhaps this is due to the fact that, until recently, many researchers were dismissive of the views of inpatients themselves, stating such beliefs as “individuals with Anorexia Nervosa exhibit interpersonal deficits, distorted thinking and extremely manipulative behaviour...whereas Bulimics have impulse control difficulties... experience mood swings...and have a high need for approval” (Sansone, Fine & Chew, 1988, p. 125-126). This way of thinking appears to me to show a lack of respect and compassion for the suffering experienced by people with Anorexia and Bulimia Nervosa, and needs to be reconsidered.

Milos, Spindler, Buddeberg and Ruggiero (2004) state that, when treating inpatients:

“clinicians consider the severity of the patient’s disorder, previous failed attempts of therapy, the presence and type of comorbidity, and the ways in which the disorder has affected the patient’s social integration and ability to work” (p. 162).

However, this focuses solely on what the clinician thinks is best. What about the feelings of the inpatients? What do *they* think is best when it comes to *their* inpatient treatment? Essentially, this is what this research study intends to discover. As Vanderlinden et al. (2007) point out, “therapists and researchers can learn a lot from their patients about which elements are needed in a successful treatment of eating disorders: one needs only to ask about their opinion and listen carefully” (p. 364).

Some may argue that inpatients would always opt for a mode of treatment which supported their ‘Anorexic thinking’. Yet, is this a reason to disregard their thinking altogether? This may suggest that their opinions were worthless; clearly untrue since they are the ones at the receiving end of the treatment. At least if their views could be considered as potential options for future treatment, it may be of some benefit to them. As Vandereycken and Vansteenkiste (2009) discovered, inpatients were far more likely to comply with treatment when they were given a choice of different treatment options. Dalle Grave, Bartocci,

Todisco, Pantano & Bosello (1993) assert that “earning commitment and trust often proves to be the determining factor in successfully treating the patient” (p. 168). Surely a way in which to earn this trust would be to listen to their views and integrate them into treatment methods.

Of course, individual differences entail that what one inpatient may find helpful, another may find unhelpful. Yet does this mean that we should rule out altogether the possibility of exploring whether their views could be taken together to identify a treatment method which worked for them? Essentially, it is not my intention to establish one resolute future treatment method for inpatients in eating disorders clinics. Indeed, “Anorexia Nervosa in adolescents is not an illness that can be treated following one simple protocol” (Fleminger, 2005, p. 148). I simply feel that for those of us in the position to make the inpatient experience as comfortable and as helpful as possible, it is important for us to listen to what inpatients say they want from their treatment, and explore whether their experiences can be used to provide some suggestions which may work for some inpatients or eating disorder sufferers, if other methods have been unsuccessful.

Overall, the literature reviewing the perspectives of inpatients is predominantly quantitative, overlooking the richness and complexity of *why* inpatients feel that certain elements are valuable or detrimental to their inpatient experience. Moreover, past literature tends to recruit *former* inpatients of eating disorder units. Yet, removal from a situation can alter a perception of a situation (Paz-Alonso & Goodman, 2008), generating a tendency to see things either through ‘rose-tinted glasses’ or – the other extreme – recalling only bad aspects and magnifying them. Thus, it is important to explore the views of inpatients who are still inpatients. This study observes inpatients nearing the end of their treatment. I believe this allows for a more contextual and complex account of their experiences. Moreover, providing near-discharge inpatients with the opportunity to discuss and explore their time on an inpatient unit may help them to process their experiences whilst they are still a part of that situation.

In order to acquire a picture of the whole inpatient experience, and potentially identify a more beneficial treatment, all aspects of the experience – both positive and negative – should be accounted for. The majority of existing literature on inpatients with eating disorders, however, tends to focus on the more negative areas of the inpatient experience. For instance, Watson, Bowers and Anderson (2000) describe how inpatients are largely admitted to inpatient units against their will, and Freeman (2002) asserts that this often results in feelings of rejection and isolation. Stewart (2004) describes how strict routines around meal times and distance from family and friends can often lead inpatients to feel overwhelmed, lonely and unhappy. As Rushford (2006) points out, many sufferers prefer the distress associated with an eating disorder over the prospect of being *forced* to gain weight. Noordenbos, Jacobs and Hertzberger (1998) found that many former inpatients of eating disorder units reported negative experiences of treatment, including compulsory behavioural therapy and being forced to consume food via a nasal-gastric tube. Additionally, Milos, Spindler, Buddeberg and Crameri (2003) found that higher rates of comorbidity were associated with inpatient units; anxiety and affective disorders being the most prevalent comorbid psychiatric disorders for eating disorders (Herpertz-Dahlmann, Wewetzer, Schulz & Remschmidt, 1996).

Whilst informative, these findings do not provide constructive ideas about how to surmount such issues as comorbidity or isolation. For example, what might help inpatients to feel less lonely and unhappy? What might be more constructive to their recoveries than being forced to eat? It is my hope that by investigating the experiences of inpatients themselves, a more helpful method of treatment may be achievable.

Ultimately, mortality rates for eating disorders exceed all other adolescent psychiatric disorders (Herzog, Rathner & Vandereycken, 1992), claiming up to 18% of sufferers (Herzog, Greenwood & Dorer, 2009). Yet, as it has been demonstrated, there is a paucity of empirical research assessing the experiences of inpatients, with a view to informing eating disorder professionals about what aspects of treatment inpatients say they find helpful or unhelpful (Kaplan, 2002; Vanderlinden et al., 2007). In particular, there appears to be a distinct lack of qualitative studies reviewing the inpatient experience, with a view to informing both eating disorder sufferers and professionals about inpatients' experiences of treatment.

Thus, in an attempt to fill some of the gaps in the research, this study explores the meanings behind current inpatients' experiences, using a qualitative method of research; specifically Interpretative Phenomenological Analysis. Epistemologically, Interpretative Phenomenological Analysis allows the opportunity to explore the different meanings behind a person's experiences, and place the meaning of this experience "within their personal, social and cultural context" (Dean, Smith, Payne & Weinman, 2005, p. 626). Indeed, as it has been shown, there is a need for more contextual constructionist work such as this to take place.

Personal Relationship with Research

My main intention in writing this research study was to explore the experiences of inpatients at an eating disorders unit. However, there were also more personal reasons for my wish to know more about inpatients' experiences. The initial idea for this study stemmed from my own experience of having an eating disorder. I suffered with Anorexia Nervosa between the ages of eighteen and twenty-two. However, I had always felt unhappy with my weight and suffered with ED-NOS since the age of fourteen; fluctuating between binge-eating and subsequently starving myself.

Thankfully, I was able to recover from my eating disorder. When I was twenty-one, I travelled around the world and came to know and understand myself a bit better, and when I consequently felt happier, I began eating properly once again. I am fairly slim now, and feel comfortable with my body, but I still have some unanswered questions. I was never admitted to an eating disorders unit – I learnt to let go of my eating disorder myself – but I wondered how eating disorders units helped those suffering to overcome theirs. This is what attracted me to working with this population in the first place, and I have worked in three eating disorders clinics in the past³. However, my curiosity ran deeper than this.

³ I have worked in one inpatient specialist eating disorders clinic (Clinic-ED, the inpatient unit observed in this study), and one inpatient non-specialist psychiatric unit which treated people suffering with eating disorders, anxiety and other disorders. I worked as a therapeutic carer in both units, and spent up to twelve hours at a time on the units with inpatients. I have also worked as a psychotherapist in an outpatient specialist eating disorders clinic.

Essentially, I wondered what it may have been like to be an inpatient in an eating disorders unit.

Having previously worked in inpatient eating disorders units, I feel I obtained a 'first-hand' insight into what it was like to be in this type of environment, although this was only from the viewpoint of a worker, not an inpatient. My experience of working in the units was that the treatment was respectful to the individual, but firm when required. They felt like secure, contained environments in which inpatients were *allowed* to kick and scream, *allowed* to find eating difficult, *allowed* to fall apart. Yet, they were also geared towards helping them manage their anxieties about eating and food. There was a sense of community and shared understanding between inpatients. Ultimately, I found working in the clinics a largely positive experience.

However, I also wished to understand the experience from the viewpoints of inpatients themselves. Did their experiences match mine? Was it positive in their eyes, or did they see it as something completely different? Indeed, much of the research examining the inpatient experience seems to report a predominantly negative view (Lars & Ove, 2008).

Interestingly, I recently went to see an exhibition at the Wellcome Collection by the artist Bobby Baker. She had been admitted to numerous inpatient units on several occasions, following a diagnosis of Borderline Personality Disorder, and depicted her view of her experiences through a series of drawings. These drawings portrayed many vivid negative images; for instance, one of them showed the artist chopping her key-worker in half with an axe. This made me wonder whether this was similar to the feelings experienced by inpatients at Clinic-ED. If so, what made them feel this way? What was it that made their experience as it was?

Essentially, I felt it was important that participants were provided with an opportunity to *discuss* and *reflect* on their experiences. This is something that has not been widely researched and it seemed important to provide inpatients with a voice regarding their treatment. I hoped that reflecting on their time at Clinic-ED would allow participants to put their experiences into perspective before their discharge, and enable them to clarify what

elements of treatment did and did not work for them. I also hoped that listening to their accounts would answer some of my personal questions about what could have potentially happened to me.

The essential ethos of Counselling Psychology states that a more holistic view of a problem should be adopted in order to better understand it. Indeed, this research study corresponds with this ethos in its endeavour to better understand inpatients' overall experiences, in order to make their treatment as beneficial as possible. My aspiration in carrying out this study was that a more beneficial method of treatment for eating disorders may be identifiable, taking into account inpatients' views. Nonetheless, I have tried to be as open-minded as possible when analysing the data, allowing whatever needs to emerge from it to emerge. Hence, if a more useful treatment method is identifiable, this can be explored and cultivated. Even if this is not the case, however, I hope that I can provide eating disorder professionals with a broader sense of understanding of what inpatient treatment might feel like for some of the people they are caring for.

Indeed, I hope that for everyone interested – not just eating disorder professionals – this study may elucidate what it might feel like to be an inpatient on an eating disorders unit.

Information on Clinic-ED

Clinic-ED is a specialist eating disorders unit, located in a house which has been converted into a clinic. The clinic treats both boys and girls, although there are predominantly female inpatients. Inpatients are generally aged between eleven and eighteen. The clinic has over thirty beds.

Treatment consists of a weight-restoration programme, individual therapy, family therapy, group therapy, key-nurse sessions, community meetings and a step-wise reintroduction to eating with the inpatient's family. The clinic's refeeding programme involves three meal times and two snack times each day (although this varies according to each inpatient, with some only having one snack time per day), whereby inpatients are expected to eat a calorie

controlled diet. Newly admitted inpatients start on a diet with less calories, and will increase their intake over the course of their treatment (as decided by a team of nurses and doctors). There is typically a clear, consistent and explicit approach to meal times, shared by the entire nursing, carer, therapist and psychiatric team. This states that inpatients are expected to finish all their meals within a specified time period. If they are struggling to do so, other feeding measures such as calorific substitution (for instance, drinking a high calorie milkshake) or nasal-gastric feeding will be introduced.

At mealtimes, inpatients who are struggling eat together in 'Kitchen-A', whilst inpatients better able to cope eat together in 'Kitchen-B'. Kitchen-A inpatients have all their meals and snacks prepared by staff, and are supervised and encouraged by staff whilst they eat. Kitchen-B inpatients are trusted to prepare their own food and eat unsupervised. If any 'foul-play' occurs in Kitchen-B (such as serving themselves less food than they are supposed to, or flicking or hiding food), inpatients are expected to report this to staff, and appropriate action (such as moving the struggling inpatient back to Kitchen-A) will be taken.

Newly admitted inpatients or those who are struggling with dominant Anorectic thoughts (for instance, feeling a compulsion to engage secretly in weight-loss methods such as exercising) are put on 'supervision'. This entails supervision by staff for twenty-four hours a day. They eat in Kitchen-A, and will sit with a staff member during school and break times. They are monitored when using the toilet, and when taking a shower. They sleep in a large room with others on supervision (as opposed to those not on supervision, who sleep in single, double or triple rooms) and are watched throughout the night by night staff. There are typically around five inpatients in the supervision group at any one time. Usually, supervision lasts a week or two, but some inpatients can be supervised for months.

Individual therapy takes place once weekly and therapists are trained in Cognitive-Behavioural Therapy, Cognitive-Analytic Therapy, Dynamic Psychotherapy and Systemic Therapy. Family therapy occurs once fortnightly, and is a key part of the therapeutic programme. It is led by the family themselves. Group therapy occurs once weekly, and has a Cognitive-Behavioural focus. Key working takes place at least once weekly, and is focused on providing the inpatient with a space to talk outside of their allocated therapy sessions.

There are also weekly community meetings which are attended by all inpatients and staff. These meetings provide inpatients with an opportunity to discuss any issues they are experiencing on the unit.

Clinic-ED also has an internal school, with a range of teachers and tutors to accommodate different age groups. It offers a full school programme, and an after school programme, incorporating activities of both leisure and therapeutic function. These include walking, horse-riding, self-defence and swimming. Inpatients are encouraged to participate in these physical activities, provided they are eating and gaining weight.

Essentially, treatment at Clinic-ED is broken down into manageable steps. Small goals are made explicit upon admission, and are monitored throughout the inpatient's stay. For instance, inpatients are weighed twice weekly, and their weight-gain is plotted against a one kilogram per week gain. Decisions regarding their clinical care are made twice weekly by the multi-disciplinary team and are always fully linked to their weight-gain.

There are a range of pre-discharge tasks to be completed successfully by both inpatients and their families, such as meals off the unit, and weekends at home. An inpatient's discharge will take place once these tasks have been successfully completed. The entire time-scale of the stay is given to inpatients and their families upon admission, therefore there is a great incentive to keep up with the rate of weight-gain and the pre-discharge tasks. The minimum length of inpatient admission is three months, although some inpatients have stayed for over a year.

Methodology

In this chapter, I will discuss qualitative research in more depth, specifically examining Interpretative Phenomenological Analysis and its epistemological underpinnings. I will then explore both my epistemological and personal positions within the research. I will subsequently comment on the validity of Interpretative Phenomenological Analysis, and explain my reasons for using semi-structured interviews in this study.

Following this, I will relay the practical details of this study, describing the sample of participants used, the procedure of constructing the interview schedule, and the recruitment and debriefing phrases. I will then explain my methodological reflexivity within the research. Subsequently, I will comment on any anticipated ethical issues, and describe my ethical standards throughout the research. After describing the process of Interpretative Phenomenological Analysis in some depth, I will finally explore the relationship between myself and the participants in the study.

Research Aim

By carrying out this study, I hoped to illustrate the feelings and perceptions associated with the phenomenon of being on an eating disorders unit. I wished to gain access to the meanings participants attributed to their daily lives, the treatment they received at the eating disorders clinic and their overall experiences. It was my intention that this thesis would provide not only eating disorder sufferers, but professionals alike, with an insight into the intricacies of inpatient life. Hopefully, this would allow them to appreciate helpful and unhelpful elements relating to the inpatient environment, in order to aid their own development and practice. I also hoped that a more helpful future method of treatment could be identified from participants' narratives.

Qualitative Design of Research

This study employed a qualitative research design, which was exploratory in nature. Unlike quantitative research, which is concerned with testing theories and establishing facts, qualitative research focuses on personal experiences and the meanings which individuals attach to their experiences (McLeod, 2001). Pidgeon and Henwood (1997) assert that perceptions of these experiences may vary greatly, depending on the individual's frame of reference. In order to capture these unique perceptions, data for the study was obtained using semi-structured interviews. The transcripts of these interviews were subsequently analysed using Interpretative Phenomenological Analysis.

Qualitative Research and Counselling Psychology

This study intended to provide participants with an opportunity to discuss their overall perspectives of treatment, taking into account positive, as well as more challenging elements of their inpatient experience. Indeed, this corresponds with the general ethos of Counselling Psychology; adopting a more holistic view of a problem or issue in order to better understand it. Based on the Humanistic principles of empathy, congruence and unconditional positive regard (Rogers, 1961), Counselling Psychology places the utmost importance on a person's feelings, experiences, perceptions, values and behaviours (Woolfe, Dryden & Strawbridge, 2003). Qualitative research reflects this philosophy, attaching great importance to an individual's subjective experiences and exploring the meanings inherent.

The researcher/participant relationship is considered to be at the heart of qualitative research (Marshall & Rossman, 2006). The trust and rapport central to this is mirrored in the therapist/client relationship in Counselling Psychology, and it is this which is believed to ultimately facilitate a client's positive development and their understanding of a situation (Clarkson, 1995). Essentially, what the qualitative researcher and therapist both intend to do is understand an individual's experience as closely and accurately as possible, interpreting, contextualising and making sense of the individual's narrative, accounting for perspectives

both in and outside awareness. This is particularly true of the researcher doing Interpretative Phenomenological Analysis. Indeed, the phenomenological element of this type of research explores the meaning of the lived experience of an individual regarding their position in their world, and the social and cultural co-constructed networks within that world (Spinelli, 2006). It focuses on the participant's story, rather than any form of objective truth, fact or cause, which the positivist would seek (Bogdan & Taylor, 1975).

Epistemological Underpinnings of Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis allows researchers to explore the different meanings behind a person's experiences, and place the meanings of these experiences "within their personal, social and cultural context" (Dean, Smith, Payne & Weinman, 2005, p. 626). Whilst positivists seek objective facts or causes in order to understand a social phenomenon, phenomenologists explore the ways participants see a phenomenon in order to better understand it. Interpretative Phenomenological Analysis adopts a non-positivistic, relativist ontology, which "emphasises the diversity of interpretations that can be applied to [the world]" (Willig, 2001, p. 13). This relativist approach correlates well with this study's aim to understand the individual subjective experiences of inpatients, who all have their own relative relationship with the inpatient environment.

Smith (1996a) explains that there are three epistemological underpinnings to Interpretative Phenomenological Analysis; Husserlian phenomenology, hermeneutic phenomenology and ideography.

Husserl's concept of phenomenology posited that experience was the source of all knowledge, and that focusing on how individuals experienced objects, events and people would provide answers about the world. This entails, for example, that an object ceases to be something 'external', but instead is defined as how a person constitutes this object (Husserl, 1931). Husserl stated that these 'essences' of things explained why two people may have different perceptions of the same phenomenon, and why one person may have many different perceptions of the same phenomenon. Husserl (1936) went on to argue that

people constituted the meanings of things through intentional awareness and consciousness. This is referred to as 'Transcendental Phenomenology'.

Husserl's phenomenological philosophy was essentially a *descriptive* enterprise. As Elliot (2008) explains, this refers to the attempt to represent events or experiences as accurately and as faithfully as possible. Giorgi (1985) agrees that phenomenological inquiry should be a descriptive method, since it is through the description of how things are constituted in consciousness that we can explain a phenomenon. However, Heidegger (1925), Husserl's non-conformist disciple, argues that the phenomenological method was basically *interpretative*, focusing on the underlying meanings of a person's narrative. He takes an ontological viewpoint (observing the nature of being, existing and reality), and states that, as a phenomenological method, interpretation is primary, and that description is a special type of interpretation (Giorgi & Giorgi, 2008).

Effectively, this Heideggerian phenomenology corresponds with the 'hermeneutic' phenomenological method, a further theoretical method underpinning Interpretative Phenomenological Analysis (Smith, 1996a). Hermeneutic phenomenology refers to the study of the interpretation of written texts, and the role of the researcher in their attempt to understand an individual's narrative. Ricoeur (1976) identifies two types of hermeneutics; the hermeneutics of empathy and the hermeneutics of suspicion. He states that whilst the hermeneutics of empathy represents an authentic account of an experience, the hermeneutics of suspicion refers to a more rigorous level of interpretation.

Ricoeur (1976) argues that the text is independent of the participant's intent and therefore the researcher determines the meaning of the text. Gadamer (1960) takes another angle within the hermeneutic approach, positing that the meaning of the text goes beyond the participant's intent, and that the subject matter determines the text's meaning. He explores the role of language, the nature of questioning and the significance of the researcher's prejudice, history and tradition in influencing their understanding of a person.

Fundamentally, hermeneutics recognises the role of 'the other' within the process of interpretation and accounts for historical, cultural and social influences. Husserlian

phenomenology, conversely, focuses on an individual's conscious experience and constructing a description of that experience. In an attempt to reconcile the tensions between Husserlian and hermeneutic phenomenology, researchers can use their interpretations to draw out and understand the meanings inherent to an experience. This is referred to as the 'hermeneutics of meaning recollection', and corresponds with the interpretative and descriptive elements of Interpretative Phenomenological Analysis (Larkin, Watts & Clifton, 2006).

Smith (1996a) proposed that the theoretical foundations of Interpretative Phenomenological Analysis rested upon another area: *Ideography*. He states that Interpretative Phenomenological Analysis has an ideographic commitment to the detailed study of each individual case. Fundamentally, ideographic research is concerned with placing value on individuals as distinct from one another. This is in contrast with the nomothetic, more positivist, mode of inquiry, which Smith, Harre and Van Langenhove (1995) argue "loses the ability to recover information pertaining to any particular individual" (p. 6).

Interpretative Phenomenological Analysis takes an ideographic approach in that it maintains that two individuals may talk very differently about the same experience and the meanings inherent. This emphasises the subjective way in which individuals make sense of their experiences (Smith, 2004). By first understanding one account, this subsequently informs the researcher's understanding of further accounts of the same experience, and indeed the understanding of a more universal experience (Warnock, 1987). In this way, the ideographic foundation of Interpretative Phenomenological Analysis forms a link with Husserlian phenomenology, and Husserl's explanation of 'essence'.

Epistemological and Personal Reflexivity

"Reflexivity requires an awareness of the researcher's contribution to the construction of meanings throughout the research process, and an acknowledgement of the impossibility of remaining 'outside of' one's subject

matter while conducting research. Reflexivity then, urges us to explore the ways in which a researcher's involvement with a particular study influences, acts upon and informs such research" (Nightingale & Cromby, 1999, p. 228).

Many questions arose when I reflected upon my own position within the research, particularly since I had previously suffered with an eating disorder. What emotions would conducting my research in this area evoke? Would I be able to cope with hearing potentially painful accounts of experiences? Essentially, I now feel able to control my eating disorder under normal circumstances, but carrying out this research may not have constituted normal circumstances. Doing a doctorate is stressful enough, notwithstanding the fact that I was willingly putting myself in the position of researching something that I had suffered from in the past. Nonetheless, researching this area was simply too important to me to have concentrated my research in another area. I fear I would have spent the remainder of my professional and personal life regretting it if I had not conducted my research on eating disorders. I have worked in the field of eating disorders for six years, and never relapsed or felt that my eating behaviours may become out of control. If anything, it has enhanced my understanding of what I went through and helped me to lay any residual eating difficulties to rest. Thus, I felt that, although it may be challenging to conduct an in-depth exploration of an eating disorders unit, I would be able to cope. Nonetheless, as a precaution, I maintained an awareness of my emotions throughout the research by keeping a reflexive diary and being open with my supervisor.

Additionally, I previously worked at Clinic-ED, the eating disorders unit observed in this study. My role (as a therapeutic carer) involved spending time in the clinic with inpatients, and providing support and assistance during mealtimes and throughout the day⁴. Many questions also arose regarding this. How did I feel about going into Clinic-ED to conduct interviews? How would my own experience of working in Clinic-ED affect my interpretations? How would I impact upon participants' propensities to talk openly? Would they find me intimidating? Or would they find me approachable?⁵ Essentially, it is crucial to

⁴ It is important to note that I stopped working at Clinic-ED two years ago, thus none of the inpatients at the time of this study were inpatients when I worked there.

⁵ A summary of my relationships with participants is provided in Appendix 10.

reflect on such personal and epistemological queries before, during and after the research process. Thus, I attempted to be open to my own experiences from the outset in my reflexive diary and consistently discuss my thoughts, values and beliefs in supervision.

This covers my personal rationale for conducting the research. As for my epistemological stance, this was harder to establish. I knew I was interested in the overall phenomenon of being an inpatient on an eating disorders ward, but I had some trouble deciding where I stood in terms of Husserlian phenomenology, hermeneutics or an alternative approach. I repeatedly went 'back to the beginning' – where did it all start for me?

My research aim was to better understand the experiences of inpatients. As Smith and Osborn (2003) assert, *understanding* captures two aspects of interpretation, "understanding in the sense of identifying or empathising with, and understanding as trying to make sense of" (p. 54). I was essentially trying to *make sense of* inpatients' experiences, yet I was aware that my own identifications and sense of empathy may influence this in some way.

It may be logical to assume that the researcher/participant relationship will inevitably have a significant impact upon the interview process. A participant's propensity to discuss certain emotions and experiences may be largely affected by this relationship; hence the information given in the interviews may be context dependent. Indeed, many researchers state that the participant/researcher relationship is a necessary part of the research process (Ajjawi & Higgs, 2007; King, 2004). Perhaps having had an eating disorder, working with eating disorders sufferers in the past, and specifically having worked at Clinic-ED, my interactions with participants may have been affected in that I may have been more aware of my perception of their experience. Hence, how could I account for my own pre-conceptions in the process of analysis?

Smith and Osborn (2003) refer to a double hermeneutic process; "The participants are trying to make sense of their world, the researcher is trying to make sense of the participants trying to make sense of their world" (p. 53). Ultimately, then, does this mean that the analytic process can never be free of the researcher's pre-conceptions? Larkin, et al. (2006), indeed maintain that a participant's account of their experience is always

constructed by both researcher and participant. I wondered whether the richness and complexity of the participant's account which Interpretative Phenomenological Analysis attempts to capture may, thus, be compromised in some way.

A potential solution to this problem can, however, be found in the theory of *contextual constructionism*. This approach "accepts the inevitability of bringing one's personal and cultural perspectives to bear on research projects. In fact, the empathy provided by a shared humanity and common cultural understanding can be an important bridge between researcher and participant and a valuable analytic resource" (Madill, Jordan & Shirley, 2000, p. 10).

I was able to recognise that contextual constructionism provided the most appropriate epistemological foundation for my research. The theory proposes that all knowledge is situation and context dependent (Jaeger & Rosnow, 1988), and "that different perspectives generate different insights into the same phenomenon" (Willig, 2001, p. 145). Contextualism involves the production of a meaningful account which takes into consideration all the multiplicities, variations and complexities of both the participants' and the researcher's worlds (Henwood & Pidgeon, 1994). This may include ideographic historical, linguistic, socio-economic and cultural influences, which are all understood to be central to the meaning and function of all phenomena (Yardley, 2000). Multiple meanings may be constructed by participants according to their context, and the way they actively try to make sense of their world. Jaeger and Rosnow (1988) explain that "like a message that makes sense only in terms of the total context in which it occurs, human actions are embedded in a context of time, space, culture and the local tacit rules of conduct" (p. 66).

Due to the fact that context has so many elements, the researcher "invariably has to make assumptions about some of these elements" (Best, 1995, p. 346). It felt useful to be able to accept myself as part of the research process. Before, I had been trying to identify my stance as distinct from the participants – trying to ignore my own feelings and perceptions so as not to affect my perception of participants' experiences in some way. Yet the contextual constructionist approach *accepts* researcher's pre-conceptions, maintaining that the researcher's avoidance of any assumptions is an impossible demand (Best, 1995).

Essentially, contextual constructionism provides a sound underpinning for Interpretative Phenomenological Analysis (Willig, 2008), positing that research results are justified as long as they are grounded in the interview data (Madill et al., 2000).

Validity and Reliability

The contextual constructionist approach to conducting Interpretative Phenomenological Analysis does not warrant using more traditional methods of measuring reliability and validity. These types of measures are rooted in positivist perspective and are traditionally employed to evaluate scientific realist frameworks (Madill et al., 2000). Whilst credibility in quantitative research depends on the instruments used, in qualitative research, the researcher is the instrument (Patton, 2002), and the credibility of the research depends on their ability and effort (Golafshani, 2003). Whilst reliability and validity are concerned with *measurements* (Stenbacka, 2001), qualitative research, and indeed constructionism, is concerned with *interpretation* (Henwood & Pidgeon, 1994).

Essentially, Interpretative Phenomenological Analysis is rooted in the belief that both researcher and participant are conscious beings interpreting the world according to their networks of cultural meaning (Giorgi, 1995). The researcher employing Interpretative Phenomenological Analysis does not claim to present findings as 'truth'. Their analysis of data must be acknowledged as *only one possible interpretation* (Pugh & Coyle, 2000).

Denzin and Lincoln (1994) assert that a researcher will demonstrate authenticity if they express a variety of different perspectives in a fair and balanced way. Therefore, both the researcher and participants' voices must be evident throughout the analysis. By using the actual words of participants as much as possible, some degree of the researcher's subjectivity is reduced (Tindall, 1994), yet total objectivity is never completely possible, as the researcher subjectively chooses which words to use.

Smith, Jarman and Osborn (1999) offer practical and accessible guidelines to conducting research using Interpretative Phenomenological Analysis. However, Smith (2004) also states

that “what determines the quality of the outcome is the personal analytic work done at each stage of the procedure” (p. 40). As such, it is essential for the researcher to be transparent and open throughout their journey of analysis. This will provide the reader with an insight into the researcher’s ideas, thought processes, incentives and developments. These can be recorded via a field diary, reflexive diary, a research log and a paper trail of the analysis (Willig, 2008).

The use of supervision is also central to understanding and developing a sense of reflexivity (Etherington, 2004). From the start of the research project, it should be utilised in such a way which promotes the generation of new ideas and reflexive thoughts. The researcher should use supervision to determine their stance in relation to the epistemology, methodology and analysis of the research. They should also use it to examine their relationship to the participants, the research project and the research topic (Pearson & Brew, 2002).

Semi-Structured Interviewing

I chose to use semi-structured interviews in this study due to the valuable insights into the worlds of participants they allow. Before deciding upon this, I did consider using other methods to gain an insight into the inpatient experience; including observation and the analysis of inpatients’ diaries.

As Bogdan and Taylor (1975) note, observing inpatients may provide a holistic overview of participants in their environments and allow the researcher “to view the dynamics of conflict and change and thus see...relationships, and group and individual definitions in process” (Bogdan & Taylor, 1975, p. 5). Nonetheless, I felt that carrying out observatory methods may have been inappropriate in this study, as it may have involved watching participants eat. The population in this study are nearing the end of their treatment and therefore eat unsupervised. They have been afforded the trust to eat by themselves as part of their treatment programme, and being watched whilst eating may have been intrusive.

Personal diaries allow a more intimate insight into the emotions connected with the inpatients' experiences, and illuminate aspects of an experience which are not directly observable or apparent. However, they require the participant to make a long commitment to maintaining a record of events, feelings, experiences and activities (Willig, 2008). Additionally, the writing process is left to the discretion of the participants, which may lead to an insufficient amount of material being generated. This extra element of 'work' may also deter participants from volunteering in the first place. Furthermore, inpatients at Clinic-ED are encouraged to talk openly to staff and therapists about their feelings and experiences and I wondered whether writing a diary may have deflected from this.

Aside from this, I valued the opportunity to actually speak to participants about their experiences. Neither observation nor personal diaries would have allowed the same degree of communication and rapport between the participants and me as interviewing would. Indeed, it is this rapport and the dynamic interaction between researcher and participant which enriches interviews (Chan, 2005). Furthermore, any intonations, poignant pauses and facial expressions perceptible in the interview dialogue may be lost in observatory methods or written documents, which may result in some degree of misinterpretation by the researcher (Robson, 1993).

Ultimately, I felt that the semi-structured interview technique was the best suited to investigate my research topic, as it affords a more co-operative element to the research. This corresponds with Smith's (1995) assertion that exploratory research is best suited to semi-structured interviews. The researcher's questions "function as triggers that encourage the participant to talk" (Willig, 2001, p. 22). As Dearnley (2005) asserts, the open nature of questions encourages depth and vitality in the participant's discourse and allows new concepts to emerge. I wished to offer participants the opportunity to talk freely and honestly about their experiences in an open-ended, flexible framework. I felt the semi-structured interview was a valuable way of enabling this.

Unlike structured interviews, semi-structured interviews offer the participant greater freedom in describing their perceptions of their experiences as they wish (Bernard, 2001). Although questions are composed prior to the interview, these act as a guide and additional,

related questions are created during the interview. This allows both researcher and participant the flexibility to discuss details in more depth. Unlike unstructured interviews, the same pre-scheduled questions are asked to every participant, thus enabling the researcher to observe contrasts and similarities between narratives (Bernard, 2001). Smith (2003) particularly recommends using Interpretative Phenomenological Analysis in conjunction with interview data on account of its ideographic, personal nature. He explains that the advantage of using the semi-structured interview is that “it facilitates rapport/empathy, allows a greater flexibility of coverage and allows the interview to go into novel areas, and it tends to produce richer data” (Smith, 2003, p. 59).

