



**‘Mum’s needs are just on the back-burner’:
An exploration of the lived experiences of
mothers diagnosed with anorexia**

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This is to certify that this research is my own work.

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‘Mum’s needs are just on the back-burner’: An exploration of the lived experiences of mothers diagnosed with anorexia

Abstract

This study is concerned with exploring the lived experiences of six mothers who have experienced anorexia while raising their children. This group of women are currently under-represented in the eating disorder and anorexia literature. Much of the current literature on anorexia focuses on younger people; particularly young women. The limited literature that does exist on mothers with anorexia is often pathologising, where the women are represented as being needy, defiant and oppositional to treatment, or are signified as failing as mothers in important respects. The six women participated in telephone interviews that focused on how they made sense of their experiences of mothering and in seeking and receiving psychotherapeutic interventions for anorexia. Interpretative phenomenological analysis was used to analyse the data. Three super-ordinate themes captured the ways in which these women made sense of their experiences. The first theme ‘We live in an Alice in Wonderland world’ illuminated the women’s feelings of ‘otherness’ through experiences of (in)visibility, shame and engaging with an anorexic identity. The second theme: ‘The windowsill syndrome’ highlighted the competing demands of motherhood and anorexia that were described by the women through the course of their narratives. The final theme: ‘Fuck you, don’t give up on me’ explored the diverse experiences of support and recovery, expressed through the stories the women told. The findings are examined in the context of dominant and feminist discourses on motherhood and anorexia. The utility of these findings for an increased psychological understanding of, and improved interventions for, mothers experiencing anorexia is also discussed. I argue that a focus on formulation, rather than diagnosis, would allow for a holistic perspective from which to inform help and support. Therapeutic interventions that acknowledge the life-world of the client offers a whole person focus that has often been lacking in therapy for the experience of anorexia. (The use of the

word 'treatment' is part of a medicalised discourse and has been used sparingly in this research, primarily when discussing research that uses this term).

Key words: counselling psychology, eating disorders, eating disorder interventions, interpretative phenomenological analysis, motherhood, telephone interviews

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Overview and Background

Anorexia has the highest mortality rate of any mental illness (Smink et al., 2013). Mortality risk estimates for anorexia are 5.9% compared to 1.6% for depression which means that many people with anorexia will die (Chesney et al., 2014). There is a general consensus that the risk for relapse is particularly high (Khalsa et al., 2017) and that there is a high risk of lifelong sub-clinical symptoms (Arcelus et al., 2011). Adult women who experience anorexia are generally under-researched as a group, as much of the focus is on adolescents (Wright & Hacking, 2012). This research will focus on women who have experienced anorexia while being mothers. This is an area that is currently under-represented in the literature, where there is a paucity of qualitative studies that give voice to what this experience is like for this group of women (Stitt & Reupert, 2013). This research acknowledges the importance of locating the experience of anorexia (and seeking and receiving professional support for it) for mothers within the wider context of contemporary socio-cultural ideas about body shape, size and eating (Gelo et al., 2015) as well as the interaction between individual lived experience and cultural and social notions of motherhood and anorexia. Using interpretative phenomenological analysis (IPA) to analyse the data means the focus of this research is the subjective experiences of the participants, where the person is seen as ‘an experiencing, meaning-making, embodied and discursive agent’ (Eatough & Smith, 2006, p.486). Attending to wider social, cultural and embodied contexts will serve to support an understanding of how these pervasive influences might be impacting upon the development, maintenance and experience of anorexia for this group of women.

In the following discussion of the literature, I will consider anorexia in a historical context in order to illustrate how the meanings of anorexia and self-starvation have changed throughout history, and how our understanding of anorexia is strongly related to the wider cultural and social context (Gelo et al.,

2015). A consideration of present-day mainstream representations of anorexia, in terms of prevalence, diagnosis and interventions, sets the stage for contextualising the predominant medical model in which many diagnosed individuals experience anorexia. A consideration of mainstream research on mothers and motherhood serves to further situate women's experiences in social and cultural contexts. 'Motherhood' as a concept, in terms of how it is differently understood and internalised from social and psychological perspectives helps to place individual women's experiences within this wider framework. Reflecting on feminist critiques on and alternative perspectives to mainstream accounts of anorexia and motherhood offers a different lens through which to view these experiences.

I will consider the body of literature that focuses on the lived experiences of women and mothers with eating disorders, and of those with anorexia, in particular. Qualitative research focusing on lived experiences offers a unique methodology from which to tap into rich seams of human experiences, capturing how these are for particular groups of people (Smith et al., 2009). This is especially relevant to the field of counselling psychology. Acknowledging and elucidating lived experiences with a focus on subjective insights and participants world views conforms to the Division of Counselling Psychology Guidelines (BPS, 200, p.1/2). These recommend that we 'work in ways that empower rather than control' in an anti-discriminatory framework. In presenting nuanced, individual accounts of the experience of mothers living with anorexia, a fuller and richer account of the internal and external aspects of the experience might be heard and understood.

A primary aim of this research is to comprehend what sense the women in this study make of their experience of mothering. This includes understanding how it is for them to feed and educate their children with regards to food and concepts of body shape and size. Consideration will be given to how this may be affected by their experiences of anorexia and embodiment within the wider context of socio-cultural norms, experiences of embodiment and their understandings of being a mother with anorexia. The experiences of these

mothers in both seeking and receiving professional help for anorexia will also be explored to expand our current knowledge of experiences of professional support. The rationale for this focus is that this research will offer valuable insights about the experiences of these women, for counselling psychologists and other health care professionals. It is hoped that this research will contribute to formulating best practice guidelines for professionals working with mothers experiencing anorexia.

Eating disorders and anorexia within a historical context

Eating disorders are defined as ‘abnormal eating habits that can threaten your health or even your life’ (American Psychological Association, 2015, p.1). They have been well-documented throughout history (Engel et al., 2007) and the incidence of behaviours associated with self-starvation and purging fluctuates significantly across particular periods of time (Brumberg, 2000). In Western Christianity there were dominant interpretations and representations of self-starvation in various religious contexts. During the twelfth and thirteenth centuries, women who starved themselves were termed “miracle maidens” (Hadfield et al., 2014, p. 71) and held in high esteem, but by the sixteenth century, ‘anorexics’ were often condemned as witches and burned at the stake (Brumberg, 2000). This volte-face, from veneration to damnation, illustrates one temporal polarisation (of many) of meanings that have been historically ascribed to similar eating practices and body sizes.

In the nineteenth century, the French psychiatrist, Charles Lasegue, contributed to psycho-social understandings of eating disorders by suggesting that *not* eating could be understood as a form of female protest against a sense of life being suffocating and repressed (Brumberg, 2000). The idea that eating practices could be understood as political, symbolic, economic, material and nutritional communications remains important in contemporary understandings of women and their relationships with food (Abbots & Lavis, 2013).

From a phenomenological perspective, Merleau-Ponty (1945/2004) contended that the body is inextricably intertwined with how we experience ourselves, our

relationships with others and our lifeworld. In this respect the body is theorised as a body-subject that perceives, knows and is a means of communicating with the world (Merleau-Ponty, 1945/2004; Moran, 2000). Acknowledging the wider historical and embodied contexts from which women might be experiencing anorexia is important in beginning to theorise a holistic understanding of their particular life-worlds.

Twentieth and twenty-first century understandings and treatments of anorexia have progressed considerably from the understanding of anorexia in the early 1900s where imposing a 'parentectomy' (isolating the patient from her parents) on individuals experiencing anorexia was believed to be essential to recovery (Murray & Anderson, 2015). The 1930s onwards saw researchers challenging the idea that anorexia was due to an organic cause (Caparrotta & Ghaffari, 2006) and psychoanalysis began to influence how professionals conceptualised anorexia by linking its existence to psychosomatic (Parry-Jones, 1991) or sexual origins; for example, Ryle (1936) contended that psychosexual traumas could be a cause of anorexia. The publication in 1973 of Dr. Hilde Bruch's highly influential book on eating disorders (*Eating Disorders: Obesity, Anorexia Nervosa and the Person Within*) highlighted the importance of considering anorexia as a serious mental illness. She also rejected a psychoanalytical model based upon sexual drives in favour of a model based on attachment and early social difficulties (Treasure & Cardi, 2017).

In 1980, the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III) added an eating disorders section to its classification system including anorexia. Brumberg (1988) suggested that the burgeoning incidence of anorexia in the twentieth century is largely due to social pressures and how they impact on meanings around food, sexuality and body shape for women. Eating disorder treatment now encompasses multiple approaches that cover medical, psychological and nutritional aspects of the experience. Clinical practice for the treatment of anorexia has tended to become more defined in terms of guidelines, parameters and recommendations (Lock, 1999). Although there has been progress in the field, it is widely

acknowledged that anorexia still poses a serious risk to those individuals experiencing it (Zipfel, 2015) and that further research into the subject in general can only benefit the wider field of eating disorders.

In terms of exploring contemporary experiences of anorexia for mothers, it makes sense to consider the prevalence of anorexia for this group, how mainstream medical and mental health communities approach individuals who may be practicing restrictive eating and the categories that are currently used and referred to in diagnosis.

Prevalence of anorexia in women of childbearing age

The Mental Health Foundation (2015) estimates that there are 1.6 million people affected by an eating disorder in the UK and that up to 1 per cent of women in the UK between the ages of 15 and 30 experience anorexia. A recent study, investigating the lifetime prevalence of eating disorders for adult women, found that 15% of the women in their study had experienced an eating disorder at some point in their lives and that 3.6% had experienced one in the past year (Micali et al., 2017).

Some research maintains that individuals that experience early-onset anorexia are most typical and that those individuals experiencing it later in life appear to have undergone a severe life event (Gowers et al., 1996; Troop et al., 1997), whereas other research does not support this claim (Schmidt et al., 1999). There is some research that indicates that motherhood may exacerbate experiences of anorexia for some women who have experienced it in the past or who experienced it while becoming pregnant and having children (Tierney et al., 2011). However, there appears to be little or no research that has examined whether becoming a mother might prompt a first experience of anorexia. Numerous cases of eating disorders go unreported or undiagnosed and figures for the prevalence of anorexia are likely to be much higher (Fursland & Watson, 2014). As it is likely that anorexia will be experienced by some women who are or may become mothers, it is worthwhile to research the experiences of this group of women, particularly as they are currently under-represented in the

eating disorder literature. The World Health Organisation (2004) has identified a whole raft of factors that may contribute to the development of eating disorders. These include unhealthy dieting; excessive weight, shape and body dissatisfaction; family and social influences; glamorising of thinness in society and the mass media; insecure attachment; physical abuse; bullying; low self-esteem; and affective stress coping. There is other research that identifies that the prevalence of childhood sexual abuse is high amongst individuals seeking treatment for anorexia (Carter et al., 2006; Oppenheimer et al., 1985). The aetiology of eating disorders is commonly considered to be multifactorial in that no single aetiological factor is thought to account for the development of the disorder in an individual (Cooper, 1995).

Diagnosis and critiques of DSM-V and NICE guidelines

In the UK, individuals undergo an assessment by a health care professional to receive a diagnosis of a particular eating disorder. The assessor usually refers to either the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V, 2013) or the National Institute for Health and Care Excellence (NICE) guidelines in making their diagnosis. The DSM-V is published by the American Psychiatric Association, is globally influential in diagnosis and is often cited in eating disorder research.

Although the DSM-V and NICE guidelines are most commonly referred to in the UK in making a diagnosis of anorexia, there is controversy around the appropriateness and relevance these particular 'diagnoses' have for the individual experiencing problems with eating. Maine et al. (2010) argued that it is more relevant to consider the *symptoms* that a person presents with. They acknowledged that many individuals move between different eating disorder diagnoses over the duration of their illness, and that shoehorning them into one diagnosis is unhelpful in making sense of their experience of and help for their eating disorder.

It has been argued that a broader classification for anorexia in the DSM-V would be more helpful (Focker et al., 2013). Furthermore, using 'diagnosis' and

'medical' terminology can be unhelpful when it becomes a barrier to transparency in making sense of, and helping with, what might be being experienced by individuals at any given time (Newnes, 2002). The DSM-V and NICE guidelines and 'diagnosis' do not allow for a more nuanced approach to making sense of living with many kinds of experiences (of which anorexia is one). The idea of 'formulation' is a useful alternative to diagnosis where there is 'a provisional explanation or hypothesis of how an individual comes to present with a certain disorder or circumstance at a particular point in time' (Weerasekera, 1996, p. 4).

Psychotherapeutic interventions for anorexia

Analysis of trends in intervention outcomes for individuals experiencing anorexia paints a stark picture of a recurring cycle of diagnosis, intervention, recovery and relapse, that often lasts at least 6 years regardless of intervention types (Beat, 2015). There remains a lack of consensus over what approaches work best in terms of developing interventions and practice guidelines for anorexia (Watson & Bulik, 2013).

Women experiencing anorexia are often negatively represented in mainstream literature on treatment and have been described as needy, oppositional and resistant to interventions (Kaplan & Garfinkel, 1999; Ramjan, 2004). Health care professionals have described feeling negative emotions in their experiences of working with this client group, including frustration (Satir et al., 2009), suspicion (King & Turner, 2000) and feeling not wanted or valued (Shipton, 2004).

Other research critiques current treatment practices that can be experienced as disempowering and pathologising for the client (Malson et al., 2008). Malson et al. (2008) highlighted the fact that some 'treatment practices' for anorexia (e.g. monitoring body-weight and eating) are 'anorexia-like' in their construction and are potentially 'anorexia-sustaining' for the individual experiencing treatment.

Eivors et al. (2003) highlighted the uneasy tension between focusing on 'symptoms' and the *meanings* of these symptoms for the client, maintaining that an aim of therapy should be to enhance a sense of self apart from that

defined by the eating behaviour. A recent systematic review of intervention outcomes for anorexia by Murray et al. (2018) found that there was a significant discrepancy between 'weight-based symptom remission' and 'psychological symptom remission' in the interventions used. Another review, focusing on specialised treatments of anorexia, found that, although weight-based symptoms of anorexia were relieved in the short term, there was little advantage over comparator treatments in relation to psychological symptoms (Fishburn, 2019). Other studies have suggested that different therapeutic approaches might be more helpful than mainstream specialised treatments for anorexia (Goss & Allan, 2014; Malson et al., 2011; McIntosh et al., 2005). These include Supportive Psychotherapy where the 'therapist helps to sustain and bolster the patient' (Bloch, 2006: p. 216) and compassion-focused therapy (CFT) which specifically addresses self-criticism, hostility and shame, through helping individuals to cultivate self-compassion and compassionate emotional responses (Gilbert, 2009). It is evident that future intervention development would benefit from having more of a focus on relieving psychological distress as well as the physical. This would represent a more holistic approach to 'recovery' in recognising the central interaction between the physical and psychological in terms of overall 'wellbeing' (Eivors et al., 2003; Fishburn, 2019; Murray et al., 2018).

At this juncture, it is important to acknowledge the fact that the therapeutic alliance (defined by Bordin, (1979) as an agreement on the goals of therapy in the context of a positive, affective bond between client and therapist) has been a consistent predictor of therapy outcomes over many years (Horvath et al., 2011). Some research questions the importance of the therapeutic alliance in therapy for eating disorders, emphasising the benefits of manual based approaches and techniques in treating anorexia (Brown & Waller, 2013/2014). Other research contends that, although the therapeutic alliance has been shown to be challenging to create in therapy for eating disorders (e.g. Ramjan, 2004), building a therapeutic alliance is a key aspect of therapy for eating disorders and is crucial for successful outcomes (Tierney, 2008; Pereira et al.,

2006; Sly et al., 2013). Where the therapeutic alliance is not an integral part of practice, ambivalence (in clients) towards the support and high drop-out rates (Tierney, 2008) have been shown to occur.

Although there are variety of therapeutic interventions recommended and offered by health care professionals to women experiencing anorexia, the research indicates that the evidence of efficacy of these is often questionable and still requires development (Bulik et al., 2007). This research is partly concerned with experiences of seeking and receiving professional help for anorexia and what this is like for different women. In this respect, it is important to examine and begin to understand how the wider context of therapy helps shape, and has an impact on, experiences of being a mother with anorexia.

Having provided a brief overview of mainstream understandings and therapies for anorexia, I now review social and psychological perceptions of mothers and motherhood, to enhance a greater understanding of other dominant discourses that may be influencing women who are mothers.

Social and psychological understandings of motherhood

Current dominant western socio-cultural understandings of mothering and motherhood can be oppressive to women (Mack, 2018; Ross, 2016). What emerges consistently from literature and research underpinned by biological or essentialist imperatives, is an image of the socially dominant and idealised mother as one who is devoted to the care of others and particularly her children (Ross, 2016). She is self-sacrificing, 'not a subject with her own needs and interests' (Bassin et al., 1994, p. 2). Dominant understandings of motherhood espouse the view that nurture and selflessness go hand in hand (Malacrida & Boulton, 2012) and in contemporary Western societies, the 'good mother' is an 'intuitive nurturer' (Krane & Davis, 2002, p.172), 'responsible' (Miller, 2005, p. 25), a mother who will put her children's needs above her own (Hays, 1996) and is 'predominantly happy' (Johnston & Swanson, 2003, p. 23). These constructions of the 'good mother' are built on ideals of what mothers should

be and are potentially oppressive to women, arguably presenting women with an unattainable ideal.

Although there *is* feminist research that captures the diversity of women's actual experiences of being a mother (e.g. Arendell, 2000; Chase & Rogers, 2001; Green, 2018; Miller, 2005; Taylor & Bloch, 2018), contemporary formulations of 'the good mother' continue to be influenced by essentialist assumptions in popular discourses that sculpt women's lives (Goodwin & Huppatz, 2010; Miller, 2005).

If a woman appears to fail in the role of 'the good mother' a discourse of blame is readily available (e.g. Courcy & des Rivières, 2017; McLaren, 2013). 'Mother-blaming' holds women responsible for the 'actions, behaviours, health and well-being of their (even adult) children' (Jackson & Mannix, 2004, p. 150). 'Mother-blaming' is an insidious practice that is particularly reflected in the attitudes and interactions that some health professionals hold in relation to women and is reflected in therapies for women experiencing eating disorders such as anorexia (Allan, 2004; Jackson & Mannix, 2004; Kaplan & Garfinkel, 1999; Ramjan, 2004). Contemporary competing discourses of the 'good' and 'bad' mother polarise the experience of motherhood in a way that does not take account of what the paediatrician and psychoanalyst D.W. Winnicott termed 'the good enough' mother. Winnicott (1964) originally advocated for the idea of the 'good enough' mother in a bid to defend the ordinary parent against formulations of the idealised mother and what he considered to be increasing intrusion into the family from health professionals (Jacobus, 2005). This is echoed in research by Jackson and Mannix (2004), where they found that health professionals contributed to this sort of intrusiveness by 'mother-blaming' in their interactions with women. Vander Ven (2003) examined trends in 'mother blaming' in accounts of the aetiology of anorexia in children and found that ideas of 'proper' social roles for women were interconnected with this 'blaming'. There are studies that have found that mothers and fathers do not share the same values and caregiving expectations with regards to their children

(Lamb et al., 1989) and that traditional discourses about 'women's work' confer responsibility for caring for the family onto mothers (Martin & Lippert, 2012).

The phenomenon of mother blaming and shaming is comprehensible within these contexts where the mother is largely held responsible for the health and well-being of her children (McLaren, 2013). Phares (1992) and Rohner and Veneziano, (2001) suggest that the lack of research pertaining to paternal influences on child and adolescent development is due to the societal norm whereby the mother is the child's main caregiver. This reinforces the idea that the mother is responsible for a child's psychological well-being, in addition to the development of maladaptive behaviours (East et al., 2006). These ideas are considered to be the basis for insidious mother-blaming attitudes (Jackson & Mannix, 2004; Phares, 1992). Furthermore, fathers or other significant caregivers have not been held responsible in the same way for their children and the father's role 'in caregiving has too often been missing from public policies, from systematic data collection and research, and from efforts to promote women's empowerment' (Levtov et al., 2015, 16).

Although the fact that men also experience anorexia has been documented in the literature (Hudson et al., 2007; Paterson, 2008), eating disorders are disproportionately experienced by women (American Psychiatric Association, 2013). Research has shown that the general public associates eating disorders in men with reduced masculinity (Räsänen and Hunt, 2014; Robinson et al., 2013) and that muscularity-oriented body and eating concerns (rather than concerns with being thin) are associated with conformity to masculine appearance norms for men (Griffiths et al., 2014; Pope et al., 2002). It is understandable then that the discourse around eating disorders is predominantly gendered; cultural meanings of food and the thin female body as represented in Western culture and feminist literature often focuses on the contradictory nature of femininity and the pursuit of being thin (e.g., Bordo, 1990, 2004; Lester, 1997; MacSween, 1993; Malson, 1998). Bordo (1990, 2004) argues that thinness can be attractive to women as it is directly related to the characteristics of autonomy, power and control that are viewed as being more masculine. Having an awareness of these

narratives is useful in making sense of what might be contributing to mothers' various experiences of their eating disorder, within and outside of the health care system. The following section highlights pervasive contemporary narratives around eating, body shape and size in acknowledgement of the fact that this is another context that might be influential in women's (and mothers) lives.

Contemporary social norms and pressures around eating, body shape and size

The notion of 'normative discontent' is recognised as being pervasive in western society. This term describes the pervasive dissatisfaction that women experience with regards to their body weight and shape (Cash & Henry, 1995; Rodin et al., 1984). There is a widespread portrayal of body shapes and sizes that are difficult or impossible to achieve healthily. Grogan (2017) and Halliwell et al. (2005) both described the destructive effects of such media portrayals on women's body image and eating habits. It is not surprising that people often feel conflicted and confused about how to feed themselves (Dodds & Chamberlain, 2017; Spiteri & Moraes, 2015). This extends to how parents might feed their children in a healthy and 'normal' way, while also conforming to the proliferation of conflicting societal and media messages about what is perceived as 'healthy' and 'normal' in terms of food, eating and physical appearance (Eckstein et al., 2006; Vereijken et al., 2011). The next section will focus on how eating disorders (and anorexia) have been conceptualised in critical feminist perspectives on the subject.

Critical feminist approaches to eating disorders

There have been significant developments in the field of critical feminist approaches to eating disorders that take account of how food and eating, bodies, weight, appearance and gender are comprehended and signified (Bordo, 1993; Holmes, 2016; Malson & Burns, 2009). Eating disorders are theorised as being constituted in and by the discursive contexts in which we live, as opposed to being viewed as individual psychopathologies that are peculiar to particularly divergent individual women. This critical feminist perspective questions the idea that anorexia exists beyond its construction in medical discourses (i.e. that 'anorexia' is not an objective reality, but rather is a

medical construct, situated in a particular time and place). Some feminist scholars argue that distress around eating and bodies is on a continuum encompassing 'normal' women and women with eating disorders, informed by the practices and discourses of normative femininity (Malson, 1998; Saukko, 2008).

Critical feminist approaches allow for the possibility of multiple and contradictory influences on the individual in making sense of particular types of experiences. For example, although Bordo's (1993a) theorises that self-starvation represents a conformist 'bodily crystallisation' of society, self-starving could be viewed as an act of defiance if it occurs in a society with an emphasis on 'health'. Anorexia has been re-theorised in a way that rejects the idea of distinguishing between 'pathological' and 'normal', offering an alternative conceptualisation of it as something that is 'culture bound' and references phenomenology, post-structuralism and post-modernism (Eckermann, 1997). Thus, anorexia can be understood as embodying practices and discourses of 'containment and discipline as well as embodied agency and resistance' (Holmes, 2016, p. 467). Reflecting on the idea that discourses on anorexia (and motherhood) are gendered, political and social, critical feminist perspectives on these constructs are important to consider in terms of highlighting 'the rarely explored disempowering underside of diagnostic discourses that define and treat eating disorders' (Saukko, 2008 p.7). These ideas have relevance for this research in offering an alternative lens through which to view the experience of anorexia for mothers. The following section offers a consideration of literature that focuses on the lived experience of eating disorders and anorexia and offers an 'insider's perspective on what these are like.

Exploring the lived experience of eating disorders and anorexia

Given that 'eating disorders' are classified in DSM-V as a 'mental disorder', it is important to recognise that this is the dominant discourse that informs the training and practice of many healthcare professionals. Thomas Szasz, an influential US psychiatrist, argued that in many ways 'mental illness' does not exist; but is a socially created category, used for the purposes of social control

and that the phenomena that we understand to represent as ‘mental illness’ is a consequence of the attempt to confront and to tackle the problem of how to live (Szasz, 2010). Using a research methodology that illuminates ‘problems in living’ is important in offering an alternative to more traditional quantitative research methods that are grounded in positivist and post-positivist research paradigms (Ponterotto, 2005). Providing an alternative to medicalised accounts of understandings and treatments of anorexia, there is a growing body of research that prizes women’s narratives and experiences as a means of gaining a deeper understanding of the lived experience of eating disorders for women (Patching & Lawler, 2008).

Some studies have used qualitative inquiry to elucidate individual experiences of the development of, living with and recovering from eating disorders (Garrett, 1998; Hardin, 2003; D’Abundo & Chally, 2004; Lamoureux & Bottorff, 2006; Patching & Lawler, 2009; LaMarre & Rice, 2015), whilst other qualitative research has illuminated experiences of seeking and receiving support for anorexia (Conti et al., 2017; Eli, 2014). In an exploration of women’s narratives about their eating disorder, Patching and Lawler (2009) found that women’s narratives and experiences were significantly themed around control, connectedness and conflict, in both the development of and recovery from their problems with eating. Other research has covered many different aspects of how it is to live with an eating disorder. For example, a study by Tozzi et al. (2003) used interviews to explore anorexic patients’ subjective accounts of the causes of their anorexia and factors that supported their recovery, while Paquette and Raine (2004), explored how women’s personal and sociocultural context influences their body image. Burton (2014) interviewed pregnant women who had eating disorders and found that they experienced their pregnancies as traumatic. Other research by Collins et al. (1998) investigated the daily lived experiences of women with eating disorders and one of the major implications of their study was that a better understanding of how eating disorders affect women on a day-to-day basis is needed to enhance the therapeutic process.

What is important about these studies is that the findings are directly related to the ways in which individual's first-hand experiences are variously communicated and described; where the women have been offered a platform from which to speak and be heard (as opposed to being told what they are like). Considering the idea that elucidating women's experiences of their eating disorder can better inform support (through taking account of what they tell us is significant, useful, and otherwise), it is helpful to examine the research around the lived experiences of interventions and support for anorexia to shed some light on how that might be for some women.

Some of the research on the lived experiences of treatment for anorexia highlight the shortcomings of what is offered to women in terms of support. The women in a study by Burton (2014) perceived their treatment as 'inadequate', while a case study, exploring the lived experience of an adolescent undergoing Maudsley family therapy, found that the participant and her family experienced the approach as blaming (Conti et al., 2017). Research by Le Grange & Gelman (1998) found that a significant minority of their participants felt that causes of the illness were dealt with inadequately in treatment, and that behavioural strategies were insufficient when symptoms were too overpowering. These findings of unhelpful experiences of treatment are reinforced by other research that illuminates the ways in which treatment for eating disorders has been experienced by women as particularly unhelpful and pathologising (Burns, 2004; Eivors et al., 2003).

Other research on lived experiences have used the insights gained from their participants to challenge the ways in which we conceive of recovery. Consideration of how lived experiences of an eating disorder have been researched from a critical feminist perspective offers a gendered lens from which to regard women's accounts of how experiences of support for anorexia is felt. LaMarre and Rice (2016) found a 'biopedagogy of eating disorder recovery, which offers individuals in recovery sets of instructions for how to be healthy that run in opposition to dominant prescriptions for health' (p.136). If what is being offered to individuals in treatment runs counter to other

dominant discourses, it is likely to be confusing for the individual and 'recovery' may be more challenging to maintain. Similarly, Malson et al. (2004) explored how the 'eating-disordered patient' was discursively constructed through the accounts of women experiencing treatment for anorexia. This study questioned the 'normality' of the treatment the women received, where the treatment experiences echoed a similar 'micro-management' of the body, evident in the experience of anorexia itself. Gremillion (2002) discussed how notions of 'feminine fitness' are constructed in ways that are central to having and being treated for an eating disorder (where the female body is understood as a 'resource'). Gremillion (2002) contended that the discursive practices related to eating disorders are reproduced in the treatment for these, which are attached to 'culturally normative ideals' and may have problematic implications for 'recovery' from anorexia for women who do not readily embody (or wish to embody) these 'ideals'.

The research outlined above reinforces the idea that the ways in which therapeutic interventions for eating disorders are conceived, constructed and executed are not always experienced as being beneficial to the woman accessing support and can often impede the likelihood of an increased sense of well-being. My argument here is that universal changes in thinking are needed in order for health and mental health professionals to become more accepting of a diverse range of bodies, rather than perpetuating stereotypes that can often interfere with recovery from eating disorders (LaMarre and Rice, 2015).

Offering an alternative to the research outlined above, other studies on lived experiences of anorexia have explored what has been perceived as helpful in supporting individuals experiencing eating disorders. For example, de la Rie et al. (2006) found that treatment in a specialised unit was perceived as being most helpful by participants. Other research on the lived experiences of women receiving professional support for an eating disorder highlighted the utility of retaining a focus on both the physical symptoms and underlying issues in the support they received (Pettersen et al., 2010; Le Grange et al., 1998). Other studies have illuminated more nuanced communications from their participants.

For example, a study by Eli (2014), exploring the narratives of individuals who had been hospitalised for treatment of their eating disorder, found that participants' accounts were concerned with the dynamics of difference and belonging and that this ambivalence had protective qualities in the context of treatment. Another study, exploring patients' experiences of a psycho-educative programme for eating disorders, found that narratives centred around 'self-development, self-determination and personal decisions to make changes' (Pettersen et al., 2010, p.16).

What emerges from the studies that use qualitative inquiry is often novel, surprising and challenging to previously received wisdom or assumptions about eating disorders. The handful of studies on the lived experiences of eating disorders highlights the diversity of experiences and findings that emerged from the data, serving to remind us that living with an eating disorder is experienced by women in multi-faceted and nuanced ways. Through listening to these voices, we gain a greater understanding of what might help and what we might wish to adapt in supporting individuals. Having examined research on mothers, eating disorders and anorexia, I now consider the research on mothers experiencing anorexia.

Research on mothers experiencing anorexia

As evidenced from the sections above, there is a growing body of largely feminist research exploring lived experiences of eating disorders (Bordo, 1993a; Fairburn & Beglin, 1990; Hepworth, 1999; Hoek, 2006; Malson, 1998; Malson & Burns, 2009; MacSween, 1993). However, the experiences of women who are mothers and are living with anorexia are woefully under-researched, within the field of counselling psychology, and psychology more broadly. Some of the research that does exist slips into pathologising the mothers by implicitly or explicitly mother-blaming in their analysis, while other studies are more compelling and less problematic in that they present a more holistic view of aspects of being a mother living with anorexia.

Some research on mothers with eating disorders reproduces dominant discourses around mother-blaming, where the mother is held responsible for their children's relationships with food and eating and with their bodies (Birch & Fisher, 2000). This tendency to mother-blame is further exemplified by case reports of mothers with eating disorders restricting the amount of food in the house (e.g. Stein & Fairburn, 1989), not cooking for their children (e.g. Woodside & Shekter-Wolfson, 1990) and not eating in front of their children, (e.g. Evans & le Grange, 1995). Other research has reported children of mothers with eating disorders failing to thrive (e.g. Brinch et al. 1988; Stein & Fairburn, 1989; van Wezel-Meijler & Wit, 1989; Vignallou, 2006). It is evident that these research studies on mothers with eating disorders are underpinned (explicitly and implicitly) by an anxiety that women with eating disorders may fail in a key maternal role, by not adequately nourishing their children.

Some qualitative studies offer a more holistic sense of what the experience of being a mother with anorexia can be like for these women. Fogarty et al. (2018) explored the experience of the perinatal period for women with eating disorders and found that pregnancy represented a period of stress and anxiety for many of the women in terms of managing the needs of the eating disorder and the unborn child. They also found that some women experienced a positive change in their eating habits and body image during pregnancy. Other qualitative research on 'treading the tightrope' between motherhood and an eating disorder heard participants talk about the challenge of maintaining a balance in which they were able to respond to their eating disorder, whilst putting the needs of their child first (Tierney et al., 2011). Motherhood has also been shown to have a positive impact on the experience of an eating disorder. Tuval-Mashiach et al. (2013) explored how mothers with eating disorders perceived the impact that their eating disorder might have upon their children. Although some of the themes in this study highlighted beliefs around not being good enough, involving the children in the eating disorder and coping strategies employed by the mothers, the idea that motherhood could also be a positive catalyst for recovery from the eating disorder was also evident in the data.

This supports findings from quantitative research by von Soest and Wichstrom (2008) that demonstrated that motherhood can have a positive effect on eating problems. In addition to this, a study conducted by Franzen and Gerlinghoff (1997) documented the fact that, although for some mothers becoming a parent can prove a major obstacle to recovery, perceptions of the negative impact on children of the eating disorder can also act as a catalyst for seeking treatment and making positive life changes. Research by Papadopoulos et al. (2013) also echoed the protective aspects of childbearing for women experiencing anorexia. What these studies have in common is that they offer multi-dimensional pictures of what the lives of the mothers participating in their research were like, emphasising the positive and protective factors that motherhood can have upon the experience of anorexia, alongside that of the more challenging aspects of being a mother with anorexia.

Other qualitative research on mothers experiencing anorexia are less holistic in the ways in which they choose to present their findings. Psychiatric nurse researcher, Rortveit (2009) explored the experience of motherhood in the context of eating difficulties. The findings centred around a main theme of “experiencing guilt as a mother in the context of eating difficulties” (p.603). This research seemed to focus specifically on eliciting the difficulties experienced by these mothers in a way that echoes other research that implicitly pathologises women. The theme of guilt is used to encompass all the experiences described by the mothers in relation to their being a mother with an eating disorder. I argue that this interpretation is narrow in its focus and does not attempt to unpick the subtleties of the communications from the mothers in ways that might be more meaningful and compassionate. The interpretations seemed to be made from a non-critical standpoint that accepted the dominant narratives around motherhood; resulting in themes that were centred on guilt.

An Australian study, conducted by Stitt and Reupert (2014), focused on the lived experiences of mothers with eating disorders. Some of the feelings expressed by the mothers in this study were similar to those described by Rortveit (2009) but were not labelled under a theme of guilt and this study is thus less-

pathologising in this respect. However, other aspects of their approach are more problematic in terms of how they present the mothers in their study. Although their findings were that mothers experienced competing demands between their eating disorder and children, and that children were often a reason to recover, they chose to entitle their research 'Mothers with an eating disorder: 'food comes before anything''. This suggested that this was the main finding of their research and is implicitly pathologising of their participants, in that it focuses narrowly on one aspect of the findings in a way that implies that food is more important than children for mothers with an eating disorder. It does not express the nuanced and sometimes conflicting experiences that the women expressed in relation to the competing demands of motherhood and experiencing anorexia. In this way, it also perpetuates, re-creates and contributes to the dominant discourse of 'mother-blaming' in some research on mothers with eating disorders.

Some research offers more specific ideas for supporting women in their role as mothers, in the context of their eating disorder. A study by Bryant-Waugh et al. (2007) focused on the development a group intervention for mothers with eating disorders that was described as 'acceptable' and 'supportive' by the women experiencing the intervention. Fogarty et al. (2018) highlighted opportunities for interventions at particular stages in pregnancy (when the women experienced more acceptance of their bodies and where their desire to protect the health of their unborn child was most strong). Fogarty et al. (2018) also recommended educating health care professionals and providing ongoing support for the women beyond their pregnancies.

