

## **The Anorexia Nervosa Experience: Shame, Solitude and Salvation**

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### **Abstract**

**Aim:** Women with anorexia are often perceived very negatively – for example, as manipulative and deceitful – both by the wider society and treatment providers. In this context, it is important for practitioners to understand the experience of living with this illness, but there is very little empirical research focused on the everyday phenomenology of anorexia. This study aimed to expand this limited literature by ‘giving voice’ to the lived experience of women with anorexia.

**Method:** A purposive sample of 12 women – 11 with a formal diagnosis of AN as a result of NHS treatment and 1 with a long behavioural history of dietary restriction who had received private treatment – who saw themselves as recovered, or in recovery, from anorexia nervosa participated in semi-structured interviews. The women were asked about the history of their eating disorder, their understandings of its cause and experiences of seeking help and treatment.

**Results:** The data were analysed with thematic analysis and three themes identified – Shame, Solitude and Salvation – which, when taken together, describe the dual role of anorexia nervosa as both problem and solution, the cyclical nature of sufferers’ behaviours and feelings, and the way in which anorexia nervosa is a form of distress that can make its sufferers feel better as well as worse.

**Conclusions:** Further light is shed on the ambivalence about recovery, and resistance to treatment, that are frequently experienced by sufferers. Implications of these findings for those who work with eating disorders clients are discussed.

**Keywords:** eating disorders; interviews; lived experience; qualitative analysis; stigma

## **Introduction**

Adults and adolescents with eating disorders including anorexia nervosa (AN), a group which is mostly female, have been described as 'manipulative' (Ramjan, 2004, p.499), 'deceitful' (King & Turner, 2000, p.142), 'naughty girls' (Vandereycken, 1993, p.15), and 'to blame' for their illness (Crisp, 2005, p.151). Treatment providers have reported feeling 'suspicious' (King & Turner, 2000, p.142), 'frustrated' (Satir et al., 2009, p.518), and 'not valued, not wanted' (Shipton, 2004, p.101) when working with this group. Furthermore, evidence suggests there exists in the wider society a degree of stigma toward people with eating disorders generally and women with AN specifically (Crisp, 2005; Stewart et al., 2008). In this context it is important for those who work therapeutically with this population to understand the day-to-day experience of living with the illness. Although a small body of qualitative research exists in this area, it has tended to focus on sufferers' experiences of developing AN (e.g., Dignon et al., 2006; Nevenon & Broberg, 2000), recovering from it (e.g., Federici & Kaplan, 2008; Weaver et al., 2005) and the ways in which they conceptualise it (e.g., Button & Warren, 2001; Nordbø et al., 2006). Some research has explored sufferers' day-to-day experiences of living with the 'anorexic voice' (Tierney & Fox, 2010) and managing the presentation of an anorexic identity and the stigma attached to it (Rich, 2006). Both of these latter studies have revealed much about the difficulties faced by sufferers as a result of the illness. It remains the case, however, that very little is known about the more general day-to-day experience of living with AN; this is knowledge that is highly relevant for practice since research suggests that those with AN often want to talk about their whole life experience, not just their struggles with eating and food (Rance, Moller, Clarke, 2014). In addition, this information is relevant because, as stated, practitioners can find working with those with AN challenging; understanding more

about how women with AN understand their own experience potentially increases empathy and reduces frustration with this client group.

This study thus aimed to give voice to the lived experiences of women with AN. Given the exploratory nature of the study a qualitative methodology and a 'purposive homogenous sampling' strategy (Smith et al., 2009, p.49) were adopted. Furthermore, Morrow's (2005) guidelines for enhancing trustworthiness in qualitative research, and Morrow (2005) and Matthews' (2005) recommendations for crafting qualitative research articles, were adhered to.

## **Method**

Ethical approval was received from the University of the West of England Health and Life Sciences faculty research committee.