Method

Sampling and Participants

Denzin & Lincoln (1994) explain that:

“Many qualitative researchers employ...purposive and not random sampling methods. They seek out groups, settings and individuals where...the processes being studied are most likely to occur” (p. 202).

This study used purposive sampling as I wished to explore and understand the experiences of a specific group of people. Smith, Flowers and Larkin (2009) assert that researchers conducting Interpretative Phenomenological Analysis should try to find a fairly homogeneous sample with which to carry out their research. This is so that the researcher will be able to intricately examine the convergences and divergences of experiences within the sample.

The population for this thesis comprised of a group of inpatients from Clinic-ED. (I originally attempted to recruit participants from another clinic, but there was only one eating disorders inpatient at the time of recruitment, and she was not nearing the end of her

treatment, therefore was unsuitable for the study.) I recruited participants via the ward manager. The details of this process are discussed in the Procedure section following.

The ages of participants were between twelve and seventeen. As some participants were under sixteen years of age, parental consent was obtained before any interviews took place.

All recruited participants were female. The reason for this was that the majority of eating disorder sufferers are female (McNamara, Hay, Katsikitis, & Chur-Hansen, 2008), hence the inpatients in Clinic-ED were mainly female. Due to the minority of males suffering with eating disorders and being admitted to inpatient units, I felt it would be more appropriate for a separate study to explore their experiences within the predominantly female environment of inpatient units.

Participants interviewed in the study were approaching the end of their treatment, and had at most four weeks left until discharge. The minimum length of stay on Clinic-ED is three months, although all participants used in the study had inpatient stays of over four months. Hence, all participants had spent over three months on the unit when their interviews took place.

In short, the principal inclusion criteria for this study were that participants were female, were between the ages of twelve and seventeen, and were still inpatients, but approaching the end of their inpatient treatment. In addition, participants should have been willing to be interviewed for approximately one hour, and willing to share their experiences of life and treatment in an inpatient unit. Exclusion criteria for the population were anyone who did not fall into the inclusion criteria above and anyone who did not speak English as a first language. This was due to the fact that research using Interpretative Phenomenological Analysis requires the production of rich descriptions of experience on the part of the participant. Therefore, it is important that participants are fluent in the English language, in order to eliminate the possibility of losing any richness or complexity of data due to a potential language barrier.

Table 1 highlights the demographics of the participants used in the study. The real names of participants have been changed to the pseudonyms below in order to protect their anonymity.

Table 1: Name, Age and Time Difference between Interview and Discharge.

Name	Age	Time on Unit	Time until Discharge
Amy	15	14 weeks	4 weeks
Beth	16	19 weeks	3 weeks
Cat	16	1 year, 3 months (since first admission) ⁶ 16 weeks (since second admission)	3 weeks
Delia	17	16 weeks	4 weeks
Emma	15	15 weeks	4 weeks
Fran	12	15 weeks	4 weeks
Gaby	15	16 weeks	1 week
Holly	15	18 weeks	3 weeks

Eight participants were interviewed from Clinic-ED. Smith (1996b) reports that when conducting Interpretative Phenomenological Analysis studies, enough verbatim evidence should be collected until ‘saturation’ has been reached; that is, until no new themes can be extracted from interviews. Smith and Osborn (2003) assert that only a small number of

⁶ Cat’s first admission lasted for six months.

participants, ranging from five to ten, should be used in Interpretative Phenomenological Analysis, in order to allow detailed analysis to be conducted. In accordance with these principles, and consistent with university regulations, eight participants were considered to be suitable number, such that a sufficient and manageable amount of information could be extracted from the interviews.

No pilot study preceded the research. Instead, the first interview conducted was used as a gauge to determine whether any major changes to the interview structure or my interviewing technique needed to be made. Had any alterations been required, the first interview would have acted as a pilot interview. However, I provided my supervisor with the transcript of the first interview to read through, and she confirmed that the overall structure and technique was appropriate and effective. Therefore, I maintained this original approach throughout the interviews.

Procedure

Recruitment and Preparation

I contacted both Clinic-ED and a second eating disorders unit before the interviews took place, (see Appendix 1 for letters asking permission to carry out the interviews), and the clinic managers offered conditional agreements for the study to take place, requiring that ethical approval was obtained from City University. Upon receiving ethical approval from City University, I subsequently sought and received NHS approval for the research study (see Appendix 2 for NHS ethical approval letter).

Recruitment for participants involved a standardized flyer, distributed to inpatients via clinic staff, (see Appendix 3). As there were no compatible participants from the second clinic, I focused solely on recruitment at Clinic-ED. Initially, only two inpatients wanted to participate in the study. Upon reflection with my supervisor, I decided that to introduce a cash incentive may be more likely to encourage inpatients to participate. Thus, after obtaining further NHS ethical approval via a notice of amendments, I offered a £10 gift

voucher for either Boots or Accessorize. This was indicated on revised copies of the recruitment flyer, and on parental and participant information sheets.

Following interest, participant information sheets were distributed to willing inpatients, reiterating information concerning the purpose of the study (see Appendix 4). Parental consent and information forms further explaining the nature of the study were distributed to the parents of each willing participant under sixteen years old, (see Appendices 5 and 6). Although I did not intend to meet parents as part of the study, if any parents had wished to meet to discuss the study further, this would have been arranged. This, however, did not happen. Parents of children under sixteen years old were informed that should they wish to withdraw their children from the study, they would be free to do so at any time; even if their child had stated that they were happy to continue.

Upon obtaining parental and participant consent, a mutually convenient time was arranged to meet participants, in order to conduct the interviews. Interviews were arranged with participants themselves before discharge took place. If parents wished to accompany their children, they would have been able to do so, and would have been asked to wait in a separate room during the interview, in order to allow the participant to speak as openly as possible. However, no parents wished to accompany their child.

Pre-Interview Discussion

Interviews took place in a pre-booked interview room, located in the clinic itself. Upon meeting, participants were provided with a verbal explanation of the aim of the study, how their interviews would be used, and the expected time of their participation. They were also provided with a consent form (see Appendix 6), which they were asked to sign. Participants were informed that should they wish to terminate the interview at any time, they should let me know. In this instance, they would have been allowed a brief period of time to think about whether they would like to continue or terminate the interview. If they had chosen to terminate, they would have been provided with a 'debriefing' form, (see Appendix 8). No participants, however, chose to terminate the interview or pause the tape. Participants were also informed that their names would be changed for the study, thus ensuring their

anonymity. Before beginning the interviews, participants were invited to ask any questions regarding the study, and were then invited to begin. Interviews took approximately one hour.

The Interview Schedule

Smith and Osborn's (2003) guidelines for conducting semi-structured interviews for Interpretative Phenomenological Analysis were consulted before composing the interview schedule. The questions were conversational in nature and were not designed to impose a rigid direction upon the interview. This was intended to encourage and facilitate openness in the participants' narratives. The questions were open-ended and served as a guide for potential areas to cover. I asked questions about daily life, their best and worst experiences, the meanings they attributed to their experiences and their perceptions of the treatment they received at Clinic-ED.

The questions were designed to enable the participants to feel as comfortable as possible at the start of the interview. Thus, the first question was a more general enquiry of a typical day at Clinic-ED, which then led onto more experiential questions. I had initially considered asking about more specific aspects of their experiences, such as the impact of family and friends. However, upon reflection in supervision, I came to realise that more general questions would be appropriate in allowing the participant to choose to discuss whatever aspects of their experience were most pertinent for them.

For a copy of the interview schedule, please see Appendix 7.

Post-Interview Debrief

A verbal debrief was conducted after each interview, to allow participants the opportunity to discuss their experiences of the interview. Participants were also provided with a debriefing form (see Appendix 8). I had intended that any material gathered in unfinished interviews would be destroyed and would not have been used in the final study in any way. However, since all participants completed their interviews, this did not need to be implemented. Upon completion of the interviews, participants were presented with a £10

gift voucher. Had any participant terminated or withdrawn from the study they would still have received this voucher as a token of gratitude.

Upon obtaining completed interviews from participants at Clinic-ED, I subsequently transcribed and analysed the data using Interpretative Phenomenological Analysis, (see Analytic Strategy section). Lastly, all work and findings were written up in this final thesis.

Methodological Reflexivity

As well as reflecting on my personal and epistemological stance within the research, I also found it useful to reflect upon the method I used. Methodological reflexivity involves reflecting on the process of research, and exploring how it may have affected the outcome (Hardy, Phillips & Clegg, 2001).

Initially, I had proposed to interview participants from a larger number of inpatient units. I recognise that this may have provided a broader range of perspectives on the experience of being an inpatient. Although I originally recruited participants from a second clinic in addition to Clinic-ED, as aforementioned, there were no suitable inpatients at the time of recruitment. I did contact five other eating disorder units but all stated that they did not require any research to be conducted. Thus, for practical reasons, I could only interview participants from Clinic-ED.

Participants were between the ages of twelve and seventeen. However, there was only one twelve year old (Fran), with the other participants ranging from fifteen to seventeen years. I wondered whether Fran's perspective would differ from her peers' perspectives, but I felt it was important to include her interview in order to provide a broader overall view of the inpatient experience. Any differences between Fran and other participants will be observed in the results chapter.

I interviewed near-discharge inpatients, as I felt that participants who had been inpatients for less time may have encountered fewer experiences than those who had been there for longer, and I wished to gain an insight into as many different experiences as possible to

enhance the richness of information about life and treatment in Clinic-ED. For practical reasons, it was not possible to interview participants with exactly the same amount of time remaining; one participant had one week left, whilst others had three or four weeks left. However, upon reflection I concluded that their accounts may, in some ways, be richer in that they would provide insights into different stages of admission. Inpatients' views may have changed the closer they were to discharge, hence different experiential accounts may have been given.

Interviews were conducted in Clinic-ED itself. This posed the challenge of actually conducting interviews in an eating disorders unit, with eating disordered and other behaviours taking place in the vicinity. For instance, in one interview, there was frequent screaming heard in the background, by a new inpatient who was very distressed at being admitted. In another interview, there was loud, consistent vomiting heard in the background. Again, the interview was conducted on a day when a new inpatient was admitted and she had been vomiting throughout the day. These background noises had different effects on each of the participants. The participant who heard the screaming (Gaby) was not overtly affected. However, the participant who heard the vomiting (Emma) was noticeably affected and cried nearly every time it happened. I did wonder whether the information given in Emma's interview may have been different if the vomiting had not been audible. As it eventuated, some of the interview was spent discussing this, when it may otherwise have been spent discussing other issues. Nonetheless, I did include this interview in the analysis. I hypothesised that this was a fundamental component of the experience of being in an eating disorders unit, and to actually explore this with a participant as it was happening may have been valuable in allowing me a deeper insight into their experience.

Ultimately, I believe that conducting interviews in Clinic-ED itself was preferable to holding them elsewhere. I feel that removing participants from the ward environment may have affected their views somewhat, perhaps hindering their inclination to talk openly, due to potential discomfort caused by unfamiliar surroundings. This would have been both unethical and unnecessary.

Ethics

Some participants interviewed in this study were under the age of sixteen. Thus, it was anticipated that a minimal knowledge of ethical issues would be held by them. As such, the stringency of my application of ethical standards was crucial.

Firstly, the anonymity of participants was critical. After conducting and transcribing interviews, all transcripts were locked under a password on my computer, and all tapes and consent forms were locked in a cupboard at my house. Transcripts were labelled using alphabetical pseudonyms, for instance, Amy, Beth, Cat, etc. The actual names of participants were not attached to any transcripts, to ensure that there was no way of identifying whose interview belonged to whom. Only I had access to this information, via a 'key' system, which was kept separately from transcripts, tapes and forms, and was also locked in a cupboard. This was explained to participants in the pre-interview discussion, and it was ensured that this was completely clear to them before they began the interviews. It was also reiterated in the information sheets and consent form.

It is worth mentioning that confidentiality could only be kept within ethical boundaries; if participants had informed me in the interviews that they were planning to revert to anorexic tendencies upon discharge, or self-harm in any way, I would be obliged to inform unit staff and breach confidentiality. As it eventuated, one participant (Beth) did disclose that she was planning on reverting to her anorexic tendencies and running away following her discharge. After discussion with my supervisor, I did let the unit know about this. However, the participant's guardian had chosen to discharge her prior to her discharge date; thus the unit were unable to intervene at that point. Beth's narrative is explored further in the results chapter, regarding whether any differences were apparent between her and other participants' accounts.

As explained in the Procedure section, participants were provided with the opportunity for both pre- and post-interview discussions. The pre-interview discussion is important in establishing a rapport with the participants, and helping them to feel comfortable. Smith Larkin and Flowers (2009) assert that this will increase the likelihood of obtaining richer data from participants.

Material discussed in the interviews was, essentially, of similar nature to that regularly discussed in the inpatient setting, thus I envisaged no unusual risk to the participants' well-being during or following the interview. Nonetheless, the possibility was considered that some participants may have become distressed during the interviews. I had intended that, should this occur, I would utilise my counselling skills to calm them down, although not actually provide therapy. If participants appeared to be anxious, I asked them if they wished to suspend or terminate the interviews, and reassured them. As it transpired, no participants wanted to stop the tape during the interviews. It was taken into consideration that Fran, being younger, (at twelve years old) may not have felt able to voice a desire to stop the interview. Throughout her interview, I was vigilant for any non-verbal communication indicating a desire to stop and would have paused or terminated the interview accordingly. Nonetheless, she did not become visibly distressed or express distress following the interview.

Post-interview discussions were intended to assess participants' experiences of the interviews. Although no participants said they felt distressed or overwhelmed following their interviews, I recommended that, if they felt they needed to, participants should discuss any residual anxiety with their existing inpatient therapists. (As participants were already receiving therapy as part of their inpatient programme, it would have been unethical to suggest utilising external counselling services.) I also ensured that there were staff on duty following the interviews whom participants would have felt comfortable talking with if required.

Analytic Strategy

This study involved participants describing and reflecting on their lives in an inpatient unit. In order to obtain richer and more intricate accounts of their experiences, a qualitative method of research was used. Essentially, the study intended to observe the "*phenomena* that appear in [a participant's] consciousness as [they] engage with the world around [them]" (Willig, 2001, p. 51). Phenomenological research allows the researcher to gain an insight into the participant's world through the analysis of the content and meaning behind

what the participant says. It focuses on the uniqueness of an individual's thoughts and perceptions about their experiences, as opposed to making objective descriptions about these experiences (Smith et al., 1999).

In order to represent participants' views of their world as accurately as possible, the researcher should focus on the basic findings in their actual descriptions (Tindall, 1994), whilst being "sensitive to the complexities of behaviour and the meaning in context" (Henwood & Pidgeon, 1994, p. 227). Smith (2004) recommends "checking ones reading again against the local text itself, and verifying it in the light of the larger text" (p. 46). This will help the researcher stay grounded in the text itself. Hence, I tried to incorporate these recommendations into my analysis of the data.

Each transcript was analysed individually. Interpretative Phenomenological Analysis involves identifying evident themes in a participant's discourse and then 'clustering' them to form 'superordinate' themes. This procedure is then repeated across all participants' transcripts, and 'master themes' are subsequently identified from clustering the themes emerging from all participants' narratives. These master themes attempt to "capture the quality of participants' shared experiences" (Offord, Turner & Cooper, 2006, p. 379). The master themes comprise of constituent themes which have emerged from the data. In drawing up a table of master themes, comparisons can be made between the superordinate themes emerging from each participant's account, and similarities and differences between the participants' narratives can be identified (Smith, 2004).

Essentially, the process of analysis is iterative and requires a number of revisions. Analysis requires a process of familiarisation, the identification of themes and connections between participants' transcripts, and coding and recoding across all narratives (Coffrey & Atkinson, 1996). Smith et al. (1999) do assert that the process of Interpretative Phenomenological Analysis is personal on the researcher's part and can be adapted to each researcher's individual style. Thus, with my supervisor, I identified a process which felt comfortable for me.

Initially, I transcribed all the interviews verbatim, including any non-verbal communications such as shifting in the chair, crying, sighing, laughing and any noises in the background. I then read through each transcript individually, dividing it up into sections every couple of sentences. I wrote down, in the left-hand margin, any initial thoughts and interpretations which related to the narrative. These thoughts did not digress too broadly from the actual words used; they simply highlighted any significant parts of the transcript. The same small sections would be read and re-read approximately four or five times, in order to allow as many reflections and interpretations to emerge as possible. Following this, I wrote in the right-hand margin a theme summarising each small section. I wrote these themes on a separate piece of paper and then clustered together similar themes to form superordinate themes. This process was repeated over all the interview transcripts. I subsequently drew a table of master themes illustrating each master and constituent theme, and identified which participants experienced these themes by indicating their corresponding transcript page and line numbers (see Appendix 9). Each transcript was then re-read and compared to the list of master themes to illuminate any connections and discrepancies between participants.

The process is somewhat subjective on the researcher's part, and is dependent on a researcher's own conceptions, which are required to make sense of a participant's personal world. Although contextual constructionism embraces this, it is important that the researcher maintains an awareness of what is theirs and what is the participant's, throughout the process. This was achieved by revisiting the contents of transcripts and making consistent use of supervision. I also followed Silverman's (2000) and Robson's (1993) recommendations to keep a research diary in order to record the progression of thoughts and ideas, and maintain a reflective stance.

The reason for using Interpretative Phenomenological Analysis in this study, as opposed to any other analytic strategy, is that it endeavours to gain an understanding of the participant's world from their own perspective. Thus I felt it may allow for a more accurate account of the phenomenon of being on an inpatient eating disorders unit. Other qualitative research methods, such as Grounded Theory, aim to formulate a specific theory or hypothesis about a phenomenon. Instead, Interpretative Phenomenological Analysis aims to explore the participant's subjective experiences, allowing them the opportunity to discuss

whatever they feel is most pertinent about their experience. Whatever emerges from the data ultimately influences how the research question is answered.

Researcher/Participant Relationship

Murray (2003) asserts that at the heart of the semi-structured interview is the participant / researcher relationship. He considers connection, rapport and trust to be essential factors in engaging the participant, thus allowing them to talk more openly. Willig (2008) asserts that the researcher's own identity should be taken into account to examine the effect that this may have upon participants. For those with eating disorders, the first and most significant thing they may notice in others is their weight and size (Sanderson, Wallier, Stockdale & Yopyk, 2008). Although I do have a fairly normal weight, the effect this may have had upon participants is ambiguous. Some may have felt competitive and intimidated by this (Maner, Holm-Denoma, van Orden, Galliot, Gordon & Joiner, 2006). Hence, their discourse may have been restricted. Alternatively, some may have felt that being slim myself I might relate to them more, thus divulging more information.

Additionally, having previously worked at Clinic-ED, I did wonder whether my interactions with participants may have been affected in any way, in that I may have been more aware of my own perception of their experience. Furthermore, I may have subconsciously been aware of my own experiences and perceptions of the eating disorders unit. I felt that my phenomenological task throughout the research was to discover more of a whole perspective on the lived, subjective experiences of participants, which they previously may not have reflected on. What emotions did different moments within Clinic-ED evoke for participants? What did it feel like to be immersed in the world of Clinic-ED? Yet, I also wished to grasp and understand more of my own perspectives on what this might feel like. As Madill et al. (2000) assert, it is impossible for either participant or researcher to attain a position of complete neutrality. In order for me to be aware of my thoughts and pre-conceptions, without cultivating them, I focused on them at separate stages of the research process.

Firstly, during the interviews, I was initially aware that my own pre-conceptions may have been in the back of my mind. Thus, in basic terms, I simply tried to listen. What were the participants saying about their experiences, feelings and emotions? This was indispensable as it actually highlighted exactly what my pre-conceptions were. Fundamentally, I had been too focused on my own feelings regarding what aspects of treatment I thought were helpful or unhelpful, what aspects I agreed and disagreed with, and what aspects I liked and disliked. By becoming aware of these pre-conceived notions, I was thus able to identify them during the interviews, and recognise them as my own, not the participants'. This helped me to follow their experiences more closely and obtain a better understanding of the meanings of these experiences.

When transcribing the interviews, although recording all the participants' words verbatim, I tried to be as accurate as possible in including all non-verbal expressions and background noises. When I was in the interview room, I often found myself totally immersed in what participants were saying. The act of transcribing, however, essentially afforded me a more objective view of participants' experiences and helped me to conceptualise my interpretations. This prepared me well for the analytic stage of my research.

Although I adopted a contextual constructionist approach to my research, which states that the researcher will inevitably influence the results of the research (Pidgeon & Henwood, 1997), I attempted to retain a sense of objectivity when analysing the data. By maintaining an awareness of my own hypotheses, values, opinions and beliefs, I was subsequently able to look beyond these to observe the participants' meanings, constructs and views, thus enabling me to stay more grounded in their accounts of their experiences. Essentially, the contextualist framework embraces the multiplicity of perspectives, and it was important to recognise that my pre-conceptions would not disappear. I had to be mindful of them, not ignore them, in order to recognise the perceptions of the participants. Indeed, Best (1995) believes that it is invaluable for the researcher to move between subjective and objective dimensions, as it ultimately allows them to gain a deeper understanding of the phenomenon they are researching.

Results

In this chapter, I will first outline the master themes which have emerged from participants' narratives. I will then explain them in more detail, illustrating constituent themes and examples of these with quotes from participants.

Overview

After carrying out Interpretative Phenomenological Analysis on the interviews, five master themes emerged. These were identified as:

1. Rules
2. The Battle between Anorexia Nervosa and the non-Anorectic self
3. The Battle between Anorexia Nervosa and Clinic-ED
4. Peer Influence
5. Distance from the 'Outside World'

The constituent themes emerging from the master themes were:

1. Rules
 - i. Rules: Unhelpful
 - ii. Rules: Helpful
 - iii. Flexibility
2. The Battle between Anorexia Nervosa and the non-Anorectic self
 - i. Split Sense of Self
 - ii. What is my Anorexia Nervosa?
3. The Battle between Anorexia Nervosa and Clinic-ED
 - i. No control

- ii. Perception of Staff (Unhelpful vs. Helpful)
- iii. Perception of Treatment (Unhelpful vs. Helpful)

4. Peer Influence

- i. Supportive impact of peers
- ii. Detrimental impact of peers

5. Distance from the 'Outside World'

- i. Feeling saddened by distance from home
- ii. Feeling protected by Clinic-ED

One omnipresent feature throughout the above themes was 'ambivalence'; when participants felt both positive and negative emotions about the same issue. Although I did consider having just one prevailing master theme of 'ambivalence', I decided against this as I have found, upon reading other studies using Interpretative Phenomenological Analysis, that constituent themes can sometimes become obscured by their master themes. Thus in the interest of preserving the richness and uniqueness of each theme and the messages conveyed by participants, I have kept the five master themes mentioned above and referred to the ambivalence felt by participants throughout the explanation of each theme.

Master Theme 1: Rules

As expressed by Beth⁷:

There's a whole bible on rules here (BETH: 12:5)⁸.

Indeed, all the participants perceived there to be an abundance of rules in Clinic-ED, stating that their entire admission was dominated by rules. There were rules for every element of

⁷ All participants' names and any identifying features have been changed in order to preserve their confidentiality.

⁸ Participant quotes are referenced as: participant name, page number and line number.

treatment, including food related rules such as eating meals within certain times, and non-food related rules such as going to bed at certain times. Whilst a couple of participants were ambivalent about the role of rules, most felt that they were either helpful or unhelpful. Some found them controlling and punitive, whereas others found them constructive and containing. A number of participants simultaneously felt that Clinic-ED also allowed some flexibility over rules, which they found helpful. It is interesting that most participants were *not* ambivalent about the rules in Clinic-ED, whereas they were about other elements of treatment. This is explored further in this chapter.

Rules: Unhelpful

Participants stated that their main reasons for finding Clinic-ED's rules unhelpful were the strict regimentation of daily life, the strictness of rules, the consequences of breaking rules and feeling controlled.

All participants expressed that daily life in Clinic-ED felt regimented. When describing a typical day, participants stated that everything was organised around meal times. I wondered whether this may have been connected to their previous experiences of not eating anything for long periods of time. I would like to invite the reader to reflect upon what it feels like for them to fast for even a day, without the structure of meals punctuating the day. Upon reflecting on this, myself, I became aware of a prolonged stretch of day ahead. This is perhaps what the inpatients at Clinic-ED may have felt in the midst of their eating disorders. When mealtimes are resumed, then, it may be somewhat inevitable that their days might feel regimented. Compounded by the fact that they may also be against food in one way or another, this may provide some reason as to why participants had negative perceptions of the rules around mealtimes and regimentation. How they experienced this varied:

Erm, it can be quite boring sometimes because it's quite like, I don't know, you do the same things quite a lot (DELIA: 1:16).

This view of daily life being boring was mirrored by many participants, whilst others described it as too structured and controlled. For example, when describing the strict daily routine in Clinic-ED, Emma stated:

It's, you feel like you're being institutionalised almost (EMMA: 2:6).

Whilst Emma's quote evokes a sense of being trapped by Clinic-ED's routine and of having difficulty managing a life outside of it, Delia's quote conjures up images of repetition and knowing what each day will involve. All participants were unanimous in their view of Clinic-ED's regimentation as highly controlling. They used language such as "we have to" or "we're only allowed to", conveying a sense of no choice. As Delia states:

The meals are, like, really strict here on timings and erm, we're not really allowed to have any input in, like, how the meals are set out and what we have and things like that. And like, there's no negotiation – they just do it and that's what we have to have (DELIA: 2:13).

In addition to feeling that all control had been taken away from them, many participants described the rules as strict, harsh, rigid and extreme. This was compounded by the consequences and conditions which were implemented if inpatients broke the rules. These were generally perceived as threatening and scary. Indeed, as Cat expresses:

If you don't eat, they, they will tube you here...What they mix up in that is just cream and horrible stuff, and to be quite honest I don't want that because that's so much more fattening and so much more horrible...Having, I don't know like, having that threat there is horrible (CAT: 14:19).

Indeed, the threat of being force-fed via a nasal-gastric tube was something that other participants mentioned; many had seen peers suffer this consequence as a result of refusing to eat. Thus, the repercussions of not managing their food were very real and very frightening, and having to face this up to five potential times a day (at the three meal times and two snack times) was terrifying. These consequences illustrate the lack of choice and control the participants experienced; they *had* to stick to the rules, otherwise the consequences would be too difficult to bear. It is interesting how all participants describe consequences as 'punishments' or 'sanctions', rather than constructive measures to help or incentivise them. Amy expresses:

It's like there are incentives here. It sort of feels a bit like blackmail sometimes though, (R: Mm-huh⁹), because it's like...if you don't eat quick enough you're going

⁹ 'R' signifies Researchers' comments.

to get a biscuit instead of an apple, (R: Right), or, er, like a cake instead of a yoghurt, or things like that...So it's kind of incentive slash blackmail (AMY: 11:10).

Many participants expressed that the rules were non-collaborative and non-negotiable – they were simply told that things were going to happen in a certain way. They stated that if they were allowed more input, this may be more of an incentive to obey the rules, whereas as things stood:

They make you want to rebel, and they make you want to go against it sometimes (AMY: 28:25).

It would seem that some participants felt 'non-negotiable' rules could be unhelpful – a hindrance even, in that they did not provide an incentive to move forwards, but instead inhibited their desire to develop and take responsibility for their recoveries. Conversely, some eating disorder professionals may argue that clear, firm rules and guidelines are necessary in eating disorder clinics. Essentially, if one rule becomes blurred, does this entail that inpatients' eating disorders become uncontained, and that individuals may try to negotiate their ways into eating less, or privately, or over a longer period of time, for example? Fundamentally, rules are established to contain and suppress eating disorders and promote healthy, normal eating. Yet, as participants demonstrate, they may simply be experienced as controlling and punitive.

Rules: Helpful

Despite most participants feeling that Clinic-ED's rules were either helpful or unhelpful, two participants, Emma and Amy, did demonstrate some ambivalence about the role rules played in their inpatient experience. Emma found the rules too controlling, but predominantly felt they could be helpful in promoting 'normal' eating. Amy perceived them as primarily unhelpful, but she also found that having no choice could be beneficial:

One thing that's nice about here is that you know you're not [eating] out of choice, (R: Yeah), you're – there's no other option...Makes it a hell of a lot easier (AMY: 22:13).

Freeman (2000) states that many people suffering from eating disorders experience a sense of guilt when they eat. I wondered whether having no choice but to eat may have reduced

the feelings of guilt for Amy. Similarly, Gaby experienced the lack of choice about food and eating related rules positively, as it meant that she was not responsible for making herself eat. However, although the rules were perceived as useful in helping them eat whilst in Clinic-ED, when they were responsible for eating once again upon discharge, would it be too difficult for them to actually do so? These rules may restore some inpatients' eating, but do they enable them to relinquish their eating disorders?

Although not all inpatients will be able to fully give up their eating disorders following their time in eating disorders clinics, some participants felt that rules did help to promote normal eating and were geared towards allowing inpatients to eat 'normal', full meals:

At [another clinic], apparently you can pick what you eat and what you don't, so one girl was there and she said like, they'd have fish and chips and people would eat the inside of the fish and the peas, and then they'd get the calories from the batter and the chips made up in PediaSure. So even if you're discharged, if you still can't eat a meal, then it's not really like you're better. Even if you're at a weight, a healthy weight again (R: Mm), it's not really. So I think the fact that we're actually made to eat things even if we wouldn't really choose to is good (EMMA: 20:1).

Some participants felt that the rules helped to contain their Anorexia Nervosa. For instance, Fran states that Clinic-ED's rules about not exercising enabled her to see why it was important to stop. Similarly, when discussing the rules about eating and food, Gaby states that they helped to contain unhelpful Anorectic behaviours:

When you have pasta, like you have to try and put two pieces of pasta on your fork (R: Mm) just to sort of break the habit that you're not slowing everything down. And just a lot of little things like that, I think it really does help in the long run. And having to scrape your plate as well, because if you leave a little bit one day, the next day you'll want to leave more and more and more, and it'll just end up ridiculous (GABY: 6:23).

When discussing the food itself, all participants stated that the food was extremely fattening and high in calories. Nonetheless, some recognised that the reasons for being given higher calorie food meant that they could eat less (for example, one hot cross bun has the equivalent calorific content as four apples). Eating smaller amounts was perceived by some participants as strategic:

I do think with the food, they are quite clever. And cos they need to get the calories, that's why we have cakes and chocolate and stuff. It's not necessarily that they try and be unhealthy. That's, I mean obviously, obviously I'm going to say that you want it to be a bit healthier, but then you, it wouldn't be going back to normality, to be honest because you would, you'd still be scared to have, like, cakes and chocolate when you get out, because you hadn't been having it here (R: Mm). So even though it's, it might sound a bit ironic, but I would rather they did that to me here so I was prepared for it (GABY: 15:13).

Similarly, Emma states that Clinic-ED's rules on eating whole portions of food (such as the fish and chips she discusses above) enabled her to overcome her phobia of different foods.

Overall, some participants felt positively about the role of rules, experiencing them as containing and finding that not having a choice was helpful. Nonetheless, the majority of participants felt that Clinic-ED's rules were unhelpful and controlling. It is interesting to consider why they felt differently about rules, whereas they were similar in their ambivalent views of other elements of inpatient life. I wondered whether it had anything to do with participants' motivations to recover. After listening to all participants' accounts, I felt I was able to develop an understanding of them beyond the individual, and recognise that as a group, there were divergences in how *ready* they felt to recover. When participants were not ready to let go of their Anorexia, they tended to dislike the rules. Perhaps wanting to oppose them was a way of exerting control in a very out of control situation, and a way of sustaining their Anorexia when Clinic-ED's goal was to suppress it. This is explored further in master theme 3. Nonetheless, it seems other participants wanted to relinquish their Anorexia, and felt ready to take responsibility for their recoveries. Hence, they may have perceived the rules as constructive and useful in providing guidance for this.

What is most noteworthy is that the notion of rules evidently plays a fundamental part in the inpatient experience – for all participants. Even though what one inpatient finds helpful, another may not, Interpretative Phenomenological Analysis maintains that it is important to obtain a range of participants' views, in order to allow richer information to emerge from their accounts of a particular phenomenon (Smith, Flowers & Larkin, 2009).

Flexibility

Most participants reported that despite the strict rules in place at Clinic-ED, inpatients were given a certain degree of trust:

Once [staff], like, sort of have confidence in you that you've sort of got the hang of it, they might reassure you sometimes, but once they're like, confident that you're like, sort of progressing a bit then they sort of let you sort of do it yourself (FRAN: 20:11).

This trust progressively increased the further inpatients advanced in their stay at Clinic-ED, and was usually mentioned in reference to their transition from 'Kitchen-A' (where newly admitted inpatients, or inpatients who were struggling, ate supervised by staff) to 'Kitchen-B' (where those who were more able to manage their meals ate, unsupervised by staff). For instance, Amy states:

When we're in [Kitchen-B], you can pour your own cereal and your milk, (R: Mm-huh), like, weigh it out, and cook your own muffin and butter it, (R: Right), so you're given that trust when you're in [Kitchen-B] (AMY: 1:26).