Additional qualitative research into mothers with eating disorders will serve to promote a more comprehensive understanding of these experiences for these women, through offering a space in the literature for their narratives to be spoken and heard (Bryant-Waugh et al., 2007).

The current study

This study aims to elicit the lived experiences of mothers who have experienced anorexia, in order to comprehend more fully what it might feel like to be them and how the world appears through their particular experiential lens. The research will also focus on the women's experiences of seeking and receiving professional support for anorexia in a bid to contribute to a greater understanding and development of therapeutic interventions for this group of women.

Research aims

This research aims to explore:

- The experiences of women who have lived with anorexia while raising their children.
- What sense these women make of their experience of mothering in general and of feeding their children and educating them with regards to food and concepts of body shape and size.
- The experiences of these women in seeking/receiving help for anorexia.

Contribution to counselling psychology

This research subject is relevant to counselling psychology, in that the counselling psychology field is concerned with locating itself within the wider 'world of helping' (Woolfe, 2016), and more specifically with understanding and formulating client experiences (Johnstone & Dallos, 2013). A central tenet of counselling psychology is that human experience is at the heart of ethical, clinical and research endeavours (Cooper, 2009). Through the focus on lived experiences of a particular group, this study is congruent with the concern within counselling psychology to engage with values, beliefs, subjectivity and intersubjectivity, through respecting first person accounts and maintaining an awareness of the impact of social contexts on individuals (British Psychological Society, Division of Counselling Psychology, Professional Practice Guidelines, 2006).

This study aims to put counselling psychology ‘values into action’ (Cooper, 2009) through situating it in a practical context that contributes to a greater understanding of the complex, diverse and nuanced life-worlds that some mothers who have experienced anorexia are operating from. This study acknowledges that the life-worlds of women who are mothers, and who have experienced anorexia in this context, are under-represented in the literature, and that where this group of women *have* been represented, it has often been in a pathologising manner. Counselling psychology seeks to facilitate growth, actualise potential and empower clients (Kasket, 2016) and this research aims to offer an alternative non-pathologising account of this group of women to add to the body of literature on this subject. Counselling psychology has a strong emphasis on well-being and human potential and challenges defining psychological distress in medical terms (Strawbridge, 2016). This research aims to embody this emphasis, through offering an alternative, empathic way to conceptualise the distress that these women experience and to advance a more compassionate way of talking about, talking to and supporting these women.

Methodology

Interpretative Phenomenological Analysis

This research uses a qualitative methodology, and specifically interpretative phenomenological analysis (IPA), to explore the experiences of six mothers who have experienced anorexia while raising their children.

Qualitative research provides a way of describing and developing insights into, and interpretations of, particular experiences (Smith, 2003; Willig, 2008). IPA is concerned with facilitating a detailed examination of personal lived experiences (Eatough & Smith, 2017). This makes IPA an appropriate methodology for gaining a detailed and in-depth understanding of what these particular experiences mean for each of the women. Although the epistemological assumptions of IPA concord with those of counselling psychology, in terms of prioritising subjective and intersubjective experiences (Kasket, 2016), it is also recognised that other methods of investigation might have been usefully applied to a study of mothers with anorexia (such as thematic analysis or

grounded theory). IPA was chosen as the methodology for this research as it coheres with the research aims in exploring lived experiences. The lived experience of mothers with anorexia is an appropriate subject for IPA, as the personal meanings ascribed to the experiences, and the context in which they occurred, is crucial to an understanding of the psychological world of the respondent. The phenomenological idea that the body is central to our 'life-world' and how we communicate with the world (Moran, 2000) is important in the context of this study, in theorising how the participants make sense of their embodied sense of self in their communications with the world. It also resonated well with my identity as a counselling psychology practitioner and researcher to use a methodology that parallels the 'double hermeneutic' process of therapy, in making sense of the individual making sense of their experiences.

IPA draws on ideas and concepts from both phenomenology and hermeneutics and combines interpretative and idiographic components (Gill, 2014). IPA is used to examine in detail the lived experiences of people in a way that seeks to unravel the meaning of particular experiences (interpretative) while focusing on 'that which is experienced in the consciousness of the individual' (Smith et.al, 2009, p.13) or is 'phenomenological' about these experiences. In this respect, the research participant is the 'experiential expert' in the phenomenon that is being studied (Eatough & Smith, 2017). In conducting an IPA study, this second level of interpretation is grounded in the text, but there should always be an awareness on the part of the researcher that this is necessarily more 'tentative' and 'speculative' than the first more descriptive level of interpretation (Willig, 2008). The idiographic orientation of IPA allows for an emphasis on the importance of the 'particular' (Smith et.al, 2004). In IPA, Smith et al. (2004) emphasised the fact that there is an implicit commitment to making sense of how certain 'experiential phenomena' have been understood, by particular people, in a particular context. In addition to this, although the analytic process in IPA travels from individual cases to more general assertions, there remains the space within the process to prioritise 'particular claims' for the individual

participants (Smith et.al, 2004). This is especially relevant to my study where it is valuable to hear the individual voices of the participants, within the context of their life-worlds, but also to draw out broader themes and concerns where appropriate.

Researchers using IPA recognise the fact that a variety of assumptions and preoccupations are unavoidably inherent in the process (Eatough & Smith, 2017). Engaging with, and reflecting upon these, in the context of interpretations and insights that emerge as part of the research, is an intrinsic part of the process of IPA, as is an acknowledgement of the fact that it is 'an always-unfinished activity' (Eatough & Smith, 2017, p. 6). It is important to acknowledge that the theories and concepts informing interpretations in this research are largely drawn from relational, integrative psychotherapeutic constructs that privilege remaining open to intrapsychic and interpersonal dynamics, while remaining aware of particular sociocultural contexts (Finlay, 2015). In counselling psychology research it is particularly important to maintain a curious reflexive attitude on how, and in what ways, the researcher has shaped each stage of the research, from its inception through each part of the process; remaining open to the paradoxes and differences in perspectives that IPA inevitably highlights (Kasket, 2012).

Eatough (2006) argued that, while IPA acknowledges that there are many influences on experience (historical and cultural 'situatedness' including language and social practices), this 'contextual' analysis only represents a part of what is occurring. In her study on anger and meaning-making she posits the idea that the narratives we share are also related to our capacity for 'human potential' and development in the way in which we construct the stories of our lives through the process of linking our past, with our present and future. This current research similarly includes explicit and implicit narratives that are representative of this human potential and capacity for positive personal growth. Concordant with the theoretical foundations of IPA, this study aimed to explore the personal lived experiences of mothers with anorexia through giving detailed attention to each woman's account of how it was for them. This

included an exploration of the meanings that the participants ascribed to these experiences and what sense they made of these in different contexts through exploring, describing, interpreting and situating how, why and in what ways, they made sense of these.

Recruitment of Participants

The relatively small sample size recommended for IPA (Smith et al., 2009) allows for a deeper and richer analysis of individual experiences than is typically possible in qualitative research oriented to identifying patterns of meaning across a dataset. Although Smith (2003, p.54) commented that there is 'no right answer to the question of sample size' in IPA research, there is the 'rule of thumb' pragmatic suggestion that between four and ten participants is acceptable for a professional doctorate thesis (Smith et al., 2009). Keeping this in mind I reviewed the data set with my supervisors after six interviews were completed. The resulting stories and experiences were notably diverse, and it was decided that this represented sufficiently vivid, distinct and powerful narratives about participants' experiences of being a mother whilst experiencing anorexia, maintaining a good balance between the individual stories and overall themes.

The recruitment criteria were that participants were mothers of at least one birth child, they were over 18 years of age, and had been formally diagnosed by a health professional as having anorexia and now considered themselves to be recovered. Individuals who considered themselves to be still experiencing anorexia were excluded from the research. Inclusion and exclusion criteria were adhered to in order to have participants who could speak to the research question, in terms of their experiences as a mother who had anorexia and to minimise the vulnerability of those participating in the research. Anorexia was chosen above other eating disorders in response to the pathologising nature of much of the available literature on mothers with anorexia. It was important for the women to have had a formal diagnosis in order to have individuals that had experienced this medical process.

Five of the six participants were recruited through the UK's eating disorder charity, Beat. Beat supports and promotes postgraduate research on eating disorders; for research to be advertised on its site, the research proposal and procedure must be submitted and approved in line with their policies and procedures (Appendix II). In addition to this, Beat offers advice to potential research participants where participant well-being is considered paramount. These factors felt important in maintaining ethical standards for recruitment in line with the British Psychological Society (BPS) standards and Code of Ethics and Conduct (2018). The remaining participant was recruited through a contact of the researcher. This participant was given the same information as was made available on the Beat website with regards to the study.

All participants were invited to complete a short demographic questionnaire in order to understand some basic details about the range of women taking part in the study and to 'situate' the sample as recommended in quality guidelines (Elliott et al., 1999). Participants age range, number of children, ethnicity employment and relationship status are shown in Table 1.

Table 1. Participants demographics

Participant	Age range	Number of children	Ethnicity	Employment status	Relationship status
Alison	40+	3	White British	Employed part time	Married
Gail	40+	2	White British	Employed part time	Married
Jane	40+	4	White British	Full-time homemaker	Divorced and currently single
Jess	Under 20	1	White British	Student	In a relationship
Kate	50+	4	White British	Employed part time	Married

Vicky	40-	2	White British	Employed full time	In a relationship
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Smith et al. (2009) suggested that it is desirable to find a reasonably homogenous sample in order that an exploration of the research question will be meaningful. In this study, the sampling was purposively homogenous in that all participants were female, mothers and had experienced anorexia while bringing up their children. However, it is also important to highlight their differences in terms of the number of children they had, their age, employment and how open I felt they were prepared to be in talking about their experiences. Some participants talked very freely about difficult, upsetting and what they experienced as shameful experiences, while there was the sense of other participants being more guarded in what they were willing to share.

Interviews

Semi-structured in-depth telephone interviews with participants were conducted. Participants were given the choice of face-to-face, telephone or Skype interviews. All six chose to be interviewed by telephone. The length of the interviews ranged from 52 minutes to 70 minutes, with an average length of 63 minutes. Participants were all in their homes when the interview took place. The women were e-mailed a participant information sheet (Appendix III), consent form (Appendix IV) and demographic information form (Appendix V). Written informed consent was obtained and demographic forms were returned before the interviews took place. The study received ethical approval from the first author's Faculty Research Ethics Committee. At the beginning and end of each interview, participants were given the opportunity to ask questions about the research. They were also given the opportunity to receive a short summary of the findings on completion of the research.

Interviewing is the recommended way in which to collect data in IPA and semi-structured or qualitative interviewing is considered to be the 'exemplary' form of interviewing in this methodology (Smith, 2004).

Participants were given a choice of face-to-face, telephone or Skype interviews as it allowed them a degree of control over the research process (Hanna, 2012). Pragmatically, it also meant recruitment was not limited by geography. and was cost efficient in terms of not incurring travel or room booking costs (Shuy, 2003). It felt particularly important to offer an alternative to (virtual) face to face interviewing in this research due to the greater anonymity afforded by a telephone interview and that potentially 'sensitive' subjects might be more easily discussed (Glogowska et al., 2011; Greenfield et al., 2000). It has often been assumed that face to face interviewing is preferable to other interview modes (Ryan et al, 2009; Schultze & Avital, 2011), because it allows the use of respondents' body language as a guide to questioning and interpreting particular comments. However, what has also been shown to be key is that the fit between the needs of the participant and the interview mode is perhaps the most important consideration in order to generate rich data (Deakin & Wakefield, 2013; Hanna, 2012).

Participants were asked planned and responsive open-ended questions (e.g. 'can you tell me about your experience of anorexia?'). Initial questions led on to more searching questions about how they made sense of their experience of living with anorexia and whether, and in what ways, it impacted on their experience of motherhood (e.g. the experience of day to day living with anorexia, the impact on their life, how they experienced motherhood, and what sense they might make of these experiences).

Some technical and practical difficulties arose as the result of the use of telephone interviewing. In the case of one participant, the phone line cut out on numerous occasions during the interview. This interrupted the flow of conversation at various junctures, which was distracting. While interviewing another participant, one of her children came into the room to ask a question. This interrupted the flow of that part of the interview. This raised the question of whether the possibility of being interrupted might have impacted on the information offered by the participant. Although all participants were asked at the beginning of the interview if they were able to talk for approximately an

hour, these were unpredictable interruptions. The other interviews ran smoothly with no problems or interruptions. The rapport created in the interviews felt relatively easy. The rich and detailed quality of the data and the intimate disclosures of often painful and traumatic experiences, in some of the interviews, would seem to support the idea that participants felt comfortable enough to talk freely.

The telephone interviews were audio-recorded and transcribed verbatim using Braun & Clarke's (2013) transcription notation system for orthographic transcription.

Piloting

The interview schedule was piloted with one participant, in order to address any potential issues with the interview schedule or the interview itself (Kvale & Flick, 2007). The questions were refined to be more specific and possible follow up questions were discussed in supervision. The pilot interview formed part of the final sample as I and my supervisors concluded after careful consideration, that this interview provided rich enough detail and depth to merit inclusion.

Ethics

Ethical approval for the study was granted by the Health and Applied Sciences Faculty Research Ethics Committee (FREC) at the University of the West of England (Appendix IV). The BPS Code of Human Research Ethics was adhered to throughout the course of the research process. The participants were made aware that the opportunity for withdrawal would not be possible in the latter stages of the research. Participants were ascribed a pseudonym to protect their anonymity and possible identifying features (e.g. family members names or geographical locations) in the transcripts were disguised.

Reflexivity

Reflexivity in research enables the researcher to adopt a 'critical attitude' towards the potential impact that they may be having in all parts of the process (Finlay and Gough, 2003). I was aware that I arrived at this particular research subject as a result of a variety of influences that prompted the idea that this

could be useful and interesting to the field of counselling psychology, in addition to representing a study in which I could be personally and professionally invested. Many of the stories I heard in therapy sessions, with women experiencing (or having previously experienced) anorexia, had a common theme of not feeling 'understood' or treated well in NHS settings for anorexia and that 'recovery' was often viewed by clients as being 'in spite of' rather than a result of these interventions. Whilst being interested in the fact that this appeared to be a common narrative (and wondering why this might be so), I tried to bracket the assumption that mainstream therapies for anorexia are not always helpful when conducting the research. In addition to this, I became aware through reading the literature on the subject and talking to academics and other clinicians, that older women experiencing anorexia (and in particular those who are mothers) are under-represented in mainstream and critical feminist research.

As a woman and a mother of three children, I am aware of feeling the weight of (internal and external) 'mother-blame' and how this is often associated with social norms and expectations of feeding practices, nurture, body weight and size in relation to one's children. Although I have not personally experienced an 'eating disorder', I am aware of experiencing 'normative discontent'. This, coupled with having often experienced the process of feeding my children as frustrating and anxiety-provoking, led me to wonder how it might be for other women who have more complex relationships with food to experience this aspect of parenting. I also acknowledge that, within an interpretative phenomenological framework, 'bracketing' is understood as an idealised process that is not fully achievable, as all perceptions are shaped by our previous experiences and current contexts (Smith et al., 2009).

In conducting the interviews by telephone and not having sight of the participants, I often experienced a fantasy about their physical embodiment and presentation in the world and how this might contrast with my sense of my own physicality. I questioned how the experience of face to face interviewing might have differently impacted on the research, wondering whether it might have

positively or negatively influenced the researcher/participant alliance. Although it is impossible to know for sure, my sense is that face to face interviewing would have aided some aspects of the research in perhaps being able to forge a stronger, more immediate bond, but that, in losing the physical anonymity afforded by the phone, some participants might feel less inclined to talk so openly about difficult experiences.

I was aware that I experienced some conflict between my identities as researcher, therapist, woman and mother, during the process of interviewing. I held a close awareness that, having worked therapeutically with individuals experiencing anorexia, I might be bringing a variety of assumptions or ideas to my experiences of research participants. I often felt the pull of my therapist identity, particularly at especially poignant or affecting parts of their narrative. I was aware of the struggle in myself in avoiding therapeutic responses and resisting the desire to interpret or offer interventions at several junctures. In these situations, I used the method of summarising what the participant had disclosed to communicate my understanding of their experience without confusing the participant/ researcher role with that of client/therapist. I was aware of consciously adopting an open and non-defensive manner with each participant, particularly at the beginning of each interview. This mirrors my clinical approach with clients, in attempting to minimise the power differential inherent in the therapist/client (and researcher/participant) dynamic. What was unique to the research experience was the aspect of self-disclosure, in that I was open about my status as a mother and that I had not experienced anorexia. In this context it felt appropriate to be transparent about aspects of my own identity.

I identified strongly with some of the participants descriptions of the challenges involved in responding to one's own needs and desires, in addition to that of one's children. I was aware of having internalised some dominant social discourses on motherhood and mothering; in particular the idea of the 'idealised' mother persona and the blame and shame involved in perceptions of falling short of this ideal. This created a sense of commonality of experience

with some of the participants that I felt aided my understanding of, and empathy with them, whilst trying to maintain an awareness of their unique individual experiences and life-worlds. Remaining conscious of the ethics of the research and my role in this, was paramount in maintaining a professional researcher stance, whilst staying empathic and open to the stories the women shared with me.

I kept a research journal for personal reflection and used supervision to discuss the process of the research. Remaining vigilant of all the possible subjective roles and assumptions, both 'in the moment' with participants, and retrospectively in the analysis, helped develop my capacity to reflect on the experience of being a researcher, whilst maintaining respect for the 'knowledge, insight, experience and expertise of participants' (BPS, 2014, p.8).

Data analysis

I carried out the analysis following a six-step process, recommended by Smith et.al. (2009). The first step involved repeated reading of the interview transcripts and listening to the audio-recordings of the interviews which led on to organising and interpreting the data in order to begin to be able to identify emergent themes (an interview extract with initial notes is to be found in appendix VI). Super-ordinate themes were developed by linking themes that evolved from the data, through an examination of similarities across the themes. This process was repeated on a case by case basis, for each set of data, followed by taking a holistic approach to the data; where patterns, similarities and differences were identified across transcripts and super-ordinate themes were developed.

Results

Table 2: IPA analysis of lived experiences of mothers with anorexia

<u>Super-ordinate theme</u>	<u>Emergent theme</u>	<u>Codes</u>
Being and feeling different from others.	Slipping under the radar: not being seen	Visibility
		Invisibility

This theme reports on how the women experienced and made sense of living in their particular life-world in the context of their experience of anorexia.		Misunderstood
	Experiences of blame and shame	By others
		By Self
		For anorexia
		For being a 'bad' mother
	Engagement with an anorexic identity	Anorexia as a separate identity
		Rejecting of separate identity
		Feeling different
Competing demands of motherhood and anorexia This theme reports on participants' accounts of the challenges and positive aspects involved in being a mother experiencing anorexia.	Impact on the children	Desire not to impact children
		Fear of judgement
	Role reversal	Mother as child
		Child as parent
	Children as a reason to recover	Protective factor
		Triggering of anorexia
		Positive long-term outlook
Disparate and diverse experiences of seeking and receiving support This theme reports on how the women made sense of their various experiences of seeking and receiving support for their experience of	Difficulty being mother and client	Child care
		Can't put self first
	Feeling (mis)understood	Positive support
		Unhelpful support
	Ongoing support	Necessary for health
		Not available
		Afraid to ask

being a mother with anorexia.		
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After closely coding each data set and immersing myself in the life world of each participant, I have arrived at 3 super-ordinate themes that are outlined in Table 2 and described in detail below

Super-ordinate theme 1: ‘We live in a topsy turvy Alice in Wonderland world’: Experiences of living with anorexia as being and feeling different from others

The first super-ordinate theme captures how the participants made sense of their experiences of living in an anorexic world, where their narratives often referred to feeling ‘other’ to people around them; and how ‘topsy-turvy’, surreal and shameful this sometimes felt. In relation to this felt sense of ‘otherness’, there was also a narrative that signified how the women variously experienced engaging with or rejecting the idea of an ‘anorexic identity’. The ‘Alice in Wonderland world’, referenced by one of the participants, alludes to the novel written by Lewis Carroll in 1865 that tells the story of Alice, a girl who falls through a rabbit hole into a fantasy world, where the laws of logic and what we take for reality are literally turned on their heads. In this world some animals behave like humans, while others have supernatural abilities of appearing and disappearing. Themes of body size (relative to other creatures), eating and drinking are prevalent, throughout the novel, as Alice has to constantly reassess her position of power and control in the fantasy world in relation to how large or small she became after imbibing food and drink. Her changing size, and what it means, is commented on by herself and other characters throughout the book. ‘Reality’ is represented as constantly shifting, unpredictable and defies the laws that govern our everyday lives. In using the ‘Alice in Wonderland’ metaphor, the participant is expressing an embodied sense of a life-world that is tangibly different from what is perceived as more usual for people (and mothers) who do not experience anorexia.

This super-ordinate theme clusters together three related themes that are detailed below:

Emergent theme 1.1: 'Slipping under the radar': Not being seen

The women described various situations in which they were not visible to other people in the context of their experiences of anorexia. They described how their experiences of psychological distress, problems with eating, food and embodiment went unnoticed by themselves and by others, and how this impacted upon them at different junctures in their lives. This theme contextualises their experiences as mothers with anorexia including what they believed might have contributed to this process. Their experiences of anorexia began (for some of the women) before they became mothers and 'slipping under the radar' played a significant role in maintaining their anorexia.

In this extract Gail recounted her sense of not realising until later life that she had experienced anorexia from a young age, before having children:

I've lived most of my life with anorexia and haven't even known that I've got it. I think it's quite easy to have an anorexic mind-set and not know that you have an eating disorder. I think it's quite an easy thing to do, and I found it really hard to recognise after, you know, when I'm nearly forty, that that's what I've been doing to myself all my life. So, I think if you slip under the net as a teenager, it's not something you just grow out of.

Gail spoke from a position of new self-awareness, indicating that she held the belief that anorexia became so familiar, it was no longer noticed and, as a result, was not able to be discarded as a 'teenage' experience. This 'slipping under the net' conjured up an image of being too small to be grasped and being outside of the containment of the net, where the net might be seen to represent safety. Although she described having an anorexic mind-set as something 'easy' to have, Gail also stated how difficult it was to recognise this. There was a big gap between what was happening, and what she was *aware* of happening. Her use of the term 'mind-set' suggested a belief in anorexia being a

way of thinking about, or an outlook on, eating that was all-encompassing. It conveyed the idea that the mindset consumed her - where the eating practices were not seen as problematic and were normalised by the mindset.

In this respect, the mindset distorted her reality as she viewed her experience retrospectively. It was also interesting that she described it as something she was 'doing' to herself, which suggested agency and action; implying responsibility. This sounded quite self-critical and suggested an acceptance of a dominant narrative that favours the idea of individual responsibility, rather than a belief of there being a wider context to her eating practices. She seemed to be trying to make sense of how she had got to a place where she was nearly forty years old, and only just realising that she had been experiencing anorexia for a long period of time. She appeared to be associating its presence in her life as a result of not having been recognised by anyone when she was a younger person. She went on to elaborate how other people were involved in this lack of 'seeing':

Just realising stuff about myself that I just hadn't realised and I think that when you're dealing with someone that's older you know - a person like me - a middle-aged person, quite often they haven't stopped - they haven't stopped to think, so you slip through the net you know really are - I realise now when I had a check-up at school. I was fourteen and I was clearly underweight - clearly, and I hadn't started my periods, and, erm, I had to stand on the scales - you had your polio thing and I remember my mum - your parent had to be there for it, and my mum had had to come off work, and it had all been a big hassle and the woman said 'right when was your last period?' and I was either fourteen or fifteen and Mum said 'she hasn't started yet.' And now I just think 'Oh my god!' you know, why did nobody look at this really skeletal girl and think there's something going on here? I was really depressed. I'd been put in boarding school you know and I just think, and I just feel quite shocked, about how it was just let slip under the net like that, and when I actually admitted to my mum and my sister, erm, a couple of years ago that I have been ill, and

that I actually had anorexia and I've had it for a long time and I've only just realised it about myself. My mum said, 'I've always known that' and I said, 'what do you mean you've always known?' And she goes 'I've always knew that about you, but you can't tell someone they're anorexic they have to find out themselves' - and I thought, 'oh my God - I'm forty years old and you're telling me now that, you've known I've been?'. My sister said, 'Oh I'm glad I didn't end up having to tell you' and I just thought 'oh my god this is my family' so I thought, you know it was quite an eye opener.

Gail questioned the fact that no-one looked at her body and made sense of what they were seeing or knew; where the physical evidence was not taken account of. Looking back, she explored the idea that not having her physical symptoms acknowledged by the adults (or care-givers) around her did not allow her to see this herself; as if this part of her remained hidden from view or notice. Not having herself reflected as worthy of eliciting concern meant that she might not have been able to access compassion for herself. Her use of 'was just let slip' suggested that, at some level, she held a belief that her distress was somehow actively ignored and this idea was shocking to her. She communicated the idea that she experienced herself as an inconvenience with the words 'it was all a big hassle' as if the medical procedure (and Gail) was an annoyance to be transacted in an objectified, rather than personalised, way. The idea that her anorexia was known, yet not acknowledged, was borne out by her statement that both her mother and sister did know, but that they were leaving it to her to come to that awareness herself. This prompted her to think both about her age (being an adult woman) and the fact that the female members of her family had not revealed to her something of such great significance.

Kate's account echoed this experience of 'not knowing' and not being 'seen' by the self and others:

Throughout my eating disorder I always sort of fell under the radar a little bit because my food groups that I chose to eat, didn't necessarily

match the pattern. I didn't really know what was going on until my late forties. I think almost as my body started to pack up.

This extract reinforced the idea that being undetected meant that the anorexia remained hidden from Kate's view and continued well into her life. She ascribed this 'falling under the radar' to her behaviour not following a 'pattern', which suggested her belief in a recognisable 'anorexic' way of being. Her choices of food meant that the 'detector' was not able to locate her and her distress. Like Gail, she was unaware of what was happening. There seemed to be a lack of interaction between her mind and her body, until her body clearly communicated that something was going wrong by 'packing up'. Both Gail and Kate seemed to be trying to account for the fact that they had become a mother with anorexia, when it is so often associated with being a younger woman and the not being seen was what allowed it to continue later in life.

In contrast to these accounts of 'not knowing', Jane communicated her experience of others' expectations that she *would* have a lack of awareness and that this was not the case for her:

There's this kind of myth that anorexics are not aware that they're ill and that was very much what my doctor felt he had to do to me – he kept turning me back, he kept weighing me and he kept pointing out to me. I remember thinking 'why is he keeping on doing this?' and it was later on when I spoke to him again. He thought my problem was that I didn't know I was thin and didn't know I was ill. But you do know that you're thin, you do know that that you're ill.

In this account, Jane has not fallen under the radar or slipped through the net in the way that Gail and Kate described. However, there remained an issue around her doctors' assumption about her *perceived* lack of awareness of her being thin and ill. She referenced and rejected the 'anorexic myth' of having no awareness of being ill. The disparity between what was assumed and what was known left Jane feeling unsure about what was going on, where her doctor was 'doing' things to her that did not make sense. This created an idea of Jane as physically

objectified, rather than attended to as a sentient being. In not communicating what he was 'doing', there is the sense of the doctor infantilising Jane or conceiving of her as a problem that he was dealing with, without her knowledge or consent. Jane's account illustrated the lack of communication between her and her doctor. There was no sense of a collective or shared understanding of what was going on. Thus, even though Jane *was* aware of her anorexia she was still not 'seen' by her doctor. The veracity of her experience slipped under his radar as a result of his own assumptions about the experience of anorexia.

Alison's account was different from that of Gail and Kate because her experience of anorexia *was* 'caught' at an earlier age; but not in a way that felt safe and containing. Despite being 'seen', notions of concealment and suppression were also evident in her narrative. In the following poignant extract, Alison described her sense of when her problems with eating began at the age of nine. She related the sequence of some events that happened to her before the point where she received a diagnosis of anorexia at eighteen (before having children). She described how the lack of acknowledgement of, and family secrecy and denial around, traumatic events impacted on her relationship with food:

It was around the time, about six months after the onset of, um my brother was abusing me and, and, um, it was like um, for me, my mum's kind of I, I, it was like, the, the whole, I mean it's kind of the classic probably, the control thing but it was the, um, for me it was like that was something that I felt safe with and (pause) and so it was always like lot of sort of focus on food, when sort of happened with my brother, it was just something that was, something secret that was always. It was started off at lunchtime; that's always my first meal that goes, em, and I started sort of chucking away my food and not eating, at nine. It wasn't mega, mega big deal it was kind of there it, sort of, it was an issue, but no one really noticed and my weight didn't massively change, and when I got to high school and we didn't have these supervised lunchtimes, em, I just used to just bring my food and do my homework at lunch, and that's

when it became more of an issue, em, and this was found out in (sigh) I was really young when it started, and I was a lot older when I finally (sigh) told my mum, em, and there was a bit of a breather in that period. I kind of ate a bit better and em my mum's, my mum didn't really cope with it very well and her way of dealing with it was 'basically this never happened. We never talk about this outside the family'. Em, so I was kind of living with all of that - the fact that obviously I'd see my brother every day and he, em, (sighing) couldn't rape me. He bullied me, em and was just generally vile, em, and, then when I was a teenager, and my parents went away, em, for - they were either out really late or they stayed out overnight, I can't remember but basically he got his friends round and they gang-raped me and he sold me to them for a tenner, and it was after that that I started, em, throwing up food.. That was my sort of angry, em, when I'm depressed, I tend to starve, but when I kind of had that anger and I couldn't really express it. So, I started taking laxatives and started vomiting and at that point my mum found out. Someone heard me throwing up at school and told a teacher, and they told my mum and my mum just was like, 'well you're throwing good money away down the toilet, you're, you know, disgusting'.

The matter-of-fact way that Alison described several shocking experiences here is particularly remarkable. The narrative was delivered in a flat, toneless voice, which served to create a sense of depersonalisation, as if she is relating something that happened to someone else, rather than to her. The focus on the *process* of the development of her problems with food also felt significant in that it served the function of keeping her away from the emotional content of what happened to her. This was also true of Kate and Gail's narratives, where their bodies and eating practices expressed what the child was unable to. In the same way that the abuse Alison experienced was hidden and secret, her relationship with food was also obscured from view. No-one paid attention to the idea that her eating practices might be serving as a communication about her trauma. What felt particularly affecting was the fact that the telling of the

abuse did not engender acknowledgement or care from Alison's mother, but rather it became a secret and something that had to be concealed from the outside world and contained within the family.

Although Alison described there being a 'breather' from the abuse which meant she was able to eat better, there was the sense that this respite was only available in the presence of her mother who knew what had happened. Her parents leaving her alone with her brother ended the respite, where the abuse escalated. The breathing space was abruptly terminated by the gang-rape. The lack of feeling expressed by Alison in this particularly traumatic part of her narrative, created a sense of emotional numbness on her part and was experienced like a jolting shock to myself as researcher when I listened to her story, both in the moment she was talking and later when I listened back. My supervisors also experienced a similar overwhelming emotional response reading the transcript. This felt like a literal and metaphorical gasp at the (apparently) insouciant way she described being sold for a 'tenner', contrasted with the horror at what is being described. This further exacerbated the parallel sense of what was seen and what was hidden; by Alison as the narrator and us as the witnesses. We experienced a powerful transference, giving us a small window into what these experiences might have been like for Alison. The fact that Alison had sublimated and repressed her feelings over what happened, created an agonising and overwhelming sense of horror for what she had to endure.

It is notable that this experience heralded a period of 'throwing up' and that Alison was able to relate her mood states to her physical relationship with food. She was able to link her experience of depression with starvation and anger with expelling food from her body. In the absence of being able and allowed to express her feelings over these traumatic events, Alison expressed this through what she did with food. It is interesting to observe that both practices of starvation and expelling food leave Alison literally empty, echoing the metaphorical emotional 'emptiness' of her narrative. She described the process by which her mother found out – by being told by someone who was told by

someone else. The experience echoed the previous experience of Alison revealing her distress where her mother's response was to chastise her rather than to exhibit concern. This also resonated with Gail's experience of being 'seen', yet not being treated with care. Becoming visible and 'seen' as someone who was throwing up, Alison was labelled as 'disgusting' by her mother which might also be linked to what her mother knew and felt about Alison being sexually abused by her brother.

A different perspective on 'visibility' was strikingly highlighted by Kate where she described her experience of her anorexia in terms of not *wanting* to be seen or 'noticed':

I remember Princess Diana saying in that famous interview she wished she could be a Disprin and dissolve and no-one ever notice her – as an anorexic, you know, we want to live in our private world and we don't want people poking their noses in, and yet we felt that our private world was always the centre of attention, and, and, and that's hard.

Her use of the word 'we' indicated her sense that she was speaking for both herself and others, aligning 'their' experiences with that of a well-known (and generally well-loved) public figure. In turning from a solid into a liquid it became more difficult to be seen. It was interesting that a Disprin also serves the purpose of being a pain-killer, which suggests the idea that the smaller and more invisible one became, the less the experience of pain. Kate expressed her desire to keep this world private, where 'poking their noses' suggested an unwelcome intrusion from other people.

Vicky's account of her experiences added a different dimension to the theme of visibility, where she described seeing herself in a way that did not reflect reality:

I would look in the mirror and I'd think 'Oh my God!' and I'd see this fat person in the mirror, even though everyone kept saying to me 'oh you know, you're not fat' and I knew that I was really slim, and probably skinny and I needed to put on weight but I wasn't seeing that.

Her private experience of seeing herself did not correspond with what other people saw and what she knew. There was a disconnect and distortion between what was known and what was seen.

Emergent theme 1.2: 'I felt very ashamed': Experiences of blame and shame

When the experience of anorexia became visible and 'known' to the outside world, the women expressed various feelings of being and feeling blamed and shamed, often in relation to their children. Alison described her mother's response to her distress over her son's 'fussy' eating habits:

My mum, at the time, said 'I'm not telling any of, anyone else that he's fussy because they'll know it's your fault'.

This sounded like a direct accusation in her mother's reported use of the word 'know' where she was stating it as a fact rather than a supposition. The 'not telling anyone' resonated with her mother's previous demand for secrecy around the family abuse and Alison's problems with food, where blame and shame for these events seemed to be directed towards Alison. Having been bombarded by maternal criticism, it was not surprising perhaps that Alison's own assumptions about how people would view her were also negative. Talking of her health visitor, she said:

I'd get her to sort of weigh them regularly just to make sure, 'cos I thought everyone's going to be looking at me like' you can't feed your child properly'.

This conveyed the sense of uncertainty that Alison felt over wanting her children to be checked up on. She created a sense of feeling negatively appraised or potentially blamed by 'everyone'. Living with a sense of heightened visibility in being 'looked at' with regards to her children, engendered a sense for her of feeling blamed for feeding them too much or too little:

The health visitor made me feel crap, so when I had Sally and she's got a similar em frame, I used to get really stressed about weight like 'Oh, God,

she's put on too much, hasn't she?' and the health visitor was all a bit sort of like 'stop trying to put your issues onto her'.

There was the sense of Alison experiencing the stressful process of weighing her child as a test of 'good mothering' that she feared she would fail. She conveyed the idea that she felt unable to judge what was 'normal' in terms of weight gain. In communicating her uncertainty to the health visitor, she was cruelly shut down in a way that sounded punitive, blaming and judgemental of her status as a mother. The health visitor was experienced as a harsh, reprimanding weight 'expert', who 'made' Alison feel 'crap', like excrement, the lowest of the low. Jane expressed a similar sentiment in her narrative in terms of feeling blamed by others:

'you're anorexic so you'll starve your child and, you know, put your issues onto them'.

