# Eating Disorders: Between People

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**THE FOLLOWING PART OF THIS THESIS HAS BEEN REDACTED FOR COPYRIGHT REASONS:**

**p 244:**          **Appendix A.** Submission criteria for the European Eating Disorders Review.

**THE FOLLOWING PART OF THIS THESIS HAS BEEN REDACTED FOR DATA PROTECTION/CONFIDENTIALITY REASONS:**

**pp 245-272:**     **Section C.** Case study: The development of an effective therapeutic relationship in CBT for eating disorders.

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# Acknowledgements

I would like to thank the ██████████████ Eating Disorder Service for giving me the clinical placement that started this journey, and their continued support that has enabled my growth. Thank you to Fran Smith and ████████, my supervisors, who both challenged and encouraged my point of view. I am tremendously thankful to my eight research participants who brought this piece of work to life with their courage and candour.

This work is dedicated to my family and friends, for being everything I need.

# Preface

This thesis is an examination of the inter-relational impact of eating disorders from a Counselling Psychology perspective. The theoretical and practical positioning aligns the parts according to both content and epistemology. I will begin by identifying the three sections of the portfolio and illustrate the connective tissues that weave the parts into a whole. I will then reflect on the learning and development that has been realized in my writing of this work.

## i. Sections of the portfolio

- Section A: This first section comprises the research study that explores the relationship between mothers, their eating disorder and their child. More specifically, this dynamic is investigated within the context of a parent feeding her child, through the research question, 'what is it like for a mother with an eating disorder to feed her child?'

- Section B: The second section is a journal article fit for publication within a reputable periodical. Based on the research presented in section 'A', this was an exercise of transforming a full-scale study into a document ready for public consumption and use. A publishable journal article takes the research from an academic exercise to a practical and applicable clinical tool.

- Section C: The third and final section is the presentation of a case study. This piece of clinical work represents a link between the research study and my clinical work, attending to professional development within a clinical example of the portfolio's thematic content.

**ii. Development of the portfolio**

This portfolio began as a seed, an idea sparked by one client's experience; a mother who spoke about her difficulties feeding her child while battling her eating disorder. As I delved into research around this topic, my research question emerged from the gaps in the literature. The study itself took on a relational element as the participant's accounts illustrated a dynamic between themselves, their child and their eating disorder. The journal article endeavours to capture this essence and present it to a wider audience. It was with the addition of the case study to the portfolio that it became clear that the thread of continuity among the parts was the inter-relational impact of eating disorders.

My training as a Counselling Psychologist emphasized the vitality of a scientist/ practitioner perspective and is illustrated in the scope of the portfolio's sections. Furthermore, the bidirectional interplay between theory and practice has profoundly influenced the development of this body of work and my clinical experience. As mentioned previously, the initial seed for this project was planted by a client's ongoing struggle to reconcile her relationship with food, shape and weight with her drive to provide a healthy role model for her child. This practical exemplar paved the way for the

theoretical investigation that took place in Section A, the research study. It is my hope that the journal article provides a further clinical opportunity to implement the learning gleaned from the thesis. I plan to submit my journal article to the European Eating Disorders Review, which is edited by Professor Fernando Fernandez-Aranda and has an impact factor of 2.252. I have selected this publication for many reasons, one of which is its outstanding reputation within the realm of eating disorder treatment: It is the professional journal of BEAT, the leading UK charity for individuals with eating disorders and their families. The European Eating Disorders Review focuses on material contributing to innovation and best practice in treatment and diagnosis.

The case study represents a piece of my professional development that was captured by the inter-relational evolution that took place between a client and myself; illustrating a non-parental relationship being mediated by an eating disorder. I have had the opportunity to participate in the developmental scaffolding built on the relationship between my clinical experience and the research than emerged: Completing the relational circle, I continue to assimilate the study's findings into my clinical approach to mothers with eating disorders.

**iii. Themes permeating the portfolio**

The impact of eating disorders is the central theme permeating this portfolio. This took the shape of the effect the disorder had on a mother's experience of feeding her child within the research study and publishable journal article.  This deep level of inquiry

unearthed the reality that the mother's eating disorder extended beyond her experience of feeding her child and into virtually all areas of parental responsibility. The mothers described an ongoing conflict between the voice of their disorder and the needs of their child. This experience seemed to be exacerbated in the context of family meal times and food prep and provision.

With the immersion of the case study into this body of work, a new perspective on the theme began to take shape. The case study illuminated the underlying interpersonal context between the eating disorder and the other (in this case, me). This clinical sample highlighted the communication facilitated by the eating disorder treatment: Essentially, talk about the eating disorder and other nonverbal communications served to distract the therapeutic process from accessing the patient's underlying conflict. This brought to light the notion of the eating disorder as a moderator, serving an interpersonal function and evolved as the thematic bond linking the three individual pieces.

The eating disorder as a moderator or tool of communication is an extension of the impact that an eating disorder has on interpersonal functioning. Within the research study and the journal article, the mothers' eating disorder acts to moderate her interaction and proximity with her child, specifically surrounding the phenomenon of feeding. The eating disorder seemed to dictate the space between mother and child, often distant or enmeshed. As a tool of communication the mothers' eating disorder served to invite others in or keep them a safe distance away. As seen in the case study, the eating disorder served a similar function in maintaining emotional anonymity for the client.

### iv. Within Counselling Psychology

The fundamental aim of this portfolio is to give a voice to the participants and their experience. Counselling psychology is built on a humanistic theoretical position that greatly values the subjective human experience as a profound tool for learning about one another. This has been highly influential on both my development as a practitioner and a researcher. Accordingly, this portfolio has positioned the participant or the client at the epicentre of this theoretical and clinical investigation.

As a trainee Counselling Psychologist, I am experienced in engaging in meaningful, one-to-one dialogues, encouraging exploration and extracting meaning within a professional context. Within both my professional and personal life, the concept of reflexivity is a driving force that encourages my keen awareness of others and myself. As a Counselling Psychologist, reflexivity lies at the heart of my clinical work. I am committed to the notion that the same attuned awareness should be present in effective research. Upon reflection, the compilation of this doctoral portfolio has been the perfect culmination of my formal training in that both elicited my tenacity, drive and passion for the theory and practice of counselling psychology.

# Section A: The Research Study

**Mothers with eating disorders experiences of feeding their children:**

**An Interpretative Phenomenological Analysis**

**Abstract**

According to existing literature, mothers with eating disorders report feeling guilty, depressed and anxious as a result of their disorder and its effect on their ability to parent. They express a variety of difficulties in feeding their children, with the most common being the needs of their child conflicting with the voice and desires of the eating disorder. The children of mothers with eating disorders are considered to be an 'at risk' group for feeding disorders, developmental disturbances and the eventual development of eating disorders themselves. Previous research has attributed this to both the child's internalization of the mother's eating behaviour and the child's reaction to the mother's distress regarding food, shape and weight. In order to address a gap in the literature, this study explores mothers with eating disorders subjective experience of feeding their children.

Eight participants were interviewed using qualitative methods. The in-depth semi-structured interviews captured the essences of the mothers' subjective experiences of feeding their children. The flexible interview structure nature allowed for an open-ended and adaptable exploration. The data was transcribed verbatim and analysed according to the principles of Interpretive Phenomenological Analysis.

One overarching theme and four superordinate themes emerged from the data. These expressed consistencies gave a glimpse into the rich and multidimensional subjective experience of the participants. The overarching theme was identified as a "Conflict between the eating disorder and the role of parenting". This was present across all participants unanimously. The four superordinate themes were: Guilt regarding the interaction of the eating disorder and the children; either extremely rigid or none existent boundaries between the eating disorder, the mother and the child; contradictory parenting regarding the ability to act as a role model while having a double standard; and the fear of transgenerational transmission of the eating disorder. Each of these themes had two sub-themes that expressed in further detail the mothers understanding of her experience.

This study extended knowledge in the field and emphasized the importance of addressing the additional parenting complexities for mothers with eating disorders. The findings of this study concurs with previous literature and suggests that feeding your children, as a mother with an eating disorder, is a significant and challenging phenomenon. Recommendations were made for treatment advances including support and therapeutic groups for the mother and her family and areas for further research were highlighted such as investigating the efficacy of family therapy for adults with eating disorders.

# 1.0  Introduction Chapter

## 1.1 Introduction

The National Institute of Health and Clinical Excellence (NICE) has suggested that 1.6 million people in the UK are affected by eating disorders (NICE, 2004). Generally speaking, eating disorders have major physical, psychological and social consequences (Hjern et al., 2006), often characterized by a poor quality of life (De la Rie et al., 2007) and a high health burden (Mond et al., 2009). Furthermore, anorexia nervosa has the highest rate of mortality of any psychiatric disorder, due to both medical complications associated with the disorder and suicide (BEAT, 2014). This statistic alone is indicative of the vitality of eating disorder research particularly that focused on treatment and prevention.

Though the 'poor quality of life' and 'high health burden' are attributed to the individual sufferer, these adverse complications often seep into the immediate family, including children (Stitt & Rupert, 2014). The majority of studies in this field have explored the impact of parental eating disorders on their children; with a focus on the quantitative relationship between the maternal eating disorder and child development, birth weight and feeding logistics (Stitt & Rupert, 2014). The mother's subjective experience has been widely neglected.

Linville et al. have explored the sociocultural influences on the development of eating disorders. Their evidence suggested that the parents, as the primary socialization agents to their children, significantly influence the development of body image disturbances and disordered eating (Linville et al., 2011). Familial eating disorder pathology has long been a source of ongoing investigation, as studies have consistently indicated that the immediate relatives of individuals with anorexia nervosa show an increased risk of developing an eating disorder themselves (Watkins, Cooper & Lask, 2012). Though the degree of correlation pertaining to genetic and environmental influence is unclear, the link itself is consistent and compelling (Lilenfeld & Kaye, 1998).

This chapter will consider the literature surrounding mothers' experiences of feeding her children while having a disordered relationship with food. First I will consider the impact that parental psychiatric disorders have on their children, specifically, the relationship between maternal eating disorders and child development. I will then review the evidence that characterizes the children of mothers with eating disorders as a 'at risk' population. Previous research has identified a number of difficulties that mothers with eating disorders encounter within their parenting role; these will be explored, with a particular focus on the mothers' subjective experience of feeding their children. And finally, the literature on the transgenerational transmission of eating disorders from mother to child will be reviewed. Treatment options will be contemplated, with a view to creating interventions specifically tailored to mothers with eating disorders and their families. A look forward in the direction of future research will be explored, specifically the effectiveness of family therapy for adults with eating disorders.

There is an uneven distribution in the literature of research focused on the quantitative impact of maternal eating disorders on children and the risk of transmission. This bias manifests in an unsaturated body of evidence exploring the mothers' experience. The current chapter will reflect this disproportionate emphasis and attend to both the majority and minority perspectives. This literature review will illuminate the need for more qualitative research, exploring the mothers' experience of being a parent while having an eating disorder, specifically, her subjective account of engaging in the function of feeding her children.

## 1.2 Impact of parental psychiatric disorders on their children

The impact of parental psychiatric disorders on children has been well documented (Micali et al., 2013). Patel, Wheatcroft, Park and Stein, (2002) support the claim that children born to parents with psychological disorders are more likely to experience developmental disturbances themselves. Further research has identified common themes in parents with psychological disturbances, including a tendency to prioritize their children's need over their own; at times at the expense of their own self-care (Montgomery et al., 2006). Additionally, enmeshment issues seemed to be prevalent in the literature, with mothers describing a desire to make up for their mental illness by being lax with their children and having overly close relationships (Ackerson, 2003).

Parental eating disorders have been researched less than other disorders, despite the fact that eating disorders statistically have the greatest impact on women of childbearing age,

and are associated with the disruption of essential daily activities (Micali et al., 2013; Agras, Hammer & McNicholas, 1999). Similar to other psychiatric disorders, research has identified a persistent link between parental eating disorders and the psychopathology of their offspring (Micali et al., 2013). Generally speaking, evidence suggests that a relationship exists between maternal disordered eating and adolescent disordered eating (Field et al., 2008; Pike & Rodin, 1991), and that maternal eating disorders are associated with childhood eating problems (Micali, Simonoff & Treasure, 2009; Stein et al., 1994).

These consistent links between a mother's eating disorder and her child's development, have been attributed both the child's internalization of the mothers eating behaviour and the child's reaction to the mother's perceived distress around food, shape and weight (Barnett, Buckroyd & Windle, 2005). Mothers with eating disorders report feeling guilt, depression and anxiety, as associated with their eating disorder and its effect on their ability to parent her children (Micali et al., 2011; Stein et al., 2006; Barnett, Buckroyd & Windle, 2005). The impact that maternal eating disorders have on the children spans from the pre to post natal period and beyond; as evidence suggests that early feeding problems often influence child development, as well as eating behaviour in later life (Micali et al., 2001; Drewett et al., 2006).

The aetiology of eating disorders is a complex and multifaceted topic of debate that has raged since the emergence of the pathology itself. These theories congregate on varying conceptual levels in an effort to explain the origin of wilful starvation stemming from a morbid fear of fatness (Hsu, 1988). Though the theories are not mutually exclusive and

overlap to some degree, their explanatory prowess and body of evidence vary in potency. For the purpose of this review, I will explore the aetiology of eating disorders from four theoretical perspectives: Sociocultural, Family systems, Psychodynamic and CBT.

Social-cultural theory posits that the pressures experienced by individuals within society contribute to the development and maintenance of eating disorders. Specifically, evidence suggests that the current emphasis on slimness as attractive and the contradictory drives of modern women to fulfil multiple roles contribute to the development of eating disorders (Hsu, 1988). Within modern and western (or western influenced) society, the measure of female attractiveness has steadily become synonymous with slimness. This trend can be vaguely monitored in the decrease of weight for height percentiles of the average Miss America and Playboy centrefolds from 91% in 1959 to 82.5% in 1978 (Garner, Garfinkel, Schwartz & Thompson, 1980). Similarly, the need for campaigns to target the use of models with unhealthy BMIs (Body Mass Index) have begun to crop up around the world in an effort to curtail the promotion of the thin ideal. Numerous studies have captured the body dissatisfaction and desire to be slimmer experienced by the majority of women (Calden, Lundy & Schlafer 1959; Huenemann, Shapiro, Hampton & Mitchell, 1966; Nylander, 1971). The irony is that this is all taking place in a population that is on the whole becoming heavier: Statistics from the Society of Actuaries suggests that the average weight for women in all height categories is on the rise (Hsu, 1988). This dynamic evokes further pressure on women to diet and appear slim (Halmi, Struss & Goldberg, 1978). It is argued that such pressure contributes to the development of eating disorders and is evidenced by the increased frequency of anorexia nervosa and bulimia

nervosa among populations where weight and shape control is paramount, such as models, athletes and dancers (Druss & Silverman, 1979; Garner & Garfinkel, 1980). To further compound the sociocultural complexity of this issue, Branch and Eurman (1980) found that the family and friends of these eating disordered individuals often admired the sufferer's perceived slimness, specialness and control.

Boskind-Lodahl (1976) took a feminist perspective on the aetiology of eating disorders in her claim that the sexual inequality inherent in our culture is directly responsible for the development of eating disorders in women. That being said, this does not account for the experience of men with eating disorders or the rarity of such disorders in developing countries where the discrepancy in sexual equality is rife (Hsu, 1988). Palazzoli, Boscolo & Cecchin (1977) accredited these lapses to the specific pressure that exists in modern westernized society for women to thrive in complex and contradictory roles. Maintaining a feminine identify while promoting gender equality, being a hands on mother and a CEO. The pressure to thrive within these diverging ideals is described by Dunn and Ondercin (1981) as the difficult integration of "masculine" independence and assertiveness with traditional femininity. As experience by the eating disorder patient, this role diffusion may intensify their striving for control and perfection (Hsu, 1988).

Evidence suggests that eating disorders often aggregate in families (Park, Senior & Stein, 2003). Family systems theorists have long tried to identify a typical anorectic mother and father (King, 1963). The inconsistency of these findings led researchers towards a focus on family interaction patterns to offer a clue. Bruch (1977) characterised the anorectic

family as having a façade of happiness and stability that masked secret competition of the parents and deep seeded disillusionment. This contributed to an immense preoccupation with success and outward appearance. Palazzoli et al. (1977) found that common to 12 anorectic families were themes of poor conflict resolution, rejection of communication messages, blame shifting and covert alliances between family members.

Minuchin and his colleagues (1978) have explored in depth the function of psychosomatic illness in families, including anorexia nervosa. The families themselves were characterised by enmeshment, rigidity, overprotectedness and lack of conflict resolution. The ill child was used to avoid open conflict and maintain stability, often trapping them in the parents' covert struggle. The illness allowed the parents to shift all focus to the child, submerging their conflict and designating the eating disorder as the sole familial problem.

Early psychodynamic theory interpreted anorexia nervosa as a rejection of female genital sexuality and oral impregnation fantasies via the patients' refusal to eat (Fenichel, 1945). Object relations theorists suggest that refusal to eat may be related to the introjection and repression of a negative object, namely an ambivalent attachment to a controlling mother (Sours, 1974). Bruch (1962 & 1970) has argued that anorexia nervosa is a struggle for an individuated identity. The fact that this struggle takes the form of wilful starvation suggested that psychological developmental deficits occurred. Bruch claimed that the parents may have failed in transmitting a sense of self-value and competence to their children where such disorders have occurred. For the eating disordered child, the illness

is representative of their attempt to assert control and escape their enmeshment from their parents.

The cognitive behavioural take on the aetiology of eating disorders emphasises thoughts and behaviours as opposed to early childhood experiences or family interactions. This perspective considers eating disorders to be multiply determined and a culmination of a series of pathological events. Garfinkel and Garner (1982) described an introverted and sensitive adolescent arriving at the idea that weight loss will alleviate their distress and dysphoria. The dieting that follows is reinforced by a sense of success and approval and concern from others. As the negative reinforcement of food avoidance and weight gain becomes more prominent, the eating disorder thoughts and behaviours become autonomous and self-perpetuating.

Park, Senior and Stein's 2003 study reviewed the impact of eating disorders on parenting and child development, chronologically, of the genetic factors that are present pre natal, and continue to impact the individual throughout their life. Though limited by the lack of sizable control studies available, their research focused on numerous case reports and recognized the cautious interpretation that this merits (Park, Senior & Stein, 2003). That being said, their thorough longitudinal evaluation will provide the scaffolding for us to examine the various life stages at which the impacts of maternal eating disorders on their children has been identified.

Evidence suggests that eating disorders often aggregate in families (Park, Senior & Stein,

2003). A series of controlled family studies provided data indicating that the prevalence of anorexia nervosa and bulimia nervosa occur seven to 12 times more frequently in the first degree relatives of those with eating disorders, as compared to the non-eating disordered control group (Strober et al., 2000; Strober et al., 1985; Lilenfield et al., 1998). This provides strong support for a genetic component in the transmission of eating disorders from parent to child, suggesting that maternal eating disorders have a potential impact on their children even before they are born.

Women with eating disorders experience a higher rate of fertility problems than their non-eating disordered counter parts (Park, Senior & Stein, 2003). However, for those that do experience pregnancy, the inevitable bodily changes that occur are often the first they have experienced since puberty and may exacerbate existing eating disorder symptoms (Park, Senior & Stein, 2003). A 2011 qualitative study by Tierney, Fox, Butterfield, Stringer, and Furber, explored the function of pregnancy for eight women with eating disorders. The researchers found that three typologies emerged among these women; the mother who was 'cured' by motherhood, the mother who was able to suppress her eating disorder during pregnancy and motherhood and the mother who was unable to cease dangerous eating behaviours during pregnancy and motherhood. The research team was multi-disciplinary and included a specialist eating disorder researcher, a clinical psychologist, two midwife lecturers and a midwife consultant. The diverse perspectives of the investigators provided an inclusive context for the emergent themes to arise. The participants explored the impact that parenthood had on their eating disorder, including topics such as the fear of failure, a transforming body and eating behaviours,

uncertainties about the child's shape and emotional regulation (Tierney et al., 2011). This robust qualitative study identified a set of experiences that merit further investigation pertaining to the implications of such themes on the parent/child relationship and how they manifest.

The postpartum period has been identified as a "normal life crisis" for all mothers, as they face a reorganization of both their physical and psychological life (Astrachan-Fletcher et al., 2008, p. 228). For mothers with an eating disorder, this period is often viewed as high-risk (Edelstein & King, 1992). Research has identified that eating disorders tend to worsen postnatal, and that the resurgence of symptoms may lead to an increased likelihood of developing a postpartum mood disorder (Astrachan-Fletcher et al., 2008). A mother's depression can result in non-responsive or inconsistent reactions to her infant, putting their initial attachment at risk of abnormal development (Astrachan-Fletcher et al., 2008). These complex psychological processes, further complicated by the presence of an eating disorder, may obscure the already fragile beginning for mother and baby. Evidence suggests that the early feeding relationship may pave the way for future successes or failures within the mother-infant dyad (Charone, 1982).

Feeding is one of the first fundamental forms of communication that takes place between a parent and child (Park, Senior & Stein, 2003). Astrachan-Fletcher et al.' review identified a connection between the preoccupation with weight and shape and maternal feeding practices. Foster, Slade and Wilson (1996) found that mothers with high levels of shape and weight concerns were less likely to breastfeed their babies. A further example

of the manifestations of shape and weight concerns on maternal feeding practices found that 15% of mothers with bulimia nervosa had restricted the caloric intake of their child intentionally during their first year of life (Lacey & Smith, 1987). Another investigation identified a tendency for mothers with eating disorders to feed their children more irregularly and use food for non-nutritive purposes, including as rewards (Agras, Hammer & Smith, 1999).

A 1994 observational case-control study indicated that mothers with eating disorders (as compared to a non-eating disordered control group) were more intrusive with their children regarding feeding practices, experienced more conflict during mealtimes and expressed more negative emotion during mealtimes than their non-eating-disordered counterparts (Stein et al., 1994). They found that mothers with eating disorders articulated more negative comments than the control group towards their infants during mealtimes, but not during play. This suggests that for the index population, there is a unique relationship between the eating disorder and parenting behaviour during feeding practices (Stein et al., 1994). Stein et al. concluded that the primary predictive factor of the infant's weight at 12 months old was the amount of mealtime conflict between the mother and child: The children of mothers with eating disorders tended to have a lower weight at this time point than the control group as related to the increased conflict during feeding (1994). This is indicative of a link between the child's growth in their postnatal year and the maternal eating disorders.

Park, Senior and Stein identified a series of case studies where mothers with eating

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disorders described their children as "too greedy, with an unnatural interest in cooking and watching food adverts on television" (p. 114, 2003). This account of the mothers' perception of their child's relationship with food seems to expose either a genuine preoccupation on the part of the child or a mother's over sensitivity to food related stimuli, manifesting her own preoccupation food in her child's behaviour. Either way, the evidence suggests that the impact of a maternal eating disorder on her offspring persists into later childhood and adolescents: Frequently, mothers with eating disorders report concerns that their children will develop problems similar to their own (Fahy & Treasure, 1989; Fairburn, Cowen & Harrison, 1999). Case studies have indicated that from an early age, children mirror their mother's eating disordered behaviour and that in later childhood, specifically the daughters of anorexic mothers, imitate their attitude towards food, and wish to be as thin as their mother (Franzen & Gerlinghoff, 1997; Timimi & Robinson 1996).

Griffiths et al. offer a provocative explanation for the relationship between maternal eating disorders and their offspring: Eight case studies of mothers and adolescents with anorexia nervosa revealed what the researchers named, 'anorexie a deux', referring to a psychological process where a dominant person (potentially the mother) imparts a belief to a submissive person (potentially the child) in an intimate, symbiotic relationship (mother/child dyad) (1995). Park, Senior and Stein (2003) imply that this explanatory hypothesis may provide support for Bruch's theories, that the strict and rigid beliefs of the mother lend themselves to the child submitting to, and participating in, the parent's eating pattern (Bruch, 1982). This qualitative investigation identified a potential cog in

the mechanism that is the relationship between maternal eating disorders and the development of eating difficulties in their offspring. This provocative hypothesis requires investigation on a large scale to induce the nature of these findings within a wider context.

## 1.3 An 'at risk' population

Existing literature has illuminated a universal understanding that the children of mothers with eating disorders are an 'at risk' group (Park, Senior & Stein, 2003; Patel et al., 2002). This population has been singled out for an increased risk of feeding disorders, developmental disturbances and the eventual development of an eating disorder themselves (Watkins, Cooper & Lask, 2012). Hoffman et al. suggested that this increased risk is due to a "passive gene-environment correlation" (2013, p. 579). This notion refers to the interplay between inherited genetic risks and disordered eating attitudes and behaviours in the home, which serve to activate this predisposition (Hoffman et al., 2013).

Various studies have explored the impacts of maternal eating disorders on eating behaviour in early childhood. Agras, Hammer and McNicholas (1999) found, that as compared to a non-eating disordered control group, the index population had a tendency to engage in more unregulated feeding practices and express more concern over their daughters' weight and encourage weight loss in their young children. Evans and Le Grange (1995) identified an increased rigidity at mealtimes in mothers with eating

disorders, while Russell et al. (1998) found that the index population more strictly managed their children's intake (for fear of them overeating). These studies have outlined the data implicated in identifying the children of mothers with eating disorders as a 'at risk' group. The consistency and replication of these themes across studies, coupled with the robust nature of the research methods employed, provide a firm foundation for the efficacy of deeper investigation into these topics of interest.

As in the previous section, the highlighted risks for the children of mothers with eating disorders will be explored chronologically, from birth to adolescence, including cases of chronic and enduring difficulties. It has been well documented by quantitative research studies that the children of mothers with eating disorders tend to have lower birth weights and be smaller for the first few years of life than the offspring on non-eating disordered mothers (Astrachan-Fletcher et al., 2008; Park, Senior & Stein, 2003). Additionally, the index infants experience an increased risk of non-organic failure to thrive and early feeding difficulties (Stein et al., 1996; Micali et al., 2009). In 2012, Hoffman et al. conducted a non-randomized cohort study of two groups of 25 mothers and their infants or toddlers, one group with a history of eating disorders and the other without. The research aimed to compare the feeding practices of the two populations. Their analysis yielded the conclusion that mothers with eating disorder histories were more likely than the control group to take a "special approach" to feeding their child, with the most common example being the limitation of the amount of processed foods the child had access to (Hoffman et al., p. 370, 2012). This was of particular interest, as often women with histories of eating disorders may be overly concerned with eating 'healthy' foods or

having persistent dietary rules that influence their shape and weight (Hoffman et al., 2012). This raises the question of whether or not mothers with histories of eating disorders are more prone to enforce their eating behaviour on their young children. Though it is not currently known if such 'special' feeding approaches are beneficial or harmful to children, previous research has indicated that overly restrictive feeding in childhood can lead to deregulated eating later in life (Fisher & Birch, 2002). Similarly, Easter et al., (2013) investigated the nutrition and dietary patterns of the children of mothers with eating disorders in a longitudinal study: They also found that the index population of mothers' with eating disorders showed a "greater adherence to the health conscious/vegetarian dietary pattern" (Easter et al., 2013, p. 176). Over time, adherence to the maternal 'health conscious' pattern of eating was more prevalent in female than male offspring, potentially indicating that maternal eating may have a greater impact on their daughters as compared to their sons (Easter et al., 2013). It is not currently known what impact an increased exposure to this type of eating behaviour in childhood could manifest longitudinally, and further research is needed to follow up on these preliminary outcomes.

In 2010, Reba-Harrelson et al. conducted a large scale, prospective, population-based study, exploring the relationship between maternal eating disorders, maternal feeding practices, children's eating behaviours and psychological symptoms. Their sample consisted of 13,006 births in Norway. Their data confirmed previous reports that mothers with binge-type eating disorders may engage in restrictive feeding practices more than other subgroups and that the maternal control associated with restrictive feeding could

take president over the children's natural ability to self-regulate their own eating (Reba-Harrelson et al., 2010). These findings seem to impact on later childhood development, as early restrictive feeding practices have been linked to the absence of hunger cues, deregulated eating and higher BMIs (Anzman & Birch, 2009). This raises concerns pertaining to the potential increased risk for the children of mothers with eating disorders of eating disorder symptomology and psychiatric disorders: This large scale cohort study illuminates the impact of maternal eating disorders on child development and child eating behaviour (Reba-Harrelson et al., 2010).

More recently, Micali et al. (2014) conducted a large-scale population-based study, examining the increased risk for childhood psychopathology in the children of women with eating disorders. With a sample of 8,622 women and their children, the researchers used structural equation models to test the relationships between the role of both in utero and postnatal factors, while taking into account gender differences. Micali et al. (2014) found that at age three and a half, the children of mothers with eating disorders had higher odds of psychopathology across the domains of emotional, conduct and hyperactivity, as compared to children who had not been exposed to maternal eating disorders. More specifically, they concluded that the daughters of mothers with anorexia nervosa were two and a half times more likely to have two or more comorbid problems, while the sons of mothers with bulimia nervosa were five times more likely to experience two comorbid mental health difficulties (Micali et al., 2014). This study supports previous literature that maternal eating disorders are associated with an increased risk of both eating and non-eating related psychopathology in their children (Reba-Harrelson et

al., 2010; Stein et al., 1994; Micali et al., 2014).

Franzen and Gerlinghoff (1997) used a large case study of a parent and child group to look at the physical and psychological repercussions of eating disorders from a qualitative perspective. The children ranged in age from one to 11. Three mother-child patterns of relating emerged from the data: The first identified the relationship as being too overprotective and enmeshed; the second was a role reversal, where the child became a 'caretaker' towards the mother; and the third involved the mother being emotionally controlled and distant in relation to her child (Franzen & Gerlinghoff, 1997). Potentially, future research would benefit by identifying what impact these relationship patterns have on child development and if they are indicative of risk for childhood psychopathology.