Interestingly, as Amy illustrates, the language participants use changes when discussing the trust they are given; instead of using phrases such as "we have to" they say things like "we can".

One area where participants felt that Clinic-ED afforded them trust was that it allowed inpatients to exercise for a couple of hours per day during activities, without making them sit or lie down incessantly. Activities included dance, horse-riding and swimming, and took place every afternoon. One feature of Anorexia Nervosa is excessive exercise, thus participants may have enjoyed the activities as they allowed them to gratify their eating disorders. Indeed, some participants stated that they had, at some stage during their visit, exercised or caught others exercising outside of the allocated activities, thus the compulsion to exercise was evidently still strong. However, most participants perceived the activities as constructive in that they provided a distraction from dwelling on problems and feeling upset. The trust they experienced from being allowed to participate in exercise orientated activities was perceived as useful:

What's nice or what's unique about this place is that they let you do exercise, whereas like a lot of places, like, I, on, I remember the first thing I asked when I came here was, do you do bed rest (R: Mm) and room rest. Cos when I was, when I was at [another clinic], erm, they did, like, bed rest and room rest, and it's just horrible just being laid on a bed all day, it's just horrible (HOLLY: 15:5).

Although participants rarely mentioned the freedom and trust they were afforded, whenever they did mention it, it was portrayed as beneficial. Essentially, it allowed them some degree of autonomy in a very controlled environment, and this felt invaluable.

Overall, when observed in conjunction, participants' responses suggest that the experience of being in Clinic-ED was dominated by rules, regimentation and consequences inherent to the treatment programme. This generally left participants feeling out of control and powerless. Nonetheless, some participants experienced the rules as containing and strategic. The lack of control was also perceived by some as positive as it meant that participants did not have the responsibility of making themselves eat.

Some also felt that they were afforded a certain degree of trust in that they were allowed to manage their meals (with reference to the quantities of food they prepared for themselves, and eating meals unsupervised by staff), and were allowed to do some exercise, which was perceived as valuable. Nonetheless, I got the impression that even though participants were able to find small spaces in which they felt more autonomous and free, these were still dominated and controlled by the overriding structure of the rules. I wondered whether participants were striving to express their independence in these small pockets of inpatient life in order to feel like they had some degree of control over their lives.

I felt that I had, to some extent, played some role within the theme of rules, in that I had once been a staff member delivering them to inpatients. I hoped that the participants would not be aware of any power dynamic which might lead them to feel even more controlled than they already did. Thus, I tried to appear as relaxed and as warm as possible during the interviews. I believe that clothing plays a large part in the impression one conveys to others. I did not wish to appear too smart and 'stiff' in case I looked unapproachable, but also did not want to appear too casual and laid back. Striking a balance was important, thus I wore

dresses to all the interviews, which were casual yet smart enough so as not to appear unkempt. Non-verbally, I tried to mirror participants' postures, for instance, leaning in when they did. I also displayed appropriate facial expressions of brightness or compassion. I feel this made me seem more approachable; indeed, all participants seemed to feel comfortable enough to speak openly about their experiences during their interviews.

Master Theme 2: The Battle between Anorexia Nervosa and the non-Anorectic self

When discussing their Anorexia Nervosa and the process of recovery, many participants referred to a conflict within themselves, whereby one side of them was telling them not to eat, or to exercise, and another side of them knew that such Anorectic behaviours were not conducive to their recovery. This conflict relates to the ambivalence felt by participants: in one sense wanting to cultivate, or *loving*, their Anorexia Nervosa, and in another sense wanting to overcome, or *hating* it. Many participants used the words "battle" or "fight":

That *battle* with yourself, saying like you should eat this but you're not going to, you're not allowed to (AMY: 23:21)

It's really hard cos you have to *fight* it...[But] it's not as easy to just fight things cos it's not necessarily like you want to, cos you've got another part of your mind telling you not to fight it (GABY: 14:1).

Relating to this internal battle, participants struggled to gain an understanding about their Anorexia Nervosa and put their feelings about it into perspective, regarding its negative impact upon themselves and its implications regarding eating again and the process of recovery. Additionally, all participants described feeling lost in that they felt unclear about their sense of self and feelings as separate from their eating disorders.

When I found myself agreeing (or disagreeing) with participants' views about certain issues, I came to identify what my own thoughts were. Indeed, when participants discussed their internal battles I empathised with them, despite not previously recognising that I, too, had experienced something similar during my Anorexia. Phenomenologically, I was effectively a

participant as well as the researcher (Finlay, 2003). This battle was so palpable both for me and participants, that when they discussed it I felt so connected to them, I almost felt my eyes burning when I looked at them. This physical, embodied sensation of empathy made participants' experiences more tangible, and allowed me to understand them more. Fundamentally, it appeared to be this battle which made recovering from Anorexia so difficult, and at times, so unbearable; the constant compulsion to fight against oneself and one's thoughts. In one sense, there was an awareness that Anorexia was a 'friend', protector and guardian. Yet simultaneously and conversely, (and this is where the battle came into effect), Anorexia was controlling, destructive and isolating. It seemed that participants' internal states of unrest dominated every part of their experiences of living in the world, and previous ways of acting or being were pushed aside as the battle intensified.

Split Sense of Self

Participants often communicated losing touch with their sense of self, and who they were. They expressed a fragmented, 'split' self; their Anorectic self and their non-Anorectic self (sometimes referred to by participants as the "other" self). Some participants also referred to an old self; who they used to be before their Anorexia. Participants experienced a struggle between these different entities and did not know which part of themselves to trust. They felt compelled to trust their Anorexia Nervosa and their Anorectic selves, yet were also ambivalent in that they felt controlled by their Anorexia and did not know whether it was trustworthy. Participants felt as though one part of their mind was telling them *not* to eat, but another part knew that they *had* to eat. Not knowing what to do or what part of themselves to listen to left them feeling lost and confused:

[I] struggle because it's like I know I shouldn't [exercise] but it's telling me to believe that I should. And you get so easily fooled, and that's like the hardest thing I think (DELIA: 7:22).

Delia's statement conjures up images of being tricked into Anorectic thoughts. Since she is generating these deceptive thoughts herself, one imagines that she is left feeling totally bewildered and alienated from herself. In a sense, it feels like she just does not know what to believe.

The confusion participants felt reverberated within me, and as the researcher I felt somewhat confused when deciding what to call this constituent theme. I did consider calling it “Lost sense of self” and “Who am I separately from my Anorexia Nervosa?” However, I felt “Split sense of self” captured the confusion which participants communicated when discussing their understanding of who they were.

All participants expressed that developing Anorexia Nervosa meant that they became dominated by an Anorectic self. Some felt that they consequently lost a former sense of who they were:

You don't really know what you want anymore. You just lose everything. You just lose all sense of confidence, what you want in life, like where you're going to go...I don't even know really who I am or what I want now (DELIA: 8:26).

I felt Delia's above comment captured not only her sense of losing an 'old' self but also becoming a 'new' self. Indeed, many participants' referred to this feeling, and expressed their difficulty in working out who they were now and not knowing who this new self was.

For Fran, it felt as though her sense of self was intrinsically linked with her Anorexia Nervosa:

I always saw myself as fat when I was little but I think I was, this sounds weird but I think I always, like, had a, been a bit Anorexic in my head (R: Mm). Because when I was little I thought I was fat...I don't remember not thinking I was fat at all. So like I remember myself as being really fat, [from when] I was probably five (FRAN: 11:19).

Essentially, if Fran perceived herself as too fat from the age of five, this may have shaped the whole foundation of her perception of who she was, and her way of thinking. Thus, her definition of self may be very different from Delia and other participants who had developed eating disorders later on in their lives, and who had 'known' themselves separately from their Anorexia Nervosa. Indeed, Fran is the youngest participant (and inpatient at Clinic-ED), at twelve years old, whereas other participants are aged fifteen to seventeen.

For Gaby, the sense of who she is is something different again:

It feels weird because you don't, it feels like you're someone else in a different body, because obviously you've been so much smaller for a while, and then you come back here and it's, all these changes are happening to you, and you just feel like someone else, like in their, in this body (GABY: 21:1).

Suffering and recovering from Anorexia Nervosa appears to have resulted in Gaby's alienation from her sense of self; however, this is experienced as more bodily than emotional or foundational. This relates to a discrepancy or a mismatch between her sense of self and her body. Rather than having a connection with her body, she rejects it, which ultimately means that she loses a sense of who she is as a whole, congruent being.

Participants commonly experienced feeling controlled by their Anorexia, and feeling compelled to listen to their Anorectic self:

It's like, it, it will say to you, right if you don't do [exercise], then actually you're going to put on weight or, erm, or you're going to get fat or, you know, because you ate this today you need to do this certain amount to burn it off. It's always, like, constantly, every single day there's always going to be something and it, it is really difficult, (R: Mm), it is really difficult (CAT: 13:16).

It seems as though Cat experiences her Anorexia Nervosa not only as controlling, but also as relentless. To have to constantly hear and battle against the Anorectic thoughts she alludes to here is extremely difficult.

Essentially, participants indicate that the inpatient experience leaves them feeling lost, controlled by their Anorexia and without a sense of who they really are. Their Anorectic self becomes bound up and confused with their non-Anorectic self, and not knowing which side of themselves to believe can feel extremely distressing. They feel lost somewhere in the middle of these opposing selves, trying desperately to work out who to believe. Furthermore, many still do not want to admit to themselves that they actually have Anorexia:

I mean sometimes still you think, well there's nothing really wrong with me, sort of thing and I'm ok, it's not that, like it's not [Anorexia]...In my head, like I don't, I don't want to believe that it's that sometimes...It's not wanting to believe, cos I think, like, that would mean giving in, and part of you just wants to [sighs], I don't know, part of you just wants to be on that [Anorexic] side. So it's like you're on two sides (DELIA: 5:19).

Delia feels that believing in her Anorexia Nervosa would mean having to give it up, whereas part of her still wants it to win the internal battle as this means staying thin. Delia's Anorexia was extremely powerful, but she also expresses elsewhere in her interview that her will to fight against it was also strong. Interestingly, with reference to all elements of inpatient life, Delia demonstrated the strongest ambivalence of all the participants. With this battle raging ferociously inside of her, it may be understandable that she is so ambivalent and unsure of who and what to believe. I imagined Delia, metaphorically, as two opposing soldiers at war pushing their shields forcefully against each other, but neither of them moving. This image allowed me to recognise how uncomfortable, confused and exhausted she felt by her whole experience.

The strength of each split self varied in different participants. For some their Anorectic self was stronger than their non-Anorectic self. For instance, Beth demonstrates that her Anorectic self is winning when she states:

[Upon discharge] I'm just going to run away somewhere so they won't find me, so then they won't have to make me put on any more. When I get home I'm just going to exercise loads (BETH: 11:5).

Although Beth demonstrates some ambivalence, she expresses less than other participants and has a generally negative view of inpatient life. Her anger is palpable throughout her interview. However, she does not experience so much of an internal conflict within herself, but more of an external conflict with Clinic-ED and those trying to take her Anorexia away. Indeed, I wondered whether she feared that if her Anorexia was taken away from her, her whole sense of self would be eliminated with it.

Other participants demonstrated that their non-Anorectic self had the upper hand. For instance, Emma states:

When I was at home over Christmas I was, like, choosing to have things. So like I asked my mum if I could have cheese on a baked potato. And before I'd have nothing, I wouldn't have cheese with anything (EMMA: 20:14).

This suggests that Emma has found some way to overcome the Anorectic thoughts which were previously so dominant, and that she is winning the battle against her Anorexia. Emma was somewhat ambivalent in her interview, but typically framed her experiences as positive.

Hence, I wondered whether the strength of participants' internal conflicts may have had an impact on their ambivalence. Fundamentally, participants with one dominant sense of self demonstrated less ambivalence, whereas those whose two selves were fighting equally against each other were more ambivalent about elements of their inpatient experience.

I felt that, on one hand, participants demonstrated an acute awareness of their split sense of self, yet they also felt stuck in that they could not recognise how to resolve this split and found it very confusing. The extent to which they experienced this varied between different participants, and also within the same participant. Essentially, each participant's perception of being an inpatient was experienced by two different selves within them. Phenomenology explores the way in which a person experiences something. Yet, if that person is split into two, it follows that they may have two different experiences of the same phenomenon. Indeed, this is what appeared to be happening within the participants' experiences; they were experiencing inpatient life and its inherent aspects as both good and bad simultaneously. Thus, the wish to have just one prevailing opinion – perhaps as an attempt to manage and reduce their confusion – resulted in a battle between their two senses of self.

I felt that each participant interacted well with me; all seemed to talk openly about their experiences within Clinic-ED. Perhaps this was because I was, in some ways, as much of a participant as them. I was learning not only about their inpatient experiences but also about my own experiences of suffering with Anorexia. Hence, maybe they sensed that I was on a similar level to them, and could therefore trust me with their feelings.

What is my Anorexia Nervosa?

Many participants appeared to seek some understanding of their Anorexia Nervosa and its implications during the interview. As the interviewer, I got a sense that many were trying to

clarify their perceptions of it through the act of talking in the interviews. Their narratives generally involved questioning their Anorexia and themselves, for example:

It's just hard because at the end of the day you don't know if you're going to relapse, you don't know whether you're going to get better, and you just sit and think, like, why do I feel this way, why can't I make myself do this, why if, I don't know, can't I just pick up some food and eat it, (R: Mm), why can't – why do I have to not? (AMY: 16:5).

As Amy illustrates, suffering from Anorexia can be extremely confusing and distressing. This was exacerbated by the fact that many were trying to deal with their eating disorders privately, and perceived Anorexia Nervosa as a very secretive illness. I wondered whether this exacerbated the internal battle between their Anorectic and non-Anorectic selves; deep down they knew they *should* tell someone when they needed help, yet their Anorexia was telling them *not* to tell anyone about their Anorectic thoughts, not to ask for help and not to let anyone know what they were thinking:

Like, with the whole illness in general...you can't tell anyone. And if you want that push, like, that slight push, it won't let, it's like the illness won't let you tell anyone that you need, you need that push (GABY: 14:19).

Hence, many participants were left battling against their Anorexia privately and struggling to understand it alone.

In seeking to understand their Anorexia Nervosa, many participants explored what it felt like to eat again. Many participants expressed some degree of ambivalence about this. For example, Beth says:

I don't mind eating, I just don't like what it does (BETH: 6:18).

Similarly, Amy states that it feels okay to eat fatty foods every now and again, but later states that food can be terrifying.

Most participants reported feeling scared of food. Indeed, Anorexia Nervosa is characterised by a '*fear of fatness*' and food is seen as the vehicle which leads to fatness. It follows, then, that the fattening food served at Clinic-ED was perceived as particularly frightening:

They make you eat, like, unsafe foods, foods that you don't feel safe with. So things like chocolate, chips, things like that you wouldn't normally feel, you wouldn't normally think of eating that if you [weren't] here, and pizza as well. Things like that are really, really hard (HOLLY: 7:14).

The experience of being at Clinic-ED is punctuated with fears of unsafe foods, of having no choice but to eat them and of living with the fear that they will put weight on. I wondered whether the ambivalence felt by participants stemmed from wanting to fight against this, but simultaneously knowing that eating again was a fundamental step towards recovery. As participants indicated, this was their ultimate goal, as it meant being discharged and allowed home with their families, and having a 'normal' relationship with food. This further supports the concept of the aforementioned split self; wanting to listen to the Anorectic self which says that food is scary as it is the vehicle to fatness, but also wanting to return home and regain a whole, coherent self which does not have to fight against itself.

In seeking to understand their Anorexia, participants also explored what it would mean to recover. Some expressed a wish to recover fully, but nevertheless, did not know how to stop thinking of themselves as fat:

Someone told me, one of the staff that worked here, once, that you can want to get better so much but you can, you can still always see a fat person in the mirror. I think that's really true (FRAN: 11:14).

This demonstrates the ambivalence felt by some participants about the recovery process: *wanting* to recover, yet not quite knowing *how* to. Other participants are ambivalent in that whilst part of them wants to recover, another part of them wants to hold on to their Anorexia Nervosa:

It would be nice to, like, think that I could recover and just get rid of it forever, cos it's one of the most horrible things to live with [pause], (R: Mm), but then at the same time you almost want to hold onto it, cos you almost think...well, at least if I have it a little bit I'll never get fat (AMY: 27:10).

Amy's statement encapsulates her split sense of self; her non-Anorectic self wants to relinquish her Anorexia, whilst her Anorectic self does not want to recover as recovery means being fat.

Nonetheless, some participants did express a sense that even though they may be larger after their recovery, they would be happier, and ultimately this is what motivated them to recover:

I've realised now that [if being larger is what] it's going to take for me to be happy then I might as well be it. Cos I'd rather be like, ten stone than be grumpy all the time (FRAN: 12:20).

Observed together, participants' responses suggest that suffering from Anorexia Nervosa can leave the individual feeling lost, out of control and confused about their sense of self. Furthermore, it can leave them struggling to understand what their eating disorders actually are. Some participants described feeling that they *were* their Anorexia; thus having to think of themselves separately from this was extremely difficult. In one sense they thought they knew their own thoughts and feelings, but in another sense, they did not know whether to trust themselves. This left them battling against themselves and unsure of which side of themselves – their 'Anorectic' self or their 'non-Anorectic' self – was trustworthy. Indeed, this non-Anorectic, other self was a self they did not know or recognise, (having suffered so severely from Anorexia, often for long periods of time), and this exacerbated their confusion and distress.

What I found most striking about the notion of the split self was that those with a dominant self were less ambivalent, whereas those with an equally strong sense of two selves were more ambivalent. Indeed, when a person's sense of self is split, it may be understandable that their thoughts and views will also be split. This may provide some reason as to why some participants were more ambivalent than others.

As participants evidently felt so confused about their split self, I felt it was of the utmost importance for me to be as acceptant and sensitive as I could to both sides of them. I hoped participants would feel that neither side had been rejected or ignored by me. Thus, whenever they mentioned having two sides to themselves, I consistently gave verbal prompts such as "mm", to show I had understood them. I often reflected participants' words back to them, allowing them to think about what they had said in as much depth as

possible. Non-verbally, I kept my palms upright and open, and my legs uncrossed whenever they discussed the split self. I believe participants were able to sense my acceptance of both sides of them, in that they all repeatedly talked about their experiences of their split self, and their resulting internal battles, throughout their interviews.

Master Theme 3: The Battle between Anorexia Nervosa and Clinic-ED

In addition to experiencing an internal battle between their Anorexia Nervosa and their other, non-Anorectic selves, participants also described an external battle between their Anorexia Nervosa and Clinic-ED. Again, many participants actually used the words “battle” and “fight”, for example:

It's a bit of a *battle* here because you're against what they're trying to do to you. You know, they are refeeding you and they're, you know, they're stopping exercise and everything like that which you want to do and you want to have control over (DELIA: 4:8).

The Anorexia inside of you just, what they do here just doesn't, doesn't want it, just doesn't, like, it'll try and *fight* it as much as it can (CAT: 3:18).

Compounded by the firm rules and regulations, this understandably left participants feeling powerless and out of control. They described experiencing hatred towards the unit. Indeed, Beth said that she hates Clinic-ED and various aspects of Clinic-ED fourteen times during her interview. Relating to the battle, most participants describe hating Clinic-ED at first, but *having* to accept and get used to it, as resistance is futile:

It's like a no win situation (HOLLY: 6:3).

Participants do state that the battle is primarily with staff, as opposed to a general battle with Clinic-ED, as it is the staff who are delivering rules and food. Hence, many participants experienced an antagonistic relationship with staff. Nonetheless, participants also recognised the good in staff and felt both negatively and positively towards them. This may be similar to a child's relationship to his or her parents; loving them and hating them

simultaneously (Klein & Riviere, 1964). Both sides of the ambivalence felt towards staff will thus be explored below.

This ambivalence was not apparent regarding the therapy participants received at Clinic-ED. Some felt that therapy was helpful in allowing them to understand their feelings about their Anorexia Nervosa, whilst others felt that therapy was stressful. Participants were, however, ambivalent about other treatment components such as the re-feeding programme.

No Control

All participants expressed feeling powerless and having no control over their treatment at Clinic-ED. As Delia states:

Because you can't have an input, something that you're, like, so against, you know, you're going to hate whatever they do...At the end of the day, as much as you cry and you hate it and you say that you don't want it, they're not going to do anything, (R: Mm). So you just sort of give in really, you have to do it (DELIA: 3:6).

Delia implies that she has no choice but to surrender to Clinic-ED's treatment, due to her lack of control over the situation. I wondered whether the strict regulations and systems implemented by Clinic-ED made participants feel like their lives had been taken over, which eventually forced them to surrender as resistance was futile. When describing what it feels like to be taken over, Beth states:

They have, like, complete control over us, (R: Mm). You have to, like, get up when they say, eat what they want, talk about what they want...[It] feels like you're no-one. Just feels like you're owned by them (BETH: 8:7).

Beth's statement taps into the aforementioned notion of participants losing their sense of self; she implies that all her autonomy has been taken away by Clinic-ED, thus she feels like she is no-one. This suggests that it is not only the internal battle which causes participants to lose their sense of self; the external one occurring with Clinic-ED may also undermine participants' senses of who they are. Not being allowed to think or do anything for themselves may ultimately cause them to lose all sense of being a person.

All participants saw their lack of control as negative. When Gaby discusses it, however, she states she would rather be constructively controlled by Clinic-ED than destructively controlled by her Anorexia Nervosa:

You have no control and [Anorexia] just controls you before you get here. But because [Clinic-ED] takes your control off your illness and you don't have to think about it, it helps you like, get your, actually your own sense of mind back (R: Mm). And even though you can't control it, the illness isn't controlling your head any more, cos they are, in a way (GABY: 19:15).

Gaby's quote captures the contradictory nature of the split self. In one sense, she states that she is initially controlled by Anorexia and then by Clinic-ED, but also states that this helps her to retrieve her own mind. Gaby implies that she feels controlled, and out of control, but also in control. This ambivalence may seem confusing for the reader at first, but actually makes sense when observed in the context of the split self. Essentially, when a person's sense of self is divided, it may be no wonder that their opinions will also be divided.

Relating to the feeling of being controlled, all participants described feeling trapped in Clinic-ED, and two participants, Emma and Holly, actually said that being in Clinic-ED was similar to being in prison, for instance:

Sometimes it feels like a prison. You're not even allowed to go out, and you're so controlled, and you're always being watched and you can't do this, and you can't do that (HOLLY: 8:12).

This sense of feeling trapped and imprisoned in Clinic-ED suggests that, in addition to feeling controlled, inpatients also feel that their freedom and independence has been taken away from them. Furthermore, many participants felt concerned that Clinic-ED's control would continue following discharge. Holly expresses annoyance at this:

There's an awful lot of boundaries when you go home. It's like you're not allowed to go in the kitchen, you're not allowed to question food, you're not allowed to ask anything about the food...The thing about having this after-care programme is, it just feels like you're permanently tied and controlled to [Clinic-ED] and you don't want that (HOLLY: 17:28).

Similarly, Gaby feels like the control simply shifts from being implemented by Clinic-ED to being implemented by parents. Overall, it seems participants feel extremely controlled by

Clinic-ED both during and after their time there. This feels constrictive, exhausting, and for some, threatening to their sense of being a whole, autonomous self.

Perception of Staff (Unhelpful vs. Helpful)

Participants' perceptions of staff varied greatly. There were far more negative words used to describe staff, and participants discussed negative staff perceptions far more than positive staff perceptions. In one sense, they found them very helpful and supportive. Positive staff behaviour included friendliness, approachability and supportiveness. They were additionally perceived as comforting. Conversely, many found staff to be harsh, firm, strict, unapproachable, mistrusting, inconsistent and powerful. Participants felt that staff gossiped to each other about inpatients, and described feeling watched and monitored by them.

The most commonly discussed aspect of staff behaviour was their approachability. Many more participants thought that staff were unapproachable. For instance, Emma states:

It sort of feels like [staff] don't really want us to [talk to them]. They always, sort of, if people ask to speak to them, sometimes they will, but I find sometimes they sort of forget, and it just, it sort of feels like they've got other things to be doing (EMMA: 13:16).

Nonetheless, some participants had different view on this:

They are very approachable, it's just depends on whether you're good at that or not...And it depends who it is as well. Cos I'm sure, like, with everybody there's people that you can approach more than others (HOLLY: 4:22).

It would seem that whilst Emma had a more negative experience of staff's approachability, Holly felt that some staff were approachable. However, this was dependent on which staff member it was, and whether the individual was confident enough to approach them.

Many participants also felt that staff were harsh:

If you ask them something they can be quite harsh about it and not very nice about it when it's, like, not really necessary to be like that (FRAN: 19:1).

Gaby agrees that staff are unnecessarily harsh but feels that this can be useful:

[Staff] can sound a bit harsh, you know, in what they're saying. They can be straightforward, like, you're eating like a three year old, stop it, you look silly. They haven't done that to me, but sometimes I think that's, that can be a bit too harsh. Then again, I can understand why they're saying it, and it's sort of shock tactics so I don't think I'd change what they're doing cos it's working for me, to be honest (GABY: 17:11).

Gaby goes on to say that this does not work for everybody, however, and that it is more likely to work if the inpatient *wants* to get better as it alerts them to the error of their ways. Indeed, Gaby, Fran and Emma all state that they *want* to get better, and that it is this which has aided their recovery more than Clinic-ED itself. They do say, however, that it was not any specific component of Clinic-ED which aided their motivation to recover, but the fact that they had been admitted to an inpatient unit at all, in that it showed them how serious their eating disorders were. This raises the question of how much staff can actually do to aid an inpatient's motivation to recover, and how much it has to come from the individual's desire to recover.

Many of the participants also experienced staff as inconsistent. The ways in which they demonstrated this varied. For instance, some stated that one staff member would say one thing, and another would say something else:

We'd had this meal and it had pickle in it, and erm, one of the carers had said it was optional, you don't have to have it, and then somebody else, well another carer said you have to have it. So some people had had it and some people hadn't, and then like some people were getting like really upset because they'd had the pickle when they didn't need to have it (HOLLY: 13:3).

Conversely, other participants felt that staff were inconsistent in that they treated different inpatients more or less favourably than others:

Anyone who's naughtier they, like, treat them differently, and if they, like, someone didn't eat and started crying they treat them differently for that week, like not talking to them properly and just ignoring them (BETH: 9:14).

Some participants also stated that mistrust was a common issue in Clinic-ED. Whilst staff had a tendency to mistrust inpatients, inpatients also mistrusted staff. This was particularly evident when participants told staff about how they were feeling, and staff would then disclose this to other staff members:

If you tell one of them then they go and tell someone else, and then it all comes back and then you got to go talk to the therapy woman about it. And then talk to someone else about it, and then everyone knows...And they say, like, that they're not going to tell anyone but then the next day you get called into the office talking about it (BETH: 5:7).

Beth experiences the nurses as 'gossiping' with one another, and as disloyal to inpatients. However, would staff not be more disloyal by not telling each other about the problems inpatients were experiencing? Fundamentally, it may be necessary for staff to disclose inpatient information to the whole nursing team in the interest of delivering the maximum care to the inpatient. However, what is interesting is that Beth and other participants do not experience it in this way, but instead perceive it as staff gossiping. It was evident from her interview that Beth experienced a particularly turbulent relationship with staff, stating that they perceived her as naughty and rebellious, and therefore did not care about her. This may ultimately have tainted her opinion of them and made her more aware of their shortcomings. Indeed, she does make more negative remarks about them than other participants.

Nevertheless, some participants did describe a good relationship with staff. Delia found them supportive, and Gaby felt that their experience in working with eating disorders sufferers meant that they knew how to help inpatients. Holly stated that they were friendly and would give inpatients hugs if they were upset. Many described them as reassuring:

They always talk to you and, like, reassure you, and make you understand a bit more (FRAN: 19:22).

Even though most of the participants did make positive remarks about staff, they were generally preceded or followed by negative ones. For instance, as Cat states:

Like at times you will absolutely hate them for what they're doing. You'll be like, oh my God, I cannot believe you are doing this to me, why are you doing this? You know, why are you making me eat this? Why are you getting me to this weight? You just literally, you want to kill them, (R: Mm), for doing it, like you just want to burn this place down, you want to get rid of it. But then other times when you're really upset and, you know, they'll be there to comfort you, you know, they're really nice, they are love- they are lovely people. Like at times I absolutely hate them, but when I'm upset, (R: Mm), they are, they are there to help and support you (CAT: 18:25).

This ambivalence is evident in most participants' narratives; in one respect they can see the good work that staff are trying to do, and understand their reasons for enforcing rules and monitoring them, but in another respect they feel that staff's delivery of certain rules and regulations can feel punitive. This exacerbates the battle between their Anorexia and Clinic-ED, in that the individual's eating disorder is fighting against what the staff are trying to make them do. This raises the notion of the split self once again. Fundamentally, it seems that participants' negative portrayals of nurses may represent their Anorectic self fighting against the staff. Conversely, their positive portrayals may represent their other self who wants to learn from staff about how to let their eating disorders go.

Perception of Treatment (Unhelpful vs. Helpful)

Upon my enquiry about the overall treatment at Clinic-ED, participants primarily discussed therapy. Nonetheless, they also discussed the re-feeding programme, being put on supervision and being weighed.

Participants' views of the therapy at Clinic-ED varied. Half the participants saw it as unhelpful and not at all helpful, and half saw it as wholly beneficial. With reference to participants' perceptions of therapy as unhelpful, reasons were varied. For instance, Amy and Beth stated that therapy was intrusive and described feeling anxious about discussing their feelings in case they were disclosed to others. Contrastingly, Cat stated that there were often silences in therapy, which made her feel like it was "a waste of time". Many participants also felt that therapy was too focused on the body and not focused enough on the mind. Hence, even though Clinic-ED helped inpatients to gain weight, most felt that their minds had not recovered in that they still had strong Anorectic thoughts:

It's like you learn how to eat again, but you don't learn how to let yourself eat again (AMY: 25:3).

Similarly, Cat states:

Here, there's nothing to help you with, like, your body image. I find that basically all [Clinic-ED] are focused on is about making sure that each week you put on that kilo a week 'til you get to your target weight, (R: Mm). Erm, I've been at my target weight for quite a while, however, my mind has not changed a single bit, (R: Right), because

I, I still look in the mirror and see what I saw when I was, like, really underweight, but now it's ten times worse because I've, cos I had to put on the weight (CAT: 13:25).

Cat goes on to say how she felt anxious as to how this would affect her discharge. This was mirrored by many participants, even those who found therapy helpful. Cat's concern was that she would be discharged and forgotten about, and as others imply, this is worrying as they do not feel they have been provided with sufficient tools to cope following discharge, or that Clinic-ED has adequately prepared them for it. (This view contrasts with the views expressed by Holly and Gaby, mentioned in the 'No Control' section, who felt that they would be too controlled following discharge. These contrasting accounts indicate the divergences in participants' experiences at Clinic-ED, and highlight the differences in how they attribute meaning to these experiences.)

Half the participants found therapy useful. The reasons for this also varied. In contrast to the views portrayed above, Gaby felt that therapy was focused on both the mind and body, which she found invaluable. Holly found therapy helpful in that it provided her with an outlet for her emotions. Emma's reasons for appreciating therapy were slightly different, in that it helped her feel understood by someone:

I've talked to a lot of people but it's the first time that I've actually felt like they understand (R: Mm), and so it has been helpful (EMMA: 16:20).

It is interesting that instead of displaying ambivalence, participants were resolute that therapy was either helpful or unhelpful. It would seem that those whose Anorectic self was stronger generally saw it as more unhelpful, whereas those who saw it as useful predominantly demonstrated that their non-Anorectic self wanted to win their internal battle. This adds further weight to the concept of stronger ambivalence arising from the 'self' which is split equally. Perhaps participants were less ambivalent about therapy as it was one of the main elements of treatment which was aimed at eliminating their Anorexia. Interestingly, the same participants were also less ambivalent about rules, which was one of the other main elements of treatment intended to reduce inpatients' Anorexia. Thus, therapy and rules may have been perceived as more of a threat or a help than other elements of inpatient life which were less focused on removing their Anorexia, (such as peer relationships, and distance from home).

There was only one participant, Delia, who was ambivalent, and saw therapy as both helpful and unhelpful:

Therapy can be a bit much, just (R: Right) because, I don't know, I think the longer you've been here, it really like, exhausts you...and it can really, like drain you. Sometimes it's quite difficult to get through...[But] therapists, they try and link things in, like know where [Anorexia] started, why it started and what happened, and they really, like, dictate sort of throughout the process of having it. I think that's quite good cos I've learnt quite a lot (DELIA: 3:24).