Like Alison (in the extract above), Jane was not quoting a particular person here, but rather indicated that this was a generalised message that she felt she received from numerous sources or faceless others. In both Jane and Alison's accounts, other people's responses were felt as accusatory, rising from others' assumption of cause and effect. The corresponding implicitly-felt criticism was that it was difficult to be a 'good mother' and be anorexic.

Anticipating condemning responses from others led Alison to attempt to conform to an ideal of how a 'mummy' should be:

Trying to just be normal, balanced Mummy, 'cos I'm just aware that everyone is going to be judging me. I felt like it's such a failure when it comes to them [her children]

There was the sense that Alison felt pressure to present this 'normal' version of 'mumminess' in response to the perceived judgement of 'everyone'; where the 'trying' felt effortful, rather than natural. There was also the sense that she felt publicly observed, as if she was performing on the stage of her life, in a way that needed to be acceptable to the onlookers. She expressed how this resulted in

her feeling like a 'failure' when it came to feeding her children, and how sometimes this effort to be 'normal' became too much for her:

and sometimes I'm just, 'fucks sake!', you know, 'don't eat then. If you don't want it, don't!'

There was the sense that the façade of behaving like a 'normal, balanced Mummy' around food was sometimes too much, and Alison's real frustration and anger spilled out, like a calm veneer that suddenly cracked and revealed the turmoil concealed just below the surface. There was also the sense that she was unable to view the venting of her frustration as a 'normal' reaction to her children struggling with eating, as if the 'performance' of being a mother had a prescriptive, idealised storyline, to which being a 'good mummy' and 'experiencing difficulty around food' did not conform.

In common with Alison's account, Jane also described feeling publicly scrutinised and blamed. The focus of this blame was for her daughter's perceived 'issues' with food. Jane responded to these criticisms by developing a heightened awareness over the possible impact of her anorexia on her children:

It really did make me have to stop and think to really be aware of it.

Her use of the words 'make me have to' suggested that this awareness felt imposed upon her, rather than it being a natural choice.

Kate met certain experiences of blame with denial:

My mother in law constantly telling me I was over-feeding them and they were overweight, I just totally denied it - I just said they're hungry - they're boys - you know they've got the – I always called them the 'fat genes' from my husband's family, and I flatly refused to believe that anything was to do with me. I just thought I was well-feeding my children.

There was the sense that this denial was a protective strategy that served to preserve her identity as a good mother. She referred to gender and genetics as

a likely cause for the weight of her sons, as a means to defend her practices of feeding her children. In addition to denying any responsibility for over-feeding her children, she squarely laid the blame for their body size and weight with her husband's family, and perhaps implicitly at the feet of her mother-in-law. Kate's denial was unequivocal and protective of her status as the 'good mother'. In this instance, public blaming did not produce heightened awareness of or reflection on the fact that the reality of Kate's world did not match that of outside observers. At this point in Kate's life, her experience of anorexia was still hidden and unknown to herself and others and there is the sense that this 'invisibility' was somehow protective against feeling blame and shame. In mentioning it here, Kate appeared to be talking from a different perspective where she was able to recognise her previous denial and had reached a place where investment in this denial was no longer necessary.

Inhabiting a world where anorexia is known, and 'visible' seemed to signal permission for other people to express blame and criticism towards some of these mothers, in relation to their children. These women variously reported these experiences as inducing shame, heightening awareness and evincing denial. Becoming more vulnerable to public scrutiny served to contribute to an emergent sense of difference and 'otherness', in the context of these women's identities as mothers.

Emergent theme 1.3: Other people speak our language: Engagement with an anorexic identity

The participants variously created an idea of themselves as inhabiting an 'other' world from that of other women and mothers, through how they were or were not seen and through their experiences of blame and shame. This sense of 'difference' in terms of visibility often began in childhood for these women and informed their interactions with themselves and others as they grew into women and then mothers. This next theme focuses on how, and in what ways, these women related experiences of engaging with (or not) a distinct anorexic identity, separate from other ways in which they perceived themselves in the world. These accounts might be theorised to serve a protective function for the

women, where the anorexic identity does not have to interfere with the good mother identity, but rather is divorced and separated off from the whole person, where it can exist independently.

Jess spoke of making a connection between her understanding of what contributes to her 'being anorexic' with her identity as a mother:

Having anorexia like, obviously you got the sort of biochemical abnormalities that other people don't have like erm very high dopamine and serotonin that was, and I think I've kind of got quite a hot temper and, erm that high anxiety levels as well 'cos that are sort of associated with those altered biochemical levels, so I would sort of link the other aspects of my personality that affect my parenting abilities and linked to anorexia.

Her account explicitly referred to a medical, physiological model of anorexia; where she connected biological elements with her emotional experience and linked this to her anorexia. She used this as a way for her to make sense of how these 'biochemical abnormalities' might have influenced her mothering abilities. There was the sense of her separating herself apart from 'other people' through her investment in this narrative. Although it is not explicitly expressed here, there is the sense that her narrative performs the function of explaining why she might not always be able to be the 'idealised mother'.

Jane explicitly made a distinction between her sense of having an anorexic self and a 'mother' self:

I was very careful, and if you make that distinction, you can erm between feeding your children, and that feeding me, and I think you're very conscious of trying to instil a good body image, and lifestyle, erm, it's almost like you're two different people. like you're two different people.

Her description emphasised the studied awareness she had of these two 'different people'. Feeding herself and feeding her children were separate and distinct experiences where one belonging to the anorexic self and the other to

the mother self. She seemed to be making the point that she believed that being anorexic and being a good mother were not mutually exclusive; they were separate parts of herself. Engaging with an anorexic identity did not preclude the possibility (and reality) of knowing what was 'good' for her children. There seemed to be an element of 'splitting' here. This is the term given to the defence mechanism whereby aspects of the self are polarised in a bid to defuse anxiety over parts of the self that may be deemed unacceptable to a person's sense of identity (Fairbairn, 1994). In this particular example, the dichotomy of anorexic self and mother self were not able to be integrated into a cohesive identity. Alison also referred to this sense of distinguishing between her own relationship with food and feeding her children:

I struggle to feed myself, but my eating disorder is about me and it's about what I put in me and I've always, always, always done my best for my children

It seemed important to Alison to be producing an account of good mothering. Her use of the word 'always' three times in a row emphasises her conviction (or protest) that she *has* done her best, but indicated that she might have felt the weight of external judgements that her experience of anorexia has somehow impaired this ability

This idea of 'splitting' the self was explicitly rejected by Gail in her account:

Lots of people say that they see their anorexia like as a different person and that, and I don't know if it's coming at it as an older sort of patient, but I never, I never could have identified with it like that. I couldn't have. I had to have control of that as an adult. I had to take responsibility for it. I couldn't have seen this as a different person if you like - a different entity - it was very much part of me and I needed to deal with it like that.

She referenced the common anorexic discourse where individuals view their eating disorder as separate from the rest of themselves. With the repetition of the word 'never', Gail reinforced the point that this was not a notion that she

subscribed to. She toyed with the idea that this might be as a result of being an older woman. She elaborated further on her rejection of this discourse when she expressed her need to have a sense of control. She conveyed the impression that, in separating off the anorexic self, she was relinquishing responsibility for it. For her to be able to 'deal with it', she had to own it.

The contrast with Jane and Alison's 'two people' narrative, is of interest. All the women subscribed to their particular viewpoints in ways that served important functions for their sense of identity, for Jane and Alison to keep the 'good' mother 'part' separate from the anorexic part, and for Gail to integrate this aspect of herself in order to deal with and take responsibility for it.

It was notable that much of Kate's narrative around the experience of anorexia referenced a further collective anorexic identity:

When you have anorexia, you hear that other people you know there is a thing called anorexia, but you think you are uniquely different in your anorexia, and unfortunately until you go through treatment and even come out. I have never met anyone with anorexia until I joined the peer group, and when we speak to each other or when we read books and things that other anorexics feel we sit there with our mouths open, because we can't believe that other people speak our language, because we have - I remember the head of Beat saying we live in an Alice in Wonderland world. Everything we think is upside down, so when other people say things you think I can't believe they've just said that because that's what I think but I've never met anyone before that speaks that language.

This excerpt charted a journey of self-knowledge and discovery for Kate. She started out describing feeling unique in her anorexic experience. This sense of being exceptional crumbled when she met other 'anorexics' and realised they were all speaking the same 'language'. The way she spoke, reflected this shift from the individual to the collective. She used the words 'you' and 'I' at the beginning of the excerpt when she described her sense of uniqueness. These

words were replaced with 'we' when she related how it was when she met and spoke with other 'anorexics'. Her account conjured up a sense of astonishing discovery. Her sense of wonder at this revelation was captured in her description of herself and others: 'with our mouths open', literally dumbfounded. She subscribed to the idea of this anorexic society being like living in an Alice in Wonderland world where everything (including the language) is 'other'. The sense of disbelief over finding a place that was shared by others was tangible. Her narrative conveyed a sense of belonging and coming home to a place that was shared by other women.

Interestingly, although Vicky's narrative did not reference a sense of her engaging with an anorexic identity, she did mention an experience with her therapist (who was also a mother who had experienced anorexia in the past) who was trying to persuade her to become an inpatient and leave her children for a period of time:

I think she was trying to, it was almost like yeah 'this has happened to me, I did this, I think that you should do the same'... you know, and I just don't know, yeah, that just wasn't the right thing for me.

Vicky's perspective on this was that the therapist tried to impose her own experiences onto her, with regards to how she should manage her anorexia. She stated that this did not feel appropriate to her and rejected the idea that their experiences might be similar in this respect. Vicky's narrative created a sense of her experience of anorexia as being personal (much like Kate's description at the beginning of her excerpt). In Vicky's case, they were *not* speaking the same language. On the one hand, Vicky's narrative represented a private individual account of anorexia and Kate's represented anorexia as a way of being and belonging to a collective identity. In Vicky's case her identity as a mother did not allow her to follow the same path as her therapist:

And I didn't want to go obviously, 'cos I didn't want to leave my children.

Her use of the word 'obviously' indicated her belief that a mother would not want to leave her children. This might be understood as Vicky subscribing to the idea that a 'good' mother stays with her children at all costs, particularly if it is in the interests of the mother to be absent for a while. The children must always come first.

In summary, this super-ordinate theme reports on how these six women described feeling like their experiences of anorexia created a sense of 'difference' and 'otherness' from that of others (either as an individual or as a member of a group of women). This sense of difference impacted on how they felt they were viewed by others and how they experienced themselves as mothers in the contexts of blame and shame. Engaging with, rejecting or separating, an anorexic identity from other parts of themselves created a different sense of reality from that of other women and mothers, which could be protective to their status as a mother. Their narratives revealed an implicit awareness of how 'mothers', 'anorexics' and 'anorexic mothers' are often pathologised, through dominant discourses that serve to oppress and engender internalised shame and self-criticism.

Super-ordinate theme 2: 'The windowsill syndrome': Experiences of the competing demands of motherhood and anorexia

The second super-ordinate theme reports on participants' accounts of the difficulties of being a mother experiencing anorexia, and how there was often a struggle with responding both to their own needs and to the needs of their children. Also captured in this theme is how far, and to what extent, the women in this study believed that their experience of anorexia affected their children, and how this, in turn, was experienced by the mothers. This super-ordinate theme clusters together three themes that emerged from the data set and are detailed below.

Emergent theme 2.1: Mother's perceptions of the impact of their anorexia on the children

This first theme captures how the mothers in this study perceived how their experiences of anorexia impacted on their children. In this excerpt, Kate

described how living in a family with children fitted well with the practices associated with her experiences of anorexia:

I think that people who aren't familiar with anorexia think that I'm going to say it's just absolutely awful being a mother. I've got four sons, and being surrounded by food, but in actual fact it's a very safe haven and to fit all the criteria of anorexia because first of all you know that we starve ourselves but nourish others. So that fits very well when you're feeding a family. Erm, being around food is actually your way of eating it, and being involved with it and I would spend as I've said I've got four sons that were always overweight - they were obese, erm, because I just fed them because that was my way of loving them. I don't think any of my boys have got an uncomfortable relationship with food then or now.

Kate created a sense of confounding expectations in her description of being a mother with anorexia. Instead of it being 'absolutely awful', she described motherhood as enabling her to protect her 'anorexic identity' in terms of feeding her children and starving herself. There was the sense of her feeling like she was conforming to the 'principles' of anorexic behaviour, in how she fed her sons. She endorsed a particular 'anorexic' discourse of women feeding others while starving themselves. Feeding her sons symbolised an expression of her love for them. In starving herself, Kate suggested that this was not something she could apply to herself. However, she also indicated that being around food allowed her to feel included in the process of sustenance in some way. Food could still be nourishing for her on an emotional, if not physical, level. The size of her children's bodies and her description of them as 'obese' might be understood as a physical manifestation of the magnitude of her love for them in that the bigger they appeared, the more obvious her love. It was noteworthy that she stated clearly that there was no negative impact on her boys' relationship with food, as a result of her maternal feeding behaviour. Her denial of them feeling 'uncomfortable' might suggest a belief in food as providing a measure of comfort and security for her sons. This assertion that her 'anorexic behaviour' had no negative consequences on her children, contrasted sharply

with another poignant excerpt, where she explained to ‘the chiefs of the NHS’ the struggle she experienced with the competing demands of anorexia and motherhood:

One of them asked me about the voice in my head and I described it to them as what I call the windowsill syndrome. I said, if my four boys were standing at a window begging me just to have a sip of water, ‘cos sometimes that was what it was like just to get me to sip some water, and the voice said to me ‘no’ - if my little boys had said ‘mum, if you don’t have a sip of water we are going to jump out of this window’ the voice was so strong I would have let them do that. So obviously I felt very bad that I should have had such wicked thoughts, that literally I would let my boys do that and, and also I felt terrible of the impact that this illness has had on all of their lives - all their lives.

Her naming of the voice in her head as the ‘windowsill syndrome’ was interesting in terms of how ‘syndrome’ was evocative of a medical condition or disorder and ‘windowsill’ suggested being on the edge. Through this dramatic metaphor, Kate described the battle between the ‘voice’ of her anorexia and the voices of her children, where the anorexic voice was most powerful in that moment. Although the personification of the anorexic voice served to split this part of her off, so that she did not have to own it as an intrinsic part of herself, holding a belief in the possible reality of jumping out of the window caused Kate to feel ‘very bad’. Her description suggested a belief that these ‘wicked thoughts’ might have been transformed into action; emphasised by her use of the word ‘literally’. There was also a confessional tone to her narrative; as if by entertaining the wicked thoughts, she had somehow committed a crime, if only in thought.

On a more basic level, this scenario could be understood to communicate a sense of Kate’s belief in the power and strength of her anorexia, and that this strength could feel all-consuming and overwhelming to her. Although not explicitly stated by Kate, the implication might be, that jumping out of the

window would result in the demise of her sons. Not to ever take a sip of water would also have resulted in her own death. The fact that she was alive to convey this narrative suggested that she did eventually sip the water and both she and her children remain intact and safe. Her previous denial that her feeding behaviour did not impact her children's relationship with food, was sharply contrasted by her assertion that the impact of her 'illness' on them could have been literally life and death. Through this narrative, Kate created a dramatic and shocking account to communicate to the 'chiefs of the NHS' the intensity and sometimes perilous nature of her experience of anorexia.

Alison also described how she sometimes struggled to balance the needs of her children with her own experiences with food:

And kind of have deliberately kept my issues away from them. Firstly, I didn't want them to be into, I didn't want them to be influenced by, my stuff with food. I've found it really hard, having three picky children to deal with and sometimes I phone my husband and say, 'do I actually have to feed them today?', which is kind of really shit.

Alison communicated the conscious effort involved in keeping her 'stuff with food' separate from her children. When she said, 'I didn't want them to be into' and corrected this to 'I didn't want them to be influenced by', there was a sense of an awareness over what might happen if they became involved with (rather than influenced by) her issues. There was the suggestion that she might be harbouring a belief that her 'issue' might also become theirs. She described how difficult the experience of having 'three picky children' could be for her. Her question to her husband illustrated how much of a struggle feeding them could be. There was the sense that she felt that she needed to be regulated by him, but that she was also aware of what she *should* do. Her statement at the end conveyed her feelings aptly; although she is trying her best and, is aware of the possible impact on her children, the effort involved in doing this is 'shit'. Alternatively, she could be expressing that it is 'shit' that she must ask her husband what she should do. Like Kate, she expressed the problematic nature

of being able to look after both herself and her children. In the context of her perceptions around how her experiences of anorexia might be impacting her children, it was difficult for her to simultaneously hold a 'good mother' identity alongside that of an 'anorexic identity'.

Gail described having retrospective guilt around the fact that she experienced anorexia whilst having children:

When I realised what I was doing to myself with the anorexia, I felt incredibly guilty that I could've, and incredibly selfish that I could have let that happen when, you know, I was a mother I thought 'how could I, how could I?'

Her account referred to the sense of agency in her experience of anorexia, where anorexia was something she was 'doing' to herself. Self-blame was a common theme throughout her narrative. Although there was the sense of 'the anorexia' being almost 'object-like' and external to herself, she was still prepared to take responsibility for it. Becoming aware of the impact of anorexia on herself, led to feeling guilt as a mother, as if being 'anorexic' and a mother should be mutually exclusive. The selfishness she ascribed to her being anorexic did not fit with her idea of how a mother should be.

Questioning how these two identities might fit was also evident in how the other women expressed concern around the impact their experiences of anorexia might have on their children. For example, both Vicky and Jess expressed apprehension around the thought that their children be 'affected':

Vicky: Oh gosh, I hope this is not going to affect them in any way.

Jess: I'm terrified that she's going to have issues with food because of me.

Vicky expressed a general fear of her children being affected at all, whereas Jess voiced her explicit fear over her role in shaping her daughter's relationship with food. In these statements, they both communicated a belief and a fear that a

mother's behaviour can have a negative impact on their child, reproducing the dominant discourse that holds mothers accountable for the health and well-being of their children.

Interestingly, both Alison and Jess explicitly expressed a fear that their children might become anorexic themselves. When asked what that would mean for Alison, she said:

It would be twofold. Obviously, one side I know what a shitty, shitty path it is and I'd want to make them better and I'd want to do everything I can to support them but then there's going to be the other side. At the end of the day I'm a competitive anorexic and it'll be 'well if they can lose weight why can't I?' I would struggle so much. I would be terrified for her. I dunno, I'd probably be a bit resentful for her for doing that 'cos that's my thing and I dunno, 'get your own problem'.

Alison made the distinction between the impact on her daughter and the impact on herself where she imagined that the mother part of her would be frightened for her daughter, but the anorexic part of her would be aggrieved at feeling that something would be taken from her. There was the sense that protecting her children from being impacted by her anorexia was also protective for herself. She conceptualised her anorexia as belonging to her and not something that she would happily share. There was the sense of her holding her anorexia tightly, like a small child unwilling to share a favourite toy with the other children. Jess expressed that having an anorexic daughter would not be the worst thing for her:

I wouldn't necessarily freak out, although the anxiety is obviously an issue but, I know there is, like a high mortality rate and things but, erm, I think that's the really severe inpatient cases and people who didn't get treatment. Those things, so I know that actually if like, say if she had, for lack of a better word, a phase of sort of eating abnormally, I wouldn't sort of hound her about it. Well the only thing I'd hate is erm, erm, I'd absolutely not be able to tolerate it if she was obese, that, like I say, I

think that's very unlikely to happen. I mean I make sure she's erm, well, I do my best to not let it happen anyway, and I often think the parents can be to blame for that sort of thing.

What Jess knows about anorexia does not correspond to her own private experience of it, and by reducing anorexia to 'eating abnormally', she diminished the power it may have over her daughter. She acknowledged that the concomitant anxiety could be problematic, but dismissed the life-threatening elements as belonging to other people. It was noteworthy that her feelings towards 'obesity' represented a polar opposite; anorexia she could deal with, but obesity could not be tolerated. At this point in her narrative, it was evident that she was invested in the dominant social discourse that references the 'obesity epidemic' (Maguire & Haslam, 2010) and the attendant scare-mongering associated with the language used in 'talk' about it (Gard & Wright, 2005). She had clear rules around what is acceptable in terms of 'disordered eating' and was reproducing a dominant discourse that references acceptance of the 'thin ideal' (Johnson et al., 1989) on the one hand, and renounces 'obesity' on the other. It seemed that she was conflating her own experiences and values with a fantasy about her daughter's future relationship with food. The function of this strategy might be that it kept her safe, in her familiarity with anorexia, and protected her (and her own mother) from the possibility of parental blame. Unlike Alison, she was willing to share the experience of anorexia with her daughter.

Alison described how her experiences with food informed how she fed her children:

I always try and find something, if they've refused something that they normally like, it's just, don't want the kids to go to bed hungry and hate that. I'm probably not doing a very good job, but I just don't want them being hungry, 'cos nothing about food was normal for me.

Alison expressed an awareness of not wanting her children to have a similar experience to her as a child, where she had been emotionally hungry, deprived

of maternal care as well as physically hungry. Sending her children to bed hungry represented a lack of maternal love for Alison, which meant it was not possible for her to carry this out and maintain her identity as a loving mother. However, doing things differently did not free her from the anxiety of whether she *was* doing a 'good job'. Gail also described how her own experience of anorexia had informed how she educated her daughter, with regards to food and exercise:

I never, ever want my kids to go through this. I stress how important it is to eat, to her, but I've definitely made a very conscious effort to get rid of any sort of hang ups about food or exercise or anything with, erm, but yeah, you know - it has definitely made a difference.

In this excerpt Gail expressed how adamant she was in wanting her children (and specifically her daughter) to have a healthy relationship with food and exercise. Her narrative conjured up the image of the anorexia being consciously cast out and banished so it cannot touch or harm her children in the way that it did to Gail. There was the sense of her having agency here, using her own experiences and power for things to be different for her children. Something similar was expressed by Jess:

But I do at the same time try not to be too restrictive, 'cos I don't want her to get into that habit.

This suggested the idea that 'restriction' was viewed as a habit that could be curtailed or expanded, also reinforcing the possibility of agency for Jess to be able to protect her daughter from getting into that 'habit'. In using the word 'habit', Jess communicated the idea that restricting eating is a repeated behaviour that tends to occur on a sub-conscious level and is a cycle that can be broken when recognised.

Having an awareness of the actual and possible impact of their experiences of anorexia on the children, led some of the women to reflect on how this could influence changes in family dynamics. They expressed concern about the

possibility of adversely affecting their children through the behaviour that they modelled to them. This feeling of trepidation often led to the mothers consciously taking responsibility for particular ways of being with their children that were motivated by the desire to minimise the possibility of the children experiencing similar distress around eating and food. In some cases, the reality of being a mother acted as an encouragement for them to stop unhelpful behaviours of their own, in pursuit of protecting their children. In all cases, the mothers expressed the wish that their children not be negatively affected by their experience of anorexia.

Emergent theme 2.2: 'Role reversal': Experiences of changes in maternal and familial roles

A dominant narrative, running through some of the women's accounts, centred on how the experience of anorexia could sometimes have a significant impact on the relationships between mother and child and the ways in which family dynamics were experienced. These shifts in relationships were experienced in different forms for different mothers. Some experienced a sense of their own mothering capabilities being restricted by an escalation in their experience of 'anorexic symptomology', others related experiences of 'role-reversal', where the child acted as care-giver and the mother as 'child-like', while others referenced more subtle shifts in traditional dominant conceptualisations of 'mother/child' dyads.

Alison described a situation where she felt that her mothering capabilities were severely restricted as a result of her anorexia:

I've spent all winter in hospital, and that was really tough, and I was really unwell, and I basically could only be a mum from the sofa, for them to come to me and sit on me and have a cuddle but I couldn't do normal things for them, and I felt like such a big failure.

In this excerpt she conveyed a sense of her feeling unable to fulfil the expected mother role; what she could do had been reduced to cuddling her children from the sofa. There was the impression that her agency had been diminished,

through her being unwell, to a level of inertia that she described as leaving her feeling like a failure, where being 'a mum from the sofa' was not enough. The magnitude of this feeling of failure was communicated by her use of the word 'big'. In not being able to do 'normal' things for her children, there was the sense of her mother identity contracting; reinforcing the idea that mothers 'do' rather than 'be'.

Vicky talked about an experience she had with her daughter where Vicky's own difficulties around food prompted a different mother-daughter dynamic:

I went into the shop one time with my daughter and I remember we were in there looking for something for dinner, and I, I practically almost had a breakdown in the shop with the while she was with me and I think that did frighten her a little bit erm 'cos she was like I don't think she could quite understand why I was like that, and why I was getting so panicky over food, erm, and but again she, she did help and say 'Mum, it's fine' you know, and as I say, because she was older - she was like in her teens, like her late teens, erm, it was fine.

Vicky described how looking for food for dinner became a distressing experience for her. Food was directly attributed as the cause of her panic. She described how she felt her behaviour impacted her daughter in terms of it being 'frightening' and confusing, although this might be comprehended as Vicky projecting her own feelings onto her daughter. In this situation, there was a sense of role-reversal where Vicky's daughter acted as the comforter to her mum. Vicky related how she believed that this experience was 'fine' as her daughter was an 'older' teen child. There was the sense that this was reassuring to Vicky, in helping to maintain her status as a 'good' mother.

Kate described a particular situation where she experienced a sense of role-reversal with one of her sons, describing how affecting this encounter was:

and if my boys just think for one minute they give me some encouragement to have some water, or have something to eat - that is the greatest gift that you can have, to nurse a parent, but being anorexic

I didn't look at it like that - I felt ashamed and awful that, even my number four when he was quite young, he used to hold me in his arms like a baby, and rock me to look after me, to console me and, and that was very difficult.

Kate described how she was unable to view the idea of looking after a poorly parent as 'gift' in the context of her experience of anorexia and being a mum. Her own emotional response to being looked after by her children was to feel dreadful shame. She created a vivid picture of 'role-reversal' through her description of herself and her young son. This image was reinforced by her phrase 'like a baby'; strongly conveying a sense of her distress and need for succour. Her son was presented as the soother and the comforter; a role commonly associated with being mother to a child. Remembering this particularly poignant experience reminded Kate how difficult this experience was for her. The notion that looking after a parent is a gift, might be viewed as a protective strategy in that she was able to maintain a sense of 'doing' something positive for her son. She appeared to be able to reconcile this shame through the process of therapy:

And again, once my therapist explained to me that if I had cancer or another illness my family would care for me, and I lost my own dad at seventeen. I never once thought, or begrudge him for the impact that his illness, and then his death had on me. I willingly looked after him - he was my parent, 'cos I used to then punish and self-harm myself for the fact that, when I had a bad attack, you know, what it did to the family, how it ruined everyone's lives.

In this excerpt, she communicated how her own experience of her father's illness and death allowed her to think about re-framing how her children's experience of her own distress might have been. Likening her anorexia to cancer or another more 'physical' illness allowed her to access a different perspective and narrative on understanding her own situation. She described how punishment and self-harm was her 'go-to' response when she had a 'bad

attack'. Using experiences of her child self, in relation to her own parent, permitted her to reflect that there might be a different lens through which to view the 'role-reversal'. It was interesting that she described this as being 'explained' to her by the therapist. There was the sense that (using her own experiences as a frame of reference) she was able to internalise the idea that the therapist was communicating a universally-acknowledged truth; families care for and look after ill parents, and do not resent doing this. However, there also appeared to be a dichotomy at the centre of this narrative; in terms of what Kate was able to consider intellectually and what she *felt* at the time. This was clearly communicated in her final statement that 'it ruined everyone's lives'. It is notable that she used the word 'it' rather than 'I', which served to distinguish 'herself' from the 'anorexia'. This separation of self and anorexia might be understood to provide a protective function for her where she might become freed from the idea of being 'responsible' for the devastation.

Emergent theme 2.3: Children as a reason to recover

All participants related, to varying degrees, how having children (and becoming mothers) provided them with a reason to contemplate recovery. In this excerpt Alison described how being pregnant was for her (after having been told that it would be extremely unlikely that she would be able to get pregnant, due to the toll anorexia had had on her body):

It was amazing! I mean a few weeks before our wedding my husband had been in a, was like 'I don't know if I can go through with marrying someone who won't be able to have children' so it was the most ama- it was like kind of like a second chance. It was almost too good to be true and it's weird, it's about the only time in my life, well since I've been about nine that it was actually easy to eat. It was the only time, I kind of, cos I wasn't then eating for me, I was eating for them.

Her initial response was one of wonder in that becoming pregnant was something that she could not quite believe. There was a sense of poignancy around her description of how her husband had contemplated not marrying her

as a result of the likelihood of her not being able to have children. Her use of the word 'someone' is de-personalising, where there is the sense of her reducing her identity to 'a woman who is unable to have children'. There was the feeling that not being able to have a mother identity, could have had a big impact on the possibility of her having a wife identity, as if her identity as 'Alison' was not enough. This part of the interview with Alison was notable for the way in which she expressed herself in an animated and enthusiastic way, not apparent in much of the rest of the interview. It felt that this period of her life was qualitatively positively different from her experience of much of the rest of her life. There was a sense of hopefulness in this part of her narrative. This was reinforced by her description of becoming pregnant as 'like a second chance'; an opportunity for things to be different. This period did mark a positive difference for her, in that she was able to eat with ease for the first time since the sexual abuse began at the age of nine. Although she described this as 'weird', she was able to make sense of it in the context of feeding the children she held inside her. She expressed an awareness of making a distinction between eating to nourish her children and eating for herself. Despite this distinction, becoming pregnant allowed her to experience a relationship with food that had not been previously available to her; almost as if she was able to return to the child who had once been and nourish her alongside her baby. Later in the interview, she described how significant these children, in utero, were to her, in direct comparison with her mother, her husband and anorexia:

In the past my mum had been like 'oh, you know, will you eat, will you eat, you would eat if you loved me' and that I'd be like 'fuck off' and I couldn't do it for anyone. I couldn't even do it for my husband, but, these babies that I never, ever thought I would have, erm, it just, you would just kind of, it's like the anorexia just went on sort of on the back shelf.

This dialogue with her mother felt quite shocking. It started out as being reminiscent of a parent pleading with a recalcitrant child refusing to eat vegetables. However, her mother's plea of 'you'd eat if you loved me', felt like a

boundary was crossed for Alison, where it became about mother rather than child and emotional blackmail was invoked. Alison's verbal response was like that of a teenager when she told her to 'fuck off'. This response felt angry and punishing, in the context of which, *not* eating may be viewed as an unspoken communication of this anger towards her mother. There was the sense that this was a response to a far deeper distress, where the unspoken question from Alison might feasibly have been 'if *you* loved me, how could you have let this happen to me?'. She went on to state that she couldn't even eat for her husband, which suggested that she felt more positive affection for him than her mother, but that even the strength of her feelings for him was not enough. The fact that she was able to eat for her children felt hugely significant to her. She created a sense of them as an unexpected 'amazing' gift that came before everything else, in a way that no one else in her life ever had. Conforming to the notion of the 'good mother' marked a significant shift in her life and her own relationship with food and eating:

Yeah, it was kind of a big turning point.

Jess also related how her daughter motivated her to stay well:

I think she's quite responsible for keeping me healthy 'cos obviously I need the strength to keep up with her and stuff all day, and be a sort of good example? Sort of, if you have a good attitude to food, erm, I try and do that. Yeah - she's a big motivator sort of for staying healthy and with eating behaviour, there's some study that sort of shows how a mother's dietary restriction was like the best indicator of a daughters eating behaviour, erm, which obviously makes me sort of again more motivated to eat well. but like I've said - I've always tried very hard to make sure that Millie gets enough nutrition and, and grows up with a healthy attitude to food.

Jess described three reasons for staying well, in the context of her identity as a mother and where she put her daughter first. Her account indicated that these were choices she was aware of making, prompted by her desire to be a good

mother. In this instance, conforming to the idea of the 'good mother' was protective for Jess in her experience of anorexia. Jane's account also made reference to conscious choices with regards to recovery, in the context of her role as a mother:

I had three older kids to support and whatever, and I just had to, had to get better I had no real option and that was part of it you know coming out of, Yeah ,I mean that was very much, I think I was probably, I mean I was tired of it anyway, I did want to, I did want to sort of get better. I don't believe I would have got to, and I would have never ever believed I would have got to a real healthy, you know, weight but I think that was due to the fact that how, when putting on the actual weight when I had to and which I have to say in the beginning it is horrendous, but I wasn't doing it for myself back then, I, I felt I had no option so it was the fact that what was being said and my kids relied on me allowed me to push through literally got to the stage where, you know, what actually – yeah, I was starting to do it for myself and which does, you know, make me think 'my God if I didn't have had kids would I ever have managed?'

It is interesting that she described not feeling as if she had a choice over getting better, almost as if it were something imposed on her by the fact that she was a mother. At this particular point in her life, her ability to mother 'well', in the context of her experience of anorexia, was under close scrutiny and being called into question by her husband and others. There was the sense of there being an element of wanting to get better for herself when she said she was tired of anorexia, but that it was believing that getting better was a necessity and the only option that instigated her first steps towards recovery. The initial stages of her 'getting better' were described as 'horrendous', but that having an awareness of doing it for her children allowed her to 'push through' this stage. The language she used created a strong sense of how effortful the process of recovery was for her. There was the sense that the process was experienced as being in stages; it began from a feeling of necessity and evolved into feeling like a choice. It started out as being for her children and resulted in her doing it for

herself as well. Her question at the end of this excerpt indicated how uncertain she was about whether the outcome would have been the same had she not had children.

Gail's account referred to the dichotomy involved in her getting better for the children, whilst holding the thought that they were, in part, responsible for triggering her anorexia:

I know that I had anorexic episodes early in my life, I know that I did, but I don't know how I would have got out of it if I hadn't got the kids. But I wonder if I would have got into it, because this time was definitely propelled by this, this break-down with my mum about the kids. So, it's funny isn't it - you just don't know but, they definitely were the reason for getting better.

Gail toyed with the idea that, although the children were a reason to 'get out of' the anorexia, they were also involved with what she saw as the cause of her most recent 'anorexic episode' (where she had argued with her mother over her mother's refusal to be actively involved in their lives). Her question seemed to be around the relationship with her mother and how that might have been negatively impacted by her own status as a mother. This interpretation might be viewed as being protective of her daughter-identity, rather than damning of her mother-identity. Although she mused over the uncertainty of knowing whether having children might have made a difference to her anorexia, her conclusion was unequivocal; the children were her reason for getting better.

This second super-ordinate theme unpicked how the women in this study understood, interpreted and negotiated their experiences of motherhood within the context of their experiences of anorexia. Their perceptions, anxieties and fears around how their experiences of anorexia might be negatively impacting on their children, were scaffolded in some instances by the more positive influences motherhood and having children had on their experiences of anorexia. The relationship between 'motherhood' and 'anorexia' was variously experienced and represented as symbiotic or mutually exclusive; creating a

sense of a temporally-shifting dynamic, that could be experienced as both positive or negative, within particular relational contexts.