Far less research has been done on the risk factors associated with later childhood. Stein et al. (2006) conducted a longitudinal study, following a group of 56 mothers (33 in the index group and 23 in the control group) and their children from 1-10 years of age. The children and mothers were assessed at various time points, looking at the eating habits and attitudes of the children and the psychopathology of the mothers. The study found that at age 10, the children of mothers with eating disorders had higher scores on three of four child-EDE sub-scales (shape concern, weight concern and dietary restraint) and on the global EDE, as compared to the control group (Stein et al., 2006). The index-children's scores were however lower than a group referred for clinical treatment and did not meet the diagnostic criteria for anorexia nervosa (Stein et al., 2006). Though generally sub clinical at this point in time, the scores of the children in the index group

were comparable to those diagnosed with food avoidance emotional disorder or selective eating disorder (Stein et al., 2006). This study provides compelling evidence for an increased risk of disordered eating in the children of mothers with eating disorders. Though it is yet unknown if these children go on to develop clinical level eating disorders or other psychopathology, the data indicates that they are more likely to be dieting and over valuing body shape and weight in their schema of self-evaluation (Stein et al., 2006). This research was robust in its use of assessment, standardized interviews and direct observation and indicates that the index children are attuned to the eating disorder psychopathology in their familial vicinity.

The relationship between maternal eating disorders and disturbed eating in adolescents has been well documented. Pike and Rodin (1991) found that the mothers of teenage daughters with anorexic or bulimic symptomology experienced a higher rate of eating disorders themselves, both historically and presently, as compared to a control group. Additionally this study uncovered a correlation between negative comments from mothers about their daughters' weight and a drive for thinness during adolescence (Pike & Rodin, 1991). Furthermore, in a large cohort study, Field et al. (2008) identified that having a mother with an eating disorder was a reliable predictor of the development of purging behaviour in teenage girls: The daughters of mothers with eating disorders were three times more likely to engage in weekly purging than their peers. This data clearly suggests that the children of mothers with eating disorders are at a higher risk of a range of longitudinal developmental disturbances, from low birth weight to feeding difficulties, increased psychopathology to higher incidence of eating disorders in adolescence and

beyond.

## 1.4 Maternal difficulties

Because eating disorders are often characterized by an over evaluation of food, shape and weight and their control, when they occur alongside motherhood, the risk of difficulty in feeding their children may increase (Agras, Hammer & McNicoles, 1999). Numerous studies (Agras, Hammer & McNicoles, 1999; Stein et al., 1994; Park, Senior & Stein, 2003) have indicated that mothers with eating disorders experience a variety of difficulties in feeding their children, the most prevalent being their internal struggle between the needs of their child and the voice of their eating disorder.

Koubaa, Hallstrom and Hirschberg (2008) investigated the early adjustment to motherhood of women with eating disorders. The study, which compared the index group to a control cohort, found that over 90% of the mothers with a history of anorexia nervosa or bulimia nervosa reported difficulties adjusting to motherhood and parenting in the three months postpartum (Koubaa, Hallstrom and Hirschberg, 2008). This statistic was independent of the presence of eating disorder symptoms during pregnancy. Within the control group, a mere 13% reported corresponding difficulties. This is indicative of an increased likelihood of a difficult start for mother and baby when a history of an eating disorder is present. This research identified maternal adjustment by using the maternal adjustment and maternal attitude questionnaire (MAMA) (Koubaa, Hallstrom and Hirschberg, 2008). The self-report measure included items such as "have you enjoyed

feeding your baby" and "have you regretted having the baby" and asked the participant to rate the statements on a four point likert scale. Though reliant only on self-report data, the statistical significance is robust. The data indicated that the majority of mothers with a history of an eating disorder responded with three or more items in the dysfunctional range in the MAMA questionnaire. This suggests a clinical level of maternal adjustment problems (Koubaa, Hallstrom and Hirschberg, 2008).

In 2007, Bryant-Waugh et al. conducted a qualitative investigation of what themes and issues were of primary concern to mothers with a history of eating disorders. Using semi-structured interviews and focus groups, seven mothers and four health care professionals who worked with mothers of young children aimed to identify skills and support that would be useful in creating an intervention targeted at this population. Thematic analysis of the interviews yielded 10 themes: These included 'Passing on traits', 'Food preparation and provision', 'Mother's intake', 'Interactions around food and mealtimes', 'Need for control', 'Self-care', 'Self-identity and parental expectations', 'Impact on general parent-child relationship', 'The group experience', and ' Practicalities and format' (Bryant-Waugh et al., 2007). Specifically the first eight themes identified, expressed the difficulties experienced qualitatively by the mothers themselves, or by proxy via the health care workers. This investigation highlighted a number of maternal obstacles and begins to develop skills and support interventions to specifically target this population's self-identified deficits. This study was limited by its focus on mothers with children under the age of five and it would be interesting for further research to explore the similarities or differences that emerge if the mean age is increased.

Rortveit et al. (2009) reflected on two particular themes identified by their exploration of the question, "what are mothers' daily life experiences when suffering from an eating disorder" (Rortveit et al., 2009, p. 603). This qualitative study used interviews and hermeneutic analysis to unearth the mothers' primary concerns that included; feeling guilty for not being a 'good enough mother' and a preoccupation with not involving the child in their dysfunctional relationship with food. These themes seemed to reveal a sense of shame inherent in the participants regarding their parental aptitude. Bringing concealed feelings such as this to the forefront may be crucial in providing adequate support and treatment for this population. This data paints a substantial picture of the difficulties mothers experience within the dynamic relationship between their eating disorders and their children.

### 1.5 A focus on feeding behaviour

The mutual engagement of mother and child in feeding behaviour is a primary activity of early neonatal life and is one of the first fundamental forms of communication that takes place between parent and child (Charone, 1982; Park, Senior & Stein, 2003). It is believed that the early feeding relationship may pave the way for future successes or failures within the mother-infant dyad (Charone, 1982). Psychoanalysts such as Friedman (1974) and Winnicott (1957) hypothesized that within the confines of early feeding experiences infants had the potential to feel secure enough to explore their entire range of excitement from its peak to subsequent decline. Charone's (1982) literature analysis posits that the feeding relationship between mother and infant may be not just a paradigm

of both future mother-child interactions, but potentially a prognostic tool for the child's future. Though this assertion is perhaps lacking in the multitude of dimensions impacting child development, evidence does support the notion that early feeding relationships are indicative of later feeding difficulties, future psychopathology and the development of eating disorders.

More recently, Micali et al. (2011) inventoried both child and maternal mediators of feeding difficulties. Their population-based longitudinal study added support to the existing literature, indicating that infant feeding difficulties are directly affected by maternal eating disorders as well as via maternal anxiety and depression, which seems to be exacerbated by the feeding problems themselves (Micali et al., 2011). This devastating cycle occurring between infant and mother often persist into the child's school years and impacts on all many elements of child development, including their eating in later life (Micali et al., 2011). The feeding dynamic between parent and child seems to be flagged as a vital indicator of the child's potential developmental trajectory.

It has long been acknowledged that maternal anxiety and depression are consistently associated with feeding difficulties in childhood (Chatoor et al., 1998). As Stein et al. (1994; 2001) posited, there is an established relationship between the controlling parenting style (primarily during mealtimes) in mothers with eating disorders and feeding problems in their offspring. This early signpost highlighted the psychopathological connection between maternal eating disorders and observed feeding problems in their children at age 4: This was evident in the mothers' tendency for over control and

mealtime disorganization (Cooper et al., 2004). Though previous research has explored the impact of maternal eating disorders on their ability to parent and on the child's development, the examination has primarily been from a quantitative perspective, focused on identifying pathology (Stapleton, Fielder & Kirkham, 2008). Furthermore, feeding, as a specific and essential element of parenting, has yet to be explored as a qualitative phenomenon, though quantitative data identifies it as a significant catalyst for mother-child difficulties, particularly when a maternal eating disorder is present.

## 1.6 The mothers' experience

Most fundamentally, qualitative research is interested in exploring a lived experience of individuals, and concerns itself with understanding how people make sense of their world (Smith, 2007). It hinges on the presumption that people are experts in their own subjective experience and that a rich, contextual investigation is paramount in understanding a phenomena and gaining access to this expertise. Smith argues that a focus on human experience is central to the field of psychology and that qualitative methods are the most effective way to investigate a person's grasp of their world (Smith, 2007).

The voices of mothers with eating disorders are scant within pertinent literature, with little research attending to the subjective experiences of the women themselves (Stapleton, Fielder & Kirkham, 2008; Stitt, 2014). The majority of research in this area has centred around the quantitative investigation of the impact of maternal eating

disorders on infant and child feeding difficulties. Few studies have investigated the phenomena from within, and rather aim to further classify female pathology. Stapelton et al. made an important step towards redressing this imbalance by using qualitative methods to "elicit women's accounts of living with and within, and eating-disordered body" (Stapleton, Fielder & Kirkham, p. 875, 2008). 16 women were interviewed in depth, who self-identified as living with an eating disorder (Stapleton, Fielder & Kirkham, 2008). The researchers detected a profound pragmatism and resourcefulness in the women that translated into their keen ability to identify their potential parenting impediments and source strategies to help them meet their children's needs more successfully: This included obtaining formal childcare, as a means to reduce the burden of the maternal feeding onus while potentially exposing the children to alternative food relationships (Stapleton, Fielder & Kirkham, 2008). Though this research relied on a non-representative sample population, the findings indicate that the daily food and consumption practices in family life can significantly impact both maternal and child health and wellbeing.  Stapleton et al. wrote that the "pressures to plan, shop, cook and serve family meals, and to eat in the company of others, was a new and frightening experience and most participants described these as areas in which they lacked skills and experience" (Stapleton, Fielder & Kirkham, p. 881, 2008).

Stitt and Rupert's (2014) qualitative investigation of parenting as a mother with an eating disorder revealed a rare insight into this population's understanding of their subjective experience, as well as the bidirectional influence that occurs between the disorder and family life. Nine mothers were interviewed. The data confirmed that these mothers juggle

the competing demands of their eating disorder and their children with great aptitude (Stitt & Rupert, 2014). Six major themes that emerged from the data: 1) the impact of the eating disorder on the children; 2) the modelling of disturbed eating behaviours; 3) 'food comes before anything'; 4) 'there would be no world without them' (children motivate recovery); 5) secrecy around the eating disorder; and 6) treatment needs (Stitt & Rupert, 2014). This comprehensive overview of the mothers parenting experience illuminates the complexity and competing nature of her struggle to satisfy her eating disorder and her children simultaneously. Furthermore, the qualitative nature of the investigation highlighted what was most salient to the index population themselves: In her own words, the 'eating disordered mother' described her ongoing battle between her eating disorder and her drive to parent her children. Stitt and Rupert provided an ideal background for future research in this field, aimed at investigating in further detail the themes identified, as well as more specific aspects of parenting (2014).

## 1.7 Transmission and treatment

Evidence suggests that a mother's awareness of her dysfunctional behaviours (and the reasons behind them) may lead to a general improvement in her eating disorder and subsequently a greater ability to meet her child's needs (Barnett, Buckroyd & Windle, 2005). In the absence of this awareness, transgenerational transmission of psychopathology is more likely, via the learned behaviour and internalized distress of the offspring (Micali et al., 2009). The familial aggregation of eating disorders is well identified within the literature, with both anorexia nervosa and food avoidance emotional

disorder presenting far more frequently in the offspring of mothers with a history of eating disorder, as compared to community samples (Watkins, Cooper & Lask, 2012). Specifically, in Watkins et al.' clinical sample, 17% of the mothers of children with a diagnosed eating disorder reported a history of an eating disorder themselves, while only three to five percentage is reported in community samples. Given these statistics for the transgenerational transmission of eating disorders, much research has turned its focus to identifying the mechanism of this transmission from mother to child (Park, Senior & Stein, 2003).

Park, Senior and Stein's 2003 literature review focused on the offspring of mothers with eating disorders and identified five mechanisms that underlie the transmission of disturbed eating patterns from parent to child. First, evidence indicated a genetic influence, though the precise nature and extent remains undetermined. Moreover, the interplay between the genetic component and the environmental stimulus appears to play an active role in transmission, though the specifics are yet to be determined and further research is required. Second, within some family groups, the parental eating psychopathology may directly impact the child, for example, if the parent wishes their child to be thinner, they may in turn withhold food, as they do for themselves. Research indicates that this is most prevalent in mothers with anorexia nervosa, as illustrated by Russell, Treasure and Eisler's 1998 study. Third, it is proposed that eating disorder psychopathology may impair general parental functioning. Stein et al. give the example that the mothers' preoccupation with food, shape and weight may detract from her ability to attend to the child's needs sensitively and responsively. Additionally, as previously

identified, the additional stress and potential friction that occurs during mealtime could influence the child's perception of food enjoyment as well as their overall intake. The fourth mechanism proposed contains the element of learnt behaviour: Parents with eating disorders may act as dysfunctional role models for their children pertaining to eating behaviours and attitudes. And finally, fifth, the prevalence of familial and marital discord that is often associated with eating disorders has been confidently linked to adverse effects on child development: Simply an increased amount of general friction in the home, as associated with the presence of an eating disorder, may be a risk factor in transgenerational transmission. The investigators concluded that these five mechanisms are the primary mediators of the intergenerational transmission of eating difficulties. This body of evidence must be interpreted cautiously; however, as it is based on a series of case studies and lacks the verification of substantial control studies.

Authors Whitehouse and Harris look at the intergenerational transmission of eating disorders as a set of self-perpetuating cycles (1998). In their own words, a series of relationships occur between "early childhood feeding problems and later eating disorders; between the way a mother was raised and her own parenting behaviour; and between parental management style and eating disorders in the child" (Whitehouse & Harris, p. 238, 1998). These cyclical relationships promote the recurrence of certain behaviour and psychological typologies. The population based quantitative investigation identified a complex interaction between children's level of food refusal and the primarily caregiver's management style, and between the management style and eating attitudes (Whitehouse & Harris, 1998). These conclusions do not imply causality, but rather may imply a

multidimensional relationship between the factors, both current and historical, inherent in the caregiver and the child themselves (Whitehouse & Harris, 1998). Further research is needed to investigate the possibility of identifying a cause and effect type connection between such caregiver and child factors.

Using a longitudinal model of investigation, Stein et al. analysed factorial influences that may contribute to the children of mothers with eating disorders developing eating difficulties themselves (2006). Their multivariable analysis yielded two potential indicators: first, the duration of the mother's eating disorder (with an increase in duration for the mother manifesting in heightened eating disorder pathology for the child), and second, the level of mealtime conflict between mother and child, as measured at age five (Stein et al., 2006). Of these two factors, the length of the child's exposure to the mother's eating disorder was the stronger predictor, potentially indicating a direct influence between maternal eating psychopathology and the development of dysfunctional eating attitudes and behaviour in the child (Stein et al., 2006). This correlation may be attributed to the child adopting the behaviour modelled by their mother, a genetic influence, or most likely, a combination of both of these internal and external prompts.

In 2005, Barnett, Buckroyd and Windle wrote "no specific programs as yet exist in the UK targeting ED mothers with the aim of addressing primary prevention for the child" (p. 2003). At the time, Rachel Bryant-Waugh and her colleagues were in the process of developing a pilot group intervention explicitly targeting this deficiency. This resulted in

a series of interviews and focus groups that led to the development of a parenting skills and support intervention for mothers with eating disorders and their young children. Initially, they conducted a qualitative investigation with seven mothers with eating disorders and four health professional who worked with preschool aged children. They aimed to identify the themes and issues that would be most useful to the target population. This yielded a series of concerns including, the fear of passing traits from mother to child, guidance in food preparation and provision, support regarding the interactions around mealtimes, the mother's food intake, parental expectations, the impact on parent-child relationship and the need for control (Bryant-Waugh et al., 2007). The thematic analysis brought to light the vast and complex array of difficulties that surround the experience of parenting with an eating disorder. Following the identification of the challenges at the ground level, the researchers, led by Bryant-Waugh, began piloting a group intervention addressing the above-mentioned themes.

In 2007, they ran an eight-session group intervention for four to five participants across three trials (Bryant-Waugh et al., 2007). Each session was structured and included a main topic, general discussion of the topic as it related to the participants' experience, education, problem solving skills and homework tasks. The eight primary session topics were; interactions around food and mealtimes, food preparation and provision, the mother's intake, self-care, self-identity and expectations of the role of parent, a need for control, the impact on the general parent-child relationship and a group debrief (Bryant-Waugh et al., 2007). Participant feedback indicated that the intervention was acceptable and valuable to the mothers, who reported a positive impact on their parenting skills and

over all confidence levels (Bryant-Waugh et al., 2007). The clinical effectiveness of the intervention was assessed by self-report questionnaires at three time points, pre-intervention, post-intervention and at one-month follow-up (Bryant-Waugh et al., 2007). Their data suggested a general reduction in parenting concerns and indicated improved depression scores (Bryant-Waugh et al., 2007). Though this intervention utilized a small sample size and self-report measures, the results indicate that the participants welcomed this type of intervention and that such a group had the potential to facilitate meaningful insight and change. The proclivity for transgenerational transmission of eating disorders from mother to child, coupled with a distinct lack of population specific interventions, increases the importance of both understanding the mothers' experience of feeding her child while having an eating disorder and developing treatment protocols that address previously identified and newly emerging difficulties.

More recently, Cristina Runfola et al. developed and piloted a group intervention aimed at mothers with histories of eating disorders (2014). This project, entitled NURTURE (Networking, Uniting, and Reaching out To Upgrade Relationships and Eating), used the finding of focus groups to construct a 16-week, four-module intervention. The scheme was delivered via interactive web conference forums and was piloted with 13 mothers with children aged birth to three years. The modules included, 1) laying the foundation, 2) general parenting skills, 3) eating and feeding and 4) breaking the cycle of risk (Runfola et al., 2014). The results indicated that the participants experienced improved maternal efficacy and competence with parenting (Runfola et al., 2014). Though it is unknown at this stage what caused the change, as confounding variables were not

controlled for, the mothers' positive reaction to the intervention via feedback questionnaires, a high participant retention rate and preliminary outcome results, suggests that such an intervention may be a viable method of supporting the unique challenges faced by mothers with a history of eating disorders.

Both intervention schemes are still in their early phases of development and require further testing of their validity and reliability. The need for specially designed clinical treatment pathways is evidenced by the complex difficulties that mothers with eating disorders experience and the cycle of transmission that will continue if the needs of this population are not more comprehensively addressed.

## 1.8 The current study

This literature review has brought to light the vast and complex array of difficulties that surround the phenomena of parenting with an eating disorder, particularly when it comes to food preparation and provision. The vitality of this proposed research hinges on its unique perspective as a phenomenological introspection into a seemingly fundamental act of parenting: providing sustenance for your child.

Most commonly, studies of maternal eating disorders measure the impact on the children in terms of birth weight, feeding practices, feeding logistics, and child development (Stitt & Rupert, 2014). Few investigations were located for this literature review that explored the mothers' subjective experiences of parenting with an eating disorder. A gap in the

literature appears to exist pertaining to the first person, qualitative account of this phenomenon, specifically, the mother's perspective of her ability to parent and feed her children while simultaneously having an eating disorder.

The current study aims to illuminate the mothers' experience of feeding her child whilst having an eating disorder. The sub textual questions involve, what does it feel like to handle the food, what does the mother experience during mealtimes, how is it to prepare the food and to aid/allow/watch her child consume the food, and what do these experiences bring up for the mother? This topic is of paramount importance, as the cross-generational transmission of eating disorders remains prevalent and the impact of living with an eating disorder for the individual and their family remains devastating (Cwikel, 2011). Research indicates that the maternal instinct and the eating disorder struggle to coexist. This study aims to better understand this internal dynamic through the first person voice. By better understanding the inner workings of this phenomenon, practitioners may gain insight into more efficient paths to recovery and potentially an awareness of how to promote the avoidance of the transmission of eating disorders from mother to child. The awareness of the mother's psychological processes could influence the development of specifically designed postnatal support for women with eating disorders as well as targeted on going treatment for her and her family. This understanding could guide future eating disorder treatment plans for this specific client group.

As a counselling psychologist, the mothers at the centre of this research are inevitably our

patients. My profession is person-centred, in the most fundamental meaning of the words: In accordance with my commitment to the inherent humanistic principles of counselling psychology, both my clinical practice and my research have developed out of the belief that individuals are the expert of their own experiences. I place great importance on the subjective human experience as the source of knowledge and understanding. My aim is that this epistemological position is captured by the content and methodology of this research. As my patients' experience is the fuel for creating a shared understanding in therapy, the participants' experience in this research has created a rich qualitative data set that echoes their voices.

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# 2.0 Methodology Chapter

## 2.1 Introduction

The aim of this chapter is to provide a description and explanation of the method and methodology with which the research question, 'what is it like to feed your child as a mother with an eating disorder?' was addressed. This account will detail the width of epistemological assumptions and the breadth of procedural functions. The purpose of illuminating the scaffolding this research is built on is to illustrate the commitment of this study to an ethically sound, valid and high quality investigation.

The notion of quality and validity were paramount from the beginning to the end of this project. Professor Lucy Yardley's principles of evaluating qualitative research were used throughout the phases of the study to maintain a stringent adherence to a high standard of research. Her four themes of 'Sensitivity to Context', 'Commitment and rigor', 'Transparency and Coherence' and 'Impact and Importance' were used as a paradigm to continually assess the project (2000).

## 2.2 Epistemology, methodology and method

Epistemology, or the study of knowledge, is concerned with establishing theories to explain how mankind attempts to make sense of the world and how we identify and come to believe 'truths' (Cardinal, Hayward & Jones, 2004). If consistency and coherence is

abided, an epistemological standpoint, methodology and method will synchronize within

a study (Willig, 2013). The term 'methodology' is used to refer to the general thematic

approach to the study of research techniques while 'method' speaks to the specific

procedures employed (Silverman, 1993). This section will outline the epistemological

position of this study, how it was obtained, and the methodology and methods that were

used to evaluate the above mentioned research question.

### 2.2.1 Consideration and rejection of the positivist position

Within psychology research, the dominant epistemological position is that of positivism:

The current study diverges from this trend. Positivism is characterized by its tendency

towards a quantitative methodology and posits that 'truths' about the world are only

known through observable and measurable means (Camic, Rhodes & Yardley, 2003).

Historically, positivism has been criticized for its reductionist nature, claiming that a

phenomenon can be boiled down to the interaction between physical, physiological and

chemical events (Bullock & Trombley, 1999). According to this position, our experience

of the world and description of it is not necessarily reflective of the objective 'reality',

but rather is merely reflective of our perception. This quantitative methodology allows

for a multitude of information gathering and the development of robust statistics on a

given subject, but may fail to capture abstract ideas and events that occur beyond

observable means. By nature, this creed of investigation is limited by the methods

employed in data collection, relying on empirical measures. Positivism only produces

answers to the questions it asks, and inherently ignores the context implicit in the

presence of an 'observer' (Fagan, 2012). For these reasons and more, the positivist position has been rejected for use in this study.

Qualitative methods allow for a flexible structure when gathering information, encouraging an organic and virtually unlimited scope of data to emerge. As quantitative research has previously identified a range of variables that are relevant to the target phenomenon, a qualitative methodology may enable a 'what it's like' insight into the individuals' subjective experience.

### 2.2.2 Acceptance of a qualitative methodology

The current research aims to present a new understanding of how mothers with eating disorders experience feeding their children. As the mothers' experience is the subject of investigation, the mothers themselves are the experts and the source of the raw data. To answer the type of question that is being asked, it is essential to remain rooted in the participants' experience and to collect the knowledge from them. The current research is committed to a qualitative research design to advance the present understanding of the target phenomenon.

I greatly value the subjective human experience as a tool for learning about one another. The humanistic theoretical position that formed the foundation of my Counselling Psychology training has been highly influential in both my development as a practitioner and a researcher. My personal worldview aligns naturally with the epistemological

underpinnings of a qualitative research design. This feels like a secure and robust position from which to implement a high standard of research.

### 2.2.3 Critical Realist position

The intention of the current study is to produce 'critical realist' knowledge; knowledge characterized by the notion that we can accurately describe our experiences in the objective world and derives meaning from them. Carla Willig describes a spectrum of knowledge ranging from realism to relativism, and the importance of understanding this expanse as it relates to a researcher's conceptualization of their data (2013). At one pole, an extreme realist position posits an objective reality that is ontologically independent of the act of perception. In terms of analysis, this position claims that the researcher's inherent bias further corrupts the data, thus spoiling the chance of producing accurate knowledge. This realist position is hence rejected, as it does not support the epistemological stance of the current research, which accepts the impact of the researcher on the data and embraces the subjects' ability to describe their experience in a meaningful way.

At the other end of the spectrum is the extreme relativist position, which claims that reality is constructed by the individual's subjective perception of it, mediated by culture, language and politics and that no objective truth or reality exists (Pilgrim & Rogers, 1997). This position is also rejected for the current research, on the essential premise that the experiences described by the participants are meaningful and occurring in an actual,

objective reality.

The position of critical realist, upheld in the current study, will produce knowledge according to the analysis of the researcher making sense, of the participant making sense of their experiences, in a double hermeneutic loop.

### 2.2.4 Methodology and Method

An Interpretative Phenomenological Analysis (IPA) method was applied to the raw data of the transcribed interviews to extract meaning from the subjective accounts of the participants. IPA is a qualitative research process, developed by Jonathan Smith (1997). It is firmly rooted in its phenomenological foundation, and primarily attends to the ways in which humans experience their world and gain knowledge (Willig, 2013). Smith et al. describe this process as double hermeneutic; with the researcher trying to make sense of the participant trying to make sense of their subjective experience (Smith, Flowers & Larkin, 2009). Larkin, Watts and Clifton describe IPA as giving voice to the participants, while the researcher evokes meaning by applying a psychological contextualization to the data (2006). The research implications are clear: "any discoveries that we make must necessarily be a function of the relationship that pertains between researcher and subject-matter" (Larkin, Watts & Clifton, p. 107, 2006). Accordingly, the researcher is an inclusive part of the findings. This reinforces the epistemological position of the current study and supports the foundation for a coherent methodology.

Edmond Husserl was the founding father of phenomenological enquiry, asserting that experience is the source of all knowledge (1927). Smith et al. apply this assertion to their research perspective, requiring a shift in focus from the activity itself to the subjective experience of that activity, referred to by Husserl as the 'phenomenological attitude' (Smith et al., 2009). Husserl advocated that we 'bracket' our understanding of the world and rather focus on examining our perception of that world. This perspective encourages the researchers' scope of interpretation that is inherent in analysing experiences through the lens of IPA (1927).

As previously discussed, it seems impossible, and not necessarily beneficial, to completely eradicate a researcher's biases and perceptions from a given data set. Smith et al. described Heidegger's (a student of Husserl) perspective, when he questioned the reliability of any knowledge other than interpretation (2009). Here, the notion that our existence is relational, to space, time and others, is essential to the derivation of meaning making activities (Smith et al., 2009). This argument has significantly informed the world of phenomenology, suggesting that access to the subjective experience of another will be inherently muddied by the preconceptions and perceptions of the external individual. Though often viewed as inhibitors to extracting 'pure' data, Heidegger and Smith et al. suggest that such influences are the catalyst for vital interpretations and extrapolations, making sense out of the raw material.

As a reflexive researcher, I am committed to reducing, as much as possible, the impact that my preconceptions have on the data. But as pointed out previously, this may be

impossible and not necessarily of great benefit. I recognize the value in what my individuality brings to this research, and from this perspective, I hope that my presence within the study, coupled with the body of literature, can aid the interpretive element of IPA analysis in capturing the essence of the participants' accounts.

The IPA research methodology is increasing its primacy within the fields of counselling and social psychology (Smith et al., 2009). The writings of Maurice Merleau-Ponty, as derived from his predecessors Husserl and Heidegger, attended to the notion that our individual sense of self and sense of the world is perceived and known through our body (1962). He wrote, "All my knowledge of the world, even my scientific knowledge, is gained from my own particular point of view…." (Merleau-Ponty, 1962, p. 4). This 20th century phenomenological philosopher suggested that as humans we reflect on the distinction between our environment and ourselves. As Smith et al. point out, while we are able to empathize with other's experiences, we are fundamentally unable to share the experience of another, simply because we embody a different position in the world than they do (Smith et al., 2009). This is where the importance of the critical realist epistemology is substantiated, as we must rely on the validity of the participants' description of their experience and the researcher's ability to elicit robust interpretation, thus creating trustworthy and meaningful knowledge.

In their most recent book, 'Interpretive Phenomenological Analysis: Theory, Method and Research', Smith et al. illustrate the effectiveness of IPA within the subjects of 'health and illness', 'sex and sexuality', 'psychological distress' and 'life transitions and identity'

(2009). The experience of feeding your child as a mother with an eating disorder could comfortably sit within all of these thematic positions. This is a further affirmation of the aptness of this method for the current study.

### 2.3 Research Design

As justified above, a qualitative IPA method and methodology was used to most comprehensively address the research question, 'what is it like for a mother with an eating disorder to feed her child'. This design is supported and informed by the epistemological position of critical realism. The analytic process of IPA cautiously moves from a detailed examination of a single case, to an examination of similarities and differences across multiple cases: This produces a meticulous account of the patterns of meaning making from a shared experience from multiple perspectives.

Eight, one-to-one, semi-structured interviews were carried out with individuals who satisfied the inclusion criteria (see below) and were willing to participate in the research study. The interviews ranged in duration from 30-80 minutes, depending on the participants' loquaciousness. As the lead investigator, I conducted the interviews, which were digitally recorded, and later transcribed.

### 2.3.1 Semi-structured interviews

Semi-structured interviews are designed to be flexible and fluid, as a means of capturing

each individual's unique perspective (Smith et al., 2009). This method is the most common form of data collection used in psychology based qualitative research (Willig, 2013). In accord with the epistemological position, semi-structured interviews situate the participant as the expert in their own experience, while the researcher's role is to facilitate an environment where the subject feels secure enough to explore their experience in new and deep ways (Smith et al., 2009). Essential to IPA, the method of data collection must elicit from participants a rich and detailed first-person account of their experience (Smith et al., 2009). Smith et al. suggest that in depth, semi-structured interviews are the optimal way to access appropriate material, however, other techniques, including diaries can be used if it is more appropriate to the context (2009).