### *Participants*

Twelve women who saw themselves as either recovered or 'on the road to recovery' from AN or Bulimia Nervosa with a history of dietary restriction participated in the study. Ethical concerns led to the decision to recruit participants who had some distance from their ED experience; at the same time, however, it was recognised that recovery from AN is a long and ill-defined process (Couturier & Lock, 2006). Allowing interviewees' to self-define themselves as recovered or 'on the road to recovery' felt respectful of participants' autonomy and in keeping with the qualitative approach. The study was advertised through Beat (a nationwide United Kingdom charity providing information, help and support for those affected by EDs) and, as the researchers were based in the South-West of England, through (non-NHS) regional counselling services and

support groups. Eleven of the women had a formal diagnosis of AN through their contact with the United Kingdom National Health Service (NHS) and one had a long behavioural history of dietary restriction but no diagnosis as she had not sought help from the NHS. Following guidance in the literature, twelve was deemed an appropriate sample size to facilitate a focus on individual experiences as well as themes/patterns across the group as a whole (Braun & Clarke, 2013). See Table 1 for participant details.

[Insert Table 1 about here]

### *Data Collection and Analysis*

Potential interviewees were given written information about the study on initial contact with the first author and were encouraged to ask questions before agreeing to take part. Prior to the interview itself they were asked to read and sign a consent form and, after the interview, were reminded of the sources of support listed on the information sheet they had received on enquiring about the study. If participants asked about the first author's interest in the research topic she disclosed her AN history – approximately half did so and all but one did so after (rather than before) the interview. Each interviewee chose the location for their interview – four chose their own home, four chose the counselling service where the first author worked, two chose the university where the first author was a student and one chose her local library. To ensure that both the unique experiences and beliefs of each participant were heard, and that the core areas of interest in the research project were covered, a semi-structured interview schedule was developed. Questions focussed on the participant's history of eating difficulties, attempts to seek help and experience of treatment, as well as their perceptions and assumptions about therapists' weight/shape, body and relationship with food (we have address the participants'

experiences of treatment (Rance, Moller & Clarke, in press) and their therapists' body and eating practices (Rance, Clarke & Moller, 2014) elsewhere). The face-to-face interviews lasted between 59 and 103 minutes and were conducted by the first author - a trainee counselling psychologist who has a history of AN and works in the eating disorders field. The first author kept a self-reflective journal (Morrow, 2005) throughout the research to capture and process her personal responses to the research process, her preconceptions about the issues being researched and the impact of her personal and professional background on her research work. All interviews were tape-recorded and transcribed orthographically.

TA was selected (over Interpretative Phenomenological Analysis) because the primary analytic focus was thematic patterning and not idiographic meaning. We utilised Braun and Clarke's (2006) six-phase approach to thematic analysis. In brief, this involved following the phases of: familiarisation with the data; generating initial codes; searching for themes; reviewing themes; defining and naming themes; and producing the report. Although the first author led this process the second and third authors also read all twelve transcripts and discussed each stage of the analysis with the first author, helping her to develop, refine and clarify her thinking. As an example, in the coding stage, the researchers coded at both the semantic and the latent level – both descriptively (e.g., “untrusting of overweight therapist”) and interpretatively (e.g., “ashamed of bingeing”). We also coded broadly (i.e., for as many potential themes/patterns as possible), inclusively (i.e., retaining contextualising data surrounding the coded data extract when appropriate) and exhaustively (i.e., not limiting the number of codes a data extract could have). Throughout the process the three authors worked together in an effort to optimise the quality and rigour of the analysis and we followed the quality steps prescribed by Braun and Clarke

(2006). This process resulted in the generation of three themes: shame; solitude; and salvation. In the results, the participants are identified by pseudonyms.

### *Reflexive statement*

Reflexivity is key to appropriate use of any qualitative method (Finlay & Gough, 2003); in this study, it required the researchers to reflect on how their personal context influenced how they made sense of the study data. The first author has a history of AN; the second and third authors have histories of compulsive eating and bulimia respectively. Our histories mean that we needed to reflect on our status as insiders and outsiders to the participants and topic, as well as the potential benefits and costs of an insider position (Labaree, 2002). Consequently we engaged in a number of processes - such as keeping a researcher diary (first author), setting out before data collection our assumptions about EDs, those experiencing EDs and ED treatment, and having regular conversations about the data and our analytic 'noticings' – in order to ensure quality and rigor of the analysis.