Super-ordinate theme 3: ‘Fuck you, don’t give up on me’: Experiences of requesting and receiving psychological support as disparate and diverse

The third super-ordinate theme reports on participants’ experiences of seeking and receiving psychological support, and how it was variously experienced as being inconsistent and diverse in terms of how helpful it was. The accounts of these experiences give an insight into the distinct ways in which these women did, or did not, feel understood and attended to, in the context of their own, and other people’s responses, to their experiences of anorexia. How that felt for participants, and the meanings that they ascribed to these feelings and experiences, is further explored in the wider context of their experience of being a mother. This super-ordinate theme incorporates three emergent themes described in detail below:

Emergent theme 3.1: ‘Being a mother – it was very difficult’

A common theme running throughout the women’s accounts was that many aspects of seeking and receiving help were experienced as being challenging, within the context of being a mother. Some participants described finding it difficult to seek support in the first place, and others found it difficult to engage with the support on offer, from both a practical and a psychological perspective. This theme captured and explored the dynamic and ‘fit’ (or otherwise) between participant’s statuses as ‘mother’ and ‘client’. This was variously reported by the women as being a good fit, fitting to a certain extent, or feeling like there was no fit at all. This superordinate theme is expanded on in the paper found in Appendix I.

In this excerpt, Jane described how difficult it was to access support for her anorexia in the context of her identity as a mother:

There’s a case where, for mums anyway – you do always have to put other people first you know – regardless, erm, of whether you’re anorexic or not, but I think that’s very much, erm, a case of, in the fact that you do

feel worthless, and you don't feel you deserve to get help, erm, and I do think that that is important, because a lot of people do think 'Oh you're not seeking help', because they don't know they're ill, but it's not – you do know you are ill – you do know you've got a problem, but you don't feel you deserve it, or that you're ill enough, and it is more that, and actually, you're not going to ask for help – it's highly unlikely that you'll ask for help, and then also you have the anorexic thing that won't let you ask for help.

Jane was referencing her awareness of, and belief in, a wider social narrative about the 'selfless' mother. Engaging with this narrative enabled her to make sense of her own experience of not asking for, or feeling that she was deserving of, help. She portrayed herself as feeling judged by other people in a way that left her feeling misunderstood, in terms of her perceived lack of awareness of her experience of anorexia. This jars with her sense that she *was* highly aware that she was unwell, but that it was the 'anorexic thing' that was stopping her from asking for help. There was the sense that anorexia and motherhood had conspired together to prevent her from accessing support.

The idea that 'mothers' needs come last' is also echoed by Kate when she stated: *'mum's needs are just on the back-burner aren't they?'* The question is presented as rhetorical; as a statement of something that we all know to be true.

Gail also reiterated this idea:

the guilt as a mother, that you're being so selfish to put yourself first. As well, I mean, I used to feel so guilty about going to this counselling, like because you do just put your kids first naturally, but why would I be thinking about myself? This wasn't right.

In this statement, Gail clearly expressed her belief in the idea that it was 'selfish' to put oneself first if you are a mother, and that this was a trigger for feelings of guilt. This references the dominant discourse where the 'good mother' never

puts herself first. She questioned the correctness of thinking about herself at all; as if, when you are a mother, this should not be okay to do (referencing again the narrative of the 'selfless mother'). Going to counselling challenged this belief, where actively seeking help was incompatible with her identity of being a mother. This offered an insight into the difficulty she experienced in reconciling the idea of 'seeking help' with the idea of what being a 'mum' means.

Vicky also talked about the difficulty of reconciling her identity as a mother with the help offered to her by her therapist:

All she kept wanting was for me to be admitted erm to erm to a hospital. And I didn't want to go obviously, cos I didn't want to leave my children, although they were older, they were grown, not grown up, but they were old enough and stuff like that. So, I you know, they weren't like babies or anything, so I didn't have to worry about anything like that.

Although it is unclear what her 'worries' were in terms of not wanting to leave her children (whether this was for herself, for them or for both), Vicky clearly related the sense that what was being offered to her was not wanted. Later on in the interview, she related just how difficult the therapy became, as a result of opposing views on the help being offered:

And, em, you know every time I knew I had an appointment with her I almost dreaded going, because I was just like, you know every time I went I knew that she would badger me about going to the eating disorder unit, and I just thought 'it's not gonna happen' you know, and then, as I say, she sort of tried to turn it around slightly differently and tried to get me to go as an outpatient instead but, eh, it couldn't be done because you had to be an inpatient first or something and it, it, it couldn't have happened. There was no way I was gonna go in there as an in-patient so I just said to her 'look', you know 'don't worry' and 'I think I'll just leave it'.

Therapy was dreaded by Vicky and became a vehicle for opposition and resistance. She conveyed her sense of the therapist persistently pursuing her idea of what Vicky should be doing (with her use of the word 'badger'), highlighting the power imbalance and lack of collaboration and alliance between therapist and client. She communicated her conviction that the offer of attending as an outpatient was not allowed for by the system and she remained unequivocal in her refusal about acquiescing to this suggestion. The reason she gave for her opposition was her status as a mother. To leave her children for an extended amount of time was unthinkable. The repeated use of the word 'tried', in relation to the therapist presenting things differently, implied an adversarial parry on the part of the therapist, which was further blocked by Vicky's reiterated, explicit 'no'. This left them in a state of deadlock and Vicky returned to a position where she was left on her own once more, where she felt unable to accept the help that was on offer. Although there was a sense of agency in Vicky deciding to 'leave it', and that she was relinquishing them of responsibility for her, when she said, 'don't worry', she expressed later in the interview how it really felt for her:

It felt very frustrating and upsetting and kind of, I dunno, I, I guess that it probably stressed me even more cos I, as I say, I knew I had an issue and I, I couldn't get the help for it, erm, erm, and I just felt that well okay maybe it's something that I've just got to try and do on my own but that you know as time was going on I just thought, no this isn't happening, so it's not going to go away.

Vicky expressed the fact that her desire for help was not being met with an offer that fitted with her sense of what might be helpful to her. There was the sense that she was being told what was best for her, despite her repeated claims that this was not okay; conjuring an image of an authoritarian parent dealing with a recalcitrant child. She was left feeling in a heightened emotional state, holding the idea that she had to deal with her distress alone. It became apparent to her that, even with the passage of time, this 'issue' was not going away. When the help that was on offer did not take account of her values as a mother (or of the

practical constraints of motherhood), Vicky was left feeling she had nowhere to turn.

Gail also talked of the difficulty she experienced reconciling being a mother with accessing support. In this extract she described her experience with one health care professional:

I had this very, em, she was a larger than life character, I'd imagine in real life, and she was quite - I felt like she was quite a bully with me - very big lady, and she was always late. So, em, anyway, she was always late and, em, I had to get back and I found it quite rude. I was like you know, 'I'm a mother', I can't. I have to look after my daughter today, and I haven't got any other childcare. I can't stay for the whole hour now, so you know quite often I'd only have a twenty-minute appointment because she'd been 40 minutes late. It was crazy, and em, in fact I only saw her twice in the end, and she signed me off because I think she sort of knew I'd had enough of her she said, 'Oh we're fine' and signed me off (laughing).

There is the sense of Gail experiencing the therapist's embodiment as overbearing, oppressive and as a tyrannical tormenter (suggested by her use of the word 'bully'). Her use of the terms 'larger-than-life', 'character' and 'in real life' created a sense of the therapist as a caricature or cartoon-like in a menacing way, with Gail experiencing an embodied and abusive power imbalance. Gail described her lateness as being 'rude' and dismissive of her identity as a mother. It was interesting to note that Gail described her as 'always late' despite only seeing her twice. Her impression of this woman as 'always late' had been set by these formative experiences and was felt by Gail to be 'enough' to have 'had enough of her'. There is the sense that she felt that her 'mother-identity' should confer respect and a boundary for therapy, when she stated, 'I'm a mother'. Engaging with this 'mother' identity felt protective for Gail, in that it allowed her to maintain a positive idea of herself, while vilifying the therapist as a bully who did not share her value for respect and

boundaries around motherhood. Gail initially attributed being 'signed off' as a result of her having 'had enough' of the therapist, but went on to describe in greater detail what led to this happening:

And, em, in this time I'd been training for this half marathon and I didn't, I couldn't give it up, I couldn't you know, total addiction and she was very like 'you have to not do this', and I said 'you're telling me not to do it like that is just going to make me do it'. You know it's not going to help me at all? And she goes, 'well if you do this, you're going to kill yourself' and I was like, 'I'm not going to kill myself you know, I'm absolutely not and I'll phone you up the next day and tell you that I'm not.' So I did the half marathon, and I phoned her up and said, 'I'm not dead. I'm here I'm still here' and she said, 'well, I'm going to sign you off. You're not accepting help, blah, blah, blah'. So she just signed me off.

Here, there was the sense of getting closer to the reason for the therapy ending. Gail described how she felt 'addicted' to training and that this, and other communications, were not attended to by the therapist. The therapist was experienced as being directive, dogmatic and dramatic in her assertion of what she believed was 'right' for Gail. This was met with rebellion from Gail; like a child defying an overbearing parent. The relationship was experienced as conflictual from the outset. There was a sense of Gail asserting her autonomy in running the marathon, although it was also interesting to note that Gail called the therapist to let her know she was 'not dead'. This detail created a sense of a child checking in with a parent, but also wanting to prove them wrong. This communication was met with a final boundary from the therapist where she places the responsibility for not being helped, squarely on Gail's shoulders.

Kate's narrative also referred to her experiencing her therapist in an embodied way, which, she felt interfered with the therapeutic relationship. This happened when her therapist 'lost a lot, all her weight and became very slim'. This was also experienced as a 'conflict of interests' for Kate.

These accounts echoed Jane's, Vicky's and other participants experiences of wanting help, but either not feeling able to access it in the first place, or feeling rejected from, or rejecting of it in ways that were related variously to their 'mother-identity' or some other important aspect of their lifeworld. What was evident from these narratives was that, seeking and accessing support as a mother was a difficult, in both practical and emotional respects; where the 'fit' between becoming or being a client, and being a mother was a decidedly uneasy one. Where the mothers *were* able to attend therapy, experiences where they felt that their autonomy was being threatened or compromised, resulted in the women resisting this or dropping out of therapy.

Emergent theme 3.2: Mother's perceptions of feeling understood in their experiences of interventions and receiving support for anorexia

The women in this study variously describe their experiences of therapeutic interventions and support for their anorexia as 'detrimental', 'helpful' and 'unhelpful'. The over-arching sense from the narratives was that all participants experienced both positive and negative interventions. Some accounts of therapy related to intervention experiences during motherhood, while others related to experiences before the women became mothers. This section reports on experiences of therapy while the women were mothers, but Alison's account of particularly de-humanising and punitive experiences of treatment before motherhood provided the title of this theme, perfectly encapsulated by her plea 'Fuck you, don't give up on me'. In common with existing research on interventions for anorexia (e.g. Rance et al., 2015), the women highlighted wanting to be treated as a 'whole person' and not for food and weight to be the sole focus of therapy.

Jane described an experience of 'treatment' where she was left feeling distressed and alone:

I was desperate to say 'No! I don't want to be like this. Please help me', there's a case where when you're very ill, as I say, I was, em, at the end, I think, sort of given up on me: 'so the best way for you just to keep yourself safe, so we've put these measures in because maybe one day

you're gonna want to change' and I said, inside I was sitting there going, saying 'but I want to change now, don't leave me like this – please don't leave me like this!'

In this extract, Jane described feeling given up on and abandoned, where her internal cry for help was not heard. What was apparent from the narrative, was Jane's desire to be different and not to be left in 'this' state. Her narrative created a sense of her feeling deserted at her lowest, most ill point. The idea of it being down to Jane to 'want to change' marked a boundary of responsibility that exacerbated her feelings of aloneness. The help she was offered was limited to putting 'measures' in to help keep herself 'safe', rather than about accessing positive change. There was a sense of the 'help' being faceless and impersonal; in Jane's use of 'we', rather than it being a named individual or service. Responsibility for change was firmly handed over to Jane by the faceless 'we'. There was the sense that Jane felt 'they' put in the safety 'measures' and retreated, leaving the option to change up to her. This seemed to render her mute and unable to explicitly voice her distress. There was the sense that her communication of distress was embodied by the anorexia but that this was not being listened to. This sense of being left alone and unheard was reiterated by Vicky's more matter-of-fact account of one experience of therapy where she stated:

Okay. Well if this isn't working, I'll try to deal with it myself again.

These narrative threads built a sense of isolation and lack of connectedness with the support-givers that was variously responded to with anger, pleading and a sense of resignation around dealing with distress alone. There is the sense that the women felt they were experienced by others as outwardly resistant to the help on offer in ways that did not mirror their internal desire for help.

An alternative narrative was also available in some of the participants' accounts of their experiences of help. In this statement Alison communicated what she appreciated about her ongoing therapy:

I think it's kind of having the continuity and the regularity of it and I know that I can, that, at the moment, I can save up all the crap and dump it at her once a week.

Alison articulated how valuable it was for her to have something that was constant and reliable. Her use of the words 'crap' and 'dump' were visceral in their evocation of bodily functions and served to describe how she felt able to expel the excrement of her week 'at' her therapist. Her language suggested that the therapy might be functioning as a depository for the 'crap' that she has saved up over the week, and her use of the word 'at' rather than 'on' indicated an element of dynamism in the relationship, where the therapist might have some autonomy over whether to take the 'crap' or leave it. Her inclusion of 'at the moment' suggested that therapy might stop at some point which begs the question of what happens when Alison has nowhere to dump the crap.

Jess also talked about the value of having continuity in her care. In this extract she compared her two different experiences of therapy: one with a consultant psychiatrist from the ages of 14 to 18 years old, and the other with a general counsellor. This time span covered the period before and after she became a mother at the age of 16:

It worked very well that I saw her [the consultant psychiatrist] for so long because we were able to build up a very good relationship, em, sort of, knew what to do when things sort of started to go bad, it was very, just very, very good, obviously and it so much helped that she just knew my entire sort of family and relational history and things, whereas it was a lot more difficult with the counsellor - having to go right back to the start and then up to the present day and throwing up and things, and she didn't have sort of the same level of specific eating disorder training, em, and obviously she focused more on, em, yeah like I said, family problems and unconscious triggers and stuff, which I know there's always sort of been an aspect of kind of vanity in my eating disorder. I mean it's not a quality I like in it, but it's true so em, so yeah, she focused less on the

eating disorder itself and more on, sort of like potential problems that I, that was quite different to be honest.

Jess described how important the therapeutic relationship was and how valuable it was to feel confident in her therapists' expertise. Having different experiences of therapy to compare has grounded Jess in a sense of awareness over what has worked best for her, although it was interesting to note that the very 'good' therapy was not able to help her stop things going 'bad'. Having a broader sense of Jess within her family and her history felt helpful to Jess, with the first therapist, but that going back and having to re-tell her story to someone else was a lot more difficult. There might have been a sense of loss around engaging with someone else. She cited levels of training specific to eating disorders, as important to her and there is the sense that the 'newer' therapist cannot live up to the previous one. The focus of the therapy is also expressed as feeling significant. She mentioned the fact that there was a significant (and important to her) difference between the two, where she intimated that a focus on family problems and unconscious triggers had felt less helpful to her than on the eating disorder itself. She expanded on this later:

Obviously, being a consultant psychiatrist, she really knew her stuff, and she would sort of break down sort of em sort of biological reasons for the disorder and stuff for me to help me sort of understand it more. Ah, em she would sort of be kind of like kind of blunt - not in a vicious way at all, but just sort of blunt about the em severity of my eating disorder at any time and, em, when she actually, when I sort of I stopped going to school em when I had it and she actually arranged for me to go to a sort of special school, em which was helpful as it gave me the time to sort of catch up and things and, and she taught me lots of coping strategies and things like em, like em, she got me into running which I've done ever since sort of thing, as a sort of alternative to starvation and things and em she was very good to keep me out of hospital - she worked really hard to do that.

Jess reiterated her belief in the psychiatrist's expertise, and how she helped her understand her eating disorder in a way that made sense to her. It appeared to be important to Jess that she felt that her therapist was honest with her, but that she also acted as an advocate for her when necessary and taught her coping strategies. There is a sense that Jess felt 'held' in many ways by her therapist, and that she found a pragmatic approach to her experiences helpful. There was the sense of this therapist maintaining an almost parental/teacher role for Jess; being there for much of her adolescence, explaining and teaching and offering solutions that Jess was able to take on board. There is the feeling that Jess ascribed a great deal of power to the psychiatrist, illustrated by when Jess talks of how 'good' she was to keep her out of hospital, that her 'working hard' was what allowed her to stay at home. Jess built a narrative of credibility with regards to her experience of her therapist. Holding a belief in this credibility allowed Jess the opportunity to trust, engage and work with her in a meaningful way. It was interesting that Jess focused more on the practical (and biological) rather than emotional content of what went well for her. The contrast with her experience of her other counsellor is described here:

She was very, not quite as scientific is how I'd put it. She was good you know she was very friendly and she sort of, she taught me a lot about sort of stuff you cope with triggers - sort of stress management type of thing but, but, like I say, she em didn't know much about eating disorders themselves and, em yeah and sort of spent far too much time talking about like, em, the stress of being a mother and the family environment and stuff which is of course, I mean obviously being a mum is very stressful thing but that wasn't sort of, was never the root cause of any of my eating problems.

Jess continued to build a narrative here that argued for a 'scientific' approach as being most helpful for her. There was the sense that she felt that her time was wasted on talking about aspects of her life that she believed were separate to her experience of anorexia. It was interesting that she did not say what she believed the root cause of her eating problems was, but rather, focused on

what it was not. She refuted the idea that family environment, and being a mum, were causes of problems with eating. With her experience of both therapists, there was a felt sense of each having separate agendas, and while the former 'fitted' well with Jess, the latter seemed to grate.

What was evident, from the extracts above, was that these women's experiences of 'treatment' for their eating disorder were varied and diverse. In accounts where the treatment was related as being unhelpful, the treatment was experienced as punitive at worst, and indifferent at best. These types of experiences tended to engender either resistance to therapy, for the women, or caused a rupture that marked a premature end to treatment. The women's narratives that highlighted treatment that was perceived as helpful referenced a variety of contributing factors such as therapist expertise and feeling able to 'offload' on a regular basis. What was common to all accounts was the underlying message that for support to be experienced as helpful, a match or 'fit' between the health care professional and mother was key.

Emergent theme 3.3: 'It's still a struggle now': the importance of ongoing support.

This theme captured storied experiences of 'recovery' and 'staying well'; interrogating the narratives for the meanings ascribed to these, and the various ways in which the experiences were interpreted and internalised by participants, in the context of their own individual life-worlds. There was a common theme that advocated for the helpfulness of ongoing support and the idea of 'hopefulness' for the future was evident across all narratives.

Gail succinctly expressed the challenges of remaining well when she stated:

It's still, still a daily struggle. I don't think if you've had an eating disorder for as long as I obviously have, that it's never going to be easy, but it's just now at least I'm conscious of it so I can, I have to try and you know, fight against it.

She described her experience of recovery in the language of the battlefield, where she was conscious of having to 'fight' and 'struggle' on a daily basis.

There was a sense of her eating disorder being the adversary. The fact that she became aware of her opponent felt empowering, in knowing what she was up against and where to fight. For her, it was being aware of her triggers and remaining watchful of these:

The fitness culture is massive here; everybody does sport all the time, and it's good but it's another little danger aspect that you know you have to watch for, that you don't - I just know I can't enter that world that it's more healthy for me not to be in the gym and in the this and that and everything else, luckily I don't have time so, (laughs) I don't have time as a mum. That's my excuse (laughs).

She expressed an awareness that what is 'healthy' and 'good' for others, may not be healthy for her. She was referencing the idea that general prescriptions for health may not be healthy for someone at risk of experiencing an eating disorder. She set herself apart from a world that is potentially dangerous for her, using her identity as a mother as a protective shield from risk. Although she laughed when she stated this and claimed it was an 'excuse', there was the sense that the time she spends on being 'a mum' is a defence that helped keep her from danger.

Although Gail relied on her own awareness and autonomy to keep well, in the wider context of her past experiences of support, she also communicated the sense of feeling that having someone there to check in with on an ongoing basis would be helpful:

You just have a series - you just have this series of counselling, you have this series of, em, series of nutrition and that bit that stopped, and that that is a really big problem I think, em, when you're, when you're when that's what you've realised especially when you're an adult, you know, with kids. When you're a teenager you've got your family who are still there. And I really needed that; someone checking up on me, and my doctor did nothing. Nothing at all. I actually asked if the nurse, if I could be weighed every other week I. So I was, but that involved me having to

walk down a really long hill, and then virtually run up it to get to school so it was just defeating the object really, and em, it was just ridiculous. But I just felt that I needed somebody to, I needed to be checked up on, you know, like a kid would, and without asking for it, I didn't get it.

Gail describes the 'stopping' of support as problematic in the context of her identity as a mother with children. She communicated that combining ongoing appointments with school runs is not practical; eating disorder care is not designed for mothers. Gail directly related this need to the cessation of her identity as a child in a family. Her GP is represented as being inactive and absent in her ongoing care, illustrated in her bald statement 'my doctor did nothing. Nothing at all.' Again, what is created is a narrative of wanting to be looked after. Gail was left feeling alone with this responsibility and communicated clearly how difficult this could be. Her plea for help was not attended to, and even when it was (in the nurse agreeing for her to be weighed regularly), it was not in a way that was ultimately helpful to her. She was aware that there was a childlike element to her desire for the support she was asking for, but also crucially, that this need was not being met. There was a sense of her doctor as an unresponsive parent, and the nurse as being responsive in a way that did not meet her needs. She was asking, but not getting. Both were experienced as being emotionally unavailable to Gail. In these extracts Gail experienced herself as both parent and child in relation to anorexia; where the parent was watchful and on guard for danger, but where the child sought attention and care.

It was clear that Alison also believed ongoing support would be helpful for her:

There needs to be something, I think, help in supporting you feeding your children, em, because they ought to know. I was always really worried when I got pregnant, I was always, I thought 'what if I either underfeed my children, cos I'm so worried that I'll feed them too much. See for me, if I have to follow a food plan, I always eat less than the food plan, cos I might accidentally have more than I'm meant to have and get big. I was so scared that I wouldn't feed my children enough or feed them too

much, cos I was trying to compensate for the fact that I might not feed them enough, and it would just to be nice to have somewhere that you could either phone or, just get that support so like my children being really fussy, the health visitor's been useless, the GP is like 'well, speak to the health visitor' and there is nowhere to go, and you just want to say 'my kids just won't eat anything I give them and my son's not eating his school dinners and he won't eat anything for packed lunch. I just want to cry'.

This section illustrated just how difficult Alison found feeding her children. She expressed how unsure she felt about what she did with her children around food, as a direct result of her own experiences of what food has meant to her. There is the sense that she experienced it as something that was easily able to 'go wrong'. Her use of the word 'accidentally' exacerbated the sense of how difficult it was to feel in control of food and eating. When she stated: 'they ought to know', she communicated her belief that someone should have access to an answer that was beyond her knowledge, with regards to what was 'right' for her children, in terms of eating. This served to increase her sense of impotence and desire for an answer that she felt was being withheld from her. She was aware that support with this would be helpful to her, but that she felt that responsibility for this was being passed on in a way that left her feeling worried and lost, with nowhere to turn. The GP and health visitor were experienced by her as unresponsive in a way that felt evocative of neglect, but not in a way that was felt by Alison as benign, or as a means by which to empower herself. What was obvious, was that food and feeding her children was an emotional experience for Alison, and left her feeling upset, alone and unsupported. Her final statement in this extract: 'I just want to cry', perfectly encapsulated her feelings of distress, invoking an image of a small child who has no one to comfort her. Kate also communicated her experience of recovery as something which was ongoing:

In January I'm starting another 6 months, 24 sessions of treatment, as as I've tried to explain to you when the weight is restored and our brain

works properly there are a lot of issues, as, for example, why we maintain an eating disorder - what spurs us on, don't necessarily get addressed along the way - the CBT doesn't cover that, and the NHS funds are that they like to leave us at a point where at least our weight is stable but with some people, particularly when you've had it for forty something years, the facts that maintain the eating disorder are still there, the psychological patterns, the self-worth, self-esteem - they still remain, so and that, all of us, we have a peer group that's been set up for people who've been discharged at a stable weight. We all struggle now that we all feel fat, and that we're living in a new world with all these new feelings, that we struggle very much with. I mean not a day goes past that I just think' oh I just want to be the way I used to be - this is just too difficult'.

Kate separated out the strands of what 'recovery' meant to her; physical and neurological recovery (attended to in CBT), but also with a deeper focus on what might have caused and maintained the eating disorder in the first place. Her use of 'we' rather than 'I' implied her belief in it being a universal experience, that she shared with other mothers who have experienced anorexia. Her description of her experience of the peer group underlined this sense of 'belonging' to a tribe of women who feel the same. She presented herself as a spokesperson for her tribe, confidently stating that she knew how it was for them and that this was the same as how it was for her. She described how 'feeling fat' was experienced as a struggle. She communicated a sense of finding herself in a foreign land where everything was new, different and difficult, and where a desire for a return to the old familiar was a daily experience. She created a sense of nostalgia for a past easier self, in a world that was known and where feelings were not a struggle. Her account evoked a feeling of 'otherness' that she believed she shared with the women in her peer group. Again, she used 'we' throughout, demonstrating her affiliation with her group:

well it's funny because we have an expression in our peer group. We say we are covering shit, excuse the language, It's just that the, we've not recovered mentally, but everyone thinks we've recovered because our bodies sort of look okay, I mean having faces that are, they're not chubby, but they're probably in the higher range of the normal. Some are still very skinny, and I think it just, the peer group for me is so important, because it just reminds me and my family that even though the house that it looks like I'm living in looks about normal - the head is far from normal.

Kate's use of language and metaphor in this extract viscerally demonstrated the contrast between how she experiences what is seen by the world on the outside, and what was really felt underneath. The 'recovered' 'chubby' bodies, presented as the 'houses', are acting as a cover-up or disguise for the 'shit' that remained both in the 'head' and 'mentally'. She cited this as a reason why the peer group was so important in her ongoing recovery; it served as a reminder that what looked 'normal' was actually concealing something far less palatable; and that this was something to be vigilant of.

The dominant message in these accounts of 'recovery' was that it was an ongoing process and something which required continued attention beyond 'physical recovery'. The women cited different aspects of this ongoing process that they believed would be most helpful. These included: support and advice for feeding and caring for children, ongoing one-to-one therapy (attending to a holistic sense of recovery that covers both physical and psychological elements), being part of a support group, and help with gaining an understanding about what works and is helpful to them as individuals. These stories expressed a common theme that referenced the idea that 'recovery' is not static or is something that necessarily has an end-point, but rather it is dynamic, evolving and requires appropriate care and attention.

This last super-ordinate theme unravelled how the women experienced seeking and receiving treatment for anorexia, and how they viewed 'recovery' looking

forward into the future. What was evident from the stories the women told was that, feeling understood and attended to within wider contexts (that had importance and resonance for them in how they experienced their worlds), was of paramount significance and that experiences of 'poor' support or interventions was likely to have a poor 'outcome' for the woman being treated. 'Being a mother with anorexia' was expressed as representing a particularly important context for the women to be treated from, throughout the process of seeking and accessing help and feeling supported on an ongoing basis.

Taken together, the three super-ordinate themes illustrated the similarities and diversity in the women's stories of living as a mother, experiencing anorexia. The stories they told highlighted the embodied experiences they had, in terms of their sense of (in)visibility in a world that feels different to that of other women. This feeling of 'otherness' was exacerbated through narratives of shame and blame which often related to their identity as mothers. How far they related to the idea of there being a separate part of them that was internalised as 'anorexic', had various impacts on their sense of being able to uphold a strong separate 'mother' identity; often creating the sense of splitting (Fairburn, 1994) where it was difficult to integrate the 'mother' with the 'self, experiencing anorexia'. This related to the often-challenging experiences of the competing demands of motherhood and anorexia; where it was sometimes difficult for the women to attend to their own needs and those of their children simultaneously. Role-reversal in families was described, where the children sometimes adopted a more parental role with their mothers, and the mothers became more child-like. These experiences were greeted with guilt and shame on occasion, but also fulfilled a restorative function for the mothers in some situations. Although having children was also described as potentially triggering (for the experience of anorexia) by some of the mothers, all of the mother's narratives referenced the idea that having children was restorative and protective in terms of supplying them with a tangible reason to recover.

In experiences of therapy and support for anorexia, the mothers variously described the difficulty of fit between being both a mother and a client; where

they often referenced dominant discourses around motherhood that rejected the idea of a mother 'putting herself first'. The diverse range of experiences of interventions and support were highlighted by the stories the women told; where they variously described positive and negative aspects of the 'help' they received. What was evident from their accounts was that perceived 'fit' between the therapist and client, and between the support being offered and the perceived acceptability of the intervention, was paramount in maintaining a positive therapeutic relationship and environment conducive to constructive change. What also emerged from the women's stories, was the importance of feeling supported beyond the 'physical recovery' of anorexia, in the context of motherhood and staying well.

Discussion

The purpose of this study was to explore mothers' narratives about their lived experiences of anorexia while bringing up their children. The study focused on what sense these women made of their experiences of mothering within this context and their experiences of seeking and receiving support for anorexia. The analysis highlighted the range of embodied emotions and feelings involved in these experiences. The over-arching findings were that these lived experiences were nuanced, multi-faceted and diverse. Although there were some aspects of the experiences (described by the women) that shared common themes, what stood out from the findings was that each woman's story was qualitatively different and unique to any other. While it is helpful to elucidate the common ground in the narratives here, this is done within an explicit awareness that each woman's story should be prized in its own right, and that each is as valuable and precious as the next.

The use of IPA allowed a presentation and interpretation of the data that had a focus on how the women expressed their thoughts and feelings about their experiences of anorexia and mothering and how, and in what ways, these aspects of their lives interacted with and influenced, each other. A non-pathologising perspective on the particular experiences of being a mother while being diagnosed with anorexia speaks to the central tenets of counselling

psychology, in terms of researching (and disseminating information on) individual subjective experiences in ways that are empowering rather than controlling. The BPS Division of Counselling Psychology Guidelines (BPS, 2005) suggests that counselling psychology has a unique role in developing phenomenological models of enquiry and research through engaging with first-person accounts that 'recognise social contexts and discrimination' (p.1-2). This research has attempted to put this suggestion into action.

The findings are contextualised in relation to the existing literature, highlighting similarities, differences and challenges involved in the experience of being a mother experiencing anorexia while bringing up children. Suggestions for therapeutic practice will be discussed, offering ideas of what might be helpful, for mothers experiencing anorexia, in terms of practical, emotional and psychological approaches. How this research contributes to the field of counselling psychology will also be considered, followed by a critical evaluation of the study and suggestions for future research.

Considering the interaction between motherhood and anorexia through social and psychological understandings

The mothers in this research described the challenges involved in attending to the competing demands of motherhood and anorexia. There was often a struggle in responding to their own needs and those of their children simultaneously. The often-uneasy relationship between being a mother and experiencing anorexia (described by participants) may be comprehended within the context of pathologising dominant social discourses on both (Jackson & Mannix, 2004; Henderson et al., 2016), where there is an expectation for mothers to think and behave in certain prescribed ways that are in direct opposition to the negatively-perceived 'anorexic' identity.

Current dominant understandings of mothering and motherhood linked to ideas of 'selflessness' are widely referenced in the literature (Chodorow, 1978; Malacrida & Boulton, 2012; Thurer, 1995). An espousal of this discourse was apparent in the stories told by the women in this study. Participants told stories referencing an internalisation of the idea of the 'selfless-mother' (Hays, 1996)

that made it difficult for them to view themselves in a compassionate way. Internalising guilt and feeling pressure to be the 'perfect mother' increases a mother's risk for experiencing anxiety, stress and decreased self-efficacy (Henderson et al., 2016) and this was borne out by some of the accounts of the women in this study. They described feeling negatively appraised as a mother, by selves and by others (often in relation to their experiences of anorexia) and that feeling like a 'failure' in this mothering role led to experiences of anxiety and low self-esteem. These internalised narratives are reinforced and perpetuated by the stories that are told and do not leave space for a consideration of Winnicott's 'good-enough' mother (1964), where a mother can attend to her own needs alongside those of her children without concern (on an individual and societal level) that there will be 'harmful' effects on the child.

Critical feminist perspectives critique dominant discourses that perpetuate gender inequality and discrimination. Some research on mothering and motherhood offers alternative discourses that *does* express nuanced and complex experiences of being a mother (Arendell, 2000; Chase and Rogers, 2001; Green, 2018; Taylor & Bloch, 2018). However, reconceptualising motherhood, as an institution reinforced by patriarchy (as opposed to mothering itself being a form of female oppression), as proposed by Adrienne Rich (1976), does not seem to have significantly influenced essentialist assumptions surrounding the 'good mother'. This is perhaps not surprising in that patriarchy is likely to fight perceived resistance to its authority (Gilligan & Richards, 2009). Alternative, less-oppressive formulations of mothers and mothering have often been silenced by the omni-present (and somewhat ominous) 'idealised mother' discourses (Bassin et al., 1994; Ross, 2010). This was starkly highlighted and reproduced in the stories communicated by the mothers in this research, where it can be theorised that their narratives stand as a testament to individual and societal internalisations of this oppressive (and unattainable) ideal. Although they might have an awareness that this ideal is unattainable, the personal narratives of the women in this study attest to the fact that they continue to be influenced by the ideological conditions in which

their discourses are constructed. This corresponds to research that argues that individual stories are shaped by political realities where it is almost impossible for women to 'embrace the ambivalence in their stories in a context where such ambivalence is not yet tolerated within the dominant ideologies' (Kruger, 2003, p. 198). Taking this perspective, it could be argued that, while it is important to hear the individual voices and personal narratives, it is also valuable to expose essentialist tendencies within these stories, in order to theorise and acknowledge sources of oppression 'found in the conceptual practices of power that are embedded in institutional cultures and practices' (Harding, 2001, p. 517).

The 'idealised' mother has her polar opposite in other dominant discourses that are involved with the insidious practice of 'mother-blaming' (Caplan & Hall-McCorquordale, 1985; Jackson & Mannix, 2004), and a concomitant internalisation of this phenomenon was also evident in some of the stories the women told. Some of the narratives created a sense of the women feeling negatively judged and blamed for struggles over feeding children, where the women's status as a mother was experienced as being publicly available for negative appraisal. Experiences of blame were described by the women as becoming internalised as guilt and shame (e.g. where Jane described questioning and doubting whether she had negatively affected her youngest daughter, after feeling blamed by her ex-partner). It was striking how much the women's introspective critical questioning of themselves, in this study, echoed those accounts in Jackson and Mannix's (2004) paper on mothers' experiences of mother blaming', highlighting the 'normative' aspect of this for many mothers. This is borne out in other research which reports on mother's experiences of guilt in the context of an eating disorder (Rortveit, 2009; Stitt & Reupert, 2014), indicating that an updating of oppressive and pathologising conceptualisations of motherhood and mothering is long overdue. This has been argued for time and again in the literature. For example Chess (1982) wrote: 'It is the height of irresponsibility to start with the assumption that the mother is at fault (no matter how elegantly such a "blame the mother" ideology

is phrased), to shape the facts to fit this ideology, and then to act accordingly' (p. 107). Critical shifts in culture, policy and the stories we tell, are needed in beginning to reconceive motherhood in a way that women can embrace, without feeling bad about themselves, or feeling judged by others. This idea was argued for by Caplan and Hall-McCorquordale, (1985) when they opined that:

'social practices that classify the responsibility for child rearing as the mother's province can only perpetuate mother-blaming...such interpretations by clinicians, researchers, and other mental health professionals strengthen the notion that the problems are the mother's fault, and the vicious cycle continues' (p. 612).

They recommend that a seismic shift away from this propensity is both desirable and necessary in order to release women who become mothers from this burdensome source of shame and anxiety.