This may provide additional evidence that Delia's strong split sense of self caused her to feel more ambivalent about some elements of Clinic-ED than other participants. Nonetheless, Delia did not feel ambivalent about the rules, perceiving them as negative. I wondered whether this may have been due to the fact that the rules were constantly and persistently trying to suppress her Anorectic self, whereas therapy only occurred for an hour a week. Thus, she may have been able to think of it as less of a relentless threat, and more of a space which allowed her to explore her Anorectic and non-Anorectic selves.

Regarding the re-feeding programme, many were ambivalent in their views. For instance, Emma stated that it was useful in allowing inpatients to eat 'normally' once again (see the 'Rules; Helpful' section above), but she later went on to say:

It's sometimes like they use food as a punishment, which I don't like. If you [dislike a certain food] then you get given a cheese or peanut butter sandwich...It's like, well if you think of them as something that's a punishment and that's bad, then isn't the point of being here meant to be that no food is, like, bad or something that you should be scared of? (EMMA: 18:5).

All participants found the food at Clinic-ED fattening and many made reference to the constant presence of food. This was sometimes experienced as threatening. For instance, Beth states:

[Staff say] you're going to have to eat it cos it's not going to go away, and like, there's no point in hiding it cos we're always going to replace it and everything you be sick or whatever, you – we can replace (BETH: 9:1).

Indeed, this persistent threat may have been what made the battle between Clinic-ED and participants' Anorexia so palpable, and left them feeling so powerless.

Another part of treatment participants discussed was being weighed. As Holly states, this was a largely degrading experience, due to staffs' disregard for inpatients' body-consciousness:

You always get weighed in your, like pants and bra, I find that very degrading...It feels like you've got no dignity, and obviously, like because you're very self-conscious about your body (R: Mm), you just want to hide it all away and then when you've got to, then when you've got to get weighed (R: Mm), not the nicest of experiences (HOLLY: 17:2).

The reasons for weighing inpatients in their underwear are to obtain a more accurate reading of their weights, and to prevent them from concealing weights in their pockets. Inpatients may hide weights in order to make themselves appear to weigh more so that staff think they are progressing faster than they actually are. Holly goes on to say that perhaps it would be less degrading to wear pyjamas or light weight clothing and have their pockets checked before being weighed. Indeed, this may help to preserve inpatients' dignity somewhat, but staff then face the problem that inpatients may hide weights in their underwear. At least if underwear is clearly visible, staff can clearly see whether there are any concealed weights in it.

Participants also stated that their body-consciousness was disregarded when they were on twenty-four hour supervision and had to shower:

You're conscious of your body enough as it is, let alone having someone sitting there watching you [shower] (CAT: 7:8).

All participants experienced the supervision element of their treatment as negative. To remind the reader; supervision involved being constantly supervised by a staff member. Inpatients were put on supervision at the start of their stay, if they were having trouble coping, or if they had been exercising outside of the allotted activities. It was intended to suppress any Anorectic behaviours and monitor inpatients' moods. Nonetheless, when discussing it, participants made statements such as:

It feels like you're almost in prison, cos you're not allowed to do anything on your own. They come into the toilet...with the door open, you have to have someone in there when you have a shower, they like check the temperature of the shower, it's just, like when you're sleeping they come in and check on you. It just feels really horrible (EMMA: 12:15).

I wondered whether a potential reason for all participants feeling negatively about supervision may have related to their own memories of being on supervision. Participants had generally been on supervision at times when their Anorectic self had been dominant. Clinic-ED's intention to suppress participants' Anorectic behaviours may thus have suppressed not only their Anorectic self but – since this Anorectic self was dominant – *any* sense of self that inpatients had. Hence, participants may have associated supervision with removing not just their privacy, autonomy and individuality, but moreover, their entire sense of 'being'.

Overall, it would seem that participants experienced therapy as either helpful or unhelpful, but were ambivalent about some other elements of treatment, such as the re-feeding programme. They also expressed largely negative views of supervision. Participants felt ambivalent about staff, perceiving them as harsh and controlling, but also as comforting and supportive. What stands out is that even though staff and the various treatment components were clearly intended to *help* inpatients overcome their Anorectic thoughts, participants still experienced a conflict against them, which exacerbated their feelings of powerlessness and distress. Even when participants felt positively about some treatment aspects – and the staff delivering the treatment – they still felt that the overall treatment was in opposition to their Anorexia, and this increased their inclination to fight against Clinic-ED.

It felt as though all participants experienced tremendous oppression and a complete lack of control in Clinic-ED. This left them feeling alienated from any sense of who they were in the world. They did not have any choice or input in their lives, therefore they felt their lives were not their own. This was experienced both bodily and emotionally. Bodily, they were being forced to gain weight, even though emotionally, this was the thing they were most terrified of. They did not know or like their new bodies, and felt terrified living inside them.

Despite not having worked at Clinic-ED for many years myself, I did wonder whether participants might associate me with being a controlling, unapproachable staff member. Would they be less inclined to be open about their private, confusing experiences; mistrusting me like they mistrusted other staff members? Hence, I tried to be as open as I could, and demonstrate that I was interested, compassionate and understanding. I hoped that if participants perceived my openness, this would encourage them to be open themselves.

I attempted to demonstrate openness both verbally and non-verbally. Verbally, I tried to reflect what participants had said in their own words. Non-verbally, I maintained eye contact and tried to lean in slightly towards them, resting my arms upon my lap, but keeping them rounded; essentially offering them a 'mock hug' (Straker, 2004). I made sure my arm movements and gestures were slow in order to indicate gentleness. I believe this allowed participants to recognise that I was not a threat and that I understood and felt compassion for any distress and lack of control they experienced.

Master Theme 4: Peer Influence

All participants mentioned that their peers at Clinic-ED had a large impact upon them and played a considerable part in their experiences of being an inpatient. Participants were ambivalent about the effect of their peers, and experienced them both positively and negatively. All participants found that peers made their stay at Clinic-ED easier, and expressed that they were supportive and understanding. Yet they all simultaneously found that peers could have a negative impact in that there was a large amount of exposure to peer distress and negativity, and a cultivated sense of competition and comparison.

Supportive Impact of Peers

Clinic-ED accommodates over thirty people; therefore, it may be understandable that participants' peers played such an important part in their inpatient experiences. Indeed, as participants discussed, there were always peers around and somebody available to talk to.

Most participants found this positive, as it meant that if they were upset they could always find someone to talk things through with. As Delia states:

They're always there and they're, you know, they always talk to you...Because there's so many of us here, there's always going to be someone in a bedroom or in a room, like downstairs so you've always got (R: Mm) that someone, sort of, there (DELIA: 12:2).

All participants felt that their peers were supportive and understanding. They were experienced by many as the best part of Clinic-ED, and participants asserted that they made the experience more bearable:

It feels like without them you have nothing here (BETH: 5:20).

Many likened their peers to 'family' and referred to a close bond between them. One potential reason for the closeness that participants experienced was provided by Cat:

You see them go through, like, everything, like happy, sad, upset, like you see all their emotions, you see them angry...you see when they shout and you see it all...You build up in here such good relationships with each other. I think it's really nice. Like, that's probably one of the best things I've found from being in here (CAT: 5:1).

I felt it was understandable that spending so much time with peers and seeing them go through so many different emotions may undoubtedly increase the bond between inpatients. However, other participants state that what makes the bond so close is that they *understand* peers' emotions, as they have experienced them too. Having similar disorders to peers provided a sense of understanding about each other that many participants had not experienced elsewhere:

A lot of people have found exact, like they've had the exact same experiences, and there's sometimes things that you can't explain that other people can...Like talking to people you sort of find reasons why you might have done things (EMMA: 14:6).

Indeed, Gaby mirrors this by stating that there is an implicit understanding about how peers are feeling:

When you're struggling you're not having to explain how you feel, you're not having to explain when you're having a bad day, people just understand (GABY: 9:7).

Aside from experiencing a sense of common understanding and shared emotions, participants also talked of the fun they experienced with peers. All stated that this had been immensely positive and helpful. Learning how to laugh again was an important feature of many participants' inpatient experiences, as they described not having laughed for a long time during their illnesses. Participants stated that actually being able to laugh and experience fun helped them to feel normal again:

You just have such good times. Like I've been in hysterics here laughing, and there is just so many good times like that, and just, I can't remember the last time, like, I'd been genuinely laughing before I came here (R: Mm). Since I've been here, I'm just sort of learning to laugh again...It's really good to start getting yourself back (R: Mm) to normal and how you should be (GABY: 12:9).

On a similar note, Fran states that having fun with peers has helped her to get through her time in Clinic-ED:

[We] had a massive disco party...We all, like, enjoyed ourselves and it was really fun. And I think that was the moment when I thought, like, oh maybe we can have fun here and it's not all going to be rubbish [laughs] (R: Mm). And it, like, now I just have so many fun times (FRAN: 14:8).

Overall, the participants' perceptions of their peers were that they were supportive and empathic, and that they shared a close bond. They had many more positive things to say about them than negative things. Nonetheless, some participants found that spending so much time in such close proximity with similar others could pose problems.

Phenomenologically, it would seem that participants' experiences of their peers and the meaning of peers in their experiences were split because their sense of self was split. Their Anorectic self may have perceived peers as a threat to their desired identity as the thinnest person in Clinic-ED. Meanwhile, their non-Anorectic self wanted to look to peers as a source of understanding the pain and distress they were experiencing; a source of helping them to get through their confusion. It was as though their desire to identify peers as either helpful or unhelpful was hindered by the mixed messages they received from their two selves.

My own experience within this was that I felt I had been allowed an insight into some intricate relationships I had witnessed during the time I had worked at Clinic-ED. Looking at

the influence of peers in the context of the split self answered an important question for me; why did participants appear to get on very well with each other outside of mealtimes, yet watch each other like hawks whenever they were eating together? Essentially, because the Anorectic self was stronger at mealtimes, when faced with its mortal enemy of food, the competition between peers was stronger at these times. Conversely, when the non-Anorectic self may have felt more dominant in settings away from food, peers could be recognised as similar people experiencing similar feelings to them. In recognising this, I felt I had been afforded an understanding about the complexity of peer relationships, allowing me to resolve a curiosity I had carried since working there four years ago.

Detrimental Impact of Peers

The most detrimental impact of peers that participants reported was being exposed to negative or distressing behaviour. All participants stated that they had seen peers in distress, struggling to eat, exercising or being force fed via a nasal-gastric tube, and this had made them feel upset. When discussing what lengths peers would go to in order to not have to eat, Beth explains:

They hide it up their sleeves, they hold it in their hand, like put it in their shoes, and some of them, like, make themselves sick at the table. Like anything not to eat, (R: Mm), and I just don't like seeing that (BETH: 6:10).

Participants reported that being exposed to such images affected other inpatients in a negative capacity, as it is not pleasant to see peers struggling. This was compounded by the fact that participants also wanted to go to such lengths to not have to eat themselves, and felt guilty as a result of eating when their peers were not.

Cat explains the impact of seeing peers in distress when she recalls an incident when a nine year old inpatient could not finish his meal. She explained how he was tube-fed as a consequence and describes what she felt when she was speaking to him afterwards:

He goes, "every time that someone puts food in front of me, it feels like someone's pushing me off the edge of a cliff". Like, and that really made me feel, like inside, like really horrible, and it shows you how much it can take over and control you...You don't just experience your own emotions in here, you, (R: No), do get very close to everyone else's and you do experience them as well, so not only your own, you're

dealing with your problems, you're actually trying to help everyone else, and sometimes that can be quite strenuous, (R: Mm), and can be quite difficult (CAT: 7:21).

When explaining the impact of seeing peers in distress, other participants became noticeably affected themselves in the interviews. When the interview with Emma took place, a newly admitted inpatient was heard vomiting loudly in the background. This occurred six times in the space of an hour long interview. The effect this had upon Emma was that she cried most times it happened and was more emotional throughout her interview than other participants. To be exposed to this may be unpleasant for most people, but when inpatients are exposed to it, as Emma explains, they are unable to escape from it:

[Crying]. [Said in a tearful voice] It's just horrible to sort of, cos, when, when you're at home, if things happen, like, at school you can always get away [from it]. And it's like here, like when someone's being sick or something like, or they're trying to run away from supervision and, just when people are doing things, you can't go home and get away from it, you're stuck here. And I don't, you haven't really got any choice (EMMA: 9:3).

This reinforces the image of being trapped inside Clinic-ED; forced to witness the distressing emotions that peers experience, and the unpleasant behaviours they engage in. Yet many felt torn between also wanting to engage in these behaviours themselves. Indeed, a major negative element of peer relationships was the sense of competition that they engendered. Holly, Gaby and Amy referred to "one big competition" between everyone. This was experienced both with newer inpatients who were noticeably thinner, and also with those who had been inpatients for similar periods of time. Holly describes some of the competitive behaviours which occur:

[There's] the person who can get away with doing the most exercise when they're not meant to, or the person who can be the slowest at the table, or cut the food the smallest. It kind of like, cos you feel bad about that and you see somebody else doing that, you feel you should be doing it as well. So then you try and do it and then it just ends up, like, unconsciously there's one big competition between everybody (R: Mm) and that can be quite difficult because, like you get sucked into it (HOLLY: 11:6).

As demonstrated in the above quote, participants felt that the sense of competition was cultivated when peers demonstrated Anorectic habits or behaviours. Other habits included 'jiggling' legs, standing up to burn calories, and secretly exercising. Participants explained

that peers often picked up habits from each other which they had not engaged in before coming to Clinic-ED. Indeed, as Delia expresses, it is tempting to copy them:

I think when you see someone doing that (R: Mm) it sort of feeds the mind to think, yeah do that as well, (R: Mm). Like we have dance classes and things and people, you just know people are going over the top to try and get the most exercise out of it. And it's like you really want to do that as well (DELIA: 7:12).

Furthermore, participants stated that peers were constantly discussing food and weight, which was tempting to engage with. Examples of discussion topics were target weights, analysing weights after weigh-days, calories going up or down and the calorific content of different meals. Although it was tempting to focus on such issues, however, most participants expressed that it was unhelpful:

When we used to get a meal, we'd all talk about it for basically the whole meal. Like, what is this? Is this this? And we'd just talk about it and analyse the whole meal. But since then, we've had a blue kitchen meeting and I've said that I think we should stop it, because it, it's just not helpful at all analysing the meal, and everyone's agreed...But I think it still could be enforced a bit more, that you should keep that talk to a minimum (GABY: 21:23).

Although participants felt that peers could promote Anorectic behaviours, what is important is that many were able to recognise that these behaviours were unhelpful and that they were not conducive to their recoveries. What I felt demonstrated great strength and insight was that some were able to modify their perceptions of peers' negative behaviours into something positive which they could learn from. For instance, Emma states that comparing her behaviour to peers' behaviours was constructive to her recovery, as it enabled her to recognise that she was not as ill as them, and provided a gauge against which to measure her progress. Therefore, the negative impact of peers could also be perceived as somewhat positive.

Overall, participants described many positive effects of their peers, including having fun, feeling understood and supported, and always feeling that peers were available to talk to. Participants also described many negative repercussions of their peer relationships, such as the cultivated sense of competition, picking up habits and witnessing peers in distress.

Essentially, putting a large group of similar people together in such close proximity is, in some degree, likely to engender both positive and negative effects. Despite the detrimental impact of peers' behaviours, however, peers were generally perceived as helpful and this stood out in the interviews far more than any negativity felt towards them.

Although participants' experiences of their peers were context specific within Clinic-ED, I was able to empathise with them in that many of my peers suffered with eating disorders when I was suffering with mine. Thus, I remembered my own particular feelings of competition (wanting to be the thinnest), yet also experiencing a kind of belonging (to a 'special', unique group). Furthermore, I had witnessed intimate, complex relationships develop between inpatients during my time working at Clinic-ED, and had often wondered whether these relationships were detrimental or conducive to their recoveries. Interviewing participants enabled me to recognise that they could be both; at times peers were "all they had", but at other times they wished they did not have them. What is interesting is that participants' ambivalence about their peers also reverberated within me; not only during the research process, but also regarding my memories of actually suffering with Anorexia, and working in Clinic-ED. Even though I empathised with participants' reflections of this element of inpatient life, I had to think of my own thoughts and perceptions as separate from those of participants, in order to clarify what were mine and what were the participants' experiences.

Throughout the interviews, I attempted to be accepting of both sides of peer relationships, demonstrating my understanding that they could be helpful and unhelpful. I felt a genuine interest in the dynamics between peers, and in the ambivalence participants felt. I communicated this by leaning forwards and maintaining eye contact, to show I was listening. To demonstrate that I appreciated the complexities of these relationships, I nodded and said "mm" whenever participants mentioned their peers. Additionally, I sometimes paraphrased what they had said previously. I feel it was evident that participants recognised my understanding, as their response was to talk in depth about peers consistently throughout the interviews.

Master Theme 5: Distance from the ‘Outside World’

Many participants referred to Clinic-ED as being separate from the ‘real world’. They described a contrast between life inside and outside the clinic. Life outside was described as more ‘normal’ than life inside, in the sense that people simply went about their daily lives, going to school and seeing friends. Contrastingly, life inside Clinic-ED was described as ‘surreal’ in that it was a separate world, primarily encompassing food, eating, and food related systems.

Distance from the outside world involved not only physical distance from family and friends, but also emotional distance, pertaining to the difference between participants’ emotional states and those of their friends at home. All participants described frequently missing their homes and families. Yet many were ambivalent in their perception of life outside Clinic-ED in that they also felt scared of it. Some described feeling vulnerable and exposed when they ventured out of Clinic-ED. This was experienced both physically, for example, when they went to places with hectic crowds of people, and emotionally, regarding the uncertainty of their home lives and whether they would be able to cope. However much they hated being in Clinic-ED, some participants felt it afforded them with a sense of being protected in a ‘safety zone’ where they knew what was going to happen and they felt shielded from the uncertainties of life outside.

Feeling Saddened by Distance from Home

A sense of physical and emotional distance was reported by all participants. Physically, some participants were miles away from their families and friends. Before they progressed to the stage where they were allowed home at weekends, the only contact they were allowed with parents were two half hour phonecalls per week and one four hour visit on or off the unit on Saturdays or Sundays. Participants stated that they nearly always ran out of time on their phonecalls and that the four hour visits were simply not long enough periods to spend with their parents. They additionally saw their families fortnightly at family therapy although this was also spent with a therapist. The only contact they had with friends from home was via letters and emails, as they generally wanted to speak to their parents on their twice weekly phonecalls. This limited contact was described as upsetting:

The little contact, that's just, that's got to be the worse thing. You just, you can feel kind of alone because there's little times when you really need, want to speak to your parents, and you just can't. That's, you just feel so helpless (GABY: 23:5).

Although participants discussed the general implications of the distance from home, many mentioned a more specific distance from their mothers. The effect of this was described as unbearable for some:

When, erm, I was really, really low in weight and stuff, I erm, I would always be with my mum, like I couldn't let her leave my side, (R: Mm), cos I'd be so scared and have to do everything with her all the time. And when they said, oh you know, you've got to go away from your mum, that just literally killed me, (R: Mm), because I just thought I can't like, I can't live without my mum, and like I can't even be away from her side for, like, two seconds (CAT: 10:26).

Cat and other participants referred to feeling exceedingly unhappy as a result of their Anorexia Nervosa, and other general issues which teenagers have to endure, and felt that their mother was the only person they could turn to, and the only person who could help them. Hence, being taken away from her, understandably, was extremely distressing.

There was also a perceptible *emotional* distance from family and friends, in that participants felt no-one from home understood what they were going through. They felt isolated from them, both as a result of being in an inpatient unit, and also in suffering from Anorexia Nervosa:

People write, like, me letters and they sort of say things like, oh I know how you feel. It's like well actually you don't know how I feel, you don't know how anybody here feels because you've never been in this position. Like the worst thing that could probably ever happen to you is, like, breaking your nail or something. Like this is our lives that have gone completely wrong and like some people just don't have an idea what it's like (FRAN: 22:10).

Similarly, when Delia discusses the impact of her Anorexia Nervosa, she refers to the complete destruction it has had over her home life:

[Anorexia] has, like, destroyed just everything like friendships and family and just and like everything like that. So it isn't just food and I think that's what's so hard, (R: Mm). It's, and it, it's a realisation as well I think because you are in here, you're away from the real world. It's like everything sort of hits you and it's like, my God, like,

look what I, what it's done and, (R: Mm) like the impact it's had and stuff (DELIA: 5:11).

Not only does Delia feel that her Anorexia Nervosa has segregated her from friends and family, she also feels that it has segregated her from the 'real world' at home. Indeed, this sense of segregation, of being 'cut off' from reality is referred to by all participants. For instance, as Amy states:

It's a bit of a daze, (R: Mm), it's like a – it's not reality, it doesn't seem like a real world, it just seems like, like a really long dream, like a really long period where it's not really life, it's not living, it's just (R: Mm), being... Because you don't really have a life because, I mean you're not at school, you're not with friends (AMY: 8:7).

Beth further illustrates this when she describes what it means for her to be an inpatient in Clinic-ED:

It just makes you feel like you're living here and just never going to go. Stay here forever (BETH: 3:14).

For many, this sense of endless time is experienced throughout the inpatient stay. In this way, there is an existential element to participants' perceptions of the inpatient experience. Essentially, being an inpatient means to *exist*, but not to live a "*real life*" within Clinic-ED. Indeed, many participants used the word "surreal" when discussing their inpatient experiences. Even though life inside the unit could be perceived as real in the sense that participants experienced very real emotions whilst they were inpatients, it was also surreal in that it removed them from the familiarity of their home lives and usual daily activities. Any sense of meaning in their lives (such as school, friends, and anything they knew prior to their admission to Clinic-ED) was lost which, perhaps inevitably, left inpatients feeling lost. Instead participants were immersed in a food orientated world which was, for many, extremely frightening.

I wondered whether this was especially frightening due to its reflection of participants' inner worlds, which were also experienced as surreal, confused, confusing and food-dominated. In a sense, as this was generated from both Clinic-ED and themselves, there was no escape from it. Perhaps this is what made the experience of being at Clinic-ED so unbearable for some. I wondered whether their disconnection from real life may have been established as

a kind of defence mechanism, in order to protect themselves from the pain they had to feel at living both an internal and external life immersed in food; that which they were most scared of.

Feeling Protected by Clinic-ED

Many participants were ambivalent about their perception of life inside Clinic-ED, in that they felt controlled by it, but simultaneously protected by it. Indeed, many expressed a sense of fear about the 'outside world': Emma actually uses the word "agoraphobia" in her narrative. The outside world was full of uncertainties, fears of relapse, and problems which may have caused or exacerbated participants' eating difficulties in the first place. The sense of familiarity and routine afforded by Clinic-ED was perceived as safe and comforting, whereas the outside world did not offer the same sense of security. Indeed, Cat, who had been admitted to Clinic-ED twice, stated:

When I went home the first time I found it so difficult because here there's such a routine, like, every day. Like, breakfast is at this set time and you have this, and then lunch is this, and then, you, it's like every single day. Whereas in normal life at home, it's not like that, like, (R: No), you know, you can't have lunch every day at this time and you can't have tea because you're going to be doing other things and I think that that's one thing I really found difficult (CAT: 8:22).

This lack of routine suggests one reason for participants' fear of the outside world. Another potential reason for participants feeling safe in Clinic-ED may be that it is a very homely environment. Unlike normal hospital environments, it is a house which has been converted into a clinic, thus it may offer a similar sense of safety that homes generally offer.

I remember when I first came here, I remember I was like, there are ornaments...It's not all, like, clinical, like white walls and corridors and like squeaky floors and like disinfectant, hospital smell (R: Mm), which can like, sometimes make it, like, a bit worse (HOLLY: 3:15).

As Delia states, going home is frightening as she does not know what will happen or how she will feel there:

I don't know how it will be at home and I'm really scared of that. Like I was really scared my first time home. I went home for Christmas like most of us did, just for a few days, (R: Mm), I think the only reason – it was really hard – but I think the only

reason I got through it was because I knew I was coming back here, (R: Mm). And it's like, I don't know, it just, it feels a bit more safe here cos you're not confronted by, just, I don't know. Even though you hate it here and I hate just the whole food thing and the gaining weight and all that, I don't know, I think just real life and just growing up and things like that as well, you're just sort of blocked out by that, (R: Mm). I think that's quite comforting as well (DELIA: 10:19).

The sense of both missing home yet feeling protected by Clinic-ED is, as may be expected, confusing for Delia. She goes on to say:

It's really confusing cos I, I really don't want to be here and when I think of home it does scare me as well. And it's not like I don't want to be there, but part of me is a bit hesitant to like just want to go. It's not like, oh I really miss home. I really would love to go, it's not, I can't really explain it (DELIA: 13:18).

This ambivalence is mirrored by other participants, who also describe feeling confused. Indeed, to not feel safe at home, but to feel safe in a place where one also feels trapped and unreal must be extremely frightening.

Observed together, the above responses imply that participants felt a considerable distance from home and their families. This was experienced as distressing in that they missed their home lives, and had little contact with family and friends. Furthermore, it meant that the emotional distance between them grew as they became progressively attached to the routines and ways of life within Clinic-ED. Having Anorexia Nervosa meant that participants' friends and families rarely understood their experiences. This exacerbated the distance between them. Moreover, participants experienced life inside Clinic-ED as surreal, and separate from 'real' life outside. They felt upset at being separated from normality, where life did not revolve around food, weight and food orientated rules and systems, but simultaneously felt protected by the familiarity and homeliness of Clinic-ED, and frightened of a potential lack of security in the outside world. What is most salient is that participants felt a real distinction between the real world and Clinic-ED's world, and many did not know where they belonged. This was experienced as confusing and distressing.

As the researcher, I was from the "outside world" which participants referred to. Not only was I penetrating their protected, inside world of Clinic-ED by actually coming into and going

out of the clinic (whereas they had to continually stay inside it), I was enquiring as to the intricacies and meanings of this inside world. I did wonder whether participants may have perceived this as threatening and intrusive, or even exciting and enviable. Nonetheless, I concluded that participants had responded to my recruitment flyer as they *wanted* to speak about their inpatient experiences inside Clinic-ED. Additionally, I did fundamentally feel comfortable in my role as interviewer. I believe that when the interviewer is comfortable, the participant will pick up on this and feel more comfortable and relaxed themselves, and I feel my comfort had an impact in that it enabled participants to speak more openly.

I felt that participants allowed me a genuine insight into their engagement with the world around them; regarding both their inside world within Clinic-ED, and the outside world at large. At times, I felt so immersed in what they were saying that I actually felt *part* of their inside worlds; once again experiencing the sensation of my eyes burning when they discussed this. I feel my non-verbal communication reflected this; I maintained eye contact with them and leant forwards towards them. However, more than simply physically leaning forwards, I really felt I was leaning into the participants' words and worlds.

I felt participants responded to this by speaking to me as though I was also, in some ways, part of their inside world. I got the sense that they felt pleased somebody had taken an interest in them, had allowed them to speak, and had taken the time to listen to and utilise what they wanted to say. I felt very privileged to have been afforded this degree of insight, and it affected the way I engaged with my own memories of living inside an eating disordered world, clarifying my experience.

Interestingly, my own memories were analogous to those which participants experienced. For me and participants, the inside eating disordered world was protected and safe. Everything was known and familiar. Yet the world outside was unfamiliar and unpredictable; new circumstances and threats could be presented at any time. Before, both participants' and my own way of coping with this had been to listen to our Anorectic selves which would protect us and tell us everything would be okay if we were thin and controlled what we ate. Yet, the stronger our non-Anorectic self became, the more we recognised that this Anorectic self was destructive and controlling. However, the fear that the same old problems would

still be there in the outside world made the inside world feel comforting. What if we were forgotten about if we recovered? How would we be able to cope without resorting to our Anorectic tendencies? What would we be without our Anorexia to help us through difficult situations? Essentially, would we be nothing without our Anorexia? Campling (2007) provides an invaluable answer to this when he states that “as [the] focus begins to move away from the illness and back into the world, the world will move back – perhaps rush in – to fill up the void”, (p. 29).

Although I did not tell participants that I too had suffered with Anorexia in the past, I felt a sense of hope that they may one day be able to allow the outside world back in, as I had been able to. I hoped they would not feel threatened by it, but excited at its prospects and possibilities. Overall, I hoped that they would be able to live their lives without having to succumb to the persistent voice of their Anorectic self.

Discussion Chapter

In this chapter, I will first review and explore the themes which emerged from participants' interviews, identifying any connections between them, and observing the literature which supports my interpretations of their narratives. I have also included some suggestions for resolving the various issues which have arisen from the analysis, employing a Person Centred therapeutic approach which I felt corresponded well with these suggestions. I will explore each master theme in the same order as the results chapter. I will not, however, break them down into separate constituent themes, as this chapter is not intended to repeat an account of the results, but rather to go beyond the actual data, offering more interpretation and reflection. I have included some quotes from participants in order to add richness to and 'bring to life' the related research.

Following a discussion of the themes, I will subsequently explore both the specific implications of this study for eating disorders clinics, and the wider implications of the study for the field of Counselling Psychology. I will finally examine the strength and limitations of this study, and discuss future studies which may be useful.

Discussion of Results

I hope I have been able to illustrate participants' experiences of being an inpatient in an eating disorders clinic, and that the reader has been able to obtain some idea of both the positive and negative experiences which were evident throughout their inpatient stay. Essentially, participants reflected that their journey was full of sadness, enjoyment, confusion, fun, segregation, protection, distress, familiarity, loneliness, togetherness, challenge, reward and desperation. These emotions were often experienced intensely and simultaneously.

Overall, participants expressed feeling controlled by both their Anorexia and Clinic-ED. They struggled to maintain their autonomy throughout inpatient life, but were frequently oppressed by the rigid rules and treatment components. They felt that the staff delivering

the rules and treatment could be difficult to get along with, but also found them supportive. They felt isolated from the outside world and their home lives, and trapped in a world full of food, rules, distress and oppression. Nonetheless, they also felt protected by Clinic-ED's sense of familiarity and routine. They felt that being in the company of similar peers could exacerbate feelings of competition and distress. Yet they also experienced a great deal of enjoyment from their peers and felt understood by them, which was invaluable.

This demonstrates the ambivalence participants experienced during their inpatient treatment. Indeed, this was the most prevalent concept arising from participant's narratives. As Emma asserted:

“Some days I'm really desperate to get home (R: Mm), and other days I almost enjoy being here” (EMMA: 4:22).

This ambivalence may be a widespread feature of other eating disorders sufferers' experiences of being on an inpatient unit. Offord, Turner and Cooper's (2006) and Colton and Pistrang's (2004) studies, the other two key studies investigating the inpatient experience in eating disorders units, also revealed that their participants experienced a large amount of ambivalence throughout their inpatient life and treatment.

Strober (1997) explains that it is common for individuals to experience crushing ambivalence as a result of being treated for Anorexia Nervosa, as on the one hand, they recognise how much suffering it causes them, but on the other hand, feel that they are not ready to let it go. Carter, McFarlane and Olmsted (2005) explain that individuals may experience ambivalence about treatment because they value certain features of their eating disorder (such staying at a low weight), but also feel ashamed about other features of it (for example, bingeing and vomiting). Skarderud (2007) reiterates this, stating that people with Anorexia Nervosa commonly experience both pride and shame in their eating disorder.

I hope that the following discussion of different themes emerging from participants' narratives will allow an exploration into how elements of treatment and inpatient life may exacerbate this ambivalence, and identify ways to manage it and the detrimental effects it may have upon inpatients.

Master Theme 1: Rules

Although participants felt ambivalent about most areas of inpatient life, they generally found the rules in Clinic-ED either helpful or unhelpful. Manley (2007) explains that it is not uncommon for inpatient units to be governed by strict rules and for inpatients to dislike this:

“Inpatient psychiatric units often have a long list of restricted behaviours and a system of privilege levels. Patients often complain that they are not allowed to do things that they did every day before admission” (p. 5).

Yet rules are evidently in place for a reason; namely to contain inpatients’ eating disorders and promote a healthy relationship with food (Garner, Vitousek & Pike, 1997). Indeed, this is the effect they had on some participants.

Interestingly, the negative words participants used to describe the rules were far more potent than the positive words they used. Indeed, their only positive words were “clever”, “good” and “helpful”. When describing how the rules were negative, however, they used words such as “hate”, “punishments”, “controlling”, “institutionalised”, “threatening” and “blackmail”.

In examining the effects of Clinic-ED’s rules on participants, I wondered how they might relate to *self-imposed* rules which those suffering from eating disorders commonly establish for themselves. Garner, Vitousek and Pike (1997) explain that:

“Over time, anticipated exposure to feared stimuli, such as certain foods...creates such anxiety that rigid rules are adopted to guard against encountering the feared consequences. The dread leads to rules or biases erring in the direction of safety” (p. 105).