As a trainee Counselling Psychologist, I am experienced in engaging in meaningful, one-to-one dialogues, encouraging exploration and extracting meaning within a professional context. My therapeutic skills and characteristics of active listening, building rapport, genuine curiosity and facilitation of meaning making are attuned to the semi-structured interview process. This method of data collection was selected over alternatives, including the use of participant diaries, as the interview process seemed more accessible and appropriate to a wider range of participants: Participant diaries would likely require a larger time commitment from participants and could elicit negative connotations of 'homework' or other required tasks that could cloud their recollection of the experience under examination.

Further reasoning for selecting the semi-structured interview method was its ability to

capture the embodied experience of the participants. Dr. Linda Finlay discussed the importance of this as a source of vital information within phenomenological research interviews (2006). She argued that the researcher should attend to both their own and the participants' body during the interview, to identify non-verbal communications. Finlay proposed that this experiential data creates a more vibrant and holistic picture of the participants' experience that is too often omitted due to method inadequacies or researcher insensitivity.

The interview schedule (See Appendix F) was developed from the conceptual framework underpinning the study and the existing body of literature that surrounds the research question. As suggested by Smith et al., the aim of the interview schedule is to promote open and expansive communication between the participant and the researcher (2009). Once formulated, it was used as a guide or starting point for the organic and purposeful conversation that followed. Within many of the interviews, the participants addressed topics in the schedule without being prompted, implying a potential overlap between the participants' experiences and the research objectives.

## 2.4 Reflexivity

Within both my professional and personal life, the concept of reflexivity is a driving force that encourages my keen awareness of others and myself. As a Counselling Psychologist, reflexivity lies at the heart of my clinical work. I am committed to the notion that the same attuned awareness should be present in effective research. Dr.

Darren Langdridge wrote about reflexivity as the researcher's essential consciousness of the impact that their "questions, methods, and very own subject position" may have on the knowledge produced by the study (Langdridge, 2007, p. 58). He acknowledged the probability that the researcher's point of view may seep into the data, but that as long as this 'contamination' is made explicit, it does not hinder the findings. Though this overt awareness will not nullify potential biases, it will allow for a reflective and thoughtful conversation about their influence (Langdridge, 2007).

It seems that the most vital element of reflexivity is attending to the circumstance that individuals are not 'blank slates' and that as a researcher I bring my history of experience into this role. Willig posits that this 'baggage' is in fact what allows us to make meaningful sense of the participants' experience (2013). She takes this one step further and claims that such predispositions should not be considered hindrances to a flawless study, but rather, the colours with which the illustration of the participants' experience is made vibrant. I agree with Willig, in that the characteristics that make me a unique individual should be exploited in my role as a researcher, allowing for potential novel perspectives to evolve freely.

With these perspectives in mind, my aim was to reflexively explore my relationship to the target phenomenon and the wider subject matter. I engaged in two reflexive interviews to make explicit my process of discovering some of the intrapersonal elements that I brought to this study. These interviews were digitally recorded and conducted by colleagues, one at university and one within the eating disorder service. Below I describe

some of the content.

### 2.4.1 Reflexivity interview 1

Langdridge provides a list of pertinent questions to encourage a reflective approach to research (2007). They include inquires such as, 'why are you carrying out this research', 'what do you hope to achieve', 'what is your relationship to the topic', 'do you empathize with your participants' experience', 'how might the findings impact the participants', 'who are you and how might you influence the research' (age, sex, class, etc.)? The use of Landgridge's interview elicited in me a deeper understanding of my relationship to the subject matter. I will discuss some of the details below.

I discovered a relational paradox in my position to the participants, in being simultaneously both an outsider and an insider. Additionally, the impact of the literature review and my clinical work will be explored.

*An outsider*

I am an outsider in relation to the participants as I am neither a mother nor do I have an eating disorder. This inevitably puts a sense of distance between the participants and myself. However, as a woman, I have extensive contact with the 'thin ideal', diet fads and other media exploitations of food, shape and weight that permeate our society. I am familiar with social pressures regarding appearance and the complex interpersonal and

intrapersonal dynamics that can incite mental health difficulties. As a daughter, I have experience of parent/child relationships and as a friend I have personal contact with eating disorders. Clinically, I have worked in a specialist eating disorder service for over two years and engaged in therapeutic treatment with mothers who have eating disorders. These elements of my past and present allow me to approach the subject matter with genuine tenderness and empathy. Though still an outsider to the participants in many ways, I have reflexively gathered my insight into their experience in order to better understand the participants' perspectives.

Alternatively, my distance from the phenomenon of interest has allowed me to approach the subject matter with an open mind and true curiosity, which may not have been possible if I had first-hand experience as a mother with an eating disorder. This has facilitated a relatively nonbiased investigation, hearing the participants' experiences without a filter of my own experience.

*An Insider*

Paradoxically, in some ways I was an insider amongst the participants. As a woman of my age, many of the participants were my contemporaries. I have worked for many years as a full time nanny, so have had contact with the maternal duties that were being discussed. These similarities manifested in a sense of comradery or sisterhood-type understanding within the interviews, which manifested in the use of phrases such as, "you know what I mean" or "you can imagine". The impact of this on the research process will

be explored further within the discussion chapter.

*Impact of the literature and clinical work*

The introductory chapter of this study is evidence that I am familiar with both current and historic literature that is relevant to this research topic. The deduced assumption is that feeding your children, as a mother with an eating disorder is a phenomenon that is significant to those involved. My aim, therefor, was to remain open to the possibility that indeed it may not be an interesting or important experience for my participants.

In my clinical work as a trainee-counselling psychologist in a specialist eating disorder service, I have been inundated with the vast range of difficulties faced by our service users. It was generally accepted within our team of professionals that the eating disorder infiltrates many aspects of an individual's life, often negatively impacting on familial and social relationships.

One of my clients was a mother with an eating disorder. She spoke frequently of her distress over the thought that her children were picking up her eating habits and developing dysfunctional relationships with food, shape and weight. This experience encouraged my investigation into the idea that this individuals experience may or may not be shared by others. I later used my understanding of this client's experience to explore the reliability and validity of my interview schedule, by answering the prompts from the perspective of this individual.

### 2.4.2 Reflexivity Interview 2

This experiential interview was completed from the perspective of a pervious client who experienced the target phenomenon. Two emergent themes from this exercise were the notion that the eating disorder was the dominant force within the household and that mothers may find handling the food for their children to be difficult, in terms of shopping, preparation, cooking and cleaning. Understanding these topics as my preconceptions is vital in allowing them to either emerge or not emerge from the research data organically. Further details from this interview are not given for the sake of confidentiality.

### 2.5 Ethics

As identified by the British Psychological Society (BPS), the term 'ethics' refers to the "the science of morals or rules of behaviour" (BPS, p. 6, 2010), both within the realm of clinical work and research. As both a scientist practitioner and member of the BPS, I place tremendous value and importance on ensuring that this study meets and exceeds the ethical guidelines outlined by this governing body. The current research was granted ethical approval by City University's ethics committee, the NHS Research Ethics Committee as well as met the standard of the NHS trust's local research and development team.

I aim to present a 'transparent and coherent' account of this study's ethical commitment,

in line with Yardley's guidelines (2000). The four primary principles described in the BPS Code of Ethics and Conduct are 'Respect', 'Competence', 'Responsibility' and 'Integrity' (2009). These pillars were considered throughout all phases of the research process. Additionally, a great effort was taken to consider each aspect of the study from the point of view of the participant, as a means of vetting their experience as closely as possible. 'The code of human research ethics' (BPS, 2010) is outlined in the headings below.

### 2.5.1 Risk

The wellbeing of the participants was prioritized in this study from beginning to end and was continually reassessed. Due to the nature of the research, there was no foreseeable risk of physical harm to the participants. There was a minimal risk of psychological harm occurring, due to possible distress arising from the sensitive nature of the interview material. However, this possibility was decreased by numerous factors, including my training as a counselling psychologist, which enabled me to monitor the participant's mental state throughout the interview.

Additionally, the participants were informed at the start of the interview to alert me if they were experiencing an unmanageable amount of psychological distress. The interviews took place in a familiar location to the participants, in the service where they have regular contact with clinical services and professionals. Other members of the participant's care team, including psychologists, psychiatrists and therapists, were on site

in the unexpected case of an emergency or risk situation.

I continually held in mind the welfare of both the participant and her child/children throughout the research process. Acting from a cautious standpoint, my aim was to balance the potential positive outcomes of the study with the potential distress of participants effectively. These potential stressors were justified on the grounds that the risk is relatively small and there are numerous safeguards in place. The evidence suggested that the usefulness of the study outweighed the potential risk.

### 2.5.2 Valid Consent

Informed, written, consent to contact the participants was obtained first, allowing me to connect with the prospective participant by phone. If their participation was agreed, additional consent to participate in the research was acquired upon meeting and before the interview took place (See Appendix C and D).

### 2.5.3 Confidentiality

Essential to upholding a high ethical standard, participants were assured of their right to anonymity and confidentiality. To maintain the confidentiality of participants, the transcriptions were stored anonymously and all information connecting the participant to her transcript was kept securely on a computer within the eating disorder service and destroyed at the end of the analysis process. Express participant consent was gained to

use excerpts from the transcripts within the presentation of the research findings: All identifying details were omitted or changed.

At the outset of the face-to-face interview, the participants were informed of the limits of their confidentiality. They were made aware of my professional and ethical duty to break confidentiality and inform the relevant services in the instance that I felt their safety or the safety of those around them was compromised. This was not necessary on any occasion throughout the research process.

### 2.5.4 Giving advice

Though this did not take place during the study, I was prepared to manage a situation where I became aware of any physical or psychological content that was significantly concerning during my interactions with the participants. The participants were pre-empted for the possibility that distress could arise after the interview had finished, due to them speaking about potentially difficult experiences. They were given the 'debrief sheet', which provided them with information should they want advice about seeking further support. This included the details of the eating disorder service they attend, the Samaritans phone line information, my contact details and advice to go to their GP or speak to their psychologist regarding any distress. They were further advised to attend their GP or A&E if they felt unable to keep themselves safe.

### 2.5.5 Deception

From my first contact with potential participants via the information sheet (See Appendix B), I did not withhold any information at any point throughout the research process. Participants were encouraged to ask questions about both the content of the study and the research process. The majority of enquiries I received from participants were pertaining to the finished product: How they could obtain the results if they were interested and what positive outcomes could result from the research. I addressed their queries by encouraging them to leave me their email address so that I could send them a summary of the outcomes, as well as described my hopes for future interventions targeting the emergent needs of the population.

### 2.5.6 Debriefing

My aim within the debrief was to ensure that participants had an accurate understanding of the research at hand, as well as were contained and safe following the interview experience. As part of the debrief, participants were given information with advice and the phone numbers necessary to obtain further support, whether or not they appeared to be distressed by the interview (See Appendix E).

### 2.5.7 Obtaining ethical approval

Ethical approval for this study was granted by City University, the National Health

Service Research Committee and the local research and development team for the

███████████ Partnership University Foundation Trust. These procedures were lengthy

and detailed: This level of scrutiny led me to increase my consideration and clarity of the

research design and procedure. The ethical approval process put me in a strong position

to begin my data collection, as I had thought through, in a nuanced and linear manner, the

procedural steps from beginning to end.

## 2.6 Data collection

IPA is idiographic in nature, meaning that it places emphasis on the individual's

experience. Smith et al. identified a "detailed examination of personal change" as a valid

way of gathering information and formulating knowledge (Smith et al., p. 164, 2009).

Attention to detail is at the forefront of the analysis process. IPA is committed to

understanding an experiential phenomenon from the subjective perspective of specific

individuals in a specific context (Smith et al., 2009).

### 2.6.1 Sample size

The methodology calls for a relatively small and homogenous sample, to provide insight

into the target phenomenon. As there are no formal guidelines on sample numbers in

qualitative research, I used other IPA studies, including those of Smith et al. to identify

eight participants as an appropriate number (Smith et al., 2009). I kept in mind both the

practicality of recruiting and processing the data and my desire to hear as many

subjective accounts as possible. Smith et al. speak about the increased difficulty in adhering to the commitments of IPA with a sample size that is too large (Smith et al., 2009). Additionally, in terms of time scheduling, I decided that eight participants was the maximum number that I could adequately attend to within the scope of this study.

### 2.6.2 Inclusion/exclusion criteria

13 current service users from the specialist eating disorder service were identified within a team meeting as appropriate prospective participants. They were invited to take part in the study with the information sheet (See Appendix B), via a professional in their care team. The specifics of the inclusion and exclusion criteria was discussed with both my research and field supervisors and agreed to be safe and sufficient.

The inclusion criteria mandated that the participant be a mother, be it biological, adopted or foster and that she had a diagnosed eating disorder. The participants' child or children must be currently living at home with the mother. This was important to capture the lived experience in a rich and current context. Additionally, the participants must have been able to communicate verbally in English due to the phenomenological nature of the research methodology. The exclusion criteria were few, in an effort to encourage the participation of a wider range of individuals. The participants could not have been current or previous patients of mine, as to not blur the roles of therapist and researcher. This decision was informed by my 'sensitivity to context', regarding the potential participants various experiences within the service, as a service user and a research participant

(Yardley, 2000). It was important to the integrity of the research and safety of the participant that they clearly understood that their participation in this study was completely separate from their clinical care within the service. Had I met with them in a different capacity, either before or after the research took place, the boundaries of our relationship would be compromised and potentially confusing. Furthermore, I did not want any participant to feel pressured or coerced into taking part in the study by my influence as their past or present therapist. And finally, the potential participant must not have been in a current state of objective or subjective crisis (as determined by the clinical judgment of myself and my supervisor) for the psychological safety of the individual. Furthermore, it was determined that the quality of the data may be compromised if the participant is in a heightened state of distress, as their account may not be an accurate representation of their reflective experience.

### 2.6.3 Participant identification and invitation

Prospective participants were identified by members of their care team as meeting the criteria discussed above. I then provided my colleagues with information sheets (See Appendix B) to share with the appropriate individuals and as well as consent to contact forms (See Appendix C). This opt-in method of contact was used as it preserves the confidentiality of the trust's electronic record system, in that no records were accessed as a means to assess the suitability of participation. Additionally, the prospective participant was able to opt in or out of the study anonymously to the researcher further preserving their confidentiality.

After reading the information sheet, the consent to contact form was signed by perspective participants if they were interested in taking part in the study and would like to be contacted by myself for further information. Once I received this signed document I was able to contact them by phone and further assess both their suitability for the study as well as enable them to assess the study's suitability for them.

The aim of the information sheet was to be transparent and accessible, so that the potential participants could give their fully informed consent if they chose to take part. Potential participants were encouraged to read the information sheet thoroughly before returning the consent to contact form. It was recommended that they take at least twenty-four hours to consider their decision. The aim of this delay was to hopefully avoid any feelings of coercion that might occur, as the research information was passed to them by a member of their care team.

All telephone contact from myself to the perspective participants was made from the eating disorder service, which meant that no service user contact details ever left the secure NHS premises. In the instance that I needed to leave a voice mail, I asked that the individual respond with a convenient time for them to be contacted. Initially, I received six completed 'consent to contact' forms back from my team members in quick succession. As I did not want to open the opportunity to participate in the study to more people than I intended to use in the sample, for ethical purposes, I only gave out two more information packs/consent to contact forms to colleagues at this time. Both were returned completed.

I began initiating telephone contact with the prospective participants. The individuals were asked if it was a convenient time to speak, if they said 'yes', I then introduced myself and the purpose of the phone call. A few asked me to call back at a more convenient time, which I was able to oblige. In the initial phone consultation I first checked with them that they had read the information sheet and asked if they had any further questions about the research. All of the prospective participants stated they had read and understood the information sheet. A few individuals asked questions pertaining to confidentiality and if they could see the results in the end. I was able to satisfy their enquiries. All eight women contacted stated that they were still interested in participating in the study and we then arranged the most convenient time for the interview to take place. All interviews were conducted in the participants' local NHS base where they are seen for their regular eating disorder treatment, in a quiet consulting room.

All eight prospective participants that were approached returned their consent to contact forms and were deemed eligible to take part in the investigation. I recognize that it is perhaps unusual for the recruitment stage to go this smoothly, but upon reflection, I think this was due to the soft approach of making initial contact through a known individual and using the consent to contact form to allow me to initiate the first contact. At the time of this phase of research, I was doing my clinical placement within the service. This may have served to increase my reliability in the eyes of the potential participants, as I was already a member of their care team, even though I had no direct contact with any of the individuals. Additionally, as later expressed by a number of participants, they had never

directly been asked about their parental experience through the lens of their eating disorder before, and they were eager to voice their struggle in this regard, with the hope of helping others.

Eight adult women participated in this study. Figure 1 displays the demographic information collected from the sample, including the age of the mother, her self-identified occupation, her marital/family status and her ethnicity. The information was gathered to enable a contextual description of the population, as related to the research question.

| PSYEUDONYM/ AGE | DIAGNOSIS | SEX AND AGE OF CHILDREN | FAMILY STATUS | ETHNIC GROUP |
|---|---|---|---|---|
| Amy, 29 | AN | b 12 g 11 b 8 | Living with partner | White British |
| Beth, 35 | BN | g 12 g 4 | Living with partner | White British |
| Claire, 53 | AN | b 17 g 15 | Living with partner | White British |
| Deb, 28 | AN/BN | b 9 g 6 | Living with | White American |

| | | | partner | |
|---|---|---|---|---|
| Emma, 51 | AN | b 23 b 21 b 17 | Living with partner | White British |
| Farrah, 31 | BN | g 3 | Living with family | White British |
| Gail, 32 | AN | g 12 b 9 | Single | White British |
| Hope, 40 | AN | g 15 | Living with partner | White British |

Figure 1. Table displaying demographic information for participants

### 2.6.5 The interviews

The interview procedure described below was replicated for each participant. I welcomed each participant and introduced myself. I started by thanking them for their time and for their interest in the study. I then gave them the opportunity to ask any questions before we started, which I answered to the best of my ability. Next, I went through each point on the consent form explicitly to ensure that they were giving informed consent and if they agreed (which they all did) the form was signed by both the participant and myself. The participants were reminded that they could terminate the interview at any point and

withdraw from the research if they wished, with no consequences to their current treatment. We then began the interview.

With the permission of the participant, the digital recorder was then switched on and I reminded them that their personal experience was important to me and that the questions were merely a guide, but that we could explore relevant topics as they arose. This was intended to free the participant to guide me and aligned them as the expert of their experience (Reid, Flowers & Larkin, 2005). The interviews ranged in time from thirty to eighty minutes.

After all eight interviews were digitally recorded I sent them to a transcription agency where they were transcribed verbatim, including all spoken words, pauses, and other noteworthy auditory communications such as laughter. The transcription agency that I used adheres to a strict information security policy and is experienced working with sensitive and confidential material. Additionally, all recordings and transcripts are kept securely in their premise that is approved by the Department of Constitutional Affairs. Once they sent the transcribed material back to me, they deleted the recordings from their files. Upon my receipt of the transcripts, I immediately anonymised the documents and saved them in a password protected file on a secure computer, using only the participant pseudonyms to identify them.

The use of an external transcription agency was necessary for me due to the time restraints of the current project. I had the opportunity to immerse myself in the

transcription by repeatedly reading the text whilst listening to the recording. This method allowed me to become intimate with the data, hearing both the nuanced details and thematic overviews in the recordings

### 2.7 Analytical procedure

An advantage of adhering to the IPA structure is that Smith and his colleagues have outlined the procedure in detail, leaving room for creativity and individual differences. This analytic tool is known for its transparency and inductive nature. The characteristics of the procedure are not prescribed in the body of literature though various suggestions for validity and reliability are discussed. Specifically, my analysis was primarily influenced by the recent and thorough guidelines described by Smith, Flowers and Larkin in their 2009 publication. The combination of structured formatting built on years of IPA experience coupled with the encouragement of flexible and creative thinking allowed me to be confident in my procedure, while allowing for the individuality that I bring to my role as a researcher.

The process of conducting IPA is essentially a continual movement from a detailed description of the text to a tentative interpretation, and from examining a specific lived experience, to a shared thematic understanding. Smith has described this process as an iterative and inductive cycle (2007). As outlined in Smith et al.' 2009 text, six stages of analysis were applied to the data in the current study. Below I describe this process and examples are provided in Appendix H-J. This is an illustration of the 'commitment and

rigor' that I applied to the analysis in order to produce valid and reliable findings (Yardley, 2000).

### 2.7.1 Reading and re-reading

The importance of 'immersing' oneself in their data is consistently highlighted throughout IPA literature (Smith et al., 2009; Langdridge, 2007; Willig, 2013). It is claimed that with each reading of the material the researcher is able to become more responsive to the data (Eatough & Smith, 2006). This process for me was essential in coming to know the accounts provided by each participant intimately. Additionally, the first two times I read each transcript I listened to the accompanying recording to re-experience the interview contextually. I then reread the transcript again, focusing only on the text. I found that as I became more familiar with the participants' words I was tempted to start making annotations and interpretations. I resisted getting ahead of the process but kept note of these thoughts and responses to the text in my research diary (Willig, 2013). I attended to only one transcript at a time, allowing me to engage with each account individually.

### 2.7.2 Initial noting

The next phase involved thoroughly examining each transcript on an exploratory level. My aim was to remain open minded and make note indiscriminately of topics that emerged from the transcript. As suggested by Smith et al., I made three types of

notations, focusing on the descriptive, linguistic and conceptual aspects of the text (2009). I used different coloured pens to maintain the distinction across transcripts. The descriptive comments labelled the content presented by the participant. I aimed to keep these initial notes close to the text by using the participants' own language where possible. This also helped to eliminate the influence of my knowledge, interpretations and preconceptions in this stage of analysis.  The linguistic comments comprised the syntax and composition of the content presented, and often included elements such as laughter and word repetition. The conceptual notes, as suggested by Smith et al. took an interrogative tone and included questions and abstractions that the text inspired (2009). I found that this type of note stemmed from my professional experience and knowledge, tentatively informing the formation of my understanding of the target phenomenon through the eyes of each participant.

The initial notes where made by hand in the margins of the text, as my preferred method of engaging with the transcript at this level. The three types of notation were made in parallel within an individual narrative of the text. This process ensured that I attended to each feature of the text while maintaining a holistic perspective of the participants' experience.

### 2.7.3 Development of emergent themes

The next stage of analysis involved reducing the volume of detail in the notes without losing the richness and complexity of the content. The focus shifted from the transcript itself to the initial notes in the margins, while keeping the overall substance of the

interview in mind (Smith et al., 2009). As Smith et al. describe, the transcript is temporarily fragmented, with the foresight that it will be brought back together as a 'new whole' at the end of the analysis, completing the hermeneutic circle (Smith et al., 2009).

At this stage of analysis, the emergent themes are intended to capture the essence of the comments relating to a specific portion of the transcript. This portion of the process also took the form of hand written notes in the opposite margin to the initial notes. The aim was to produce succinct and pithy statements that reflect both the sentiment of the participant as well as my own interpretations. At this point I listened to my first recorded reflexivity interview as a means to remain thoughtful about what I was bringing to the analysis and to ensure that the analysis remained closely connected to the text (Langdridge, 2007). For an example of stages two and three of the analysis process, please see the exemplar in Appendix H.

### 2.7.4 Connections across themes

The next stage of analysis involved eliciting connections and relationships from among the emergent themes. The emergent themes were typed into a table and cut out on to separate strips of paper. A large floor space was then used to physically experiment with the potential interactions: This process allowed me to observe the themes together and creatively consider various associations. This technique is one of many suggested by Smith et al. (2009). I chose to implement this technique specifically within my analysis as it fits with my personal kinaesthetic tendency to use concrete methods to represent

abstract connections.

The next phase was to label the resulting clusters of themes. The intention was for the 'name' of the group to capture the essence of the themes within it. A summary table of the cluster themes, subordinate themes, and citations or key words that represent the presence of the theme in the text, was created to keep track of the data emerging from each transcript (Willig, 2013). At this stage I met with my research supervisor to discuss some of the clustered theme titles. Her probing me on the thought processes behind the groupings allowed me to justify and make further sense of my interpretations of the data. Simultaneously, this method was a way of checking and validating my analysis process. For a copy of an exemplar table of stage 4 please see Appendix I.

### 2.7.5 The next case

In light of the idiographic nature of IPA, I engaged with each interview individually from step one to four before moving on to the next transcript. The reasoning behind this technique was to encourage each text to stand alone by 'bracketing', to the best of my ability, the ideas that had emerged from previous transcripts. To that end, I held in mind that each transcript was an individual's subjective experience and thus important for me to approach every account with equal curiosity and open mindedness.

### 2.7.6 Patterns across cases

Once all of the transcripts had been analysed from step one to four, I began to consider the cluster themes from each text and their relationships across transcripts. This was where the emergence of the superordinate themes took place. Cases were integrated into one another in a cyclical manner, meaning that when broader themes developed, they were grounded in the text of the transcript. This process took a similar shape as the previous grouping technique: I printed out the summary tables for each text, cut out the rows of cluster themes, spread them out on a floor space and considered them in relationship to one another.

A table illustrating how the emergent themes were grouped under super-ordinate themes and references of where the super-ordinate theme was expressed in the text was constructed. This led to a relabeling of themes. Again the aim was to produce a title that captured the individual experiences of each participant whilst simultaneously representing the theoretical ideas present. At this point, the recurrence across cases was considered when grouping and naming the superordinate theme (Smith et al., 2009). For an exemplar of stage six please see Appendix J.

### 2.8 Methodological and procedural reflexivity

The participants' trust and vulnerability in this research allowed the target phenomenon to come to life through their words. In both the data collection and analysis phases, a

relationship was constructed between the participants and myself as the researcher. Their deep engagement in our dialogue was a product of the bond built during our interaction. The participants brought their experience into the interview room and presented their vulnerability to a stranger: I was struck by the bravery and resourcefulness of these women.

This reflection reminded of the reality of my presence within the data. As described by the epistemological position, the participants' experience occurred in reality; however the interview was the collaborative product of them and I making sense of their account together. Throughout the research process I kept a diary where I noted my thoughts, feelings and experience of the interviews, as well as reflections on my interaction with the participants (Finlay, 2006). I also made note on my experience as an 'outsider' to the phenomenon under investigation. Three participants made comments at the end of the interview once the recorder was turned off, when I was thanking them for their time and saying goodbye: The content of the statements were to the effect of, 'you must think I am a terrible mother'. This seemed to be a powerful and shared communication of her experience as a mother with an eating disorder.

I met with my supervisor during the data collection phase of the study explore the interview process and my experience of it. As I had not previously conducted research interviews, this was my first experience in this role. Through supervision I became more open in the interviews to following the participants' lead and allowing them to veer away from my prompts. The interviews following this meeting were more organic in their

structure, which I think allowed both myself and the participant to relax into speaking more freely. My training and experience as a Counselling Psychologist helped me to be flexible in my approach and contain my anxiety about being in a novice researcher.

Throughout the interview process, I was continually surprised by the content that arose. This reassured me that my perspective was flexible enough to encourage novel information to emerge. My experience as a researcher was challenging and eminently rewarding: I feel privileged to have had contact with each courageous mother.

**2.9 Cost**

My travel to service sites (public transport) - £60

Participants' reimbursed travel - £20

Total cost - £80

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# 3.0    Analysis Chapter

## 3.1 Introduction

This chapter presents the findings derived from the interpretive phenomenological analysis of eight semi-structured interviews exploring mothers with eating disorders experiences' of feeding their children. The expressed themes give a glimpse into the rich and multidimensional subjective experiences of these women. The analysis presented is reflective of my interpretation of the participant's account of their experience, as related to the research question.

The derived themes are representative of the participant's process of meaning making, as related to their experience of feeding their children as a mother with an eating disorder. I encouraged the participants to reflect on their personal experiences of this phenomenon. An overarching theme emerged from the data, linking the participant's accounts unanimously: This theme was identified as a 'conflict between the eating disorder and the role of parenting'. The diagram below illustrates this interaction: each axis (eating disorder, mother and child) is bi-directionally impacting on the others.

EATING DISORDER

CONFLICT

CHILD                    100                    MOTHER
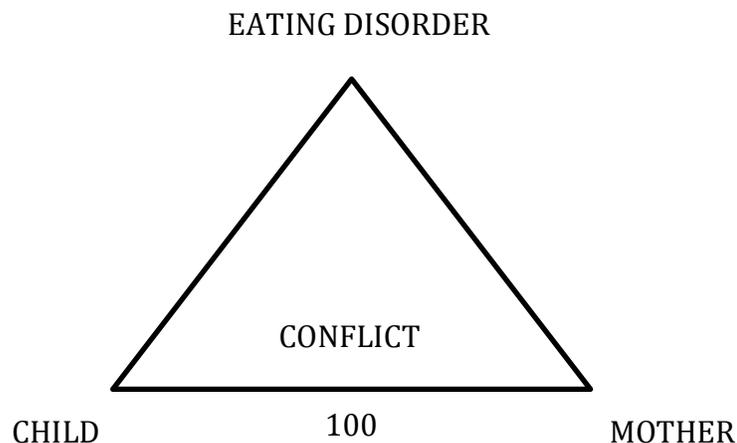
Within this dynamic structure, the analysis yielded four additional superordinate themes and distinct sub-themes, listed below.

1. The mothers' guilt surrounding the interaction of the eating disorder and the children
   a. Predominance of the eating disorder for the mother
   b. Mother hiding self and eating disorder, resulting in isolation

2. Unclear boundaries among the 3 axes (eating disorder, mother and child)
   a. Extreme presentation of boundaries as either rigid or indistinct
   b. Role reversals between mother and child

3. The mothers' experience of parenting as being full of contradiction
   a. Questioning the right to be a role model
   b. Double standard, "Do as I say, not as I do"

4. Fear of transgenerational transmission of the eating disorder
   a. Children's awareness of the eating disorder
   b. Impact of the eating disorder on the children

All participants expressed the overarching theme, while the super-ordinate themes (1-4) were consistently present in the majority of the sample. Not all of the sub themes were applicable to each participant. Please see Appendix K for a table of the appearance of themes for each participant.