Dominant discourses associated with anorexia are also often characterised in pathologising and oppressive ways in the descriptions that are used to describe individuals experiencing it. This is particularly evident through the narratives created by mainstream research into mothers with eating disorders (e.g. Stein & Fairburn, 1989; Vignalou, 2006). There is often an implicit assumption, in this research, that mothers are entirely responsible for their children's relationships with food and eating and that, in the context of their anorexia, they will somehow fail in this role (e.g. Stein & Fairburn, 1989; Birch & Fisher, 2000). What is often omitted from this assumption is the additional impact of other relationships and the wider cultural context on a child's relationship with food and feeling pressure to conform to the cultural thin ideal (Tiggemann & Slater, 2014). Other factors that may usefully be taken into account include government regulation of the food industry, schooling, the influence of fathers, other parents and family members (Savage et al., 2007).

The women in this study described ways in which they felt negatively judged by others or by themselves with regards to their 'status' of 'being anorexic' which included being shamed (by family members and others) for 'being anorexic' and

having to be hidden from public view. In this respect, the 'shamers' might be said to personify the body of literature that pathologises anorexic mothers as being somehow 'unfit' (Brinch et al., 1988; Vignalou & Guedeney, 2006). It is no surprise, therefore, that some of the literature exploring mothers who experience anorexia, report the mothers expressing guilt and shame (e.g. Rortveit, 2009). Other narratives in this study, referred to mothers self-blaming for engaging with the practices of anorexia; deeming this 'wrong' (and a source of guilt and shame) in the context of being a mother. This might be theorised as an internalisation of the 'anorexic' as fundamentally 'wrong' or 'bad' in some way; where anorexia is not perceived as being acceptable to experience, but rather is something to be hidden and be silent about (Rich, 2006). From this perspective, it makes sense that it becomes difficult for the mother experiencing anorexia to conceive of herself as someone to be cared for and attended to with compassion. It is important to expose the implicit and explicit existence of these 'unfit mother' narratives in beginning to make sense of women's experiences of how it is to be both a mother and experience anorexia. Through acknowledgement and recognition of these prevailing unhelpful and pathologising narratives, it becomes possible to begin to challenge and re-frame these, in a bid to access and construct alternative, more helpful and compassionate ways of conceiving of, and supporting these experiences.

There were variations in individual narratives about how much the women perceived that their experience of anorexia impacted negatively on their children. Only one of the women in this research related her belief that her anorexia had no impact whatsoever on her children, while the other women communicated fear that their problems with eating would negatively affect their children. Their fears involved ideas that they might cause, or be responsible for, disordered eating in their children and engender unhelpful attitudes to body shape and size. This echoed findings in research by Bryant-Waugh et al. (2007) where mothers with eating disorders also described concerns about passing on traits of disordered eating to their children. The mother's stories in this study revealed that being a mother experiencing

anorexia could be inherently challenging and anxiety-provoking and as such experiences worthy of support.

At the heart of Kate's narrative lay a contradiction that perfectly encapsulated the complexities of simultaneously holding a mother and anorexic sense of identity. Part of the narrative communicated that experiencing anorexia in the context of motherhood could be 'safe' and 'nourishing', while another account conveyed the sense that the experience of anorexia could be potentially dangerous (and even life-threatening) for the children. In this story, the narrative referenced a battle between the 'good' and 'bad' mother, where one or other must win and where it is impossible to be both. The sometimes-paradoxical nature of the narratives, in and between mother's accounts in this study, highlighted the contradictions and complexities that lie at the centre of much of human experience and experiences of distress (e.g. Werner & Malterud, 2004).

Critical feminist approaches offer theories of eating disorders that aim to serve as alternatives to the pathologising accounts that dominate the research literature (e.g. Holmes, 2016; Malson & Burns, 2009). These include studies that avoid subscribing to the idea that there is anything that is 'pathological' or 'normal' about what we know as 'eating disorders'. They advocate for the idea that these might be more helpfully regarded as 'distressed experiences and practices that simultaneously express a multiplicity of potentially contradictory positions and effects' (Malson & Burns, 2009, p.4). The idea that distress around eating and bodies is on a continuum, which is informed by practices and discourses of normative femininity (Malson, 1998; Saukko, 2008), might be a more helpful lens through which to view the experiences of anorexia described by the women in this study. In re-framing their experiences in this way, distress associated with guilt, blame and shame might be somewhat alleviated, where blame is shifted from the individual woman and anorexia does not necessarily have to be experienced as divergent from some perceived 'norm', but is replaced with and understood as a communication of distress.

Feminist approaches theorise anorexia and eating disorders as being constituted in, and by, the discursive contexts in which we live (Malson, 2009). The field of counselling psychology is also well-placed to contribute to an alternative conceptualisation of anorexia in terms of how it values the process of formulation (BPS, 2011) in making sense of experiences of distress. The women in this study expressed numerous factors that shaped how and why they came to experience anorexia. Some women made explicit reference to the idea that difficult relationships might have contributed to their experience of anorexia, while others related their belief that it was a 'mind-set' or way of being that became habitual. Alison's account connected experiences of sexual abuse to having a difficult relationship with food, while others related it to having low self-worth or to biological and sociocultural reasons. In many accounts, the women expressed a belief that their experiences of and with anorexia were a result of many different influences which (with the exception of one mother) pre-dated their becoming mothers. The diversity in their narratives about their beliefs about the origin of their experience of anorexia corresponds with recent understandings of what triggers and sustains anorexia for individuals in which it is acknowledged that this is likely to be multi-factorial (Beat, 2016; Zipfel et al., 2015). What appears to be important in recognising that each woman had a unique story to tell, is that this furthers the case for using formulation to relate theory to practice in order to make sense of their experiences and inform what support might be most appropriate for each (Johnstone & Dallos, 2013).

Holmes (2016) discussed the idea that the practice of 'self-starving' could be understood as embodying practices and discourses of 'containment and discipline as well as embodied agency and resistance' (p.X). This fits well with some of the experiences and beliefs, related by the mothers in this study where discourses around starving the self, while nourishing others were described as conforming to particularly 'anorexic practices'. There was the sense that the women were able to hold both 'conforming' and 'defiant' stances through these practices. While it is helpful and desirable to have other non-pathologising

lenses through which to view both motherhood and anorexia, it is evident that there is still a great deal of work to be done in achieving this; for the women experiencing blame, shame and guilt and in the way these pathologising narratives are produced and reproduced in wider social contexts.

Considering disparate experiences of therapy and support for mothers with anorexia

Studies reporting on public attitudes to anorexia have revealed an underlying blame culture towards individuals experiencing anorexia (e.g. Crisp, 2005; Stewart, 2006). Worryingly, this blame has been reported in studies of health providers' attitudes toward their patients (e.g. Crisafulli et al., 2008).

Experiences of feeling blamed for their experiences of anorexia were poignantly expressed by some of the participants in this research; reinforcing the sense that this blame culture is still pervasive today. In addition to this, women experiencing anorexia have often been described in the literature as being needy, oppositional and resistant to treatment (Kaplan & Garfinkel, 1999; Ramjan, 2004). In this study, different accounts of therapeutic interventions and support were expressed by the women - some of which were characterised by feeling objectified in ways that could be dehumanising and unsupportive. Some of the women responded to these experiences by rebelling against, resisting or dropping out of the services that were supposed to be supporting them.

Questioning *why* women experiencing anorexia are described in negative ways, in the context of interventions, might help inform the development of more compassionate and helpful interventions, rather than blaming the women for 'non-compliance'. This idea resonates with critical feminist accounts that question the 'normality' of the treatment women with anorexia received (Malson et al., 2004) and theorises that treatment experiences have been shown to echo a similar 'micro-management' of the body, evident in the experience of anorexia itself. Some of the women in this research communicated that a focus on food, weight, body shape and eating were experienced as unhelpful and were sometimes perceived as exacerbating the 'symptoms' of anorexia. This echoes research by LaMarre and Rice (2015) in

which they found that the advice given to individuals in recovery was in diametric opposition to dominant recommendations for health, which results in understandable confusion over what is 'healthy' eating behaviour. Having a 'treatment' focus purely on the physical embodiment of the experience of anorexia, was variously experienced by the women in this research as punitive, frightening and unhelpful in different ways. For Alison this was reminiscent of abusive embodied experiences in her past, while for other participants it was experienced as infantilising, patronising and not considerate of their status as mothers. Their accounts of opposition and resistance to some of the interventions speaks to the literature (outlined above) that propagates these harmful stereotypes of women experiencing anorexia. This suggests that discourses disseminating the idea of the 'anorexic patient' as 'needy', are unhelpful for women (in general) seeking help for anorexia, and particularly for women who are mothers (who might also be bound up in the 'idealised mother' mythology). This signals a need for the healthcare profession at large to think about *why* particular clients or patients might be experienced and represented in pathologising ways and to recognise the attendant relational aspect of the treatment dynamic where responsibility should be most helpfully conceived as a shared endeavour (Hepworth, 1999; Sandoz et al., 2010).

The women's accounts of their experiences of professional support, in this study, illuminated how difficult it could sometimes be to achieve and maintain a good 'fit' between being a client experiencing anorexia and being a mother. Some of the accounts described the women not feeling deserving of help; particularly in the context of being a mother where 'other people' must come first. They described how difficult it could be to even think about accessing treatment (as a mother) suggesting the problematic nature of maintaining an 'idealised mother' status alongside that of being a 'distressed woman' in need and want of support. Other stories of interventions in this study highlighted difficulties experienced by the women in reconciling aspects of their treatment with their status of being a mother (e.g. where in-patient interventions were recommended for Vicky and where Gail's therapist was continually late). These

recommendations were met with either opposition or feelings of guilt at the prospect of having to leave their children. The tendency in treatments for anorexia, to focus on (sometimes prescriptive) clinical pathways and recommendations (Lock, 1999) has meant that some women fall beyond or outside the helpfulness of these treatments for their particular experiences.

Some of the women in this research related embodied experiences of health care professionals that proved unhelpful. Gail reported feeling 'bullied' by a health care professional who was described as 'larger than life', while Kate related experiencing her therapist's weight loss over the course of therapy as a barrier to the relationship. Merleau-Ponty (1954/2004) contended that the body is inextricably intertwined with how we experience ourselves and our relationships with others. It might be theorised that this particular aspect of experience appears to be especially significant in psychotherapeutic relationships that have their focus on distress that has a strongly embodied element to it. Taking into consideration the idea that the body perceives and knows and is a means of communicating with the world (Moran, 2000) suggests that maintaining an embodied awareness of self and other (and the dynamics it produces) in the context of therapy is important for health care professionals working with clients who might be struggling with body weight and size.

Despite the fact that the women in this research were ultimately able to resist the challenges they faced in their experiences of seeking and receiving support (and go on to seek more 'helpful' help elsewhere), these facets of the women's stories testify to the fact that oppressive power dynamics and discourses (described above) can sometimes be an insurmountable barrier to giving and receiving help and support. This idea is reinforced elsewhere in the literature that documents other women's accounts of experiences of interventions (in the context of the experience of anorexia) as unhelpful and pathologising (Burns, 2004; Eivors et al., 2003; Gremillion, 2002).

Although some of the women in this study related some of their experiences of seeking and receiving support as unhelpful, other women had a more positive

story to tell. This resonates with other accounts in the literature where women reported both helpful and less helpful aspects of the treatment they received (e.g. Le Grange et al., 1998). Some of the women reported the value they placed on having a continuity of care, which allowed them the opportunity to build a 'good relationship' with their therapist. This corresponds with research which recognises the therapeutic alliance as an important aspect of 'successful' treatment for eating disorders (Pereira et al., 2006; Sly et al., 2013; Tierney, 2008) and indicates that this might be usefully considered by health care professionals in their interactions with clients experiencing eating disorders.

Another aspect of treatment that was experienced as valuable was the sense of the therapist being a 'specialist' in her field and being educated into 'biological' and 'scientific' explanations for eating disorders. In addition to this, developing practical coping strategies was also experienced as helpful. This resonates with literature (Brown & Waller, 2014) which suggested that a focused approach on techniques in helping with the experience of anorexia can be helpful.

The diverse nature of what the women in this research found 'helpful' in their treatment, suggests that a pluralistic approach might be usefully employed by clinicians. Supporting their clients in a holistic way that takes account of their values and life experiences might be useful, in addition to acknowledging the other multifarious influences that might impact on what is perceived and experienced as helpful. Similarly, a recent systematic review of intervention outcomes for anorexia recommended the utility of therapists' engagement with a more holistic approach to treatment than that which has traditionally been employed (Murray et al., 2018).

Transformative experiences of motherhood in the context of experiences of anorexia

There was also a common theme in the narratives that referenced how having children could be transformative in a mother's life and could have a positive impact on their experience of anorexia. Experiences of pregnancy and becoming a mother signalled periods of respite from the experience of anorexia, for some of the women. This echoed findings from Fogarty et al. (2018) in which some

women in the research experienced a positive change in their eating habits and body image during pregnancy. Likewise, in this study, some of the women described that by putting the child first (in utero and when they were delivered), anorexia had to take a back seat against nourishing the child, through the mother's body. In this respect, the narrative of the 'selfless mother' functioned in a positive, rather than oppressive way, where the women reported being able to experience a period of liberation from rules around size and eating. Although this experience of liberation was often short-lived, whereupon the women returned to less helpful patterns of behaviour, it could be theorised that the experience of becoming a mother allowed them access to a different way of being that would not perhaps have been otherwise available. Fogarty et al. (2018) suggested that these 'windows of opportunity' (where things could be different) might be usefully exploited in gaining longer term positive effects on mother's relationships with food and eating.

Studies by Rortveit (2009), Tuval-Mashiach et al. (2013) and von Soest and Wichstrom (2008) described how motherhood could have a positive effect on eating problems, often citing children as a reason to recover. These findings were replicated in some of the women's stories in this study. Not wanting the children to have the experience of anorexia, being a good role model and being able to physically keep up with the children were cited by some of the women as being strong motivators for staying 'well' themselves. It might be theorised that the women were subscribing to the role of the 'idealised mother' in these accounts, but in ways that become protective and helpful rather than pathologising. This idea might benefit from further exploration in future research and may have utility in the context of therapeutic practice as it offers a way to positively re-frame the identity of a woman who becomes a mother or to access a more compassionate self-image. In this research, the women variously described ways in which they had been able to re-frame previously critical, blaming and shaming narratives into ones which they were able to conceive of as positive, liberating and much more helpful in the context of the process of recovery. Tuval-Mashiach et al., (2013) also suggested that there could be

benefits to developing interventions that fostered self-confidence for these women (rather than focusing specifically on the eating disorder). Although there were similarities in the women's stories about how they felt about their children, it was also notable that there were some qualitative differences in the narratives. This diversity in narratives furthers the case for the value of exploring women's lived experience (Bryant-Waugh et al., 2007) and understanding that what makes sense for, and resonates with, one woman will not necessarily be the same for the next.

Suggestions for therapeutic practice

This study aims to offer suggestions for therapeutic practice, using the information from the interviews with these women as a guiding source. It is important to acknowledge that this study cannot claim to offer 'certain knowledge', but rather, that it hopes to tentatively offer some new knowledge that may have some value to clinicians, clients and those with an interest in the subject. This is done through acknowledging, giving voice to and understanding the needs and concerns of this particular group of women.

Feminist approaches (e.g. Bordo, 1988; Malson, 1998) can offer helpful, empathic and non-pathologising lenses through which to view the world of women in general, and mothers experiencing anorexia in particular. However, it can be challenging to translate these theories into clinical practice; where 'feminist work often takes place at considerable remove from treatment intervention' (Holmes, 2016, p.465). There is acknowledgment that feminist research offers valuable insights into discourses and constructions that constitute normative femininities (Malson, 2009) and how these translate into experiences of 'treatment'. However, what is also acknowledged is that there is a 'scholarly distance' between critiquing the biomedical model and offering alternative ways in which to support and help individuals who are experiencing eating disorders (Holmes, 2016).

Counselling psychologists (and other health-care professionals) are well-placed to begin to think about bridging this gap in clinical settings through taking a more holistic view of clients in general, and mothers experiencing anorexia in

particular. It is important to maintain an active understanding that the role of being a mother with anorexia can be variously supporting and/or triggering, and that these contradictions should be empathically responded to in the assessment, formulation and help offered to these women. This could be addressed in the dissemination of literature and training for health care professionals (at all levels) that presents the experience of anorexia (for men and women) as a communication of distress in order to begin to break down stigmas, assumptions and prejudices that remain prevalent across society towards anorexia (Jenkins & Ogden, 2012; Stewart et al., 2006).

In this study, mothers described a variety of concerns relating to their children, which included anxiety about: passing on traits, interactions around food and mealtimes, mothers food intake in front of children and creating body-image issues. This is similar to findings from a study by Bryant-Waugh et al. (2007). Bryant-Waugh et al. (2007) used their findings to develop an intervention that was informed by what the mothers said they would find useful. The mothers reported finding the intervention helpful, suggesting that listening to what is important for women is useful in considering what might be most helpful and relevant to their lives within their families. Bryant-Waugh et al., (2007) suggested that specifically-tailored support and advice for mothers, around their parental role, might be beneficial in promoting positivity and self-esteem around being a parent.

In this current study some of the women explicitly expressed how having practical support with feeding their children would have been helpful, while others related how they sought flexibility around treatment that accommodated school-runs and child care. They variously commented on the fact that their self-esteem could be negatively affected by anxiety that their experience of anorexia might adversely impact on their children. Being educated in distinguishing one's own needs from that of their children was also commented on as being useful within the context of eating and feeding. Further research into the concerns that mothers experiencing anorexia have, and using this to inform clinical practice and support, would acknowledge the 'experience-

expert' alongside that of the 'researcher-expert' or 'clinician-expert' (Smith et al., 2010). A dynamic formulation that can be multi-layered, textured and sometimes contradictory will help avoid a 'one-size fits all' approach to the experiences of and meanings ascribed to anorexia by these women. The idea that formulation should guide understanding and clinical practice, feels particularly appropriate when considering help and support for this group of women, since historically and anecdotally, a holistic approach has not been available, where the focus has often been on the embodied practices of anorexia and motherhood, rather than taking account of the individual woman seeking help. While it is important to take account of context in making sense of experience, it is also important to recognise that contexts also have different meanings for different individuals and that hearing the client is key to the therapeutic process

An emphasis on acknowledging and minimising power differentials, in the context of therapy, is also desirable regardless of the presenting problems in living (Tierney, 2008; Pereira et al., 2006; Sly et al., 2013). This is particularly important in the case of anorexia, where this power differential has traditionally, and anecdotally, been keenly felt by clients in relation to their care providers (Malson et al., 2004). An emphasis on the 'relational', 'transparent' and 'collaborative' should be at the centre of all therapeutic interactions in managing distress that is embodied as well as psychological. This is in recognition that traditional practices of 'therapy', for the experience of anorexia, have often focused on the embodied experience as distinct to the psychological, in ways which have been reported by women as feeling punitive, harmful or oppressive. It is important to recognise and acknowledge (in the context of treatment) that current recommendations for 'staying healthy', in the context of the experience of anorexia, can be contradictory to other dominant discourses around 'eating healthily' (LaMarre & Rice, 2016).

Responding to the stories the women told about their treatment, it is evident that flexibility with the practicalities of 'treatment' would be helpful in creating a strong working alliance (which still remains the most robust predictor for

‘successful’ therapy, Horvath et al., 2011). The idea that the therapeutic alliance is an important factor in therapeutic interventions with individuals experiencing eating disorders is supported by a meta-analysis conducted by Graves et al., (2017) which acknowledged the bidirectional relationship between therapeutic alliance and outcome. On a practical level, the building and maintaining of a therapeutic alliance might involve the therapist having an awareness of the potential impact of child-care on a mother’s ability to engage with the therapeutic process and responding to this. On a therapeutic level, using a dynamic formulation that is a ‘recursive process of suggestion, discussion, reflection, feedback and revision as part of the moment-to-moment process of therapy’ (Johnstone & Dallos, 2013, p.4), alongside a recognition of the particular function (or meaning) of anorexia for an individual might be a useful first step in thinking about what might be ‘helpful’.

Given the fact that the women in this study variously referenced guilt and shame in the stories they told, it may be helpful if an approach that focused on developing self-compassion might be more widely available. Compassion-focused therapy (CFT) was originally developed to address self-criticism, hostility and shame, through helping individuals to cultivate self-compassion and compassionate emotional responses (Gilbert, 2009). It has also been adapted to address the biological, social and psychological challenges of recovery from eating disorders (CFT-E) in a way that integrates aspects of CFT with other evidence-based practices (Goss & Allan, 2014). Although the existing literature indicates that CFT-E offers a promising treatment for outpatients (e.g. Goss & Allan, 2014), the women in this research made no mention of this kind of therapy being offered to them in their various experiences of private and NHS interventions.

Fardella (2008) found that in exploring the ‘lived experiences’ of recovery, the importance of ‘collaboration between client and professional...to re-appropriate a healthier sense of self’ (*ibid.*, p.114) after the diagnostic symptoms have reduced was key. This resonated with the findings of the current research in which the women in this study communicated the idea that ongoing support

would be helpful to them, after 'recovery' was achieved. Fardella (2008) is a proponent of the 'recovery model' which recognises that the recovery journey is an intensely personal and individual process that is also related to an individual's community and society (Repper & Perkins, 2003). Fardella (2008) reminds us that 'the recovery model urges professionals to be mindful that the 'client' is always more than the sum of her symptoms and that the recovery of self always involves more than adherence to medical protocols for care' (*ibid.*, p.114). The idea of supporting clients in a more holistic way is particularly pertinent to the mothers in this research; where protocol-driven interventions were often experienced as punitive and unhelpful; and being understood proved key to positive experiences of therapy.

Malson et al. (2011) made recommendations for therapeutic interventions that take account of the 'multi-faceted self' in 'attending to aspects of the client that are not food or weight related' (p.34). The mothers in the current research communicated diverse stories about what they believed prompted the development of anorexia and what they believed maintained it, both in the context of their lives before and after motherhood. Some of the participants in this research expressed that when the multiplicity of contexts and life experiences were taken into account, the therapy was experienced positively. Malson et al. (2011) recommended therapies that distinguishes between the person and the 'problem' in order to foster positive outcomes for clients. In particular, they recommended that narrative therapy might be well-placed to implement interventions that respond to these needs. The results of the current research also go some way to suggesting that this type of approach might be helpful in supporting mothers who are experiencing anorexia (Lock et al, 2005). When the women in the current research experienced therapy as impersonal and, experienced themselves as 'problematic' to the health-care professionals, the outcomes, not surprisingly, were not positive. Another suggestion for psychotherapeutic interventions for anorexia (Malson et al., 2011) was Supportive Psychotherapy where the 'therapist helps to sustain and bolster the patient' (Bloch, 2006: p. 216). In a randomised control trial, comparing cognitive

behaviour therapy and interpersonal psychotherapy with non-specific supportive clinical management for adults experiencing anorexia, McIntosh et al., (2005) found that those individuals who received non-specific support (supportive psychotherapy) had positive outcomes that were rated as being as good as, or better than outcomes of those who had received specialised therapies; suggesting that some of the current recommended psychotherapeutic interventions for anorexia might usefully be re-visited and revised in order to take a more holistic view of client need.

Implications for counselling psychology

This research offers a non-pathologising perspective on the particular experiences of being a mother while being diagnosed with anorexia. This is in line with the central tenets of counselling psychology in terms of researching (and disseminating information on) individual subjective experiences in ways that are empowering rather than controlling. The Division of Counselling Psychology Guidelines (BPS, 2005) suggests that counselling psychology has a unique role in developing phenomenological models of enquiry and research through engaging with first-person accounts that 'recognise social contexts and discrimination' and does not 'assume the automatic superiority of any one way of experiencing, feeling, valuing and knowing' (p.1-2). Using IPA responds to this proposition in the way in which it employs a detailed and inductive approach, grounded in phenomenology and hermeneutic inquiry (Smith et al., 2004), which allows for a process of interpretation of and exploration into the perceptions, understandings, perspectives and feelings of women who have lived the phenomenon of anorexia in the context of motherhood (and motherhood in the context of anorexia). IPA and its epistemological assumptions fit well with the values of counselling psychology in appreciating individuals as unique, having a focus on facilitating growth and an application-in-practice of these (and those mentioned above) concepts and values (Cooper, 2009; Kasket, 2016; Orlans & van Scoyoc, 2009).

In terms of comprehending subjective experiences of anorexia, the idea of 'formulation' rather than 'diagnosis' relates well to the philosophy of

counselling psychology, as an antidote to the medical approach. The BPS (2011, p. 5) recommends that formulation should 'draw on and integrate a wide range of interpersonal, biological, social and cultural factors' and that this should be a core competency for psychology practitioners. The fact that the women related many challenging, unhelpful and sometimes harmful stories with regards to their experiences of support, indicates that current practices potentially remain inadequate in some areas, and could benefit from thinking about the experience from the client's perspective.

It is hoped that this research will inform therapeutic practice and will be considered in terms of beginning to think about bridging the uneasy gap between traditional therapies (that contribute to the construct of 'an eating disordered patient' from the perspective of the medical model), and the recovery model (where 'recovery' is conceived as being part of an empowered journey that results in a better quality of life). In addition to this, providing individualised, phenomenological formulations which offer 'provisional explanations or hypotheses of how an individual comes to present with a certain disorder or circumstance at a particular point in time' (Weerasekera, 1996, p. 4) might engender the possibility of gaining an understanding of why anorexia might have developed for each client, finding the 'meaning' in the experience against the background context of social, political and economic perspectives and being informed by critical feminist (e.g. Malson & Burns, 2009; Saukko, 2008) and other theories (e.g. Grogan, 2017; Rodin et al., 1984).

Evaluation of the study

This research has provided a rich and detailed account of the life-worlds of mothers who have experienced anorexia while raising their children, using the qualitative research methodology of IPA. It is helpful to reflect on and evaluate this study in terms of quality and worth in order to assess its contribution to qualitative research in general, and IPA in particular.

Lucy Yardley (2015) offers four guiding principles for assessing the quality of qualitative research and I will use these to consider the credibility of this study. These are *sensitivity to context, commitment and rigour, transparency and*

coherence and impact and importance. The first principle Yardley (2015) suggests is that a good qualitative study will demonstrate *sensitivity to context*. The 'context' referred to here is used in the loosest of terms and includes existing theory, research, socio-cultural influences and interpretations among others. What is important is maintaining an active awareness of these throughout the process of the research. In choosing IPA as a methodology for this study, I recognised and acknowledged the need for sensitivity in engaging with the participants in a study that aimed to explore the life-worlds of mothers experiencing anorexia. An awareness of the socio-cultural contexts in which the mothers experienced anorexia was important in terms of acknowledging the influences on the ways in which the research unfolded. The research explicitly acknowledged the 'normative, ideological, historical, linguistic and socioeconomic influences on the beliefs, objectives, expectations and talk of all participants' (Yardley, 2015, p.220). An example of this is evident in recognising the cultural imperative that many of the participants demonstrated in subscribing to constructions of the 'good mother' and 'mother blaming' when talking of their relationships with themselves and with others. This awareness extended to an acknowledgement of the often-pathologising representation of mothers experiencing anorexia in the extant literature. In the participant information sheet, and at the beginning of each interview, it was explicitly acknowledged that there is little research on the lived experiences of mothers with anorexia and that this research was aiming to help redress this gap in the literature.

The process of collecting data also reflected a sensitivity to context, as evidenced by the depth and richness of the material resulting from the interviews. This came about as a result of developing a good rapport with participants, being open and curious about what was being shared and being sensitive to unpredictable influences on the interview process (e.g. pausing the interview while a participant's daughter was present with her in the room, summarising what had previously been said when the phone was unexpectedly

cut off during an interview and pausing to check in with risk and available support when a participant became distressed during the interview).

Sensitivity to the raw material is evident through the many verbatim extracts that are presented in order to truly hear the voices of the participants and to allow the reader direct access to the interpretations that were being made. The interpretations themselves were presented tentatively and general claims were proffered thoughtfully and cautiously.

The second principle that Yardley (2015) introduced is that of *commitment and rigour*. In this research, commitment was shown in the attentiveness towards each participant during the process of data collection, where each individual was invited to talk freely about their experiences at a time that felt convenient and comfortable for them. They were attentively listened to and the interview often followed their lines of thought organically, avoiding becoming caught up with prescriptive questioning. The in-depth case by case analysis that was carried out (and is recommended for quality IPA) also demonstrated a commitment to the process of sensitively attending to and giving voice to each participant as a prized element of the overall study.

Rigour refers to the 'thoroughness of the study' (Smith et al., 2010, p. 181) and includes how appropriate the samples used are to the research question, how detailed the analysis is and the quality of the interviews. Five of the six participants were recruited through Beat and one was recruited through my personal network, all were white, identified as heterosexual mothers and had had a diagnosis of anorexia. However, it is also important to acknowledge differences in terms of geographical location, age, number of children, employment experiences and so on, as these contexts necessarily shape and influence individual experiences in particular ways; which in turn, impact the stories and the meaning-making that participants relate. It is important to hold an awareness of the fact that this research includes accounts of participants who responded to a request and were willing to share their stories, and that there are many other women who fulfilled the inclusion criteria who chose not to, and who may have had very different stories to share. This is important to

acknowledge in that some of the findings in this study might be qualitatively different if other mothers had agreed to participate (e.g. mothers who did not share the sense that their children gave them hope for the future in the context of their general wellbeing might find motherhood more of a burden than a benefit).

Telephone interviews were used in this study, which can be useful in some respects, for example with regards to cost efficiency (Shuy, 2003), greater anonymity when approaching sensitive subjects (Greenfield et al., 2000; Glogowska, 2011) and accessing a wider diversity of respondents (Adams et. al, 2007). In this feminist research, it felt important to give the women a choice of interviewing mode (and arguably more control over the process). The richness of the data the interviews generated points to the fact that, in this case, telephone interviewing worked well.

A pilot interview was conducted in order to test and trial the interview for depth, relevance and quality and this proved extremely useful when undertaking further interviews (e.g. it flagged up the worth of using open and curious questioning such as ‘how was this for you?’ with regards to different phenomena introduced by participants). The experience of conducting the pilot interview also encouraged more questioning around the experience of being a mother in general, rather than an immediate focus on perceptions about children’s body shape and size. This helped to avoid a directive approach that could have been experienced as pathologising. Rigour was also evident in the idiographic engagement, which related important details about individual participants, in addition to shared themes (e.g. Alison’s story highlighted her understanding of how the abuse she experienced contributed to the development of her eating disorder and how this impacted on how she raised her children). In addition to this, the results demonstrated balance between descriptive and interpretative analysis, which is another key element of good IPA (Smith et al., 2010). Paraphrasing and summarising were presented alongside comments that probed and deconstructed the women’s narratives in a bid to further analyse and interpret the stories that they told.

Transparency and coherence constitute the third broad principle that Yardley (2015) suggested and this refers to how clearly the individual steps of the research are presented and how well the finished write-up hangs together for the reader. The methodology clearly lays out what happened in the process of the research and includes tables to aid understanding of this process. This research study has been extensively revised, edited and re-written and care has been taken to ensure that it fits with the underlying principles of IPA in holding an active awareness that the research is both interpretative and phenomenological in its analysis. Hopefully this is evident to the reader as they peruse this research through an awareness that they 'are positioned as attempting to make sense of the researcher trying to make sense of the participant's experience' (Smith et al., 2010, pp. 182-183).

Yardley's final broad principle is *impact and importance* which relates to how interesting, important or useful a piece of research is to the reader. It is hoped that this research offers an interesting and useful insight into how it might be to be a mother experiencing anorexia while bringing up her children. This research has attempted to present the nuanced, poignant, joyful, challenging, hopeful and distressing experiences, in all their detail, in order to begin to give voice to, make sense of, empathise with and support this group of women who have hitherto remained at the margins of qualitative psychological inquiry. A key strength of the study is that it adds to the substantial body of theoretical literature that gives voice to 'lived experiences', while also contributing to the small body of literature that gives voice to mothers who have or are experiencing anorexia. It is hoped that this will encourage more research in this area, in order to begin to recognise, break down and replace prejudicial and pathologising accounts of these women in mainstream literature (e.g. Cutting et al., 1999; Vignallou, 2006) and in the ways in which they are supported (e.g. Kaplan & Garfinkel, 1999; Ramjan, 2004).

Suggestions for future research

I recommend that future research on mothers with eating disorders that seeks to make sense of women's lived experiences might helpfully focus on qualitative

approaches that value women's narratives and prizes providing meaningful and compassionate support for women. Given that a recent review and meta-analysis of treatment outcomes for anorexia (Murray et al., 2018) questioned the usefulness (and efficacy) of interventions focused on weight-based symptom remission, future research might be usefully directed to looking towards what women (and in this case, mothers) have found helpful in supporting them with problems with living with anorexia.

The mothers in this study variously referenced ongoing support as being helpful and future longitudinal research could usefully explore the impact of ongoing support for mothers experiencing anorexia. Peer support was mentioned by one of the participants in this research as being particularly valuable and has been evidenced in some of the literature as being perceived as helpful (Becker et al., 2010; Cardi et al., 2015). This type of support is currently actively promoted by Beat on their website and other potential research could examine more specifically the perceived impact of peer support on ongoing recovery and well-being.

The recruitment criteria in this research were that the women should consider themselves to be 'recovered'. However, it is recognised that 'recovery' was conceived subjectively by participants and their 'stories' represented different points on the continuum of 'recovery'. Future research on this subject might usefully take account of and acknowledge the fact that 'recovery' and what is meant by the term is not black and white and has diverse meanings for different women. If researchers want women to have achieved a specific type of 'recovery', it might be helpful for them to specify this.

It is acknowledged that mothers experiencing anorexia can often represent a 'hidden' population. Accessing this group through specialist eating disorder charities such as BEAT or through already established specific online or face to face support groups might provide researchers and practitioners with a way in which to give these women a voice and to help with further supporting them with their experiences of anorexia and other eating disorders.

Other future research could usefully explore the lived experience of particular types of therapy used to support mothers experiencing anorexia. The women in this research indicated that they found particular aspects of their therapy both helpful and unhelpful. The perceived usefulness (or otherwise) of therapies such as CFT-E, (Goss & Allan, 2014), narrative therapy (Lock et al, 2005). and supportive psychotherapy (McIntosh et. al., 2005) could be explored through asking the women receiving such therapies how they were experienced and reporting on this to extend health care professionals understandings of what helps.

Conclusion

Adult women experiencing anorexia are under-represented in the literature, where much of the research focuses on adolescents and younger women (Wright & Hacking, 2012). This study has contributed to the small body of research that places at its centre women who are and have been mothers while experiencing anorexia. What makes this research unique is the focus on understanding the meanings ascribed by women to their experiences of being a mother within the context of their experiences of anorexia. This includes their experiences of seeking and receiving support for anorexia. This research offers a fresh and hopefully non-pathologising perspective on how participants comprehend and negotiate the often-challenging aspects of their life-worlds as a mother experiencing anorexia.

This research has emphasised the importance of understanding the various contexts from which these women are living their lives and underscores the significance of considering this when health care professionals come into contact with this group of women. A consideration of the intersection between being a mother and experiencing anorexia highlighted the fact that it is often very challenging for these two aspects of experience to co-exist for the women in this study. This is often as a result of living in a society that re-produces essentialist (often stigmatising and pathologising) dominant discourses on 'being anorexic' and 'being a mother'. Through focusing on the lived experiences of the women in this study, the complex dynamics involved in being a mother who has experienced anorexia while raising her children has been

illuminated in a way that offers a more empathic lens through which to view the lives that they inhabit.