Abraham and Llewellyn-Jones (2001) describe how many individuals suffering with eating disorders make long lists of food and exercise related rules which are intended to control their body and their lives. They stick to these rules stringently and will not allow themselves

to break or deflect from them. Croll and Neumark-Sztainer (2005) explain that typical food related rules associated with Anorexia Nervosa include:

“No eating after a certain time in the evening, no eating of specific foods (such as meat, sweets, fats, snacks), eating foods in a specific order, following certain caloric or fat gram daily limits, trying to go all day without eating, and isolating [oneself] from others [whilst] eating. Foods are often categorised as ‘good’ or ‘bad’, or ‘safe’ or ‘scary’, and these categorisations often determine eating behaviours” (p. 379).

In order to afford the reader with a sense of what it feels like to be governed by these rules, I have provided an excerpt from a narrative given by an eating disorders sufferer, which Abraham and Llewellyn-Jones (2001) include in their book:

“I don’t want to be like this, but what I eat still rules my life so that at times every waking minute seems occupied with thoughts of food and the day passes in measured times between when I last ate and when I’ll eat again. I’m still plagued with guilt about everything I consume unless I nearly fast” (p. 91).

I felt this statement illuminated the pain and relentlessness of Anorexia Nervosa and the rules it imposes on the individual. Anorexia does not just control mealtimes; it controls the sufferer’s entire day and entire life. Therefore, the rules do not apply only to mealtimes, but to every element of their life.

I wondered whether the implementation of rules by Clinic-ED effectively acted as ‘counter-rules’ to the self-imposed rules participants abided by. Hence, some may have experienced Clinic-ED’s rules as controlling and negative, as they conflicted with their own rules about eating. Moreover, since the self-imposed rules controlled their entire lives, these conflicts would occur not just at mealtimes, but over their entire inpatient lives. This may provide some reason as to why some participants felt so distressed and oppressed; their whole sense of being, and living according to their own rules, may have been shattered by Clinic-ED’s rules.

This would also help to explain why some participants felt more acceptant of the rules than others. Interestingly, the participants in this study who viewed the rules as more positive than negative – Gaby, Emma and Fran – also generally expressed a prevailing desire and readiness to lay their eating disorders to rest. I wondered whether their readiness to recover had enabled them to lay their own rules to rest. In their study investigating the process of recovery from Anorexia Nervosa, Beresin, Gordon and Herzog (1989) found that for all former sufferers, an element of recovery included recognising and accepting their self-imposed rules, and then discarding them in order to feel freer and less controlled. Furthermore, Benson and Futterman (1985) assert that inpatients who demonstrate a readiness to recover are desperate for rules and direction from those treating them. Hence, it is conceivable that the participants who felt more motivated to recover may have recognised a desire to relinquish their self-imposed rules and looked to Clinic-ED's rules as a guide to their recovery.

Nonetheless, it is important to investigate how the strict structure of rules can be made more bearable for those inpatients less ready to recover, and indeed, act as a motivation to help them feel more ready. Upon discussing how to help eating disorder sufferers in a home environment, Treasure (1997) advises parents and families that holding regular meetings to collaboratively decide rules enables the sufferer to feel that they have had an input and motivates them to follow the rules.

It may be useful to carry out similar techniques in inpatient clinics. The majority of participants in the present study experienced simply being told or "dictated" the rules, but said they may feel less controlled and oppressed if they were allowed some input. Of course, holding collaborative meetings to discuss rules may be difficult in a unit of thirty inpatients, especially since each inpatient may hold different values regarding what rules they perceive as helpful or unhelpful. Yet, it may not be unreasonable for staff to hold such meetings with a view to establishing *some* rules which everybody agreed on. Furthermore, if some inpatients were not confident enough to speak in front of the entire community, practices such as an anonymous voting or suggestions box may allow them to put forward their views (as suggested by one participant, Holly).

Thus, a more collaborative way forward may be identified for both inpatients and staff, motivating inpatients to work *with* staff, and enabling them to feel less controlled. Indeed, Colton & Pistrang (2004) state that when participants from their study found the unit collaborative, “they more often wanted to comply than when they found it punishing and dictatorial, which often led to their feeling rebellious” (p. 313). Offord et al. (2006) explain that a collaborative approach to treatment may afford inpatients with some regained degree of autonomy, and empower them to feel progressively more able to look after themselves and recover.

Master Theme 2: The Battle between Anorexia Nervosa and the non-Anorectic self

In 1999, Serpell, Treasure, Teasdale and Sullivan wrote a paper entitled “Anorexia Nervosa: Friend or Foe”. I felt this title encapsulated the ambivalence participants felt towards their Anorexia. In a sense, participants both loved and hated their Anorexia; they could not live with it and they could not live without it. It was like a warm, comforting embrace that simultaneously suffocated them. Their relationship with their Anorexia was not an ‘either/or’ relationship, in the sense that they did not either want it or not want it; they both wanted it *and* did not want it. Thus, they had both an Anorectic side which loved and nurtured their Anorexia, and a non-Anorectic side which hated and fought against it. Many participants actually described having two sides to themselves, or two parts to their minds. This notion of a ‘split self’ was evident throughout their interviews.

Winnicott (1960) discusses the notion of a ‘false self’. He explains that most people have two selves, the true self and the false self. The false self splits off from the true, whole self in babyhood, when the baby complies with its mother’s rules in order to gain her love. In adulthood, this false self complies with external or societal rules, and follows social codes, customs and conventions. It defines itself in terms of others and how others perceive it. Its compliance is driven by an insecure need for approval. In terms of eating disorders, Orbach (2002) asserts that peoples’ false selves may be responding to society’s rules that it is preferable to be thin. The false self notices even minute discrepancies between its own body and digitally-airbrushed, thin idealised images promulgated by the mass media, and develops a lack of recognition of these images in its body. In this sense, the notion of the

false self extends to a notion of a false body, which develops an instability in response to society's thin ideal. Orbach (2009) explains that those suffering with Anorexia will greatly overestimate their size, unable to see themselves as they are. Thus, their bodily existence or connection to their true body (a body which is content in itself and does not need to be defined by society) is extremely fragile. Hence, I wondered whether participants' alienation from their 'true' body further alienated them from their 'true' self (a whole, coherent self which relied upon itself and did not need to comply with society's rules in order to obtain approval), and meant that they became dominated by a 'false', Anorectic self.

Costin (1997) states that "anyone who works closely with eating disordered individuals realises that in each patient, to a greater or lesser degree, there is a separate adaptive, disordered self (the eating disordered self) with a separate set of perceptions, thoughts, needs and behaviours" (p. 122). She explains that this eating disordered self is developed alongside what she refers to as the 'healthy self'. Epston, Morris and Maisel (1995) explain that people working with eating disorder sufferers should encourage them to view their eating disordered self as separate, speaking about Anorexia and Bulimia as something which is removed from and external to the sufferer. They state that this will undermine the sufferer's guilt and self-blame, and replace it with "Anorexia-blame". Furthermore, externalising their Anorexia may enable them to think of it as separate to themselves, therefore helping them to see that they are not just an eating disorder; not just an 'Anorexic' or 'Bulimic' (Costin, 1997). Bruch (1973) has written extensively about the practice of psychotherapy with eating disorders. Hsu (1990) states that "Bruch conceptualises Anorexia Nervosa as a misguided quest for identity, [therefore] the development of a new personality is the ultimate goal for her treatment" (p. 144).

Upon reflecting on the above statements, and observing participants' accounts, I wondered whether it was being admitted to Clinic-ED which actually *caused* their sense of self to 'split'. Although Winnicott (1960) states this split between the false and true self occurs in babyhood, was it participants' *awareness* of their two separate selves which was initiated by Clinic-ED? Many participants stated that it was only being referred to Clinic-ED which made their Anorexia seem real. Therefore, did acknowledging it and believing in it also mean that the split self was created? Prior to admission, participants may only have experienced

having one self (their dominant, Anorectic self), whereas when they were admitted to Clinic-ED, they were taught to think of their Anorexia as different to themselves. As Amy states:

You say one thing and it's like, that's your anorexia talking, it's your anorexia, you can't possibly think that cos it's your anorexia (AMY: 14:24).

Therefore, it may be understandable that participants experienced an internal battle, as one part of them was listening to their formerly trusted Anorectic self and another part was listening to a different non-Anorectic self, potentially nurtured and cultivated by Clinic-ED.

Although it may be necessary (or even unavoidable) to create a split self in order to allow the inpatient to recognise that they can and should think in a different, healthier way to their Anorectic thinking, I wondered whether instead of subsequently trying to suppress the Anorectic self, it might be more beneficial to work in such a way which aimed to *integrate* the Anorectic and non-Anorectic selves into one. This might involve not trying to eliminate the Anorexia which inpatients are desperately trying to hold onto, but rather allowing them to be mindful and acceptant of it. Interestingly, this reminded me of Jung's (1938) concept of the 'shadow'. He suggested that everyone has a presentable self which they wish to show to others, and a shadow which represents a more sinister side of them, consisting of their weaknesses and shortcomings. Jung explains that no matter how much we try to ignore this shadow, it is a part of us, and that the more we try to eradicate it, the more it will haunt us with increasing vengeance. Thus, the best way to deal with it is in fact to be mindful of it and integrate it into our lives. Similarly, instead of trying to ignore the Anorectic self, accepting and integrating it may allow the sufferer to come to terms with it and relinquish it.

Rollnick and Miller (1995) explain that motivational interviewing is a Person Centred way of treating eating disorders. They state that ambivalence is the principal obstacle in allowing changes to occur, and that the therapist should facilitate the client's expression of both sides of their ambivalence and guide them towards a more acceptable resolution which will trigger change. If ambivalence is caused by the two sides of the split self, then motivational interviewing may be a sound way to facilitate inpatients' acceptance and understanding of both their eating disordered and non-eating disordered sides.

Upon exploring eating disorders from a Person Centred perspective, Campling (2007) states:

“Rather than being in our organismic self we are in some kind of self-concept. The self-concept is a rigid, black/white thinker, wildly fluctuating, unable to see beyond a narrow line. Because at the beginning it seems a positive thing, energy grows in an artificial *eating disorder*. This eating disorder self has the same characteristics as the self-concept. Additionally it is desperately frightened and often paranoid and sees no way out other than ritualised behaviour, denial of normal bodily needs and strict discipline. We cannot fight the eating disorder/self concept head on – it is rooted in the emotional centre and is not available to our intellectual arguments. It has to be *negotiated* with, it has to be *understood* for what it is – trying to do a job but with the wrong set of tools” (Eating Disorder Self-Cure webpage).

Campling (2007) goes on to say that the self-concept needs to be loved, appreciated and thanked, and then gently disengaged and allowed to let go. He explains that as the client’s focus begins to move away from their illness and back into the world, they will be able to replace eating disordered behaviours with healthier, non-eating disordered behaviours such as reading books. I felt the participants in this study were going along the right pathway by searching for a sense of meaning about their Anorexia, regarding what it felt like to eat and what it might feel like to recover. In this sense, they may have been ‘testing the waters’ of negotiation with their eating disorder, entertaining the concept of a non-Anorectic self, but still unsure as to whether to fully let their Anorectic self go.

Interestingly, the words participants used, and the words which came to my mind upon analysing their interviews were commonly war related. They used words such as “battle”, “fight”, “conflict”, “struggle”, “give in”, “no win”, and “lose”. The battle they experienced was palpable, yet they felt there was no choice for them but to surrender, both to their Anorexia (regarding the battle between their non-Anorectic self and their Anorexia) and to Clinic-ED (regarding the battle between Clinic-ED and their Anorexia). Being in battle, unable to resolve a conflict, may additionally imply feeling stuck. This is also what participants alluded to; using words such as “prison”, “trapped” and “locked in”.

Upon considering potential ways to set participants free and resolve their internal and external conflicts, I started thinking about peace processes used to settle wars. This does

not include simply eliminating one side – both sides must be taken into account and listened to. Thus, I wondered whether participants could resolve their conflicts by trying to stop making one side win and the other lose, but rather by accepting that both sides are present, and need to be acknowledged. In this respect, perhaps they could reach an inner peace settlement with their Anorexia Nervosa, and an outer peace settlement with Clinic-ED.

Whilst political peace settlements are intended to allow two countries or communities to co-exist following conflict, the metaphor may not be taken so literally with regard to eating disorders. In some cases, the fact that an inpatient has been able to come to peace with their Anorexia during treatment may mean that the disorder may fade away over time and no longer continue to be such a significant part of their lives. In other cases, however, the Anorexia may not fade away, and like in political settlements, the sufferer may have to learn to live side by side with it for the rest of their lives. The important factor regarding treatment is *how* the settlement is delivered to the inpatient, and that it is sustainable following discharge.

Fundamentally, it is the responsibility of eating disorder clinics to facilitate the peace settlement. *Externally*, this may involve not dictating strict rules which inpatients are forced to abide by, but working collaboratively with them to establish rules which might help inpatients feel more autonomous. Ultimately, this may reduce their will to fight, taking their focus off the battle, and gearing it towards recovery (Offord et al, 2006).

Likewise, clinics may facilitate inpatients' *inner* peace settlements in therapy, by working with them to form a collaborative relationship between their Anorectic and non-Anorectic selves. This may involve encouraging the inpatient to negotiate with their Anorectic self, and consider alternative healthier, non-Anorectic behaviours. For example, instead of thinking about their Anorexia Nervosa for twenty-four hours a day, perhaps the inpatient could think of ways to spend a small portion of their day doing a completely unrelated enjoyable task, such as reading a book (Campling, 2007). Instead of loving and cultivating the Anorectic self, it may be useful to recognise elements of their non-Anorectic selves they might value, such as having the freedom of not being consumed by Anorectic thoughts and rules. Conversely, instead of blaming the Anorectic self for destroying their lives, it may be more useful for the

inpatient to understand that the Anorectic self was trying to do its best for the person and that it is not their fault that things turned out the way they did (Campling, 2007). Furthermore, it may be helpful to draw upon some of the Anorectic self's valuable qualities, such as its strong will power and determination, to facilitate recovery and strengthen the non-Anorectic self.

Ultimately, having an eating disorder may be likely to engender feelings of internal conflict. Yet, the sufferer may be too enmeshed with this battle to recognise how to find peace within themselves. Hence, by gently facilitating an inner peace settlement, encouraging them to understand and negotiate with their Anorexia, eating disorder clinics may allow sufferers to lay this battle – and hopefully their eating disorders too – to rest.

Master Theme 3: The Battle between Anorexia Nervosa and Clinic-ED

Participants commonly experienced a conflict between their Anorexia Nervosa and Clinic-ED. They felt, in one sense, compelled to do what their Anorexia told them, and in another, compelled to follow Clinic-ED's directions. This conflict appears to be a widespread feature of the inpatient experience. Offord et al. (2006) and Colton and Pistrang (2004) also found that their participants experienced a battle with their inpatient units. Nonetheless, these studies do not consider the extra element of the Anorectic self. It would seem that this is crucial in informing our understanding of why the battle is so hard for participants, for not only does it involve fighting against the powerful Clinic-ED (as participants perceived it to be), it also involves a painful split in their sense of self; not knowing which part of themselves is genuine or trustworthy. Indeed, when a person's sense of self is split, their opinions may also be split. Thus, their ambivalence about which part of themselves was trustworthy extended to not knowing whether to trust Clinic-ED or not. On one hand, Clinic-ED claimed to help them, yet on the other hand, it controlled them. This was mirrored by their Anorexia Nervosa's claim to help them, but its simultaneous control over them.

Upon reading and re-reading the interviews, a dominant image kept reappearing in my mind. This image was of a 'tug of war'. It was as though each participant was the rope, being pulled equally as forcefully in two opposing directions, one direction representing their Anorexia, and the other representing Clinic-ED. As the rope, each participant (and their

sense of self) was stretched so thin they had no idea where to go or what to do; they simply felt controlled, torn and unhappy.

Many participants described that the battle against Clinic-ED left them feeling out of control. There has been much research into the link between Anorexia and the need for control. Fundamentally, researchers have maintained that compulsive dieting may be seen as a way to gain some control over a life that seems very out of control (Chatoor, 1999). Costin (1997) states that control battles are common when working with eating disorder sufferers, and that therapists should help sufferers relieve the need to fight for control by attempting to “resolve issues that result in the need for control” (p. 134). Reid, Burr, Williams and Hammersley (2008) assert that treatment should facilitate sufferers’ needs for control by achieving a balance between including them in treatment and providing governing guidance. It would seem this balance is needed in most elements of treatment, for instance, providing rules to contain inpatients’ Anorexia Nervosa, but allowing them some degree of collaboration in these rules which enables them to feel they have had some control over their lives.

Another predominant aspect of the battle with Clinic-ED included a staff-specific battle. It would seem that participants’ relationships with staff may have mirrored their perception of the whole inpatient experience, in that staff were managing and coordinating this experience. For example, if rules were perceived as controlling, participants also implied feeling controlled by staff. If being allowed to manage one’s own meals and portion sizes (as inpatients were in Kitchen-B) was perceived as trusting, staff were also viewed in this way. Hence, staff and Clinic-ED in general were commonly referred to interchangeably.

Magagna (2000) explains that battles for control between staff and inpatients are common features of inpatient treatment. Constant monitoring by staff members and continually enforcing control can add strain to staff/inpatient relationships, and result in a battle of wills which can distract both staff and inpatients from the goals of recovery (Beaumont, Beaumont, Touyz & Williams, 1997; Sallas, 1985).

Yet, Costin (1997) states that staff can become positive role models for Anorexic inpatients and provide an example of healthy interpersonal relationships and “family systems”; for instance by eating together with inpatients, which may serve to normalise eating and mealtimes. They can utilise their experience and expertise in the field of eating disorders by empathically talking through some of the problems inpatients face, and using their intuition to discern when an inpatient may be struggling; not just during mealtimes. Additionally, Van Ommen, Meerwijk, Kars, Van Elburg and Van Meijel (2009) assert that following discharge, staff behaviours which are perceived by inpatients as significantly contributing to their recoveries are the normalisation of their eating behaviours, the structure they afford to inpatients, and their endowment of responsibility for their care.

Participants also experienced some feelings of conflict in relation to their therapists. Many described the therapist as unhelpful in that she was frequently silent, cancelled sessions and “gossiped” to other staff members. Others described her (and staff members) as working against inpatients. I wondered whether the bad feeling they experienced towards the therapist and staff cultivated their will to fight against them, rather than collaboratively working with them towards the goal of recovery. Fundamentally, did the client perceive the therapist as a threat to removing their Anorexia Nervosa, which increased their hostility? Hence, what could the therapist do to appear less threatening, and more acceptant of the client’s Anorexia?

As Goodsitt (1997) explains, it is crucial that the therapist lets the client know that they are on their side. This includes both the Anorectic and non-Anorectic side. From a Person Centred perspective, this might involve showing mindfulness of both sides, and acknowledging how hard both sides are working to be dominant. This may lead the client to become more understanding of their Anorexia and Anorectic self. They may thus recognise that their Anorexia merely serves a function which they hoped would help them feel better about themselves, but that there are other, healthier ways in which to do this.

Troop (2003) states that it is not uncommon for inpatients to feel resistant to treatment and therapy, but that this is not a reflection of their lack of motivation, or ambivalence, but more of a mismatch between what inpatient and therapist perceive to be effective, and a

discrepancy in the therapeutic goals. Indeed, Troop (2003) maintains that it is vital that therapist and client are on the same page if they are to work forwards in therapy.

Garner, Vitousek and Pike (1997) assert that because many inpatients are ambivalent about the goals of therapy and treatment, it is crucial for the therapist to retain an awareness of the inpatient's ongoing evaluation of the quality of their relationship. They state that:

"The therapist must strive to convey qualities of appropriate warmth, sensitivity, compassion, genuineness, honesty, flexibility, engagement, acceptance and positive regard; he or she must also be acutely attuned to how the patient is feeling about treatment progress, and about the therapist's role in this process" (p. 99).

I wondered whether the aforementioned more united, collaborative approach to treatment might facilitate a more harmonious relationship with not just therapists, but all members of staff. By giving participants a voice in their treatment, they may be given a token of faith that they are trustworthy and capable (Anderson, Bowers & Evans, 1997). This may allow them to lay their ambivalence about treatment (wanting and simultaneously not wanting to recover) to rest, as they may develop more faith in themselves that they will be *able* to recover.

A predominant aspect of therapy which participants found unhelpful was that it was too focused on the body and not focused enough on the mind. Treacy (2009) states;

"Some [sufferers] are completely disassociated from their bodies and won't even look in the mirror...The connection between mind and body has been severely damaged and must be repaired by developing new coping mechanisms and an improved self-image" (CRC Health Group webpage).

Indeed, Gaby expressed this view, when she said she felt disconnected from her body, and Cat explained that she could not look at a reflection of herself in a full length mirror as she found it difficult to accept her larger body. Treacy (2009) encourages her clients to complete a body image exercise, whereby they are asked to write a letter from their mind to their body, and from their body to their mind. Clients are then asked to share their work with

peers. This body-image exercise includes both mind and body, and may help people experiencing similar issues to Gaby and Cat.

When discussing their participants' ambivalent views of treatment, Colton and Pistrang (2004) found it difficult to determine whether these views were a reflection of their motivation to recover, (hence, experiencing treatment positively if they were more ready to recover, and vice versa), or whether they resulted from specific challenging aspects of treatment. When observed in the context of the split self, it would seem that participants in the present study demonstrated a clear split in their perception of the rules, treatment components and therapy, dependent on whether their Anorectic or non-Anorectic self was dominant. It would seem that those whose Anorectic self was dominant (and who were therefore less motivated to recover) – Amy, Beth, Cat and Holly – experienced a more negative perception, whereas those whose non-Anorectic self was dominant (and who were more motivated to recover) – Emma, Fran and Gaby – experienced a more positive perception. Whilst both types of participant were still ambivalent, there was a clear inclination towards either negative or positive perceptions. Delia, who experienced an equally split sense of self, demonstrated a stronger sense of ambivalence, and thus a more ferocious battle between her Anorectic and non-Anorectic selves, and between her Anorexia and Clinic-ED. This would suggest that the degree to which Colton and Pistrang's (2004) participants (and, indeed, the participants in this study) felt more or less motivated to recover may have had a large impact on their perceptions of treatment.

Master Theme 4: Peer Influence

Participants described mixed views about the role of their peers. They generally found them supportive and understanding, and most portrayed them as the best aspect of their inpatient experience. Yet they also found that being with similar others bred a sense of competition and exposed them to peer distress. These findings correspond with Colton and Pistrang's (2004), and Offord, Turner and Cooper's (2006) studies, which found that inpatients experienced their peers as both helpful and detrimental.

Essentially, comparison with peers is a common human trait. Social comparison theory maintains that most *non-eating* disordered individuals compare their bodies to those of their friends, or against media portrayed images, in any case (Thorton & Moore, 1993). Orbach (2009) explains that we assume our bodies (and our sense of what an ideal body looks like) in response to how others present their bodies. Thus, for someone as preoccupied with their body-image as a person suffering from an eating disorder, this comparison is perhaps to be expected. Indeed, Toro, Salamero and Martinez (1994) assert that comparing one's appearance to that of other people is a common form of behaviour in people with eating disorders. Heinberg and Thompson (1992) reiterate this, stating that eating disorder sufferers compare themselves repeatedly to peers since the compulsion to do so can be relentless and too tempting to ignore.

Colton and Pistrang (2004) suggest that separating extremely unwell inpatients from those closer to recovery and discharge may provide a solution to the problem of peer comparison and other detrimental impacts. Yet, they recognise that "such a solution...might deny those who are very unwell the opportunity of being helped by, and gaining motivation from, those further along the recovery process" (p. 314). Indeed, separating inpatients may not only be detrimental to newly admitted inpatients, but also to those closer to discharge. More unwell inpatients may provide a gauge against which to measure their progress, and serve as a reminder of how destructive the effects of Anorexia Nervosa can be at the stage where admission to an inpatient unit is necessary. As one participant, Emma, explained:

We had a New Year's Eve party (R: Mm) and we were given a big brief beforehand that we weren't dancing, we weren't walking around, we just had to sit down. And, er, as soon as the day staff left and the night staff came on everyone jumped up and literally from seven 'til twelve it was dancing. And me and two other girls were lying on the sofa, and I was just thinking if, like, if I can lie on the sofa and everyone else feels like they can't then I don't need to be here (EMMA: 7:20).

Overall, it would seem more logical to keep all inpatients in one environment, as the beneficial impacts are far greater than the detrimental ones. Offord et al. (2006) explain that being with similar others can help inpatients feel less alone. Borkman (1999) found that this realisation that people are not alone in their distress can often act as a life-line when everything else seems hopeless. Costin (1997) recognises:

“By sharing and listening to others, patients learn that they are not alone in their suffering, their feelings and their experience of having an eating disorder. Even though individual stories vary and patients are all unique, a camaraderie exists among people who are suffering from eating disorders. It can enhance a person’s self-esteem just to realise that she is neither crazy nor alone. Some patients handle certain issues better than others, and they help each other in this way. Furthermore, a common trait in individuals with eating disorders is the desire to be special and unique, and the eating disorder helps provide that. In a group of peers also with eating disorders, patients must explore and find other, more constructive ways to be unique” (p. 156).

Ultimately, although peers did engender some negative feelings in participants, it would seem that the benefits of being with similar others far outweighed the disadvantages. Negative feelings are perhaps bound to exist within a group of people in such close proximity to each other, but the positive feelings experienced by the group of participants in this study were far more prevalent, and this made peer relationships invaluable.

Master Theme 5: Distance from the ‘Outside World’

Participants all expressed a sense of disconnection from the outside world and their home lives. This corresponds with Offord et al.’s (2006) study, which found that participants experienced feeling removed from normality. It may be understandable that removing adolescents from their families, friends and home lives will consequently cause them to feel isolated from them. Adolescence is often a time of searching for a sense of self, and this is difficult enough, let alone without the consistency and familiarity afforded by family and friends (Erikson, 1950; Heilbrun, 1964).

Participants often referred to specifically missing their mothers. Indeed, Lock and le Grange (2005) explain how it is not uncommon for inpatients to cry out for their mothers during their time on inpatient units. A great deal of research has been conducted on the role of the mother in Anorexia Nervosa; the consensus being that eating disorders are commonly related to a strong attachment to the mother and a difficulty in developing autonomy from

her (Cunha, Relvas & Soares, 2009). It would certainly seem that some of the participants in the present study demonstrated this. For instance, Cat said “it killed me” when she learnt she was going to have to be separated from her mother upon her admission to Clinic-ED.

Many participants in the current study used the word “surreal” to describe their inpatient experience, feeling that they were simply “existing” in Clinic-ED, rather than living a life. Indeed, any familiarity was lost upon admission to Clinic-ED; the people were new, the environment was new and even they were being encouraged to become a new person. They had no connection with the things they had previously known, such as school and friends, and had instead become immersed in a world full of food, and food-related rules or systems.

This also reflected their internal world. I previously mentioned in my discussion of rules in Clinic-ED that those suffering with eating disorders find that their whole lives, thoughts and behaviours are dominated by food and weight, and how the relentlessness of this can feel distressing (Abraham & Llewellyn-Jones, 2001). Perhaps ironically, Clinic-ED was trying to stop inpatients from attaching so much meaning to food internally, yet the main meaning within Clinic-ED was food. It felt that there was no escape for inpatients, either internally or externally, from the issue of food. This may, paradoxically, provide some explanation as to why participants also felt protected by Clinic-ED; no matter how oppressive the constant presence of food was, at least it was familiar to them.

I wondered whether participants’ feelings of ‘surrealness’ were created upon admission or whether they had been present throughout their experience of suffering from Anorexia. Anorexia Nervosa has been described as a “non-life”, an “anti-life”, and a silent rebellion against life by refusing to eat the food which nourishes the sufferer and sustains life (Breillat, 2009). Indeed, upon discussing her experience of having Anorexia, Gaby states:

You don’t really have a life, like you’re not really yourself (GABY: 6:2).

Hence, it seems this surrealness may have been experienced both before and during admission. This led me to wonder about the existential impact this may have had upon participants. Chen (2001) asserts that it is a natural element of existence to search for

meaning in one's life. Tillich (1952) discusses the concept of 'existential anxiety'. He explains that this is a feeling associated with the recognition of meaninglessness. Fox and Leung (2009) assert that people may develop Anorexia Nervosa as a way of dealing with this existential anxiety, as it gives them a sense of meaning in their lives. This meaning is, fundamentally, food-related.

On a deeper note, I wondered whether participants' feelings of surrealness were exacerbated by the split self. Upon admission, participants may have experienced Clinic-ED repeatedly conveying to them that their previous sense of self (their dominant Anorectic self) was bad and trying to remove it. Therefore, it would seem conceivable that if their Anorexia (the main source of meaning in their lives) was taken away from them, this might entail that their existential anxiety would return and their lives would become meaningless once again. This may, understandably, be a frightening prospect.

Specific Implications for Eating Disorders Clinics and Sufferers

It would appear that there are a number of implications for the field of eating disorders, and some potential recommendations for those both suffering from and treating eating disorders. As a result of engaging with the analysis, and carrying out interpretative (as opposed to descriptive) phenomenology, I feel I have obtained, through my interpretations, a clearer understanding of not only what participants' experiences feel like, but what they *mean*. Hence, my recommendations are directly informed by this deeper understanding of the meaning of participants' experiences. However, I must reiterate that everyone is different and responds differently to different treatment methods, thus the following ideas are in no way intended to be prescriptive. They are simply suggestions as to what eating disorder sufferers may respond to, either at a first attempt, or if other treatment techniques do not produce beneficial results.

The most predominant notion arising from participants' narratives was the notion of the split self; the Anorexic self and the non-Anorexic self. This split was distressing for participants and made them feel lost and disconnected from a unified, coherent sense of

self. Although it may be useful to externalise Anorexia Nervosa and create an Anorectic self in order to reduce the self-blame and increase the “Anorexia-blame” (Epston et al., 1995), what participants said they found unhelpful was when their Anorexia was held responsible for anything they said, and when treatment was focused on trying to eradicate their Anorectic self. Indeed, when Anorexia is at its strongest, it may be difficult to understand that when someone attempts to remove it, they are only trying to remove a part of you; especially since you may feel that it *is* the whole you. This can feel threatening and confusing (Andersen, Bowers & Evans, 1997; Strober, 1997).

Hence, instead of treating the individual as two separate selves, it may be more helpful to view them as one person. Encouraging mindfulness of the eating disordered self, (instead of suppressing it, which can feel suffocating), and learning to integrate it into the whole self by appreciating and accepting it may allow the individual to feel less threatened. Once it has been accepted, it can be gently negotiated with and constructive, healthier behaviours can be identified with which to replace unhealthy, Anorectic ones. This introduces a valuable way of working in a Person Centred manner with people suffering with eating disorders (Campling, 2007). In this sense, the Anorectic self-concept is embraced and loved as much as the non-Anorectic self-concept, but the person can become increasingly aware that the Anorectic self may be harmful to them, and explore ways which feel bearable to let it go.

It may also be useful to implement a more collaborative approach to treatment. This may involve holding regular meetings to discuss rules (Treasure, 1997), in which staff and inpatients could collaboratively discuss which rules or elements of treatment felt beneficial and nurturing, and which felt punitive and controlling. For those not confident enough to participate in meetings, it may be useful to introduce an anonymous box which inpatients could use to voice their fears, worries, disagreements or suggestions (proposed by the participant, Holly, as aforementioned). Staff could monitor this box and introduce any issues at the meetings. As Offord et al. (2006) explain, this collaborative approach may enable inpatients to feel they have been instrumental in their recoveries.

Moreover, since it is a motivation and a readiness to recover which many studies have shown to be the key factor in influencing inpatient’s recoveries (Colton & Pistrang, 2004;

Lamoureux & Bottorff, 2005; Rorty, Yager & Rossotto, 1993) perhaps it would be useful to focus on nurturing this motivation in therapy. This may be done by precisely what participants in the present study felt their inpatient treatment lacked: by focusing equally on the mind and the body. By adopting Treacy's (2009) suggestion of encouraging inpatients to write letters from their mind to their body and their body to their mind, inpatients may feel permission to explore both sides of themselves and learn to accept, and integrate the two. Furthermore, instead of simply replacing Anorectic behaviours, it may also allow an exploration of why an eating disorder may have started in the first place, and the feelings and emotions this engendered. Ultimately, once the eating disorder has been understood for what it is, a recognition of how to fulfil the function of an eating disorder in a healthier way may be facilitated.

These suggestions have been drawn from the people who are receiving treatment for their eating disorders and I feel that we owe it to them to listen to what they say works and does not work. It seems remarkable that their opinions have been overlooked for so long. Hopefully conducting more studies like this one, and those conducted by Colton and Pistrang (2004) and Offord et al. (2006), will substantiate these findings, and provide richer and more detailed accounts of the inpatient experience and potential treatment ideas.