I will begin to explore the analysis by outlining the overarching theme, which will be visited again in the summary where the relationships between the themes will be further established. The superordinate themes represent the most prominent participant expressions of the overarching conflict. Each will be described by detailing their sub-themes, illustrated by the participant's own words.

To preserve the participants' anonymity, pseudonyms will be used, and all other identifying details have been changed or omitted. When quoting a transcript, both the pseudonym and location in the text will be named (e.g. Sarah, 1.1), referring to the page and line number in the transcript. The transcripts themselves are verbatim accounts of the participant's interviews.

### 3.2 Overarching theme

A 'conflict between the eating disorder and the role of parenting' is the thread of continuity that connects the subjective experiences described by the eight women who participated in this study. Though expressed through diverse content and style, the mothers' struggle between her eating disorder and her function as a parent was universally echoed in all accounts. Hope poignantly described this as:

> "…two warring parts of myself" (Hope, 2.27).

The two parts she is referring to are what she later describes as her "eating disorder head" and her "mother head", which are in constant competition for her attention (Hope, 2.35). Hope alludes to a battle in her description of the essential conflict that underpins the coexistence of her eating disorder and her role as a parent: The 'warring parts' is reflective of the violence and discord that characterises this interaction. Each participant described a similar phenomenon, as either an overt or covert friction. The remainder of this chapter describes my experience and interpretation of the participants' subjective conflicts.

### 3.3 Superordinate theme 1 The mothers' guilt surrounding the interaction of the eating disorder and the children

Participants described their children's inevitable exposure to their eating disorder behaviour as guilt inducing. The mothers' primary source of this feeling seemed to be the self-identified subpar parenting that they were inflicting upon their children as a result of the consuming nature of their disorder. Farrah succinctly expressed the sentiment that many of the mothers alluded to when she said:

> "I feel guilty because I'm just too wrapped up in my own problems" (Farrah, 7.19).

Farrah described the egocentrism that often accompanies eating disorders: The immense portion of psychological and physical energy that is consumed by the eating disorder leaves little space for other entities to flourish. Many of the mothers expressed concern

and guilt that they were not giving their children enough of themselves. Gail expressed this feeling when she says:

> "I guess that if you could you wouldn't feed them, you know, but obviously you're going to, um, so yeah I would think really with that its guilt that you're not doing it properly, or you're not doing it as well as you know you would if you were well" (Gail, 6.22).

Gail referenced the eating disorder part of herself that would rather not feed her children. Though she went on to clarify that she would never act on this thinking, she felt guilty for simply bringing the thought into existence. When she refers to 'not doing it properly', she recognized that she could potentially be doing a better job of feeding her children if her eating disorder was not interfering, and she was 'well'. Gail went on to express her feelings of guilt that the eating disorder, or the eating disordered part of her, is essentially ruining what was meant to be pleasant, family time around the dining table.

### 3.3.1 Predominance of the eating disorder for the mother

Emma described herself as, "living in the world of anorexia", which her children, by default, cohabitate (Emma, 12.28). The all-consuming nature of eating disorders makes for a difficult bedfellow with the all-consuming nature of parenthood. Amy spoke about the overwhelming presence of her eating disorder as:

> "…completely taken over everything" (Amy, 1.26).

She was referring to the eating disorder having infiltrated every aspect of her life. She went on to say:

> "…my whole life is, or my brain is, just preoccupied with food and mealtimes" (Amy 1.32).

The preoccupation with food, shape and weight is an essential feature of eating disorder diagnosis. Amy described it as a persistent background noise, impossible to silence. She referred to her brain as being consumed with eating disorder cognitions, asserting its position as the dominating force in her life. Hope described her eating disorder as something that was completely hers, and that this exclusivity created a sense of seduction. She described:

> "Anorexia sort of puts you first. It sort of says I'm going to do what the hell I want…it feels like it's yours, and I think that is one of the things that as a mother sometimes you don't feel…like you've got anything" (Hope, 10.31).

Hope's description of her special relationship with her eating disorder explicitly depicts just how important it is in identifying her sense of self. I was struck by the intimacy with which Hope spoke of her disorder; it prompted me to wonder if there was space for other intimate relationships in her life.

The general prominence of the eating disorders in the lives of these women was staggering, with the average duration by self-report of 24 years. Deb spoke of the

difficulty she experienced in relation to the consuming nature of her disordered relationship with food:

> "It's [the eating disorder] coloured my whole life...I'm not
> sure exactly what normal is anymore" (Deb, 3.13).

Deb's reflection that her eating disorder has cast a shadow over her entire life was profound; with the impact extending far beyond the kitchen. Her exclamation that her eating disorder has left her not knowing what normal is anymore encouraged me to think about the insidiousness of this illness and how it often comes to ingest not only the sufferer, but the entire environment in which it exists. Due to this tendency for the eating disorder to dominate its environment, many of the mothers described extensive attempts to hide their eating disorders from her children and appear 'normal'.

### 3.3.2 Mother hiding herself and eating disorder, resulting in isolation

The concept of normalcy was mentioned frequently throughout the interviews, and was conceptualized as the 'holy grail' of motherhood. As mentioned previously by Deb, through her years of disordered eating, she had lost sight of what constituted 'normal'. Farrah spoke about her drive to appear normal to others, even when that meant sacrificing the needs of her eating disorder. She said:

> "...you don't want to appear abnormal, so you are eating
> just as a show so that people see you eating normal
> amounts of food, and then that's really hard, because you
> know you don't want it but you're doing it to appear
> normal so no one will guess there's a problem, but then it

makes you quite angry and then, and then the results are
that you take more laxatives or you make yourself sick or
you just feel horrible" (Farrah, 5.1).

Here Farrah described eating beyond the tolerance of her eating disorder as a means of

keeping up a façade of normalcy; this was more important than the consequences of

purging or feeling 'horrible'. I was struck by the lengths that Farrah was willing to go to,

in order to hide her eating disorder, and wondered about the emotional consequences of

suppressing her authentic feelings. Gail described going to the extent of leaving fake dirty

dishes around the house to help falsify her claim. Amy emphasized the importance of

acting normally with food in front of her children; this idea of presenting a brave face or

a façade was common amongst the mothers. Emma, Farrah and Gail spoke about

wearing a disguise in front of their children, in an attempt to keep a distance between

their children and their eating disorder. Farrah spoke about the brave face she put on

when trying to instil the importance of sharing in her toddler. She described feeling split

between what she feels she should do as a mother and what her eating disorder desires of

her. Farrah said:

"She'll try and feed me her chocolate buttons…I don't
really want them…I have them because I don't want to say
no to her and, because she's trying to share, but at the same
time I feel quite annoyed with her" (Farrah, 4.35).

The emotional strain this creates was palpable, as Farrah's eyes became teary when she

said:

"I want to burst into tears, and I have to try and hold that back" (Farrah, 8.1).

Farrah brought to life the difficulty of being pulled in two different directions by her eating disorder and her role as a mother. The feeling of needing to 'burst' into tears, like a dam overflowing, felt like a dangerous thought for Farrah and prompted me to wonder about the loneliness and strain inherent in always holding back her tears. Similarly, Emma spoke of her distress, which she tries to keep hidden from her children. She recounted:

"I always say, I'm fine, I'm full, I've had enough, don't need any more, they couldn't bare the pain. No one likes to see their mummy hurting, so you disguise it…" (Emma, 13.17).

Emma reported hiding her pain from her children because she presumed that they would be unable to tolerate it, consequently, isolating a portion of herself from her loved ones. This struck me as an exhausting pursuit that seemed to result in persistent deception and a resounding feeling of guilt. This guilt appeared to promote isolation, as wearing such extensive disguises meant that others were not able to share in her struggle.

The desire to shield the children from the eating disorder was unanimously present in all of the participant's accounts. This predominantly resulted in a form of deception, be it lying or secrecy, so that, at least to a certain extent, the eating disorder remained the mother's private domain. Gail spoke about the struggle between feeling guilty for lying, while recognizing its necessity to keep the eating disorder safe:

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> "…you can't speak to anybody because then they'll try and make you stop, um, so you have to just lie to everybody, and then of course you feel bad and it makes it worse" (Gail, 3.35).

She went on to say:

> "…it's all lying, it's all deception, and then of course that makes you feel guilty and it's just a mess" (Gail, 6.32).

This 'mess' is referring to the entanglement of both wanting to keep the eating disorder separate from the children, while still participating in their meal times; the result was a web of deception, and consequently, guilt. I was also struck by Gail's explicit desire to keep the eating disorder intact: She commented on her awareness that if others knew about her disorder, they would try and take it away, and at this point, the potential of this was unacceptable to her. This prompted me to consider the function of hiding the eating disorder for the participants and that perhaps maintaining the vitality of the eating disorder was worth the resulting guilt and isolation.

The presence of the eating disorder often resulted in the mother eating different foods, at different times, in different places, from the rest of her family. This physical separation seemed to be a catalyst for her feeling of emotional and psychological isolation. Amy spoke of how her children see her as different to them, as having an illness that creates divergent realities for them and her:

> "I'm ill and what I'm like isn't good" (Amy, 12.37).

She then went on to say that, in reference to her family:

"…they've just got used to me not being the same as them" (13.7).

Amy referenced the fact that her family have become 'used to' her disorder's presence in the home and the distinction it promotes between 'them' and her. When I asked Claire if she thought her husband understood her difficulties, she said:

"Not really, no…but then I probably hide it" (11.35).

Claire verbalized both her isolation and the reason for it: I was surprised by the seemingly parallel existences of the eating disorder and family life and the mothers' ability to (at least to a certain extent) nurture them simultaneously. The need to hide the eating disorder appeared to extend beyond the antisocial behaviours common to this psychopathology of an eating disorder and into the emotional and psychological burden: The mother's isolation with her eating disorder resulted in her carrying the stress and strain of it on her own.

### 3.4 Superordinate theme 2 Boundaries between the eating disorder, the mother and the child

The content of the eight interviews centred on the interaction of three primary components: the mother, her eating disorder and her children. For each individual, the

specific dynamics varied greatly. Six of the eight participants either directly or indirectly alluded to the relationship between the three axes. This presented itself in polarized counterparts; the mothers described their boundaries between the three components as either rigid and extremely boundaried, or lacking any differentiation among the parts.

### 3.4.1 Extreme presentation of boundaries as either rigid or indistinct

The mothers, who described their experience as highly boundaried, expressed a strict distinction between themselves as eating disorder sufferers and themselves as mothers. Most commonly, this resulted in the mothers' acknowledging an ability to nourish their children in a way that they are unable to do for themselves. Claire spoke about the discrepancy between feeding herself and feeding her children. She used phrases such as, "I won't do it for myself", "I can't do it for myself", "I don't bother to do it for myself" on numerous instances throughout the interview (5.33, 8.6, 8.12). Though Claire was unable to feed herself adequately, she described providing balanced meals for her children. This is an example of the rigid boundaries she has constructed in an attempt to control the interaction between her eating disorder and her children.

Beth described her experience of needing strict boundaries between herself and her children as an essential way of coping with both pregnancy and motherhood. She experienced a sense of dissociation from her child, which allowed her to provide the necessary nourishment. She spoke of her pregnancy:

> "…it wasn't me, it was a life inside me that was growing, and needed that space and the food" (Beth, 10.24).

She went on to say:

> "…it's strange but it kind of like didn't feel like me, it was just a completely different thing, I was, I was the machine holding on to the baby, and it was my responsibility to make sure it lived" (Beth, 11.1).

Beth described the importance of this extreme conceptualization as an essential element in allowing her "radical diet" to coexist with her children's "normal diet", both pre and post natal (Beth, 11.25). Mothers who maintained rigid boundaries between herself, her eating disorder and her children described the function as allowing the eating disorder and her children to coexist while having a sense of control over their interaction.

Another portion of the participants described a different type of relationship among the three axes, one characterized by indistinct boundaries. There was a common sense of enmeshment or diffuse boundaries in these individuals' accounts. This manifested in two categories of behaviour, one that can be described as overcompensating and the other as vicarious experience, lived by the mother through the child. The 'overcompensation' presented itself as the mothers' way of mitigating her own food restrictions by applying no food rules to her children. Both Amy and Deb spoke of wanting their children to have better relationships with food then they had themselves. Deb said:

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> "I would never make food a reward, I would never make food an issue, and I would let them have access to whatever food they liked" (Deb, 1.12).

Deb is clearly trying to differentiate her children's' experience with food from her own: The reality of it seems to be a complete lack of boundaries in an attempt to counteract the rigidity of her eating disorder. Similarly, Amy spoke of overcompensating for her eating disorder behaviour by allowing her children free rein of the cupboards:

> "I try really hard now not to comment on anything they eat or if they ask me for anything I just say, yeah you can have it" (Amy, 2.44).

By deeming everything permissible, Amy seemed to be operating in the extremes of all or nothing; with 'all' being allocated to her children and 'nothing' to herself. The extreme dichotomy between what is acceptable for the mother versus the child, presents a vast rift for both parties to navigate. This prompted me to wonder how both mother and child cope with this contradiction and if the inevitable confusion over why different standards exist for mother and child is discussed within the family.

Emma also described her experience of overcompensating, though it manifested slightly differently than the others. She spoke about her need to feed, and at times overfeed, her children:

> "If I'm going out for an evening my boys will still have a three course dinner all labelled and set out for them when they come home" (8.40).

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She reflected on the function of this behaviour, as a way of making up for the presence of the eating disorder in the home. Emma said:

> "Now I realize that I would have been a better mum if I didn't have an eating disorder and have subjected them to what they've had to go through" (8.44).

Emma's realization is evidence of her self-awareness and ability to stand outside of her psychopathology and objectively look at the impact her behaviour has on her children. She was able to name her overcompensating behaviour and acknowledge its function. Similarly to Deb and Amy, Emma made the link between her overcompensating feeding behaviour and her desire for it to overshadow the influence of the eating disorder on her children.

Some mothers described feeding their children as a vicarious experience, through which their experiences became enmeshed with their children's. Gail spoke about her confusion regarding her children's hunger, as she was unable to empathise with this physical state. She reflected on this when she said:

> "I started saying to my kids, well you can't possibly be hungry, or you know, I'd do them, like I say, a bowl of pasta or whatever, and they'd scoff it down really quick and to me that's like, you know it's disgusting, and they'd be hungry and want more, and I'd be like oh, you, what do you mean you want more?" (Gail, 4.15).

Gail's lack of hunger and repulsion by food, appeared to colour her theory of mind when it came to her children's relationship with food. It seemed that she found it difficult to

imagine their experience as being different from her own. Similarly, Emma described her experience of coping with her self-denial by feeding others. The evident lack of boundaries between herself and her children is illustrated when she gives the example:

> "…he plays sport at 6:30, between, um, finishing school and then when I pick him up. Now at 6:30 I am really starving…so I always put a snack in his bag, sometimes he eats it, sometimes he doesn't but I just presume he's going to be starving at that time, because I'm starving at that time" (14.6).

On the one hand, it is possible that Emma is recognizing her apparent enmeshment with her children, but it could also be interpreted that she is simply acknowledging her own hunger, but because the disorder does not allow her to satisfy this, she acts it out in a more acceptable way to her psyche, by feeding her child. The issue of boundaries between the three axes of mother, child and eating disorder have been explored in both of their extremes, as either rigid or indistinct: though communicated in polarizing expressions, it was common amongst the participants to explore a conflict within this triad.

### 3.4.2 Role reversals amongst mother and children

An additional presentation of diffuse boundaries emerged amongst participants, in the form of role reversals between mother and child. The majority of the mothers described incidents where they experienced being parented by their child, initiated by either the mother moving into the position of 'child', or the child moving into the position of

'parent'. The most prominent example of the mothers taking on the role of the child was the tantrum-like reactions they described in relation to food and meal times. Amy spoke about her difficulty with family mealtimes when she said:

> "I find that really hard if I'm eating with them and there's quite a lot of friction I just get really, because I get quite panicky anyway eating. And I just want to pick up mine and chuck it in the bin" (5.14).

This extreme reaction to the strain of a family mealtime exemplifies the child-like capriciousness she experiences. Bringing the attentions to Amy's language, she seemed to find it difficult to articulate this anecdote. This prompted me to reflect on the possibly that her struggle to find the words was illustrative of an internal struggle she was trying to voice. Amongst the participants, the role reversals primarily took place in the presence of food and eating activities, when the mothers seemed to be at their most vulnerable. Amy went on to describe how she finds it difficult to stay seated during mealtimes, another common behaviour of children who are avoiding eating their food. She explained:

> "I find it hard to stay sitting down as well so I would find reasons to jump up and get things out of the fridge…" (7.11).

She spoke about the importance of having this type of distraction from having to engage fully in the meal with her family. Farrah also described mealtimes as strained, because she is simultaneously trying to ensure her child is eating, while hiding the fact that she is not. This tension seemed to initiate a role reversal:

> "…trying to hide the negative behaviour from her and you can't, kids are very clever and they do pick things up and the feelings as well…she'll say, mummy angry?…she comes over to give be a big kiss or cuddle" (5.10).

Farrah described her experience of her toddler picking up on her negative feelings surrounding mealtimes and the child moving into the parental role to offer comfort to her mother. Most commonly, the mothers described instances of their children encouraging them to eat and then praising them for their effort; this is more typically seen in the reverse, from parent to child, in mealtimes where an eating disorder is not present. Hope described her child's involvement with her eating:

> "…she praises me when she thinks I've done well…she might ask me what I've eaten" (4.8).

This is a clear example of the child taking on the parenting role when it comes to encouraging and monitoring their mother's eating. This role reversal is an example of the diffuse boundaries between the mother, the child and the eating disorder. Furthermore, the ambiguity seems to compound the overarching conflict between the eating disorder and the role of parenting.

Farrah spoke about her family's palpable desire to see her eat, and the ongoing praise and encouragement she receives throughout mealtimes. This type of commendation was also described by Amy, who was told by her children, "well done, mummy, that's so good" in the context of her participating in a family meal (2.18). The role reversals of both parent

to 'child' and child to 'parent' can be interpreted to illustrate both the mother's vulnerability around mealtimes, manifesting in their regression and the children's awareness of their mothers' distress, resulting in them providing care. Emma described an extreme example of this when she spoke of her children's encounter with the force of her eating disorder:

> "I've been really unwell, starved for days and they've done everything to coax me to have a sip of water and none of them could ever persuade me. I called it my window sill syndrome that the anorexia head could be so strong that if my boys were standing on a windowsill, and I love my boys with all my life, if they were standing on a windowsill and said, Mum, we're all going to jump off unless you just have a sip of water because you need it so badly, I could still not have a sip of water" (10.40).

Clearly no amount of praise or persuasion was a match for the eating disorder in this case: Emma was locked inside her eating disorder, with her children unable to break in. She was not the only mother to describe instances when her eating disorder was impenetrable, even by the profound love and commitment they expressed for their children. This is a prime illustration of the conflict between the mothers' parenting role and their eating disorder: As Hope profoundly named it previously, a war is taking place internally between these two parts of the self.

**3.5 Superordinate theme 3 The mothers' experience of parenting as being full of contradiction**

The theme of contradictory parenting was expressed by the majority of mothers, as questioning their ability to adequately act as a role model while having a double standard for themselves and their children. The exposure of these conflicts left many participants asking the rhetorical question, 'how can I tell my children what to do if I can't do it myself?' This is best illustrated by the juxtapositions the mothers use to describe the contradictory nature of feeding themselves versus feeding their children. Emma spoke of feeding herself as "hell", while the experience of feeding her children was "pleasing": She made sense of this stark contrast by explaining that "I could live through my denial by feeding other people" (10.51, 8.22, 8.8). Beth also described her experience of this disparity when she spoke about a mealtime with her children:

> "…for the children it's a moment of pleasure, for me it's a
> moment of torture" (6.12).

She went on to describe food as her "poison", further illustrating the divergent experiences of mother and child (6.13). The two sub-themes are represented by the mothers' concern that her difficulties deem her an unsuitable role model for her children, and the exploration of the double standard inherent in the 'do as I say, not as I do' approach to parenting.

### 3.5.1 Questioning her right to be a role model

This sub-theme was most apparent in the mothers' concern that the presence of their eating disorder somehow nullified their 'right' to parent their children, as well as brought into question their suitability as a role model. Amy explained:

> "I've come to think that I can't or shouldn't comment on anything they eat because my relationship with food is so wrong" (2.38).

Amy is exploring if her disordered relationship with food implies that she is incapable of being involved in that aspect of parenting her children. The impact of this exploration could result in her removing herself from this parental domain; Amy potentially experiences herself as a not 'good enough' mother, in this regard. She went on to describe how her eating disorder has taken away her 'right' to enforce rules and structure around her children's eating. For Amy and many of the other mothers, their struggle with food has meant that they feel not only less able, but also less entitled to parent this portion of their children's lives.

Both Hope and Farrah spoke about what it was like to be a role model for their children while being acutely aware of their disordered thoughts and behaviours. Hope described her feeling of being inextricably linked to her children and the inevitable impact her illness would have on them. She explained:

"I didn't want to get better just for my daughter, but I did, really, because, I mean, what good am I to her if I'm, you know, ill?" (10.41).

This rhetorical question illuminates the mothers' concerns of how they can simultaneously be both eating disordered and a parent. Can these two states coexist? And if so, what are the ramifications for the children? Farrah brought this to light when she spoke about her difficulty in differentiating between her child's normal toddler behaviour and her mimicking eating disorder pathology. She explained:

"Sometimes she won't have breakfast and then it'll get to lunchtime and she says that she doesn't want something…and I'm thinking, is, sometimes it's hard for me to think, it that just normal toddler behaviour or is that because she's seeing me, and she's starting copying some of my things, like being a bit picky with food, or wanting too much chocolate because I'll have binges" (4.1).

Farrah was questioning how much of her own behaviour is being copied by her child. The complication of being a parental role model whilst having an eating disorder is that the children inevitably have contact with both positive and negative behaviours. Clearly this is true for all parents, as no one is a perfect role model, however, the additional obstacle of a dominating eating disorder leaves the mothers' questioning the influence of this over their children. Once again, the potential consequences of this are the mother feeling deskilled, and unable to provide confident care to their child.

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### 3.5.2 Double standard, 'Do as I say, not as I do'

Many of the mothers managed the conflict between the drive to be a role model for their children and the power of the eating disorder by adopting a 'do as I say, not as I do' approach to parenting. The prevailing coping mechanism was explained by both implicitly and explicitly differentiating their disordered behaviour from how they feed their children. The mothers readily expressed a knowledge and dedication to providing balanced nutrition for their children. The majority of participants mentioned phrases such as, "I know what's right and wrong eating" (Farrah, 4.40), "balanced meals" (Amy, 3.30), "healthy eating" (Gail, 5.13), "I know what nutrition they need" (Beth, 5.37), when referring to feeding their children. However, this knowledge of, and dedication to, nutrition did not extended beyond the children, as many of the mothers acknowledged the contradiction between what they are able to provide for their children versus themselves. This was where the, 'do as I say, not as I do' motto comes into play, as the children were often not provided with a sound dietary role model, but rather a set of instructions. Gail recounts:

> "I try to say that, you know, they're growing, they need to eat lots, so of course I'm contradicting myself because when I'm bad and I'm going, no you don't need to eat anymore, oh, contradiction, um, but oh, I don't know, I guess I try to put them straight with what you know to be true, not what you feel is true" (7.37).

Gail reflects on the fact that she cannot trust her feelings about food but rather must rely on what she 'know[s] to be true'. The contradiction she refers to is the discrepancy

between what she considers to be acceptable for herself and what is acceptable for her children. She must rely on the hope that her children will listen to her advice, rather than follow her example. Deb further illustrates this when she says:

> "…oh I don't eat properly, I don't eat, er, very often…I don't have breakfast, you know, and yet I tell the children they've got to have the breakfast, it's the best meal of the day. So really I'm not practicing what I preach, as such, and I do feel hypocritical and I do feel I've got no come back if they do start arguing back…I don't think I'd have a leg to stand on really" (7.1).

This illustrates the conflict inherent in maintaining a parental stance, while living a double standard. Deb recognizes the fact that if her children were to challenge her authority on the subject, her only retort would be a 'do as I say, not as I do' type of response, which does not seem to carry the same weight as modelled behaviour.

Many of the mothers then went on to explore how they make sense of this double standard and the feelings of contradiction and conflict that it promotes. Farrah expresses this struggle when she says:

> "Feeding her, I like it, I enjoy it, I like the fact that I've made something nice, because of her, she's eaten well, she's got good, you know its good food going into her giving her energy, making her healthy, but feeding myself is, I don't know really, I just, it's all negative, it's not very nice, it's just, I don't know, feeding her is easier because I'm, I can feed her healthy things, where I find that harder to do to myself, to be nice to myself" (7.36).

Here Farrah addressed the source of the discrepancy, in that she is able to provide nice food and all that that represents (perhaps love, nurturing, care) to her child, but struggles to allow herself that same psychical and emotional nourishment. Deb echoes this same conflict when she explores the different value she attributes to herself and her children. In speaking of her children she says:

> "…they're far more important and if I've got, they have the best of everything and I will get the leftovers or the crap" (7.29).

She went on to say:

> "…they're allowed to eat properly, I'm not allowed to eat properly" (7.35).

This set of statements seemed to cut to the heart of the issue; by categorically differentiating mother and child qualitatively, it became more acceptable for the mothers to live the double standard. I was moved by Deb's emotional candour and ability to so succinctly verbalize her experience of self-worth. She was able to openly articulate her feelings of inferiority. This conceptualization seemed to allow Deb to attend to the needs of her children while neglecting her own. Hope spoke directly to this self-neglect:

> "…it's just totally, totally not consistent, and it, I think the other thing is that, I mean, food kind of is love, isn't it? And, and I, I it's, it would be inconceivable that I wouldn't provide that care to my kids" (9.33).

Hope's use of language struck me as vital to understanding her experience more accurately. Her questioning, 'food is kind of love, isn't it?' left me wondering if she had ever experienced food as love. Additionally, Hope seemed to imply that giving that 'love' to her children was inexorable: I found myself asking, 'Does Hope not love herself?'. Though it is inconceivable to Hope that she would not provide love in all its forms for her children, it is implied that not providing that care for herself is somehow more acceptable.

## 3.6 Superordinate theme 4 Fear of transgenerational transmission of the eating disorder

Many of the mothers spoke of their determination not to pass on their eating disorder to their children. Recognizing both the genetic and observational components of transmission, all of the mothers voiced their concerns that they would inevitably be unable to provide a firm enough partition between their eating disorder and their children. This worry took many forms amongst the participants; from the fear of their children's genetic predisposition to them observing their children mirroring their dysfunctional behaviour. Claire spoke about her fear that her habits and behaviours would 'rub off' on her children. Claire, whose daughter was also diagnosed with an eating disorder, described this phenomenon:

> "I think one of the worries is…your habits do unfortunately…rub off on them" (13.26).

She went on to reflect on the potential impact this had on her daughter when she says:

> "Which is the worst, which if I had my way again, I would change absolutely everything and I would never let my daughter get to the, never, if I had known my daughter was going to get the way she was, I would've changed everything" (13.29).

Claire clearly takes some responsibility for her daughter's development of her disordered eating: her fear of transmission realized. Claire draws a link between her daughter's current presentation and her exposure to Claire's own negative relationship with food, shape and weight. The power of her phrasing, 'I would've changed everything' is reflective of the regret she harbours over the interaction between her child and her eating disorder, and the potential transmission it facilitated. Farrah reflected on the messages that she is giving her children about food and mealtimes, both consciously and subconsciously. She explained:

> "…if I don't eat with her then she sits there and eats on her own and then that's not giving her the right message, she's learning to eat by herself, for the sake of the eating disorder (2.8).

Farrah's reflection that the consequence of her child having to eat on her own is the fault of the eating disorder is profound, as it seems to imply that Farrah is conscious of the eating disorder dominating her parental instinct in this scenario. Deb spoke of her determination not to pass on her negative feeling about food onto her children. She recognized that her conscientiousness is not enough to hide her eating disorder from her children when she says:

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"…the children are not silly, and even my nine year old,
she's aware" (2.12).

The majority of participants expressed feelings of guilt and regret that their children had been exposed to their illness, and more vitally, that this could potentially impact on their development. Deb went on to speak about her own experience of transgenerational transmission, when she reflected on her childhood with a mother who had an eating disorder. This situation was not unique amongst the mothers, three of whom specifically mentioned that they thought their own mothers, fathers or grandparents had disordered relationships with food. The participants' experience of the fear of transgenerational transmission of their eating disorder to their children was expressed in two primary veins; the first being the mothers' experience of how aware her children are of her disorder and the second, the mothers' observing the impact that her eating disorder has had on her children.

### 3.6.1 Children's awareness of the eating disorder

The majority of participants acknowledged their children's' awareness of their eating disorder and the potential ramifications of this perception. Even the mothers of toddlers noted their children mimicking their disordered behaviour, while the mothers of older children experienced more direct evidence of their awareness in the form of probing questions, scolding and preoccupations with food, weight and shape. The most common evidence of the children's' awareness, was their praise and encouragement the mothers received from their children when observed eating. Additionally, this seemed to indicate

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that the child was in touch with their mother's distress. Emma addressed the culture of diet and preoccupation with food that existed within her immediate and extended family. She reflected:

> "I live in a family with five people constantly watching what they eat, constantly talking about it, almost feeling guilty about over eating that's very, very difficult when you're on the other spectrum" (3.34).

For Emma, her primary concern was to help her children cope with their difficult relationships with food: When speaking of her husband, she said:

> "He says all of them have an issue because of me" (15.1).

Though Emma did not verbally express the impact that this statement had on her, her tone of voice and facial expression indicated a sense of resignation: This prompted me to wonder how she copes with the inevitable weight of this acceptance. Amy described her children's' awareness of her eating disorder as them being understanding and tolerant of her ongoing battle to eat. She explained:

> "If I've snapped I'll say, look you know, I'm really sorry. I know, you know it's because I'm finding it really hard to eat at the moment and they say yeah, it's ok" (2.26).