This research has acknowledged how emotionally challenging it can sometimes be to be a mother experiencing anorexia. Hearing the stories of the participants in this research has been beneficial in theorising therapeutic input for this group of women. Specifically, this study has emphasised formulation, as an alternative to diagnosis, in making sense of what is being communicated and in understanding how the different contexts of a woman's life have contributed to their life-world. By engaging with formulation, therapeutic input can be tailored to meet the needs of individual women, rather than a one-size-fits-all approach. Having a holistic approach, as a therapist, is paramount in acknowledging both the physical and psychological aspects of the experience of anorexia. Where the goal in therapy has been solely weight-oriented, the women reported feeling that much of their experience was left unattended to, and that this was ultimately unhelpful in their journey towards a sense of increased well-being. Recognising that the experience of anorexia, particularly within the context of motherhood, can be experienced as shameful, is important to consider in providing therapeutic responses that help foster self-compassion. In addition to this, considering the practical barriers to therapy that might be present for mothers (e.g. childcare constraints) is also important for therapists in their relationship with these women. The importance of having ongoing support (both practical and psychological) emphasised the fact that the practical and emotional needs of a mother experiencing anorexia can endure beyond the restoration of what is considered to be a 'healthy weight' and is another factor worthy of consideration for the professionals involved in the care of these women. From a counselling psychology perspective, working relationally and engaging with the values and beliefs of these women to create formulations that respond empathically to individual experiences, will be helpful in creating the best possible environment to facilitate positive growth for mothers experiencing anorexia.

The narratives in this study drew attention to the fact that the women's lives and experiences, in the context of motherhood and anorexia, were multi-faceted, nuanced, challenging, contradictory, awful and wonderful in different measures, and at different points in time. In accessing this often-hidden population, this research offers a unique opportunity for researchers, clinical practitioners and mothers experiencing anorexia, to access an insider's view of how it can feel to be a mother with anorexia and what might help and support women who are mothers are experiencing anorexia. What feels important is that through an exposition of these results, their voices can be heard and attended to, in all their complex glory.

References

- Alexander-Mott, L. & Lumsden, D.B. (1994). *Understanding eating disorders: anorexia nervosa, bulimia nervosa and obesity*. Washington, D.C: Taylor & Francis.
- Allan, J. (2004). Mother blaming: A covert practice in therapeutic intervention. *Australian Social Work*, 57(1), 57-70.
- Allen, K.L., O'Hara, C.B., Bartholdy, S., Renwick, B., Keyes, A., Lose, A., Kenyon, M., DeJong, H., Broadbent, H., Loomes, R., McClelland, J., Serpell, L., Richards, L., Johnson-Sabine, E., Boughton, N., Whitehead, L., Treasure, J., Wade, T. & Schmidt, U. (2016). Written case formulations in the treatment of anorexia nervosa: Evidence for therapeutic benefits: Case formulations in treatment of anorexia nervosa. *International Journal of Eating Disorders*, 49(9), 874-882.
- American Psychiatric Association (APA) (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: APA.
- American Psychiatric Association (APA) (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: APA.
- Andrews, B. (1998). Methodological and definitional issues in shame research. In P. Gilbert & B. Andrews (Eds.), *Shame: Interpersonal behaviour, psychopathology and culture* (pp. 39–54). New York: Oxford University Press.
- Arcelus, J., Mitchell, A.J., Wales, J. & Nielsen, S. (2011). Mortality rates in patients with anorexia nervosa and other eating disorders. A meta-analysis of 36 studies. *Archives of General Psychiatry*, 68(7), 724-31.
- Arendell, T. (2000). Conceiving and investigating motherhood: The decade's scholarship. *Journal of Marriage & the Family*, 62(4), 1192-1207.
- Bachar, E., Latzer, Y., Kreitler, S., Berry, E.M. (1999). Empirical comparison of two psychological therapies. Self psychology and cognitive orientation in the

treatment of anorexia and bulimia. *Journal of Psychotherapy, Practice and Research*, 8(2), 151.

Bachelor, A. (1995). Clients' perception of the therapeutic alliance: A qualitative analysis. *Journal of Counselling Psychology*, 42(3), 323-337.

Ball, K., Lee, C. (2000). Relationships between psychological stress, coping and disordered eating: a review. *Psychology & Health*, 14(6), 1007–1035.

Bassin, D., Honey, M. & Kaplan, M. M. (1994). Introduction. In D. Bassin, M. Honey & M. M. Kaplan (Eds), *Representations of motherhood* (pp. 1-25). New Haven: Yale University.

Bastiani, A.M., Rao, R., Weltzin, T., Kaye, W.H. (1995). Perfectionism in anorexia nervosa. *International Journal of Eating Disorders*, 17(2), 147–52.

Becker, A. E., Grinspoon, S., Klibanski, A., & Herzog, D. (1999). Eating disorders. *New England Journal of Medicine*, 340(14), 1092–1097.

Bell, J. S., Whitehead, P., Aslani, P., Sacker, S., & Chen, T. F. (2006). Design and implementation of an educational partnership between community pharmacists and consumer educators in mental health care. *American Journal of Pharmaceutical Education*, 70(2), 28.

Bemporad, J.R. (1997). Cultural and historical aspects of eating disorders, *Theoretical Medicine*, 18(4), 401-420.

Benton-Hardy, L.R., Lock, J. (1998). Pregnancy and early parenthood: factors in the development of anorexia nervosa? *International journal of Eating Disorders*, 24(2), 223-226.

Beumont, P. J., & Touyz, S. W. (2003). What kind of an illness is anorexia nervosa? *European Child and Adolescent Psychiatry*, 12(S1), 20–24.

Bezance, J. & Holliday, J. (2013). Adolescents with anorexia nervosa have their say: a review of qualitative studies on treatment and recovery from anorexia

nervosa: review of adolescents' treatment and recovery. *European Eating Disorders Review*, 21(5), 352-360.

Birch, L.L. & Fisher, J.O. (2000). Mothers' child-feeding practices influence daughters' eating and weight. *The American Journal of Clinical Nutrition*, 71(5), 1054-1061.

Bloch, S. (2006). *An Introduction to the Psychotherapies*, 4th edn. Oxford: Oxford University Press.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, 16(3), 252-260.

Bordo, S. (1993a, 2004). *Unbearable weight*. Berkeley, California: University of California Press.

Bordo, S. (1990). Reading the slender body. In Jacobus, M., Keller, E. F., Shuttleworth, S. (Eds.), *Body/politics: Women and the discourses of science* (pp. 83–112). New York: Routledge.

Bourdieu, P. (1991). *Rethinking popular culture: contemporary perspectives in cultural studies*. Berkeley, California: University of California Press.

BPS, Division of Counselling Psychology (2006). *Professional practice guidelines*. Leicester: BPS.

Branch, C.H.H. & Eurman, L.J. (1980). Social attitudes toward patients with anorexia nervosa. *American Journal of Psychiatry*, 137(5), 631–32.

Bratman, S. (2017). Orthorexia vs. theories of healthy eating, eating and weight disorders: Studies on anorexia. *Bulimia and Obesity*, 22(3), 381-385.

Braun, V. and Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. London: Sage.

Brinch, M., Isager, T., & Tolstrup, K. (1988). Anorexia nervosa and motherhood: Reproduction pattern and mothering behavior of 50 women. *Acta Psychiatrica Scandinavica*, 77(5), 611–617.

Brown, A., Mountford, V.A. & Waller, G. (2013). Is the therapeutic alliance overvalued in the treatment of eating disorders? *International Journal of Eating Disorders*, 46(8), 779-782.

Brown, A., Mountford, V. & Waller, G. (2014). Clinician and practice characteristics influencing delivery and outcomes of the early part of outpatient cognitive behavioural therapy for anorexia nervosa. *The Cognitive Behaviour Therapist*, 7(10), 1-12.

Bruch, H. (1974). *Eating disorders: Obesity, anorexia nervosa and the person within*. London: Routledge & Kegan Paul.

Brumberg, J. J. (2000). *Fasting girls: The history of anorexia nervosa*. New York, NY: Vintage Books.

Bryant-Waugh, R., Turner, H., East, P. & Gamble, C. (2007). Developing a parenting skills-and-support intervention for mothers with eating disorders and pre-school children part 1: Qualitative investigation of issues to include. *European Eating Disorders Review*, 15(5), 350-356.

Buckroyd, J. & Rother, S. (2008). *Psychological responses to eating disorders and obesity: Recent and innovative work*. Chichester; Hoboken, N.J: John Wiley & Sons, Ltd.

Bulik C, Berkman N, Brownley K, Sedway J, Lohr K. (2007). Anorexia nervosa treatment: A systematic review of randomized controlled trials. *International Journal of Eating Disorders*, 40(4), 310–20.

Burney, J., & Irwin, H. J. (2000). Shame and guilt in women with eating disorder symptomatology. *Journal of Clinical Psychology*, 56(1), 51–61.

Burns, M. (2004). *Constructing bulimia: Implications for subjectivity and practice*. unpublished PhD thesis, New Zealand: University of Auckland.

Burns, M. (2009). Bodies as (Im)material? Bulimia and body image discourse. In Malson, H. & Burns, M. (Eds.), *Critical feminist approaches to eating dis/orders*, (pp.124-135). London: Routledge.

Burton, T. (2014). Walking a tightrope: Women's experiences of having an eating disorder while pregnant. *Australian Nursing and Midwifery Journal*, 21(9), 45.

Campos, P., Saguy, A., Ernsberger, P., Oliver, E., & Gaesser, G. (2006). The epidemiology of overweight and obesity: public health crisis or moral panic? *International Journal of Epidemiology*, 35(1), 55–60.

Caplan, P. & Hall-McCorquodale, I. (1985). The scapegoating of mothers: A call for change. *American Journal of Orthopsychiatry*. 55(4), 610–613.

Carter, J.C., Bewell, C., Blackmore, E. & Woodside, D.B. (2006). The impact of childhood sexual abuse in anorexia nervosa. *Child Abuse & Neglect*, 30(3), 257-269.

Cash, T. F., & Henry, P. E. (1995). Women's body images: The results of a national survey in the U.S.A. *Sex Roles*, 33(1), 19–28.

Chase, S.E. & Rogers, M.F. (2001). *Mothers and Children: Feminist Analyses and Personal Narratives*. London: Rutgers University Press.

Chesney, E., Goodwin, G.M. & Fazel, S. (2014). Risks of all-cause and suicide mortality in mental disorders: A meta-review. *World Psychiatry*, 13(2), 153-160.

Chess, S. (1982). The blame the mother ideology. *International Journal of Mental Health*, 1 (1)95-107.

Chodorow, N. (1978). *The reproduction of mothering*. Berkeley: University of California Press.

- Claudino, A.M., Hay, P., Lima, M.S., Bacaltchuk, J., Schmidt, U. & Treasure, J. (2006). Antidepressants for anorexia nervosa. *Cochrane Database Systematic Review*, 1.
- Collier, D.A. & Treasure, J.L. (2004). The aetiology of eating disorders. *The British Journal of Psychiatry: The Journal of Mental Science*, 185(5), 363-365.
- Collins, P.L., Collins, C.J. & Montgomery, M.J. (1998). An investigation of the daily lived experiences of women with eating disorders: Implications for counsellors. *College Student Affairs Journal*, 17(2),56.
- Connan, F., Campbell, I. C. & Katzman, M. (2003). A neurodevelopmental model for anorexia nervosa. *Physiology and Behaviour*, 79(1), 13-24.
- Conti, J., Calder, J., Cibralic, S., Rhodes, P., Meade, T. & Hewson, D. (2017). Somebody else's roadmap: Lived experience of Maudsley and family-based therapy for adolescent anorexia nervosa. *Australian and New Zealand Journal of Family Therapy*, 389(3), 405-429.
- Cooper, P.J., Coker, S. & Fleming, C. (1996). An evaluation of the efficacy of supervised cognitive behavioral self-help for bulimia nervosa. *Journal of Psychosomatic Research*, 40(3), 281-287.
- Cooper, M. (2009). Welcoming the other: Actualising the humanistic ethic at the core of counselling psychology practice. *Counselling Psychology Review*, 24(3/4), 119-129.
- Costanzo, F., Menghini, D., Maritato, A., Castiglioni, M.C., Mereu, A., Varuzza, C., Zanna, V. & Vicari, S. (2018). New treatment perspectives in adolescents with anorexia nervosa: The efficacy of non-invasive brain-directed treatment. *Frontiers in Behavioral Neuroscience*, 12(133), 1-10.
- Courcy, I. & des Rivières, C. (2017). From cause to cure: A qualitative study on contemporary forms of mother blaming experienced by mothers of young

children with autism spectrum disorder. *Journal of Family Social Work*, 20(3), 233-250.

Crisafulli, M.A., Von Holle, A. & Bulik, C.M. (2008). Attitudes towards anorexia nervosa: The impact of framing on blame and stigma. *International Journal of Eating Disorders*, 41(4), 333-339.

Crisp, A. (2005). Stigmatization of and discrimination against people with eating disorders including a report of two nationwide surveys. *European Eating Disorders Review*, 13(3), 147-152.

D'Abundo, M. & Chally, P. (2004). Struggling with recovery: Participant perspectives on battling an eating disorder. *Qualitative Health Research*, 14(8) 1094-106.

Dare, C., Eisler, I., Russell, G., Treasure, J., Dodge, L. (2001). Psychological therapies for adults with anorexia nervosa: Randomised controlled trial of outpatient treatments. *British Journal of Psychiatry*, 178(3), 216-221.

Data Protection Act (1998). *An introduction*. Wilmslow: Office of the Data Protection Registrar.

Davies, K. & Wardle, J. (1994). Body image and dieting in pregnancy. *Journal of Psychosomatic Research*, 38(8), 787-799.

De Jong, H., Broadbent, H. & Schmidt, U. (2012). A systematic review of dropout from treatment in outpatients with anorexia nervosa. *International Journal of Eating Disorders*, 45(5), 635-47.

De la Rie, S., Noordenbos, G., Donker, M. & van Furth, E. (2006). Evaluating the treatment of eating disorders from the patient's perspective. *International Journal of Eating Disorders*, 39(8), 667-676.

Deter, H. and Herzog, W. (1994). Anorexia nervosa in a long-term perspective: Results of the Heidelberg-Mannheim study. *Psychosomatic Medicine*, 56(1), 20-7.

Devlin, B., Bacanu, S. A. & Klump, K. L. (2002). Linkage analysis of anorexia nervosa incorporating behavioral covariates. *Human Molecular Genetics*, 11(6), 689-696.

Dodds, A. & Chamberlain, K. (2017). The problematic messages of nutritional discourse: a case-based critical media analysis. *Appetite*, 108(1), 42-50.

Dorozenko, K.P., Ridley, S., Martin, R. & Mahboub, L. (2016). A journey of embedding mental health lived experience in social work education. *Social Work Education*, 35(8), 905-917.

East, L., Jackson, D. & O'Brien, L. (2006). *Father absence and adolescent development: a review of the literature*. London: Sage Publications.

Eatough, V. & Smith, J. (2017). Interpretative phenomenological analysis. In Willig, C. & Rogers, W. (Eds) *The Sage Handbook of Qualitative Research in Psychology*, (pp. 193-209). London: Sage.

Eckermann, L. (1997). Foucault, embodiment and gendered subjectivities: The case of voluntary self-starvation. In Petersen, A. & Bunton, R. (Eds.), *Foucault, health and medicine* (pp. 151–171). London: Routledge.

Eckstein, K.C., Mikhail, L.M., Ariza, A.J., Thomson, J.S., Millard, S.C., Binns, H.J. & Pediatric Practice Research Group (2006). Parents' perceptions of their child's weight and health. *Pediatrics*, 117(3), 681-690.

Eivors, A., Button, E., Warner, S. & Turner, K. (2003). Understanding the experience of drop-out from treatment for anorexia. *European Eating Disorders Review*, 11(2), 90–107.

Eli, K. (2014). Between difference and belonging: Configuring self and others in inpatient treatment for eating disorders. *PloS One*, 9(9), 1-9.

Engel, B., Staats Reiss, N. and Dombeck, N. (2007). Historical understandings at <https://www.mentalhelp.net/articles/historical-understandings/> on MentalHelp.net.

Engeln-Maddox, R. (2006). Buying a beauty standard or dreaming of a new life: Expectations associated with media ideals. *Psychology of Women Quarterly*, 30(3), 258-266.

Fairbairn, W.R.D. (1994). *Psychoanalytic studies of the personality*. London: Routledge.

Fairburn, C.G., Welch, S.L., Doll, H.A., Davies, B.A. & O'Connor, M.E. (1997). Risk factors for bulimia nervosa—a community-based case-control study. *Archives of General Psychiatry*, 54(6), 509–17.

Fairburn, C.G., & Beglin, S.J. (1990). Studies of the epidemiology of bulimia nervosa. *American Journal of Psychiatry*, 147(4), 401-408.

Fairburn, C.G., Cooper, Z., Doll, H.A., Norman, P & O'Connor, M. (2000). The natural course of bulimia nervosa and binge eating disorder in young women. *Archives of General Psychiatry*, 284(15), 659–65.

Fairburn, C. G. (2008). *Cognitive Behavior Therapy and Eating Disorders*. New York: New York: Guilford.

Fishburn, K.E. (2019). When compared to comparator treatment, specialist interventions for anorexia nervosa are more effective in reducing weight-based symptoms, but not psychological symptoms. *Evidence-based Nursing*, ebnurs-2018-103006.

Flegal, K.M. (2006). Excess deaths associated with obesity: Cause and effect. *International Journal of Obesity*, 30(8), 1171-1172.

Föcker, M., Knoll, S. & Hebebrand, J. (2013). Anorexia nervosa. *European Child & Adolescent Psychiatry*, 22(S1), 29-35.

Fogarty, S., Elmir, R., Hay, P. & Schmied, V. (2018). The experience of women with an eating disorder in the perinatal period: a meta-ethnographic study. *BMC Pregnancy and Childbirth*, 18(1) 121-18.

- Forcey, L.R. (1994). Feminist perspectives on mothering and peace. In: Glenn, E.N., Chang, G. & Forcey, L.R. (Eds.), *Mothering: Ideology, experience, and agency* (pp. 355-376). New York: Routledge.
- Frank, E. S. (1991). Shame and guilt in eating disorders. *American Journal of Orthopsychiatry*, 61(2), 303–306.
- Franko, D.L. & Walton, B.E. (1993). Pregnancy and eating disorders: A review and clinical implications. *International Journal of Eating Disorders*, 13(1), 41.
- Franzen, U. & Gerlinghoff, M. (1997). Parenting by patients with eating disorders: Experiences with a mother-child group. *Eating Disorders*, 5(1), 5–14.
- Frost, N. & Holt, A. (2014). Mother, researcher, feminist, woman: Reflections on maternal status as a researcher identity. *Qualitative Research Journal*, 14(2), 90-102.
- Fursland, A. & Watson, H.J. (2014). Eating disorders: A hidden phenomenon in outpatient mental health. *International Journal of Eating Disorders*, 47(4), 422-425.
- Gaesser, G., & Blair, S. (2011). *Big fat lies: The truth about your weight and your health*. Carlsbad: Gurze Books.
- Garcia Coll, C., Surrey, J.L. & Weingarten, K. (1998). *Mothering against the odds. Diverse voices of contemporary mothers*. New York: The Guilford Press.
- Gard, M. & Wright, J. (2005). *The obesity epidemic: Science, morality and ideology*. London: Routledge.
- Garrett, C.J. (1998). *Beyond anorexia: Narrative, spirituality and recovery*. Cambridge University Press.
- Gelo, O.C.G., Vilei, A., Maddux, J.E. & Gennaro, A. (2015). Psychopathology as social construction: The case of anorexia nervosa. *Journal of Constructivist Psychology*, 28(2), 105-125.

Gilbert, P. (1998). Shame and humiliation in the treatment of complex cases. In Tarrier, N., Wells, A. & Haddock, G. (Eds.), *Treating complex cases: The cognitive behavioural therapy approach* (pp. 241–271). London: Wiley.

Gilbert, A.A., Shaw, S.M. & Notar, M.K. (2000). The impact of eating disorders on family relationships. *Eating Disorders*, 8(4), 331-345.

Gilligan, Carol, & David A. J. Richards. (2009). *The deepening darkness: Patriarchy, resistance, & democracy's future*. New York: Cambridge University Press.

Gleaves, D.H., Lowe, M.R., Snow, A.C., Green, B.A. & Murphy-Eberenz, K.P. (2000). Continuity and discontinuity models of bulimia nervosa: A taxometric investigation. *Journal of Abnormal Psychology*, 109(1), 56–68.

Glenn, E. N., Chang, G. & Forcey, L. R. (Eds.), (1994). *Mothering: Ideology, Experience and Agency*. New York: Routledge.

Gordon, R. A. (2000). *Eating disorders: Anatomy of a social epidemic*. Malden, MA: Blackwell Publishers.

Goodwin, S., Huppatz, K. (2010). *The good mother: Contemporary motherhoods in Australia*. Sydney. Australia: Sydney University Press.

Gordon, R.A. (2001). Eating disorders East and West: a culture-bound syndrome unbound. In Nasser, M., Katzman, M. A. & Gordon, R.A. (Eds.), *Eating disorders and cultures in transition* (pp. 1-23). New York, NY: Taylor & Francis.

Goss, K. & Gilbert, P. (2002). Eating disorders, shame and pride: A cognitive-behavioural functional analysis. In Gilbert, P. & Miles, J. (Eds.), *Body shame: Conceptualisation, research and treatment* (pp. 219–255). Hove, UK: Brunner-Routledge.

Graves, T.A., Tabri, N., Thompson-Brenner, H., Franko, D.L., Eddy, K.T., Bourion-Bedes, S., Brown, A., Constantino, M.J., Flückiger, C., Forsberg, S., Isserlin, L., Couturier, J., Paulson Karlsson, G., Mander, J., Teufel, M., Mitchell, J.E., Crosby,

- R.D., Prestano, C., Satir, D.A., Simpson, S., Sly, R., Lacey, J.H., Stiles-Shields, C., Tasca, G.A., Waller, G., Zaitsoff, S.L., Rienecke, R., Le Grange, D. & Thomas, J.J. (2017). A meta-analysis of the relation between therapeutic alliance and treatment outcome in eating disorders. *International Journal of Eating Disorders*, 50(4). 323-340.
- Green, F.J. (2018). Empowering mothers and daughters through matroreform and feminist motherline. *Journal of the Motherhood Initiative for Research & Community Involvement*, 9(1), 9-20.
- Gremillion, H. (2002). In fitness and in health: Crafting bodies in the treatment of anorexia nervosa. *Signs*, 27(2), 381–596.
- Grilo, C.M., Crosby, R.D., Wilson, G.T. & Masheb, R.M. (2012). 12-month follow-up of fluoxetine and cognitive behavioral therapy for binge eating disorder. *Journal of Consulting and Clinical Psychology*, 80(6), 1108-1113.
- Grogan, S. (1999). *Body image*. London: Routledge.
- Grogan, S. (2017). *Body image: Understanding body dissatisfaction in men, women and children*. London: Routledge.
- Grosz, E. (1994). *Volatile bodies: Toward a corporeal feminism*. Bloomington: Indiana University Press.
- Gull, W.W. (1997). Anorexia nervosa (apepsia hysterica, anorexia hysterica). *Obesity Research*, 5(5), 498–502.
- Gutwill, L. (1994a). Women's eating problems: Social context and the internalization of culture. In Bloom, C., Gitter, A., Gutwill, S., Kogel, L. & Zaphiropoulos, L. *Eating problems: A feminist psychoanalytic treatment model*. New York: Basic.
- Hadfield, A., Dimmock, M. & Shinn, A. (2014). *The Ashgate research companion to popular culture in early modern England*. Farnham, Surrey, UK, England; Burlington, VT.: Ashgate Publishing Limited.

- Halliwell, E., Dittmar, H. & Howe, J. (2005). The impact of advertisements featuring ultra-thin or average-size models on women with a history of eating disorders. *Journal of Community & Applied Social Psychology*, 15(5), 406-413.
- Hardin, P.K. (2003). Social and cultural considerations in recovery from anorexia nervosa: A critical post-structural analysis. *Advances in Nursing Science*, 26(1), 5-16.
- Haudek, C., Rorty, M. & Henker, B. (1999). The role of ethnicity and parental bonding in the eating and weight concerns of Asian-American and Caucasian college women. *International Journal of Eating Disorders*, 25(4), 425–33.
- Haworth-Hoepfner, S. (2000). The critical shapes of body image: The role of culture and family in the production of eating disorders. *Journal of Marriage and Families*, 62(1), 12–27.
- Hays, S. (1996). *The cultural contradictions of motherhood*, Yale University Press.
- Heatherton, T.F. & Baumeister, R.F. (1991). Binge eating as escape from self-awareness. *Psychological Bulletin*, 110(1), 86–108.
- Heenan, C. (2005). A feminist psychotherapeutic approach to working with women who eat compulsively. *Counselling and Psychotherapy Research*, 5(3), 238-245.
- Heenan, C. (2002). Looking in the fridge for feelings. Bolton: *University of Bolton Institutional Repository*.
- Horvath, A., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). The alliance. In J. C. Norcross (Ed.), *Relationships that work* (pp. 25–69). New York, NY: Oxford University Press.
- Hudson, J.I., Hiripi, E., Pope, H.G. & Kessler, R.C. (2007). The prevalence and correlates of eating disorders in the national comorbidity survey replication. *Biological Psychiatry*, 61(3), 348-358.

Jackson, D. & Mannix, J. (2004). Giving voice to the burden of blame: A feminist study of mothers' experiences of mother blaming. *International Journal of Nursing Practice*, 10(4), 150-158.

James, D.C. (2001). Eating disorders, fertility, and pregnancy: relationships and complications. *Journal of Perinatal, Neonatal Nursing*, 15(2), 36.

Jefferson, G. (2004). Glossary of transcript symbols with an introduction. In Lerner, G. H. (Ed.), *Conversation analysis: Studies from the first generation*, 13-31. Amsterdam/Philadelphia: John Benjamins.

Jenkins, J. & Ogden, J. (2012). Becoming 'whole' again: A qualitative study of women's views of recovering from anorexia nervosa. *European Eating Disorders Review*, 20(1), 23-31.

Johnson, C. L., Tobin, D. L., & Steinberg, S. L. (1989). Etiological, developmental and treatment considerations for bulimia. Special issue: The bulimic college student: Evaluation, treatment and prevention. *Journal of College Student Psychotherapy*, 3(2-4), 57-73.

Johnstone, L. (2014). *A straight-talking introduction to psychiatric diagnosis*. Ross-on-Wye: PCCS Books.

Johnston, D.D. & Swanson, D.H. (2003). Invisible mothers: A content analysis of motherhood ideologies and myths in magazines. *Sex Roles*, 49(1), 21-33.

Johnstone, L. & Dallos, R. (2013). *Formulation in psychology and psychotherapy: making sense of people's problems*. Second edn, London: Routledge.

Joiner, T.E., Heatherton, T.F., Rudd, M.D. & Schmidt, N.B. (1997). Perfectionism, perceived weight status, and bulimic symptoms: Two studies testing a diathesis-stress model. *Journal of Abnormal Psychology*, 106(1), 145-53.

Jones, A. & Clausen, L. (2013). The efficacy of a brief group cbt program in treating patients diagnosed with bulimia nervosa: A brief report. *International Journal of Eating Disorders*, 46(6), 560-562.

- Kaplan, A.S. & Garfinkel, P.E. (1999). *Difficulties in treating patients with eating disorders: A review of patient and clinician variables*. Los Angeles, California: Sage Publications.
- Karwautz, A., Rabe-Hesketh, S. & Collier, D. (2002). Pre-morbid psychiatric morbidity, comorbidity and personality in patients with anorexia nervosa compared to their healthy sisters. *European Eating Disorders Review*, 10(4), 255-270.
- Kasket, E. (2012) The counselling psychologist researcher. *Counselling Psychology Review*, 27 (2), 64-73.
- Keski-Rahkonen, A. & Mustelin, L. (2016). Epidemiology of eating disorders in Europe: prevalence, incidence, comorbidity, course, consequences, and risk factors. *Current Opinion in Psychiatry*, 29(6), 340-345.
- Khalsa, S.S., Portnoff, L.C., McCurdy-McKinnon, D. (2017). What happens after treatment? A systematic review of relapse, remission, and recovery in anorexia nervosa. *Journal of Eating Disorders*, 5(20), 270-281.
- King, S.J. & Turner, D.S. (2000). Caring for adolescent females with anorexia nervosa: Registered nurses' perspective. *Journal of Advanced Nursing*, 32(1), 139-147.
- Krane, J. & Davies, L. (2002). Sisterhood is not enough: The invisibility of mothering in shelter practice with battered women. *Affilia*, 17(2), 167-190.
- Kruger, L. (2003). Narrating motherhood: The transformative potential of individual stories. *South African Journal of Psychology*, 33(4), 198-204.
- Lacey, J.H. (1986). Pathogenesis. In Downey, L.J. & Malkin, J.C., *Current approaches: Bulimia nervosa*, (pp. 17–26). Birmingham, England.

- Lai, B.P., Tang, C.S. & Tse, W.K. (2006). A longitudinal study investigating disordered eating during the transition to motherhood among Chinese women in Hong Kong, *International Journal of Eating Disorders*, 39(4) 303-311.
- LaMarre, A. & Rice, C. (2016), Normal eating is counter-cultural: Embodied experiences of eating disorder recovery. *Journal of Community & Applied Social Psychology*, 26(2), 36-149.
- Lamoureux, M.M.H. & Bottorff, J.H. (2006). Becoming the real me: Recovering from anorexia nervosa. *Healthcare for Women International*, 26(2), 170-88.
- Lasègue, E.C. (1873). On hysterical anorexia. In: Kaufman, M.R., Heiman, M. (eds). (1964). *Evolution of psychosomatic concepts: Anorexia nervosa: A paradigm*. New York: International Universities Press.
- Leary, M.R., Schreindorfer, L.S. & Haupt, A.L. (1995). The role of low self-esteem in emotional and behavioral problems: Why is low self-esteem dysfunctional? *Journal of Social & Clinical Psychology*, 14(3), 297– 314.
- LeBesco, K. (2009). Weight Management, good health and the will to normality. In Malson, H. & Burns, M. *Critical feminist approaches to eating dis/orders*. Routledge, London.
- Le Grange, D. & Gelman, T. (1998). Patients' perspective of treatment in eating disorders: A preliminary study. *South African Journal of Psychology*, 28(3), 182-186.
- Leon, G.R., Keel, P.K., Klump, K.L. & Fulkerson, J.A. (1997). The future of risk factor research in understanding the etiology of eating disorders. *Psychopharmacology Bulletin*, 33(3), 405–11.
- Lester, R.J. (1997). The (dis)embodied self in anorexia nervosa. *Social Science and Medicine*, 44(4), 479-489.

Letherby, G. (1994). Mother or not, mother or what? Problems of definition and identity. *Women's Studies International Forum*, 17(5), 525–32.

Levine, M.P., Smolak, L., Moodey, A.F., Shuman, M.D. & Hessen, L.D. (1994). Normative developmental challenges and dieting and eating disturbances in middle school girls. *International Journal of Eating Disorders*, 15(1), 11-20.

Levtov, R., van der Gaag, N., Greene M., Kaufman M. & Barker G. (2015). *State of the world's fathers: A men care advocacy publication*. Washington, DC: Promundo.

Lewis, H. B. (1987). Introduction: Shame—the 'sleeper' in psychopathology. In Lewis, H. B. (Ed.), *The role of shame in symptom formation* (pp. 1–27). Hillsdale, NJ: Erlbaum.

Linardon, J., Fairburn, C.G., Fitzsimmons-Craft, E.E., Wilfley, D.E. & Brennan, L. (2017). The empirical status of the third-wave behaviour therapies for the treatment of eating disorders: A systematic review. *Clinical Psychology Review*, 58(1), 125-140.

Lindsay-Hartz, J., de Rivera, J., & Mascolo, M. F. (1995). Differentiating guilt and shame and their effects on motivation. In Tangney, J. P. & Fischer, K. W. (Eds.), *Self-conscious emotions: The psychology of shame, guilt, embarrassment, and pride* (pp. 274-300). New York: Guilford.

Lock, J. (1999). How Clinical Pathways Can Be Useful: An Example of a Clinical Pathway for the Treatment of Anorexia Nervosa in Adolescents. *Clinical Child Psychology and Psychiatry*, 4(3), 331-340.

Löwe, B., Zipfel, S., Buchholz, C., Dupont, Y., Reas, D. & Herzog, W. (2001). Long term outcome of anorexia nervosa in a prospective 21 years follow-up study. *Psychological Medicine*, 31(5), 881–90.

Lunner, K., Werthem, E.H., Thompson, J.K., Paxton, S.J., McDonald, F. & Halvaarson, K.S. (2000). A cross-cultural examination of weight related teasing,

body image, and eating disturbance in Swedish and Australian samples.

International Journal of Eating Disorders, 28(4), 430–35.

Lyon, M. E., Chatoor, I., Atkins, D., Silber, T., Mosimann, J., & Gray, J. (1997).

Testing the hypothesis of a multidimensional model of anorexia nervosa in adolescents. *Adolescence*, 32(125), 101–111.

Mack, A. Ed. (2018). Critical approaches to motherhood. *Oxford research*

encyclopedia of communication. Retrieved 7 Mar. 2019, from:

<http://oxfordre.com/communication/view/10.1093/acrefore/9780190228613.001.0001/acrefore-9780190228613-e-579>.

McCoyd, J.L. and Kerson, T.S. (2006). Conducting intensive interviews using email: A serendipitous comparative opportunity. *Qualitative Social Work*, 5(3), 389–406.

McIntosh, V.V., Jordan, J., Carter, F.A., Luty, S.E., McKenzie, J.M. & Bulik, C.M.

(2005). Three psychotherapies for anorexia nervosa: A randomized, controlled trial. *American Journal of Psychiatry*, 162(4), 741–7.

MacSween, M. (1993). *Anorexic bodies: A feminist and sociological perspective on anorexia nervosa*. London, New York: Routledge.

Maguire, T. & Haslam, D.W. (2010). *Obesity epidemic and its management: A text book for primary healthcare professionals on the understanding, management and treatment of obesity*. London: Pharmaceutical Press.

Maine, M., McGilley, B.H. & Bunnell, D.W. (2010). *Treatment of eating disorders: Bridging the research practice gap*. Amsterdam: Academic Press/Elsevier.

Malacrida, C. & Boulton, T. (2012). Women's perceptions of childbirth "choices": Competing discourses of motherhood, sexuality, and selflessness. *Gender & Society*, 26(5), 748.

Malson, H., Clarke, S. & Finn, M. (2008). I don't think that's normal: A reflection on accounts of experiences of treatment for eating disorders. *Feminism & Psychology*, 18(3), 417-424.

Malson, H., Bailey, L., Clarke, S., Treasure, J., Anderson, G. & Kohn, M. (2011). Un/imaginable future selves: A discourse analysis of in-patients' talk about recovery from an eating disorder. *European Eating Disorders Review*, 19(1), 25-36.

Malson, H., Finn, D.M., Treasure, J., Clarke, S. & Anderson, G. (2004). Constructing the eating disordered patient: A discourse analysis of accounts of treatment experiences. *Journal of Community and Applied Social Psychology*, 14(6), 473-89.

Malson, H. (1998). *The thin woman: Feminism, post-structuralism and the social psychology of anorexia nervosa*. London: Routledge.

Malson, H. & Burns, M. (2009). *Critical feminist Approaches to eating dis/orders*. London: Routledge.