Wider Implications for Counselling Psychology

The ethos of Counselling Psychology maintains that all areas of a person's life should be observed in order to ascertain how best to help that person (du Plock, 2010). I feel the present study was able to provide a sound parallel to this ethos by taking into account all areas of inpatient life in an eating disorders clinic. By asking participants what areas of inpatient life *they* felt had impacted their experience, they were able to develop my, and I hope others' understandings of what they felt was most valuable and what was ineffective, and what could be done to enhance their overall experience.

Farber, Manevich, Metzger and Saypol (2005) explain how Counselling Psychologists, therapists and mental health nurses may have a tendency to see things through their own

eyes. Whilst these professionals may have opinions on how to best treat their clients, Farber et al. (2005) state that it is crucial for them to hold these opinions as secondary to the opinions of the clients themselves. First and foremost, in the therapeutic space, the wishes and needs of their clients should be attended to.

The main issue which kept arising for me as a Counselling Psychologist, as someone who has worked with eating disordered clients, and as someone who has suffered from an eating disorder myself, was that of *trust*. The Oxford Dictionary (2009) defines trust as “a firm belief in the reliability, truth, ability or strength of someone or something” (Oxford Dictionary Online). As therapists we put a great deal of trust in our clients that they are telling us the truth about their lives (Legg & Donati, 2006). Yet, much literature has asserted that people suffering with Anorexia Nervosa may have a tendency to misrepresent the truth in order to suit their eating disorder, for example saying they have eaten when they have not (Abraham & Llewellyn-Jones, 2001; Harshbarger, Ahlers-Schmidt, Mayans, Mayans & Hawkins, 2009).

It seemed fundamental to my experience of being a Counselling Psychologist that whilst this may sometimes be the case, this should not provide a sound enough reason to not listen to what our clients, or inpatients are saying helps or does not help them; on the premise that they *might* be lying. Those suffering with Anorexia are often in a deep state of distress, anxiety, isolation and fear, and it is my belief as a Counselling Psychologist that they should be listened to and given a voice in their treatment, on the essential grounds that they are people who simply want to find a way to make the inpatient experience more bearable.

When I was in the midst of my eating disorder, did I lie? Yes. I said I had eaten when I had not, I said I had eaten more than I had, and I said I would eat when I knew I would not. Did that mean I was in any less distress? No. In fact, it meant I was, at times, in more distress due to the guilt I felt at lying. What I needed was to be listened to, to be understood and to be given a voice which, in conjunction with being guided by others, would allow me to put my opinion forwards and collaboratively work out a way forwards with them. This seemed to be the message I received from the participants in this study. Instead of being doubted, controlled, dictated to and oppressed, they needed to be trusted that their opinions

counted and that they could have some input into their treatment. With reference to a complex example such as inpatients' opposition to the rules, this might include sitting down with them, discussing their perceptions of the rules and maybe adjusting them to make them seem more manageable.

I hope that this will be a valuable message for all Counselling Psychologists. Fundamentally I hope this study has been able to highlight the importance of listening to our clients, the service-users, and drawing upon what they tell us, to create a more useful, constructive therapeutic environment for them.

Strengths and Limitations of the Study and Ideas for Future Studies

There were a number of both strengths and limitations to this study. Perhaps the most apparent limitation was the small scale of the study. Only focusing on one inpatient unit with a specific way of working may not have yielded analogous results to other units. Furthermore, not all inpatients may have provided similar accounts of their experiences to those given by the current participants. Nonetheless, the findings of this study do show similar results to those produced by Offord, Turner and Cooper (2006) and Colton and Pistrang (2004). Thus, this study adds weight to their findings and also goes further by extracting additional findings from the data.

It seems that more research is needed in the same area to further substantiate the current and two preceding studies. This research would be more valuable if conducted on a larger scale, perhaps across the range of eating disorder clinics, both in the UK and elsewhere. Evidently this will require a large investment of both time and money, but my view is that if it could go some way to making the experience of being an inpatient more helpful, it would be worth it.

On a similar note, it might have been useful to interview inpatients in non-specialist eating disorders units to compare the accounts provided. It would seem that inpatients' perceptions of treatment may differ according to many elements. For instance, is non-

specialist treatment as geared towards helping them overcome their eating disorders as specialist treatment may be? Has being with non-eating disordered peers helped to diffuse their all-consuming Anorectic thoughts, or made them feel less understood (Gowers & Green, 2007)? Are non-specialist staff less knowledgeable or sympathetic about eating disorders (Martin, 1998; Nitsun, 1996)? All these questions and many more may be answered upon carrying out studies in both specialist and non-specialist settings. Although I did wish to carry out the present study in another, non-specialist clinic, in addition to Clinic-ED (a specialist clinic), I was not able to do so as there were no suitable inpatients at the time of recruiting participants.

Additionally, I wonder whether it may have been somewhat restrictive to only interview females. Interviewing male inpatients may provide a broader view of what females and males may find helpful or unhelpful. I did not carry out research of this kind as there were no male inpatients in Clinic-ED at the time of recruitment. Indeed, it is rare for there to be male inpatients in Clinic-ED. Future research on males' perspectives would be valuable either in conjunction with, in comparison to, or separately from studies investigating female inpatients' experiences.

With respect to learning more about the notion of the split sense of self, it may be useful to conduct more research on this area. Had I known that the findings of the study would suggest that the split self (and the inpatients' awareness of it) might be created upon admission to an inpatient clinic, I may have carried out a preceding study assessing whether there is a perception of one (Anorectic) sense of self prior to admission and therapy. This might have reinforced my suggestion of integrating the Anorectic self with the non-Anorectic self, as opposed to forcibly trying to destroy the Anorectic self, and potentially cultivating the internal battle which inpatients may experience. Moreover, can there be some way of integrating a non-Anorectic way of thinking into the individual's way of thinking without threatening their whole sense of being? Essentially, this provides a good foundation on which future studies may take place.

It would be useful to carry out more research into inpatients' motivations to change and how this can affect the inpatient experience. As Colton and Pistrang (2004) indicate,

readiness to change does not necessarily imply a lack of ambivalence, or a wholehearted commitment to the treatment programme. Nonetheless, it may provide some insight into whether the inpatient experience is less or more manageable, and elucidate some idea of where the motivation to change comes from. Is it connected to a particular aspect of inpatient life or treatment, or is it a more personal impetus which increases the desire to lay an eating disorder to rest?

As aforementioned, I found it of the utmost importance to trust the participants. Although some may postulate that they might have proposed modifications in the treatment at Clinic-ED in order to gratify their eating disorders, I felt it was evident both from conducting the interviews and looking back over participants' narratives that what they gave of themselves in the interviews was heartfelt and sincere. The emotion and confusion participants evidently experienced allowed me to feel this way; I felt it would have been very difficult for them to have provided misleading answers whilst demonstrating such raw emotion. Participants spoke openly and thoughtfully, and did not suggest any unreasonable modifications that Clinic-ED could make, instead talking about their own feelings and experiences in depth and with sincerity.

Ultimately, I felt this was a key strength of the study. Not only did it provide the participants themselves with an opportunity to tell their story, it also aims to provide the reader with a sense of what inpatients may go through during their time in an eating disorder clinic. Hopefully, eating disorder professionals may be provided with a clearer picture of what inpatients might benefit from in treatment by becoming aware of what they find challenging and distressing, or useful and constructive. Of course, what works for one person may not work for someone else. However, I hope that the findings of this study might at least provide some suggestions for future practice.

Conclusion

The fundamental message received from inpatients was that we should listen to them in their time of need, and utilise what they tell us, as Counselling Psychologists, nurses,

therapists or eating disorder professionals, to help them through this time of need. Participants described feeling both internal and external battles, between their Anorexia and their non-Anorectic self, and their Anorexia and Clinic-ED. For some, these battles were exacerbated by Clinic-ED's strict rules, and a message from staff that their opinions were somehow less valuable and believable as they essentially came from their Anorexia. They were ambivalent about many areas of inpatient life such as the role of peers, and their relationship with family and friends at home.

There are some potential ways to help participants through their experiences. By integrating their Anorectic self with that of their non-Anorectic self, the inpatient may not feel so torn between two sides of themselves, and experience such a palpable internal battle against their Anorexia. This may enable them to feel less ambivalent, and facilitate an awareness and trust in themselves and how they feel. From a Person Centred perspective, this may involve a reconnection with their 'organismic valuing process' – an ongoing, inherent process whereby experiences are accurately valued according to the optimal enhancement of the self (Rogers, 1951) – thus enabling them to recognise what is good for them in terms of facilitating their recovery process. Furthermore, by allowing inpatients to have a more collaborative role in their treatment, they may come to rely progressively more upon their own opinions, thus internalising their locus of evaluation and connecting with their inherent wisdom to guide and promote change (Rogers, 1951). This may reduce their experiences of being controlled and dominated, and feeling like they simply exist in Clinic-ED, as they may feel more 'real', valued and trusted as a person, rather than just an Anorexic.

Reflective Statement

At the start of this study, I was unsure of what might emerge from the research. I personally thought that the treatment at Clinic-ED was useful and beneficial, and it has been enlightening to recognise that despite what someone who cares for an inpatient may think, this is not necessarily what inpatients themselves think and feel. I am appreciative that I have been made aware of this and I am certain this will inform my future practice, as it has

highlighted the importance of really listening to what inpatients say, and striving to understand the meanings behind this.

I was also initially uncertain as to whether anything could be done to make these participants' voices heard. Nonetheless, I feel glad that some potential recommendations have been able to emerge from this research and hope that they may be of some benefit to interested parties.

Throughout the research process, my hermeneutic reflection (that is to say the process of conducting phenomenological research) evolved and developed consistently. Although I read and re-read the interview transcripts and this thesis a number of times, I felt that new ideas and threads kept appearing all the time. It was not simply a matter of reading the transcripts and then feeling ideas spilling out; at first my ideas were simple, and it was only when I repeatedly read over them that new ideas and questions would arise. These questions were aimed at myself, the participants (theoretically, not literally; I had no actual contact with participants following the interviews), the Anorectic self, and the non-Anorectic self. This process of questioning allowed the research to evolve more and more, and involved putting aside my initial ideas and pre-suppositions to make space for new perceptions. This was invaluable as I feel it allowed me to be more transparent to myself; I became aware of *all* my ideas – initial and developed – and understood the way my thoughts progressed throughout the process of analysis and writing up. I came to know myself and my optimal level of working, for instance, identifying that time away from the text would allow me to approach it with fresh eyes, and would present new concepts and visions. I feel it was my hermeneutic reflection which allowed potential treatment recommendations and ideas to emerge; I had to hear what the participants had said, and then take this forwards by *listening* to what their words actually meant. I had to put myself in their shoes and try to feel what they felt. By identifying inherent meanings and feelings within their words, I was then able to recognise treatment methods which accounted for what they wanted and which might work best for them.

Looking back over the journey of writing this thesis, I feel a similar sense of ambivalence to the participants in the study, about what it has meant to me. I feel glad that it has ended as

it is wonderful to see the product of all my hard work. Moreover, it has been arduous at times, and I have struggled to stay focused. I think this difficulty may have come from the fact that this is the longest and most important piece of work I have ever done, therefore there are so many different bits of research and participants' opinions and implications and recommendations to tie together. Coupled with wanting it to be 'perfect', it could feel overwhelming. Nonetheless, I have at times felt very excited when writing my thesis, and I will miss that 'eureka' feeling! Overall, now that I have finished this thesis I feel proud, and believe that I have been able to achieve something, both personally and professionally.

On a personal note, before I started writing the thesis, I wondered whether past emotions about my own eating disorder might be stirred up. I felt well supported by my supervisor, Carla, my therapist and my family, partner and friends. Additionally, I have worked with eating disorder sufferers for some years, and not suffered a relapse or had any unmanageable, overwhelming emotions. Yet I could not rule out the possibility that interviewing participants might affect me in a negative way. However, I feel that ultimately, instead of stirring up emotions, it has allowed me to utilise what participants have said to better understand my own eating disorder. In recognising the trauma and distress that participants have suffered, I have been able to confirm to myself that I never want to suffer like them again. I feel lucky and secure that I have been able to lay my own eating disorder to rest and hope more than anything that they will be able to do the same someday.

Professionally, the most poignant word which comes to mind is 'courage'. Particularly with reference to writing the discussion chapter of this thesis, I have at times wondered whether it is okay to say what I want to say. I was anxious I may have been too prescriptive in recommending future ways to work with eating disorder inpatients and sufferers. Nonetheless, I have to thank my supervisor, Carla, for encouraging me to keep taking my analysis one stage further; to go beyond my interpretations and search for the meanings within them. Whilst it is scary to be original, originality is all about taking the risk of saying something new and using your interpretations to make an original contribution. Essentially, if you think something but do not say it, it is lost, and therefore the original recommendations that may be able to help someone are also lost.

Ultimately, I think that having identified the titles for each emerging theme, I have come to recognise that what participants felt throughout their inpatient journeys mirrored what I, myself, have felt throughout my doctoral journey. I have felt confined by rules that I must follow, feeling that I should be working when I have not always wanted to. I have experienced having two senses of self – a work self and a non-work self. I have felt a physical and emotional distance from my family and friends, sometimes so engrossed in my work I have been unable to spend time with them. Most of all, I have felt a great deal of ambivalence towards my research, loving and feeling excited by it at times, and feeling tired of it at other times. It certainly has been a tough journey! But, overall, it has been worth it...

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Appendices

Appendix 1: Correspondence to Clinics

Sent via email on 11/12/07

Dear Joanne (Clinic-ED) / Fred (second clinic)¹⁰,

Further to our telephone conversation last Friday, I am writing to you with details of my Counselling Psychology Doctoral research proposal.

I intend to use a qualitative method of research which will involve interviewing participants with eating disorders, nearing the end of their treatment. The interviews will enquire about their subjective experiences of their time on an inpatient unit. I will also be interviewing inpatients at Clinic-ED / second clinic. Following the interviews, I plan to identify common themes in the interviews. This may include beneficial or non-beneficial aspects of therapy, useful or unhelpful tips and ideas that they picked up on the ward - generally any inherent messages or themes which emerge from their interviews. The interviews, however, will not be leading or directional in any way.

I intend to obtain parental consent from all parents of participants. I have constructed a parental consent form containing information about the study, which I will pass onto you if you agree to this study taking place. In the interest of confidentiality, I will not include the real names of any participants used in the study.

As I explained on the phone, I am in the process of writing my research proposal, so these are very early stages. I am really writing to ask your permission to carry out this study with Clinic-ED / second clinic inpatients. If you agree, I shall then send you a copy of my finished proposal (to be handed into university at the end of January 2008), and completed ethics form. I will, of course, also give you a finished copy of my project in 2009.

¹⁰ All names of people and Clinics have been changed in order to protect the anonymity of the participants.

I feel this will be a valuable opportunity for inpatients to discuss and reflect on their time at Clinic-ED / second clinic, and put the feelings about treatment into perspective.

Thank you for allowing me the opportunity to put my ideas forward to you - I hope you will agree to this research taking place.

Best wishes,

Anna

Anna Spivack BSc, MSc

Trainee Counselling Psychologist

City University, London

Appendix 2: NHS ethical approval letter

Barnet, Enfield & Haringey Local Research Ethics Committee

R&D Dept,
Royal National Orthopaedic Hospital
Brockley Hill
Stanmore
HA7 4LP

Telephone: 020 8909 5318
Facsimile: 020 8385 7151

03 July 2008

Miss Anna J. Spivack
DPsych Student Researcher
City University
Northampton Square
London,
EC1V 0HB.

Dear Miss Spivack

Full title of study: An Interview Study to Explore the Subjective Experiences of Patients with Eating Disorders on Inpatient Units.
REC reference number: 08/H0723/30

The REC gave a favourable ethical opinion to this study on 27 May 2008.

Further notification(s) have been received from local site assessor(s) following site-specific assessment. On behalf of the Committee, I am pleased to confirm the extension of the favourable opinion to the new site(s). I attach an updated version of the site approval form, listing all sites with a favourable ethical opinion to conduct the research¹¹.

R&D approval

The Chief Investigator or sponsor should inform the local Principal Investigator at each site of the favourable opinion by sending a copy of this letter and the attached form. The research should not commence at any NHS site until approval from the R&D office for the relevant NHS care organisation has been confirmed.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

¹¹ Sites have not been included in order to protect the anonymity of Clinics and participants involved in the study.

08/H0723/30**Please quote this number on all correspondence**

Yours sincerely

Mrs. Alison Okane
Committee Co-ordinator

Email: alison.okane@rnoh.nhs.uk

Copy to:

Dr. Carla Willig

Appendix 3: Flyer to Recruit Participants

Hello to you all!

My name is Anna Spivack, and I am a Doctoral student at City University. I am doing a course in Counselling Psychology, and I am conducting a research study on the experiences of teenage girls with eating disorders on inpatient units. This research study will be submitted as part of my Doctoral programme.

The purpose of this study is to find out what you thought about your time at Clinic-ED / second clinic. It will involve looking at parts of your treatment which you found helpful or unhelpful, and thinking about particular aspects which you enjoyed or did not enjoy. Hopefully it will be a good opportunity for you to discuss and think about your time here.

I am looking to interview female inpatients who will be nearing the end of inpatient treatment between July and October 2008. I am looking for participants between ages twelve and seventeen. For those of you under sixteen, your parent's consent will be required. The interview itself will occur within a couple of weeks of your discharge date.

If you agree to take part in this study, you will be asked to take part in a tape-recorded interview, which is expected to last approximately one hour. This will occur on Clinic-ED / second clinic.

Please let Joanne (Clinic-ED) / Fred (second clinic) know if you are interested in taking part in the study. You can also contact me at annaspivack@hotmail.com or my supervisor at City University; Prof. Carla Willig at c.willig@city.ac.uk.

Thank you for your time!

Anna

(Trainee Counselling Psychologist, City University)

Appendix 4: Participant Information Sheet

An Interview Study to Explore the Subjective Experiences of Patients with Eating Disorders on Inpatient Units.

My name is Anna Spivack, and I am a Doctoral student studying Counselling Psychology at City University. I am conducting a research study on the experiences of teenage girls with eating disorders on inpatient units. This research study will be submitted as part of my Doctoral programme. The research may be published in an academic journal upon completion. Participants will not be identifiable by name or characteristics in any publications arising from the research. The study will be supervised by Prof. Carla Willig, a supervisor at City University.

The purpose of this study is to find out what you thought about your time at Clinic-ED / second clinic, looking at elements of your experience which you found helpful or unhelpful, and thinking about certain aspects which you enjoyed or did not enjoy. Hopefully it will be a valuable opportunity for you to discuss and look back on your time here. Your input would be of great value, as it will allow eating disorder professionals to understand what you thought about your experience.

If you agree to take part in this study, you will be asked to participate in a tape-recorded interview, which is expected to last approximately one hour. Your participation is completely voluntary and should you wish to withdraw from the study now or at any time during the interview, you are free to do so. Any data in unfinished interviews will be destroyed immediately. Any data in finished interviews will be transcribed fully for analysis, and destroyed upon the completion of the study in 2009. Your name will not be attached to the interview tapes or transcripts; nor will it be used in the final study. This consent form will be kept separately to any other records from the study. This corresponds with the Ethical Principles for Conducting Research with Human Participants, as established by the British Psychological Society. If, however, I felt you were at risk of harm to yourself I would be obliged to inform ward staff.

If you would like to take part in this study and agree to have your interview tape-recorded, please sign the attached consent form. Signing this consent form will show that you understand and agree to the information on this consent sheet. You may also keep a copy for yourself.

Finally, if you do take part in the study you will receive a £10 gift voucher for Boots or Accessorize – your choice!

Thank you for your participation in the study.

Anna Spivack

Trainee Counselling Psychologist,

City University, London

Appendix 5: Parental Information Sheet

An Interview Study to Explore the Subjective Experiences of Patients with Eating Disorders on Inpatient Units.

Dear Parent,

My name is Anna Spivack, and I am a Doctoral student studying Counselling Psychology at City University. I am conducting a research study on the experiences of teenage girls with eating disorders on inpatient units. This research study will be submitted as part of my Doctoral programme. The research may be published in an academic journal upon completion. However, participants will not be identifiable by name or characteristics in any publications arising from the research. The study will be managed by City University and supervised by Prof. Carla Willig, a supervisor at City University.

The purpose of this study is to explore inpatients' perspectives of their time at Clinic-ED / second clinic, observing elements of their experience which they found beneficial or unhelpful. It aims to provide them with a valuable opportunity to discuss and reflect on their time in the clinic.

Your child's participation in this study will involve their answering questions from an interview schedule (attached). Interviews will be tape-recorded and are expected to last approximately one hour. Participation is entirely voluntary and should you wish to withdraw your child from the study, you are free to do so. Similarly, should your child wish to withdraw from the study before, at any time during, or after the interview, they are also free to do so. Any data gathered from unfinished interviews will be destroyed immediately. Any data gathered from finished interviews will be transcribed fully for analysis. All tapes and transcripts will be kept under lock and key, and will be destroyed upon the completion of the study in 2009.

Once interviews have been completed, I intend to identify recurrent themes contained within the interviews, and document these in a final paper. This paper intends to provide those working with eating disorders with an insight into inpatients' personal perceptions of their experiences.

Your child's real name (or any identifying characteristics) will not be attached to the interview tapes or transcripts; nor will it be used in the final study. This consent form (which will also be signed by your child prior to the interview) (attached) will be kept separately to any other records from the study. This corresponds with the Ethical Principles for Conducting Research with Human Participants, as established by the British Psychological Society. If your child were to inform me in the interview that they were planning to revert to anorexic tendencies upon discharge, or self-harm in any way, I would be obliged to inform the ward staff.

Ultimately, any material discussed in the interviews will be of similar nature to that discussed in the inpatient setting. Therefore, I envisage no foreseeable risk to your child's well-being during or following the interview. Indeed, the study aims to enable them to put their experiences into perspective. Nonetheless, should your child feel they would like any additional psychological support following the interview, they will be encouraged to discuss this with their therapists at Clinic-ED / second clinic.

You are asked to sign the attached consent form to indicate your willingness to your child taking part in the study and to have their interview tape-recorded. Please sign it to show that you have read and understood this information and consent sheet. You may also keep a copy for yourself.

Please do not hesitate to contact me, should you wish to discuss this study further. My email address is annaspivack@hotmail.com. My telephone number is 07870705349. I will be happy to answer any questions you may have.

If you wish to accompany your child to their interview, you will be able to do so beforehand, in order to discuss any information about the interview. In the interview itself, however, you will be asked to sit in a separate room. This is intended to provide your child with the space to discuss their experiences as openly as possible.

Thank you for your cooperation in the study.

Anna Spivack (Trainee Counselling Psychologist, City University, London)

Appendix 6: Participant and Parental Consent Form

An Interview Study to Explore the Subjective Experiences of Patients with Eating Disorders on Inpatient Units.

Researcher: Anna Spivack

Please initial

Parent Participant

1. I confirm that I have read and understood the information sheet provided for the above study.

☐☐

2. I understand that my / my child’s participation is voluntary and that I am free to withdraw my information at any time, without giving reason.

☐☐

3. I understand that my / my child’s interview will be tape-recorded and transcribed. I also understand that these materials will be destroyed upon completion of the research study.

☐☐

4. I understand that any material gathered in unfinished interviews will be destroyed immediately.

☐☐

5. I understand that anything that is said in my / my child’s interview will be completely confidential and anonymous. However, I understand that ward staff will be informed if the researcher perceives me / my child to be at risk of harm to myself /themselves.

☐☐

6. I understand that the findings from this research study will be submitted as part of the researcher’s Doctoral programme in Counselling Psychology at City University, and may ultimately be submitted in an academic journal.

☐☐

7. I have had sufficient opportunity to ask questions about the research.

☐☐

8. I agree to take part in the above study.

☐☐

Name of Participant

Date

Signature

Name of Parent

Date

Signature

The researcher agrees to comply with all of the above statements

Name of Researcher

Date

Signature

Appendix 7: Interview Schedule

- 1) Can you describe a typical day?
- 2) What has it been like for you to be here?
- 3) What does it mean for you to be an inpatient here?
- 4) What was your best experience here?
- 5) What was your worst experience here?
- 6) Was there anything that stood out for you here?
- 7) How did you experience the treatment you received here?
- 8) Are there any elements of the treatment that stood out for you?
- 9) Overall, how would you describe your experience at Clinic-ED / second clinic?
- 10) Is there anything you would like to add?

Appendix 8: Debriefing Form

Thank you for taking part in this study!

The intention of this interview has been to allow you to discuss your experiences of your time at Clinic-ED / second clinic. You will have been asked about your positive and negative experiences, and things which stood out for you. It may be beneficial for you to make a note of what was discussed in the interview, in order to help you remember all the helpful tips and ideas which gave you an incentive to recover.

Your input in this research study has been extremely valuable, as it will provide the staff of your and other eating disorder units with an awareness of *your* experience of your treatment. This may allow staff to identify certain elements of treatment which could be useful for future inpatients.

I would like to reassure you that your input has been completely anonymous and confidential, and to say again that your name will not be attached to any part of the research study.

The information from this research study will be submitted as part of my Doctoral programme in Counselling Psychology at City University. If you would like a copy of the finished research study, please contact me via email at annaspivack@hotmail.com. It is intended that the study will be completed in September 2009.

After completing the interview, if you feel you would like to withdraw your input from the research study, or make any further comments about the interview, please contact me at the above email address. You can also contact my City University supervisor, Prof. Carla Willig, at c.willig@city.ac.uk.

Following the interview, if you feel you would like any additional psychological support, please let me know and I can inform ward staff and your therapist immediately.

Thanks again for you input!

Anna

Appendix 9: Table of Master Themes

Key

Bold red, e.g. **Rules** = Master theme

Red, e.g. **Rules unhelpful** = Constituent theme

Black, e.g. Punishment = Example of constituent/master theme

Numbers = page number: line number

AN = Anorexia Nervosa

	Amy	Beth	Cat	Delia	Emma	Fran	Gaby	Holly
Rules		12:5 – ‘bible’ on rules						
Rules unhelpful								
Regimentation / routine / Strict / extreme	2:2 / 28:25	1:21	1:14	1:16 - boring	2:17 – boring	1:16	2:2 - boring	2:6 – distracting/ vs. 22:26 – too controlled
Consequences / Punishments / conditions	11:10 – blackmail	4:14	14:27 – threat of being tube-fed/ sectioned	18:19	10:10	3:23		7:18 / 8:1 – feels like a punishment to be here

No choice / input / negotiation	13:16	8:7	3:19	2:13	16:9	3:3	16:23	
Rules Helpful								
No choice – eliminates responsibility and guilt	22:13 / 23:20 – Clinic ED reduces battle between AN & self				20:1		16:13	
Sense of routine = safe / help to contain AN	2:16				2:8		6:23	
Rules are strategic		8:3			5:14 – eating helps overcome food phobia	21:20	15:10 – clever – reduce fear of food	
Flexibility								
Freedom / trust	2:18 / 1:26	2:7	2:24		1:17	20:11	1:19	1:23
Some choice	4:15	10:11			2:24	1:16		
Battle against AN	24:21 – battle with self			7:11			14:1 – fighting with your mind	
Split sense of self								

Split sense of self - Feeling lost	27:25 / 14:21	3:11	12:9 – can't let AN win	8:26 – lose yourself	9:24 – Lost sense of self	6:10 / 11:19 – always felt too fat, since 5 years old	21:2	18:18
Being controlled by AN	7:19	15:1- strength of AN	13:16	7:19 – easily fooled			14:20 / 19:5	8:3
Understanding AN	16:4 – Why can't I eat?			22:16 – Clinic ED helps to understand AN	20:15 – regaining normal relationship with food	11:14 – will always see fat person in mirror	17:18 – have to want to recover in order to recover	
Secretive / lonely / isolating illness	19:15		4:9 / 12:1	7:10	6:21 – isolated from everyone	22:2	14:20 – importance of telling staff before it gets worse	7:22
Implications of eating	14:17 – okay to eat vs. 18:1 - terrifying	6:18	4:15	3:8	17:14		16:25 – Clinic ED takes focus off food	7:14 – eating unsafe foods
Implications of recovery	27:6 – recovery = fat	11:12 – not ready		5:24 – believing in AN = giving in	5:23 – something clicks	2:14 – some-thing clicks/ 20:15 / 12:28	20:25 – realisation that skinny = unhappy	22:18
Battle AN and Clinic ED			3:18	4:8 – battle / 8:17			7:9	7:17
Constant presence / threat of food	13:5	9:1		4:27	18:5 – food used as punishment		13:12 – at first but you get used to it – 16:27	13:13

Hatred		7:14	18:21 – hating staff and treatment	3:6		5:3 – hate everything at 1st		
No control								6:3 – no win situation
Powerlessness / No choice / being taken over	15:7 – like a toy	14:19 / 7:12	4:15 – battle	13:9	15:23	7:15	19:15	22:27
Feeling trapped		10:17	8:7	4:12 / 21:19	9:3 / 2:6 – institutionalised			8:12 - prison
Perception of Staff (Unhelpful vs. Helpful)								
Being monitored / no privacy	16:21	7:9	3:21 / 7:6		12:15 – supervision is like prison	8:15		8:22
Powerful	20:7	8:12		16:5 – head nurse v powerful				21:19
Unapproachable / harsh	16:17	29 / 82			13:19	19:1	17:11 – but the firmness works	19:13
Gossiping	16:21	5:7						
Inconsistent		9:14			13:20		23:15	13:2
Mistrusting	18:22	12:19			12:3			
But helpful - Comforting / supportive	20:5		18:29	21:9		18:22	17:4	3:24
Approachable				19:17			11:28 – some are approachable	4:22

Distance from the 'outside world'												
Feeling saddened by distance from home												
Emotional distance	18:21	16:1	13:3	5:12	6:21	22:10	8:25	6:5				
Physical distance	6:4	16:12		13:22	22:10	5:3	23:5	23:2				
Wanting to be rescued by mum	7:9		10:26	6:13			9:22					
Surreal in Clinic ED – contrast to 'real world'	8:8	3:14	8:25	7:2 / 8:4		6:17	5:15	5:21				
Existing / passing time	5:20	3:14	12:27	5:9 – you lose yourself	23:27	6:3	18:16 – life just happens & then you die	7:3				
Feeling safe / protected by Clinic ED												
Safe – protected from 'real world'			8:23	10:18	11:9 – agoraphobic at 1st							

Summary

- 1. Rules**
- 2. The Battle between Anorexia Nervosa and the non-Anorectic self**
- 3. The Battle between Anorexia Nervosa and Clinic ED**
- 4. Peer Influence**
- 5. Distance from the 'Outside World'**

The constituent themes emerging from the master themes were:

- 1. Rules**
 - i. Rules; Unhelpful
 - ii. Rules; Helpful
 - iii. Flexibility
- 2. The Battle between Anorexia Nervosa and the non-Anorectic self**
 - i. Split sense of self
 - ii. Understanding Anorexia Nervosa
- 3. The Battle between Anorexia Nervosa and Clinic ED**
 - i. No control
 - ii. Perception of Staff (Unhelpful vs. Helpful)
 - iii. Perception of Treatment (Unhelpful vs. Helpful)
- 4. Peer Influence**
 - i. Supportive impact of peers
 - ii. Detrimental impact of peers
- 5. Distance from the 'Outside World'**
 - i. Feeling saddened by distance from home
 - ii. Feeling protected by Clinic ED

Appendix 10: Summary of reflections on my relationships with participants

- ❖ I felt my interview style evolved the more interviews I did, in that I became more confident in asking questions after carrying out two or three. I feel the first and third participants, Amy and Cat, were very talkative and open in their interviews, so these lasted an hour without the need for further exploratory questions. This was really relieving to get at the beginning! I do feel that Beth's interview may have benefitted from this, as she gave quite short answers. Nonetheless, I feel her interview was good at highlighting the experiences of someone whose Anorexic side was evidently very dominant and who was quite resentful towards Clinic-ED. It is good to have obtained a range of views about the same experience, as it makes the results richer.
- ❖ Delia was the most ambivalent of all the participants. I found myself wanting to use her quotes more than any other participants' in the study, as she came up with lots which fitted perfectly with the emergent master and constituent themes. The strength of her Anorexia, fighting against the strength of her will to recover was immense and this battle was palpable throughout her interview; she looked and sounded exhausted by the entire ordeal.
- ❖ Emma was noticeably distressed in her interview due to the loud, frequent vomiting that was audible in the background. I felt I was able to utilise my counselling skills the most with her; supporting and reassuring her, and frequently stating that it was okay to stop the interview if it was too much for her. Nonetheless, Emma described her experience as more positive than negative at the end of the interview, as she says that the negatives are also positives, e.g., showing her what could have happened. This demonstrated tremendous insight and strength.
- ❖ I became quite emotional when analysing Fran's transcript. Perhaps because she was the youngest, I felt that someone of twelve years old should not have had to have experienced Anorexia. Learning that she had had Anorexic thoughts since the age of five made me feel especially upset. I think with the other participants I had some degree of empathy, but at five years old, I didn't even know what body-image was. I think it was what Fran's early development of Anorexic thoughts represented; an all-

encompassing, invasive, omnipresent societal focus on thinness. The effect this can have is quite disheartening.