## **Results**

### *Shame*

Self-disgust, self-hatred, inadequacy and, in particular, a deep sense of shame appeared to be key features of the women's experience: Alice described herself as 'self-loathing', while Claire and Sophie spoke about hating parts of themselves. As Megan said: 'It does feel shameful, it is embarrassing that you can't handle food which, you know, is such a basic part of life'. The women appeared, however, to be caught in a double-bind as, even when they were able to refrain from bingeing, purging and restriction for long enough to gain a little weight, they were still beset by negative emotions:

Every time I do put on a couple of pounds I immediately feel disgusting and think “Anything is better than [this], even feeling tired all the time is better than feeling disgusted with myself.” . . . And then I’ll lose it [weight] and I’ll feel like crap. (Claire)

A further source of the interviewees’ shame seemed to stem from their experience of being controlled by, rather than in control of, their AN. As Lucy explained:

It’s like you’re slipping into a whole different world . . . like you’re stepping out of your body, you’re looking at yourself and you’re doing these things and like even though I felt I had control over it there were times when I really didn’t think I had any control of it at all.

Lucy’s use of the word “slipping” is evocative not only of the sense of suddenly being out of control of one’s body, but also the ease with which this can occur and the uncertainty about what the outcome will be. Thus the women were all aware of the very fine line between feeling and being in, and feeling and being out, of control of their AN.

It appeared that the women’s feelings of shame were further fuelled by their awareness of the irrationality of their thinking. Indeed, at times the women seemed baffled by their thinking. Claire, for example, spoke of the way in which she could not understand the discrepancy between the information given by the objective measure of her weight and her subjective experience of her body: “Well I just feel fat, I know that I’m technically the sc-, the numbers say that I’m underweight but I feel [fat], how can this be?” The tone of frustration in Claire’s voice seemed to convey a genuine desire on her behalf to understand an experience that she found incomprehensible. In contrast, Katie spoke with a sense of helplessness about the way in which her inability to override her AN thinking was putting her life at risk:



I was meant to have it [blood transfusion] on Monday and it didn't work because my blood pressure fell too low because I'd been in the gym all morning, so I should learn not to do that again because the same thing will happen again, but I'm thinking "I'm gonna lie on a hospital bed all day I can't not do any exercise" I'm so scared about that.

Feelings of confusion and helplessness were common threads running throughout the interviewees' narratives. They seemed to find themselves floundering in a no-(wo)man's land' where they were unsure whether they could trust what Amy described as the 'voice in the head'. Indeed, Amy spoke of the way in which she found herself questioning what was and was not 'normal': 'You know you go through that whole . . . "What is . . . normal?" . . . And maybe you know "Is it my anorexic stuff that's making me think it's not normal . . . or is it that it isn't just normal?"'. Such self-questioning evidenced once again the aforementioned phenomenon of the women oscillating between being 'in' and 'out' of their AN. When 'in' their AN, their thoughts, feelings and behaviours appeared out of their control and they seemed compelled to think and act in ways they could not stop. In contrast, when they were 'out' of their AN they appeared able to take on an outsider's perspective and exhibited evidence of metacognition. As such the women were, at times, only too aware that the thoughts, feelings and behaviours they experienced when 'in' their AN were not 'normal'.

Despite feeling such immense shame as a result of their AN, the women nevertheless also appeared to feel shame that their AN was not worse and that there were 'more successful' anorexics than them. They spoke of the way in which being in treatment (or contemplating

going into treatment) made them feel their bodies were (or would be) scrutinised and judgements made about how ill they were. For Katie it was the prospect of being admitted to an ED unit that led to her concerns:

At the moment I feel like I'm too big, umm, and I don't want to be the biggest one there, I don't think I'm bad enough . . . I feel like I'll be laughed at and like a joke and things like that.