Mazzeo, S. E., Zucker, N. L., Gerke, C. K., Mitchell, K. S., & Bulik, C. M. (2005). Parenting concerns of women with histories of eating disorders. *International Journal of Eating Disorders*, 37(S1), S77-S79.

McLaren, H.J. (2013). (Un)-blaming mothers whose partners sexually abuse children: In view of heteronormative myths, pressures and authorities. *Child and Family Social Work*, 18(4), 439-448.

Medvedyuk, S., Ali, A. & Raphael, D. (2017). Ideology, obesity and the social determinants of health: A critical analysis of the obesity and health relationship. *Critical Public Health*, 28(5), 1-13.

Merleau-Ponty, M. (1945/2004). *Phenomenology of perception* (C. Smith, Trans.). London: Routledge.

Metzger, H. (2018). Let people love themselves (the body positivity movement). Uloop Opinion:, Inc, Carlsbad.

Micali, N., Hagberg, K.W., Petersen, I. & Treasure, J.L. (2013). The incidence of eating disorders in the UK in 2000-2009: Findings from the general practice research database. *BMJ Open*, 3(5), e002646.

Micali, N., Martini, M.G., Thomas, J.J., Eddy, K.T., Kothari, R., Russell, E., Bulik, C.M. & Treasure, J. (2017). Lifetime and 12-month prevalence of eating disorders amongst women in mid-life: A population-based study of diagnoses and risk factor. *BMC Medicine*, 15(1), 12.

Miller, T. (2005). *Making sense of motherhood: A narrative approach*. New York, Cambridge: Cambridge University Press.

Minuchin, S., Rosman, B.L. & Baker, L. (1978). *Psychosomatic families: Anorexia nervosa in context*. Cambridge, MA: Harvard University Press.

Mischoulon, D., Eddy, K.T., Keshaviah, A., Dinescu, D., Ross, S.L. & Kass, A.E. (2011). Depression and eating disorders: Treatment and course. *Journal of Affective Disorders*. 130(3), 470–477.

Monaghan, L. F., Colls, R., & Evans, B. (2013). Obesity discourse and fat politics: Research, critique and interventions. *Critical Public Health*, 23(3), 249–262.

Moran, D. (2000). *Introduction to phenomenology*. London: Routledge.

Murray, S.B., Quintana, D.S., Loeb, K.L., Griffiths, S. & Le Grange, D. (2018). Treatment outcomes for anorexia nervosa: A systematic review and meta-analysis of randomized controlled trials. *Psychological medicine*, [Epub ahead of print], 1-10.

Nasser, M., Katzman, M. & Gordon, R. (2000). *Cultures in transition: Eating disorders as a global marker*. Hove: Brunner/Routledge.

Nasser, M. & Malson, H. (2009). Beyond western dis/orders: Thinness and self-starvation of other-ed women. In Malson, H. & Burns, M. *Critical Feminist Approaches to Eating Disorders*, London: Routledge.

Nathanson, D. L. (1989). Understanding what is hidden: shame in sexual abuse. *Psychiatric Clinics of North America*, 12(2), 381–388.

National Institute for Clinical Excellence (2004). *Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa, and related eating disorders*. London: The British Psychological Society and the Royal College of Psychiatrists.

Neumark-Sztainer, D., Story, M., Hannan, P.J., Beuhring, T. & Resnick, M.D. (2000). Disordered eating among adolescents: Associations with sexual/physical abuse and other familial/psychosocial factors. *International Journal of Eating Disorders*, 28(3), 249–58.

Newnes, C. (2002). The powers that shape our lives. *The Institute of Physics*, London.

O’Kearney, R. (1996). Attachment disruption in anorexia nervosa and bulimia nervosa: A review of theory and empirical research. *International Journal of Eating Disorders*, 20(2), 115–127.

Oppenheimer, R., Howells, Palmer, R.L. & Chaloner, D.A. (1985). Adverse sexual experience in childhood and clinical eating disorders: A preliminary description. *Journal of Psychiatric Research*, 19, 357-361.

Orbach, S. (1978). *Fat is a feminist issue*. London: Paddington Press.

Orbach, S. (1982). *Fat is a feminist issue II*. London: Hamlyn Paperbacks.

Orbach, S. (1985). Accepting the symptom: A feminist psychoanalytic treatment of anorexia nervosa. In Garner, D. M. & Garfinkel, P. E. (Eds.), *Handbook of Psychotherapy for Anorexia Nervosa and Bulimia*. New York: Guilford Press.

- Orbach, S. (1986). *Hunger strike*. London: Faber and Faber.
- Orlans, V. & Van Scoyoc, S. (2009). *A short introduction to counselling psychology*. Los Angeles, London: Sage.
- Orpana, H.M., Berthelot, J., Kaplan, M.S., Feeny, D.H., McFarland, B. & Ross, N.A. (2010). BMI and mortality: Results from a national longitudinal study of Canadian adults. *Obesity*, 18(1), 214-218.
- O'Shaughnessy, R. & Dallos, R. (2009). Attachment research and eating disorders: A review of the literature. *Clinical Child Psychology and Psychiatry*, 14(4), 559-574.
- Palmer, R. (2004), Bulimia nervosa: 25 years on. *The British Journal of Psychiatry: The Journal of Mental Science*, 185(6), 447-448.
- Papadopoulos, F.C., Karamanis, G., Brandt, L., Ekbom, A., Ekselius, L., (2013). Childbearing and mortality among women with anorexia nervosa. *International Journal of Eating Disorders*, 469(2), 164-170.
- Paquette, M. & Raine, K. (2004). Sociocultural context of women's body image. *Social Science & Medicine*, 59(5), 1047-1058.
- Paradis, E. (2016). Obesity as process: The medicalization of fatness by Canadian researchers, 1971–2010. In J. Ellison, D. McPhail, & W. Mitchinson (Eds.), *Obesity in Canada: Critical perspectives* (pp. 56–88). Toronto: University of Toronto Press.
- Patching, J. & Lawler, J. (2009). Understanding women's experiences of developing an eating disorder and recovering: A life-history approach. *Nursing Inquiry*, 16(1), 10-21.
- Patel, P., Wheatcroft, R., Park, R. J. & Stein, A. (2002). The children of mothers with eating disorders. *Clinical Child and Family Psychology Review*, 5(1), 1–19.
- Paterson, A. (2008). *Anorexia nervosa in men*. London Sage.

- Pennesi, J. & Wade, T.D. (2016). A systematic review of the existing models of disordered eating: Do they inform the development of effective interventions? *Clinical Psychology Review*, 43(1), 175-192.
- Pereira, T., Lock, J. & Oggins, J. (2006). Role of therapeutic alliance in family therapy for adolescent anorexia nervosa. *International Journal of Eating Disorders*, 39(8), 677-684.
- Petersen, A. (2007). *The body in question: A socio-cultural approach*. London: Routledge.
- Pettersen, G., Rosenvinge, J.H. & Wynn, R. (2010). Eating disorders and psychoeducation – patients' experiences of healing processes. *Scandinavian Journal of Caring Sciences*, 25(1), 12-18.
- Pettersen, G. & Rosenvinge, J. H. (2002). Improvement and recovery from eating disorders: A patient perspective. *Eating Disorders*, 10(1), 61-71.
- Phares, V. (1992). Where's poppa?: The relative lack of attention to the role of fathers in child and adolescent psychopathology. *American Psychologist*, 47(5), 656-664.
- Phoenix, A. & Woollett, A. (eds.) (1991). *Motherhood, meanings, practices and ideologies*. London: Sage.
- Pike, K.M., Rodin, J. (1991). Mothers, daughters and disordered eating. *Journal of Abnormal Psychology*, 100(2), 198–204.
- Podfigurna-Stopa, A., Czyzyk, A., Katulski, K., Smolarczyk, R., Grymowicz, M., Maciejewska-Jeske, M. & Meczekalski, B. (2015). Eating disorders in older women. *Maturitas*, 82(2), 146-152.
- Polivy, J. & Herman, C.P. (2002). Causes of eating disorders. *Annual Review of Psychology*, 53, 187-213.

Ponterotto, J.G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology*, 52(2), 126-136.

Pope, H.G., Phillips, K.A. & Olivardia, R. (2002). *The Adonis complex*. New York: Free Press.

Press, A.L. (2012). The price of motherhood: Feminism and cultural bias. *Communication, Culture & Critique*, 5(1), 120-125.

Raffi, A.R., Rondini, M., Grandi, S. & Fava, G.A. (2000). Life events and prodromal symptoms in bulimia nervosa. *Psychological Medicine*, 30(3), 727–31.

Räisänen, U. & Hunt, K. (2014). The role of gendered constructions of eating disorders in delayed help-seeking in men: a qualitative interview study, *BMJ Open*, 4(4), e004342-e004342.

Ramjan, L.M. (2004). Nurses and the ‘therapeutic relationship’: Caring for adolescents with anorexia nervosa. *Journal of Advanced Nursing*, 45(5), 495-503.

Reid, K., Flower, P. and Larkin, M. (2005) Exploring lived experience. *The Psychologist*, 18 (1), 20-23

Rennie, D.L., Watson, K.D. & Monteiro, A.M. (2002). The rise of qualitative research in psychology. *Canadian Psychology/Psychologie Canadienne*, 43(3), 179-189.

Repper, J. & Perkins, R. (2003). *Social inclusion and recovery: a model for mental health practice*. Edinburgh: Baillière Tindall.

Ribbens McCarthy, J., Edwards, R. & Eillies, V. (2000). Parenting and step-parenting. Contemporary moral tales. *Occasional paper 4, Centre for Family and Household Research*, Oxford Brookes University.

Rich, A. (1976). *Of woman born*. New York: Norton.

Rich, E. (2006). Anorexic dis(connection): Managing anorexia as an illness and an identity. *Sociology of Health & Illness*, 28(3), 284-305.

Rodin, J. Silberstein, L.R. & Striegel-Moore, R.H. (1984). Women and weight: A normative discontent. In Soderegger, T.B. (Ed.), *Nebraska symposium on motivation: Psychology and gender* (pp.267-307). Lincoln, NE: University of Nebraska Press.

Rohner, R.P. and Veneziano, R.A. (2001) The Importance of Father Love: History and Contemporary Evidence, *Review of General Psychology* 5(4), 382–405.

Rorty, M. & Yager, J. (1996). Histories of childhood trauma and complex post traumatic sequelae in women with eating disorders. *Psychiatric Clinics of North America*, 19(4), 773–87.

Ross, L. (Ed) (2010). *Feminist counselling; theory, issues, and practice*. Ringgold Inc, Portland Women's Press

Royal College of Psychiatrists (2010) Eating disorders: Key facts. Available at: <http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/eatingdisorders.aspx> (accessed 31May 2011). Royal College of Psychiatrists (2010) Eating disorders: key facts.vailableat:<http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/eatingdisorders.aspx> (accessed 31 May 2011). Royal College of Psychiatrists (2010). Eating disorders: key facts. Available at: <http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/eatingdisorders.aspx> (accessed 16 January 2018).

Ruddick, S. (1989). *Maternal thinking—towards a politics of peace*. London: The Women's Press.

Rumsey, N. & Harcourt, D. (2012). *Oxford handbook of the psychology of appearance*. Oxford: Oxford University Press.

Russell, G. (1979). Bulimia nervosa: An ominous variant of anorexia nervosa. *Psychological Medicine*, 9(3), 429-448.

- Sandoz, E.K., Wilson, K.G. & DuFrene, T. (2010). Acceptance and commitment therapy for eating disorders: A process-focused guide to treating anorexia and bulimia. Oakland, California: New Harbinger.
- Satir, D.A., Thompson-Brenner, H., Boisseau, C.L. & Crisafulli, M.A. (2009). Countertransference reactions to adolescents with eating disorders: Relationships to clinician and patient factors. *The International Journal of Eating Disorders*, 42(6), 511-521.
- Saukko, P. (2008) *The anorexic self: A personal, political analysis of a diagnostic discourse*. University of New York Press.
- Schmidt, U., Tiller, J., Blanchard, M., Andrews, B. & Treasure, J. (1997). Is there a specific trauma precipitating anorexia nervosa? *Psychological Medicine*, 27(3), 523–30.
- Schmidt, U., Tiller, J. & Treasure, J. (1993). Self-treatment of bulimia nervosa: A pilot study. *International Journal of Eating Disorders*, 13(3), 273-277.
- Serfaty, M.A., Turkington, D., Heap, M., Ledsham, L., Jolley, E. (1999). Cognitive therapy vs dietary counseling in the outpatient treatment of anorexia nervosa: effects of the treatment phase. *European Eating Disorder Review*, 7(5), 334–350.
- Shahtahmasebi, S. & Cassidy, B. (2015). Young women's perception of body shape/weight and health: A measurement problem. *International Journal of Child and Adolescent Health*, 8(3), 277-287.
- Sheridan, G. & McArdle, S. (2016). Exploring patients' experiences of eating disorder treatment services from a motivational perspective. *Qualitative Health Research*, 26(14), 1-10.
- Shipton, G. (2004). *Working with eating disorders*. Basingstoke: Palgrave Macmillan

Shisslak, C.M., Crago, M., McKnight, K.M., Estes, L.S., Gray, N. & Parnaby, O.G. (1998). Potential risk factors associated with weight control behaviors in elementary and middle school girls. *Journal of Psychosomatic Research*, 44(3), 301–13.

Shuy, R. W. (2003). In-person versus telephone interviewing. In Holstein, J.A. & Gubrium, J.F. *Inside interviewing: new lenses, new concerns*, (pp. 75-193), Thousand Oaks, California; London: Sage.

Sly, R., Morgan, J., Mountford, V., & Lacey, J. (2013). Premature termination of treatment for anorexia nervosa: The roles of therapeutic alliance, motivation, and behaviour change. *Eating Behaviours*, 14(2), 119–123.

Smink, F.R.E., van Hoeken, D. & Hoek, H.W. (2013). Epidemiology, course, and outcome of eating disorders. *Current Opinion in Psychiatry*, 26(6), 543-548.

Smith, S. M. & Hanson, R. (1972). Failure to thrive and anorexia nervosa. *Postgraduate Medical Journal*, 48(560), 382–384.

Smith, J. A. & Osborn, M. (2003). Interpretative phenomenological analysis. In Smith, J. A. (Ed.), *Qualitative psychology: a practical guide to research methods* (pp. 51–80). London: Sage.

Smith, J. A. & Osborn, M. (2003). Interpretative phenomenological analysis. In Smith, J. A. (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 51–80). London: Sage.

Smith, V., Chouliara, Z., Morris, P.G., Collin, P., Power, K., Yellowlees, A., Grierson, D., Papageorgiou, E. & Cook, M. (2016). The experience of specialist inpatient treatment for anorexia nervosa: A qualitative study from adult patients' perspectives. *Journal of Health Psychology*, 21(1), 16-27.

Spiteri C. L. & Moraes, C. (2015). The impact of consumer confusion on nutrition literacy and subsequent dietary behavior. *Psychology & Marketing*, 32(5), 558-574.

- Starcevic, V., & Aboujaoude, E. (2015). Cyberchonria, cyberbullying, cybersuicide, cybersex: New psychopathologies for the 21st century? *World Psychiatry*, 14(1), 97-100.
- Stark, C. (2000). *All about anorexia nervosa: A booklet for those wanting to know more about anorexia nervosa*. London: The Mental health Foundation.
- Steiger, H., Stotland, S., Trottier, J. & Ghadirian, A.M. (1996). Familial eating concerns and psychopathological traits: Causal implications of transgenerational effects. *International Journal of Eating Disorders*, 19(2), 147-57.
- Stein, A. (2002). Eating disorders and childrearing. In Fairburn, C. G. (Ed.), *Eating disorders and obesity: A comprehensive handbook* (pp. 221-225). New York: Guilford.
- Stein, A. & Fairburn, C. G. (1996). Eating habits and attitudes in the postpartum period. *Psychosomatic Medicine*, 58(4), 321-325.
- Stein, A. & Fairburn, C. G. (1989). Children of mothers with bulimia nervosa. *British Medical Journal*, 299(6702), 777-778.
- Stein, A., Woolley, H., Senior, R., Hertzmann, L., Lovel, M., Lee, J., Cooper, S., Wheatcroft, R., Challacombe, F., Patel, P., Nicol-Harper, R., Menzes, P., Schmidt, A., Juszczak, E. & Fairburn, C.G. (2006). Treating disturbances in the relationship between mothers with bulimic eating disorders and their infants: A randomized, controlled trial of video feedback. *The American Journal of Psychiatry*, 163(5), 899-906.
- Stice, E. (1998). Modeling of eating pathology and social reinforcement of the thin-ideal predict onset of bulimic symptoms. *Behavior Research and Therapy*, 36(10), 931-44.
- Stice, E. (2002). Risk and maintenance factors for eating pathology: A meta-analytic review. *Psychological Bulletin*, 128(5), 825-848.

- Stewart, M., Keel, P.K. & Schiavo, R.S. (2006). Stigmatization of anorexia nervosa, *International Journal of Eating Disorders*, 39(4), 320-325.
- Stitt, N. & Reupert, A. (2014). Mothers with an eating disorder: Food comes before anything. *Journal of Psychiatric and Mental Health Nursing*, 21(6), 509-517.
- Striegel-Moore, R.H., Silberstein, L.R. & Rodin, J. (1986). Toward an understanding of risk factors for bulimia. *American Psychologist*, 41(3), 246–263.
- Striegel-Moore, R. (1997). Risk factors for eating disorders. *Annals of the New York Academy of Sciences*, 817(1), 98–109.
- Striegel-Moore, R.H. & Smolak, L. (2002). In Fairburn, C.G. & Brownell, K.D. *Eating disorders and obesity: A comprehensive handbook*, 2nd edn, New York; London: Guilford,
- Strober, M. & Humphrey, L.L. (1987). Familial contributions to the etiology and course of anorexia nervosa and bulimia. *Journal of Consulting and Clinical Psychology*, 55(5), 654-659.
- Stunkard, A. (1959). Eating patterns and obesity, *Psychiatric Quarterly* 33(2), 284-295.
- Swan, S. & Andrews, B. (2003). The relationship between shame, eating disorders and disclosure in treatment. *The British Journal of Clinical Psychology/ the British Psychological Society*, 42(4), 367.
- Sweeting, H., Walker, L., MacLean, A., Patterson, C., Räisänen, U. & Hunt, K. (2015). Prevalence of eating disorders in males: A review of rates reported in academic research and UK mass media. *International journal of men's health*, 14(2), 86.
- Szasz, T.S. (2010). *The myth of mental illness: Foundations of a theory of personal conduct*. Updated edition, Harper Perennial, New York; London.

- Talukdar, J. (2012). Thin but not skinny: Women negotiating the "never too thin" body ideal in urban India. *Women's Studies International Forum*, 35(2), 109.
- Tamakoshi, A., Yatsuya, H., Lin, Y., Tamakoshi, K., Kondo, T., Suzuki, S., Yagyu, K., Kikuchi, S. & JACC Study Group (2010). BMI and all-cause mortality among Japanese Older adults: Findings from the Japan collaborative cohort study. *Obesity*, 18(2), 362-369.
- Taylor, T. & Bloch, K. (2018). *Marginalized mothers, mothering from the margins*. United Kingdom: Emerald Publishing.
- Thomas, J.J., Vartanian, L.R. & Brownell, K.D. (2009). The Relationship between eating disorder not otherwise specified (EDNOS) and officially recognized eating disorders: Meta-analysis and implications for DSM. *Psychological Bulletin*, 135(3), 407-433.
- Thorne, B. (1993). Feminism and the family: Two decades of thought. In Thorne, B. & Yalom, M. (Eds.), *Rethinking the family: Some feminist questions* (2nd ed., pp. 3–30). New York: Longman.
- Thurer, S. (1995). *The myths of motherhood: How culture reinvents the good mother*. New York: Penguin.
- Tierney, S. (2008). The individual within a condition: A qualitative study of young people's reflections on being treated for anorexia nervosa. *Journal of the American Psychiatric Nurses Association*, 13(6), 368–375.
- Tiggemann, M. & Slater, A. (2014). NetTweens: The internet and body image concerns in pre-teenage girls. *The Journal of Early Adolescence*, 34(5), 606-620.
- Tomiyama, A.J., Carr, D., Granberg, E.M., Major, B., Robinson, E., Sutin, A.R. & Brewis, A. (2018). How and why weight stigma drives the obesity 'epidemic' and harms health. *BMC medicine*, 16(1), 123.

- Touyz S., le Grange D., Lacey H., Hay P., (eds) (2016). *Treating severe and enduring anorexia nervosa: A clinician's guide*. New York: Routledge.
- Tozzi, F., Sullivan, P., Fear, J., McKenzie, J. & Bulik, C.M. (2003). Causes and recovery in anorexia nervosa: The patient's perspective. *International Journal of Eating Disorders*, 33(2), 143–154.
- Treasure, J., Todd, G., Brolly, M., Tiller, J., Nehmed, A. & Denman, F. (1995). A pilot study of a randomised trial of cognitive analytical therapy vs educational behavioural therapy for adult anorexia nervosa. *Behaviour Research and Therapy*, 33(4), 363–7.
- Treasure, J.L. & Ward, A. (1997). Cognitive analytical therapy (CAT) in eating disorders. *Clinical Psychology and Psychotherapy*, 4(1), 62–71.
- Treasure, J. (2007). The trauma of self-starvation: Eating disorders and body image. In Nasser, M., Baistow, K. & Treasure, J. (Eds), *The female body in mind: The interface between the female body and mental health* (pp. 57-71). London, England: Routledge.
- Troop, N. A., Sottrilli, S., Serpell, L., & Treasure, J. L. (2006). Establishing a useful distinction between current and anticipated bodily shame in eating disorders. *Eating and Weight disorders*, 11(2), 83–90.
- Treasure, J., & Schmidt, U. (2013). The cognitive-interpersonal maintenance model of anorexia nervosa revisited: A summary of the evidence for cognitive, socio-emotional and interpersonal predisposing and perpetuating factors. *Journal of Eating Disorders*, 1(1), 13.
- Tuval-Mashiach, R., Ram, A., Shapiro, T., Shenhav, S. & Gur, E. (2013). Negotiating maternal identity: mothers with eating disorders discuss their coping. *Eating Disorders*, 21(1), 37-52.
- van Wezel-Meijler, G. & Wit, J. (1989). The offspring of mothers with anorexia nervosa: A high risk group for undernutrition and stunting. *European Journal of Paediatrics*, 149(2), 130–135.

- Vereijken, C. M., Weenen, H., & Hetherington, M. M. (2011). Feeding infants and young children. From guidelines to practice-conclusions and future directions. *Appetite*, 57(3), 839–843.
- Vignalou, J. & Guedeney, N. (2006). About offsprings of mothers with anorexia nervosa: What about clinical practice in paediatric settings?. *Archives de pédiatrie : organe officiel de la Société française de pédiatrie*, 13(5), 484.
- Vitousek, K.B. & Hollon, S.D. (1990). The investigation of schematic content and processing in eating disorders. *Cognitive Therapy Research*, 14(2), 191– 214.
- Vogler, R. J. M. (1993). *The medicalization of eating: Social control in an eating disorders clinic*. Greenwich, CT: Jai Press, Inc.
- Vohs, K.D., Bardone, A.M., Joiner, T.E., Abramson, L.Y. & Heatherton, T.F. (1999). Perfectionism, perceived weight status, and self-esteem interact to predict bulimic symptoms: A model of bulimic symptom development. *Journal of Abnormal Psychology*, 108(4), 695–700.
- von Soest, T. & Wichstrøm, L. (2008). The impact of becoming a mother on eating problems. *International Journal of Eating Disorders*, 41(3), 215-223.
- Walsh, B.T. (2009). *Report of the DSM-V eating disorders work group*. Washington, DC: American Psychiatric Association (APA).
- Walsh, E. & Malson, H. (2010). Discursive constructions of eating disorders: A story completion task. *Feminism & Psychology*, 20(4), 529-537.
- Ward A., Ramsay, R. & Treasure, J. (2000). Attachment research in eating disorder. *British Journal of Medical Psychology*, 73(1), 35-51.
- Watson, H.J. & Bulik, C.M. (2013). Update on the treatment of anorexia nervosa: Review of clinical trials, practice guidelines and emerging interventions. *Psychological Medicine*, 43(12), 2477-2500.
- Welch, S.L., Doll, H.A. & Fairburn, C.G. (1997). Life events and the onset of bulimia nervosa: A controlled study. *Psychological Medicine*, 27(3), 515–22.

Wertheim, E.H., Paxton, S.J., Schutz, H.K. & Muir, S.L. (1997). Why do adolescent girls watch their weight: An interview study examining sociocultural pressures to be thin. *Journal of Psychosomatic Research*, 42(4), 345–55.

Wicker, F.W., Payne, G.C. & Morgan, R.D. (1983). Participants descriptions of guilt and shame. *Motivation and Emotion*, 7(1), 25-39.

Wildes, J. E., Ringham, R. M., & Marcus, M. D. (2010). Emotion avoidance in patients with anorexia nervosa: Initial test of a functional model. *International Journal of Eating Disorders*, 43(5), 398–404.

Willig, C. (2008). *Introducing qualitative research methods in psychology*. Second Edition. Maidenhead: McGraw-Hill/Open University Press.

Windle, K., Barnett, S. & Buckroyd, J. (2005). Eating disorders from parent to child: Mothers' perceptions of transgenerational effect. *Counselling and Psychotherapy Research*, 5(3), 203-211.

Wright, W, K. & Hacking, S. (2012). An angel on my shoulder: A study of relationships between women with anorexia and healthcare professionals. *Journal of Psychiatric and Mental Health Nursing*, 19(2), 107–115.

Yamamiya, Y., Shroff, H., & Thompson, J. K. (2008). The tripartite influence model of body image and eating disturbance: A replication with a Japanese sample. *International Journal of Eating Disorders*, 41(1), 88–91.

Zerbe, K. J. (1995). The emerging sexual self of the patient with an eating disorder: Implication for treatment. *Eating Disorders*, 3(3), 197–215.

Zugai, J.S., Stein-Parbury, J. & Roche, M. (2018). Therapeutic alliance, anorexia nervosa and the inpatient setting: A mixed methods study. *Journal of Advanced Nursing*, 74(2), 443-453.

Appendices

Appendix I: Journal article

**Being a mother with anorexia: A phenomenological study of seeking and
receiving care**

**Marie-Claire Fitzpatrick, Victoria Clarke, Christine Ramsey-Wade and Naomi
Moller**

To be submitted to: *Psychology and Psychotherapy: Theory, Research and
Practice*

On being a mother with anorexia: A phenomenological study of seeking and receiving care

Abstract

Objectives

This paper explores the lived experiences of seeking and receiving professional help for anorexia for six mothers who have experienced anorexia while raising their children. This group of women are currently under-represented in the eating disorder literature. Research on clients' experiences of psychotherapeutic interventions for anorexia more broadly indicates that therapy is often perceived as aversive and limited in promoting recovery. This paper aims to illuminate what sense the women in the study made of their experiences of therapy, within the context of their identity as mothers, and offers suggestions for clinical practice.

Design

The study used an in-depth phenomenological qualitative approach to explore participants' lived experiences of seeking and receiving help for anorexia.

Methods

Six mothers who had experienced anorexia while bringing up their children were interviewed and the data from the interviews were analysed using interpretative phenomenological analysis.

Results

This paper reports four themes that capture the women's disparate and diverse experiences of seeking and receiving professional support for anorexia, on the difficulty of being mother and client, feeling (mis)understood, and the need for ongoing support.

Conclusions

The participants' experiences of therapy highlighted what was experienced as pathologising or helpful. The women's experiences suggest that health care professionals could adopt a more holistic approach when working with mothers

experiencing anorexia. Therapeutic interventions that acknowledge the life-world of the client (including their mother-status) and that respond empathically to communications of distress and resilience would offer a whole-person treatment focus.

Practitioner Points

- Awareness of the importance of the therapeutic relationship is key for practitioners working with this group of women and has the potential to improve therapy drop-out rates and promote positive therapy outcomes.
- Mental health services that remain sensitive to potential issues related to clients' mother status, when responding to the needs of this client group, can improve clients' perceptions about the quality of support offered.
- Adopting a pluralistic and holistic approach, using individual formulation in therapy, can minimise a 'one-size-fits-all' approach and help foster a sense of shared understandings of distress.

Keywords: Eating disorders, interpretative phenomenological analysis; interviews, women, therapy, treatment.

On being a mother with anorexia: A phenomenological study of seeking and receiving care Background

Anorexia has the highest mortality rate of any mental illness (Smink et al., 2013). Mortality risk estimates for anorexia are 5.9% compared to 1.6% for depression (Chesney et al., 2014). There is a general consensus that the risk for relapse is particularly high (Khalsa et al., 2017) and that there is a high risk of lifelong sub-clinical symptoms (Arcelus et al., 2011). Adult women experiencing anorexia are generally under-researched, as much of the focus is on adolescents (Wright & Hacking, 2012). A recent study, investigating the lifetime prevalence of eating disorders for adult women, found that 15% of female participants had experienced an eating disorder at some point in their lives and that 3.6% had experienced one in the past year (Micali et al., 2017). Numerous cases of eating disorders go unreported or undiagnosed, which means that rates of anorexia are likely to be higher than currently identified (Fursland & Watson, 2014). As it is likely that anorexia will be experienced by some women who are or may become mothers, it is important to research the experiences of this group of women, particularly as they are currently under-represented in the eating disorder literature

Social and psychological understandings of motherhood

Current dominant western, socio-cultural understandings of mothering and motherhood can be oppressive to women (Mack, 2012; Ross, 2016). What emerges consistently from literature and research underpinned by essentialist imperatives, is the socially dominant and idealised mother as one who is devoted to caring for others, particularly her children (Ross, 2016). She is self-sacrificing and 'not a subject with her own needs and interests' (Bassin et al., 1994, p. 2). In contemporary Western societies, the 'good mother' is an 'intuitive nurturer' (Krane & Davis, 2002, p. 172), 'responsible' (Miller, 2005, p. 25), will put her children's needs above her own (Hays, 1996) and is 'predominantly happy' (Johnston & Swanson, 2003, p.23). This arguably presents women with an unattainable ideal.

Although there *is* feminist research that captures the diversity of women's actual experiences of being a mother (e.g. Arendell, 2000; Chase & Rogers, 2001; Green, 2018; Miller, 2005; Taylor & Bloch, 2018), contemporary formulations of 'the good mother' continue to be influenced by essentialist assumptions in popular discourses that sculpt women's lives (Goodwin & Huppertz, 2010; Miller, 2005). If a woman appears to fail in the role of 'the good mother', a discourse of blame is readily available (e.g. Courcy & des Rivières, 2017; McLaren, 2013). 'Mother-blaming' holds women responsible for the 'actions, behaviours, health and well-being of their (even adult) children' (Jackson & Mannix, 2004, p. 150). 'Mother-blaming' is an insidious practice that is particularly reflected in the attitudes and interactions that some health professionals hold in relation to women and is reflected in therapies for women experiencing eating disorders such as anorexia (Allan, 2004; Jackson & Mannix, 2004; Kaplan & Garfinkel, 1999; Ramjan, 2004).

Interventions for women experiencing anorexia

Analysis of trends in intervention outcomes for individuals experiencing anorexia paints a stark picture of a recurring cycle of diagnosis, intervention, recovery and relapse, that often lasts at least 6 years, regardless of intervention type (Beat, 2015). There remains a lack of consensus over what approaches work best in terms of developing interventions and practice guidelines for anorexia (Fishburn, 2019; Watson & Bulik, 2013).

Women experiencing anorexia are often negatively represented in mainstream eating disorder literature, variously described as being needy, oppositional and resistant to interventions (Kaplan & Garfinkel, 1999; Ramjan, 2004). Care providers have described experiencing negative emotions when working with this client group, including feeling frustration (Satir et al., 2009), suspicion (King & Turner, 2000) and not wanted or valued by the client (Shipton, 2004).

Research on the lived experiences of treatment for anorexia highlights client perspectives on the shortcomings of such treatment. Interventions are variously described as blaming, inadequate, unhelpful and pathologising (Burton, 2014; Conti et al., 2017; Eivors et al., 2003; Le Grange et al., 1998; Walsh & Malson,

2010). Evidence from clients suggests that they value a focus on formulation, the therapeutic alliance and psychological interventions, instead of, or in addition to, body-weight and eating focused regimes (e.g. Bordin, 1979; De la Rie et al., 2006; Pettersen et al., 2010). Formulation, as an alternative to diagnosis, provides dynamic hypotheses about individual difficulties, drawing on psychological theory (Johnstone & Dallos, 2013) and has been shown to aid interventions and the development of the therapeutic alliance for individuals experiencing anorexia (Allen et al., 2016).

The therapeutic alliance, defined as an agreement on the goals of therapy in the context of a positive, affective bond between client and therapist, is an essential aspect of therapeutic interventions (Bordin, 1979). Although the therapeutic alliance has been described in eating disorder research as being challenging to create (Ramjan, 2004), it has also been shown to be crucial to successful outcomes (Pereira et al., 2006; Sly et al., 2013; Tierney, 2008).

Although there are variety of therapeutic interventions recommended and offered by health care professionals to women experiencing anorexia, the research indicates that the efficacy of these is questionable and interventions for anorexia would benefit from input from the women experiencing the eating disorder (Fishburn, 2019; Watson & Bulik, 2013).

Support for mothers experiencing anorexia

Because the (stereo)typical anorexia client is an adolescent female, it is likely that interventions are developed with this population in mind. It is not clear how mothers experience these interventions. Although evidence on interventions for adult women is limited, there is sense that anorexia in middle-aged and older women can be difficult to treat (Podfigurna-Stopa et al., 2015). A small number of studies, focusing on women's experiences, offer specific ideas for supporting women in their role as mothers in the context of their eating disorder (e.g. Bryant-Waugh et al. 2007; Fogarty, 2018). In a study examining the experiences of women with an eating disorder during pregnancy and two years after birth, Fogarty et al. (2018) recommended educating maternity health care professionals about eating disorders and providing ongoing support

for mothers. Bryant-Waugh et al. (2007) developed a group intervention for mothers with eating disorders, using focus groups and interview data. They suggested that further research into the lived experiences of mothers with eating disorders would support the development of novel interventions for this group of women.

The current study

This aim of this research was to explore the experiences of mothers seeking and receiving therapy and support for anorexia. Based on these experiences, this research offers suggestions for good practice for health care professionals working with these women.

Method

This study used interpretative phenomenological analysis (IPA) (Smith, Flowers & Larkin, 2009) to explore the experience of six mothers who have experienced anorexia while bringing up their children. IPA is concerned with facilitating a detailed examination of personal lived experiences, drawing on ideas and concepts from both phenomenology and hermeneutics, while combining interpretative and idiographic components (Eatough & Smith, 2017; Gill, 2014).

Participants and recruitment

Six women who were mothers, aged 18 or older, self-defined as 'recovered' from anorexia and had received a diagnosis of anorexia from a health professional were recruited for this research. The relatively small sample size recommended for IPA (Smith et al., 2009) allows for a deeper and richer analysis of individual experiences than typically possible in qualitative research and is oriented both to identifying patterns of meaning across data (the thematic) and the unique features of individual experience (the idiographic). Five participants were recruited through the UK eating disorder charity, Beat, and the sixth was recruited through a contact of the first author. Participants were aged between eighteen and fifty-two years of age and all identified as white British. Five participants were married or in a relationship and one woman was single. The

number of children they had ranged from one to four. Participants were allocated pseudonyms to protect anonymity.