Again, the seeming acceptance or resignation to their mother's behaviour illustrates the deep integration the eating disorder has had into the family dynamic. The way Amy described it, I imagined an additional person, 'eating disorder', sat at the dining table.

Amy was also the only mother to comment of her children's awareness of the physical manifestation of her eating disorder. She recalled:

> "…they ask me why I'm so thin…why you aren't strong anymore. I don't get undressed in front of them anymore" (3.9).

Amy adapted to her children's' awareness by adjusting her behaviour; in this case, not allowing them to see her body. This prompted me to consider the numerous and possibly extensive lengths the mothers go to prevent their eating disorder from having contact with their children, and potentially, the amount of parenting that is lost in this avoidance. Clearly, the children express their awareness of the eating disorder in different ways, though it is hard to imagine that something with such a large presence could go unnoticed within the home. One mother was adamant that her children were both unaware and unaffected by her eating disorder. Though her perspective was unique amongst the participants, I felt it important to express the entire spectrum of the mothers' experiences. Beth spoke about her children being "unaware of mummy not eating", and that her difficulties are "not noticeable" to her children (1.21, 1.36). Beth goes on to say that her family is "used to" her eating habits, alluding to the possibility that her eating disorder has been accepted as normative behaviour within her home. A subtle but important distinction is that the acceptance of her behaviour as the norm, is not indicative of the children being unaware that the behaviour is dysfunctional. It became clear through the interview with Beth, that she had a unique way of conceptualizing her triad of the interaction between parenting, the eating disorder and her children. She used very cognitive language, speaking about teaching her children the "benefits and the

disadvantages" of eating, "arming them with information" and helping them to make an "informed decision", pertaining to their development of disordered or non-disordered eating habits (3.12, 3.17, 3.25). Beth went on to speak about the primary source of weight and shape conversations in the home being from the media or from school, both external to her. At one point in the interview Beth shared a very powerful insight when she said:

> "The children…if they weren't there I don't think I'd be
> where I am today, and I don't think there would have been
> anything to stop me taking my life" (6.42).

Though Beth spent much of the interview trying to keep her children and her eating disorder very separate from one another, in this moment, the impact become clear when she reflected on the fact that her love for her children was the only thing in her life that was stronger than her eating disorder. Clearly, being a mother with an eating disorder is complex on many levels, as is indicated by the various methods of coping employed by the mothers to manage the coexistence of two needy entities, their eating disorder and their children.

One participant, Claire, had a very different experience to many of the other mothers, as she currently had a teenage daughter who was very unwell with an eating disorder herself. Her experience provided another unique insight into what can happen when the mothers' fears of transmission come to life. She spoke of the guilt and responsibility she feels:

"…there's a big portion of it that's genetically linked, um so I feel incredibly guilty" (8.5).

She goes on to explore how this guilt became magnified as the carer for her daughter, she was responsible for enforcing her dietary requirements, often making her daughter eat things that she actively avoids within her own eating disorder. She recalled:

"…it's soul destroying…that was horrendous having to sit with her and make her eat these foods, that was really hard knowing that you couldn't really eat them yourself" (15.15).

Claire went on to speak about her feeling that she does not have the will power to push herself into recovery, yet she has been able to manage her daughter's weight restoration. This is a powerful illustration of the strength and determination of an eating disorder, that even her daughter's deterioration into her same condition did not facilitate her recovery. She acknowledged the potential transgenerational transmission that occurred:

"I think my daughter developing an eating disorder was partly my fault…when they were younger…we never sat down enough as a family when they were younger and she never saw me eat enough in front of her and maybe I do have, wasn't a good, good body image…maybe I never explained enough to her" (22.19).

Claire's account is rife with feelings of regret and remorse: She feels a causal link exists between her and her daughter's disorders.

### 3.6.2 Impact of the eating disorder on the children

The transgenerational transmission of eating disorders is a topic that many of the mothers found difficult to address, as feelings of guilt and remorse were prevalent, particularly when the mothers recognized their own disordered behaviours being mirrored by their children. The mothers expressed a palpable fear that they were potentially responsible for this developmental spanner in their children's growth. For many of the mothers, this specific topic was particularly emotive and revealing of the deep impact that their eating disorder has had on their children. Amy recounted numerous instances where her children seemingly acted out her pathology. She recalled:

> "…this morning he had three Weetabix for breakfast. And he said, oh, I'm going to get strong. I'm going to be really strong and then he put the wrong school trousers on that were too tight. And then he was like, oh no, I've eaten too much. I've been eating too much. I'm getting fat" (2.32).

The child's immediate use of the word 'fat' and the absence of more child friendly language, such as 'growing' or 'bigger', perhaps are reflective of the language that he hears more frequently in the home. Amy provides another account of her other child:

> "…when my scales were in the bathroom he used to weigh himself and then he started saying things like, oh I weighed myself before breakfast. Now I've had breakfast I'm going to weigh myself again and see if I'm the same weight" (8.6).

Amy described this experience as "horrendous" and recognized the behaviour as her own (8.11). These two examples of the children's behaviour are not, in isolation, worrying. However, it is an awareness of the environment in which they are occurring that lends itself to the interpretation that the mothers' behaviour is directly impacting the children's view of food, shape and weight.

Emma directly addressed her concerns about transmitting her eating disorder to her children. She acknowledged both the nature and nurture elements:

> "I'm very aware of the fact that they say eating disorders
> can run in families and if anyone of a child is going to get
> an eating disorder, and I'm sure one of my children will,
> not only because they've witnessed me but because
> they've got this genetic background" (11.29).

She went on to talk about her worry for their future, as she is intimate with the difficulties inherent in a life with an eating disorder.

Farrah expressed her concern that by copying her behaviour, her child would come to think that is normal, and adopt her mother's attitudes as her own. She said:

> "My overall concern is that she's going to end up with the
> same sort of problems as me, simply because she's seen it
> or copied me" (5.17)

Farrah went on to give the example:

> "she sees me eating a lot of junk, like chocolate, things like, and crisps, then she wants it, and I can't hardly say to her, I'm going to have a packet of crisps but you're not allowed…and there are times when I've realized I'm giving her too much chocolate in the day, just because I want to" (3.1).

Farrah expressed her fear of transmission through learned behaviour. She seemed to be including her child in her binge behaviour, to an extent, allowing both the eating disorder and the child to coexist while not forcing Farrah to choose one over the other.

Gail too, described her battle to keep her food attitudes from impacting her children. She reported:

> "I am aware of things I say, that my children mirror, now, because obviously there's things I won't eat, or um, certain attitudes obviously I have that I should keep to myself maybe, more" (2.10).

Gail seems to be struggling to limit the impact that her behaviour has on her children. Throughout the interview, she repeated the phrase:

> "I just don't want them to be like me" (3.30, 8.7).

Gail's worry was not unfounded, as her children's primary care giver, her fear of transmission was based on the recognition of her eating disordered behaviours in her children. She recalled:

> "…if I've had chocolate or something, which, you know,
> its ok, um, I'll comment on it maybe, like, no I don't, I
> don't want anymore, I don't need that, and my daughter, I
> mean she's 12, has, every now and again shell say, oh,
> I've been eating too much chocolate lately" (2.17).

Though the phrasing is different, the content seems to be the same, from mother to daughter. She goes on to describe another scenario with her young son:

> "…my son at the moment, he keeps saying, am I, am I
> fat…so I said no, you've got to put on a little bit of weight
> to grow taller…I think, why are you saying that, you're
> nine, why are you worrying that, you know, you're fat"
> (7.40).

Gail's anxiety regarding her children's behaviours and cognitions surrounding food, shape and weight were shared by many of the mothers. The most prevalent cause for concern was when the mothers recognized their own eating disordered pathology being acted out by their children; this invited the question, am I giving my children my eating disorder?

Hope addressed the concept of transgenerational transmission, as she experienced it in her family. She explained:

> "I know people say there is a genetic component, I think
> there probably may be a genetic component, but I think a
> lot of it is the observational this is what Mum does, and
> it's very common for it to go down in families, and you
> know, and, in fact I think my granny probably had some
> kind of eating disorder. My parents were very weird about
> food" (5.31).

When reflecting on her children's relationship with food, she commented that she felt that their anxiety level was high, most likely related to the fact that her own anxiety regarding food, shape and weight was likely higher than average. Hope, like the majority of the mothers, was fearful of the negative impact that her disorder had on her children. I had the sense that she was not exaggerating when she spoke about the possibility of her children developing an eating disorder in their future as "her worst nightmare" (5.25).

### 3.7 Summary

This chapter has presented the interpretive phenomenological analysis of the transcribed interviews of eight mothers with eating disorders. When prompted to speak about their experiences of feeding their children, the above data emerged, revealing both shared and divergent understandings of this phenomenon amongst the participants. The overarching theme of 'conflict between the eating disorder and the role of parenting' was consistently present amongst all participants and provided a backdrop, against which the rest of the content developed. Within the context of the overarching theme, four super-ordinate themes of guilt regarding the interaction of the eating disorder and the children; either extremely rigid or none existent boundaries between the eating disorder, the mother and the child; contradictory parenting regarding the ability to act as a role model while having a double standard; and the fear of transgenerational transmission of the eating disorder, further illustrate the participants' more nuanced understanding of their experiences. The data painted a rich and dynamic picture of the mothers' experiences, rife with conflict

and complexities. The participants expressed their difficulty in keeping their eating

disorder separate from their children, and addressed the perils of their coexistence.

# 4.0 Discussion Chapter

## 4.1 Introduction

The content of this chapter is structured to give the reader a sense of the analysis within the wider context of the literature surrounding the topic at hand and the field of counselling psychology. I will start with an overview of my analysis in relation to the research aim, outlining a tentative model of the interaction between the overarching and superordinate themes. I will explore their relationship to one another and to the broader body of literature, illustrating how the themes express the participants' experience as understood through the analysis. The next section will describe the contributions of this research to the field of counselling psychology, looking at theory, research and practice: The strengths and limitations of this study will be highlighted. Finally, a few directions for future research are identified, and concluding notes and reflections presented.

## 4.2 Discussion of analysis in context

The primary aim for this research was to illuminate the mothers' experience of feeding her child whilst having an eating disorder. More specifically, the research promoted an exploration into the meaning of the fundamental parenting activity of feeding a child for an individual who experiences a difficult relationship with food, shape and weight themselves. In an attempt to understand this phenomenon from a first person perspective, the participants engaged in a process of reflection and guided self-exploration during the

interview. The analysis endeavoured to capture this journey of discovery and bring it to light.

### 4.2.1 Model of themes

The overarching theme of 'conflict between the eating disorder and the role of parenting' was expressed unanimously among participants through varying language, experience and metaphor. Please re-refer to the diagram in the analysis chapter to refresh the conceptualization of the interrelational elements of the eating disorder, the mother and child that is encapsulated within this theme.

As explored in detail within the analysis, the four superordinate themes of mothers' guilt surrounding the interaction of the eating disorder and the children, unclear boundaries among the 3 axes (eating disorder, mother and child), the mothers' experience of parenting as being full of contradiction, and the fear of transgenerational transmission of the eating disorder, distinctly illuminate the participants' experience of the overarching theme. As to avoid a repetition of the analysis chapter, the results will not be explored further here, but rather discussed relationally to one another, to the body of eating disorder literature at large and to the field of counselling psychology.

### 4.2.2 Relationship of themes to one another

The four superordinate themes represent the most prevalent participant expressions of the overarching conflict.  In this sense, the 'conflict between the eating disorder and the role of parenting', acts as a background noise to the mothers' specific experiences. The

individual notes of guilt, diffuse boundaries, contradiction and fear were heard by allowing the space for the mothers' safe exploration. These themes derived from the overarching theme in that the defining conflict between the eating disorder, the mother and the child, was present individually within each superordinate theme. Specifically, the first superordinate theme of 'the mothers' guilt surrounding the interaction of the eating disorder and the children' reflects the conflict in the form of the mother's guilt that her children are being exposed to her dysfunctional relationship with food, shape and weight. Next, the 'unclear boundaries among the 3 axes', illustrates the conflict by illuminating the tendency towards indistinct roles and ambiguous distinctions between the eating disorder, the mother and the child. Third, 'the mothers' experience of parenting as being full of contradiction', exemplifies the overarching conflict in that participants expressed an ongoing struggle between the desire of the eating disorder and the needs of their child. And finally, 'the fear of transgenerational transmission of the eating disorder', is perhaps a reduction of the overarching conflict into the mothers' most feared conclusion, that their illness would have a lasting and grievous impact on their child's wellbeing

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┌─────────────────────┐
│  Conflict between the│
│  eating disorder and │
│   the role of        │
│     parenting        │
└─────────────────────┘
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| The mothers' guilt surounding the interaction of the eating disorder and the children | Unclear boundaries among the 3 axes (eating disorder, mother and child) | The mothers' experience of parenting as being full of contradiction | Fear of transgenerational transmission of the eating disorder |
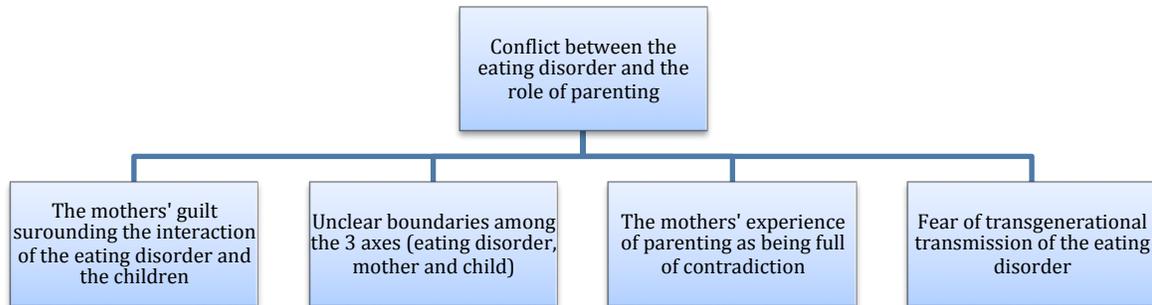
Figure 2. Relationship between themes

## 4.3 Within theory and literature

The following discussion will synthesize the primary findings of this research with current theory. As mentioned previously, the majority of studies looking into this phenomenon have explored the impact of parental eating disorders on their children, with a distinct focus on the quantitative relationship between the maternal eating disorder and child development, birth weight and feeding logistics (Stitt & Rupert, 2014). The mother's subjective experience has been extensively neglected in previous investigations. However, both qualitative and quantitative research examining parenting with an eating disorder has built a firm foundation on which current studies can scaffold, fill in gaps and elaborate, to construct a more comprehensive structure.

### 4.3.1 Overarching Conflict

Many studies have ventured to identify the range of specific difficulties that mothers with eating disorders face within their parental role. A common thread in this investigation is the mothers' internal struggle between the needs of their child and the voice of their disorder (Agras, Hammer & McNicoles, 1999; Stein et al., 1994; Park, Senior & Stein, 2003). Mothers with eating disorders were observed to be less facilitating and more intrusive in both mealtimes and play with their children (Stein et al., 1994). Additionally, the index group expressed more negative emotion during mealtimes, but not during play, while mealtimes were characterized by conflict between mother and child (Stein et al., 1994). This identifies mealtimes as a special interaction that triggers an adverse emotional display from mothers with historic or current eating disorders. The behaviour typologies described by Stein et al. are distinguished by an underlying conflict between the needs of the child and the mother's eating disorder. These findings have been replicated and used widely to support the claim that mothers with eating disorders have a special need for parenting support. The conflict described by Stein et al. in 1994, and others since, can be interpreted as the mother's preoccupation with her own food, shape and weight as interfering with her ability to detect and meet the needs of her child. This thread weaved its way through the current study, with all eight participants referring to their experience of this conflict. The mothers' struggle between her eating disorder and her duties as a parent was described by one participant as a war within her head, between the voice of her eating disorder and her desire to mother her children.

In 2014, Stitt and Rupert produced a qualitative investigation of the challenges of parenting as a mother with an eating disorder. This study looked broadly at the many aspects of parenting, while the current study focused in on the primary act of feeding. Interestingly, the emergent themes from both studies share many commonalities: Although the current investigation was aimed towards the specific phenomenon of feeding, the participants unanimously used the interview space to speak more broadly to the complex infiltration of the eating disorder into all aspects of their experience of parenting. This lends itself to the interpretation that for these individuals, the experience of feeding your child perhaps acts as a stage where the various obstacles of parenting with a psychological disorder are acted out. As the index group was composed of mothers with eating disorders, the most poignant microcosm for the expressed challenges to reveal themselves was around the dinner table. Furthermore, Stitt and Rupert's study may have indirectly alluded to the maternal conflict between the needs of the child and the voice of the eating disorder when they identified the two themes of 'food comes before anything' and 'there would be no world without them' (referring to their children) (2014). Though seemingly paradoxical, the prevalence of both of these theme is representative of the struggle between the part of the mother that is motivated by parenting her children and the part that is ruled by her dysfunctional relationship with food.

With that in mind, the mothers simultaneously employed a profound pragmatism in their general ability to identify their parental deficits and develop resources to assist them in meeting their children's needs. Stapleton et al. spoke about the mothers' sourcing formal childcare to potentially reduce the burden of maternal feeding as well as exposing the

children to alternative food role models (Stapleton, Fielder & Kirkham, 2008). Similarly, the current research identified a comparable resourcefulness, with the majority of participants both recognizing their limitations and engaging their partners and extended family members in parental support.

In 2014, Stitt and Rupert interviewed nine mothers and identified six major themes, many of which map onto the primary finding of the current investigation. Each will be explored further as part of the superordinate theme discussions below. The Stitt and Rupert study was published and brought to my attention after the completion of my data analysis; and thus acts to corroborate our shared findings (2014). The salient overlap of our thematic content points towards validation that these expressed difficulties are indeed the primary obstacles faced by the index population when it comes to parenting and more specifically, feeding their children as a mother with an eating disorder.

### 4.3.2 Guilt surrounding interaction

Guilt was a common theme elicited in research examining the effect of maternal eating disorders on the ability to parent and the impact that their disorder has on her children (Micali et al., 2011; Barnett, Buckroyd & Windle, 2005). This was also true within the current research, as the majority of participants expressed a feeling of guilt that their eating disorder was affecting the wellbeing of their child on various levels. In 2008 Koubaa et al. used the MAMA to evaluate maternal adjustment and attitude of a cohort of mothers with eating disorders. They found that their index population responded

affirmatively more frequently when asked if they regretted having their baby and replied negatively more frequently when asked if they enjoyed feeding their baby. In accordance to the sample within the current study, such responses were guilt inducing for the mother, who identified her maternal adjustment as 'abnormal' or 'not right'. Such self-depreciation may lead to feelings of parental inadequacy and disengagement. This is evidenced both by the current study, as well as Rortveit et al. 2009 research. They found that the daily experiences of a mother with an eating disorder were partially characterized by a sense of not being an adequate parent and the guilt that this feeling evokes. This guilt was prevalent throughout the analysis, linked both to a sense of deficiency, in terms of what they are unable to provide as a mother with an eating disorder, as well as supplementary, pertaining to the added influence of the eating disorder in the parental dynamic.

Park, Senior and Stein's 2003 literature review identified five mechanisms that underlie the transmission of disturbed eating patterns from parent to child, all of which presented within the analysis of the current study. The genetic influence, parental eating psychopathology, impaired general parental functioning, the element of learnt behaviour and the prevalence of familial and marital discord were all aspects that the index group recognized as sources of their guilt, as related to the potential for adverse effects on their child's development. The mothers described their children's inevitable exposure to their eating disorder behaviour as guilt inducing, most commonly expressed as the subpar parenting that they were inflicting upon their children as a result of their eating disorder psychopathology.

### 4.3.3 Boundaries

'Unclear boundaries between the eating disorder, the mother and child' was the second superordinate theme that emerged from the analysis. The majority of participants in the current study described either enmeshed or rigid boundaries as a means of managing the interaction between the three moving parts. Additionally, role reversals between mother and child were prevalent bidirectionally with the child parenting the mother as well as the mother experiencing infantilisation. Variations of this theme were present throughout the pertinent literature (Franzen & Gerlinghoff, 1997)

More broadly speaking, Ackerson reported that boundary issues are prevalent among parents with mental illness, with mothers describing a desire to make up for their disorder by being lax and having overly close relationships with their children (2003). Both enmeshment and permissive boundaries were consistently unearthed among participants of the current study. Additionally, a portion of the sample spoke about their use of structure and rigidity as a means of compensating for the above mentioned tendency towards extreme leniency.

Data suggests that that 15% of mothers with bulimia nervosa restricted the caloric intake of their child intentionally during their infancy, while another study found that mothers with eating disorders had a tendency to feed their children more irregularly and use food for non-nutritive purposes (Lacey & Smith, 1987; Agras, Hammer & Smith, 1999). The implications of these statistics could suggest that the maternal boundaries between the

mother and child are porous, in that her disordered relationship with food often seems to seep through to impact the child. This was evident in the current study, as a portion of participants described a fixation on their child's healthy diet, balanced nutrition and monitored intake, potentially exceeding the expected parental intensity and leaning towards a manifestation of their eating disordered behaviour. On the other hand, other participants described an effort to counter balance their own desire to control food by promoting a free-for-all attitude towards their child's eating. Perhaps regardless of the direction, both sets of boundaries are expressions of the mothers difficult relationship with food and her desire to 'get it right' for her child.

The theme of the presence of unclear boundaries between the mother, her eating disorder and her child, is further confirmed by additional research: Increased rigidity at mealtimes (Evans & Le Grange, 1995) and managing their children's intake for fear of them overeating (Russell et al., 1998) are both clear examples of problematic boundaries allowing the maternal eating disorder to be acted out on her children. Franzen and Gerlinghoff identified three mother-child patterns of relating when an eating disorder is present within the mother-child dyad: The first is a relationship characterized by being overprotective and enmeshed; the second, a role reversal, where the child parented their mother; and the third, the mother presents as emotionally controlled and distant towards their child (Franzen & Gerlinghoff, 1997). These relational models can be interpreted as samples of varying boundary discrepancies between the mother, child and eating disorder. Each of the typologies described above was present in the current study.

Park, Senior and Stein's 2003 literature review discussed the potential mechanisms that underlie the transmission of disturbed eating patterns from parent to child. Their second mechanism explored the potential for the parental eating psychopathology to directly impact the child, and gave the example that if the parent wishes their child to be thinner, they may in turn withhold food from them, as they do for themselves. Though none of the participants in the current study reported to actually withholding food from their child (though some mentioned a desire to), this illustrates the fused boundaries that may occur, with the mother struggling to insulate her thoughts, feelings and behaviours as they relate to food shape and weight.

### 4.3.4 Parenting as contradictory

The third superordinate theme of contradictory parenting was characterized in the analysis by the acknowledgement of a double standard. The majority of mothers questioned their ability and right to enforce guidelines on their children that they themselves cannot abide. This was most clearly demonstrated by the mothers who spoke about providing balanced meals for their children, while they binged and purged, or feeding their kids regularly, while they were not allowed by their eating disorder to eat until 8pm. Such contradiction left the mothers questioning their parental authority and aptitude.

The contradiction experienced by the mothers was described as a general instability in their parental role, undermined by their eating disorder. They expressed a sense of

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feebleness with regards to providing a theoretical and practical model of a good enough food relationship for their children. Park, Senior and Stein's 2003 literature review found that a key mechanism in a child's development of disturbed eating is the element of learnt behaviour. As parents are most often their child's primary paradigm, the index population may inadvertently act as dysfunctional role models for their children pertaining to eating behaviours and attitudes. In the current study, the mothers discussed their methods of trying to nullify this effect by either hiding their eating disorder or overtly offering the contradiction to their children, do as I say, not as I do'. Further research would be necessary to explore how or if the children perceive this contradictive parenting. The current research identified a level of discomfort and ineffectuality that the mothers experienced when providing this type of care.

### 4.3.5 Fear of transgenerational transmission

The literature suggests that a relationship exists between maternal eating disorders and adolescent disordered eating (Field et al., 2008; Pike & Rodin, 1991), and that maternal eating disorders are associated with childhood eating problems (Micali, Simonoff & Treasure, 2009; Stein et al., 1994). This supports the notion that eating disorders tend to aggregate in families (Park, Senior & Stein, 2003). Often based on learned behaviour, case studies have indicated that from an early age, children mirror their mother's eating disordered behaviour, and that the daughters of anorexic mothers wish to be as thin as their exemplar as well as imitate their attitude towards food (Franzen & Gerlinghoff, 1997; Timimi & Robinson 1996).

In the current study, the mothers' fear of this type of transmission was expressed unanimously. Bryant-Waugh et al. identified this theme in their 2007 analysis as the mothers' concern that they would pass on traits of their disorder to their offspring. Similarly, Stitt and Rupert's 2014 qualitative investigation identified the themes of 'impact of the eating disorder on the children' and 'modelling of disturbed eating behaviours'. In combination and perhaps at the root of these concerns lies the fear of transmission; that their eating disorder will negatively impact their child's development of a healthy relationship with food, shape and weight, and that this could in part be due to their modelling of disordered eating. In the current study, all of the mothers spoke of their fear of passing of elements of their eating disorder to their children. This trepidation took many forms amongst the participants as well as in other studies: The primary consistency throughout the literature and including the current study was the extreme effort that mothers exerted in an attempt to keep their dysfunctional behaviour from negatively impacting the development of their children.

The current study identified two sub themes that were scarce in the literature. These unique findings may offer a novel vantage point from which to approach treatment with this population. The majority of the sample in the current study directly spoke about their identity in relationship to their eating disorder. This often took the form of a sense of isolation from their family and friends due to the secretive nature of colluding with their illness. The participants described hiding their thoughts, feelings and behaviours from their loved ones in a complicated effort to both protect their family from the disorder as well as protect the disorder from scrutiny and potential destruction by the family. This

isolation left the mothers starved for true intimate contact: They experienced a paradox of wanting to keep the details of their eating disorder a secret while wanting to share the burdensome load. This theme, encompassing both the isolation of her true self and the paradox of her exposure may have a profound impact on the nature and direction of therapeutic input. It seems that the eating disorder often acts as a wall, serving to keep the family a safe distance from the sufferer. A therapeutic intervention that gingerly invites the family to join the mother on her side of the wall may provide a stronger front from which to tackle the eating disorder.

The second novel finding from the current study involves the relationship between multiple eating disorders within one home. This was identified in the participant 'Claire's' experience. Her interview presented as an account of the relationship between her and her daughter's eating disorders. As described in more detail within the analysis, Claire was virtually unable or unwilling to reflect on her experience as a mother with an eating disorder, but rather used the time and space to reflect on being a mother with an eating disorder with a daughter with an eating disorder. Or an alternative interpretation, Claire's experience of being a mother with an eating disorder was encapsulated by simultaneously managing her and her daughter's illness. The content of our interview centred on her experience as a career for her daughter, with little space for Claire's introspection on feelings about her own illness. The daughter's eating disorder was clearly identified as the dominant force within their family home. This dynamic appeared to be a function of the family's coping strategy: The daughter's eating disorder allowed Claire's to thrive in the background, while the daughter potentially identified in her

mother's method of procuring care by being ill, which she adopted as her own. The relationship between the two eating disorders is a potent example, captured in this study, of the systemic nature of the illness. This synthesis provides a unique insight into the power struggle of a parent and child's eating disorder, perhaps indicating a need for family interventions targeting such dynamics.

Family therapy is the number one recommended and evidence based treatment method for child and adolescent eating disorders (NICE, 2004). The development of systemic therapeutic models, such as the Maudsley model, have been created and evidenced as effective interventions to treat anorexia nervosa in adolescents, within a family context (Lock, 2011; Rhodes, 2003). It is widely acknowledged that family therapy is the superlative mode of eating disorder treatment, as compared to individual therapy, for the child and adolescent population (Keel & Haedt, 2008). There is lapse in research exploring the efficiency of family therapy among adults with eating disorders (Bulik, Baucom, Kirby, & Pisetsky, 2011).

The recovery model suggests that treatment within a system of support including family, friends, and professionals promotes meaningful and lasting personal growth. It potentially follows that treating adult eating disorders from a systemic family approach may provide a higher level of support to the client, as well as addressing the prominent relational complications, some of which were explored in this chapter. Previous research has identified that family and other social systems significantly impact an individuals' onset, trajectory and recovery from eating disorders (Linville, Stice, Gau, & O'Neil,

2011).

Numerous theories have evolved to describe the function of eating disorders within a family. Minuchin described the role of eating disorders structurally, as an attempt to promote boundaries between parent and child in a family dynamic defined by enmeshment and poor conflict resolution strategies (Minuchin, Rosman, & Baket, 1978). In addition to a shortage of data on family therapy for adults with eating disorder, limited data exist on therapeutic approaches for couples affected by eating disorders. Bulik et al. (2011) developed a model called Uniting Couples in the treatment of Anorexia Nervosa, or UCAN, which applies a cognitive behavioural couple's therapy (CBCT) model. The primary aim of the treatment is to unite the couple as a team, working towards a shared goal of recovery (Bulik et al.). Though this model is specifically adapted to working with couples, the need for systemic interventions for adults with eating disorders is evidenced. The current study further confirms the complex and multi layered dynamics that are inexorable when an eating disorder infiltrates a family unit. Further research and pilot studies are needed to explore the efficacy of such treatment interventions.

Additionally to treating the family unit as a whole from a systemic perspective, support and therapeutic groups could be developed to better contain the children of these dynamics. As transgenerational transmission remains a clinical obstacle, targeted interventions need to access and asses the family members, specifically the children, whose others are being treated. Lippett and Nolte (2007) write about the importance of parents talking to their children about their mental health difficulties. Exploration of such

topics as what is happening in the family and why, issues of responsibility, role distinction and practical concerns may improve the child's understanding and help them to differentiate their parent's experience from their own. Within a specially developed support group, parents could learn the skills needed to feel confident to have such conversations, while their children could simultaneously be supported by the service in hearing and processing the information.