The comparisons inherent in the idea of not being 'bad enough' led, in some instances, to the women questioning whether or not they were even ill. Susie in particular spoke of the way in which she had compared herself to a friend with an extremely severe ED:

I've got a friend who had an eating disorder . . . she nearly died actually so it was really really serious . . . I always kind of used her as a kind of polling station to rationalise at what point it is a problem.

Thus by comparing themselves not to people who had a 'normal' body weight or relationship with food but instead to people who were ill – even to the point of being near death – the women increased their feelings of shame and inadequacy, as even their AN became something they had failed at. Consequently, the women's experience of themselves, their bodies, their behaviours and their thinking was underscored by a pervasive sense of shame.

### *Solitude*

This theme encapsulates the deeply isolating and isolated nature of the AN experience. A key element of this seemed to stem from the sense of 'otherness' the women

experienced as a result of the differences between their own and others' behaviours.

Sophie, for example, spoke of the way in which she had realised that her dieting differed from that of her friends:

Everyone would always be like "Oh yeah I'm on a diet" or something, and I'd sit there and be like "I'm not saying anything," because I knew that something about the way I was doing things was completely different to them.

Katie spoke of the way in which her first experiences of bingeing and purging had left her feeling not just different but 'alien': "'Oh my gosh what am I doing?' . . ." "This is crazy why can't I stop?" and I thought I was really unusual and kind of, an alien.'

At the same time as feeling isolated as a result of their behaviours, it also appeared that the women felt alone as a result of the lack of understanding of AN they perceived in society. Both Sam and Sophie spoke of the 'stereotypical' views of the illness (e.g., that it is driven by a desire to look like a skinny pop star or supermodel) that they believed led others to make 'some crass joke' (Sam) or tell you to just 'get over it' (Sophie). In contrast, Hayley offered an alternative explanation for this lack of understanding when she suggested that people actually try to empathise by extrapolating from their own experiences, something she felt led them to inaccurately believe they knew what AN is about:

You can see the obsession that the average person has and how that looks like an eating disorder, like how their assumption is "I weigh myself every morning and it's a bit obsessive" . . . their assumption that that's what an eating disorder is just an extreme of it.

Although one might imagine that fellow AN sufferers would be the one group of people the women could feel some degree of connection or reciprocated understanding with, it was

clear from their narratives that this was not always the case. One reason for this appeared to be linked to the aforementioned comparisons that the women made between themselves and their fellow sufferers, comparisons that frequently set the other up as a competitor: 'You see people that are thinner than you and you hate them.' (Sarah). There was, however, another aspect to the women's experiences of their fellow sufferers, one which reflected the way in which they were simultaneously both 'in' and 'out' of their illness. Despite describing her own experiences of feeling fat even in the face of contrary evidence and struggling to eat even though she recognized that she needed to, Claire nevertheless sometimes found herself feeling not compassionate but deeply frustrated by her fellow day patients:

It makes me want to shake them sometimes when I listen to somebody who probably weighs about under six stone saying "I feel so fat, umm I really don't want to go back into hospital but I can't I can't eat my lunch" and you think "Eat the fucking sandwich just eat the damn thing," you know, it makes me incredibly frustrated.

The women also seemed to experience a profound sense of aloneness as a result of their awareness of the difficulties they faced in trying to convey the nature of AN to others. Megan, for example, described the sheer inadequacy of language in communicating her inner experience:

Words are never enough, you know you can never, if you could just take your head out and put it on a table . . . and say "There you go, that's how I am." . . . Wouldn't it be easy . . . so frustrating, words are so limiting, and you never know whether you've managed to convey what you think you're conveying.

Thus, whether it was the result of their own or others' limited understanding, the women seemed to find themselves trapped in a world that could not be fully communicated to those around them.

The sense of solitude that arose as a result of the factors described above was further compounded by the women's awareness of the secrets, lies and manipulation that are so frequently hallmarks of the illness. Sarah described the way in which she was in danger of being found out as a result of lying to those around her:

I'm losing track of what lies I'm telling different people . . . I saw two different people yesterday and I told them both completely different stories of why I'm losing weight and, you know, why I'm tired all the time and I look like crap and, you know, and I'm just thinking "Please don't discuss it."