Data Collection

Participants were given the choice of a face-to-face, telephone or *Skype* interview. All six chose to be interviewed by telephone. Semi-structured in-depth interviews were conducted by the first author. Participants were asked planned and responsive, open-ended questions about their experiences of therapy for anorexia (e.g. can you tell me about your experience of sources of support for you as a mother with anorexia?). The length of the interviews ranged from 52 minutes to 70 minutes, with an average length of 63 minutes. Participants were all in their homes when the interview took place. They were sent a participant information sheet, consent form and demographic form via email. The participants returned a signed consent form before interviews took place. The study received ethical approval from the authors' Faculty Research Ethics Committee.

Data analysis

The first author transcribed the data for the purposes of analysis. Analysis was led by the first author and followed the six-step process recommended by Smith et.al. (2009). The authors met to discuss their initial impressions of the interviews. The first author then engaged in a process of immersing herself in the data through repeated reading of the interview transcripts and listening to the audio-recordings of the interviews and making notes on features of analytic interest. These notes were reviewed and discussed with the other authors before organising and interpreting the data to identify emergent themes. These emergent themes were reviewed and discussed and super-ordinate themes were then developed. This process was repeated on a case by case basis, for each set of data, followed by taking a holistic approach to the data. Patterns, similarities and differences were identified across all transcripts and themes were developed.

Results

This paper reports on four themes that capture the women's diverse experiences of seeking and receiving support. The themes are presented with illustrative extracts in Table 1.

Table 1. Themes with supporting extracts

Themes	Supporting extracts
1: Conflict between being a mother and a client	Gail: 'I used to feel so guilty about going to counselling.' Jane: 'You do always have to put other people [children] first.'
2: Feeling blamed, bullied or misunderstood	Gail: 'I felt she [therapist] was quite a bully with me.' Alison: 'The health visitor was all a bit sort of like 'stop trying to put your issues onto her' [daughter]
3: Positive experiences of support	Jess: 'She [therapist] really knew her stuff.' Alison: 'I can save up all the crap and dump it at her [therapist] once a week.'
4: The importance of ongoing support	Gail: 'I really needed that; someone [health care professional] checking up on me.' Alison: 'It would just be nice to have somewhere that you could either phone, or just get that support [with children].'

Overview

It was evident that these women's experiences of professional support for their eating disorder were varied and diverse. Where therapy was described as unhelpful, the mothers' reported experiencing resistance to therapy or a rupture that marked a premature end to therapy. When therapy was perceived as helpful, the women referenced a variety of contributing factors, such as therapist expertise and feeling able to 'offload' on a regular basis. Common to all accounts was the underlying message that for support to be experienced as helpful, a match or 'fit' between the health care professional and mother was key. Feeling understood and attended to within wider contexts was of

paramount significance, and 'being a mother with anorexia' was expressed as representing a particularly important context for support.

'Being a mother – it was very difficult': The conflict between being a mother and client

A common theme running throughout the women's accounts was that many aspects of seeking and receiving help were experienced as challenging within the context of motherhood. Jane described how difficult it was for her to access support:

But I mean, I do think there's a case where, for mums anyway – you do always have to put other people first you know – regardless, erm, of whether you're anorexic or not, but I think that's very much, erm, a case of, in the fact that you do feel worthless, and you don't feel you deserve to get help. And then also you have the anorexic thing that won't let you ask for help.

Here Jane referenced an awareness of a wider social narrative about the 'selfless' mother. Engaging with this narrative enabled her to make sense of her own experience of not asking for, or feeling deserving of, help. There was the sense that anorexia and motherhood conspired together to prevent her from accessing treatment. Gail also articulated this idea:

The guilt as a mother, that you're being so selfish to put yourself first. As well, I mean, I used to feel so guilty about going to this counselling, like because you do just put your kids first naturally, but why would I be thinking about myself? This wasn't right.

Gail clearly expressed her belief in the idea that it was 'selfish' to put oneself first as a mother, and that this belief was a trigger for feelings of guilt. She references the socially dominant notion that a 'good mother' never puts herself first, to the point where any amount of self-reflection was forbidden. Vicky also talked about the difficulty of reconciling her identity as a mother with treatment offered to her by her therapist:

All she kept wanting was for me to be admitted erm to erm to a hospital and I didn't want to go obviously, 'cos I didn't want to leave my children.

Vicky clearly related the sense that the help on offer was unacceptable to her as a mother. This idea was further reiterated when she related how difficult the therapy became:

Every time I knew I had an appointment with her [the therapist] I almost dreaded going, because I was just like, you know every time I went, I knew that she would badger me about going to the eating disorder unit, and I just thought 'it's not gonna happen'. There was no way I was gonna go in there as an in-patient. So I just said to her 'look', you know 'don't worry' and 'I think I'll just leave it'.

Therapy was dreaded by Vicky and became a vehicle for opposition and resistance. She conveyed her sense of the therapist persistently pursuing her idea of what Vicky should be doing (with her use of the word 'badger'), highlighting the perceived power imbalance and lack of alliance between therapist and client. The reason she gave for opposition was her status as a mother, where it was unthinkable for her to leave her children. This resulted in a state of deadlock where Vicky was left on her own, unable to accept the offered help.

'I felt she [therapist] was quite a bully with me': Experiences of feeling blamed, bullied or misunderstood

Some of the stories the mothers told referenced feeling blamed, bullied or misunderstood by therapists and other health professionals. Alison described an interaction with her health visitor, after her daughter was born, where she felt blamed:

And then the health visitor made me feel crap. So when I had Sally [daughter] and she's got a similar em frame, I used to get really stressed about weight like 'Oh, God, she's put on too much, hasn't she?' and the health visitor was all a bit sort of like 'stop trying to put your issues onto her'.

There was the sense of Alison experiencing the process of weighing her child as a stress-inducing test of 'good mothering' that she feared she would fail. She communicated that she felt unable to judge for herself what was 'normal' in terms of weight gain. In revealing her uncertainty to the health visitor, she felt cruelly shut down in a way that sounded punitive, blaming and judgemental of her status as a mother. The perceived power-differential was strongly communicated through Alison's narrative. The health visitor was experienced as a harsh, reprimanding weight 'expert' who 'made' Alison feel 'crap', like excrement, the lowest of the low. Gail also shared the difficulties she experienced with a therapist:

I had this very, em, she was a larger-than-life character, I'd imagine in real life, and she was quite - I felt like she was quite a bully with me - very big lady, and she was always late. So, em, anyway, she was always late and, em, I had to get back and I found it quite rude. I was like you know, 'I'm a mother', I can't. I have to look after my daughter today, and I haven't got any other childcare. I can't stay for the whole hour now, so you know quite often I'd only have a twenty-minute appointment because she'd been 40 minutes late. It was crazy, and em, in fact I only saw her twice in the end, and she signed me off because I think she sort of knew I'd had enough of her she said, 'Oh we're fine' and signed me off (laughing).

There is the sense of Gail experiencing the therapist's embodiment as overbearing, oppressive and suggestive of a tyrannical tormenter (in her use of the word 'bully'). Her use of the terms 'larger-than-life', 'character' and 'in real life' created a sense of the therapist as a caricature or cartoon-like in a menacing way, with Gail experiencing an embodied and abusive power imbalance. Gail described her lateness as being 'rude' and dismissive of her identity as a mother. There is the sense that she felt that her 'mother-identity' should confer respect and a boundary for therapy when she stated, 'I'm a mother'. Engaging with this 'mother' identity felt protective for Gail, in that it allowed her to maintain a positive idea of herself, while vilifying the therapist as

a bully who did not share her value for respect and boundaries around motherhood.

Kate's narrative also referred to her experiencing her therapist in an embodied way, which Kate felt interfered with the therapeutic relationship and left her feeling misunderstood. This happened when her therapist '*lost a lot, all her weight and became very slim*'. This weight loss was experienced as a 'conflict of interests' and 'unfair' for Kate having to watch her therapist 'losing' as she 'gained', where 'losing' represented what Kate desired for herself.

Jane's narrative highlighted her sense of feeling misunderstood by her GP:

There's this kind of myth that anorexics are not aware that they're ill and that was very much what my doctor felt he had to do to me – he kept turning me back, he kept weighing me and he kept pointing out to me. I remember thinking 'why is he keeping on doing this?'. And it was later on when I spoke to him again, he thought my problem was that I didn't know I was thin and didn't know I was ill. But you do know that you're thin, you do know you're ill.

In this extract, Jane described her doctors' assumption about her perceived lack of awareness of her being thin and ill. She referenced and rejected the 'anorexic myth' of having no awareness of being ill. She conveyed the sense of her doctor 'doing' things to her that did not make sense. This created a sense of Jane as feeling physically objectified, rather than attended to as a sentient being. In not communicating what he was 'doing', there is the sense of the doctor infantilising Jane or conceiving of her as a problem that he was dealing with, without her knowledge or consent.

'She [therapist] really knew her stuff': Positive experiences of therapy

Other narratives referenced more positive experiences of therapy. In the following extract, Jess talked about the value of having continuity of care:

You know, it worked very well that I saw her [the consultant psychiatrist] for so long because we were able to build up a very good relationship, em, sort of, knew what to do when things sort of started to go bad, it

was very, just very, very good. Well obviously being a consultant psychiatrist she really knew her stuff.

Jess described how important the relationship was and how valuable it was to feel confident in her therapists' expertise, while Alison communicated what she appreciated about her ongoing therapy:

It's kind of having the continuity and the regularity of it and I know that I can, that, at the moment, I can save up all the crap and dump it at her once a week.

Alison articulated the value for her to have consistent and reliable support. Her use of the words 'crap' and 'dump' were visceral in their evocation of bodily functions and served to describe how she felt able to expel the excrement of her week 'at' her therapist. Her language suggested that therapy might be functioning as a depository for 'crap' she had saved up over the week. Her use of the word 'at' rather than 'on' indicated an element of dynamism in the relationship, where the therapist might have some autonomy over whether to take the 'crap' or leave it. Her inclusion of '*at the moment*' suggested that therapy might stop at some point - begging the question of what happens when Alison has nowhere to dump the crap?

'It's still a struggle now': The importance of ongoing support

Although the women were recruited as recovered, in practice recovery was not black and white and they variously reported how ongoing support would be helpful. Gail felt that having someone there to check in with on an ongoing basis would be helpful:

You just have this series of counselling, you have this series of, em, series of nutrition and that bit that stopped, and that that is a really big problem I think, em when you're, when you're when that's what you've realised especially when you're an adult, you know, with kids. I really needed that; someone checking up on me, and my doctor did nothing. Nothing at all. I actually asked if the nurse, if I could be weighed every other week I. So I was, but that involved me having to walk down a really

long hill, and then virtually run up it to get to school so it was just defeating the object really, and em, it was just ridiculous. But I just felt that I needed somebody to, I needed to be checked up on, you know, like a kid would, and without asking for it, I didn't get it.

Gail describes the 'stopping' of support as problematic in the context of her mother role. She communicated that combining treatment with school runs was not practical; eating disorder care is not designed for mothers. Gail's GP is represented as being inactive and absent in her ongoing care, illustrated in the bald statement '*my doctor did nothing. Nothing at all.*' What is created is a narrative of wanting to be cared for. Gail was left feeling alone with this responsibility and communicated clearly how difficult this was. Her plea for help was not attended to. When it was (in the nurse agreeing for her to be weighed regularly), it was not in a way that was ultimately helpful. She was aware that there was a childlike element to her desire for the support she requested, but crucially, this need was not met. There was a sense of her doctor as an unresponsive parent, and the nurse responding in a way that did not meet her needs. Both were experienced as being emotionally unavailable. Gail experienced herself as both parent and child, in relation to anorexia, where the parent was watchful and on guard for danger but where the child sought attention and care.

Alison also communicated the belief that ongoing support would be helpful for her:

There needs to be something, I think, help in supporting you feeding your children, em, because they ought to know. I was so scared that I wouldn't feed my children enough or feed them too much, cos I was trying to compensate for the fact that I might not feed them enough, and it would just to be nice to have somewhere that you could either phone or, just get that support so like my children being really fussy, the health visitor's been useless, the GP is like 'well, speak to the health visitor' and there is nowhere to go, and you just want to say 'my kids just won't eat anything

I give them and my son's not eating his school dinners and he won't eat anything for packed lunch. I just want to cry'.

This extract illustrated just how difficult Alison experienced being a mother, in the context of the practice of feeding her children. She expressed how unsure she felt about what she did with her children around food, as a direct result of her own experiences of what food has meant to her. When she stated: 'they ought to know', she communicated her belief that someone should have access to an answer that was beyond her knowledge, with regards to what was 'right' for her children to eat. This served to increase her sense of impotence and desire for answers that she felt were being withheld. She was aware that support with this would help, but felt that no-one was taking responsibility for this, which left her feeling worried and lost. The GP and health visitor were experienced by her as unresponsive in a way that felt evocative of neglect. What was obvious was that food and feeding her children were challenging emotional experiences for Alison. She was left feeling upset, alone and unsupported. Her final statement in this extract: 'I just want to cry', perfectly encapsulated her distress, invoking an image of a small child who has no one to comfort her.

Kate also communicated her experience of recovery as something which was ongoing:

In January I'm starting another 6 months, 24 sessions of treatment. As, as I've tried to explain to you when the weight is restored and our brain works properly there are a lot of issues, as, for example, why we maintain an eating disorder - what spurs us on, don't necessarily get addressed along the way - the CBT doesn't cover that, and the NHS funds are that they like to leave us at a point where at least our weight is stable. But with some people, particularly when you've had it for forty-something years, the facts that maintain the eating disorder are still there, the psychological patterns, the self-worth, self-esteem - they still remain. So and that, all of us, we have a peer group that's been set up for people who've been discharged at a stable weight. We all struggle

now that we all feel fat, and that we're living in a new world with all these new feelings, that we struggle very much with. I mean, not a day goes past that I just think' oh I just want to be the way I used to be - this is just too difficult'.

Kate separated out the strands of what 'recovery' meant to her: physical and neurological recovery (attended to in CBT), but also with a deeper focus on what might have caused and maintained the eating disorder in the first place. Her use of 'we' rather than 'I' implied her belief in it being a universal experience that she shared with other mothers who have experienced anorexia. Her description of her experience of the peer group underlined this sense of 'belonging' to a tribe of women who feel the same. She presented herself as a spokesperson for her tribe, confidently stating that she knew how it was for them and that this was the same as how it was for her. She described how 'feeling fat' was experienced as a struggle. She communicated a sense of finding herself in a foreign land where everything was new, different and difficult and where a desire for a return to the old familiar was a daily experience. She created a sense of nostalgia for a past, easier self, in a world that was known and where feelings were not a struggle. Her account evoked a feeling of 'otherness' that she believed she shared with the women in her peer group and that ongoing care was essential to help with the challenges of the new world of 'recovery'.

Discussion

Disparate experiences of therapy and support for mothers with anorexia

The women's accounts of their experiences of treatment in this study illuminate how difficult it could sometimes be to achieve and maintain a good 'fit' between being a client experiencing anorexia and being a mother. Some of the women felt undeserving of help, particularly in the context of being a mother where 'other people' have to come first. They described difficulty with accessing treatment (as a mother), suggesting the problematic nature of maintaining an 'idealised mother' status alongside that of being a 'distressed woman' in need and want of support. This resonated with oppressive dominant 'mother'

narratives, where mother's needs are secondary to those of her children (Hays, 1996). The women in this study highlighted other difficulties experienced in reconciling aspects of therapy with their mother status (e.g. where an in-patient intervention was recommended for Vicky and where the therapist did not take Gail's child-care responsibilities into account). In these cases, the women felt they were experienced as oppositional and resistant to 'treatment'. This echoes other qualitative research where women have reported experiencing treatment for anorexia as pathologising (Holmes, 2016; Walsh & Malson, 2010).

Some of the women in this study described feeling blamed for their anorexia. This echoes findings in a study of health providers' attitudes toward their patients (e.g. Crisafulli et al., 2008) and reinforces the idea that there might be an underlying blame culture in anorexia treatment (e.g. Crisp, 2005; Stewart et al. 2006). In addition to this, the women in this study reported sometimes feeling misunderstood or bullied by health care providers. This resonated with other accounts of the lived experiences of treatment for anorexia, where treatment has been variously described as blaming, inadequate, unhelpful and pathologising (Burton, 2014; Conti et al., 2017; Eivors et al., 2003; Le Grange et al., 1998).

Questioning *why* women with anorexia are experienced in negative ways, in the context of interventions, might help inform development of more compassionate approaches, rather than blaming the women for 'non-compliance'. This idea resonates with critical feminist accounts that question the 'normality' of the treatment women with anorexia received and theorise that treatment experiences echo a similar 'micro-management' of the body, evident in the experience of anorexia itself (Malson et al., 2004). Discourses disseminating the idea of the 'anorexic patient' as 'needy' are unhelpful for women (in general) seeking help for anorexia, and particularly for women who are mothers (who might also be bound up in the 'idealised mother' mythology). This signals a need for the healthcare profession at large to think about *why* particular clients or patients might be experienced and pathologised and to recognise attendant relational aspects of the therapy dynamic, in terms

of building a strong therapeutic alliance and where responsibility should be most helpfully conceived as a shared endeavour (Hepworth, 1999; Sandoz et al., 2010; Zugai et al., 2018).

The women in this study also told more positive stories about their experiences of treatment. These resonated with existing literature (e.g. Le Grange et al., 1998; Zugai et al., 2013). Some women described the value they placed on having a continuity of care, allowing them the opportunity to build a 'good relationship' with their therapist. This coheres with research that recognises the therapeutic alliance as an important aspect of 'successful' treatment for eating disorders (Pereira et al., 2006; Sly et al., 2013; Smith et al., 2016; Tierney, 2008). Another aspect of treatment that was experienced as valuable was the sense of the therapist being a 'specialist' in her field (Bachelor, 1995; Bezance & Holliday, 2013) and developing practical coping strategies was also experienced as helpful (Brown & Waller, 2014).

Implications for Practice

Health care professionals are well-placed to begin to think about bridging the gaps in support for mothers experiencing anorexia. Although critical feminist approaches (e.g. Bordo, 1988; Malson, 1998) offer helpful, empathic and non-pathologising lenses through which to view the world of women in general, and mothers experiencing anorexia in particular, it can be challenging to translate these theories into clinical practice, where 'feminist work often takes place at considerable remove from treatment intervention' (Holmes, 2016, p.465).

It is important to maintain an understanding that being a mother can be variously supporting and/or triggering of anorexia and that this should be empathically responded to in assessment, formulation and treatment of these women. This could be addressed in the dissemination of literature and training for health care professionals (at all levels) that presents the experience of anorexia (for men and women) as a communication of distress (Jenkins & Ogden, 2012). This will help to break down stigmas, assumptions and prejudices that remain prevalent across society towards people with anorexia (Stewart et al., 2008).

Bryant-Waugh et al. (2007) suggested that specifically-tailored support and advice for mothers, around their parental role, might be beneficial in promoting positivity and self-esteem around being a parent. In this current study, some of the women explicitly expressed how having practical support with feeding their children would have been helpful, while others related how they sought flexibility around treatment that accommodated school-runs and child care. Using these observations to inform clinical practice and support, would acknowledge the 'experience-expert' alongside that of the 'clinician-expert' (Smith et al., 2010). A dynamic formulation that can be multi-layered, textured and sometimes contradictory would help avoid a 'one-size fits all' approach to the experiences of and meanings ascribed to anorexia by these mothers.

An emphasis on acknowledging and minimising power differentials in the context of therapy is also desirable, regardless of the presenting problems in living (Tierney, 2008; Pereira et al., 2006; Sly et al., 2013). This is particularly important in the case of anorexia, where this power differential has traditionally, and anecdotally, been keenly felt by clients in relation to care providers (Malson et al., 2004). Experiences of this type of power imbalance were evident in the narratives of the women in this study. An emphasis on 'the relational', 'transparent' and 'collaborative' should be at the centre of all therapeutic interactions in managing distress that is embodied as well as psychological. This is in recognition of the fact that traditional practices of 'therapy', for the experience of anorexia, have often focused on the embodied experience as distinct from the psychological, in ways which have been reported by women as feeling punitive, harmful or oppressive. It is also important to acknowledge and challenge the fact that treatment recommendations for 'staying healthy', in the context of the experience of anorexia, can contradict other dominant discourses around 'eating healthily' (through focusing on eating and weight control) (LaMarre & Rice, 2016), and that this is potentially confusing to those being treated, especially mothers with children to feed.

Responding to the stories the women told about their treatment, it is evident that flexibility with the practicalities of 'treatment' would be helpful in creating

a strong working alliance (Horvath et al., 2011). It has been evidenced that the therapeutic alliance is an important factor in therapeutic interventions with individuals experiencing eating disorders (Graves et al., 2017). On a practical level, building and maintaining a therapeutic alliance might involve the therapist responding to the potential impact of child-care on a mother's ability to engage with the therapeutic process. On a therapeutic level, using a dynamic formulation, that is a 'recursive process of suggestion, discussion, reflection, feedback and revision as part of the moment-to-moment process of therapy' (Johnstone & Dallos, 2013, p.4), alongside a recognition of the particular function (or meaning) of anorexia for an individual, might be a useful first step in thinking about what might be 'helpful'. The diverse nature of what the women in this research found 'helpful' suggests that a pluralistic and holistic approach might be usefully employed by clinicians. This resonates with a recent systematic review of intervention outcomes for anorexia, which recommended the utility of therapists' engagement with a more holistic approach to treatment than that which has traditionally been employed (Murray et al., 2018).

Conclusion

This study offers insight into the therapy experiences of mothers who have engaged with help for anorexia. Interventions and support were experienced by the participants in diverse ways and confirms that developing a greater understanding of what helps will be beneficial to both the client and the health care professional working with her. Treatments that take a narrow view of the experience of anorexia for mothers are potentially missing opportunities for developing holistic and supportive environments for recovery. Through hearing these women's stories and attending to what is deemed important, it is hoped that this paper might help disseminate the message that a nuanced, sensitive and holistic approach to therapy for these women might improve the quality and experience of the care they receive.

References

Allan, J. (2004). Mother blaming: A covert practice in therapeutic intervention.

Australian Social Work, 57(1), 57-70.

Allen, K.L., O'Hara, C.B., Bartholdy, S., Renwick, B., Keyes, A., Lose, A., Kenyon, M., DeJong, H., Broadbent, H., Loomes, R., McClelland, J., Serpell, L., Richards, L., Johnson-Sabine, E., Boughton, N., Whitehead, L., Treasure, J., Wade, T. & Schmidt, U. (2016). Written case formulations in the treatment of anorexia nervosa: Evidence for therapeutic benefits. *International Journal of Eating Disorders*, 49(9), 874-882.

Arcelus, J., Mitchell, A.J., Wales, J. & Nielsen, S. (2011). Mortality rates in patients with anorexia nervosa and other eating disorders. A meta-analysis of 36 studies. *Archives of General Psychiatry*, 68(7), 724-31.

Arendell, T. (2000). Conceiving and investigating motherhood: The decade's scholarship. *Journal of Marriage & the Family*, 62(4), 1192-1207.

Bachelor, A. (1995). Clients' perception of the therapeutic alliance: A qualitative analysis. *Journal of Counselling Psychology*, 42(3), 323-337.

Bassin, D., Honey, M. & Kaplan, M.M. (1994). Introduction. In D. Bassin, M. Honey & M. Kaplan (Eds.), *Representations of motherhood* (pp. 1-25). New Haven: Yale University.

Beat (2015) *The costs of eating disorders: Social, health and economic impacts*, PricewaterhouseCoopers (PwC).

Bezance, J. & Holliday, J. (2013). Adolescents with anorexia nervosa have their say: A review of qualitative studies on treatment and recovery from anorexia nervosa. *European Eating Disorders Review*, 21(5), 352-360.

Bordin, E.S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, 16(3), 252-260.

Bordo, S. (1993a). *Unbearable weight*. Berkeley, California: University of California Press.

Brown, A., Mountford, V. & Waller, G. (2014). Clinician and practice characteristics influencing delivery and outcomes of the early part of outpatient cognitive behavioural therapy for anorexia nervosa. *The Cognitive Behaviour Therapist*, 7(10), 1-12.

Bryant-Waugh, R., Turner, H., East, P. & Gamble, C. (2007). Developing a parenting skills-and-support intervention for mothers with eating disorders and pre-school children part 1: Qualitative investigation of issues to include. *European Eating Disorders Review*, 15(5), 350-356.

Burton, T. (2014). Walking a tightrope: Women's experiences of having an eating disorder while pregnant. *Australian Nursing and Midwifery Journal*, 21(9), 45.

Chase, S.E. & Rogers, M.F. (2001). *Mothers and children: Feminist analyses and personal narratives*. London: Rutgers University Press.

Chesney, E., Goodwin, G.M. & Fazel, S. (2014). Risks of all-cause and suicide mortality in mental disorders: A meta-review. *World Psychiatry*, 13(2), 153-160.

- Conti, J., Calder, J., Cibralic, S., Rhodes, P., Meade, T. & Hewson, D. (2017). Somebody else's roadmap: Lived experience of Maudsley and family-based therapy for adolescent anorexia nervosa. *Australian and New Zealand Journal of Family Therapy*, 389(3), 405-429.
- Courcy, I. & des Rivières, C. (2017). From cause to cure: A qualitative study on contemporary forms of mother blaming experienced by mothers of young children with autism spectrum disorder. *Journal of Family Social Work*, 20(3), 233-250.
- Crisafulli, M.A., Von Holle, A. & Bulik, C.M. (2008). Attitudes towards anorexia nervosa: The impact of framing on blame and stigma. *International Journal of Eating Disorders*, 41(4), 333-339.
- Crisp, A. (2005). Stigmatization of and discrimination against people with eating disorders including a report of two nationwide surveys. *European Eating Disorders Review*, 13(3), 147-152.
- De la Rie, S., Noordenbos, G., Donker, M. & van Furth, E. (2006). Evaluating the treatment of eating disorders from the patient's perspective. *International Journal of Eating Disorders*, 39(8), 667-676.
- Eatough, V. & Smith, J. (2017). Interpretative phenomenological analysis. In C. Willig & W. Rogers (Eds.), *The Sage handbook of qualitative research in psychology* (pp. 193-209). London: Sage.

Eivors, A., Button, E., Warner, S. & Turner, K. (2003). Understanding the experience of drop-out from treatment for anorexia. *European Eating Disorders Review*, 11(2), 90–107.

Fishburn, K.E. (2019). When compared to comparator treatment, specialist interventions for anorexia nervosa are more effective in reducing weight-based symptoms, but not psychological symptoms. *Evidence-based Nursing*, ebnurs-2018-103006.

Fogarty, S., Elmir, R., Hay, P. & Schmied, V. (2018). The experience of women with an eating disorder in the perinatal period: A meta-ethnographic study. *BMC Pregnancy and Childbirth*, 18(1) 121-18.

Fursland, A. & Watson, H.J. (2014). Eating disorders: A hidden phenomenon in outpatient mental health. *International Journal of Eating Disorders*, 47(4), 422-425.

Gill, M.J. (2014). The Possibilities of Phenomenology for Organizational Research, *Organizational Research Methods*, 17(2), 118-137.

Goodwin, S. & Huppertz, K. (2010). *The good mother: Contemporary motherhoods in Australia*. Sydney, Australia: Sydney University Press.

Graves, T.A., Tabri, N., Thompson-Brenner, H., Franko, D.L., Eddy, K.T., Bourion-Bedes, S., Brown, A., Constantino, M.J., Flückiger, C., Forsberg, S., Isserlin, L., Couturier, J., Paulson Karlsson, G., Mander, J., Teufel, M., Mitchell, J.E., Crosby, R.D., Prestano, C., Satir, D.A., Simpson, S., Sly, R., Lacey, J.H., Stiles-Shields, C., Tasca, G.A., Waller, G., Zaitsoff, S.L., Rienecke, R., Le Grange, D. & Thomas, J.J.

- (2017). A meta-analysis of the relation between therapeutic alliance and treatment outcome in eating disorders. *International Journal of Eating Disorders*, 50(4), 323-340.
- Green, F.J. (2018). Empowering mothers and daughters through matroreform and feminist motherline. *Journal of the Motherhood Initiative for Research & Community Involvement*, 9(1), 9-20.
- Hays, S. (1996). *The cultural contradictions of motherhood*. New Haven, Connecticut: Yale University Press.
- Hepworth, J. (1999). *The social construction of anorexia nervosa*. Thousand Oaks, California: Sage.
- Holmes, S. (2016). Blindness to the obvious: Treatment experiences and feminist approaches to eating disorders. *Feminism & Psychology*, 26(4), 464-486.
- Horvath, A., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). The alliance. In J.C. Norcross (Ed.), *Relationships that work* (pp. 25–69). New York: Oxford University Press.
- Jackson, D. & Mannix, J. (2004). Giving voice to the burden of blame: A feminist study of mothers' experiences of mother blaming. *International Journal of Nursing Practice*, 10(4), 150-158.
- Jenkins, J. & Ogden, J. (2012). Becoming 'whole' again: A qualitative study of women's views of recovering from anorexia nervosa. *European Eating Disorders Review*, 20(1), 23-31.

Johnston, D.D. & Swanson, D.H. (2003). Invisible mothers: A content analysis of motherhood ideologies and myths in magazines. *Sex Roles*, 49(1), 21-33.

Johnstone, L. & Dallos, R. (2013). *Formulation in psychology and psychotherapy: Making sense of people's problems*, 2nd ed. London: Routledge.

Kaplan, A.S. & Garfinkel, P.E. (1999). *Difficulties in treating patients with eating disorders: A review of patient and clinician variables*. Thousand Oaks, California: Sage.

Khalsa, S.S., Portnoff, L.C., McCurdy-McKinnon, D. (2017). What happens after treatment: A systematic review of relapse, remission, and recovery in anorexia nervosa. *Journal of Eating Disorders* 5(20), 270-281.

King, S.J. & Turner, D.S. (2000). Caring for adolescent females with anorexia nervosa: Registered nurses' perspective. *Journal of Advanced Nursing*, 32(1), 139-147.

Krane, J. & Davies, L. (2002). Sisterhood is not enough: The invisibility of mothering in shelter practice with battered women. *Affilia*, 17(2), 167-190.

LaMarre, A. & Rice, C. (2016). Normal eating is counter-cultural: Embodied experiences of eating disorder recovery. *Journal of Community & Applied Social Psychology*, 26(2), 136-149.

Le Grange, D. & Gelman, T. (1998). Patients' perspective of treatment in eating disorders: A preliminary study. *South African Journal of Psychology*, 28(3), 182-186.

Mack, A.N. (2018). Critical approaches to motherhood. *Oxford Research Encyclopedia of Communication*, 1-22.

Malson, H. (1998). *The thin woman: Feminism, post-structuralism and the social psychology of anorexia nervosa*. London: Routledge.

Malson, H., Finn, D.M., Treasure, J., Clarke, S. & Anderson, G. (2004). Constructing the eating disordered patient: A discourse analysis of accounts of treatment experiences. *Journal of Community and Applied Social Psychology*, 14(6), 473–89.

McLaren, H.J. (2013). (Un)-blaming mothers whose partners sexually abuse children: In view of heteronormative myths, pressures and authorities. *Child and Family Social Work*, 18(4), 439-448.

Micali, N., Martini, M.G., Thomas, J.J., Eddy, K.T., Kothari, R., Russell, E., Bulik, C.M. & Treasure, J. (2017). Lifetime and 12-month prevalence of eating disorders amongst women in mid-life: A population-based study of diagnoses and risk factor. *BMC Medicine*, 15(1), 12.

Miller, T. (2005). *Making sense of motherhood: A narrative approach*. Cambridge, Massachusetts: Cambridge University Press.

Murray, S.B., Quintana, D.S., Loeb, K.L., Griffiths, S. & Le Grange, D. (2018). Treatment outcomes for anorexia nervosa: A systematic review and meta-analysis of randomized controlled trials. *Psychological Medicine*, 1-10.

Pereira, T., Lock, J. & Oggins, J. (2006). Role of therapeutic alliance in family therapy for adolescent anorexia nervosa. *International Journal of Eating Disorders*, 39(8), 677-684.

Pettersen, G., Rosenvinge, J.H. & Wynn, R. (2010). Eating disorders and psychoeducation – patients' experiences of healing processes. *Scandinavian Journal of Caring Sciences*, 25(1), 12-18.

Podfigurna-Stopa, A., Czyzyk, A., Katulski, K., Smolarczyk, R., Grymowicz, M., Maciejewska-Jeske, M. & Meczekalski, B. (2015). Eating disorders in older women. *Maturitas*, 82(2), 146-152.

Ramjan, L.M. (2004). Nurses and the 'therapeutic relationship': Caring for adolescents with anorexia nervosa. *Journal of Advanced Nursing*, 45(5), 495-503.

Ross, L.R. (2016). *Interrogating motherhood*. Edmonton: AU Press.

Sandoz, E.K., Wilson, K.G. & DuFrene, T. (2010). *Acceptance and commitment therapy for eating disorders: A process-focused guide to treating anorexia and bulimia*. Oakland, California: New Harbinger.

Satir, D.A., Thompson-Brenner, H., Boisseau, C.L. & Crisafulli, M.A. (2009). Countertransference reactions to adolescents with eating disorders: Relationships to clinician and patient factors. *The International Journal of Eating Disorders*, 42(6), 511-521.

Shipton, G. (2004). *Working with eating disorders*. Basingstoke: Palgrave Macmillan.

Sly, R., Morgan, J., Mountford, V., & Lacey, J. (2013). Premature termination of treatment for anorexia nervosa: The roles of therapeutic alliance, motivation, and behaviour change. *Eating Behaviours*, 14(2), 119–123.

Smink, F.R.E., van Hoeken, D. & Hoek, H.W. (2013). Epidemiology, course, and outcome of eating disorders. *Current Opinion in Psychiatry*, 26(6), 543-548.

Smith, J.A., Flowers, P. & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage.

Smith, V., Chouliara, Z., Morris, P.G., Collin, P., Power, K., Yellowlees, A., Grierson, D., Papageorgiou, E. & Cook, M. (2016). The experience of specialist inpatient treatment for anorexia nervosa: A qualitative study from adult patients' perspectives. *Journal of Health Psychology*, 21(1), 16-27.

Stewart, M., Keel, P.K. & Schiavo, R.S. (2006). Stigmatization of anorexia nervosa. *International Journal of Eating Disorders*, 39(4), 320-325.

Taylor, T. & Bloch, K. (2018). *Marginalized mothers, mothering from the margins*. United Kingdom: Emerald Publishing.

Tierney, S. (2008). The individual within a condition: A qualitative study of young people's reflections on being treated for anorexia nervosa. *Journal of the American Psychiatric Nurses Association*, 13(6), 368–375.

Walsh, E. & Malson, H. (2010). Discursive constructions of eating disorders: A story completion task. *Feminism & Psychology*, 20(4), 529-537.

Watson, H.J. & Bulik, C.M. (2013). Update on the treatment of anorexia nervosa: Review of clinical trials, practice guidelines and emerging interventions.

Psychological Medicine, 43(12), 2477-2500.

Wright, W. K. & Hacking, S. (2012). An angel on my shoulder: A study of relationships between women with anorexia and healthcare professionals.

Journal of Psychiatric and Mental Health Nursing, 19(2), 107–115.

Zugai, J., Stein-Parbury, J. & Roche, M. (2013). Effective nursing care of adolescents with anorexia nervosa: A consumer perspective. *Journal of Clinical Nursing*, 22(13-14), 2020-2029.

Zugai, J.S., Stein-Parbury, J. & Roche, M. (2018). Therapeutic alliance, anorexia nervosa and the inpatient setting: A mixed methods study. *Journal of Advanced Nursing*, 74(2), 443-453.