## 4.4 Contributions to counselling psychology

The inherent value in a first hand, qualitative awareness of the phenomenon in question is twofold: Primarily, the index population has the opportunity to have their experience be heard and attended to in a meaningful and robust way. Secondly, this expression can be transformed into action, addressing the difficulties and needs outlined by the participants, in the form of the development of therapeutic interventions. The translation of research data into practical application lies at the heart of a commitment to the field of counselling psychology. Previous investigations, alongside the current study, have confirmed that mothers with eating disorders are a population with unique and specific treatment needs. By targeting these needs overtly, practitioners may be able to reduce transgenerational transmission by providing an intervention aimed at addressing the impact of an eating disorder on a mother's parental conviction and facility.

In 2005, Barnett, Buckroyd and Windle wrote, "no specific programs as yet exist in the UK targeting ED mothers with the aim of addressing primary prevention for the child"

(p. 2003). At this time, Rachel Bryant-Waugh and her colleagues were in the developmental phase of constructing a group intervention explicitly targeting this treatment deficit. The outcome was a parenting skills and support intervention for mothers with eating disorders and young children. Their focus group identified a set of themes including, the fear of passing traits from mother to child, guidance in food preparation and provision, support regarding the interactions around mealtimes, the mother's food intake, parental expectations, the impact on parent-child relationship and the need for control (Bryant-Waugh et al., 2007). This initial analysis brought to light the most prominent difficulties that these women face. The current research offers support to this trial, as the themes of transmission, mealtime interactions, the parent-child relationship, need for control and food prep/provision were prominent among the participants in this study. This contributes a sense of robust validity, as the thematic recurrence may indicate statistical significance. Following this phase of initial discovery, Bryant-Waugh et al. began piloting a group intervention addressing the above-mentioned themes.

In 2007, they ran an eight-session group intervention across three trials (Bryant-Waugh et al., 2007). Participant feedback indicated that the intervention was valuable to the mothers and had a positive impact on their parenting skills and confidence levels (Bryant-Waugh et al., 2007). The outcome measures indicated a general reduction in parenting concerns and improved depression scores for the participants (Bryant-Waugh et al., 2007). The target population reportedly welcomed this type of intervention, suggesting that such a group has the potential to facilitate meaningful insight and change for mothers

with eating disorders.

More recently, Cristina Runfola et al. created and piloted a group intervention aimed at mothers with histories of eating disorders. The NURTURE (Networking, Uniting, and Reaching out To Upgrade Relationships and Eating) project used the input of focus groups to construct a 16-week intervention. The scheme was delivered via interactive web conference forums and was piloted with 13 mothers. The topics covered included parenting skills, eating and feeding and breaking the cycle of risk. Once again, there is a profound overlap in thematic content between the Bryant-Waugh study, NURTURE, the current research as well as other studies examining the mother's perspective on parenting with an eating disorder (Stitt & Rupert, 2014). The results of the NURTURE project indicated improved maternal efficacy and competence in parenting. The aptness of the above mentioned trials are indicative of both the need and efficacy of such interventions. The literature, along with the current study, signpost the themes discussed as the essential components to target in the specific treatment of mothers with eating disorders. As a scientist-practitioner, the learning gleaned from research paves the road for clinical advancement. The current study clearly supports the literature in the thematic overlap of the mothers' experiences. The two interventions mentioned above used their insight to create treatment protocols to fit the target population's needs. The current study further exemplifies and specifically indicates the difficulties that mothers with eating disorders face surrounding the phenomenon of feeding their child. Whether utilizing group interventions or providing individual therapy, practitioners should hold these prominent themes in mind when providing treatment for mothers with eating disorders. Evidence

suggests that by addressing the parental concerns in these trail interventions, the mothers'
depression, competence and efficacy all showed improvement.

As mentioned previously, there is a tremendous need for future research to investigate the
efficacy for systemic family interventions for adults with eating disorder. Evidence from
the current study, as well as existing literature suggests that the family unit becomes
inevitably entangled with the eating disorder. As Linville et al. described, the family and
other prominent social systems are essential components in the onset, trajectory and
recovery in the life course of an eating disorder (Linville et al., 2011). The value of
family therapy in the treatment of child and adolescent eating disorders hinges on the
systemic nature of the illness itself: The eating disorder did not evolve in a vacuum, nor
should it be treated in a vacuum. Similarly, the mother is a part of a family unit where
both her and the illness exist. Excluding the other members of that unit from the
treatment process seems an illogical and one-dimensional approach to recovery.

The current study aimed to illuminate the specific parental function of feeding your child,
as a mother with an eating disorder. It was discovered that in eliciting the participants'
experience of interest, the mothers were unable to contain the vast overflow of the eating
disorder into all aspects of childrearing and life as a mother. As a counselling
psychologist, all of my clients are a parent, a child or both. This research provides insight
into the experience of being a mother with an eating disorder and maintaining the
parental responsibility of feeding your child. The contribution to the field specifically, is
the thematic identification of the needs expressed by this population, with the aim of

developing further clinical applications to alleviate the maternal distress and child risk. More comprehensively, this research alludes to the maxim of counselling psychology: The individual is inherently valuable and their experience is the catalyst in facilitating effective therapeutic growth. If we listen closely and with clarity, as professionals, we can provide the care that they are asking for.

### 4.5 Evaluation of the Research

As is the nature of qualitative research, often the qualities that are considered to be its strengths as a methodology are often scrutinized as its limitations. Formally assessing the merit of qualitative research remains a contested issue. Whilst proponents do not want to impose qualitative rules on a research structure that's fundamental forte is its adaptability; guidelines for quality control are agreed to be important. In 2000, Professor Lucy Yardley outlined four evaluative criteria of robust qualitative research: "Sensitivity to context", "commitment and rigor", "transparency and coherence" and "impact and importance" (p. 215). These guidelines have been considered within the context of the current study as a measure of efficacy.

The extensive literature review surrounding the index phenomenon and spanning several fields ensured an initial sensitivity to the context. This background knowledge enabled me to engage with the discourse, rhetoric and conceptual material more comprehensively. Furthermore, my work within a specialist NHS eating disorder service has facilitated a clinical context for this study. Within my personal reflection I have aspired to maintain

an awareness of the social context that inevitably exists between the participants and me. Ethical issues have been considered extensively and monitored externally by the NHS ethics committee, to ensure that the current study upheld a high level of sensitivity to the experiences of those taking part.

"Commitment and rigor" refers to in depth engagement with the topic, thorough data collection and methodological competence (Yardley, 2000). Within this study, methodological commitment and rigor is evidenced in the extensive reviewing of literature, and the multifaceted engagement with the index phenomenon in both the interview and analysis phases. Additionally, the data analysis further illustrates commitment and rigor, in the potent lineage connecting the emergent themes from their roots in the participants' texts. My commitment to the wellbeing of the participants is evident in the high professional and ethical standards of the study, while the analysis of the data itself was rigorous and supervised. I met with my research supervisor periodically throughout the analysis process where we examined the evolution of the data from transcripts to themes. This discourse made the process explicit whilst my supervisor provided feedback from an impartial perspective, as her engagement in the topic and with the data was limited within her role.

The notions of transparency and coherence can be evidenced throughout the study. Transparency within the analysis process is illustrated by the overt contextual link between the original transcript, the thematic analysis and the tentative interpretation. Furthermore, I am explicit with my reflexivity, exploring potential biases and

preconceptions openly, as to limit their impact on the quality of the research. The coherence throughout the study is in the sound coupling of theory and methodology. This study is built on the notion that the research aims and questions could only be comprehensively achieved by the application of a qualitative model of analysis.

The impact and importance of this research in the wider world of counselling psychology and eating disorder treatment, has remained a driving force in developing the initial idea for this study into a vital and viable contribution to the field. In part, producing an impactful piece of work serves to commend and thank the participants for the time and courage they dedicated to the project through their participation. The importance of this research is defined by the deficit of both qualitative and quantitative studies of the experience of mothers with eating disorder, giving a coherent voice to a growing population. The impact, hopefully, is that this voice is attended to, and that clinical innovations continue to improve the quality of care that service users and their families in similar positions receive.

### 4.5.1 Limitations of the current study and ideas for future research

A notable limitation of the current research is the small scale of the study. This potentially had multiple implications on the emergent findings, many of which will be discussed below.

For the current study, all of the participants interviewed were being treated for their eating disorder within the same specialist service in the NHS. That being the case,

individuals from other services or trusts may have different experiences, such as having access to parenting support, thus potentially creating a very dissimilar set of data. It may be valuable in the future to explore this phenomenon across treatment settings in order to gain perspective on a wider range of experience. However, it was not the aim of the current study to produce generalizations about mothers with eating disorders across the United Kingdom, but rather to learn about these 8 women's understanding of their experiences.

The current study did not invite fathers with eating disorders to participate in the study. This methodological decision was made based on maintaining homogeneity within the sample, the fact that a smaller percentage of men are affected by eating disorders in the UK than women (approximately 11%), and that currently, mothers are more often the primary caregivers to their children (NICE, 2004). This potentially creates a cause and effect cycle, where the research focus on women with eating disorders serves to further alienate the man's experience from topical awareness and in turn potentially discouraging those men affected to seek treatment as the clinical setting remains female dominated. I suggest that it may be important and valuable to carry out a similar study with male participants. It would be interesting to compare the experiences of fathers and mothers, as well as creating a platform for men with eating disorders to tell their story. A large-scale study across multiple eating disorder services could provide insight into a wider range of experiences and potentially account for these limitations.

As discussed previously, a homogenous sample is an important factor in designing an

effective IPA study (Smith et al., 2009). The sample in the current study was homogenous regarding the shared index phenomenon, feeding your child as a mother with an eating disorder. However the participants were heterogeneous in other ways. First, the age of the participants' children varied from toddler to adult. Regardless of the current life stage of the child, all participants were able to reflect on their role as a parent and the impact that their eating disorder has or had on feeding their child. It is this reflexivity that was of the utmost importance to producing rich data. Additionally, the prospective from various time points throughout the child's development encapsulated a broader range of experience and a realistic picture of the enduring effect the eating disorder has on the parent/child relationship. The second heterogeneity among participants was the combination of mothers with bulimia nervosa and anorexia nervosa among the participants. As was revealed throughout the literature, some discrepancy occurs in parenting and feeding practices between the diagnostic groups. However, in the current study, this difference was not accounted for on two bases: First, as disseminated by Fairburn and Waller, there is strong evidence for a transdiagnostic perspective on eating disorders (Fairburn, 2007; Waller, 2008). This suggests a focus on the core psychopathology that is common between anorexia nervosa and bulimia nervosa, as well as considers the frequent fluctuation for individuals between diagnoses. Additionally, the current research is interested in the common experience of having a dysfunctional relationship with food and not on the nature of the dysfunction itself. A larger scale investigation could group and compare participants based on the age of their children and diagnosis, looking at the evolving variances that take place chronologically as well as potential differences that arise among those experiencing anorexic versus bulimic

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symptoms.

The use of the interview as a tool for data collection was found to be the most appropriate tool for the current study and its research aims. It provided the ideal setting for me to gain access to the participants' lived experience. The outcome of this study in the form of knowledge gained, is an embodiment of my subjective experience of participants' subjective experience. As each interview progressed, I could feel myself and the participant becoming more at ease with one another, allowing the interviewee to be forthcoming with their experience, as well as allowing me to flexibly explore the material presented. In listening back to the recorded interviews, it is clear that a rapport was established, characterized by trust and empathy. This facilitated the rich disclosure that we are privileged to access in the current research. My skills as a counselling psychologist were an asset in building the type of relationship that promoted a sense of safety and genuine interest in the participants' unique experience of the index phenomenon. I consider this to be strength of the current study.

Two pathways for future research have evolved out of the current study. The first involves the generation of evidence on the value and efficacy of supporting of mothers with eating disorders and their children with targeted interventions. Though the mothers themselves seem to be asking for such treatment, the question remains needing further exploration and validation, 'does this approach to treatment improve outcomes for both mother and child?'. Secondly, more research is needed to explore the efficacy of family interventions for adults with eating disorders (as opposed to children and adolescents) in

order to better serve the needs of this population. As evidenced by the systemic approach to eating disorder and the Maudsey Model, family therapy is widely effective in treating eating disorders in young people. Logically, the principals that promote recovery through this treatment model could be applied to a slightly older population. Issues in systemic functioning do not necessarily eradicate themselves when 'adulthood' is achieved, nor do the efficacious elements of the treatment become nullified. It is from this perspective that the value in investigating the efficacy for family therapy for adult eating disorders is promoted. Furthermore, evidence suggests that the impact of parental mental health can be devastating on child development. If that is indeed the case, then a parent's mental health difficulty must be addressed via all of those affected, including the children.

### 4.5.2 Reflections on analysis

As discussed in further detail in the methodology chapter, IPA was used in this study, as this system of enquiry is best suited to the research aims and questions at hand. Furthermore, the type of knowledge I hoped to generate was that characterized by first person insight in to a qualitative experience. Epistemologically, a critical realist perspective enabled me to draw meaning out of the subjective experiences of the participants and situate the data in the 'real' world.

As a methodological procedure, IPA is scrutinized within the field of qualitative research. This ongoing operational inspection gives proponents of IPA the opportunity to address the common challenges raised and pacify the opponents with robust research. Carla

Willig catalogues three major challenges to IPA research (2013), each of which will be retorted in relation to the current study. First, she addresses the perhaps faulty assumption within IPA that language is representationally valid. We assume that language is an appropriate tool for our participants to actually describe their lived experiences. Furthermore, the assumption permeates the researcher as well, presuming that language is a sufficient means of analysis. Perhaps language on its own or in isolation from context is less representationally valid than we assume it to be. However, an interview is more than the exchange of language between two people. Tone, body language, laughter, emotion, are all ways of communicating. Coupled with linguistic content, this creates a more vibrant and perhaps more valid picture of how meaning is extracted from language.

Willig goes on to challenge the reliability of participant reports in terms of the individuals' ability to communicate accurately and fully the rich texture of their experience to the researcher within an interview (2013). Her argument is based on the idea that self-expression requires practice and that without this; the participants may lack the facility to communicate their thoughts, emotions, sensations and perceptions in a comprehensive manner that is true to the vibrancy of their experience. According to Willig this limits the value of IPA where the sophisticated use of language is not available to participants and thus dampening their communication of experience.

I however had a very different experience of the language used in the current study. The participants, ranging in education level, work experience and sociocultural background, painted vivid, emotionally vibrant, detailed and deep pictures of their experiences with

their words: Perhaps not always sophisticated, but real, and this, I argue is where the rich texture of their experience is communicated.

Willig's third challenge to the methodology invites the debate between description and explanation (2013). This phenomenological divergence, she contends, promotes the exploration of *how* we experience phenomenon, but lacks adequate consideration of the *why*. She proposes that in order to move beyond description and into explanation, we must have an awareness of the conditions that perpetuate the index experience.

My experience of exploring an experience within an interview was that a first person account is an ideal insight into both the *how* and the *why* of the phenomenon. Though on the surface of the data lies the description, as Willig suggests, the explanation is just below this plane and was accessible through flexible and creative questioning. This occurred collaboratively, within the interview, as the participant and I not only explored the two dimensional narrative but delved into a third dimensional understanding of the *why*. This was made possible by facilitating an interview space that was safe, collaborative and creative. Additionally, the application of conceptual and theoretical frameworks to the data, take the analysis from a description of the index phenomenon to an understanding that allows the appropriate consideration of clinical implications.

The current study was my first applied contact with IPA. The process of analysis was a surprisingly exciting and organic experience. I was encouraged by the sense of discovery and emergent knowledge. In part, the ease with which this process unfolded may have

been due to my personal epistemological perspective being a natural fit with IPA, specifically on the basis of my humanistic and person centred outlook. The Smith, Flowers and Larkin book acted as a guide to my process of analysis (2009). The analysis became a multisensory experience, drawing connections between themes by physically placing the cut-out words together and listening back to passages to evoke the tone and voice of the speaker. This is evidence of my dedication to arousing themes that were true to my understanding of the content as presented by the participants. I was thorough and exhaustive in both the labelling of themes and identifying quotes that accurately represented the inherent meaning of the data.

### 4.5.3 Reflections on the impact of the researcher research

The use of Langridge's reflexivity interview elicited a deeper understanding of the relationship between myself and the current research (see methodology chapter for further details). One aspect in particular struck me as it presents a relational paradox: My position as both an outsider and an insider in perspective to the participants.

*An outsider*

There are innumerable 'stories' that the participants in the current study may have told themselves about me and my interest in their experience. Perhaps some thought I had a historic or current eating disorder, or that I had children or that I had no direct link to the research topic. Whatever their perception, my position as an outsider to the experience of

feeding your child as a mother with an eating disorder, unavoidably impacted both the data collection and analysis.

At this point I think that it is appropriate to note my appearance as a woman with a relatively average body shape that could be described as slim. Amongst a wide range of possibilities, participants may have felt that I could not understand their experiences of struggling with an eating disorder. Furthermore, as was made overt in the information sheet they received pre interview that this research was part of my doctorate degree in counselling psychology. Again I am conjecturing, but some may have thought that because of my career choice, mental health difficulties do not affect me personally and thus I cannot relate to their exertion.

Within the context of this reflexivity, I have considered the impact that different elements of my appearance could have on the research, including but not limited to shape, age and gender. I reflected on what may have been different had I been a male researcher or distinctly heavy or thin, old or young. The variability is vast and the impact only speculation. Though the alternative can also be argued, I believe that my distance from the phenomenon of interest allowed me to have a genuine curiosity and relatively unbiased perspective that may have been impossible had I had additional prior contact with the subject matter. Not having an eating disorder, historic or present and not having children of my own enabled me to ingest the participants' experiences without applying a filter of my experience.

Paradoxically, in some ways I was an insider amongst the participants, which will have had an impact of the data collection and analysis. As a woman of my age, many of the participants were contemporaries. I have worked for many years as a full time nanny, so have had contact with the maternal duties that were being discussed. These similarities manifested in a sense of comradery or sisterhood-type understanding within the interviews. Many participants used phrases like, "you know what I mean" or "you can imagine". I think that this alludes to a belief in the participant that I have some sort of an insider's perspective of what they are talking about. The consequences of this are twofold: Firstly, the intimacy created by the perception of shared experiences potentially allowed the participants to be more revealing within the interview, exposing emotional and daunting material (and as a trained counselling psychologist, I was prepared to contain this experience for the participants and myself). Secondly, the sense from the participants that I knew what they were talking about could have negatively impacted on the amount and richness of data collected, in that details were omitted as they sensed I already understood their meaning. However, I recognized the use of the above-mentioned phrases by the participants early on and began to take that as a cue to follow up with statements such as, "could you tell me a little more about what that was like for you specifically". Without a doubt, me, as the primary researcher had various impacts on the findings of this study. However, I do not perceive these influences as either positive or negative, but rather as a manifestation of me as an individual producing this specific piece of research. My impact on the data was both inevitable and reflexively considered. I

believe there is more value in my presence among and within the study, adding an authentic dimension, than attempting the impossibility of being absent from it.

## 4.6 Clinical implications

### 4.6.1 Eating disorder services

As far as I am aware at the time of writing this, there are no specifically designed support or treatment groups for mothers with eating disorders or their children in the UK. The evidence presented suggests that this is a viable and potentially valuable intervention pathway. The participants in this study were interested in the research and the meaning of its impending outcomes. They wanted to know if their experiences were shared, how others managed in similar situations and how to better cope with their difficulties. Barnett, Buckroyd and Windle suggest that a mother's awareness of her dysfunctional behaviours (and the reasons behind them) can induce generalized improvement in her eating disorder and parental functioning (2005). By addressing the needs identified by the mothers in the current research and pertinent studies prior, the introduction of specialized group interventions (be it support or therapy based) as an aspect of treatment may induce clinical benefits. If the aim of eating disorder treatment is to reduce risk and minimize the impact of the disorder on the service user, then as practitioners we are obliged to unearth and implement safe, effective and novel pathways towards this goal.

### 4.6.2 Prevention

The current government campaigns for health and fitness, though vastly beneficial are also highly one sided. With the UK having the highest rate of eating disorders in Europe, little is being done on a large scale to tackle the obvious hurdles of thin-promoting media and inducing a culture of a dreaded fear of fatness (Anorexia & Bulimia Care, 2014). Although some campaigns do exist that promote healthy and varied body images, for example Dove's 2003 advertising campaign 'Campaign for real beauty', this move away from the thin-ideal remains in the minority.

Perhaps these socio-political and cultural issues too considerable to tackle here: However, on a smaller scale, prevention, in the form of reducing transgenerational transmission is highly accessible to all eating disorder practitioners. Many of our service users are women and a rising number are mothers (Tuval-Mashiach et al., 2013). This is where we can immediately impact the rate of diffusion. By directly targeting the needs of this population we promote the chance of effecting change. This is a role for Counselling Psychologist within eating disorder services. It is widely agreed that psychological resources are often scarce (Kagan, 2007). This further enhances the validity of developing effective group interventions, as there may be a percentage of participants that do not require subsequent treatment, without compromising the quality of care provided. This has implications for tailoring individual therapy to better meet the identified needs: It is clear that psychoeducation and exploration of the mother's experience of feeding her child may positively affect treatment outcomes.

Specific recommendations for promoting the improved treatment of mothers with eating disorders and their families will be encapsulated below. Eating disorder services can routinely address the parenting complexities that mothers with eating disorders face, as outlined in this study and other relevant literature. As identified previously, the mothers' eating disorder impacts on the entire family unit. Treatment services can use this understanding to create more effective care in individual therapy, parental support groups and child support groups. Staff, patients and their families require psychoeducation specifically addressing the experience and needs of mothers with eating disorders. This information can be empowering, as it may provide comfort and affirmation that their experience is one shared by others. The interventions could include, but are not limited to, support groups that helps parents talk to their children about their mental health, as well as groups to support children in digesting this information in a safe and contained environment. As a novel treatment care pathway, both support and therapeutic groups could be offered to mothers with eating disorders and their families, targeting the needs identified and initiating a discourse on parenting with mental health difficulties and transgenerational transmission.

### 4.7 Reflections

My engagement with this research topic has personally affected me I in numerous ways, some of which I will discuss here. My interest in both the psychology of parenting as well as eating disorder treatment has profoundly impacted my current career direction. I

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have accepted a permanent position within a specialist eating disorder team to further my understanding of our service users and to pursue the implementation of the group interventions discussed in this research. Additionally, I plan on undertaking a systemic training in the future so I can more fully develop my ideas about mental health transgenerationally.

Furthermore, the notion of conflict that underpinned the thematic development in the analysis is a concept that has resonated within my personal life. Explored within my personal therapy, my own experience of conflict as a woman between my career aspirations and my desire to be a mother has evolved as a topic of frequent reflection. Feeling pulled in two different directions was a feeling that I could empathize with intimately. Like the participants in the current study who were calling out for the support of those with shared experiences and an understanding of their specialized needs, I sought the confidence of other women who have been and are currently in a similar position to my own.

### 4.8 Concluding Notes

The mothers who took part in this study seemed to be experiencing a great degree of conflict over the needs of their child and the needs of their eating disorder; with each side experiencing satisfaction and dissatisfaction. The content of the interviews primarily centred on the concept of managing this conflict. This manifested as coping strategies, both effective and ineffective. Despite extreme emphases on food, shape and weight

among the participants, the paramount concern remained the welfare of their child. Though at times overshadowed by the demands of the eating disorder, the desire to be a 'good enough' mother was steadfast.

The findings of the current study compliment recent investigations of the implication of parenting with an eating disorder. As this body of evidence grows, so does the argument for implementing an intervention aimed at targeting these specific needs.

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**Appendix A**
**City University Ethics Release Form**

# Ethics Release Form for Student Research Projects

All students planning to undertake any research activity in the School of Arts and Social Sciences are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal clearly stating aims and methodology**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department or the Schools does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2009) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- **Students are not permitted to begin their research work until approval has been received and this form has been signed by Research Supervisor and the Department's Ethics Representative.**

## Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

D.Psych

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

An eating disordered mother's experience of feeding her child:
An Interpretative Phenomenological Analysis.

2. Name of student researcher (please include contact address and telephone number)

Katherine Kalinowski

███████████████
██████████

3. Name of research supervisor

Fran Smith

4. Is a research proposal appended to this ethics release form?
   Yes

5. Does the research involve the use of human subjects/ participants?    **Yes**

If yes,
a. Approximately how many are planned to be involved?

6-8

b. How will you recruit them?

Potential participants will be notified of the research project by their care coordinator within their regular contact at the ███████████████ Eating Disorder Service, via an information sheet. It will be made clear in this initial contact that their decision to participate or not, will have no effect on their ongoing treatment. If they express an interest in participating, they will consent to their contact details being passed on to the researcher, by signing the information sheet. I will then contact the potential participants and conduct a brief telephone screening to assess their suitability for participation. Following this conversation, if the individual and I agree to their suitability and the potential participant is still interested, then we will arrange a time to meet for the interview. The interviews will take place in either the Watford or Hitchen location of the service, depending upon where the participant is engaged in treatment.

   c. What are your recruitment criteria?
(Please append your recruitment material/advertisement/flyer)

The recruitment criteria for this study is as follows:
1) The participant must be a mother (biological, adopted, foster)
2) The participant must have a diagnosed eating disorder
3) The participant's child or children must live at home
4) The participant must be able to communicate verbally, in English (due to the phenomenological nature of the research method)

d. Will the research involve the participation of minors (under 18 years of age) or vulnerable adults or those unable to give informed consent?                No

> Based on the definitions provided below, and using mine and my supervisors' clinical judgement, participants will be considered to be vulnerable adults if their ability to give written consent is questionable.
>
> "Any person of 18 or over who is or may be in need of community care services by reason of mental or other disability, age or illness and who is, or may be, unable to take care of himself or herself against significant harm or serious exploitation."
> Department of Health (2000 )No Secrets. www.doh.gov.uk/scg/nosecrets.htm
>
> The Safeguarding Adults ADSS Guidance further defines a vulnerable adult as someone who is unable to retain independence, well being and choice and to access their human right to live a life that is free from abuse and neglect.
> ███████   Interagency Procedure for the Protection Vulnerable Adults (Safeguarding Adults from Abuse) and Essential Guidance  nww.hpft.nhs.uk

d1. If yes, will signed parental/carer consent be obtained?
       Yes          **No**

d2. If yes, has a CRB check been obtained?
       Yes          **No**
(Please append a copy of your CRB check)

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? (If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).

> Each participant will be asked to engage in a semi-structured interview on the research topic. This will take place in one session, lasting between 60-90 minutes.

7. Is there any risk of physical or psychological harm to the subjects/ participants?
                                                                      **Yes**

If yes,
a. Please detail the possible harm?

> There is no foreseeable risk of physical harm to the participants.
>
> There is a minimal risk of psychological harm occurring, due to possible distress arising from the sensitive nature of the interview material. This will be minimised by numerous factors, including the fact that the researcher is a Counselling psychologist in training, and thus able to assess the participant's mental state throughout the interview. The participant will also be informed at the start of the interview to stop if they are experiencing an unmanageable amount of psychological distress. Furthermore, the interviews will take place within a location with which they are familiar and in a setting where they have contact with other clinical services and professionals. Other members of the participants care team, including psychologists, psychiatrists and therapists will be on site in the rare case of an emergency or risk situation.
>
> Time burdens on the participant will be minimised by making an effort to arrange the interview at a time convenient to the participant.
>
> Additionally, the participants will be made aware on numerous occasions that they are entitled to withdraw from the research with no consequences to their care.

> As a counselling psychologist in training, I will be continually holding in mind the welfare of both the participant and her child/children throughout the research process. Acting from a cautious stand point, I am to balance the potential positive and useful outcome of the study with the potential distress of participants effectively. Furthermore, as the research is taking place within the eating disorder service, all participants are supported by multidisciplinary clinicians.

b. How can this be justified?

c. What precautions are you taking to address the risks posed?

> As mentioned above, the study is well supported by experienced supervisors, both within City University and the clinical service itself. My work on site will be overseen by Dr ████████ (Clinical Psychologist, ████████████████████████) who is highly experienced in working with this particular population. The interviews will take place within this familiar setting to the participants and in near proximity to members of their care team, should the unlikely need arise for a more in depth debrief or intervention
>
> Furthermore, all participants will be thoroughly debriefed following their interview, and given the opportunity to raise any questions or concerns. At this point, all participants will be reminded to contact myself or a member of their care team if they feel distressed.

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

Yes

(Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

9. Will any person's treatment/care be in any way be compromised if they choose not to participate in the research?

No

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

Yes

If no, please justify

If yes please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

Both the consent to contact and the consent to participate forms (which will have the participants names and phone number) will be kept securely (in a locked desk drawer) and separately from the audio recordings. The audio recordings will be transcribed into a secure home computer that is password protected. The audio recordings will be deleted immediately following transcription. At this point, all identifying details will be removed within the transcribed material and be identified by participant number only.

## 12. What provision will there be for the safe-keeping of these records?

As mentioned above, the consent forms containing identifying information will at all times be kept separately from the audio recordings/transcripts and under lock and key. Furthermore, the recordings will be deleted as soon as transcription occurs onto a password protected computer. All identifying details will be changed or removed from the text.

## 13. What will happen to the records at the end of the project?

All records (transcripts and consent forms) will be destroyed following the prescribed waiting period of a study involving nhs participants.

## 14. How will you protect the anonymity of the subjects/participants?

All unnecessary identifying details will be removed in the transcribing process and participants will be allocated a number for my identifying purpose only. As the consent forms and transcripts will be kept separately and names/identifying details removed, the participants anonymity will be protected completely.

## 15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

A post research debrief will take place for each participant individually following their interview. At this time they will be encouraged to raise and questions or concerns. Furthermore, they will be reminded to contact myself or a member of their care team should they require further support. This would be a simple process as the interviews will take place on site and the appropriate clinical professionals will be made aware of their client's participation.