- ❖ I enjoyed both conducting and analysing Gaby's transcript as she was by far the most positive of the participants and was able to give constructive, helpful answers. She helped me to think "it's not all doom and gloom" as some other participants (Amy, Cat, Holly and particularly Beth) had implied.
- ❖ In her interview, Holly said that in therapy she named her Anorexic friend "Anna". I wondered what emotions might have been evoked in her to hear that I was also called "Anna". She does describe it as a "friend" – did this mean she wanted to open up to me more / that she trusted me more? Maybe she wanted me to empathise with her more and help her to keep this friend alive? Or did she have some fantasy that I would substitute her Anorexia friend that Clinic-ED was trying to take away from her?

Section C: Critical Literature Review

**The Media and Eating Disorders: Does
the Media Affect Adolescent Girls' Eating
Behaviours and Body-Concepts?**

Introduction

Gossip magazines, aimed at an adolescent market, widely encourage self-improvement through fashion dressing and physical beautification (Park, 2005). Glossy images of exceptionally thin celebrities and models fill these magazines, and jargon, such as 'skinny celebs' (the sub-cultural referent for 'skinny celebrities') and 'size zero' (an American clothes size 0 or a UK clothes size 4) serves to normalise these images and invest in them aspirational qualities (www.healthyweightnetwork.com, 2007). Similar images of idealised bodies are also found in television media, including adverts, music videos, movies and soap operas. Indeed, such programmes have been widely linked to body image disturbance (Anschutz, Engels, Van Leeuwe & Van Strien, 2009).

Through advertising products such as dieting techniques, the media plays a large part in glorifying slenderness and weight loss (Stice, Maxfield & Wells, 2003). The social advantages to be gained from this, such as increased attractiveness (Lavin & Cash, 2000), are drummed into often highly susceptible adolescent magazine readers and television viewers (Giordano, 2005). This is reinforced by a societal prejudice against adiposity (Chan & Gillick, 2009).

Many of today's celebrities portrayed in the media are extremely underweight. What is most worrying is that these celebrities often represent role models for adolescents (Battles, 2009). Vandereycken (2006) asserts that the images portrayed in the media are frequently internalised by the adolescents who observe them, at a time of life when identity searching and social comparison are especially significant. Thus, it is feasible that some adolescents may use these images to develop their image and the way they look.

There is no shortage of literature reporting the effects of the media upon people with eating disorders. Blowers, Loxton, Grady-Flessner, Occhipinti and Dawe (2003) assert that the media is the main source of pressure upon females to be thin, whilst Lee (2004) introduces the concept of a 'cultural fear of fatness', promulgated by the mass media. Willinge, Touyz and Charles (2006) describe the media as the "single most powerful transmitter of the idealised body images of males and females" (p. 576). Furthermore, Harrison (2000a) and Thompsen,

Weber and Brown (2002) link media exposure to symptoms of eating disorders amongst female audiences.

Nonetheless, it is also important to consider that the media may not have an effect on eating disorders. There is a small body of work supporting this outlook. Indeed, nearly everybody inevitably has some degree of exposure to media images depicting thin celebrities and media messages promoting the thin-ideal. As Jade (2002) points out:

“About 95% of people own a TV set and watch for an average of 3-4 hours per day...Over 60% of men and 50% of women read a newspaper each day and nearly half of all girls, from the age of 7 read a girl’s magazine each week” (p. 1).

Yet not everybody exposed to these images develops an eating disorder, with only 2.5% of the UK population suffering from one (Lipczynska, 2005). Therefore, it is possible that *certain* individuals may interpret the messages in a way which fosters a pre-existing insecurity about the way they look, or unconsciously process the images and construe them as ‘ideal’ ways to look (Polivy & Herman, 2004).

Overall, the bulk of existing literature states that the media has a largely *negative* impact on eating disorders (Almond, 2000; Hawkins, Richards, Granley & Stein, 2004;), maintaining that it may not only exacerbate but also potentially cause negative eating behaviours and disordered thinking (Levine & Murnen, 2009). Such studies explore the role of magazine and television exposure, and also investigate the function of pro-anorexia websites. These websites essentially serve to promote eating disorders, providing tips on how to lose weight and depicting images of exceptionally thin celebrities.

There is also some literature reporting on the *conflicting* messages inherent in the media. This involves the simultaneous glamorisation and criticism of eating disorders, and the messages to both eat and be thin – and the effect this may have on adolescent girls. Indeed, there are many magazines depicting images of skinny models on one page, but on the next page, reporting the dangers and adversities of eating disorders. This can be extremely confusing for the potentially impressionable and young readers the magazine is aimed at, and lead them to feel unsure as to how they are ‘supposed’ to look.

My main motivation in exploring the potential effects of the media upon eating disorders stems from my work in eating disorders clinics. The inpatients, mostly adolescent girls, spent a significant amount of time reading magazines depicting images of thin women. They scrutinized these images, referring to extremely thin models as “perfect”, and discussed different ways to lose weight in order to look like them, techniques for which were often provided in the same magazines. Yet, as Almond (2000) states:

“Models are born with a specific body type, and what the public doesn’t understand is that they cannot diet to achieve it” (p. 367).

It clearly seemed unwise that the inpatients were reading these magazines, since they appeared to potentially exacerbate their situations. This highlighted a need for an investigation into the media’s impact on eating disorders.

Given the omnipresence of fashion magazines and television programmes, and their numerous inherent messages that thin equals beautiful (Hanba, 2009), it is important to identify any detrimental effects this may have upon vulnerable groups such as eating disorder sufferers, or those who may be susceptible to eating disordered thinking and behaviours. It is my hope that by examining these effects, it may then be possible to determine ways to rectify them.

Overview of Literature

This review will first investigate literature asserting that the media is not responsible for promoting eating disorders. It will then focus on potential ways in which the media does promote eating disorders, considering the potential effects of television, magazines and Pro-anorexia websites. The review will then observe how conflicting messages may promote eating disorders further.

The effect of the media on eating disorders is a widely researched area, and as such, there is an abundance of studies reporting how the media cultivates and exacerbates eating disorders. Although I cannot report on all of these studies due to the sheer volume of text it

would generate, I have chosen to discuss the following studies as I feel they illustrate a range of potential effects and influences of the media.

Conversely, there is a paucity of literature stating that the media is not responsible for eating disorders, and on the effects of pro-anorexia websites and the media's conflicting messages on eating disorders. Nonetheless, I hope illustrate in this review some of the limited number of studies that are available. I hope the studies I have included will provide an insight into different perspectives around this area.

The topic of the media and eating disorders is so widespread that there are many studies investigating it in social, psychological and media literature. However, since this review is concerned with psychological research, the majority of studies critiqued in this review are taken from a range of psychological and eating disorder literature and journals.

This review only focuses on literature concerning adolescent females, as they are the people most affected by eating disorders (Olson, 2006), and the population I have studied in my research.

Literature Suggesting the Media is not responsible for Eating Disorders

Although the majority of literature examining the effects of the media on eating disorders has maintained that it fundamentally encourages Anorectic and Bulimic thinking and behaviours, there is a small body of literature suggesting that the media does not affect eating disorders. Much of this literature suggests that the level of affect which media images may produce is largely dependent on the individual, and their interpretations of the material they view. Indeed, some adolescents may be exposed to media images of thin celebrities, and not be affected by them at all. As Polivy and Herman (2002) assert:

“Exposure to the media is so widespread that if such exposure were *the* cause of eating disorders, then it would be difficult to explain why anyone would *not* be eating disordered” (p. 192).

Jansen and de Vries (2002) point out that many of the participants taking part in studies investigating eating disorders and the media are conscious that the research is *about* eating

disorders, therefore, their comments regarding their eating behaviours may be influenced by wanting to fulfil the nature of the study. Hence, they conducted a study testing whether *subliminal* exposure to thin models triggered overeating in highly restrained eaters. They showed participants a series of neutral slides in which they interspersed 'ultra-short' images of thin and obese models. They found that when the size of a model was not consciously processed, the model had no effect on the mood or eating behaviour of women with either restrained or unrestrained eating behaviours. They concluded that:

“The automatic processing of thin ideal bodies does not influence the feelings and behaviour of women” (p. 215).

Nonetheless, the fact is that people who read magazines depicting images of thin, beautiful models do *supraliminally* process these images. Not only are there hundreds of images of thin models, there are also numerous tips about losing weight and healthy eating. These media messages are not subtle and inconspicuous; they are blatant and abundant.

Mills, Polivy, Herman and Tiggemann (2002) conducted a study *explicitly* asking participants to view images of thin models in advertisements. They subsequently asked them to rate their effectiveness as advertising tools. Mills et al. (2002) found that exposure to thin media images not only led participants to feel better about their own body-images, but in fact also caused increased appearance self-esteem in restrained eaters. They claimed dieters could relate to thin-ideal images, as thinness was an achievable concept for them as dieters. Nonetheless, Mills et al. (2002) do not take into account the effect thin-ideal images may have upon those suffering with eating disorders. Essentially, sufferers do not know when they have achieved thinness, and, indeed, work on the premise that they can never be too thin (Derenne & Beresin, 2006). Therefore, even though Mills et al. (2002) maintain that *dieters* viewing thin-ideals may be positively affected, for those with *eating disorders* viewing the thin-ideals, the effect may be damaging (Levine & Murnen, 2009).

Additionally, Mills et al. (2002) do not take into consideration the amount of time the general population spend viewing forms of mass media. Media messages that thin is attractive and normative (Harrison & Hefner, 2006) and fat is ugly and disgusting (Klein &

Shiffman, 2006) are profuse. Yet Mills et al. (2002) expose their participants to thin idealised images for only a short amount of time; unreflective of real-life circumstances.

Another study was conducted by Henderson-King and Henderson-King (1997). Participants were asked to listen to a judgemental conversation between two people about a fictional friend's weight gain, and were subsequently shown slides of ideal images of women. They were then asked to fill out body-esteem and self-monitoring questionnaires. The study found that people who were less concerned with self-presentation and how they were perceived by others were less affected by media idealised images. They also found that participants' self-perceptions were actually enhanced following exposure. They stated that people who weighed less experienced less body dissatisfaction, as the images seemed more attainable. However, one characteristic of eating disorders is that people affected by them perceive themselves as being larger than they actually are, thus it is questionable as to whether the study would produce the same results if participants used had suffered with eating disorders. Henderson-King and Henderson-King (1997) claim that the media may not cause eating disorders, but they do not consider whether the media may exacerbate the eating behaviours of individuals already suffering with them.

None of the above studies take into account the effects of *indirect* media exposure; the acquisition of eating behaviours and body ideals learnt from family and peers, who may have directly learnt them from different forms of media (Clark & Tiggemann, 2006). Direct media effects may be minimal in controlled research studies such as those mentioned above, but in real-life, the combination of direct and indirect effects, and the cumulative effects this might have may be substantial (Harrison & Hefner, 2006).

Ultimately, the majority of women who are exposed to images of idealised women in the media do not develop eating disturbances (King, Touyz & Charles 2000). Yet, that does not entail that its effect can be ruled out altogether. Indeed, a large body of literature with diverse methods of testing has shown that the media has many damaging effects on eating disorders. As Polivy and Herman (2004) indicate, it is *how* people process media images which affects their body-esteem. If they compare themselves to models directly, their body

dissatisfaction may increase, whereas if they do not compare themselves, they may experience no subsequent body discomfort.

Promotion of Eating Disorders in the Media

There is a significant body of research assessing the media's promotion of eating disordered behaviour. Many of these studies investigate how repeated exposure to thin models and celebrities decrease body-esteem in both eating disordered and non-eating disordered individuals. In a study in 2002, Thomsen, Weber and Brown asked five hundred girls to fill out questionnaires, stating how often they read fashion magazines and reporting any eating disordered dietary practices. Participants were predominantly white, corresponding with the fact that eating disorders are most commonly found amongst white communities (Atlas, Smith, Hohlstein, McCarthy & Kroll, 2002; Harrison, 2000b). Thomsen et al. (2002) found that frequent readers reported increased pathogenic eating disordered behaviour, such as calorific restriction and diet pill intake, whereas non-frequent readers reported less eating-disordered behaviours. Essentially, although this may have been due to extraneous variables other than magazine reading, the study is important in highlighting a potential link between frequent media exposure to thin ideal images and eating disturbances.

Thomson et al.'s (2002) findings are supported by many other studies. For example, O'Riordan and Zamboanga (2008) found that exposure to fashion magazines exacerbated participants' Bulimic tendencies, and Field (2000) found that;

“The more effort a girl reported making to look like females on television or in movies or magazines, the more likely she was to start purging over a one year period” (p. 95).

Nonetheless, it is questionable as to whether such eating disordered behaviour can be solely blamed on the effect of exposure to thin images in the media. Although this may certainly have some impact, other variables such as life pressures and relationships must be taken into account when considering the aetiology of an eating disorder (Levine & Murnen, 2009). Notwithstanding this, the effects of peer and family messages about weight and shape issues themselves much be taken into consideration (Peterson, Paulson & Williams, 2007).

A large portion of the literature supports the view that *repeated* exposure to the media's portrayal of the thin ideal leads women to internalise this stereotype. This internalisation subsequently engenders heightened body dissatisfaction by creating unattainable body-dimension goals (Mautner, Owen & Furnham, 2000). Indeed, body dissatisfaction is considered to be a primary determinant of eating disorder symptoms (Neumark-Sztainer, Paxton, Hannan, Haines & Story, 2006; Stice & Shaw, 2002). Martin and Gentry (1997) suggest that the mass media is commonly used for comparative or self-evaluative purposes, particularly by young women who are anxious to evaluate their own personal and physical traits, abilities, and opinions against the ideals of their culture. Thus, it is possible that upon viewing thin ideals, people will both *internalise* and *compare* themselves to these images. This may result in feelings of inadequacy and body dissatisfaction, potentially inducing a variety of eating disordered behaviours, such as dieting, increased exercising, and pathogenic practices.

Nonetheless, what much of this research tends to overlook is that it is not only the frequency and intensity of exposure to thin ideals which may generate negative effects, but also the nature of the images, television programmes and articles to which participants are exposed. Specifically, do the thin models used in different forms of media generate negative effects, or are other factors responsible, such as messages that fat is ugly and undesirable?

In 2002, Groesz, Levine and Murnen assessed data from twenty-five research studies investigating the effect of mass media images. Overall, they found that controlled exposure to thin models caused an immediate increase in participants' negative feelings about their bodies. They reported that these effects were amplified for women who had previous concerns about their weight, and for women who had internalised the 'thin ideal of beauty'. Groesz et al. (2002) state that their findings indicate that the media may "promote, if not establish, a standard of slender beauty that leads many females to feel badly about their weight and shape" (p. 12).

Essentially, given that adolescents spend a large proportion of time viewing media such as television and magazines, saturated with images of the thin ideal (Anderson, Huston, Schmitt, Linebarger & Wright, 2001), it would follow that such exposure may have an

accumulative effect on body dissatisfaction. Frequently encountering images of seemingly flawless models, appeals for dieting and beautification, and messages imparting that 'looks are everything' may recurrently activate schema-driven processes and thereby worsen body-image attitudes and affect (Lavin & Cash, 2000, p56). This assumption is supported by Zajonc's (2001) repeated exposure theory:

"The mere repeated exposure of a stimulus is entirely sufficient for the enhancement of preference for that stimulus" (p. 225).

Tiggemann (2002) suggested that repeated exposure to idealised media images would maintain and reinforce levels of anxiety about appearance and weight. Based on this suggestion, Hargreaves and Tiggemann (2003) sought to examine the development of body dissatisfaction over a two year period. They initially exposed participants to images epitomizing societal ideals of thinness, and measured body dissatisfaction before and after exposure. Two years later, using the same body dissatisfaction measure, they found that participants' dissatisfaction did accumulate over time, and that 'drive for thinness' increased.

This study appears to have a number of flaws, however. Like many studies reporting that the media promotes eating disorders, Hargreaves and Tiggemann (2003) do not take into account the effects that exposure to thin idealised images followed by an explicit self-evaluation of body-satisfaction may have. As Halliwell and Ditmar (2005) assert, this is highly likely to activate self-comparison processes, which themselves tend to engender negative feelings about one's body.

Furthermore, Hargreaves and Tiggemann (2003) do not investigate how much exposure to idealised media images participants had in the two year interim. If, for example, some participants had not had repeated exposure, their body dissatisfaction may have increased due to other variables. Notwithstanding this, it is unclear whether any of the 80 participants (selected from a school) suffered from eating disorders. It is likely that in such a large sample, some suffered more than others. Testing participants with similar levels of eating disordered behaviour may have yielded more accurate results, indicating whether media

exposure exacerbates body dissatisfaction in those with pre-existing eating disorders, and whether it may potentially cause eating disorders in those with no previous eating disturbances.

Research conducted by Tiggemann (2003) has sought to demonstrate that television and magazines each have differing impacts on eating disorders. Her research indicates that the more magazines women read, the greater their internalisation of the thin ideal; however, the more television they watch, the lower their awareness of socio-cultural ideals. She attributes this to the fact that watching large doses of thin idealised female figures on television might normalize such figures. In contrast, due to the explicit depiction of societal ideals of beauty in fashion magazines, it may be more difficult for readers to overlook such ideals (Tiggemann, Gardiner & Slater 2000). Harrison and Cantor found similar effects in their 1997 study. They reported that women who read more magazines were more likely to report eating disorder symptomatology, yet, more exposure to television did not correlate with eating disorder symptomatology.

The above studies assert that magazines promote eating disorders more than television exposure. One study, however, which demonstrates the apparent dramatic impact of television upon eating behaviours in adolescents, is conducted by Becker, Burwell, Herzog, Hamburg and Gilman (2002). They investigated eating behaviours in Fijian girls, following the arrival of television in 1995. Becker et al. (2002) explain that prior to 1995 there was only one reported instance of an eating disorder in Fiji. By 1998, however, the prevalence of dieting had increased from 0 to 69%! Adolescents routinely cited the appearance of thin actors on television shows as the inspiration for their weight-loss. It would follow, then, that despite Tiggemann's (2003) assertion that television watching may not impact eating behaviour, in cultures where such idealised images have not been previously portrayed, television can have a significant effect. Indeed, the relentless indoctrination of media messages to Westerners from such an early age may entail a subsequent 'desensitisation' to the damaging components of such messages, thus making it difficult for studies such as Tiggemann's (2003) to measure the actual impacts on eating disorders.

Essentially, although it may not be possible to label television or magazines as the main culprit, the above studies illustrate that both may play some part in promoting eating disorders. Through repeated exposure, adolescent girls may internalise thin ideals in the media. The effect may be to increase body dissatisfaction, exacerbating or even precipitating eating disordered behaviour.

Pro-Anorexia Websites

Pro-anorexia (or the sub-cultural referent, 'pro-ana') websites are internet communities which have been created for "individuals who advocate Anorexia and other eating disorders as a lifestyle choice, rather than a psychological disorder" (Bardone-Cone & Cass, 2006, p. 257). An analysis of the content of these websites, conducted by Norris, Boydell, Pinhas and Katzman in 2006, revealed that they provide tips and advice on how to lose weight, and encourage starvation. Many contain 'thinspiration' photo galleries, exhibiting pictures of extremely thin and often emaciated people to aspire to be like, and of morbidly obese people as a reminder of what they could become if they do not adhere to their dieting routines. They also provide 'thin commandments' for added motivation (see Appendix 1). Several websites include systems whereby members have 'buddies' to encourage each other to continue losing weight. In 2003, Dolan reported that there were over four-hundred of these websites in operation, yet as Harshbarger, Ahlers-Schmidt, Mayans, Mayans and Hawkins (2009) state, new websites continue to appear daily. Conger (2005) explains that the majority of website users are adolescents.

Research conducted by Bardone-Cone and Cass in 2006 appears to be the one of the first examining the effects of pro-anorexia websites. They exposed twenty-four participants, aged eighteen to twenty years, to a pro-anorexia website (constructed by the authors for the purpose of the study), and subsequently measured perceived weight status. Following exposure to the website, results showed that women reported increased negative affect and perceptions of being overweight, and decreased self-esteem, appearance self-efficacy and perceived attractiveness.

This study is useful in highlighting the potentially harmful effects of viewing pro-anorexia websites. However, Bardone-Cone and Cass (2006) do not specify whether participants had pre-existing eating disorders. Had such participants been used in the study, the research might have offered an insight into how pro-anorexia websites may precipitate and/or exacerbate eating disorders. Nonetheless, exposing participants with pre-existing eating disorders to these websites may be unethical if exposure did indeed exacerbate eating disorders.

Another report on pro-anorexia websites comes from Giles (2006). He conducted discourse analysis on the dialogue used in pro-anorexia websites, to explore how identities were formed within eating disordered communities. He used comments from websites which he believed to be “typical of pro-ana sites in terms of structure” (p. 467). Giles’s (2006) study provides a comprehensive account of how Anorexia is promoted within these sites, and reflects the intensity of website users’ experiences. He includes a wide spectrum of perspectives on what it *means* to be Anorexic or Bulimic, and investigates the hierarchical system within pro-anorexia websites relating to this:

“Anorexia is constructed as a display of personal discipline and ultimately a triumph of the will, and Bulimia is seen as a failure or lack of these attributes. Bulimia involves...undertones of ill-discipline, feeble surrender to hunger pangs, guilt and moral laxity. All the things, indeed, that anorexics pride themselves on resisting” (p. 468).

Giles (2006) also discusses so-called ‘outside’ groups, such as ‘fakers’ and ‘wannabes’, reporting that these ‘untrue’ Anorexics and Bulimics reinforce the identities of the ‘true’ ones, ultimately highlighting their sense of being and belonging. Unfortunately, their sense of belonging is to a group which claims to offer support, but conversely, appears to breed competition and encourage disordered thinking (Dias, 2003). Moreover, adolescence is a time when identities are being searched for and experimented with (Kroger, 2004). For people so desperate to gain a sense of identity, these websites may be an inviting community (Polivy & Herman, 2002).

Giles's (2006) study does appear to have some methodological flaws. He includes comments in his study from websites which he believes to be "typical of pro-ana sites in terms of structure" (p. 467). However, he does not reveal what constitutes a typical structure in his view. Essentially, his choice of websites, and the comments he takes from them, are fairly subjective; other researchers may have chosen other websites and comments to investigate, potentially yielding different results to those which Giles's (2006) study produces.

Nonetheless, what Giles's (2006) report highlights is that pro-anorexia websites may have enabled those suffering with eating disorders to find and maintain a sense of identity. This is reinforced by the threat posed by 'untrue' Anorexics and Bulimics, and indeed, by members of the public with concern for the safety of website members. This appears to be of great significance to the field of Counselling Psychology. By understanding the identities created within eating disorders websites, we may be given a clue as to why many people suffering from Anorexia and Bulimia Nervosa resist treatment. Indeed, their endeavour to 'find' themselves is reinforced by such websites, whereas treatment threatens to take these identities away.

Conflicting Messages within the Media

Many television advertisements and 'sitcoms' portray excessively skinny models and actresses. Yet a large number of commercials display appealing 'junk' food. Essentially, it would seem that the media is telling the public to eat, but not to get fat. Moreover, due to the societal stigma attached to obesity, the media promulgates the message that it is preferable to stay thin, rather than experience the same stigma that obese people do. Adiposity is criticised, and associated with greed and self-indulgence, yet seductive advertisements for luxury foods remain (Hepworth, 1999). Conversely, models portrayed in the media have become slimmer over the past ten or so years. These conflicting messages may potentially be very confusing for adolescent girls. Smith (1993) asserts that "classic bulimia reflects the tension from receiving both messages" (p. 101).

Not only does mass media relay conflicting messages to eat and starve, it simultaneously glamorises and criticises eating disorders. Furthermore, these messages are often contained within the same media source. In their study investigating the relationship between reading magazines and Anorexia Nervosa, Williams, Thomsen and McCoy (2003) report how one participant commented:

“I mean, on one page, you’ve got the girl with the disease. On the other page, you’ve got the model. And they look exactly the same” (p. 58).

Indeed, it seems somewhat contradictory to promote the beauty ideal, but in the same magazine, attempt to educate the public about eating disorders. One wonders how effective these educational articles are in the midst of such inconsistency.

Gordon (2000) explains that “in an environment where many fashion models border on anorexia, it is not surprising that the disorder itself has become ‘fashionable’” (p. 130). Moreover, he claims that since the disorder symbolizes cultural ideals such as slenderness, self-control and competition, its glamorisation in the media is almost to be expected. This raises an important question as to whether it is the media at fault for portraying these images, or whether the media portrays these images in response to what the public wants to see. Indeed, when appraising a popular gossip magazine, ‘Heat’, Cochrane (2005) stated that “the words ‘skinny celebrities’ on the cover (with the promise of shocking photos inside) boost its sales by 20%, to as high as 600,000” (New Statesman Magazine webpage). Nonetheless, without the media the public would not be exposed to fashion models as much. Thus, perhaps the public only want to see skinny models because the media has already ‘brainwashed’ them into thinking that these images are desirable (Giordano, 2005).

The media also presents many criticisms of eating disorders, offering horrific stories of the effects of eating disorders, and printing photos of dramatically underweight celebrities. Often, however, these messages intended to criticise eating disorders can have the opposite effect on those who suffer from them. Thomsen, McCoy and Williams (2001) conducted qualitative semi-structured interviews with outpatients at an eating disorders centre, to explore the ways in which women suffering from Anorexia Nervosa used and experienced

fashion magazines, and to understand how their eating disordered behaviour was affected. What emerged was that articles intending to describe the dangers of eating disorders were actually used by some patients to support their eating disordered behaviour. Thomsen et al. (2002) include one patient's confession:

"If a magazine said, "Bulimia ruined my life, a true story," I would read it just to find ideas...I wanted to get people's secrets and I wanted to figure out what Karen Carpenter did because I needed to do the same thing" (p. 58).

It is thus easy to see how attempts to educate can easily be misused. Essentially, it would seem that the media produces such articles or programmes in an attempt to compensate the effects of their thinness promoting messages, but that viewers 'twist' these warning messages to suit their own needs and purposes. In this sense, it appears that any educational purpose of such material is disregarded, and the media, in its attempt to criticize eating disorders, may actually exacerbate them. In support of this, in a content analysis of magazine articles about eating disorders, Inch and Merali (2006) found that disordered behaviours used to achieve weight loss were mentioned significantly more than the physical consequences of such behaviours. This could be potentially damaging for readers susceptible to eating disordered thinking.

It would appear that perhaps the media's conflicting messages may exacerbate the internal conflicts occurring within most people suffering from Anorexia and Bulimia (Smith, 1993). There are messages telling them to both eat and be thin, coupled with messages glamorising and criticizing eating disorders. If the media promotes and encourages the thin ideal, yet simultaneously criticizes it and promotes the consumption of "luxury" or unhealthy food, it is no wonder that young girls, striving to find an identity, are left feeling confused and out of control. Whether this results in a combination of both eating and remaining thin (Bulimia), or starving to achieve the thin ideal promoted in the media (Anorexia), it is evident that the conflicting messages may play some part in contributing to eating disordered behaviour.

Summary of Literary Review

I hope this review has demonstrated the diverse potential effects of the media upon eating behaviours and eating disordered thinking. In investigating how the media promotes eating disorders, studies have generally found that thin idealised messages may increase pathogenic behaviour and body dissatisfaction. Furthermore, repeated exposure can lead to self-comparison and the internalisation of thin ideals, ultimately increasing the likelihood of perpetuating eating disordered thinking. Studies investigating the impact of pro-anorexia websites have shown that such communities may provide a sense of identity for those suffering with eating disorders, and afford them a sense of belonging. In assessing the conflicting messages that the media presents to adolescents, it was found that such messages could potentially be confusing and damaging to those with eating disorders. There are also some studies asserting that the media has no impact on eating disorders and that the majority of people exposed to media idealised images are not affected.

Discussion

There is substantial evidence supporting the fact that the media does promote eating disorders, and much less research stating that the media is not responsible. It remains uncertain from the literature whether the media can be solely blamed for either causing or exacerbating eating disordered thinking. Nonetheless, all studies reviewed in this report maintain that the media have spread an 'unnatural' representation of beauty, using extremely thin models as role models for young girls.

There do appear to be a number of flaws in the existing studies. Many do not consider how eating disordered behaviour may be influenced by extraneous variables (Thomsen, Weber & Brown, 2002; Tiggemann, 2002). This ultimately makes it difficult to accurately assess, through conventional quantitative methodology, the complex ways in which media imagery permeates body-image (Becker, 2004). Additionally, the majority of studies do not all account for the fact that no two people are the same and that everyone will interpret media images in different ways.

Moreover, the majority of the research does not explore the effects on those already suffering from, or susceptible to eating disorders (Fister & Smith, 2004; Hargreaves & Tiggemann, 2003; Thomsen et al., 2002). This includes literature asserting that the media has no impact on eating disorders. Whilst it may be unethical, and potentially damaging to test such participants, it may be necessary, as sufferers in the community have unrestricted access to thin idealised images on a daily basis. An investigation of this kind would ultimately allow an exploration of a solution. It may be effective to conduct research with sufferers, using Jansen and de Vries's (2002) technique, i.e. not previously informing participants that body dissatisfaction was being measured, in order to minimize preconceptions about resulting body image.

There is a paucity of literature asserting that the media has no impact on eating disorders. In order to verify this, more evidence is needed. Furthermore, most of the authors seem to underestimate the effects that media exposure to thin ideals may have on those with body image disturbance, assuming that thinness is an attainable concept for the general population, without considering that those with eating disorders will not recognise when they have become too thin.

Many studies include exposing participants to very thin models and average-sized models together. This may immediately trigger participants' awareness of the size difference and subsequently entail a critical evaluation of how their own size compares with this. Studies exposing participants solely to average-sized models may result in less consequential body-dissatisfaction, as they would be less aware of the size difference and their comparative own body size. Fister and Smith (2004) assert that "the media could actually provide a positive health learning experience by showing attractive but not overly thin images of women" (p. 396). Thus, if future research on this area reported less body dissatisfaction, this may inform a subsequent agenda for the media; to incorporate larger models into magazines and television.

It is interesting that there are, as yet, limited studies reporting on the conflicting messages within the media. One reason for this may be that the simultaneous glamorisation and criticism of eating disorders is a fairly new occurrence. It has only been in the last few years

that the 'size zero' phenomenon has received so much publicity, thus not warranting as much criticism until recently. Additionally, this area may not be recognised as one which may potentially contribute to eating disorders. The literature tends to focus on the promotion of underweight models, rather than the effects of confusion and internal conflict which may result from media messages that it is both bad and good to be thin.

In future studies, it may thus be useful to carry out more research on the effects of conflicting messages in the media. It would be valuable to assess levels of confusion, levels of body dissatisfaction, and the extent to which participants either wanted to lose or gain weight following exposure to conflicting messages. This could be done using an ordinal level of scaling, to obtain information about the intensity of each variable. It may be useful to test people with and without eating disorders, to compare their difference in responses.

It may also be useful to investigate how media messages affect obesity. As Jade (2002) asserts; "the gap between actual body sizes and the cultural ideal is getting wider, and giving rise to anxiety among almost all women" (p. 2). Do media messages that thin equals beautiful also mean that fat equals ugly? If so, what kind of effect does this have on people who are overweight or obese, or those who perceive themselves to be overweight?

Additionally, it may be beneficial to assess the impact of media messages on males. There has been some research into this area in the past. For instance, Duggan and McCreary (2004) found that males' drives for muscularity increased after exposure to idealised male images. A comparison against the effect of the media on females' body images and eating behaviours may provide a useful insight into whether media messages have different detrimental or beneficial impacts on females or males, and why this may be the case.

It would also be interesting to investigate the effects of the media on different cultural groups. Garfinkel and Garner (1982) point out:

"When food is not abundantly available to all, overeating and obesity are viewed with admiration. It seems that only when food is plentiful can the luxury of dieting and slimness-consciousness develop" (p. 106).

Indeed, eating disorders have been shown to predominantly affect Western countries. Yet, as Becker et al. (2002) demonstrated, the media significantly affected eating behaviours in Fiji. Hence, investigating the arrival of Western magazines and television shows in other, poor countries may further illustrate their potential effects.

On a par with cultural differences are historical changes, and attitudes towards food, thinness and the media. Indeed, in the 1950s, a more curvaceous female figure was considered beautiful, and icons such as the voluptuous Marilyn Monroe were admired. Has the media's changing face thus affected people's changing attitudes, or has the arrival of skinny female figures really had no impact, as some researchers claim?