Lying and manipulating, while creating barriers with those around them, appeared to be very much a part of the women's self- and other-management. For Lucy, keeping others ignorant of her eating behaviours had even been a motivator for the onset of her purging behaviours:

It [starting to purge] was literally about "How can I keep doing what I am doing . . . and keep w- whilst trying to keep ev- shut everybody up?" . . . Basically sort of "Let's get everyone off my back" . . . and do it in a more sort of discreet way where they're still seeing I'm physically putting food into my body so they go "Oh that's fine she's okay now," when in actual fact "No I'm not I'm going off and I'm getting rid of it later."

Although Sarah and Lucy both laughed as they made these remarks, it was clear they did not in fact view their behaviour as trivial. Indeed, the women appeared very aware of the frustration and dissonance that arose as a result of their actions:

I feel like I'm leading this double life because I feel that my, yeah I'm you know, I feel like I talk all the, all I say all the right things and yet when it actually comes down to "Shall I eat this or shall I eat that?" I'm like, "No."

This internal conflict described by Claire demonstrates just one element of the solitude experienced by the women as a result of the self-consuming nature of AN. Indeed, in Katie's words: 'Eating disorders are so self-obsessed, that sounds horrible but they are, like you just think about yourself the whole time'. Such self-focus appeared to come, in particular, at the price of relationships, especially relationships with family. Amy, for example, remembered the excitement, detachment and sense of 'bizarre[ness]' she had experienced on entering hospital and the complete lack of awareness she had had for the fact that her parents were: 'Just watching [their] daughter completely waste away'. Furthermore, as Nina described, even during the recovery phase of AN the impact on the family continued:

You have to concentrate so much on your food that you don't want any other you know and even sort of when I first came home [from hospital] I couldn't eat with my son or my husband because I was just like "I just need to sit on my own and focus on what I'm meant to be doing."

At times the illness also threatened to consume their very self, for as Katie said: 'It doesn't feel like me anymore, I feel like I've lost myself'. In many ways it was as if the pre-AN self became increasingly lost until the AN self was all that was left. In light of the striking depth

of the women's solitude and shame it is consequently difficult to comprehend why someone would wish to defend the very thing that causes them so much pain.

### *Salvation*

The theme 'Salvation' describes those elements of the AN Experience which seemed to offer the women a solution to the shame and solitude that were such pervasive parts of their day-to-day lives. As such it should be considered in conjunction with the two previous themes as part of a 'Catch-22' cycle. For many of the women AN seemed to offer a way to cope with life and keep other, less preferred, coping mechanisms in check. Megan explained the way in which her AN enabled her to keep depression at bay:

I use it to keep life ticking over and keep the happy smiley face on and keep the umm competent image in . . . if I didn't use that then I think I'd be in the point where I can't get out of bed in the morning and I just shut d- shut down you know, and the depression wins . . . so I think it's the lesser of two evils really.

In addition to helping them function, AN also appeared to provide the women with a source of positive self-feelings – feelings which could counter the very shame and solitude it also created. Both Claire and Katie, for example, spoke of the 'pure', 'holy' nature of AN. For Claire this enabled her to feel detached from the 'bodily concerns and needs' that occupied others:

I used to have that kind of stereotypical view that, you know, that Holy anorexia thing . . . saints and mortifying the body to live in this kind of ethereal world of of the mind and you know if you don't eat then it's all about mind and spirit and you can kind of detach yourself from the bodily concerns and needs that everybody else does.

Katie distinguished between her original 'pure' AN and her more recent bingeing and purging AN: 'I hated bingeing and purging so much . . . and I still do, I was so scared it was going to make me enormous and I wanted my pure anorexic cleanness back'. Furthermore, many of the women drew on the notion that being thin, self-controlled and able to resist eating is valued by society. Claire, for example, described: 'The old cliché of one of the nurses saying "oh I wish I co- wish I could catch a bit of that anorexia . . . I wish I had that self-control"'. The women appeared to accept society's adoption of a thin ideal unquestioningly and thus, understandably, felt that by being (and trying to be) thin they were doing something that was valued (and, as such, an antidote to their shame).