(Please append any de-brief information sheets or resource lists detailing possible support options)

If you have circled an item in **underlined bold** print or wish to provide additional details of the research please provide further explanation here:

Signature of student researcher

*Katherine Kalinowski*        Date *November 23, 2012*

**CHECKLIST**: the following forms should be appended unless justified otherwise

Research Proposal
Recruitment Material
Information Sheet
Consent Form
De-brief Information

## Section B: Risks to the Researcher

1. Is there any risk of physical or psychological harm to yourself?
   No

If yes,

a. Please detail possible harm?

b. How can this be justified?

c. What precautions are to be taken to address the risks posed?

## Section C: To be completed by the research supervisor

(Please pay particular attention to any suggested research activity involving minors or vulnerable adults. Approval requires a currently valid CRB check to be appended to this form. If in any doubt, please refer to the Research Committee.)

Please mark the appropriate box below:

Ethical approval granted

Refer to the Department's Research and Ethics Committee

Refer to the School's Research and Ethics Committee

Signature
_____
Date--------

## Section D: To be completed by the 2nd Departmental staff member (Please read this ethics release form fully and pay particular attention to any answers on the form where **underlined bold** items have been circled and any relevant appendices.)

I agree with the decision of the research supervisor as indicated above

Signature
_____
Date -------

**Research:**
The Experience of feeding her child for Mothers with an Eating Disorder:
An Interpretative Phenomenological Analysis.


You are invited to take part in this research study. Before deciding if it is right for you, I would like to tell you a bit about why the research is being conducted and what it will involve. Please read the following information carefully and feel free to discuss it with whomever you wish. If you have any questions or concerns, please contact the researcher (details provided at the end of this information sheet). Thank you.

**Part 1:**

**Why is this research happening?**

Previous research has shown that maternal eating disorders often affect the family dynamic. It is thought that a mother's eating disorder may influence her thoughts, feelings and behaviours surrounding the experience of feeding her child.

To date, no research has explored what it is like for the mother to engage in feeding behaviour (i.e. cooking, shopping, preparing, spoon feeding) with her child, while experiencing an eating disorder.

**Why have I been invited to take part?**

Taking part in this research is entirely voluntary. Mothers within the service who have a child or children living at home are being invited to participate in this research.

If you decide to take part in the research but then change your mind at any stage, you are free to withdraw. A decision not to take part or withdraw from the research will in no way affect the standard of care you receive from the ███████████████ Eating Disorder Service.

**What happens if I take part?**

If you decide to take part, I will first contact you by phone to discuss the research further and for you to ask any questions. If both you and I agree that it is appropriate for you to participate, we will arrange a convenient time for you to come into the service and be interviewed. You would meet with me for an interview about your experiences of feeding your child, as a mother with an eating disorder. The interview questions are not designed to be difficult and there are no right or wrong answers. I am simply interested in your experiences from your personal viewpoint. The interview will usually take between 60

and 90 minutes. At the end of the interview you will have the chance to ask any questions about the research, the interview or what happens next.

The interview will be audio-recorded and later transcribed. Once it has been written up the audio recording will be destroyed.

**What are potential disadvantages of taking part?**

Any potential disadvantages or risks in taking part in this research are considered to be minimal. In the unlikely case that you feel distressed (e.g. very sad, anxious, etc.) during or following your participation, it is important that you contact myself and your care coordinator within the service to voice your concerns. After the interview, I will also check in with you regarding your experience of speaking about this topic and any feelings that may have arisen.

**What are the potential benefits of taking part?**

As mentioned previously, no research has yet explored the experience of feeding your child as a mother with an eating disorder. Therefore, taking part in this research will help improve how this aspect of motherhood is understood and supported in treatment.

Furthermore, the interview process may provide you with an additional space to reflect on your experiences, which some people find useful.

This completes PART 1 of the information sheet. If you are interested and considering giving consent to participate, please read PART 2 before deciding.

**PART 2:**

**What if there is a problem?**

If you have any queries or complaints about the research, prior, during or after, please contact the researcher, who will do her best to answer any of your questions in consultation with Dr Fran Smith (Counselling Psychologist and research supervisor at City University London) and Dr ███████████ (Clinical Psychologist and research supervisor at the ███████████████ Eating Disorders Service). If you are unsatisfied with the response and wish to complain formally, you can do this through the NHS Complaints procedure. Details can be obtained from any NHS service.

**Is this research confidential?**

All information collected about you during the research will be kept strictly confidential in accordance with the 1998 Data Protection Act. Any information about you that leaves the interview room will have your name and personal information removed so that you cannot be identified from it. Ethics requirements stipulate that the researcher must keep

all material related to this research for a maximum of five years. During this time, the information will be kept safely and securely and in a way that would not allow for you to be identified. After the five years has passed, all information will be destroyed.

Furthermore, the researcher will abide by the code of ethics outlined by the British Psychological Society. If at any time during the research process, I become concerned for the safety of a participant or child mentioned, I will use my clinical judgment to decide whether to step outside the bounds of confidentiality and contact the relevant services. The participant would be informed if such concerns were to arise.

**What happens when the research has finished?**

The interviews will be analysed, and written up as part of my doctoral thesis project and may potentially be published. All information and quotes taken from interviews will be anonymised.

**Who is organising and funding the research?**

This research is part of a doctoral project being carried out independently, as part of my studies at City University London. The project is part of my qualification and is not funded by the ▮▮▮▮▮▮▮ Community Eating Disorder Service.

**Who has approved this study?**

Before the research begins, it has to be approved by a Research Ethics Committee within City University. They make sure that the research is ethical and safe for both the participants and researcher. This project has additionally been approved by a London NHS Ethics Committee.

**Researcher's contact details:**

Katherine Kalinowski ▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮
Trainee Counselling Psychologist
City University London
Northampton Square London EC1V 0HB

**Research supervisor's contact details:**

Dr. Fran Smith ▮▮▮▮▮▮▮▮▮▮▮▮▮▮
Chartered Counselling Psychologist
City University London
Northampton Square London EC1V 0HB

**Thank you for taking the time to read this information sheet. This is your copy to keep.**

**Appendix C**
**Consent to Contact**


## Research

The Experience of feeding her child for Mothers with an Eating Disorder:
An Interpretative Phenomenological Analysis.


I am interested in participating in the research about my experience of feeding my child
as a mother with an eating disorder.

I give permission for the researcher to contact me by telephone regarding my
participation.

Name:
.......................................................................................................................................

Contact telephone number:
.......................................................................................................................................

Signature:
.......................................................................................................................................

Thank you for your interest,

Researcher and Trainee Counselling Psychologist
Katherine Kalinowski
City University London
Northampton Square London EC1V 0HB

**Appendix D**
**Consent Form**

<div align="center">

**Research:**
An eating disordered mother's experience of feeding her child:
An Interpretative Phenomenological Analysis.

</div>

☐ I have read and understand the information sheet for the above mentioned research.

☐ I have had the opportunity to consider the information and ask questions.

☐ I am aware that I may contact the researcher for further information or with concerns.

☐ I understand that my participation is voluntary and that I am free to withdraw at any time and without my care being affected.

☐ I understand that this interview will be audio-recorded and later written up.

☐ I understand that this interview is part of a doctoral research project and that anonymous quotes may be published in a thesis and/or article.

☐ I understand that the information I provide will be confidential and that all material will be stored securely and anonymously and will be destroyed after 5years.

☐ I understand that at any point if the researcher feels that my safety or that of a child may be at risk she will contact the relevant professionals and potentially need to break confidentiality.

☐ I agree to participate in this research

_____ _____ _____
Name of participant Date Signature

_____ _____ _____
Name of researcher Date Signature

**Research:**
The Experience of feeding her child for Mothers with an Eating Disorder:
An Interpretative Phenomenological Analysis.


Sometimes, after talking about our experiences, we can find ourselves being more upset than usual and thinking more about the things we talked about. Should this happen to you, please do not hesitate to contact someone for additional support.

• You can contact your care coordinator within the service and/or speak to your psychologist about your concerns.

• You can contact your GP. It is best to discuss your concerns with your GP and they will be able to take further action if necessary.

• You can contact The Samaritans, 24 hours a day, 7 days a week. They specialize in supporting people who are experiencing distress and despair. Their telephone number is 08457 909090

If you ever feel so distressed that you consider causing harm to yourself or to others, please go immediately to your GP practice and request an emergency appointment. If you feel this way when the GP practice is not open, go to A & E of your nearest hospital and they will arrange for you to meet with someone.

If you have any further queries please do not hesitate to contact the researcher on the above number.

Yours Sincerely,

Researcher and Trainee Counselling Psychologist
Katherine Kalinowski
City University London
Northampton Square London EC1V 0HB

**Appendix F**
**Interview Schedule**

**Research:**
An eating disordered mother's experience of feeding her child:
An Interpretative Phenomenological Analysis.

1. Can you tell me what roll your eating disorder plays in your life currently?

       Possible Prompts: How does it affect your day to day functioning? Family life?

2. How aware do you think your child/children are of your eating disorder?

       Possible prompts: Do you speak to them about it (or they to you)? What do
       you/they say?

3. What involvement do you have in food preparation for your child/children (i.e.,
shopping, cooking) and what is it like for you?

       Possible Prompts: How do you find it? What thought/feelings can you recall?

4. How is feeding yourself different or similar to feeding your child/children?

       Possible Prompts: What are your feelings about feeding yourself? About feeding
       your children?

5. Please describe in as much detail as possible an experience of feeding your
child/children?

       Possible Prompts: Thoughts? Feelings? If difficult, how do you cope? If easy,
       why do you think?

6. Are there any challenges that you face in feeding your child as a mother with an eating
disorder?

       Describe.

**Appendix G**
**Ethical approval letter**

12 September 2013

Mrs. Katherine Kalinowski


Dear Mrs. Kalinowski

**Study title: Mothers with eating disorders' experiences of feeding
their children: An Interpretative Phenomenological Analysis**

**REC reference: 13/EE/0317**
**IRAS project ID: 128142**

The Research Ethics Committee reviewed the above application at the meeting held on 09 September 2013. Thank you for attending to discuss the application.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Manager Ms Tracy Leavesley, NRESCommittee.EastofEngland-Norfolk@nhs.net.

**Ethical opinion**
The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

**Ethical review of research sites**
NHS Sites The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

**Conditions of the favourable opinion**
The favourable opinion is subject to the following conditions being met prior to the start of the study.

1. The committee would like the researcher to consider offering to reimburse out of pocket travel expenses for participants.

**You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.**

**It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

**Approved documents**

The documents reviewed and approved at the meeting were:

Evidence of insurance or indemnity City University London
Interview Schedules/Topic Guides 1 20 August 2013
Investigator CV Katherine Kalinowski
Letter from Sponsor Signed by Carmai Pestell 15 July 2013
Other: CV Dr Fran Smith
Other: Protocol Summary 1 20 August 2013
Other: Consent to Contact 1 20 August 2013
Participant Consent Form 1 20 August 2013
Participant Information Sheet 1 20 August 2013
Protocol 1 05 August 2013
REC application 128142/491613/1/579 07 August 2013
Referees or other scientific critique report Unsigned


With the Committee's best wishes for the success of this project.

Yours sincerely

**Dr Michael Sheldon**
**Chair**

Email: NRESCommittee.EastofEngland-Norfolk@nhs.net

**Appendix H**
**Exemplar of stage two and three of analysis**


Scanned copy of a transcript section, with initial noting and emergent themes.

Um, mealtimes. Um, yeah that's the main one but my whole life is or my brain is just preoccupied with food and mealtimes the whole time.

**And I guess this, you've kind of answered, family life how is that affected?**

Um, yeah I mean the boys know I've got a problem. They don't know the term anorexic. Um, but yeah I don't like having other people round to eat with us. And if we do I don't eat.

*Respondent laughs*

Um yeah, so it does affect them. ...

**OK. Thank you. Um, how aware do you think your boys are of your eating disorder?**

Very.

**And how do you know that?**

Um, they know that if we do eat together they know I can't stand it if they're too noisy. They know that I get upset around food. They know that I find it hard to eat. And sometimes if I say to them, oh I've eaten a lot, they'll say well done, mummy, that's so good, um yeah.

**And do you speak to them or they to you about it directly?**

Sometimes. Not massively because I don't want it to completely take over for them. Um, but no I do talk to them about it and

**What do you say and what do they say?**

If I've *snapped* I'll say, look you know, I'm really sorry. I know, you know it's because I'm finding it really hard to eat at the moment and they say yeah, it's OK. And they'll hug me and, but I'm also very aware of not letting or trying not to let my bad relationship with food rub off on them. Um, and that's hard and because if they make any comment, things like, well my son this morning he had three Weetabix for breakfast. And he said, oh I'm going to get so strong. I'm going to be really strong and then he put the wrong school trousers on that were too tight. And then he was like, oh no, I've eaten too much. I've been eating too much. I'm getting fat. And immediately I was and you're not getting fat. You're, you know you eat well. You need to eat well. You need energy. These trousers are just too small and, you know, I kind of overcompensate. Um, and um, I've come to think that I can't or shouldn't comment on anything they eat because my relationship with food is so wrong, um, even though I mean my, I suppose my anorexia is not kind of typical in the way that I've been obsessed with healthy fads over in the past. And if it's one fad it's another and then, ugh, so I try really hard now not to comment on anything they eat or if they ask me for anything I just say, yeah you can have it. Or instead of like, you know, no you

*words/phrases in italics may not be accurate*

2

*... indicates inaudible words/phrases*

*Transcribed by:* ████████

*Handwritten left margin:*
- Food rules for self + kids
- Repitition of key words
- true self vs. kid-friendly version

can't have pudding if you don't eat anymore of your potato or whatever because how can I, you know. I just feel like I haven't got the right to comment on what they eat at the moment.

*Handwritten right margin:* • Can't impose food rules on kids. too many for self? "have the right" • Repitition of "healthy" ↳ trying to convince herself?

**So you've kind of stepped back from commenting at all?**

Um yeah, completely. And they are healthy. They're healthy boys and they've not got any weight problems or anything, um, but yeah

**So what are some of the other things that either you say to them or they say to you about the eating disorder?**

Um, they ask me why I'm so thin. I don't get undressed in front of them anymore, um.

*Handwritten right margin:* • Avoiding showing self to kids

**And how do you respond when they say those things?**

I just say I need to eat properly. I don't eat properly. Um, and that sort of because they're quite, the, the younger two are really sporty and, and I used to be really into exercise which was another like obsession. But now I haven't got the energy to exercise properly. Um, and yeah they sort of say why aren't you strong anymore? Why don't you go running anymore? Why don't you do this anymore? And I just have to say, well you know I haven't got the energy at the moment because I haven't eaten enough. Yeah.

*Handwritten right margin:* Simplified for self or kids. • Not Strong

**OK. Thank you for that. Um, what's it like for you as a mother who also has an eating disorder**

Umhum.

**To feed your children?**

Um, it's OK. Um, it's not, yeah I kind of find that OK because I mean I'm vegan anyway and have been for years and years. And they're not. The eldest one has chosen to be vegetarian which is, you know it pleases me.

*Handwritten right margin:* Following Mum? ↳ pleased

*Respondent laughs*

But that's from an ethical point of view. But, um, no feeding them is fine. I mean I try and make them balanced meals and, you know, things that they enjoy.

*Handwritten right margin:* • Clarify, pleased balanced + enjoy both unable to do for self

**And what does it feel like emotionally or**

Yeah. Good, I want them to be well fed and I want them to have nutritious meals and, yeah.

*Handwritten right margin:* • Contradicts how she treats self. conflict

*Handwritten left margin:* Copying Mum

*Handwritten left margin:* Contradiction – • Me vs. them • different standard

**So it just feels good and nurturing?**

Yeah. Yeah.

**Um, what do you think the issues are for mothers with eating disorders in terms of feeding their kids?**

**Appendix I**
**Exemplar of stage four of analysis**

The table illustrates cluster themes, with associated emergent themes and quote references.

| Cluster Themes | Emergent Themes | Page/Line | Key Words |
|---|---|---|---|
| Eating Disorder as illness | • Mum describing the ED as a bad relationship with food<br>• Mum experiencing remorse/apologizing for ED<br>• Mum's experience of identifying her eating as disordered to kids | • 1.12<br><br><br><br>• 2.24<br><br><br><br>• 12.37 | • bad relationship with food<br><br>• I'm really sorry<br><br><br>• I'm ill, isn't good |
| Eating Disorder as omnipresent | • Mum experiences ED as taken over her life<br>• Mum is preoccupied with ED | • 1.26<br><br><br>• 2.1 | • completely, everything<br><br>• whole life, whole time |
| Kids awareness of ED | • Mum's perception of her kids awareness of her ED when socially eating<br>• Mum's response to it being too noisy when trying to eat<br>• Mum being upset around food<br>• Mum recognizing that the kids praise her for | • 2.7<br><br><br><br><br>• 2.16<br><br><br><br>• 2.17<br><br><br>• 2.18 | • other people, don't eat<br><br><br><br>• can't stand it<br><br><br>• hard to eat<br><br>• well done |

| | | | |
|---|---|---|---|
| | eating | | |
| | • Mum's perception of the kids being accepting of her ED | • 2.26 | • its ok |
| | • Mum's perception of the kids awareness of her body | • 3.9, 8.11 | • why I'm so thin |
| | • Mum' experience of her kids questions re ED | • 3.11 | • thin, strong, energy |
| Contradiction | • Mum's experience of the double standard for self and kids, and explores her right to parent | • 2.3, 12.9, 2.38, 6.1, 6.22, 8.40, 11.22 | • shouldn't comment, haven't got the right, parenting less, portions, five a day |
| | • Mum reflects on the conflict between herself and others, the concept of do as I say, not as I do | • 3.30, 13.1, 14.10, 11.17, 11.20, 8.39 | • balanced meals, enjoy, healthy, unhealthy, no pleasure |
| | • Mum described ED's effect on kids as minimal (says not big deal, describes big deal) | • 2.21, 4.2, 4.10, 4.31, 5.1, 8.2, 8.30, 9.13 | • sometimes, try not to emphasize food, not really, weekly plan, don't mind, fine, ok, had a lot of fat, scales, normal |
| | • Mum uses food as metaphor (conflict between meaning for mum and kids, juxtaposition) | • 2.16, 9. 2, 9. 12, 9.24, 10.25 | • food is upsetting, food is reward, food is fun/good for kids nut not mum, food is medicine, |

| | | | |
|---|---|---|---|
| | | | food is comfort for kids and pain for mum, food is enjoyable for kids, opposite for mum, mixed messages |
| Role reversal | • Mum describes kid's behaviour as parental in nature<br><br>• Mum experiences chid-like reaction to food and meal times | • 2.18, 8.2<br><br><br><br>• 5.14, 7.11, 8.15, 11.2 | • well done, that's good<br><br><br><br>• chuck it in the bin, hard to stay sitting down, noticed, jumping up, distraction |
| Kids copying mum | • Mum experiences kids as acting out her ED pathology (preoccupied with food, shape and weight)<br>• Mum describes kids liking being the same as mum | • 2. 32, 3.26, 8.6, 5.33, 3.26, 8.29, 11.30, 12.12, 13.13,13.2, 13.35<br>• 5.27, 12.1 | • I've eaten too much, I'm getting fat, vegetarian, vegan, weigh himself, enjoys cooking, shouldn't have, fat today, a lot of fat, don't like that, convince to eat, talk about food, carbs, energy, not going to have, strict<br>• same, 5 apples |
| Mum as separate/isolated | • Mum experiences herself as different from family/others | • 10.32, 12.31, 12.37, 13.7 | • didn't eat, sat with , pushed it around, different, I'm |

| | | | |
|---|---|---|---|
| | • Mum describes drive to pretend to be normal | • 12.28, 5.17 | ill, not good, not same as them<br>• act normally, prefer not to eat with them, important to all sit down |

**Appendix J**
**Exemplar of stage six of analysis**

The table illustrates the overarching and superordinate themes for individual participants,

with page and line numbers to indicate quotes.

| Theme | Cluster | Participant | Page/Line |
|---|---|---|---|
| Conflict between the eating disorder and the role of parenting | • Eating disorder as everything<br>• Kids' awareness of eating disorder (Mum is upset around food)<br><br>• Contradiction between self and others (kids can eat but I can't)<br><br>• Kids' behaviour as parental<br>• Kids copying mum' behaviour<br><br><br><br><br>• Mum avoiding family meal times | Amy | • 1.26, 2.1<br><br>• 2.17<br><br><br><br>• 3.30, 13.1, 14.10, 11.17, 11.20, 8.39<br><br>• 2.18, 8.2<br><br>• 2.32, 3.26, 8.6, 5.33, 3.26, 8.29, 11.30,12.12, 13.13, 13.23, 13.35<br><br><br>• 5.12, 7.14, 7.19, 11.2, 7.13 |
| | • Mum hides her feelings from her family<br>• Feeding children as 'job', describes disassociation<br>• No food rules for children | Beth | • 1.21, 3.14, 5.4, 6.20, 9.6, 10.20, 11.26, 12.8<br><br>• 3.35, 11.12, 10.24, 11.1, 11.25<br><br>• 4.1, 5.9, 5.19 |
| | • Eating disorder has taken over family | Claire | • 2.12, 4.19, 5.10, 6.13, 6.24, 10.36, 16.9 |

| | | | |
|---|---|---|---|
| | • Relationship between mum's ED and daughter's ED | | • 4.9, 9.15, 1.26, 6.32, 1.29, 2.4, 2.18, 4.13, 7.21 |
| | • Impact of mum's ED on family | | • 7.23, 7.31, 13.17, 19.22, 2.32, 20.6, 21.32 |
| | • Mum's guilt for being contradictory | | • 8.2, 19.22, 13.26, 13.29, 14.2, 22.18, 15.15, 15.27, 16.1, 21.2 |
| | • Mum hiding self from family | | • 9.9, 22.13, 11.35 |
| | • Eating disorder as everything | Deb | • 1.26, 3.29 |
| | • Different standard for self and kids | | • 3.42, 4.22, 7.1, 1.27, 6.39, 7.4, 7.29, 7.35, 8.3 |
| | • Isolating self from family | | • 2.11, 2.40, 4.5, 4.31, 6.31, 6.36 |
| | • Mum coping wither fear of ED transmission to children | | • 3.36, 2.12, 9.15, 9.19 |
| | • Family meal times as difficult | | • 8.23 |
| | • Eating disorder as most important | Emma | • 4.36, 5.31, 8.17, 10.22, 12.28 |
| | • Eating disorder as escape from family | | • 2.16, 9.44 |
| | • Mum as different from family, isolated | | • 2.18, 4.33, 7.1, 7.3, 9.40, 10.1 |
| | • Meal times as battle | | • 2.31, 10.30, 11.6 |
| | • Eating disorder in | | • 5,25, 7.46, 3.34, |

| | | | |
|---|---|---|---|
| | entire family | | 4.9 |
| | • Conflict between parenting and ED | | • 9.6, 9.21, 11.9 |
| | • Mum acting out ED on children | | • 8.26, 8.40, 11.29, 15.1 |
| | • Consumed by ED | Farrah | • 1.16, 2.1, 1.25 |
| | • Family meal times as overwhelming | | • 2.7, 3.12, 6.21, 2.5, 2.15, 4.26, 7.31, 9.1 |
| | • Confusion between normal children's behaviour and ED symptoms, child as parent | | • 4.3, 2.26, 5.16 |
| | • Impact of ED on kids | | |
| | • Mum hiding herself from her family | | • 2.8, 2.36, 3.3, 4.14, 4.19, 7.7, 9.32 |
| | • Mum's fear of transmission | | • 2.16, 3.1, 4.35, 5.10, 8.2, 9.45 |
| | • Contradiction between standard for self and children | | • 3.5, 5.17, 3.12, 5.30 |
| | | | • 3.28, 4.40, 6.14, 6.17, 7.36, 8.4, 9.24 |
| | • Impact of ED on kids | Gail | • 2.10, 2.17, 3.22, 4.13 |
| | • Being secretive and deceptive | | • 2.12, 6.32, 3.17, 3.20, 3.35, 4.27, 7.12 |
| | • 'Do as I say, not as I do' | | • 2.8, 5.13, 6.12, 7.37 |
| | • Conflict between needs of children and needs of ED | | • 2.21, 2.32, 3.2, 4.2, 4.7, 4.39, 5.2, 5.8, 5.10, 5.36, 6.22, 7.6, 7.27, 4.15, 5.18 |
| | • Panic of family | | • 2.33, 4.23, 5.20, |

| | | | |
|---|---|---|---|
| | • meal times<br>• Worry over transmission<br>• Parental guilt for having ED | | • 5.26<br>• 3.30, 7.40, 8.4<br><br>• 3.35, 6.22, 6.37 |
| | • Eating disorder is always there<br>• Conflict between children and ED<br><br>• Double standard<br><br><br><br><br>• Child as parent<br><br><br>• Transmission as 'worst nightmare' | Hope | • 1.3, 1.20<br><br>• 2.9, 2.25, 2.28, 2.32, 3.2, 4.31, 10.26, 10.30<br><br>• 4.22, 9.10, 9.19, 9.25, 9.28, 9.33, 10.4, 10.11, 10.21, 10.41<br>• 3.22, 4.7, 4.8, 4.38, 4.42, 5.13<br><br>• 4.32, 5.20, 5.25, 5.31, 5.32, 6.10, 6.16, 6.20, 6.22, 7.14, 8.9 |
| Mothers guilt | • Eating disorder as everything<br>• Kids' behaviour as parental<br>• Kids copying mum' behaviour<br>• Mum avoiding family meal times | Amy | • 1.26, 2.1<br>• 2.18, 8.2<br>• 2.32, 3.26, 8.6, 5.33, 3.26, 8.29, 11.30,12.12, 13.13, 13.23, 13.35<br>• 5.12, 7.14, 7.19, 11.2, 7.13 |
| | • Mum's experience of guilt | Claire | • 8.2, 19.22, 13.26, 13.29, 14.2, 22.18, 15.15, 15.27, 16.1, 21.2 |
| | • Guilt for feeling like a not good enough mother | Deb | • 6.36, 2.12, 7.1, 8.3, 2.11, 2.40, 4.5 |
| | • Guilt for allowing ED into family | Emma | • 3.34, 4.9, 4.34, 8.26, 11.29, 15.1 |
| | • Blames self for child's behaviour<br><br>• Guilt for letter | Farrah | • 2.8, 2.36, 3.3, 3.5, 3.12, 4.40, 8.4, 9.24<br>• 5.21, 7.10, 7.19 |

| | | child see ED | | |
|---|---|---|---|---|
| | • Feeling guilty for lying to family and for ED interfering | Gail | • 3.35, 6.22, 6.37, 7.40, 8.4 |
| | • Guilt that ED has impact on kids | Hope | • 10.41, 3.22, 4.7, 4.8, 4.38, 4.42, 5.13 |
| Boundaries | • Kids' behaviour as parental<br>• Kids copying mum' behaviour | Amy | • 2.18, 8.2<br><br>• 2.32, 3.26, 8.6, 5.33, 3.26, 8.29, 11.30,12.12, 13.13, 13.23, 13.35 |
| | • Disassociation between self and baby<br>• No food rules for kids | Beth | • 3.35, 11.12, 10.24, 11.1, 11.25,<br>• 4.1, 5.9, 5.19 |
| | • Relationship between mum's ED and daughter's ED<br>• Impact of mum's ED on family | Claire | • 4.9, 9.15, 1.26, 6.32, 1.29, 2.4, 2.18, 4.13, 7.21<br><br>• 7.23, 7.31, 13.17, 19.22, 2.32, 20.6, 21.32 |
| | • Compensating for self-restriction by allowing kids anything | Deb | • 1.21, 3.29, 1.27, 6.39, 7.4, 7.29, 7.35, |
| | • Mum acting out ED on children | Emma | • 8.26, 8.40, 11.29, 15.1 |
| | • Boundaries between normal children's behaviour and ED symptoms, child as parent | Farrah | • 4.3, 2.26, 5.16 |
| | • Mother's ED having direct impact on kids | Gail | • 2.10, 2.17, 3.22, 4.13 |
| | • Child as parent, role reversal | Hope | • 3.22, 4.7, 4.8, 4.38, 4.42, 5.13 |

| Parenting as contradiction | • Contradiction between self and others (kids can eat but I can't) | Amy | • 3.30, 13.1, 14.10, 11.17, 11.20, 8.39 |
|---|---|---|---|
| | • Feeding children as 'job', describes disassociation<br>• No food rules for children | Beth | • 3.35, 11.12, 10.24, 11.1, 11.25<br><br>• 4.1, 5.9, 5.19 |
| | • Mum being contradictory | Claire | • 8.2, 19.22, 13.26, 13.29, 14.2, 22.18, 15.15, 15.27, 16.1, 21.2 |
| | • Conflicting standard for self and kids | Deb | • 3.42, 4.22, 7.1, 1.27, 6.39, 7.4, 7.29, 7.35, 8.3 |
| | • Conflict between parenting and ED | Emma | • 9.6, 9.21, 11.9 |
| | • Contradiction between standard for self and children | Farrah | • 3.28, 4.40, 6.14, 6.17, 7.36, 8.4, 9.24 |
| | • 'Do as I say, not as I do'<br>• Conflict between needs of children and needs of ED | Gail | • 2.8, 5.13, 6.12, 7.37<br>• 2.21, 2.32, 3.2, 4.2, 4.7, 4.39, 5.2, 5.8, 5.10, 5.36, 6.22, 7.6, 7.27, 4.15, 5.18 |
| | • Conflict between children and ED<br><br>• Double standard<br><br>• Child as parent | Hope | • 4.22, 9.10, 9.19, 9.25, 9.28, 9.33, 10.4, 10.11, 10.21, 10.41<br>• 3.22, 4.7, 4.8, 4.38, 4.42, 5.13<br>• 4.32, 5.20, 5.25, 5.31, 5.32, 6.10, 6.16, 6.20, 6.22, 7.14, 8.9 |
| Transgenerational transmission | • Mum seeing worrying food behaviour in kids | Amy | • 2.32, 3.26, 8.6, 5.33, 3.26, 8.29, 11.30,12.12, 13.13, 13.23, 13.35 |

| | | | |
|---|---|---|---|
| | • Eating disorder has taken over family | Claire | • 2.12, 4.19, 5.10, 6.13, 6.24, 10.36, 16.9 |
| | • Relationship between mum's ED and daughter's ED | | • 4.9, 9.15, 1.26, 6.32, 1.29, 2.4, 2.18, 4.13, 7.21 |
| | • Impact of mum's ED on family | | • 7.23, 7.31, 13.17, 19.22, 2.32, 20.6, 21.32 |
| | • Mum coping wither fear of ED transmission to children | Deb | • 3.36, 2.12, 9.15, 9.19 |
| | • Eating disorder in entire family | Emma | • 5,25, 7.46, 3.34, 4.9 |
| | • Mum's fear of transmission | Farrah | • 3.5, 5.17, 3.12, 5.30 |
| | • Worry over transmission | Gail | • 3.30, 7.40, 8.4 |
| | • Transmission as 'worst nightmare' | Hope | • 4.32, 5.20, 5.25, 5.31, 5.32, 6.10, 6.16, 6.20, 6.22, 7.14, 8.9 |

**Appendix K**
**Table of Recurrent Themes by participant**

|  | Amy | Beth | Claire | Deb | Emma | Farrah | Gail | Hope | Present in over half the sample? |
|---|---|---|---|---|---|---|---|---|---|
| Overarching Conflict | YES | YES | YES | YES | YES | YES | YES | YES | YES |
| Guilt | YES | NO | YES | YES | YES | YES | YES | YES | YES |
| Boundaries | YES | YES | YES | YES | YES | YES | YES | YES | YES |
| Contradiction | YES | YES | YES | YES | YES | YES | YES | YES | YES |
| Transmission | YES | NO | YES | YES | YES | YES | YES | YES | YES |

# Section B: The Publishable Piece

# 4.0   Journal Article

This article is intended to be submitted for publication to the European Eating Disorders Review. I have selected this publication as it is the professional journal of BEAT, the leading UK charity for individuals with eating disorders and their families as well as has a reputation for investigating avenues of prevention and related health policy. The European Eating Disorders Review focuses on material contributing to innovation and best practice in treatment and diagnosis.  Please see appendix for publication guidelines.