One way to combat the media's exacerbation of eating disorders may be through media literacy programmes, designed to educate people about mass media influences on beauty ideals and body objectification. These programmes draw on cognitive-behavioural theory, attempting to reduce risk factors for eating disorders through using learning activities that build skills to resist social persuasion (Wilksch, Tiggemann & Wade, 2006).

Piran, Levine and Irving (2000) performed a study assessing the effectiveness of media literacy education. Results indicated that, following exposure to the programmes, participants demonstrated a reduction in their internalisation of the slender ideal, and an increase in their sense of self-acceptance. Participants also reported feeling more critical towards the media and acquiring a greater understanding of media tricks, such as the inclusion of artificially enhanced images of models. Wilksch Tiggemann and Wade (2006) conducted a similar study. They reported that 92% of participants who received media literacy lessons considered them valuable. Commonly identified learned themes were a decreased focus on appearance, a greater knowledge about advertising techniques and increased self-acceptance.

It seems that media literacy programmes may entail that the public takes a more critical, informed and objective view to such images, rather than internalising them, and potentially exacerbating their body dissatisfaction and eating disordered behaviour. This may require more widespread implementation of these programmes, however, and may also necessitate

administering repeated sessions. As Stice and Shaw (2004) assert, a single session is likely to be insufficient in achieving meaningful reductions in levels of eating pathology risk. Essentially, it would seem that such prevention programmes are not readily available in schools and youth programmes. Nonetheless, despite receiving such prevention programmes, adolescents would still unquestionably receive superseding messages from the media that thin equals beautiful (Posavac & Posavac, 2002). Ultimately, these are far more ubiquitous, powerful and attractive.

Fundamentally, literacy programmes use 'curative' methods when 'preventative' methods may be more effective in the first place. Essentially, it would seem that it is the media's responsibility in contributing to the prevention of eating disordered thinking, by ceasing to glamorise eating disorders and underweight celebrities, and by altering the models they use, from underweight to average-sized ones.

The findings from this study highlight many implications for the field of Counselling Psychology and for the Counselling Psychologists who treat individuals with eating disorders. Essentially, Counselling Psychology should examine all areas of a person's life which may affect their well-being. This includes constant exposure to media messages that thin equals beautiful. If a person is suffering from body-dissatisfaction or even a full-blown eating disorder, Counselling Psychologists should consider all factors potentially affecting this, including the omnipresent media messages endorsing thinness and discouraging adiposity. Fundamentally, if this review's findings are to be taken into account – that the media may have some impact upon eating disorders – it is important for Counselling Psychologists to recognise any warning signs or indications that their clients may be using media messages to reinforce their eating disordered thinking. This involves *all* types of media, including television, magazines and the internet. Furthermore, it would be useful for Counselling Psychologists to consider how their adolescent clients' search for a sense of identity may be affected by the media. Crucially, they should assess whether their clients are at risk of copying their thin role-models in the media to determine their own identities.

After researching the existing literature, it has become clear that the media may play some part in exacerbating, and potentially causing eating disorders. What is important is that it

becomes more aware of this, and attempts to make use of its role as the most potent communicator of social and cultural standards (Siochrú, 2004). Although not everyone will develop an eating disorder after exposure to media idealised images, it is nonetheless important to be mindful of what changes need to be made in order to not further contribute to what has already reached epidemic proportions in the UK. Eating disorders may continue, but it is up to the public and the media to ensure as little exacerbation of this as possible.

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Appendix 1: Examples of the content of Pro-Anorexia Websites

Thin Commandments:

1. If you aren't thin, you aren't attractive.
2. Being thin is more important than being healthy.
3. You must buy clothes, cut your hair, take laxatives, starve yourself, do anything to make yourself look thinner.
4. Thou shall not eat without feeling guilty.
5. Thou shall not eat fattening food without punishing oneself afterwards.
6. Thou shall count calories and restrict intake accordingly.
7. What the scale says is the most important thing.
8. Losing weight is good / gaining weight is bad.
9. You can never be too thin.
10. Being thin and not eating are signs of true will power and success.

Ana Creed:

- I believe in Control, the only force mighty enough to bring order to the chaos that is my world.
- I believe that I am the most vile, worthless and useless person ever to have existed on the planet, and that I am totally unworthy of anyone's time and attention.
- I believe that other people who tell me differently are idiots. If they could see how I really am, then they would hate me almost as much as I do.
- I believe in perfection and strive to attain it.
- I believe in salvation through trying just a bit harder than I did yesterday.
- I believe in bathroom scales as an indicator of my daily successes and failures.
- I believe in hell, because I sometimes think that I am living in it.
- I believe in a wholly black and white world, the losing of weight, recrimination for sins, abnegation of the body and a life ever fasting.

(Numb to the Bones Pro-Anorexia website, 2007).

Section D: Client Study

The Use of Person Centred Therapy when working with a Client with a Negative Body-Image

Introduction

Context of the work

This client study explores my work with Isabelle (pseudonym), a client I saw when I worked in the renal unit of a hospital. Isabelle had a negative body-image, experiencing dissatisfaction towards her physical appearance. She also dialysed three times weekly, which she found difficult to cope with. This left her feeling distressed, and she asked dialysis nurses to refer her to the renal psychotherapy service for psychological support. I practiced Person Centred therapy with Isabelle. At first, I saw her whilst she was dialysing but subsequently saw her in a private therapy room. I received fortnightly supervision from a renal psychotherapist within the service.

Rationale for Choosing this Case

Isabelle's experience of dialysis was intrinsically linked with her negative body-image, as renal failure had caused her to develop abdominal ascites¹². Body-image issues are of particular interest to me, both from a theoretical perspective and in terms of how therapy can help to allay the impact of such issues on an individual's life. I used Person Centred therapy with Isabelle, as I felt it would be useful in allowing her to understand her body, with regard to both dialysis and body-dissatisfaction. Indeed, I feel my work with Isabelle reflected the value of Person Centred therapy, in that we were able to meet at a relational depth consistently throughout our therapeutic journey and move forwards together, to a place where Isabelle was able to feel more mindful and acceptant of her body. This assignment explores this, observing our journey together, and the application of theory in practice.

¹² Ascites is an accumulation of fluid in the abdominal cavity, and can be a symptom of renal failure (Health A-Z, 2006). The effects ascites can have on an individual include tiredness, suppressed appetite, nausea and shortness of breath. The severity of ascites ranges from mild to moderate to severe. Treatment includes sodium restriction and diuretic therapy.

Summary of Theoretical Orientation

Person Centred theory states that within everyone is the ability to achieve their full potential as a person. This is referred to as the 'self-actualising tendency' (Maslow, 1943). It is believed that the client is the expert of their own worlds, and that through the expression of six *core conditions*, the therapist nurtures the client's ability to create the changes they need to achieve self-actualisation (Rogers, 1957). The most potent of these conditions are:

'Empathy'; the therapist's ability to sense "the feelings and...meanings which the client is experiencing in each moment" (Rogers, 1961, p. 62),

'Unconditional Positive Regard'; the therapist's expression of a warm, acceptant attitude towards the client (Rogers, 1961),

'Congruence'; when the therapist's communications are "genuine and without front or façade" (Rogers, 1961, p. 61).

Clarkson (1995) maintains that at the heart of Person Centred therapy is the therapist/client relationship in facilitating therapeutic change. This involves the therapist and client meeting at a 'relational depth' whereby the client feels understood and in no way judged by the therapist (Mearns and Cooper, 2005). Relational depth is defined as;

"a state of profound contact and engagement between two people, in which each person is fully real with the Other, and able to understand and value the Other's experiences at a high level" (Mearns and Cooper, 2005, p. xii).

Mearns and Cooper (2005) assert that relational depth refers to both specific moments during therapy and to a particular quality of the therapeutic relationship. For example, even though there may be times during therapy when the therapist feels *more* connected to the client, there is also a consistent underlying sense of understanding and valuing (Mearns & Cooper, 2005). Mearns and Cooper (2005) maintain that it is the combination of empathy, congruence and unconditional positive regard which allows the therapist to experience relational depth when they are with a client.

Rogers (1951) explains that inside everyone is an 'organismic valuing process'; an ongoing, innate process whereby experiences are accurately valued according to whether they are good for the individual or not. A client who is able to connect with their inherent wisdom to guide and promote change has an *internalised* 'locus of evaluation' (Rogers, 1951). Isabelle's experience, however, may be understood in terms of an *externalised* locus. In this situation, the client may "have great difficulty...in knowing what he thinks or feels" (Mearns and Thorne, 1999, p. 11), and their 'self-concept' (perception of the self) may be poor. Negative 'conditions of worth' featuring in a client's past relationships may cause the client to lose trust in their self-concept and organismic valuing process (Mearns and Thorne, 1999).

From a Person Centred perspective, a negative 'body-concept' (perception of the body) may occur when conditions of worth are imposed upon the client by society and/or significant others (Bryant-Jeffries, 2006). The client may thus feel that their worth is conditional on being thin. Therapeutic progress involves learning how to integrate the negative body-concept into the self-concept; acknowledging it, and then gently relinquishing any negative thoughts about it (Campling, 2007).

Background Information about the Client

Isabelle is a thirty-seven year old woman who suffered renal-failure eighteen years ago. She has had two kidney transplants, which both failed after around six years, and she has spent a total of six years dialysing. Her last transplant failed three years ago and she has dialysed since. Isabelle is not on a transplant waiting-list, as there is a chance that another kidney may fail. She does not work as she dialyses three times weekly.

Isabelle is married with one daughter. Her daughter is sixteen. She has two sisters and a brother. She lives nearby her mother and father, and one sister. She used to see her parents and siblings regularly and described having a good relationship with them whilst she was growing up. However, she does not see them as much recently, as she frequently feels physically exhausted after dialysing.

Aside from her family, Isabelle mentioned not having many friends or a supportive social network, as her exhaustion after dialysis left her feeling too tired to go out and socialise.

Furthermore, many of the people she used to be friendly with had engaged in a drinking culture, whereas Isabelle's renal doctors had advised her not to drink alcohol. Thus, she had lost touch with many of them. She did mention two friends she still kept in touch with, although she rarely saw them.

Isabelle suffers from body-dissatisfaction. She is short and slender, but as aforementioned, she developed abdominal ascites due to her renal failure, thus her stomach is noticeably distended. Her ascites has developed progressively over the past three years. It is 'moderate', meaning that Isabelle's abdominal girth has increased and she has gained some weight. The tiredness she suffers from could be a result of her ascites, as well as her dialysis. She does receive some diuretic treatment for her ascites, although she did not discuss it in therapy, other than once mentioning that she was on a low sodium diet. Isabelle is struggling to come to terms with her distended stomach, and feels fat and uncomfortable. Indeed, she had been slender for most of her life until she developed ascites and her body shape noticeably changed.

I saw Isabelle weekly for six months.

Initial Assessment/Psychological Formulation

My initial impression of Isabelle was that she was warm and friendly. However, her smiles were strained and she looked emotionally and physically drained. I immediately felt a connection with Isabelle. She talked openly, and seemed to trust me.

In our first meeting, Isabelle described experiencing absolute lack of control over her body and her environment. She had stopped dialysing for a total of twelve years following her two kidney transplants, and then had to endure it again when they failed. Isabelle said this made her feel like a prisoner in her own body; incessantly attached to a machine. Isabelle's self-concept seemed to be defined by her unremitting illness, and consequent distended abdomen.

Even though Isabelle's abdominal ascites may have been an *unavoidable* consequence of her renal failure, and was not a direct cause of her eating behaviour (for example, eating too

much or eating high calorific foods), the effect it had upon Isabelle was, understandably, that she felt very distressed and uncomfortable in her own body. Regardless of whether she was responsible for it or not, fatness was still fundamentally fatness to Isabelle, particularly as she had previously been very slender. Bryant-Jeffries (2006) might suggest that Isabelle's body-dissatisfaction could have been a result of negative conditions of worth endorsing thinness and discouraging fatness. I wondered where these conditions of worth might have been generated. Could Isabelle's family have instilled a belief in her that it was better to be thin than fat, or was it a more environmental influence such as society or the media? Rather than asking Isabelle directly about this in our first meeting, however, I hoped she would discuss it in her own time over the course of therapy.

I also wondered whether other conditions of worth maintaining that it is better to be healthy than ill had led Isabelle to believe that being ill was a sign weakness or failure. Even though Isabelle's renal failure was unavoidable, it nonetheless was something that she had to endure every day, and this inevitably had an effect on her ability to live a 'normal' life. She did not have a job as dialysing took up too much time, and she did not attend social gatherings due her tiredness. Furthermore, she could not engage in the same alcohol related social activities that friends may have done, as she did not drink. Notwithstanding this, Isabelle had developed renal failure at nineteen years of age, thus any 'normal' activities which twenty year olds do such as going out to clubs, drinking or going on holiday was impossible. Thus, in Isabelle's mind, had her renal failure resulted in the failure of her ability to have a normal social life? Fundamentally, it was clear from our first meeting that Isabelle felt isolated and lonely. Yet there was nothing she could do to change her renal failure, her requirement to dialyse or her ascites. She felt totally powerless.

In our initial meeting, Isabelle said she recognised that although she could not change her situation, she did want to accept it. Nonetheless, she felt this was unattainable, and was unsure of *how* to accept it. She hoped for some guidance towards this. It seemed she was unable to recognise *inside herself* the knowledge or understanding about how to move forwards. Rogers (1959) asserts that if a client appears to find it difficult to make decisions and judgements about what is best for them, this may represent a disconnection from their organismic valuing process. Indeed, I felt this to be the case with Isabelle.

Furthermore, she frequently asked me how I thought she could move forwards, and sought my opinion on what might be best for her. This suggested her *externalised* locus of evaluation. As Mearns and Thorne (1999) assert, those with an externalised locus may experience a sense of internal confusion or blankness, and search for guidance from sources external to themselves. Moreover, Mearns and Thorne (1999) state that “the client with the externalised locus is extremely vulnerable to the evaluations others place upon him” (p. 49). Therefore, I discussed in supervision from the outset that I would have to be cautious in my empathic reflections with Isabelle, taking care not to introduce my own ideas or values when exploring her experience, in case she accepted these ideas as truth.

The Person Centred approach views the client as fully capable of recognising their internal wisdom regarding how to bring about change and achieve ‘self-actualisation’ (Rogers, 1957). However, Isabelle seemed unable to connect with this internal wisdom about how to move forwards, as her thoughts were dominated by an ensuing sense of hopelessness about her unchangeably bleak future. Thus I hoped that by providing the right core conditions, I could empower Isabelle to recognise and trust her inner resources for therapeutic growth. Essentially, by showing her that I accepted, understood and valued what she said and felt, I hoped she could come to see herself as trustworthy and learn to accept herself and her feelings.

Person Centred therapy appeared well suited to Isabelle, as it seemed she needed someone to be with her through her distress; to feel listened to and understood. Indeed, the therapist’s presence with the client was perceived by Rogers (1957) to be one of the core conditions. I wondered whether maintaining a mindfulness of her self- and body-concept may enable Isabelle to recognise ways to accept herself and her situation. Ultimately, she could not control her distended abdomen or her need to dialyse; she *had* to learn how to accept them as part of her life. Indeed, as Rogers (1961) states;

“When I accept myself as I am, then I change...We cannot change, we cannot move away from what we are, until we thoroughly accept what we are” (p. 17).

Rogers (1961) maintains that the Person Centred approach demonstrates to the client that they are trustworthy and can be relied upon to recognise the best way to reach this acceptance. This empowers them to trust their own innate capacity to identify a way forwards, rather than relying on others for direction. By empowering Isabelle to feel that she had been instrumental in her own therapeutic progression, I hoped she could feel more in control of her situation.

Negotiating a Contract/Therapeutic Aims

Bozarth (2005) asserts that Person Centred therapy should take place at the client's own pace. Thus, Isabelle and I arranged to meet for as long as she felt she needed therapy. We would meet whilst she dialysed, in a private dialysis-room connected to the ward. This was intended to allow her to explore the emotions connected with her situation, as she experienced them.

Person Centred therapy is non-directional, allowing clients to explore their difficulties as they wish (Rogers, 1942). Rogers's (1959) explains that people have the capacity to find their own answers, and tend to move towards growth and healing. With this in mind, I asked Isabelle how she would like to use our time. She did not explicitly establish any therapeutic goals other than her desire to accept her situation. Hence, I felt my role with Isabelle was to create an environment conducive to this acceptance, by listening, empathising and collaboratively exploring her experience.

Development of Therapy

Beginning of Therapy

Cooper (2005) posits that in order to engage with the client at a relational depth, it is essential that the therapist expresses their congruence and authenticity and that this is recognised by the client. Hence, I felt it important to articulate from the outset that I would never presume to understand exactly what Isabelle was experiencing, but that I would be

there with her whilst she dialysed, and that I would listen to whatever she wanted to say. When I said this, she cried and said it had felt good to hear my words. She felt lost, lonely and out of control.

Mearns and Thorne (1999) explain that the “organismic valuing process helps the person to have a sense of what they need for their enhancement, both from their environment and from other people” (p. 9). However, it seemed Isabelle could identify no resources which would guide her through her situation, representing a disconnection from her organismic valuing process. She felt stuck. Thus, I tried to create a nurturing, acceptant space for her, communicating my unconditional positive regard and a belief in her ability to reconnect with her inner wisdom (Rogers, 1957).

Isabelle said that, whilst supportive, her family did not fully understand her situation. They did not experience the trauma of dialysis and the ensuing emotional exhaustion. This intensified her isolation. I believe that the therapist empathically responds to what the client needs (Duncan, Solovey and Rusk, 1992). Hence, I felt the need to demonstrate that Isabelle was not alone; empathising with her desperation, and conveying my presence with her through her isolation. I used supervision to help me stay with her through this.

Mearns (2003) posits that the therapist will feel the client with an *externalised* locus of evaluation looking to them for advice. I certainly felt this to be the case with Isabelle. She wanted me to be with her through her loneliness, but she also wanted me to provide answers about how to get through this. In order to promote her regard for her own feelings as a guide to her actions, I stayed as close as possible to Isabelle’s *own* words when reflecting on what she said (Nelson-Jones, 1995). In this sense, I attempted to empathise with her without introducing my own ideas or values to interpret her experience. I hoped this would encourage her to exercise internalising her locus of evaluation.

Over the first four sessions, I felt that there was a great deal of mutual understanding between us, and it felt as though we were both in very similar spaces in the therapy room. Our relationship felt very real, warm and in the moment, and I felt as though I could sense what Isabelle was experiencing and appreciate the depths of her emotions. Although I felt

an immediate connection with Isabelle, she did seem to trust me progressively more over the first four sessions. Mearns and Thorne (1999) explain that when the client senses the therapist's expression of the core conditions, they will become more trusting towards the therapist. I felt as though my expression of empathy with what she was feeling, my congruence in expressing what I was feeling and my acceptance of Isabelle increased her trust in me.

I did not bring up Isabelle's body-dissatisfaction in therapy, as I felt it was important for her to mention it when she felt ready. In our fifth session, Isabelle mentioned it herself. I feel this represented a significant development in the therapeutic process, and it demonstrated to me that I had met Isabelle at a relational depth. Indeed, Mearns and Cooper (2005) state that when the client feels they have met the therapist at a relational depth, they will begin to bring significant material into therapy.

In the fifth session, Isabelle said that she felt perpetually uncomfortable and bloated. She described hating her stomach and said she wished she had her old figure back. She also recalled feeling embarrassed by her appearance. In the past three years, since developing her ascites, many people had mistakenly asked her if she was pregnant, enquiring as to when she was due to give birth. She laughed as she said this. Mearns and Thorne (1999) state that clients may commonly disguise important messages in a 'cloak' of humour in order to protect themselves from the pain of a revelation. They explain that the therapist needs to take care when responding to this; choosing whether to acknowledge "the important message or the humorous packaging" (Mearns and Thorne, 1999, p. 120). I simply gave Isabelle a small sympathetic smile and a look of compassion, and remained quiet in order to allow her to elaborate.

Isabelle's laughter stopped when she went on to discuss how embarrassed and awkward she felt. The humiliation she experienced at having to explain she was not pregnant was so overwhelming, that she sometimes told strangers she was in fact expecting a child. She would then tell people she was in a rush and walk away as people happily congratulated her and asked questions about her pregnancy. She felt as though she was being rude, but she simply could not bear to lie her way through a conversation. Crucially, Isabelle

acknowledged she could not control this situation, just as she could not control her swollen stomach; she simply had to learn to accept it. Yet she understandably found this difficult and could not identify how to accept it. Isabelle felt stuck and desperately unhappy.

Middle of Therapy

Over the next few weeks, Isabelle further explored her body-concept. She described feeling alienated from her body and dehumanised by her dialysis. Yet she was also conscious of her body; particularly her swollen abdomen. This was extremely distressing for her. I recall feeling stuck at this point. How was Isabelle ever going to accept her situation? Personally, I would not want to. Retrospectively, I think I empathically sensed Isabelle's distress and subsequently perceived it as my own. Supervision helped to reiterate that Isabelle needed me to be *with* her through this. By allowing her to access and explore her desperation, and demonstrating the core conditions through my presence, active listening and reflections, I had to trust Rogers's (1957) suggestion that Isabelle would eventually be able to recognise how to change her situation herself.

In our tenth session, Isabelle showed me a fashion magazine she had been reading before our session. She often read these magazines to pass time whilst dialysing. She described wishing she could have the models' bodies. Gendlin (1981) discusses how the therapist may sense underlying feelings of which the client is not aware; thus, in order to attend to the edge of Isabelle's awareness, I asked her how seeing the models made her feel about her own body. Upon exploring this, she recognised that the magazines had been exacerbating her negative body-image. She had ultimately been indulging in an unattainable comparison.

Rogers (1951) explains that the self-concept is largely comprised of conditions of worth imposed by others, powerfully informing our perceptions of ourselves. It seemed Isabelle may have internalised a prevalent societal message that "we are most worthy if we are slim" (Freeth, 2007, p. 31), something the media commonly endorses (Posavac and Posavac, 2002). These negative conditions of worth imposed by society may have influenced Isabelle's body-dissatisfaction. Her previous unawareness of the magazine's effect upon her

was further evidence of her disconnection from her organismic valuing process; she was unable to recognise what was good for her.

Isabelle subsequently explored the meaning behind reading the magazines. She recognised that in comparison to the models, she perceived herself as disgusting. This 'self-disgust' appeared to dominate her self-concept. Her self-disgust, however, was not just to do with her own perception of herself; she also talked of how unattractive she felt as a wife. Her stomach was so large and uncomfortable that sexual intimacy with her husband was difficult. She said her husband was supportive and loving nonetheless, but that this did not reduce her disgust towards her distended stomach.

Isabelle also talked of how she felt disappointed in herself for being, in her words, "ill and useless". She felt that requiring dialysis had rendered her unable to look after her family, unable to spend time with her daughter and unable to enjoy family time. She said she could never go on family holidays as she had to dialyse three times a week. Furthermore, even going out for the day with her husband or daughter was difficult as she was frequently too tired on the days in between dialysing. Isabelle explained that this was compounded by the fact that she had been able to enjoy a 'normal' family life when she had had her kidney transplants. When they failed, however, she was left feeling trapped and useless once again.

This suggests that Isabelle may also have felt that she was most worthy if she was well. It is feasible that conditions of worth may have been imposed on her maintaining that the role of a wife and mother was to care for their family. Yet conversely, her husband and daughter often had to care for her, cooking meals and cleaning the house. As a consequence, Isabelle distanced herself from them as she felt inadequate and guilty.

Essentially, it felt as though Isabelle's life, rather than being oriented around family and socialising, had become oriented around her illness. In a sense, her life had *become* her illness. She said all she felt she did was dialyse in hospital, or feel too tired as a result of dialysing. Moreover, her ascites was a constant reminder of her illness. It seemed that her entire self-concept was defined by her renal failure, her dialysis and her ascites. Isabelle discussed this frequently over the next month. On our fifteenth session, after nearly four

months of therapy, she acknowledged that she needed to separate her illness from her life if she was to move forwards and accept herself as she was. Isabelle recognised that a dialysis patient was not who she was, her swollen stomach was not who she was – they were just aspects of her life.

In identifying who she was not, Isabelle was free to explore who she was. She needed to focus on developing a more positive self-concept; essentially moving towards self-actualisation (Rogers, 1959). Rogers (1961) famously discusses 'becoming a person'. It seemed Holly would have to learn how to *become* herself. This sense of becoming would, ultimately, involve living contentedly as a person with renal-failure and abdominal ascites. This included being a wife and mother with renal-failure who was not able to care for her family as much as a well person might be able to. Essentially, unless she was able to accept her situation, she would continue to feel incessantly, sad, desperate and lost.

End of Therapy

Four months into therapy, the hospital changed Isabelle's dialysis time. We continued to meet at our usual time, though in a separate therapy-room, away from the dialysis machines. This had an immense impact on Isabelle. No longer being hooked up to a machine increased her propensity to talk openly and more freely explore her experiences, emotions and fears.

Rogers (1977) maintains that every person is trustworthy and that the therapist should trust in the client's instinctive movement towards the accomplishment of their inherent potential. Thus, I consistently encouraged Isabelle to explore her experience, reflecting and empathising with her. Whenever she sought my opinion, I summarized what she had previously said, using her words, and invited her to examine her own opinion. My trust in Isabelle and the therapeutic process allowed her to trust in herself more. As Rogers (1951) asserts, when a client is able to sense the therapist's sense of their worth, they will eventually recognise their own sense of self-worth.

Isabelle increasingly understood how to accept her situation, exploring her thoughts more and seeking my opinions less, thereby progressively internalising her locus of evaluation

(Raskin and Rogers, 1989). She focused on trying to think of her swollen stomach as a part of her, hence integrating her body-concept into her self-concept (Campling, 2007). She could be mindful of it and proceed with her life, or continue to be disgusted by it and feel miserable. An acceptance of her distended stomach, however, could only occur after an ultimate acceptance of her illness, as the two were intrinsically linked. To facilitate this, Isabelle explored ways to reduce the impact of dialysing upon her life. She spent her non-dialysis-days doing completely unrelated activities, such as cooking and going for short walks. Furthermore, she tried to be good to herself whilst dialysing; reading books instead of scrutinizing fashion magazines. Isabelle's ability to value these experiences as beneficial or detrimental suggested a reconnection with her organismic valuing process (Rogers, 1959).

Mearns (2003) asserts that the Person Centred therapist can become freer in their expression when the client has internalised their locus of evaluation. Therefore, I reflected to Isabelle that I wondered whether her distress may be exacerbated by her disconnection from her family. Essentially, she was able to recognise that she had been excluding her family as they had not known how to help her through her illness. She had effectively shut them out due to her own insecurities about being a bad wife and mother, and they had not known how to respond to this. Yet this was not their fault, or anybody's fault – things had simply evolved this way. Thus, Isabelle subsequently tried to include them more; inviting them to dialysis, and sharing her feelings with them.

After six months, my placement contract ended. I informed Isabelle of this a month beforehand. Our final sessions were spent reviewing her progress. It became clear that she no longer felt lost; she felt mindful of her situation. She was more reliant on her own thoughts and feelings, and trusted them as a guide to help her move forwards (Raskin and Rogers, 1989). She had developed a more positive self-concept, recognising that she was not defined by her illness or her distended stomach. This journey of personal growth would not terminate once therapy ended, and Isabelle insightfully identified ways to sustain her progress by keeping a journal, and trusting herself and her family more.

Discussion

Therapeutic Process/Changes in the Formulation

At the start of therapy, Isabelle stated that she wanted to accept her situation, but that she was unsure how to. This indicated that she had lost touch with her organismic valuing process, unable to recognise how to move forwards (Rogers, 1951). Furthermore, she frequently sought my opinion; evidence of her externalised locus of evaluation (Mearns, 2003). Her self-concept was negative, defined by societal conditions of worth that she must be thin to be acceptable to herself and others, and personal conditions of worth that she was most worthy as a wife and mother if she was well.

Isabelle's difficulty in accepting herself as a person living with renal-failure, and her disgust at her distended stomach were essentially barriers to her self-actualising tendency. By expressing the core conditions to Isabelle, I hoped to convey the message that she could be valued (Rogers, 1951), and that my positive regard for her was unconditional, in spite of her own feelings of disgust towards herself. Indeed, I would stay with her through her disgust. Thus, Isabelle was able to overcome these barriers by understanding that although she was powerless to change her body, she could change her perception of her situation.

Although there was no explicit shift in formulation, I feel our roles as client and therapist became more enhanced. Isabelle was able to recognise that I could not give her all the answers to her problems, but that we could work collaboratively to explore her situation. As a client, she would convey her fears to me, and I would encourage her to trust her innate ability to guide herself through her desperation.

As Hazler and Barwick (2001) assert, the environment in which therapy takes place can dramatically alter a client's inclination to talk openly. In this regard, it felt useful for Isabelle to have experienced therapy both on and off dialysis. Seeing Isabelle during dialysis certainly facilitated a better understanding of that environment. However, seeing her away from the dialysis machines seemed to enable a more open exploration of her feelings.

Difficulties In Therapy/Use of Supervision

Isabelle was highly reflexive, yet at times she felt *stuck*. Perhaps this was due to her feeling overwhelmed by her circumstances. Isabelle's experience of dialysis was an immensely dehumanising one, yet she was acutely aware of – and disgusted by – her swollen body. She felt 'lost' between these two states. I sensed Isabelle's desperation and left many of our sessions feeling overwhelmed and stuck myself. In supervision, I discussed how to apply Mearns's (1997) suggestion that the therapist must be "*willing and able to meet the client at sufficient depth to work at the existential level of the client's experiencing*" (p. 16). Essentially, I needed *stay with* Isabelle's experience. She felt desperate, she felt disgusting, but she also felt lonely. By being with her in her distress, at least she was not alone; she had someone to explore the implications of her situation with, ultimately facilitating an acceptance of this.

Isabelle felt disconnected from her family and seemed to reach out to me as a result. I was concerned about becoming a "substitute" for them. Thus, I used supervision to help me clarify my role; supporting her in a more collaborative manner, rather than cultivating her need for me to provide advice in the way that she may expect a family member to. Essentially, I needed to "enter the client's frame of reference and walk alongside [her] in [her] world...commenting on what [I saw]" (Mearns and Thorne, 1999, p. 43), empathising with her experience, whilst encouraging her to find solutions herself.

Working with Isabelle taught me that even when a client feels stuck and desperate, the therapist's role can be so powerful in *staying with* the client (Mearns, 2003). Many of my clients feel stuck and hopeless, yet with Isabelle I was able to recognise that trusting in the therapeutic process may help the client, and therapist, to feel a little less stuck.

Evaluation of Therapy

I believe I met Isabelle at a relational depth at specific times during the therapy and also in a more general capacity. Effectively, I felt that the specific moments of understanding we shared stimulated our connection, and enabled our general therapeutic relationship to be honest, open and trustworthy. Furthermore, I feel Isabelle was able to feel my unconditional

presence and acceptance, and thus feel *held* by me (Mearns and Cooper, 2005). I believe this ultimately allowed her to feel less lonely.

Retrospectively, I do not feel I found out enough about Isabelle's relationships with friends. I wondered how she had lost touch with many of them and what impact this had upon her and her loneliness. Exploring this may have allowed Isabelle to recognise the value of a support network and encouraged her to get in touch with old friends, or make new friends.

I also do not feel I found out enough about Isabelle's specific family relations with her wider family, including her parents and siblings. I did wonder whether conditions of worth leading her to consider that she was most worthy if she was healthy may have been learnt from them. Nonetheless, Person Centred therapy is non-directive (Rogers, 1942), thus I tried to stay as close as possible to what Isabelle chose to discuss. Yet I feel that exploring her relationships with friends and individual family members may have elucidated a deeper understanding of her loneliness and its causes. Perhaps I could have investigated this in terms of Gendlin's (1981) 'edge of awareness', encouraging her to listen to her inner feelings more on the rare occasions she mentioned her wider family and friends.

Overall, I feel that the Person Centred approach was effective in allowing Isabelle to explore her self-concept and the difficulties arising from her illness. Although she wanted me to provide solutions for her problems, I communicated that I trusted in her ability to find these herself. I mirrored her own words, encouraging her to explore the inherent meanings and implications of these words and feelings. Asay and Lambert (1999) posit that crucial factors responsible for therapeutic change are the client's level of motivation and the quality of the therapeutic relationship. Isabelle was motivated from the start and I was privileged enough to witness her self-concept become more positive as therapy progressed. I believe this was due to her insightfulness and willingness to explore her feelings. Furthermore, our therapeutic connection and her subsequent receptiveness to my demonstration of Person Centred principles promoted this and allowed her, ultimately, to accept her situation and herself.

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