Alice also highlighted the role of AN as a physiological boost to one's inner experience. In describing the effects of bingeing and restricting she said:

They're both a high because . . . if you've been restricting yourself and you binge you do get a high . . . you know blood sugar high and you can actually feel it, it makes you feel dizzy . . . and then if you, if you, umm if you, restrict you get the same sort of high which is a light, it's different but it's the same in the sense that it's light-headed, makes you feel dizzy, because you haven't had enough food.

For someone stuck in a place of shame and solitude it is easy to see how such a physiological response could become addictive. Furthermore, as if this high were not enough, Amy explained how having AN got her the high that comes from attention:

'Everybody knew that I'd been in [a hospital ED unit] so there was the sort of attention . . . I was different and I had this identity'. Once again, being 'different' is framed here not as a negative (i.e., something which makes the sufferer feel alone) but as a positive (in this instance in terms of eliciting welcome attention) – a phenomenon that can be understood



in terms of the positive emphasis in western culture on uniqueness and individuality (Gill et al., 2005).

The AN Experience is all-encompassing; it takes over, controls and, as a result of its irrational, incomprehensible nature, leaves its sufferers living in 'a very weird world' (Megan). The interconnections between the women's feelings of shame, their sense of solitude, and the incentives fuelling their desire not to relinquish their AN are thus clearly manifold and complex.

## **Discussion**

The results of our study highlight the dual role of AN as both problem and solution, the cyclical nature of sufferers' behaviours and feelings, and the way in which AN is a form of distress that makes its sufferers feel both better and worse. As such the results shed further light on the ambivalence about recovery and resistance to treatment so frequently experienced by those with AN and witnessed by those practitioners who work with them. Furthermore, the results enable a greater appreciation of the misery encountered when someone has AN – an appreciation which will hopefully enhance both empathy and compassion for sufferers in counsellors who work with this client group. Though ambivalent about recovery, the women in our study also demonstrated high levels of awareness – about both their illness and themselves. Irrespective of their position in the recovery process, all the women spoke both from a position of being caught up in their AN, and from one of being at a distance from, and able to reflect on, it. Thus, the results also facilitate an understanding of the AN experience as something which sufferers can be both 'in' and 'out' of (e.g., they can be aware of the irrationality of their thinking while simultaneously responding to it, and can limit their own food intake while feeling frustrated at both

themselves and their fellow sufferers for doing the very same thing). This is particularly interesting as it demonstrates the fact that, despite having firsthand experience of AN, sufferers can feel many of the same reactions to it (and to those with it) as people (and counsellors) without such personal experience.

Our findings accord with the results of Skarderud's (2007) qualitative descriptive study of shame and pride in AN; the accounts of our participants showed evidence of both 'Globalised internal shame' (i.e., a general sense of being unworthy) and individual 'Focuses of shame' (e.g., shame of having an eating disorder). Furthermore, as discussed below, the Catch-22 cycle evident in the data has a number of parallels with the 'Shame-pride cycle' described by Skarderud (2007), and thus helps further enhance functional analyses of the illness (e.g., Goss & Gilbert, 2002). The results also link with the theorising of Goss and Allan (2009) who have proposed an outline model of shame and pride cycles that help to explain the maintenance of EDs, and further support the idea that treatment approaches such as Compassion Focused Therapy (Gilbert, 2010), which have been specifically developed for clients with high levels of shame, might be particularly useful in the ED field (Gail et al., 2012; Goss & Allan, 2009, 2010; Goss & Gilbert, 2002).