# Mothers' With Eating Disorders Experiences of Feeding Their Children

Katherine Kalinowski, Fran Smith & ███████████

**Research Location:**

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**Abstract**

The experience of mothers with eating disorders was examined through the lens of the parental responsibility of feeding their children. The participants were interviewed using qualitative methods and the data was analysed using an Interpretive Phenomenological Analysis. One overarching theme and four main themes emerged.

The overarching theme was a "Conflict between the eating disorder and the role of parenting". The four main themes were: guilt regarding the interaction of the eating disorder and the children; extremely rigid or none existent boundaries between the eating disorder, the mother and child; contradictory parenting regarding the ability to act as a role model while having a double standard; and the fear of transgenerational transmission.

This study extended knowledge in the field and emphasised the importance of addressing the parenting complexities that mothers with eating disorders face. Recommendations were made for treatment advances and areas for further research were highlighted.

**Introduction**

Eating disorders have major physical, psychological and social consequences (Hjern et al., 2006), often characterized by a poor quality of life (De la Rie et al., 2007) and a high health burden (Mond et al., 2009). Though the 'poor quality of life' and 'high health burden' are attributed to the individual sufferer, these adverse complications often seep into the immediate family, including children (Stitt & Rupert, 2014). Existing literature

has illuminated a universal understanding that the children of mothers with eating disorders are an 'at risk' group (Park, Senior & Stein, 2003; Patel et al. 2002). This population has been singled out for an increased risk of feeding disorders, developmental disturbances and the eventual development of an eating disorder (Watkins, Cooper & Lask, 2012).

According to the literature, mothers with eating disorders report feeling guilty, depressed and anxious, as a result of their disorder and its effect on their ability to parent. Because eating disorders are often characterized by an over evaluation of food, shape, weight and their control, when they occur alongside motherhood, the risk of difficulty in feeding their children may increase (Agras, Hammer & McNicoles, 1999). Numerous studies (Agras, Hammer & McNicoles, 1999; Stein et al., 1994; Park, Senior & Stein, 2003) have indicated that mothers with eating disorders experience a variety of difficulties in feeding their children: The most prevalent being their internal struggle between the needs of their child and the voice of their disorder.

The impact of maternal eating disorders on eating behaviour in early childhood has found, as compared to a non-eating disordered control group, the index population tend to engage in more unregulated feeding practices and express more concern over their daughters' weight (Agras, Hammer & McNicholas, 1999), show increased rigidity at mealtimes (Evans & Le Grange, 1995), manage their children's intake (for fear of them overeating) (Russell et al., 1998), and encourage weight loss in their young children (Agras et al., 1999). Evidence suggests that a mother's awareness of her dysfunctional

behaviours may lead to a general improvement in her eating disorder and subsequently a greater ability to meet her child's needs (Barnett, Buckroyd & Windle, 2005).

The phenomenon of parenting with an eating disorder, particularly food preparation and provision, appears to be complex and present an array of difficulties. The vitality of this research hinges on its unique perspective as a phenomenological introspection into a seemingly fundamental act of parenting: providing sustenance for your child. The study aims to illuminate the mothers' experience of feeding her child whilst having an eating disorder. By better understanding the inner workings of this phenomenon, practitioners may gain insight to more efficient paths to recovery for both the mother and her family.

**Methodology**

*Participants*

Participants were recruited from the ████████████████ Eating Disorder Service in the UK and met the diagnostic criteria for Anorexia Nervosa or Bulimia Nervosa (including atypical variations). Eight mothers with at least one child living in their home chose to take part. The children ranged in age from 0-25.

*Analysis*

Eight, one-to-one, semi-structured interviews were carried out with the participants. An Interpretative Phenomenological Analysis (IPA) method was applied to the transcribed interviews and the data was assessed according to this procedure (Smith, Flowers & Larkin, 2009). IPA is firmly rooted in its phenomenological foundation, and primarily

attends to the ways in which humans experience their world and gain knowledge (Willig, 2013). Smith et al. describe this process as double hermeneutic; the researcher is trying to make sense of the participant trying to make sense of their experience (Smith, Flowers & Larkin, 2009).

**Results**

All participants expressed the overarching theme, while the 4 main themes (1-4) were consistently present in the majority of the sample. Not all of the sub themes were applicable to each participant.

*Overarching theme*

The overarching theme that emerged from the data was a 'conflict between the eating disorder and the role of parenting. This is the thread of continuity that connected the subjective experiences described by the eight women who participated in this study. Though expressed through diverse content and style, the mothers' struggle between her eating disorder and her function as a parent was universally echoed in all accounts. Hope poignantly described this as:

"…two warring parts of myself" (Hope, 2.27).

The two parts she is referring to are what she later describes as her "eating disorder head" and her "mother head", which are in constant competition for her attention (Hope, 5.4). Each participant described a similar phenomenon, as either an overt or covert friction.

*Main theme 1: mothers' guilt*

Participants described their children's inevitable exposure to their eating disorder behaviour as 'guilt inducing'. The mothers' primary source of this feeling seemed to be the self-identified 'subpar parenting' that they were inflicting upon their children as a result of the consuming nature of their disorder. Farrah succinctly expressed the sentiment that many of the mothers alluded to when she said:

"I feel guilty because I'm just too wrapped up in my own problems" (Farrah, 7.19).

Farrah described the egocentrism that often accompanies eating disorders: The immense portion of psychological and physical energy that is consumed by the eating disorder leaves little space for other entities to flourish. Many of the mothers expressed concern and guilt that they were not giving their children enough of themselves. Gail expressed this feeling when she said:

"I guess that if you could you wouldn't feed them, you know, but obviously you're going to, um, so yeah I would think really with that its guilt that you're not doing it properly, or you're not doing it as well as you know you would if you were well" (Gail, 6.22).

Gail referenced the eating disorder part of herself that would rather not feed her children. Though she went on to clarify that she would never act on this thinking, she felt guilty for simply bringing the thought into existence.

*Sub-theme 1.1: Predominance of the eating disorder for the mother*

Emma described herself as, "living in the world of anorexia", which her children, by default, cohabitate (Emma, 12.28). The all-consuming nature of eating disorders makes for a difficult bedfellow with the all-consuming nature of parenthood.

*Sub-theme 1.2: Mother hiding self and eating disorder, resulting in isolation*

The concept of normalcy was mentioned frequently throughout the interviews, and was conceptualized as the 'holy grail' of motherhood. Gail described going to the extent of leaving fake dirty dishes around the house to help falsify her claim of regular eating. Deb emphasized the importance of acting normally with food in front of her children; this idea of presenting a brave face or a façade was common amongst the mothers. Emma, Farrah and Gail spoke about wearing a disguise in front of their children, in an attempt to keep distance between them and their eating disorder. Farrah spoke about the brave face she put on when trying to instil the importance of sharing in her toddler. Farrah said:

> "She'll try and feed me her chocolate buttons…I don't
> really want them…I have them because I don't want to say
> no to her and, because she's trying to share, but at the same
> time I feel quite annoyed with her" (Farrah, 4.35).

The emotional strain this creates was palpable, as Farrah's eyes became teary when she said:

> "I want to burst into tears, and I have to try and hold that
> back" (Farrah, 8.1).

Farrah brought to life the difficulty of being pulled in two different directions by her eating disorder and her role as a mother. The desire to shield their children from the eating disorder was unanimously present in all of the participant's accounts. This predominantly resulted in a form of deception, be it lying or secrecy, so that at least to a certain extent, the eating disorder remained the mother's private domain.

*Main theme 2: Boundaries between the eating disorder, mother and child*

The content of the eight interviews centred on the interaction of three primary components: the mother, her eating disorder and her children. For each individual, the specific dynamics varied greatly. The mothers described their boundaries between the three components as either rigid or lacking any differentiation among the parts.

*Sub theme 2.1: Extreme presentation of boundaries as either rigid or indistinct*

The mothers, who described their experience as highly bounderied, expressed a strict distinction between themselves as eating disorder sufferers and themselves as mothers. Most commonly, this resulted in the mothers' acknowledging an ability to nourish their children in a way that they are unable to do for themselves. Claire spoke about the discrepancy between feeding herself and feeding her children: Though she was unable to feed herself adequately, Claire described providing balanced meals for her children. This is an example of the rigid boundaries she has constructed in an attempt to control the interaction between her eating disorder and her children.

Another portion of the participants described indistinct boundaries between herself, the eating disorder and the child. There was a common sense of enmeshment or diffuse boundaries in these individual accounts. The 'overcompensation' presented itself as the mothers' way of mitigating her own food restrictions by applying no food rules to her children. Both Deb and Deb spoke of wanting their children to have better relationships with food then they had themselves. Deb said:

> "I would never make food a reward, I would never make
> food an issue, and I would let them have access to
> whatever food they liked" (Deb, 1.12).

Deb is clearly trying to differentiate her children's experience with food from her own: The reality of it seems to be a complete lack of boundaries in an attempt to counteract the rigidity of her eating disorder.

*Sub theme 2.2: Role reversals amongst mother and children*

An additional presentation of diffuse boundaries emerged amongst participants, in the form of role reversals between mother and child. The majority of the mothers described incidents where they experienced being parented by their child. The most prominent example of the mothers taking on the role of the child was the extreme reactions they described in relation to food and meal times. Deb spoke about her difficulty with family mealtimes when she said:

> "I find that really hard if I'm eating with them and there's
> quite a lot of friction I just get really, because I get quite
> panicky anyway eating. And I just want to pick up mine
> and chuck it in the bin" (5.14).

This extreme reaction to the strain of a family mealtime exemplifies the extreme capriciousness she experiences.

Additionally, the mothers described instances of their children encouraging them to eat and then praising them for their effort; this is more typically seen in the reverse, from parent to child, in mealtimes where an eating disorder is not present. Hope described her child's involvement with her eating:

> "…she praises me when she thinks I've done well…she might ask me what I've eaten" (4.8).

This is a clear example of the child taking on the parenting role when it comes to encouraging and monitoring her mother's eating. Emma described an extreme example of this when she spoke of her children's encounter with the force of her eating disorder:

> "I've been really unwell, starved for days and they've done everything to coax me to have a sip of water and none of them could ever persuade me. I called it my window sill syndrome that the anorexia head could be so strong that if my boys were standing on a windowsill, and I love my boys with all my life, if they were standing on a windowsill and said, Mum, we're all going to jump off unless you just have a sip of water because you need it so badly, I could still not have a sip of water" (10.40).

Clearly no amount of praise or persuasion was a match for the eating disorder in this case: Emma was locked inside her eating disorder, with her children unable to break in. She was not the only mother to describe instances when her eating disorder was

impenetrable, even by the profound love and commitment they expressed for their children.

*Main theme 3: The mothers' experience of parenting as being full of contradiction*

The theme of contradictory parenting was expressed by the majority of mothers, as questioning their ability to adequately act as a role model while having a double standard for themselves and their children. This is best illustrated by the juxtapositions the mothers used to describe the contradictory nature of feeding themselves versus feeding their children. Emma spoke of feeding herself as "hell", while the experience of feeding her children was "pleasing": She made sense of this stark contrast by explaining that "I could live through my denial by feeding other people" (10.51, 8.22, 8.8). The two sub-themes are represented by the mothers' concern that her difficulties deem her an unsuitable role model for her children, and the exploration of the double standard inherent in their 'do as I say, not as I do' approach to parenting.

*Sub-theme 3.1: Questioning her right to be a role model*

This sub-theme was most apparent in the mothers' concern that the presence of her eating disorder somehow nullified their 'right' to parent their children, as well as brought into question their suitability as a role model. Deb explained:

> "I've come to think that I can't or shouldn't comment on anything they eat because my relationship with food is so wrong" (2.38).

Deb was exploring if her disordered relationship with food implied that she was incapable of being involved in that aspect of parenting her children. The impact of this exploration could result in her removing herself from this parental domain; Deb potentially experienced herself as a not 'good enough' mother, in this regard.

*Sub-theme 3.2: Double standard, 'Do as I say, not as I do'*

Many of the mothers managed the conflict between the drive to be a role model for their children and the power of the eating disorder by adopting a 'do as I say, not as I do' approach to parenting. The prevailing coping mechanism was explained by both implicitly and explicitly differentiating their disordered behaviour from how they fed their children. The mothers readily expressed a knowledge and dedication to providing balanced nutrition for their children. This was where the, 'do as I say, not as I do' motto comes into play, as the children were often not provided with a sound dietary role model, but rather a set of un-exemplified instructions.

Here Farrah addresses the source of this discrepancy, in that she is able to provide nice food and all that that represents (perhaps love, nurturing, care) to her child, but struggles to allow herself that same psychical and emotional nourishment. Deb echoes this same conflict when she explores the different value she attributes to herself and her children. In speaking of her children she says:

> "…they're far more important and if I've got, they have the best of everything and I will get the leftovers or the crap" (7.29).

She went on to say:

> "…they're allowed to eat properly, I'm not allowed to eat properly" (7.35).

This set of statements seemed to cut to the heart of the issue; by categorically differentiating mother and child qualitatively, it became more acceptable for the mothers to live the double standard. This conceptualization seemed to allow Deb to attend to the needs of her children while neglecting her own.

*Main theme 4: Fear of transgenerational transmission of the eating disorder*

Many of the mothers spoke of their determination not to pass on their eating disorder to their children. Recognizing both the genetic and observational components of transmission, all of the mothers voiced their concerns that they would inevitably be unable to provide a firm enough partition between their eating disorder and their children.

Deb spoke about her own experience of transgenerational transmission, when she reflected on her childhood with a mother who had an eating disorder. This situation was not unique amongst the mothers, three of whom specifically mentioned that they thought their own mothers, fathers or grandparents had disordered relationships with food. The participants' experience of the fear of transgenerational transmission of their eating disorder to their children was expressed in two primary veins; the first being the mothers' experience of how aware her children were of her disorder and the second, the mothers' observing the impact that her eating disorder has had on her children.

*Sub-theme 4.1: Children's awareness of the eating disorder*

The majority of participants acknowledged their children's' awareness of their eating disorder and the potential ramifications of this perception. Even the mothers of toddlers noted their children mimicking their disordered behaviour, while the mothers of older children experienced more direct evidence of their awareness in the form of probing questions, scolding and preoccupations with food, weight and shape. Emma addressed the culture of diet and preoccupation with food that existed within her immediate and extended family. She reflected:

> "I live in a family with five people constantly watching what they eat, constantly talking about it, almost feeling guilty about over eating that's very, very difficult when you're on the other spectrum" (3.34).

For Emma, her primary concern was to help her children cope with their difficult relationships with food: When speaking of her husband, she said:

> "He says all of them have an issue because of me" (15.1).

*Sub-theme 4.2: Impact of the eating disorder on the children*

The transgenerational transmission of eating disorders is a topic that many of the mothers found difficult to address, as feelings of guilt and remorse were prevalent, particularly when the mothers recognized their own disordered behaviours being mirrored by their children. The mothers expressed a palpable fear that they were potentially responsible for this developmental spanner in their children's growth. Deb recounted numerous instances where her children seemingly acted out her eating disorder behaviours: For example,

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> "…when my scales were in the bathroom he used to weigh himself and then he started saying things like, oh I weighed myself before breakfast. Now I've had breakfast I'm going to weigh myself again and see if I'm the same weight" (8.6).

Deb described this experience as "horrendous" and recognized the behaviour as her own (8.11). In isolation this account may seem innocuous, however knowing the environment in which they are occurring, lends itself to the interpretation that the mothers' behaviour is directly impacting the children's view of food, shape and weight.

## Discussion

The primary aim for this research was to illuminate the mothers' experience of feeding her child whilst having an eating disorder. More specifically, the research promoted an exploration into the meaning of the fundamental parenting activity of feeding a child for an individual who experiences a difficult relationship with food, shape and weight themselves.

### *Overarching Conflict*

Many studies have ventured to identify the range of specific difficulties that mothers with eating disorders face within their parental role. A common thread amongst investigations is the mothers' internal struggle between the needs of their child and the voice of their disorder (Agras, Hammer & McNicoles, 1999; Stein et al., 1994; Park, Senior & Stein, 2003). Mothers with eating disorders were observed to be less facilitating and more intrusive in both mealtimes and play with their children (Stein et al., 1994). Stein et al.

identified that among the index group, mealtimes were characterized by conflict between mother and child (Stein et al., 1994). In the current study, the mothers' struggle between her eating disorder and her duties as a parent was described as warring parts of herself, a battle between the voice of her eating disorder and her desire to mother her children.

In 2014, Stitt and Rupert produced a qualitative investigation of the challenges of parenting as a mother with an eating disorder. This study looked broadly at the many aspects of parenting, while the current study focused on the primary act of feeding. Interestingly, the emergent themes from both studies share many commonalities: Although the current investigation was aimed towards the specific phenomenon of feeding, the participants unanimously used the interview space to speak more broadly to the complex infiltration of the eating disorder into all aspects of parenting.

With that in mind, the mothers simultaneously employed a profound pragmatism in their general ability to identify their parental deficits and develop resources to assist them in meeting their children's needs. Stapleton et al. spoke about the mothers' sourcing formal childcare to potentially reduce the burden of maternal feeding as well as exposing the children to alternative food role models (Stapleton, Fielder & Kirkham, 2008). Similarly, the current research identified a comparable resourcefulness, with the majority of participants both recognizing their limitations and engaging their partners and extended family members in parental support.

*Guilt surrounding interaction*

Guilt was a common theme in research examining the impact of maternal eating disorders on the ability to parent and the impact that the disorder has on the children (Micali et al., 2011; Barnett, Buckroyd & Windle, 2005). This was true to the current research, as the majority of participants expressed a feeling of guilt that their eating disorder was affecting the wellbeing of their child on various levels. In 2008 Koubaa et al. used the Maternal Adjustment and Maternal Attitudes scale (MAMA) to evaluate maternal adjustment and attitude of a cohort of mothers with eating disorders. They found that their index population responded affirmatively more frequently when asked if they regretted having their baby and replied negatively when asked if they enjoyed feeding their baby. In accordance to the sample within the current study, such responses are guilt inducing for the mother, who identified her maternal adjustment as 'abnormal' or 'not right'. Such self-depreciation may lead to feelings of parental inadequacy and disengagement. This guilt was prevalent throughout the analysis, linked both to a sense of deficiency, in terms of what they are unable to provide as a mother with an eating disorder, as well as supplementary, pertaining to the added influence of the eating disorder in the parental dynamic.

*Boundaries*

The majority of participants in the current study described either enmeshed or rigid boundaries as a means of managing the interaction between the mother the eating disorder and the child. Additionally, role reversals between mother and child were prevalent bidirectionally with the child parenting the mother as well as the mother

experiencing infantilisation.

Ackerson reported that boundary issues are prevalent among parents with mental illness, with mothers describing a desire to make up for their disorder by being lax and having overly close relationships with their children (2003). Both enmeshment and permissive boundaries were consistently unearthed among participants of the current study. Additionally, a portion of the sample spoke about their use of structure and rigidity as a means of compensating for the above mentioned tendency towards extreme leniency.

Franzen and Gerlinghoff (1997) identified three mother-child patterns of relating when an eating disorder is present within the mother-child dyad: The first is a relationship characterized by being overprotective and enmeshed; the second, a role reversal, where the child parented their mother; and the third, the mother presents as emotionally controlled and distant towards their child. These relational models are samples of varying boundary discrepancies between the mother, child and eating disorder. Each of the typologies described above was present in the current study.

*Contradiction*

The third main theme of contradictory parenting was characterized in the analysis by the acknowledgement of a double standard. The majority of mothers questioned their ability and right to enforce guidelines on their children that they themselves cannot abide. This was most clearly demonstrated by the mothers who spoke about providing balanced meals for their children, while they binged and purged, or feeding their kids regularly,

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while they were not allowed by their eating disorder to eat until 8pm. Such contradiction left the mothers questioning their parental authority and aptitude.

*Transmission*

The literature suggests that a relationship exists between maternal eating disorders and adolescent disordered eating (Field et al., 2008; Pike & Rodin, 1991), and that maternal eating disorders are associated with childhood eating problems (Micali, Simonoff & Treasure, 2009; Stein et al., 1994). This supports the notion that eating disorders tend to aggregate in families (Park, Senior & Stein, 2003). Often based on learned behaviour, case studies have indicated that from an early age, children mirror their mother's eating disordered behaviour, and that the daughters of anorexic mothers wish to be as thin as their exemplar and imitate their attitude towards food (Franzen & Gerlinghoff, 1997; Timimi & Robinson 1996).

In the current study, the mothers' fear of this type of transmission was expressed unanimously. Bryant-Waugh et al. identified this theme in their 2007 analysis as the mothers' concern that they would pass on traits of their disorder to their offspring. In the current study, all of the mothers spoke of their fear of passing on elements of their eating disorder to their children. This trepidation took many forms amongst the participants in this study and throughout the literature: The primary consistency was the extreme effort that mothers exerted in an attempt to keep their dysfunctional behaviour from negatively impacting the development of their children.

*Additional Findings*

The current study identified two sub themes that were scarce in previous literature. These findings may offer a unique vantage point from which to approach treatment with this specific population. The majority of the sample in the current study directly spoke about their identity in relationship to their eating disorder. This often took the form of a sense of isolation from their family and friends due to the secretive nature of their illness. The participants described hiding their thoughts, feelings and behaviours from their loved ones in a complicated effort to both protect their family from the disorder and the disorder from scrutiny and potential destruction by the family.

This isolation left the mothers starved for true contact: They experienced a paradox of wanting to keep the details of their eating disorder a secret while needing to share its burdensome load. This theme, encompassing both the isolation of her true self and the paradox of her exposure, may have a profound impact on the nature and direction of therapeutic input. It seems that the eating disorder often acts as a wall, serving to keep the family a safe distance from the sufferer. A therapeutic intervention that gingerly invites the family to join the mother on her side of the wall may provide a stronger front from which to tackle the eating disorder.

The second finding involves the relationship between multiple eating disorders within one home. This was identified in one particular participant's experience ('Claire'). Her interview was an account of the relationship between her and her daughter's eating disorders. As described in more detail within the analysis, Claire was unable to reflect

upon her experience as a mother with an eating disorder, but rather focused on her experience of being a mother with an eating disorder to a daughter with an eating disorder. The content of our interview centred on her experience as a career for her daughter, with little space for Claire's introspection. This dynamic appeared to be a function of the family's coping strategy: The daughter's eating disorder allowed Claire's to thrive in the background, while the daughter, potentially, identified with her mother's method of procuring care by being ill, which she adopted as her own. The relationship between the two eating disorders is a potent example, captured in this study, of the systemic nature of the illness. This synthesis provides insight into the power struggle of a parent and child's eating disorder, perhaps indicating a need for family interventions targeting such dynamics.

**Implications for research and practice**

Family therapy is the number one recommended, evidence based treatment methods for child and adolescent eating disorders (NICE, 2004). The development of systemic therapeutic models, such as the Maudsley model, has been developed to treat anorexia nervosa in adolescents, within a family context (Lock, 2011; Rhodes, 2003). It is widely acknowledged that family therapy is the superlative mode of eating disorder treatment, as compared to individual therapy, for the child and adolescent population (Keel & Haedt, 2008). There is lapse in research exploring the efficiency of family therapy among adults with eating disorders (Bulik, Baucom, Kirby, & Pisetsky, 2011).

The recovery model suggests that treatment within a system of support, including family,

friends and professionals promotes meaningful and lasting personal growth. It follows that, potentially, treating adult eating disorders from a systemic family approach may provide a higher level of support to the client, as well as addressing the prevalent relational complications (some of which were explored above). Previous research has identified that family and other social systems significantly impact adult individuals' onset, trajectory and recovery of eating disorders (Linville, Stice, Gau, & O'Neil, 2011).

In addition to a shortage of data on family therapy for adults with eating disorder, limited data exist on therapeutic approaches for couples affected by eating disorders. Bulik et al. (2011) developed a model called Uniting Couples in the treatment of Anorexia Nervosa, or UCAN, which applies a cognitive behavioural couple's therapy (CBCT) model. The primary aim of the treatment is to unite the couple as a team, working towards a shared goal of recovery (Bulik et al.). Though this model is specifically adapted to working with couples, it is not a big leap to infer a similar principle could be applied in the larger family unit. The current study further confirms the complex and multi layered dynamics that are inexorable when an eating disorder infiltrates a family unit.

*Eating disorder services*

As far as I am aware at the time of writing this, there are no specifically designed support or treatment groups for mothers with eating disorders and their families in the UK. The evidence presented suggests that this is a viable and potentially valuable intervention. The participants in this study were interested in the research and the meaning of impending outcomes. They wanted to know if their experiences were shared, how others

managed in similar situations and how to better cope with their difficulties. Barnett, Buckroyd and Windle (2005) suggest that a mother's awareness of her dysfunctional behaviours (and the reasons behind them) can induce generalized improvement in her eating disorder and parental functioning. By addressing the needs identified by the mothers in the current research and pertinent studies prior, the introduction of specialized group interventions (be it support or therapy based) as an aspect of treatment may induce clinical benefits. If the aim of eating disorder treatment is to reduce risk and minimize the impact of the disorder on the service user, then as practitioners we are obliged to unearth and implement safe, effective and novel pathways towards this goal.

*Prevention*

The current government campaigns for health and fitness, though vastly beneficial, are also highly one sided towards obesity prevention. With the incident of eating disorders on the rise, little is being done on a large scale to tackle the obvious hurdles of thin-promoting media and a culture permeated by a dreaded fear of fatness. Although some campaigns do exist that promote healthy and varied body images, for example Dove's 2003 advertising campaign 'Campaign for real beauty', this move away from the thin-ideal remains in the minority. Perhaps these socio-political and cultural issues too considerable to tackle here; however, on a smaller scale, prevention, in the form of reducing transgenerational transmission is highly accessible to all eating disorder practitioners. Many of our service users are women and a rising number are mothers. This is where we can directly impact the rate of diffusion.

*Limitations of the current study*

A limitation of the current research is the small scale of the study. This potentially had multiple implications on the outcome, some of which will be discussed below. All of the participants interviewed were being treated within the same specialist NHS service. That being the case, individuals from other services may have had different experiences, such as having access to parenting support, thus potentially creating a dissimilar dataset. It may be valuable in the future to explore the target phenomenon across treatment settings in order to gain perspective on a wider range of experience.

A homogenous sample is an important factor in designing an effective IPA study (Smith et al., 2009). The sample in the current study was homogenous regarding the shared index phenomenon, feeding your child as a mother with an eating disorder. However the participants were heterogeneous in other ways including the age of the participants' diagnosis and children's age. Participants were able to reflect on their role as a parent and the impact that their eating disorder has or had on feeding their child: It is this reflexivity that was of the utmost importance to producing rich data. As was revealed throughout the literature, some discrepancy occurs in parenting and feeding practices between the diagnostic groups. However, in the current study, this difference was not accounted for on two bases: First, as disseminated by Fairburn (2008) and Waller (2007), there is strong evidence for a transdiagnostic perspective on eating disorders. Additionally, the current research is interested in the common experience of having a dysfunctional relationship with food and not on the nature of the dysfunction itself. A larger scale investigation could group and compare participants based on the age of their children and diagnosis,

looking at the evolving variances that take place chronologically, as well as potential differences that arise among those experiencing anorexic versus bulimic symptoms.

**Concluding thoughts**

The aim of this study was to assert the importance of addressing the needs of this specific client group. The experience of feeding your child, as a mother with an eating disorder can be addressed throughout treatment, from assessment to discharge. Psychoeducation for staff and mothers, support for families and children, multi family, child and couples groups should, all be evaluated for their efficacy in filling this pathway lapse. Research plays a key role in improving clinical services: The evaluation of family therapy for adults with eating disorders is a prime example of work still to be done towards better serving the clinical needs of our clients.

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