Given that loneliness (both real and perceived) is known to fuel ED symptoms (Levine, 2012; Stewart, 2004), the fact that there were so many factors contributing to our participants' sense of solitude suggests that strategies to reduce such feelings will need to be broad ranging if they are to have a meaningful impact. Previous research has found that one way in which people with an ED attempt to make social connections is through relationships with their fellow sufferers (e.g., Rich, 2006). This is not, however, uncomplicated as fellow sufferers might also be seen as a source of competition (e.g., Colton & Pistrang, 2004; Rich, 2006). This study sheds further light on the complex nature

of such relationships by highlighting the fact that fellow sufferers' might additionally be experienced as frustrating and untrustworthy in the same way that people without an ED see sufferers as frustrating and untrustworthy.

Although the 'benefits' of AN have been spoken of before (e.g., Nordbø et al., 2012; Williams & Reid, 2010), the way in which they can interact with, and even mitigate, some of the costs (as opposed to the causes of the ED) has not. This link is important as it has the potential to enhance current conceptualizations of the maintenance systems involved in AN and thus offers new avenues for treatment protocols to consider. It also speaks to the literature on ambivalence about recovery (e.g., Cockell et al., 2003; Williams & Reid, 2010). One of the benefits highlighted by our participants was that AN facilitates the thinness which is esteemed and valued by society. As such, it challenges those discourses (many of which are medicalised) which posit AN as a pathology that exists within an individual without reference to the wider sociocultural context within which they live (Malson, 1998; Malson et al., 2004).

When considering the results described above it is important to note some of the potential limitations of the study. In particular, it should be noted that the recruitment criteria meant all participants had been in counselling and saw themselves as recovered or on the road to recovery – nevertheless, they spanned a wide variety of points in that process (from being on the verge of hospitalization to fully recovered). It is therefore of note that despite this difference in degree of recovery, the interactions between the experiences described in the Shame, Solitude and Salvation themes, and the phenomenon of being both 'in' and 'out' of the illness, ran throughout all their narratives.

Given that the interviewees had all had therapy for their AN, it would be useful if future research could examine whether or not people who have not had therapy also talk

about their AN in the same (or a similar) way as the women interviewed here. Future research could also further explore the cyclical nature of the Shame, Solitude and Salvation experience to see if therapy might be effectively employed to find ways to break the cycle and enable those with AN to find alternative methods to meet the needs underlying their illness. Finally, research might look more specifically at the 'in' and 'out' of it phenomenon discussed above to examine whether or not there might be some way in which sufferers' identification with their 'out' of it experience can be encouraged in order that they might strengthen their desire to recover and weaken their identification with the illness.

The results discussed above have clear implications for clinical practice, not only in terms of increasing practitioners' understanding of the contradictory and multilayered experiences of those with AN, and thus potentially increasing their understanding and hence empathy when working with these clients, but also in terms of suggesting possible avenues that might usefully be explored with clients. In particular, practitioners and clients might work together to develop a better understanding of the unique ways in which the sufferer's AN both causes and solves problems for them. Similarly, practitioners might work to develop their clients' sense of being 'out' of the illness to build their non-anorexic identity and help loosen the grip of the illness on them, thus facilitating both a reduction in ambivalence about recovery, and an increase in desire to recover.

In addition to using the results of our study to augment their work with clients, practitioners might also like to reflect on the study's findings and consider their own responses to, and preconceptions about, people with AN. They might also like to ask themselves what it must feel like to be perceived, and treated, by others as 'manipulative', (Ramjan, 2004, p.499), 'deceitful' and 'untruthful' (King & Turner, 2000, p.142).

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**Table 1***Age, Illness and Recovery Details for Interviewees*

Name	Age (years)	Age at onset of illness (years)	Self-reported % recovered (%)	Duration of illness (years)
Katie	26	11	no data	15
Sarah	32	16	<50	16
Alice	50	22	60	28
Megan	41	14	60	27
Sophie	19	13	60	6
Claire	33	12	50-80	21
Nina	34	30	70	4
Sam	18	12.5	95	5.5
Amy	42	19	95	16
Hayley	25	10	100	12
Susie	23	16	40-50	7
Lucy	25	16	100	2